

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

FORMAL AND INFORMAL SUPPORT SYSTEMS IN
A RURAL TOWN AND COUNTY

REPORT OF THE RESEARCH ON MENTAL HEALTH
IN DANNEVIRKE BOROUGH AND COUNTY



A thesis presented in
fulfilment of the requirements for the degree
of Masters
in Philosophy at
Massey University

W. Randolph Herman, M.S.W.

1983

ERRATA

page 7, line 30: "Semmel" should read "Simmel".

page 9, line 19: "conflicts if" should read "conflicts of".

page 14, line 17: "wonder if" should read "wonder of".

page 24, line 12: "the Taranaki region" should read "the
Wanganui and South Taranaki region".

page 42, line 16: "Ruatahura" should read "Ruatahuna".

ABSTRACT

The Dannevirke project was designed to provide a view into one rural borough and county in order to discern how that community provided services for those in need of emotional and psychological support. Professional human service providers and a representative sample of the general population were interviewed to identify the formal and informal supports that were available to the community and to define mental health and mental illness. This project was based on two assumptions: 1) rural and small town life in New Zealand had networks of self-help and support and these networks were different from those found in the urban environment; 2) clinical and professional practitioners adopted unique responses to practice in a rural area.

This study demonstrated that a rural community based on the romantic notion of a small homogenous, caring community was simplistic. Intrarural differences in the numerous settlements revealed a more complex fabric.

The data did reflect an intricate and caring network of informal supports but it was unclear as to how different (e.g. more supportive) these rural networks were to those in an urban/suburban community. Respondents with low group membership and low visitation from family and friends reported a statistically significant low sense of psychological well-being using the Bradburn Well-Being Scale (1969). The actual roles these networks played in caregiving and prevention needed further inquiry.

The pathways to service for people experiencing emotional/psychological problems were traced, including a ten year statistical analysis of inpatient psychiatric care. The general practitioner was identified by the respondents

in the community and by other professionals as the primary gatekeeper for services, underlining the medical bias in their definitions of mental illness.

Delivery of services by the professionals in the rural area was complicated by distance, minimal interprofessional coordination, shortage of specialist services, and a lack of ongoing professional education in the field of community mental health. Treatment in the community was favoured over sending the clients away for services and the local hospital was a unique resource for short-term respite care.

The findings brought forth numerous questions including: What models of practice are effective for mental health care in the rural context? How do geographical distance and isolation affect community mental health practice? Does the urban base of most professional training prepare formal caregivers for life and practice in the rural setting? Specific recommendations for policy development and for further research were discussed.

ACKNOWLEDGEMENTS

A transition occurred when I began to do research, during which I queried, "Why am I pursuing this particular topic of concern?" This was not an easy question to answer and in attempting to illuminate the reasons, personal biases, assumptions and life experiences came slowly to the foreground. In this specific research, why did I choose to query issues concerning the practice of rural social work in the field of mental health? The answers to this question certainly had a bearing on how the problem was perceived, defined and subsequently explored.

Developmentally, I am a product of an urban-suburban lifestyle. My education was in large urban schools and urban universities. Politically my secondary education was infused with the challenges of John F. Kennedy. His presidential endorsement of community responsibilities in mental health, racial equality, and social justice filled me and my peers with idealism and a powerful, albeit ill-defined, sense of commitment to structural change. There was complete certainty that all of us would work toward a just and caring community and that the federal government would be an interested partner in ensuring that this justice prevailed.

Graduate school at the University of Maryland School of Social Work and Community Planning in city centre Baltimore was focused on social change strategies for the numerous problems society was facing in twentieth century urban America. The structural deficiencies of the society and its economic systems were inextricably linked to the individual and familial struggles for survival and development. As a counterpoint to the stark realities of social work practice, my family became involved in a rural restaurant, a social hub of my mother's very small home town. Weeks were spent being challenged by peers, professors

and clients in the seemingly impossible urban mire of crime, unemployment, sexual and racial inequality.

Weekends were retreats into the sylvan countryside where urban anonymity was replaced by rural friendliness and clear networks of historical relationships. Rural life seemed simpler and safer - always in my mind the solace for my week's reality in urban stress, a symbol of the last place left where community spirit and individuality could be experienced.

But my training was urban based and I saw my role professionally remaining in the arenas of urban practice for the next six years. When an opportunity eventually surfaced to work in the field of mental health in a rural community mental health centre, it seemed a chance for a less complicated professional and personal life.

Yet the reality of rural practice was far from the expected ideal. Despite the seemingly friendly small town, feelings of estrangement were constantly surfacing. Advanced education, a "big city" orientation, and psychiatric expertise seemed to create barriers initially for me professionally. My romanticised picture of the sylvan rural life did not match the complicated and difficult problems facing the people served by our centre.

Practice expectations had to be altered to meet the unique demands on service delivery in a large geographical area with a sparsely scattered population. In my initial period of uncertainty a conflict resulted from the tendency to rely on "bringing in" professional skills instead of developing a new model of service delivery blending the professional expertise with the existing strengths of the community. To the people of Madera County and especially to the staff and clients of the mental health centre, I owe a great deal of gratitude for their patience and support in helping me resolve that conflict and for teaching me so much about rural life.

My practice experiences produced many questions about assumptions on community mental health and on urban and rural differences. I am grateful for Merv Hancock's early backing to continue my questioning through this research project. His continual excitement over learning has been an inspiration. Special thanks to the students (Barbara Scarfe, Wheturangi Walsh and Murray Walker) who stood by me in the early stages of the research and who, during the field survey, survived hundreds of cups of tea and biscuits. The support of numerous people in Dannevirke was instrumental in the research, including Cec Taylor, Grace Benson, Jennie Taylor and Edith Nicoliason who gave many hours on the survey and community feedback, as well as to Dr Mulvihill and the medical fraternity of Dannevirke who supported the project. Special thanks to John Robinson, the Department of Social Welfare social worker who opened so many doors for me and the research team and who cared so much for the community of Dannevirke. Also a note of appreciation is due to Dr Mason Durie for his statistical support from Manawaroa.

A special thanks to Graeme Fraser whose excellent supervision enabled this project to be finally completed. His occasional prodding kept me going when all seemed hopeless. Also a blanket thank you to my colleagues in the Social Work Unit who aided me throughout the project and knew the difficulty of doing research and working full-time. My wife, Angie, is also to be thanked for her caring and consistent belief in me, also for letting me use her superb typist, Jill Cheer, who understood my cryptic handwriting. Last but not least, thank you to the Mental Health Foundation for the financial support, without which this project could not have occurred.

FORMAL AND INFORMAL SUPPORT SYSTEMS IN
A RURAL TOWN AND COUNTY

REPORT OF THE RESEARCH ON MENTAL HEALTH
IN DANNEVIRKE BOROUGH AND COUNTY

TABLE OF CONTENTS

	<u>Page</u>
Abstract	ii
Acknowledgements	iv.
Chapter One INTRODUCTION	1
Section I Definition of the Problem: Community Mental Health in a Rural Context	1
Section II The Goals of the Study	2
Section III Site Selection	2
Section IV Format of the Study	4
Chapter Two A SELECTED REVIEW OF THE LITERATURE	6
Section I The Rural-Urban Debate	6
Section II Psychiatric Impairment in Rural-Urban Communities	13
Section III Networks of Support	16
Section IV Alternatives to Urban Based Models	20
Section V Community Mental Health Theory	22
Section VI Rural New Zealand	23

	<u>Page</u>
Chapter Three FIELD WORK METHODOLOGY	26
Section I Gaining a Foothold in a Rural Community	26
Section II Field Interviews	28
Section III The Questionnaire	29
Section IV Sampling	32
Section V Problems in Rural Field Work	37
Section VI The Community Feedback	40
Section VII Dilemmas for the Rural Researcher	47
Chapter Four THE CONTEXT OF THE SURVEY	50
Section I Impressions	50
Section II Brief History	53
Chapter Five THE FINDINGS	60
Section I Formal Psychiatric Support for Dannevirke Borough and County	60
Section II Case Studies of Formal Caregivers	65
Section III Community Survey	95
Chapter Six CONCLUSIONS	118

