Abstract

This article follows the development and progress of the US Department of Housing and Urban Development’s ‘Healthy and Safe Communities’ initiative as it was implemented by a community empowerment organization during a four-year community revitalization project in the aftermath of the Los Angeles riots. The author explores practical aspects of Community Health Psychology through assessing the ways in which its organizing principles were manifest in community-wide processes of individual and community change in one low-income housing project in South Central Los Angeles called Avalon Gardens. Specifically highlighted is how a group of African American and Latino men in the community created a group forum that helped foster, support and sustain an empowerment process that supported health promotion, health consciousness and significant health improvement in the community.

Keywords

Avalon Gardens Men’s Association, community health psychology, empowerment, men’s health, prevention
IN THE FIELD of community psychology, empowerment is synonymous with health; intervention is manifested in the practice of consciousness raising, health promotion and prevention of stressors underlying chronic health problems. In response to the riots experienced in South Central Los Angeles in 1992, city officials sought a community-based empowerment approach to address both the explosive community crisis and the chronic trauma in the area. A community-based empowerment approach opposes the use of experts handing down advice about individuals’ adjustment to social realities. Rather, the focus is on a collaborative process between service providers and community members to enhance existing community resources and strengths to promote health. Los Angeles city officials contracted the Community Health Realization Institute (CHRI) to implement an empowerment intervention that would address chronic issues such as racism, poverty, intra-racial violence, unemployment, drug/alcohol abuse, epidemic health problems, academic failure and acute problems related to the crisis itself, such as rioting, looting, arson and inter-racial violence. The underlying premise of the CHRI model is that each individual in the community plays an indispensable role in accessing their own personal state of health and well-being and that such states are maximized in collaboration with others in the community (Fischer, 1998; Mills, 1995; Pransky, Mills, Blevens, & Sedgeman, 1996).

This article explores the health-related implications of individual and community change in one low-income housing project in South Central Los Angeles called Avalon Gardens over the course of a four-year field trial. Specifically highlighted is how a group of African American and Latino men in the community formed an organization called the Avalon Gardens Men’s Association (AGMA) that helped foster, support and sustain the empowerment process. AGMA helped establish ongoing and self-sustaining processes of health promotion and health consciousness throughout Avalon Gardens.

It has been suggested that the source of disease and illness may be social in addition to being organic (Davies & MacDonald, 1998; Schorr, 1988; Sullivan, 1964). The process initiated by AGMA supported the amelioration of a community-wide sense of powerlessness, hopelessness and apathy that indicated chronic traumatic experience. These had, intergenerationally, saturated the experience of individuals in the community (Borg, Garrod, & Dalla, 2001), and were likely to be contributing to the community’s chronic health problems. The process of addressing this chronic experience of trauma, in turn, resulted in the formation of a larger community-wide organization that would play a leading role in improving functioning and health among members of the Avalon Gardens community.

Applied community psychology

The concepts and interventions of the general Avalon Gardens project, and the specific work of AGMA was generally derived from current primary prevention and community empowerment theories (Kessler, Goldston, & Joffe, 1992; Mills, 1995; Rappaport & Seidman, 2000; Seidman, 1983). The contextual approach of the empowerment model rested on a view of health as being a reflection of the social, economic and environmental circumstances of the individuals in the community. Community-based health promotion, according to the Ottawa Charter of the World Health Organization, is the process of addressing the interplay of community dynamics and health-related problems at the community or group level (World Health Organization, 1986).

The overriding mission of the CHRI organization was to help community residents to improve overall health and reduce behavioral maladjustment in the community. Prevention guidelines implemented by CHRI are consistent with the understanding of health that underlies the community-based health promotion, in that they are based on a socio-environmental approach that encompasses medical, behavioral and community developmental strategies (Abee, 1991; Labonte, 1992). The guidelines assert a recognition of the different levels of power that groups within a society hold and of the fact that power levels influence the ability of individuals to regulate their own health (de Konig & Martin, 1996). As such, the CHRI intervention was based on initiatives that derived from issues identified from residents of
the community, rather than imposed by the intervention team. Avalon Gardens residents were seen as being integral to the planning, implementation and evaluation of the initiatives.