Appendices

Bibliography

LIST OF TABLES

		Page
TABLE ONE	Sex Distribution of Sample and of 1976 Census by Domicile	34
TWO	Household Distribution of Sample and of the 1976 Census	35
THREE	Ethnic Group Distribution of Sample and 1976 Census	35
FOUR	Marital Status of Sample and 1976 Census	36
FIVE	Place of Birth of Sample and 1976 Census	36
SIX	Age of Sample and 1976 Census	37
SEVEN	Perceived Advantages of Rural Living	95
EIGHT	Perceived Disadvantages of Rural Living	96
NINE	Access to Television or Radio and Reported Quality of Reception in Dannevirke Borough and County	97
TEN	Respondents Reporting Membership to Civic, Sports, and/or Cultural Clubs	99
ELEVEN	Combined Visits of Family, Friends, Workmates and Others	100
TWELVE	Towns Most Often Used by Respondents for Services	101
THIRTEEN	Respondents Choice of Regional Boundaries	102
FOURTEEN	3-Point Happiness Question	103
FIFTEEN	Place of Residence and Happiness	104
SIXTEEN	Affect Balance Scale Responses	105
SEVENTEEN	Affect Balance in Percent	106
EIGHTEEN	Well-Being by Place of Residence	107
NINETEEN	Membership in Clubs by Well-Being	110

List of Tables (Contd.)		Page
TABLE TWENTY	Family Visitation by Well-Being	111
TWENTY ONE	Categorisation of Respondents' Conceptions of Mental Illness	113
TWENTY TWO	Problems Identified by Respondents	116

LIST OF FIGURES

		Page
FIGURE ONE	Properties of 5,000 Acres or More 1890	55
FIGURE TWO	Location Map	56
FIGURE THREE	Enterprise Size (Work Situations)	57
FIGURE FOUR	Helping Networks - Family Caregivers Viewpoint	94
FIGURE FIVE	Respondents Description of Pathways for Help with Mental Illness	115

APPENDICES

- APPENDIX A (i) Extract from Dannevirke Evening News, 12 June 1980
- A (ii) Extract from Dannevirke Evening News, August 1980
- A (iii) Extract from Dannevirke Evening News, 10 March 1981
- B Letter to Professionals Requesting Interviews
- C Questions for Professional Caregivers
- D Questionnaire
- E Index of Intercoder Agreement
- F (i) 1976 Census of Population & Dwellings. Population and Dwelling Details by Mesh Block and Area Units - Hawkes Bay Statistical Area
- F (ii) 1976 Census of Population & Dwellings. Population and Dwelling Details by Mesh Block and Area Units
- F (iii) Dannevirke County Ridings
- G "How People Support Each Other In a Rural Town and County" - A Preliminary Report
- H (i) Map of Dannevirke Borough
- (ii) Map of Dannevirke County
- I Referrals to Manawaroa Inpatient Facility from Dannevirke Borough and County 1971-1981
- J List of Clubs in Dannevirke

CHAPTER ONE: INTRODUCTION

Definition of the Problem: Community Mental Health in a Rural Context

Deinstitutionalisation, decentralization, and community control have been seen as basic to the development of community based mental health service. But these processes have assumed the existence of resources within the local community. Most of the research and practice models in community mental health have originated in an urban environment and concentrated on ensuring the availability of professional expertise, paraprofessional support and coordination of existing services on a local level. The question of what supports existed before the advent of community mental health has been often overlooked. The assumption has been made that certain basic services (inpatient, outpatient, day care, emergency services) were essential without first considering the possible differences that might have existed in rural and urban communities. A case could be made that the rural environment presents different challenges because of its unique characteristics: scattered population centres, extreme shortages of trained human service providers, difficulty in recruiting professionals, limited public transport in large geographic areas, and health care facilities which are scarce and widely dispersed. A vast proportion of New Zealand can be considered rural, even though the majority of the population now resides in urban areas.

There has been little research done in New Zealand on how people in a rural environment manage emotional and psychological problems. This brought forth two major concerns:

1. How do rural people experience, manage, and resolve their emotional and psychological problems; is it handled differently from those people residing in urban areas?

2. Does the rural context demand a different approach to mental health services? What are the differences and what are the implications in professionals practising in this rural context?

In addressing these two major areas of concern, the difficult task emerged of defining concepts like mental illness, mental health, community, networks of support; urban and rural. Each concept in its own right represents considerable research, thought, and disagreement - which made the task of describing mental health care in a rural community complex. Three different methods of investigation have been utilised to broaden the data base and aid in the exploration: a statistical analysis of the use of an inpatient psychiatric unit over ten years, a rural community household survey and personal interviews with a group of rural professionals.

The Goals of the Study

This study aimed to provide baseline data on the formal and informal supportive networks which existed in a rural borough and county in New Zealand, a county which does not have a formalised community mental health programme. This project was an exploration of the gaps in resources and the existing strengths of the rural community in dealing with personal and family problems. Therefore both the professional community and the population at large were queried as to their view of mental health and mental illness. This information would be essential before policy development could occur, service delivery planned, or any model of practice put into action.

Site Selection

The Dannevirke Borough and County was selected because it met certain key criteria for defining a rural environment.

The area was defined as rural because it covers a large geographic area (over 2245 sq.kilometres) with 10,413 people widely dispersed. Dannevirke County statistics reflected a depopulation trend since 1971, common in many rural areas.

The designation of rural by the New Zealand Census has been defined as less than 1000 people and in the U.S.A. less than 2500 people. But a rural environment based on low numbers of inhabitants has been challenged as simplistic. Pearson (1980) suggested that New Zealand has been characterised historically by small businesses and small enterprises and that even today much of New Zealand could be considered rural in context - if rural could be equated to small. Dannevirke Borough and County for the most part met this criteria. Positioned between two major metropolitan areas, Palmerston North and Hawkes Bay, Dannevirke demonstrated the "in between" status of many rural areas. This in between position has affected service development, service allocation, and service delivery.

The large geographic area contained a scattered population who depended on agriculture as their economic base. Numerous small settlements had been established, experienced growth and decline but continued to survive, despite the emergence of Dannevirke Borough as the main centre of many services. Because Dannevirke had its own hospital, numerous health care services were available locally which would not have been the case in other rural areas of New Zealand. However, there was no formalised community mental health service in Dannevirke. In fact, the following were not present in Dannevirke Borough and County:

1. An established centre of mental health professionals.
2. A coordinating committee of professionals concerned with mental health issues.
3. A community advisory council of citizens concerned with mental health.

4. An established community mental health education/prevention programme.
5. Peripatetic or satellite centres from Hawkes Bay or Palmerston North Hospital Boards.
6. Inpatient psychiatric facilities (Manawaroa at the Palmerston North Hospital, and Lake Alice outside Marton, are the two closest available institutions).

There were numerous technical considerations supporting the choice of Dannevirke as a research site. It was an area which had not been investigated before and was accessible to the researcher and the research team. The small number of professionals in the community provided a realistic size group to be interviewed. Informal networks were highly visible and local contacts were enabling to the researcher in gaining access to the professionals and in facilitating the house-to-house survey in the community. The proximity to the University, the good roads, and the endorsement of major community leaders combined to make Dannevirke County and Borough an ideal area for surveying attitudes and discovering the ways in which people understood mental health and illness in a rural context.

Format of the Study

The report of the study is divided into six chapters. The present chapter states the problem, the goal of the study, the site selection and the format. The second chapter contains a selected review of the literature and examines the rural-urban debate, psychiatric impairment in rural and urban communities, networks of support, alternatives for rural based practice and the lack of theoretical background to the community mental health movement. The review includes an overview of literature concerning social life in rural New Zealand. The methodologies utilised, how the data was analysed, and how the community feedback process occurred are described in the

third chapter. Dilemmas which can occur for a rural researcher are also highlighted in this chapter.