Further, AGMA was founded specifically on a set of tested community action guidelines designed to foster and support the ongoing process of collaboration among community residents as well as between residents and the intervention team (Berger & Neuhaus, 1977; Borg, 1997; Rappaport & Seidman, 2000). Prior to AGMA’s existence, the intervention team looked for a naturally occurring group with stability, cohesion and strong leadership. The members of the men’s group shared one characteristic that was absolutely essential—they were volunteering to develop and sustain the process of change and growth in the community. There were other groups that shared this characteristic and volunteered to participate in the intervention (e.g. the women, members of the Resident Advisory Council), but the men in the community had traditionally, and stereotypically, maintained an overall group identity that countered this sense of volunteerism and commitment to community development. As such, their voluntary commitment to the program goals was, in and of itself, perceived within the community to be a novel and unexpected preliminary result of the intervention.

Based on a spirit of volunteerism, AGMA was able to build ownership into their organization from the start and they used this to enhance the group’s cohesiveness. Over the course of the four-year project, they were able to promote communication and define their roles, boundaries and expectations. They were able to work through areas of significant conflict between Avalon Gardens and the wider South Central Los Angeles social service community. Ultimatey AGMA provided the cornerstone of an intra-community service structure that would, and did, outlast the intervention while simultaneously increasing the involvement of other community organizations working in Avalon Gardens.

Community in distress

The riots that were sparked by the verdict in the Rodney King police brutality case on 29 April 1992 were perceived by the Los Angeles government to be the equivalent of the ‘presenting problem’ in individual therapy and, as such, resulted in the implementation of a community revitalization program. This program would serve to address both the acute and chronic distress of the community. The intervention addressed a problem specified by recent community health psychology advocates.

Health research findings indicate that a multi-service, community informed practice is critical to meeting health care and human services needs of subpopulations among communities of color. Current health care delivery systems serving these subgroups are grossly inadequate. Therefore, advocacy for these subgroups must be comprehensive and inclusive of clinical, health education, and community services. (De la Cancela, Chin, & Jenkins, 1998, p. 28)

I argue that it was crucial to Avalon Gardens that community health advocacy was grounded upon empowerment solutions that were self-determined, internally driven and collaboratively supported from both inside the community itself as well as from the service agencies in the local community.

Avalon Gardens exists in the center of South Central Los Angeles as a United States Department of Housing and Urban Development (HUD) government subsidized housing project. Avalon Gardens contains 161 housing units and 419 residents. The racial composition of the community is 82 percent African American, 17 percent Latino and 1 percent Caucasian. Forty-eight percent of the residents are men. Eighty-five percent of the residents are on public assistance.

Rather than detail the actual history and development of Avalon Gardens itself, I will focus on the general South Central Los Angeles environment. Avalon Gardens was chosen because HUD considered its population to be representative of the South Central community in general. The following data provide a more chronic indication of the need for intervention not reflected in the ‘presenting problem’ of the riots. These demographic data had been stable over time and reflect the nature of South Central as a ‘distressed community’ (Mills, 1996). According to HUD, this status was, in and of
itself, valid rationale for the implementation of the intervention and the data presented in this summary was, according to HUD, indicative of 'epidemic levels of chronic stress and associated health problems' (HUD, 1997, p. 16).

Of the 22,913 estimated households in South Central, LA in 1995, 65.7 percent had incomes of under US$24,999 (as compared to 30.9 percent county-wide); of the total labor force only 38.6 percent were employed (as compared to 62.2 percent county-wide). Of the population that is 25 years or older, 18.0 percent had a high school diploma or equivalent or more, with 3.3 percent possessing a bachelor's or graduate degree (as compared to 50.0 percent and 22.3 percent county-wide). Thirty-three percent of children from kindergarten to twelfth grade were enrolled in school (as compared to 67 percent county-wide). Of school-age children, 43.6 percent lived in a married couple household, 43.6 percent lived with a female head of household and 12.8 percent lived with a male head of household (as compared to 70 percent, 22 percent, 8 percent county-wide).

In the first three-quarters of 1995, attempted and committed crimes within the police district that included Avalon Gardens numbered 9243. Of those crimes, 2620 (28 percent) were aggravated assaults; 1580 were burglaries (16.8 percent); and 1676 were robberies (17.8 percent). The 71 murders in this period accounted for 10 percent of all murders in the city of Los Angeles.