The fourth chapter is divided into two sections: the researcher's impressions and a brief socio-cultural history of Dannevirke Borough and County. In the fifth chapter the findings are reported. Included is the 10 year statistical analysis of Dannevirke Borough and County's use of inpatient hospitalisation at Manawaroa, the interviews with the formal caregivers and the household survey. This chapter includes the interpretation of these findings. The last chapter covers the conclusions and implications of this project. Areas for further research are discussed and recommendations for practice are included.

CHAPTER TWO: A SELECTED REVIEW OF THE LITERATURE

The Rural-Urban Debate

The small community is another of these prevailing and conspicuous forms in which humanity obviously comes to our notice. In all parts of the world, in all human history there are and have been little communities.

(Robert Redfield, 1961)

Country life...is constantly in a state of internal adjustment between one part and another. This is a much less neat and tidy concept than the orthodox gemeinschaft view of rural social structures.

(W.M. Williams, 1962)

In reviewing the literature on the much debated rural-urban continuum, it became clear that the rural community had, in many ways, been polarised to the urban community. The rural community was depicted as an idealised model of close kin contacts, informal networks of support, a sylvan retreat from the destructive, impersonal anomie produced by urbanisation and industrialisation. In a survey of the major theoreticians, it is important to note the difficulty of interpreting their conceptualisations and model building. Levi-Strauss delineated two basic models: the ideal model represented the concepts as they should be without considering other variables. These models represented society as it is or they could present a falsified society; the second basic model reflected empirically based assumptions (Mathiew, 1982). Models have often been equated with what actually transpires in society but the values of the researcher and the lack of empirical evidence have not been made clear. Even Redfield noted his folk society model did not exist in

reality and was "created only because through it we may hope to understand reality" (Redfield, 1947).

Tonnies' original concept of *gemeinschaft* and *gesellschaft* have become sociological cornerstones for denoting social relationships in pre-industrial and industrial society. *Gemeinschaft* denoted a community where informal relationships were traditional and status was ascribed rather than achieved. The contribution of church and family were well established and their values easily identified. The relationships were geographically limited and although *gemeinschaft* could be found in urban areas, it most often existed in the rural pre-industrial sector. His writing reflected a concern for the demise of these relationships seen as a change which was an essential prerequisite for the rise of capitalism and industrialisation (Newby, 1980). *Gesellschaft* translated as an "association" referring to all the relationships that do not reflect *gemeinschaft*. It denoted impersonal, rational relationships often based on contracts. It reflected the loss of community values and morality. But Tonnies' work recognised the contingent nature of locality and attempted to describe various types of relationships that characterised society before and after industrialisation. Instead his original concepts were distorted to reflect a rural-urban continuum where the locale itself affected the type of relationships established. The rural environment was seen to play the major influence on how people lived and related to each other.

Many of the writers of the turn of the century romanticised *gemeinschaft*. George Semmel used Tonnies' concepts to describe urban society and this was done "with thinly veiled hostility" (Newby, 1980). Urban life was seen to foster all the problems of isolation and alienation. Juxtaposed to this urban environment was the "natural" countryside where ruralism was a highly valued way of living and relating:

The farmer-peasant environment, on the contrary, has been much more 'natural' and much more identical with that to which man has been trained by thousands of years of preceding history. The basic impulses of man, as they have been shaped by the past, are to be satisfied much easier in the environment and by the occupational activity of the farmer. There is neither the lack of nature, nor the killing monotony of work, nor extreme specialization, nor one-sidedness. His standard of living may be as low as that of a proletarian; his house or lodging may be as bad; and yet the whole character of his structure of living is quite different and healthier and more natural.

(Sorokin and Zimmerman, 1929)

Robert Redfield, the anthropologist who studied rural communities in Mexico, wrote about the "folk society". Redfield's "folk-urban" distinction reflected social processes which were vitally linked to the geographic environment (Redfield, 1947). Urbanisation was depicted as the major disruption to the structure of social relationships. Oscar Lewis began a debate with Redfield by challenging his work as value laden and simplistic.

It contains the old Rousseauian notion of primitive people as noble savages and the corollary that with civilization comes the fall of man.

(Lewis, 1949)

In England Family and Kinship in East London (Young and Willmott, 1957) described an urban "village" where gemeinschaft relationships existed and stabilised interactions were reinforced by shared values and kinships. This was counterpointed by James Littlejohn's (1963) work in a rural parish where a class system existed that was characterised by impersonal contractual relationships. (Littlejohn, 1963).

Herbert Gans (1962) enlarged this debate by stating that life style was not clearly influenced by locality but

was influenced by social class and by the stages in the family development cycle. A family's financial ability would give them a degree of choice and the specific stage of development would affect their needs and influence their choice of community.

In another landmark study, R.E. Pahl stated that there was little empirical evidence to support the rural-urban continuum and that the "locality and how one lives" argument was an over simplification.

Any attempt to tie patterns of social relationships to specific geographical milieux is a singularly fruitless exercise.

(Pahl, 1966)

Pahl's analysis focused the impact of national on local; the conflict existed between small scale and large scale, not rural-urban. Bowles continued this analysis by contending that rural areas could no longer be seen in isolation. The conflicts if alliances between interests within a community and with those beyond the local community must be considered. The existing horizontal connections between social units within the rural community intersect with the vertical alliances of subsystems extending beyond the rural environment on a national basis (Bowles, 1981).

Maurice Stein (1964) suggested that these vertical ties to centralised decision making were replacing the traditional horizontal relationships of local autonomy. This centralising influence had major ramifications for the concept of a rural community. It meant networks of communication operated over and above geographical boundaries and shared kinship.

The rural-urban continuum was severely criticised by the contemporary theorist, Richard Sennett. Not only did he see rural-urban as a false dichotomy, but he identified

the idealisation of gemeinschaft and the romanticising of the rural community as a major impediment to clear analysis of relationships in the industrialised western world.

Community becomes a weapon against society, where great vice is now seen to be its impersonality. But a community of power can only be an illusion in a society like that of the industrial West, one in which stability has been achieved by progressive extension to the international scale of structures of economic control. For some, the belief in direct human relations on an intimate scale has seduced us from converting our understanding of the realities of power into guides for our own political behavior.

(Sennett, 1977)

If this rural gemeinschaft and urban gesellschaft was no longer a completely accurate reflection of community life, what could be used to facilitate community analysis? Stacey defined 31 propositions that characterise a local social system existing without a geographically defined territory. Her locality studies examined the establishment and maintenance of a local social system which reflected interactions between local and national systems (Stacey, 1969). Her propositions include the following:

- Majority of population display stable residency on the locality.
- Majority play multiple roles to each other.
- The more institutions present in the locality, the chance of multiple roles is increased.
- There is an overlapping of group memberships which results in a convergence of elites.
- Conflict and cooperation exist within the social system.
- Part of the local system are parts of the wider system.
- Where the majority of locals do not share common beliefs, groups and institutions, then a local system does not exist.

- Changes in social systems outside the local one will be felt by the local one due to:
 - (a) the presence of persons not involved in the local systems.
 - (b) the element of other systems present in the local system.

(Stacey, 1969)

These propositions began to identify the dynamic nature of a locality and could be utilised in the analysis of a rural community.

Roland Warren described a community as a combination of social units and systems which perform the major social functions having locality relevance. He offered four dimensions for community analysis:

- (1) Autonomy can be measured by the extent of dependence or interdependence on extra community units to perform its five major functions.
- (2) Clarity of Boundaries is the extent to which service areas of local units (churches, schools, stores) coincide or fail to.
- (3) Psychological identification with locality is the cognitional emotional identification with the community as a significant reference group.
- (4) Horizontal integration is the extent to which local units have a strong structural functional relationship to each other. It also is the degree of linkage of behavior patterns of individuals within the community.

(Warren, 1963)

In a vital community, Warren described networks of informal support providing many services. These networks (horizontal integration) varied in their structure, ranging from voluntary exchanges to highly formal institutions with rules and obligations.

Both Warren's community analysis and Stacey's locality analysis account for the various networks of relationships which were homogenised under the rural-urban continuum.

But locality did not preclude some of the geographical issues which must be considered in developing a concept of a rural community.

Rural Typologies

Bunce puts forth six basic criteria in developing a rural typology to distinguish a nucleated form from a dispersed settlement: 1. the morphology or form of the settlement, which may be influenced by the geography (e.g. linear village on a river or road); 2. the location in relation to the geography; 3. the genesis or history of the community and its settlement patterns from early colonisation to the present; 4. the function of the community, its economic base and its place in the hierarchy of central places for distribution and consumption; 5. the increasing population density; 6. centralisation and regionalisation (Bunce, 1982).

Decreasing population density was often used as the sole criterion for "rurality" but there was never a perfect cutting point for density to widely dispersed populations. Another difficulty in defining rural by population density or scarcity alone, was that population size belies the heterogeneous quality of rural settlement; varying from cultural and ethnic backgrounds to land use (dairy farm, sheep farm, etc.). Centralisation and regionalisation, due to competition and changing market influences have had a major impact on the changing size of settlements (e.g. closure of branch office, local court, maternity hospital) (Bunce, 1982).

In attempting to analyse the rural community, Perez used the ecological approach to provide five major components which combine the geographical, the sociological and the economic concerns:

- (1) Population density
- (2) Settlement patterns
- (3) Locality groups
 - (a) neighbourhoods

- (b) communities
 - internal functioning
 - external relations to other communities and central government
- (4) Man-Land relations
 - agricultural
 - usage of non-agricultural land
 - renewable (forestry, fishing)
 - non-renewable (mineral)
 - recreational
- (5) Processes
 - (a) competition
 - (b) conflict
 - (c) accommodation
 - (d) assimilation

(Perez, 1979)

This ecological approach demonstrated the complexities in rural community analysis and contributed to the increasing evidence that the rural-urban continuum was simplistic and romanticised. In one sense, a theoretical vacuum has been created in the sociology of the rural community. But these challenges have provided new impetus for a more rigorous examination of community and of our understanding of how people relate in a rural environment.

Psychiatric Impairment in Rural Urban Communities

The disparities and conflicts inherent in the debate of rural and urban differences are not dissimilar in content to the debate of rural and urban mental health. Some recent research has demonstrated very little differences between prevalence of psychiatric impairment in rural and urban communities. Contrary to their expected outcome, Gray and Reinhardt (1977) using the Midtown Manhattan Screening Instrument, found that impairment of the lower socio-economic class was similar in both rural and urban areas. On the contrary using this same Impairment Index, Summers, Seiler and Hough (1971) found that prevalence rates were lower in rural communities when compared with

previously studied urban areas. Srole, who developed the Prevalence Index, compared a rural county in Nova Scotia (Stirling County) with his Midtown Manhattan Study and refuted the anti-urbanists' claims that rural areas have less prevalence of psychiatric impairment. He stated:

...that the results offer no support whatsoever to the antique presuppositions of the superiority of rural mental health. On the contrary, as calibrated, Stirling County's estimated mental morbidity rate is higher than Midtown's by a wide and thoroughly significant statistical margin.

(Srole, 1972)

Srole continued by stating that urban mobile areas were actually psychologically eugenic whereas rural immobile areas were pathogenic. In querying this, Kennedy (1978) wondered of Srole was in fact measuring a change in rural culture which had been brought about by the disruption and devaluation of rural life in the transition to urbanised society. These three research projects using the same index reported diametrically opposed findings. Similarly in a review of nine studies reporting rural/urban differences in prevalence of psychiatric impairments, Dohrenwood and Dohrenwood found the following:

One study reported higher incidence in rural areas
 One study reported no difference
 Seven studies reported higher incidence in urban areas.

(Dohrenwood and Dohrenwood,
 1971)

All the studies were criticised for methodological differences and a plea was made for more epidemiological investigation using matched study sites and more rigorous methodological control.

Rural Values

Rogers and Burdge (1972) characterised the rural poor by five strongly held values, which were in contrast with

and devalued by the dominant middle class society: individualism, traditionalism, familism, fatalism, and person-centred relationships.

Reynolds, Barks and Murphie (1976) stated that not only were these values characteristic of rural areas, but that they were so rigid that they caused social structures to be resistant to change or new innovations. One strong belief was that rural public services should be run by the ordinary citizen with a minimum of technical qualifications and that residual welfare services were only necessary when individual and family could not perform by themselves (Ford, 1969). Community poverty and its effects were not acknowledged as a structural feature of rural U.S.A.

Hassinger and Whiting's (1976) research agreed that there were urban/rural value differences but that these differences were more variations than dysfunctions in belief systems. They warned that there was a danger in magnifying the differences to stereotypes which would overlook the intrarural variations.

Cummings and Cummings (1957) produced a major study on a rural Saskatchewan county and reported negative attitudes toward the mentally ill and mental health services. In 1960 a large survey comparing urban and rural America's attitudes toward mental health achieved similar results:

<u>Rural %</u>	<u>Urban %</u>	<u>Of Sample</u>
20%	31%	defined problems in mental health terms
9%	20%	actually used professional help
11%	3%	didn't think professional help would be beneficial

(Gurin, Veroff and Feld, 1960)

But in repeating the Saskatchewan research in 1969, Rootman and La Fave (1969) found a significant attitude change

and a greater degree of tolerance and understanding.

Perceptual disparity has been seen as particularly dysfunctional in dealing with the rural poor (Reul, 1974). Leininger (1971) stated the major problem in community mental health has been a perceptual and cognitive gap between professional staff and lay persons' view of the problem, treatment and rehabilitation. Wagenfeld defined two major barriers to mental health care in a rural environment:

1. The professional providers use models inappropriate for the region, minority groups and often for the social class of the client populations.
2. The rural clients' attitudes and values militate against the use of existing services and impede the development of new services. Also there are different sets of beliefs about the etiology of dysfunctional behaviour and alternate systems of "healers" are already in use.

(Wagenfeld, 1977)

Networks of Support

In addressing the "networks of support" problem of perceptual disparity, Torrey (1970) suggested that rural service providers must start with the assumption that mental health services (support networks) already exist and that they are at least partially effective. There is a body of research which examines the networks of support that may or may not exist in rural areas. In studying unemployment, Gore (1978) found that unemployed people who were unsupported experienced high elevations and more changes in cholesterol, illness symptoms, and effective responses than those with support systems. The rural unemployed evidenced a significantly higher level of social support than the urban unemployed. In Laos, Westermeyer and Pattison (1981) found that in studying social networks

of mentally ill villagers, that mental illness was associated with a decrease in size of social networks and a disproportionate reliance on family.

Coulton (1981) found that isolated individuals tended to experience a greater number of illnesses, both physical and mental. Network studies have found that people with open and supportive networks find it easier to get a job (Granovetter, 1974), find information about and obtain an abortion (Lee, 1969), get pre-natal care (McKinley, 1973), and to have communication between social groups (Korte and Milgram, 1970). The difficulty in much of the network research has been that it does not separate and measure the different types of support. For example, Julie Park's (1982) research in Pakuranga found that neighbouring as a concept meant different things to her respondents and represented a continuum of personal closeness to friendly distance. Litwak and Szelenyi (1969) stated the importance of acknowledging the different functions of kinship, friendship and neighbourhood groups. These differences in function were important in considering the use of informal networks in seeking help for mental and emotional problems.