Based on the assessment of these data, a primary goal of the intervention team was to address how the influence of current models of health policy, public health and health care administration had traditionally served to exclude and disempower communities of color. Whether as a result of under-use, lack of access, poor health education or distrust of the health care system, communities of color have remained underserved and their health care needs have not met with mainstream delivery systems (de la Cancela et al., 1998).

Empowerment

Empowerment theory establishes a wider contextual understanding of individuals inclusive of their multiple biological, psychological, political and social environments. From this perspective individuals are understood to behave within family, community, societal and political contexts as well as within their own psychological make-up, which work together to shape human health (de la Cancela et al., 1998). Therefore, we cannot speak of individual health without recognizing the external stressors that routinely deplete rather than enhance community resources (Hobfoll, 1998).

The practice of community empowerment draws on the work of Freire (1972) who suggested that the key stages in community development practices were as follows:

1. reflection on people's lived reality;
2. analysis and collective identification of the root causes of that reality;
3. examination of the implication of root causes; and
4. development of a plan of action to bring about change.

In this process intervention staff and community residents meet as equals in order to foster a collaborative dialogue based on trust. The combination of empowerment and health promotion was written into the initial CHRI proposal. This was utilized as the foundation for what the USD department of Housing and Urban Development called the 'Healthy and Safe Communities Initiative' (HUD, 1997), and initially manifested in a process of critical consciousness raising around health and safety issues.

From the perspective of community health psychology, physical health and psychological empowerment are interchangeable. Furthermore, in the context of empowerment interventions, the practice of health psychology must be expanded to examine the systems of health care. Psychological health addressed within community intervention must include the influences of chronic illness, infectious disease, transmission of illness; institutional and societal pathologies such as racism, prejudice and internalized oppression; as well as environmental factors, such as exposure to toxic waste and pesticides, and substandard housing. Health care in the context of empowerment theory requires that systems of health care respond not only to the needs and health status of individuals, but also to needs shaped by the different contexts of the communities in which these individuals live (Albee & Gullotta, 1997).
Social policy and change developed from an empowerment perspective requires a redefinition of terms, roles and methods. Professional help that limits itself to experts giving advice about intra-psychic adjustment to current social realities is antithetical to an empowerment approach (Felner, Felner, & Silverman, 2000). An empowerment approach is concerned with identifying already existing resources, enhancing natural helping systems and creating opportunities for participatory decision making of community members. Rather than superficially addressing risk factors, the focus is on enhancing strengths and promoting health (Zimmerman, 2000). The emphasis was not only on what impedes and constrains community growth, but also on what can enhance and mobilize it. Ultimately the aim was to help the community to develop new patterns of interaction, understanding and experience.

Empowerment theory connects individual well-being with the larger social and political environment, and suggests that people need opportunities to become active in community decision making in order to improve their lives and their communities (Gullotta & McElhaney, 1999; Seidman & Rappaport, 1986). Individual participants may develop a sense of empowerment even if wrong decisions are made because they may develop a greater understanding of the decision-making process, develop confidence to influence decisions that affect their lives and work to make their concerns known. Organizations may be empowering even if policy change is not achieved because they provide a setting in which individuals can attempt to take control of their own lives (Cowen, 2000). Communities may enhance opportunities for residents to participate in the policy process even if some battles are lost. A community can be empowered because the citizens engage in activities that maintain or improve their collective quality of life (Speer & Hughey, 1995).

Empowerment is thus a multilevel construct that requires us to think in terms of health promotion and multiple definitions of competence (Rappaport & Hess, 1984). Empowerment is an individual-level construct when one is concerned with intra-personal and behavioral variables, an organizational-level construct when one is concerned with resource mobilizations and participatory opportunities and a community-level construct when socio-political structure and social change are of concern (Borg, Garrod, & Dalla, 2001; Zimmerman, 1995). We can begin to learn about the contexts in which empowerment takes place and the processes by which empowerment develops as we study settings, such as Avalon Gardens, that provide opportunities for natural helping systems to flourish and grow.

**Participatory intervention**

The CHRI empowerment intervention in Avalon Gardens began as a series of workshops that were initiated with the question: ‘What is a healthy and safe community?’ The workshops were designed as a series of educational-participatory forums and led to ongoing group discussions revolving around community health, safety and empowerment. These groups began to meet regularly and sustained ongoing dialogues among community members wherein residents could develop a sense of safety in order to organize the improvement of their community. The facilitators suggested that the residents could define empowerment for themselves, according to their own needs, in such collaborative processes. Within this process the practitioners and invited agency representatives served as witnesses to the internal development of community members, verifying and validating their struggles and supporting the agency and ownership of the residents for their community.