Kadushin coined the term "social circles" in his research to describe indirect chains of acquaintanceships that were linked by common social, cultural activities. Those social circles familiar with psychiatric problems and services were utilised in aiding people in the referral process (Kadushin 1969). Horwitz (1977) found that individuals in closed networks tended to be encapsulated within their primary groups and were insulated from professional services. He also found that individuals were prone to labelling their own psychiatric problems without seeking professional help, but that this high rate of self-labelling did not lead to self-referral to professional service. His study underlined the importance of professionals as bridges from the informal networks to psychiatric treatment, especially for people in closed

networks without connections or familiarity with psychiatric services.

In a rural Montana (U.S.) boom town, the informal (natural) helping systems were studied in relation to how the longtime residents and newcomers utilised them. This was done by sampling administrators, supervisors and direct service providers in health, education, and welfare services. The longtime residents relied less on professional services and used family and church much more extensively than the newcomers. The newcomers were seen as utilising informal caregivers like the hairdressers, bartenders or workmates. Although the professionals were aware of the informal networks they demonstrated little information as to how these informal networks were utilised and ignored them as a potential resource (Davenport and Davenport, 1982). In another study of rural community leaders, they identified the hospital, the G.P., the minister and the family in order of preference for referral when there was a mental problem, thus giving preference to the formal caregivers before the informal (Bentz, Edgerton and Hollister, 1971). Research that queried rural people about networks found a different viewpoint. Hinkle and Ivey (1969) found that in one rural community with a mental health centre only one-third of the sample even knew about the centre and 79% of the sample relied on familiar authority figures for help. They felt that when help was needed that could not be handled by an informal network, then the G.P., minister, teacher and lawyer would be sought out.

A classic study in rural Martha's Vineyard in New England in the United States found that less than 2% of the population used the formal mental health centre and relied heavily on their general practitioner. Eight percent of the G.P.s caseload was psychiatric problems.

It is evident that in this community and, in no doubt others, the burden of treating psychiatric patients is being and must be shared by the General Practitioner.

Although 22% of the population experienced what they called a "parapsychiatric" event which involved other members of the human service community (e.g. lawyer for marriage dissolution, probation officer for juvenile crime, school counsellor for school disruptions), those people who did use the mental health centre wanted relief from their problem in the quickest time possible and were not interested in reflective psychotherapy (Mazer, 1976).

Distance as an Issue

In a major survey of rural mental health centres, Bachrach (1974) found that utilisation of professional mental health services was on a continuum based on the degree of "rurality" of the community, from least usage in rural areas to greatest usage in an urban/suburban mixed catchment. Cohen (1972) found an inverse linear relationship between decreasing distance from the treatment source and a decreasing utilisation of the services. He suggested the use of satellite clinics, travelling teams, and a greater use of the "healthy" population in the form of family life councils to counter the lower utilisation of services in a rural environment.

The Rural Professional

Schoff (1976) claimed that the lower utilisation of professional mental health services in rural areas was due to the professional failing to make the essential transitions from urban to rural practice. These included active involvement in the existing political and human service agencies, analysis of the demographic factors unique to that rural community, demonstrating adaptability and a willingness to be involved in the community, sensitivity to the conveyance of professional and private life, and patience in developing cooperation between indigenous community caregivers and professionals. Kamien (1975) described the sense of isolation as a rural psychiatrist in Australia and the initial rural distrust of "outsiders"

and "academics". These studies seemed to underline the importance of professionals' perceptions of rural people and their lifestyle as well as the rural populace's perceptions of the professionals working in the mental health field.

Alternatives to Urban Based Models

Another major question to be asked was what models of community mental health were effective in a rural environment? In Japan the rural community had to be approached differently from the urban due to the stigma attached to mental illness, the strong beliefs that mental illness was inherited, and the narrow definition of mental illness (mental illness = violent, incoherent behaviour). A Kumiai, an organisation that coordinates professional consultants, community leaders and indigenous professionals was utilised to identify existing resources and natural helping systems. This Kumiai was a unique model of community mental health care tailored to the rural people of Japan (Shupe, 1974). There were numerous articles demonstrating alternatives to the urban based models of community mental health (Mahoney and Hodges, 1969; Rockoff, 1977; Arutumian, Kroll and Murphy, 1976; Benoit and Roy, 1974; Bloom and Richards, 1974; Bartoletti, 1975; Dyck and Ediger, 1977). All these models attempt to differentiate elements essential in service delivery specific to the rural environment.

Needs Assessment

Another facet of the community mental health movement has been needs assessment - a process of discerning the needs of the client group to be served. There has been an increasing amount of research examining needs assessment techniques for rural communities. This has reflected the concern to create informed policy which will enable

appropriate and functional development of services. Rojek, Clements and Summers (1974) define at least four relatively independent dimensions for assessing community satisfaction: public services, medical services, commercial services and educational services. They state the need to "develop social indicators based on individual subjective evaluations of the environment."

In a study in rural New Mexico, rural people stated that they preferred rural life despite fewer and less adequate services, but they also stated availability does affect the use of services and underlies a need for innovative health care practices. One of the difficulties in this research project was the lack of available mechanisms for using the results of rural community service research. The researchers called for further testing of social indicators, more research on the effectiveness of alternative organisational structures, and comparative analysis of service delivery systems and leadership structures. This would aid in the development of a composite view of community services appropriate for rural areas (Carruthers, Erickson and Renner, 1975).

An example of an innovative needs assessment project was done in Craig, Colorado where researchers surveyed the concerns of rural women and found a high degree of male chauvinism and lack of understanding for women in the community. There was an absence of day care for children, no resources for problem children, and women reported feeling frustrated and hopeless. Women's support groups and specialist services for problem children were developed in response to their reported needs (Angerman, 1976). The National Institute of Mental Health has developed, under Project Share, a clearing house for research with a bibliography series for Needs Assessment in the Human Services. These projects range from guides for household surveys, to models for estimating mental health needs to systems analysis for rural community services (Human Services Bibliography Series No.2, 1976).

Community Mental Health Theory

Implicit in these alternative models of care was their "success" in the rural environs. The research that proposes these models rarely provided any theoretical analysis of the community mental health movement. In one Canadian study, the peripatetic psychiatric teams had been credited with reducing hospitalisation outside the region from 170 to 47 (Amyot and Messier, 1973). This implied that the goal of deinstitutionalisation is occurring and that utilisation of state (central) institutions was being reduced. In a major study in the U.S.A., 16 states with active rural community mental health programmes were surveyed over a five year period as to the utilisation of state hospitals. The centres in rural areas had not reduce the resident rates in the state hospitals (Windle and Scully, 1976). Although the admission rate was retarded, the deinstitutionalisation process was not as evident as predicted. Reducing numbers of long term psychiatric hospitalisation is only one measure of success in community mental health, and does not provide any information as to the quality and the cost of the community based care, or to client satisfaction. The basic concepts informing community mental health need questioning just as much as the models of service and the rural/urban differences that affect the delivery of services.

The community mental health movement has been successful in keeping large numbers of people in their homes and communities while they receive some medical-psychiatric assistance on an out-patient basis. The present strength of this movement is its economic advantage insofar as it has reduced the costs of supporting a growing hospital population. The movement, however, still lacks a strong theoretical basis for re-examining the whole concept of mental illness as a disease that resides in an afflicted person.

(Perucci, 1974)

Rural New Zealand

There has been an increasing amount of descriptive and empirical research on social life in rural New Zealand. Some of this has reflected the concern of rural social activists who have underlined the importance for politicians, planners, and providers of social services to be aware of the unique needs of rural people. Why Did They Leave Eketahuna? (Glendinning, 1978) was an excellent example of a community survey/community action document. Houghton (1981) and Henderson (1976) have been researching the social implications of the impact of large scale development in rural areas. The series "Studies in Rural Change" covered a wide range of social-economic concerns for rural people (Bedford, 1979). Kaplan's (1979) study in Mangamahu investigated the social aspects of productivity in hill country sheep farmers.

Wheeler (1980) has investigated the communal character of settlements and provided insight into the functions of these statistically small but important clusters so common throughout New Zealand. Cant (1974) explored the concept of rural ecology and the need to develop knowledge of the variation of socio-economic well-being in rural New Zealand. This research has been particularly important as regional development policies evolve.

The Canterbury Regional Planning Authority (1980) has examined criteria which can be used for defining the extent and nature of control in non-settlement areas. This included the function and accessibility of these settlements. The issue of rural residential zones and the use of small rural properties has also been studied (Gardner, 1978; Mountfort, 1978; Harris, 1975).

A survey of rural needs and services was the result of a joint effort by the Commission for the Environment and the Rangitikei County Council. The Rangitikei County Council was particularly interested in the residents'

needs for services in the hill country around Hunterville, Taihape, and Waiouru. They listed the following needs: more doctors, better school bus service, maintaining maternity hospitals, reducing party lines, improving reception of TV2, more and better housing (especially rental housing was inadequate), and mitigating the disadvantages felt by isolated rural women. Some roading needed improvement and the high cost of transport for rural people to get to education, health services and shopping needed to be considered (Commission for the Environment, 1979).

The Wanganui Health Survey was a major health survey of the Taranaki region (Asher, Fordham and Pitcher, 1979). Although it did not specifically investigate mental illness, it did provide consumer opinion of their state of health and use of medical services. The G.P. was identified as the gate-keeper for specialised services and a resource for mental illness. Twenty percent of those who reported health problems stated their problems concerned their mental health. But their definition of mental health problems ranged from chronic psychiatric illness, childhood behaviour problems, problems of aging, alcohol and drug use, to marital and family problems. Overall, the rural residents stated they were in good health with less than 12% stating they had poor or variable health. Using the amount of psychotropic medication prescribed, instead of consumer opinion, revealed a less optimistic finding on the state of mind of rural New Zealanders. Webb and Collette (1977) found that the per capita psychotropic drug prescription rate varied inversely with the size of locality; the rural rate was two times that of urban cities.

A national study of rural women revealed numerous areas of difficulties for women, with isolation and little or no employment opportunities as major obstacles to mental health (Gill, Koopman-Boyden, Parr and Willmott, 1976). The Society for Research on Women in New Zealand did a study on Immigrant Women which revealed similar dilemmas

for rural women complicated by cultural differences and the absence of their own family support systems (O'Reilly, Fenwick and Kuiper, 1979). In a much less scientific manner, a farm management consultant extrapolated a series of statistics from his experience with the farming community. Out of 100 farmers it would "appear" there were potentially 20 involved in divorce, 10 with serious drinking problems, three with drug problems (hard drugs and prescription), five involved with the death of a spouse or child, and two in the throes of bankruptcy and forced sale (Etwell, 1982).

There was no known New Zealand research that specifically examined mental health and mental illness in the rural context. There was a recent summary of the state of community mental health programmes in New Zealand but it did not differentiate the rural community's unique concerns and/or services (Abbott, 1983). Peter Davis address this dilemma in terms applicable to both urban and rural New Zealand:

Historically mental illness has received a wide range of social responses, at least in the case of more extreme disorders. At different times and in different places, the response has been one of imprisonment, ridicule, expulsion, and even death. Nor is there ever complete social consensus on how mental illness should be defined or treated.

(Davis, 1981)

CHAPTER THREE: FIELD WORK METHODOLOGY

Gaining a Foothold in a Rural Community

Establishing a base in the community was essential to developing rapport with the local community leaders and in minimising resistance to the presence of a researcher in the community. A previous contact with the only Department of Social Welfare social worker in the area proved to be quite helpful as he aided in gaining acceptance for the interviewing team and me. His initial list of contacts included the Superintendent of the hospital who facilitated our lodging and meals at the Dannevirke Hospital's nurses' home and who provided four nurses to participate in the interview team. The nurses were all longtime residents of the borough and county and their local knowledge of people and places enabled us to carry out the survey with a minimum of resistance. The social worker arranged a meeting with the Mayor, the Borough Clerk and the Assistant County Clerk. The local newspaper was contacted and they ran a feature story on the project and a picture of part of the team in our new headquarters (see Appendix A). After much searching (limited by availability of rooms and money) the Federated Farmers rented us an office and their secretary provided essential information about the outlying farming areas. These initial contacts created the necessary level of community awareness.

Once the geographic location for the research was selected it seemed quite natural to initiate discussions with the persons in the community with formal training and community sanction who were identified as part of the human services resources. In some respects they could be regarded as subcommunities: each professional group with its code of ethics, training, community sanction, and commitment to service. The major professional groups which were interviewed were the general practitioners, the ministers, the

public health nurses, the school guidance counsellors, the social worker and the senior sergeant of police. On reflection, lawyers and teachers should have been included as they deal considerably with couples and families under stress, but the resources and time did not allow for expanding this initial group of respondents.

Only one non-professional was interviewed. He was an identified leader in the Maori community and although he was not trained or engaged professionally as a formal caregiver, many of the other formal caregivers identified him as a major resource for the Maori community.

There were four assumptions made before constructing the questionnaire schedule for these professionals. The first assumption was that the rural context (vs. urban) of practice altered in some ways how the caregivers provided service and experienced their roles:

The broad limits to those work settings are dictated by the formal characteristics of the profession, but their concrete structure is something to be analysed in and of itself. Once the structure of work settings can be specified, I suggest, it becomes possible to understand and predict systematic variation in the work performance of professionals.

(Freidson, 1975)

The second assumption was that professions were a type of community with boundaries, although they were not based on geographic criteria.

Presumably, the body of theory used for analysing a community must be translated, qualified, or changed when the community exists within a large society.

(Goode, 1969)

Thirdly, professional communities would demonstrate similar methods of approach within their profession which would differ from other professional groups.

The last assumption was that a community's definition of mental health must be a multidisciplinary task. The variance between professions and their viewpoints needed to be understood.

Field Interviews

Letters were sent to all the formal caregivers asking for a time limited (30 minutes) visit (see Appendix B). Appointments were made despite some initial resistance to becoming involved and concern over giving up time in their already busy schedules. Each interview took 30-45 minutes and was taped and then transcribed. The interview consisted of eight open ended questions and the questions were asked in the same way but not necessarily in the same order in each interview (see Appendix C). The respondents were quite open and seemed genuinely concerned with issues related to the mental health of their community. Even the few who were resistant initially, answered all the questions and spent extra time on specific issues of concern. Their perceptions were helpful in constructing the survey questionnaire and provided an initial framework to begin to understand how rural professionals perceive their role in dealing with people experiencing mental illness.

Researcher's Validity

Urie Bronfenbrenner defines phenomenological validity as the correspondence between the subject and the investigator's view of the research situation. Phenomenological validity is only part of ecological validity or the:

...extent to which the environment experienced by the subjects in a scientific investigation has the properties it is supposed or assumed to have by the investigator.

(Bronfenbrenner, 1979)

In interviewing the formal caregivers in Dannevirke I was

aware of my own experience as a rural social work practitioner and administrator. I felt I had some understanding of the setting and subculture (albeit in the U.S.A.) and of the expectations of the role of a rural professional. Although there was still room for misconception, this familiarity with the rural professional lessened the likelihood of gross misunderstanding.

The Questionnaire

The development of the Dannevirke Community Survey posed methodological questions due to the complexity of the concepts of mental health and illness. In attempting to tap the rural family's response to how they perceive mental illness, numerous questions were initially included in the pilot questionnaire and then refined for the survey itself. The interviews with the professional caregivers helped formulate questions concerning alcoholism which they identified as a major community problem; these questions were similar to the ones used in the Wanganui Health Survey (Asher, Fordham and Pitcher, 1980) (see Appendix D, Q.79-87). The questions dealing with well-being were drawn from the work done by Norman Bradburn (1969) (see Q.88-116). Of particular note, Q.102-111 compiles the Bradburn Affect Balance Scale which was used extensively as the dependent variable in the analysis. This scale has been used in international research as well as in other areas of New Zealand (Chamberlain, 1981). The questions used to define mental illness were to be similar to those questions asked of the formal caregivers (see Q.117-142). The open-ended nature of these questions made coding difficult, although the inter-rater reliability proved to be quite high.