Over the next four years the question of what would make a safe and healthy community reverberated throughout the social fabric of the community. Answering this question would, perhaps necessarily, reveal interactive patterns running throughout the community that maintained the intergenerational transmission of a deeply entrenched sense of anxiety, distrust and futility. This resulted in a community-wide experience of chronic distress that was thought to be an underlying factor in numerous medical and psychological problems inherent in the community. These problems impacted how the residents related to and interacted with each other as well as to the service agency representatives who would prove to be essential to the health initiative component of the intervention. In order to access more productively health-related services, relationships would need to be fostered.
with the agency representatives. As this occurred the question of health in the community transformed into: What systems of care are needed to reach all segments of the community?

Through the workshops and ongoing group meetings, the residents, in their renewed connections with others inside and outside the community, had the opportunity to recreate psychological capacities that were damaged or never fully developed as a result of historical experience of trauma and distress (Garland, 1998; Tedeschi, Park, & Calhoun, 1998). Essential to the intervention was a core group of people, that included members of AGMA, who were hopeful about change, committed to their community and willing to become involved. Whether conscious of these qualities or not, it seemed that the individuals who attended the initial workshops were people who believed that they could make a difference, that change was possible and that the community could be revitalized.

The community as a whole (Avalon Gardens) and its different ethnic and gender subgroups (e.g. African Americans, Latinos/as, men, women, etc.) worked together to influence how individuals operated alone. Different subgroups within the community seemed to be perceived by other subgroups as the ‘cause’ of the community’s problems. However, it seemed likely that the current scape-goating manifest between diverse groups in the community was more symptomatic of the problems than they were causative of the intergenerational picture of the distress in the community. A more long-term goal seemed to be related to how the intervention could mediate between different subgroups in the community. In order for the practitioners to be able to assess and intervene, they often had to be involved actively in the community’s daily activities. In this context, active involvement became the means of deepening awareness of pervasive community interactions and patterns of thinking, feeling, relating and behaving.

After the initial workshop series, some of the men in the community had begun meeting to discuss ways that they might be able to establish a sense of ownership and responsibility for their community. They arranged to meet regularly with the community practitioners on a weekly basis to discuss pertinent issues in the community and to formulate plans for implementing their own empowerment efforts. Soon they began to identify themselves as the Avalon Gardens Men’s Association. The men of AGMA, by focusing on empowerment rather than the pathology of the community, helped open up possibilities for themselves and their community. This aim focused primarily on finding ways to address the serious health risks that members of this community faced on a daily basis.

To address the work of AGMA and the Avalon Gardens community in general, is also to address the ways that this community confronted and worked through a general resistance to change. This resistance formed the basis of the protective yet defensive mechanisms that had, intergenerationally, kept the community in a state of homeostasis that was predictable and familiar, yet stressful and stifling. Many of the health problems related to chronic stress that might have been prevented had been historically ignored in the context of such widespread resistance.

Resistance manifested importantly in interaction patterns among members of the community. The ways that stereotypes of irresponsibility, apathy and laziness that the men in the community, including members of AGMA, were played out by the members themselves was explored in the context of the weekly group meetings. What defensive purpose might such stereotyped roles serve for the men in the community? What fear or anxiety might be sustaining their traditional, albeit unconscious, commitment to sustaining these stereotypes within the community? Might the men, playing out these stereotypes, in some way be lessening the likelihood of them being perceived as a target in such a hostile environment? After all, to be perceived as apathetic or uninvested in community change, a threatening proposition to the community in many ways, is to lessen the odds of being perceived as a threatening person.

To address how the men developed a defensive adherence to these stereotypes, it must be noted that one of the streets that formed the boundary between Avalon Gardens and the surrounding neighborhoods was McKinley. McKinley Street was also the accepted line of demarcation between two powerful rivaling
gangs, the Cripps and the Bloods. Due to consistent eruptions of violence between the rivaling gangs and subsequent, though considerably ineffective, police intervention, this community had a well-established relational pattern, heavily steeped in paranoia and suspicion, set up between itself and the outside world (e.g. service agency representatives, Los Angeles Police Department [LAPD] officers). Members of this community, long before their experience of or participation in the LA riots, lived within a 'war zone'. This was one of the most serious health risks of the community and an issue that had to be addressed prior to the men of AGMA being able to address other health-related initiatives. A member of AGMA stated, 'It's hard to think about the danger of smoking or eating greasy foods when you're fearing for your life'.

It was clear initially that a strong sense of insularity permeated this community. A sense of basic trust in the environment just outside the community’s borders had not been established and this was based on a very real sense of the hostility that surrounded this community. This lack of trust had existed, as far as anyone could tell, for as long as there had been an Avalon Gardens.

When considering the high rate of homicide in the community, it makes sense to view some of the defensive posturing and stereotyped roles of the men in terms of health promotion. Clearly, violence was the most visible and severe health risk for the men of the community. As such, when the men enacted these stereotyped roles, they were in some ways complying with prescribed scripts to preserve safety that had been dealt out to them and thereby unwittingly enforcing the status quo. It is possible that the stereotyped roles of apathy and laziness may have worked to lessen the danger of standing out and being targeted by gang members and the police. However, these enacted stereotypes that were geared to reduce one's risk of being the target of physical violence also instilled a sense of apathy about personal health care. In regard to their physical safety and health the LAPD must be considered the primary health care provider. Yet there were certainly high suspicions about the willingness or the ability of the LAPD to provide such services, and many men regarded the LAPD as playing a significant role in perpetuating violence in the community.

Addressing violence as a health issue was central to the efforts of AGMA members in focusing on health promotion within the community as an ongoing and integral aspect of their overall mission and vision for an ideal community. Health promotion was the general description of what was to be the collaborative project with the other groups in the community. The collaboration aim was also concerned about other health issues such as drug and alcohol abuse, HIV/AIDS prevention, cigarette smoking and dieting habits leading to such problems as heart disease, diabetes and hypertension. When this project was agreed upon, AGMA and the other groups began to hold meetings with local service agency providers to develop partnerships between residents and professionals to meet their health needs.

LAPD officers were among the first to attend meetings to discuss a partnership that would result in a ‘community police’ initiative throughout South Central Los Angeles (deLeon-Ganados, 1999). The community police agenda was viewed from the perspective of health promotion and primary prevention in order to reduce the threat of violence to the health of the men of this community. In the meetings, AGMA members discussed with LAPD officers their perspective that, aside from the fear of ongoing gang warfare, the police officers themselves were generally seen as being a major cause of violence in the community. As such, the initially tense partnership that was formed between AGMA and the LAPD was absolutely essential to forming more widespread and comprehensive approaches to sustaining a health and safety initiative. The first step in the healthy and safety initiative was the formation of a relationship between residents and the LAPD. After all, to address the possibility of a ‘healthy’ community could not be conceived of without first addressing the establishment of a ‘safe’ one.

The alliance formed with the LAPD also became an important entry point to forming relationships between the community and other service agencies. In addition to the LAPD representatives, AGMA invited medical and social service providers into their weekly meetings. AGMA sponsored programs in which service providers were invited to provide education on medically related topics that, according to epidemiological research in the area (Stokols, 1992;
Winett, King, & Altman, 1989), were particularly salient in this community. Topics such as dieting, HIV/AIDS-related high-risk behavior and prevention, education on sexually transmitted disease and teen pregnancy, stress reduction and cigarette cessation were targeted. Topics also included signs, symptoms and risk factors associated with chronic and severe illnesses such as heart disease, hypertension, kidney disease, lung and prostate cancer, substance abuse and related conditions (i.e. cirrhosis, hepatitis, diabetes). AGMA sponsored outreach programs between the community and local hospitals (e.g. King-Drew Medical Center, USC Medical Center), health organizations (e.g. Red Cross, Watts Health Foundation), social services agencies (e.g. Family Preservation Network, African American Unity Center), as well as between local schools, churches and numerous other services agencies that would ultimately join the health and safe communities initiative. Also, related to the historic unavailability of health care for Avalon Gardens residents (Mills, 1996), AGMA began working more closely with a local community-based health care clinic, Unihealth, to form a relationship with this organization that fostered improved access to medical services for community members.