Questions about rural life, the definition of community and subjective satisfaction with rural life were designed to provide information that would reflect the rural context of the research (see Q.1-37 and 60-76). Questions about

network of acquaintances were utilised to elicit information about socialisation patterns and networks of support (see Q.38-59). The travel time questions (Q.21) were drawn from the Banks Peninsula Survey (1979) in Christchurch. There are 178 variables in the questionnaire.

The original questionnaire was compiled and then a seminar was conducted to review the structure and various members of Massey University staff critiqued the questionnaire. A rewritten questionnaire was then submitted to an Extramural Research class and critiqued by the students. Their comments and changes were incorporated into the questionnaire's third rewrite.

A pilot survey was conducted with rural students in the Bachelor of Social Work degree which led to a fourth and final questionnaire which was used in the actual survey. Despite all the time that was placed into the design, there were numerous problems which surfaced during the administration of the questionnaire. Questions relating to time and feeling states were especially difficult for respondents (e.g. Do you worry more now than a year ago? or What have you enjoyed most in the last few weeks?).

Administering the Questionnaire

The interviewing team comprised three BSW students, four nurses from the Dannevirke Hospital Board and the researcher. The students were involved in all stages of questionnaire design and administered the pilot survey. Numerous sessions were held on the interviewing and the objective(s) of each question. Then several more training sessions were held in Dannevirke with the four nurses on the interview team.

After conducting role plays of different types of interview situations, each interviewer was then asked to interview a respondent who would remain constant for all the interviewers.

The coding sheets were then analysed using an index of intercoder agreement to determine the amount of agreement in judgement between interviewers when coding the same data independently. The intercode agreement was .867 (see Appendix E for formula). When the respondent gave a range of answers and the interviewer had to make an interpretation, the interviewers often wrote comments on the questionnaire reflecting their dilemma of accurately recording the respondent's answer. These comments later proved to be quite helpful in selecting the categories for coding.

The interviewers ranged in ages from 18 - 45, all were New Zealanders except the researcher, all were Pakeha except for one Maori female student, and six of the eight interviewers were female.

During the first few weeks of the survey, debriefing sessions were held each night to review difficulties, ensure that questions were being asked in a consistent manner, and to increase confidence in our abilities as interviewers. After twelve weeks of interviewing we were far below the number of necessary respondents, so another eight students (5 female, 3 male) were recruited, trained and utilised in the last week of interviewing the most geographically isolated families. The interviewing began in June 1980 and finished in August 1980.

The interview was scheduled to take 45 minutes and would proceed from the least personal questions to the most personal questions which came two-thirds of the way into the interview. The last questions were demographic. All family members over the age of 16 were interviewed.

To ensure confidentiality no addresses, names, or identifying material was included on the questionnaire coding sheet. Only a code number designating the geographical region was utilised to confirm representation in the sample. Coding

was done during the interview and the data was transferred onto disc by staff at the Computer Centre at Massey University. The computer analysis was done in the Prime 750 using the SPSS (Statistical Package for the Social Sciences) to analyse the data.

Sampling

Numerous representative sampling plans were considered for the Dannevirke survey. Initially a random sample of the Power Board's list of customers was considered to be the best option. But during the time of the research the Dannevirke Power Board was concerned about access to the list without customer approval and about the issues of confidentiality so that my request was denied. The second option was a random sample of the electoral roll but both the Dannevirke Borough and County Clerks were concerned about the numbers who would not be on the electoral rolls. A third option utilising a random sample derived from Grid Squares used in taking the Census was chosen. The New Zealand Department of Statistics has the borough and county of Dannevirke divided into population and dwelling mesh blocks. Each mesh block reflects the population in that area, the number of occupied dwellings, unoccupied dwellings, and those under construction (see Appendix F).

For the borough and county, grid square maps made by Lands & Survey Department (New Zealand Mapping Series 17, Dannevirke 2nd Edition 1976 - Census User Maps) were utilised to ensure that the entire large geographic area was represented in the sample. The mesh blocks from the grid square maps were traced into the borough street map (Map of Dannevirke, Department of Lands & Survey, New Zealand Mapping Series 17, Dannevirke, 2nd Edition, 1979). Then, each street in each grid zone was covered and the dwelling count checked. Within each mesh block, each dwelling was given an identification number. To garner a 10% sample, a table

of random numbers was used to determine which houses were to be visited. Once a number was chosen, every third number was selected until the total sample was selected from each mesh block.

A similar process was utilised for the County. The Dannevirke County Council Roding Plan (No.689, November 1976) has the county boundaries and riding boundaries which coincide closely with the Census mesh blocks. Therefore the ridings were utilised and traced onto the Farm Location Map of Southern Hawkes Bay (Dannevirke Lions Club, Aerial Surveys Ltd. Revised 1974). Because the distance was too great to resurvey and number the farm dwellings, the numbers of dwellings in each mesh were assumed correct. The named farms on the Lions map were given numbers and a 10% sample was selected using the table of random numbers until the required number of farm or settlement dwellings in each riding were acquired. This required a great deal more travel time than if we had selected one road and used every nth farm. With one car, the logistics were extremely difficult.

In both the borough and in the county if the family in the dwelling selected was unavailable a letter was left to notify the occupants. Numerous people contacted the Federated Farmers headquarters and new appointment times were arranged. If no-one responded, then a second visit was made and another letter was provided. In each mesh block, only the selected houses were visited and if there was no response a substitute was not selected. Distance, weather, and limitations on the number of interviewers and transportation were all restrictions to the numbers surveyed, but nevertheless we were able to contact 114 households, which approached a 5% sample of households including 212 respondents.

Characteristics of the Sample

In the following a comparison has been made between the demographic characteristics of the sample with those of

the population of Dannevirke Borough and County. A representative sample should reflect similarities between the sample population and the Census population. If this sample had been representative then some generalisations could be made about the borough and the county. This comparison of two populations also illuminated some of the various profiles that exist within the sample. Table One shows the sex distribution of the sample and the 1976 Census.

TABLE ONE
Sex Distribution of Sample and of 1976 Census by Domicile*

Sex	Dannevirke Borough and County Sample		1976 Dannevirke Borough and County Census	
	B %	C %	B %	C %
Female	58.9	48.6	53.4	46.6
Male	41.1	51.4	46.6	53.4
TOTAL	100%	100%	100%	100%
	N of sample = 212		N of population = 10,413	

* The statistics used in the preliminary report were the de facto population numbers and did not include Akitio County which was annexed in 1976.

B = Borough
C = County

The slightly higher percentage of females and lower percentage of males in the borough sample may reflect the large number of interviews that had to be conducted during the work day.

Table Two refers to the distribution of households within the sample and the Census.

TABLE TWO

Household Distribution of Sample and of the 1976 Census

	Dannevirke Borough and County Sample		1976 Dannevirke Borough and County Census	
	B %	C %	B %	C %
Households	54	46	58.2	41.8
TOTAL	100%		100%	
	N of sample = 114		N of households = 3090*	

* The number of households utilised in the preliminary report do not reflect Akitio County, therefore the figure of 2,829 households was utilised for the sampling. The 1976 Census figures did not combine Dannevirke and Akitio County.

One hundred and fourteen households represent a 4% sample of the total number of households in Dannevirke Borough and County combined. The sample has 3.5% of the Borough and 5% of the County.

TABLE THREE

Ethnic Group Distribution of Sample and 1976 Census

	Dannevirke Borough and County Sample		1976 Dannevirke Borough and County Census	
	B %	C %	B %	C %
European	90.3	93.5	89.5	90.0
Maori	8.6	4.7	8.5	8.0
Cook Is. Samoan Polynesian				
Other	1.1	1.8	2.0	2.0
Chinese Indian Maori descent				
TOTAL	100%	100%	100%	100%
	N of sample = 207		N of population = 10,413	

The ethnic breakdown of the combined sample (borough and county) is 91.9% European, 6.7% Maori, and 1.4% other. This is comparable with the Census figures although the percentage of non Europeans in the county sample is low.