In collaboration with professionals, AGMA members utilized their knowledge of the community collaboratively to identify and analyze local health issues in conjunction with these numerous agencies in order to implement self-determined initiatives. As a result, some service providing agencies began to offer their services within the community. For instance King-Drew Medical Center sent teams out to offer general health screenings and follow-up care and the AIDS Services Foundation offered confidential testing, education and prevention services. As a result, Avalon Gardens had essentially opened its gates to local providers and services agencies that had previously seemed inaccessible. The relationships formed served to create a social environment inclusive of what de la Cancela et al. referred to as an essential ingredient in community health and empowerment initiatives: ‘a culture of interdependency’ (1998, p. 37). The community, as it increased its support and service providing resources, began to describe prevention as a focus for the overall healthy and safe communities initiative as defined by HUD. As such, prevention of illness, early identification of health problems, health education, community outreach, advocacy, health promotion and early intervention were viewed as being essential focus areas that could be addressed through the community’s collaboration with various agencies. Strategies for effective prevention meant forming coalitions that went beyond community boundaries to form relationships with these outside organizations. These coalitions, in turn, were to form important links in the network of comprehensive care that was being developed from within Avalon Gardens, and for which the men of AGMA were key initiators.

**Evaluation**

In the Avalon Gardens intervention there were a number of evaluation or assessment techniques that served as both a means of measuring the outcomes and progress within the community’s general functioning as well as interventions to sustain the empowerment process. In general, Avalon Gardens residents evaluated their own community at several different points throughout the intervention rather than relying solely on practitioners to evaluate progress as outsiders. Taken as a whole, the underlying philosophy for the evaluation procedures chosen were based on the practice of empowerment-oriented participatory action research (Hoshmand & O’Byrne, 1996). Baum describes this evaluative process as:

A spiral process of planning, fieldwork, analysis, reflection, and then a spiraling up to planning again. The spiral analogy is particularly suited to community-based health promotion because it captures its dynamic nature and incorporates the shifting and changing nature of this work. (1998, p. 72)

An assessment process called capacity asset mapping was implemented during the initial site visits to Avalon Gardens. The underlying philosophy of the asset-based approach supports the idea, and practice, of building healthy communities from the inside out, and assumes that even the most devastated communities contain the foundation for their own development (Borg, 1997; Mills, 1995). The asset-based approach
started with people in the community assembling for themselves a full description of their own situation, as well as a comprehensive inventory of their community’s strengths and resources. The intervention team and residents utilized this information to help the community develop new relationships within the community, to frame their own sense of priorities and to determine the extent of need for engagement with outside resources. This process resulted in a partnership with outside agencies, including the intervention team, one in which the community itself would initiate contact and articulate what it needed. This set up a process of self-assessment wherein the people who expect the benefits were able to create their own goals and alliances and evaluate the results of their own efforts. New needs, alliances, projects and goals were continually formulated.

Another assessment technique was the physical quality of life plan. Developing this plan essentially entailed assessing the physical environment, inventorying and recording the current states of buildings, residences and playgrounds, etc. and accounting for changes that were made within the physical structures in the community. Community members utilized this information as a possible point of reference for general progress in the community.

Empowerment-oriented evaluation looks beyond measurable goals and objectives; rather it examines whether a participatory process has taken place that engages people in critical evaluation of the causes of health problems as the basis for community action (de la Cancela, 1995). Practitioners actively sought and encouraged community members’ own impressions of their community as a main source of empirical data on the community itself. Eventually community members became accustomed to their active role in the community intervention and developed a healthy sense of assertiveness in advocating for their own health needs to be addressed. Such participatory evaluation procedures required significant flexibility and inevitably led to some conflicts with the demand for scientific rigor (A llison & Rootman, 1996). However, combining the evaluative skills of the team members with the comprehensive knowledge of local residents proved invaluable throughout the project.

The idea that personal empowerment, as a foundation for community empowerment, is intimately associated with health and well-being has been strongly supported in the literature on empowerment (R appaport, 1986; S cileppi, Teed, & Torres, 2000). The CHR I model that served as a foundation for the AGMA groups specifically focused on empowerment of individuals and communities. Therefore, it can be inferred from the results of this study that there is a strong relationship between one’s sense of empowerment and one’s affective state and one’s general health and well-being. It makes sense that there would be an increase in one’s sense of well-being associated with empowerment training when it has been noted repeatedly that powerlessness is a major source of numerous health-related problems and psychopathology (B loom, 1996; M ill, 1995; S perry, 1995).

This relationship between powerlessness on the one hand, and health and psychological problems on the other, was borne out in the final report to the funding agency. The findings accounted for changes in factors such as health status, criminal behavior, drug and alcohol use, employment rates and violence in the community, as well as the physical characteristics of the community. Each of these factors could be related to psychological and environmental stressors, as well as being related to chronic health problems, and each of these areas showed significant improvement (B org, 1997). Specifically, the report consisted of data collected from residents and service providers working with Avalon Gardens residents and highlighted outcomes that were considered either directly or indirectly related to change in chronic community health problems. Significant outcomes that were considered particularly relevant to HUD’s healthy and safe community initiative were as follows:

1. reported incidence of violence reduced by 43 percent;
2. drug- and alcohol-related incidents reduced by 38 percent;
3. reduced sexually transmitted disease cases by 25 percent;
4. reduced family violence and child abuse by 40 percent;
5. reduced overall crime rate by 35 percent;
6. reduced teen pregnancy by 25 percent;
7. increased health screenings by 32 percent;
8. increased HIV/AIDS testing by 27 percent;
9. reduced unemployment rate by 30 percent; and
10. reduced school truancy and failure by 40 percent (Boyd, 1998, pp. 15–16).

Each of these changes was individually assessed in comparison with baseline data and in comparison with control group and each was shown to be significant at the \( p < .05 \) level (Boyd, 1998, p. 17).

The report described the project’s goals, achievements and failures as well as an overall assessment of the value of the initiative. Five criteria were utilized to assess the overall outcome of the program, and these criteria accounted for some of the flexibility inherent in the initiative’s participatory evaluation methodologies. The criteria were:

1. Efficiency: The report suggested that the participation of residents increased the efficiency of the health promotion initiative as people in the community were responsive to the benefits of initiatives that they helped define and develop.

2. Effectiveness: The increase in health and well-being of the Avalon Gardens community was stated to be more effective because the process allowed residents to have a voice in determining objectives, supporting project staff and making their local knowledge, skills and resources available. As an example, in the final evaluation, it seemed that without the resources offered and sustained through community groups (e.g. AGMA), the intervention, specifically in areas of health promotion, would have resulted in an imposed solution. Therefore, this would have been merely a repetition and confirmation of the powerlessness of this community to attain an internalized sense of agency. Health promotion that is imposed is rarely effective; the idea of an imposed empowerment solution is an oxymoron (Borg et al., 2001).

3. Self-reliance: The fact that members of this community initiated partnerships with local social, medical and political service agencies, including the LAPD, led to the development of an ongoing commitment to HUD’s ‘Safe and Healthy Communities’ agenda. In essence, the work of groups such as AGMA led to the development of self-sustaining health projects, including involvement with consciousness raising and ‘community policing’. This participation within the field of the community’s overall health status, helped to break a cycle of chronic dependency while simultaneously promoting self-awareness and confidence that helped residents to examine their problems and be positive about solutions. It was apparent among AGMA members that their involvement in community development increased their sense of control over issues that affected their lives as individuals and as members in a larger community. This helped create ‘social capital which is the hallmark of a healthy community’ (Baum, 1998, p. 85).

4. Coverage: The inclusion of the men in the community, through AGMA, was acknowledged by community members both inside and outside (agency representatives) as being a case of finding a way to work with, as one agency staff member said, ‘the people who are least healthy’. It was key to the intervention that the program staff were committed, from the start, in involving the residents who had historically been excluded from such opportunities. In the case of Avalon Gardens, there was no doubt that the men had, historically, represented such an excluded group. In fact, a primary concern in the initial stages of evaluation, from the perspective of the local governance was how, or if, the men of Avalon Gardens were going to be willing or able to become involved in the promotion of health in the community.

5. Sustainability: In the Avalon Gardens project, the residents and their interactive patterns were considered the main dynamic of the intervention. Empowerment was shown to be a powerful means of encouraging residents regarding their own potential for health and ongoing development. As such, it seems likely that issues such as health promotion were sustained internally, rather than through imposed solutions or external reinforcements for participation. Sustainability was, from the start, a key factor in ensuring that all program activities, from running groups to evaluation procedures, were of a participatory and collaborative nature.
Follow-up

Upon follow-up in 2000, the members of AGMA had sustained alliances with the other organizations established within the revitalization project. The most significant change occurred within the community service organization that was initiated by AGMA that solidified an alliance between the functioning groups in the community. The alliances formed within the community groups served as the foundation of a resident-driven comprehensive community revitalization organization: the Avalon Gardens Community Service Association (AGCSA). AGCSA provided a formalized means of sustaining the collaborative empowerment process after the intervention was completed. Working in conjunction with an umbrella organization called Community Partners, AGCSA had obtained non-profit organization status and were able to develop and receive funding for their own community service projects. By the end of the intervention, this agency was able to give and receive support to and from other major community revitalization efforts underway in the area. A report compiled by an outside agency and submitted to the funding agency reads:

The emergence of new resident leadership has marked Avalon Gardens with a new vision and renewed hope among residents. This is particularly the case with the adult male population that before now, had almost no presence in community building activities. The most striking of these appears to be exhibited in their commitment to community safety (through their ongoing collaboration with the LAPD’s ‘community police’ initiative) and their commitment to health promotion in the community. The inclusion of the men in the community building process, although initially met with some skepticism by the existing female leadership, now offers a more healthy, mutually respectful relationship between residents of Avalon Gardens residents and their neighbors in the service providing community. (Boyd, 1998, p. 6)

AGCSA, through their links with other community service organizations, eventually formed the Los Angeles Urban Communities Task Force. This task force was to be a vehicle for public health advocacy, prevention of potential threats to community safety and the ongoing promotion of the healing of local distressed neighborhoods.

Conclusion

It has been suggested that the source of disease and illness may be social in addition to organic (Davies & MacDonald, 1998; Sullivan, 1953, 1964). As such, the social participatory element of the Avalon Gardens intervention was crucial to its success. The prescribed and internalized stereotyped roles, specifically manifest in the men in the community, had sustained a sense of isolationism that had to be worked through prior to establishing the possibility of a social intervention that was amenable to the particular character of this community. As this was addressed in group processes and collaboration, a sense of group cohesion began to serve protective functions against stress, isolation and a chronic sense of hopelessness and powerlessness.

By addressing the factors that perpetuated the isolation and actual threats in the community, the men were able to confront traditional means of perceiving their environment as hostile and work toward forming solutions that sustained their commitment to the safety and health of the community. Establishing a functional relationship between AGMA and the LAPD initiated the process of challenging stereotypes as well as creating a partnership for ensuring and taking responsibility for the safety of the community. Once a sense of safety was established through this partnership, the men of AGMA were able to invite other community members and health care professionals into the collaborative process, thus increasing the possibility of establishing an ongoing and self-sustaining practice and commitment to general health in the community.

Embracing the notion of interpersonal functioning, health can be described as ‘a dynamic relationship focused on the physical, social, and psychological well-being of the individual and/or group and their interaction with the physical and social environment’ (Warren, 1998, p. 219). In Avalon Gardens it was clear that threats to health were driven by social, behavioral, economic, cultural and political factors. The history of health and safety problems, such as illness,
sickness, disability, oppression and violence could be viewed as failures of the social system. By addressing itself to the social system, the men in the community, through AGMA, were able to encourage community-wide participation in HUD’s healthy and safe communities initiative. The Avalon Gardens community had sustained a history of seemingly intractable health and social problems. When members of the community were able to work together to collaborate on establishing and maintaining a primary focus on enhancing the community’s well-being, the long-term health and safety of individual community members was able to be optimistically addressed and sustained.

References


CALL FOR PAPERS

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Food, diet and health are key concerns in contemporary society, and people are increasingly aware of what they eat and its consequences for their health. With a rise in interest in food and health across the social sciences, it is timely for health psychologists to consider the food-health nexus.

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Specific issues that could be addressed are: health consequences of eating and not eating; dietary practices and their relation to health; food, obesity and health; food preferences, dietary supplementation and health; health foods, functional foods, modified foods and health; risk, food and health; food allergies and health; understandings of food, diet and health; social constructions of healthy food and diet; social relations, food and health; gender, food and health; media representations of food and health; food, diet and the body.

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