TABLE FOUR
Marital Status of Sample and 1976 Census

	Dannevirke Borough and County Sample		1976 Dannevirke Borough and County Census	
	B %	C %	B %	C %
Single	18.9	13.1	18.7	22.0
Married	64.2	77.6	75.0	66.5
Widowed	12.6	4.7	5.1	8.6
Engaged	0.0	0.9		
Divorced	2.1	0.0		
de facto	2.1	3.7	0.7	1.0
TOTAL	99.9%	100%	99.5%	98.1%
	N of sample = 207		N of population = 10,413	

The lower percentage of single people interviewed in the sample reflected the large number of farm owners and their families who were interviewed. The use of the Lions Farm Map (Dannevirke Lions Club, Aerial Survey 1974 reference) often excluded small settlements where single farm workers or support services workers resided.

TABLE FIVE
Place of Birth of Sample and 1976 Census

Born	Dannevirke Borough and County Combined Sample	1976 Dannevirke Borough and County Combined Census
New Zealand	93.7%	93%
U.K.	5.3%	5%
Australia	0.5%	0.9%
Other	0.5%	0.95%
TOTAL	100%	100%
	N of sample = 207	N of population = 10,413

The sample reflected a population with over 90% New Zealand born. Seventy-five percent of the sample population have lived in Dannevirke for more than 10 years and of that group 44% have lived in Dannevirke all their lives. Although the largest percentage of the population is quite stable, over 37% of the sample had moved at least once in the last five years.

TABLE SIX
Age of Sample and 1976 Census

Age	Sample		Census 1976	
	B %	C %	B %	C %
0-29	46.9	30.8	52.0 (23)*	56.5 (22.5)*
30-49	24.0	41.1	18.4	24.0
50-69+	29.2	28.0	28.6	19.5
TOTAL	100%	100%	100%	100%
	N of sample = 207		N of population = 10,413	

The largest percentage of the borough and county population is in the under 29 age group. Within that age grouping the largest population falls within the 15-24 grouping. The second highest percentage in the borough falls into the 49-59 age grouping and the third highest percentage falls into the 65+ age grouping, reflecting the higher number of retired people who live in the borough and not the county. In the sample the percentage interviewed under 29 was lower than the Census until the percentage between 16 and 29 is computed (* in brackets).

Problems in Rural Field Work

Conducting interviews in a rural community posed some unique dilemmas for the researcher. The initial plan to interview all the members of the household over 16 made numerous return

trips to the home essential. This was quite easy but time consuming in the borough, requiring a complex time schedule to match the interviewer's available time with the missed member of the household. In the county, the return visits were difficult to arrange and required an expenditure of substantial periods of time and extra transport costs.

The interview team was only available for two days and one night per week and many of the missed family members wanted to be seen in the evening, making the evening schedule most pressured. Also many rural residents retired early, limiting how late the team could interview.

Although the roads were expected to be a problem, all the farms sampled were on or near tarsealed roads. The mobility of the team was limited by having only one car and the distance between farms was underestimated, stretching the time required for each interview. The refusal rate was less than 2% of the sample and the borough and county households were most welcoming. But the essential "tea and biscuits" added even more time to the interview, which made holding to prearranged time schedules almost impossible.

The winter was ideal in some respects to conduct farm interviews because the sheep farmers were more available. As the time grew close to lambing, more and more farmers were unavailable or extremely reticent about the time required for the interview. Dairy farmers' schedules were difficult, and visits had to be late morning, early afternoon, or late in the evening. In the borough, many members of the household were working or in school during the day, which again placed pressure on late afternoon or evening interviews. Having four interviewers from the community was most helpful and they often completed households by visiting them at other times during the week.

The winter weather made driving difficult and numerous storms and some flooding made some areas of the county difficult to traverse. Darkness came early and finding some of the

farms which looked easy on the map, proved to be quite a challenge, especially when the landmarks were "overtured fridge in a paddock" or a small yellow marker on the "third metal drive to the left".

Some questions proved to be dysfunctional in the borough and areas close to the borough, where distance to services was a non-issue, because of the close proximity of all services and facilities.

Confidentiality was also a major concern to the research team. Great care was taken to ensure that no identifying material was retained. This proved to be more our concern than the people interviewed. It also created a major problem for the feedback sessions to the community because personalised letters could not be sent to the respondents to invite them to the meetings. Due to the good press coverage and the "bush telegraph" our presence was widely known, so that neighbours knew who and when we were visiting many of the respondents. The four local interviewers were also concerned at times because they either "knew" or "knew of" the respondents.

Finally, the expense of interviewing in the homes was underestimated. The cost of hiring vehicles, petrol and providing meals and lodging for the team proved to be the major expense of the entire project. Since there was no public transport in Dannevirke, the car was essential for most of the interviews. The commuting relationship was difficult for the team and living in Palmerston North while being intensely involved in Dannevirke for two days a week was quite physically and emotionally draining.

The Community Feedback

This section describes the use of public meetings in the transfer of findings from a community study on the caring system of a rural town and county (Appendix G). It details the ways in which the researcher endeavoured to communicate with residents of the community in different parts of the county. The public meetings were an attempt to create a congenial atmosphere for dialogue, as well as offering an opportunity to evaluate "the fit" of the preliminary survey information with what the local residents were in fact experiencing. In the study, the meetings were the third phase of the research project.

Pressures on the Researcher to Provide Feedback to the Community

Researchers, no less than other professionals have been experiencing the pressure to explain themselves to a wider constituency. There have been at least four factors which could exert pressure on community based research to be relevant and not to be esoteric or meaningless to those people in the community. The first pressure could arise early on in preparing submissions to obtain funding.

A consequent difficulty for social scientists has been that of keeping up with trends in research funding, with the conditions, ethics, and compromises involved in undertaking research for a 'client' or 'sponsor' with the standards demanded for successful grant applications, with the practices of peer and expert review, and with the frontiers of research.

(Social Science Fund
Committee Newsletter, 1981)

Social science research in communities has been expected to act as a catalyst for potential social change. The concept of action research has been defined as:

A process whereby, in a given problem area, research is undertaken to specify the

dimensions of the problem in its particular context; on the basis of this evidence a possible solution is formulated, and is translated into action with a view to solving the problem; research is then used to evaluate the effectiveness of the action taken.

(Higgins, 1980)

With the increasing emphasis on Government accountability, efficiency and responsiveness to the community, the link of researchers to policy and policy development has become more important. The political implications then of research have become evident. How the findings have been used to inform policy makers and influence social policy could indeed be another subtle pressure. The fourth area has been the pressure from the community members themselves. Although the survey had a refusal rate of less than 2%, many respondents were initially quite hesitant about participating. We received continuous comments like "I don't want to help another Ph.D. go on a dusty shelf", or "The last researcher never sent us results", or "What good is all this research anyway, it never gets back to the community". Once we informed people that we were returning to give community feedback, the resistance subsided. After the questionnaire was finished many people expressed interest in certain sections and wanted to know "the community response" and how it compared with their own.

Public Meetings

In surveying citizens' opinions, the use of public meetings was not new. It has been a time honoured cornerstone of democratic societies. There was an extensive body of literature on the study of public opinion and attitude and opinion polls. But there was minimal discussion on the alternatives of public feedback available for use in action research. The only alternative discussed at length was the written report. Very little was written about how to establish community rapport in order to discuss the results of the research and how to examine the effects the research has had on the community. Yet there were

past and recent successful examples of the use of public meetings in New Zealand to relay findings and promote an ongoing dialogue with the community.

In 1954, Hawerea - A Social Survey was published by the Hawera Star. It was significant in that it recorded how a New Zealand community discovered its needs through research,

...in order intelligently to plan immediate future social action.

(Congalton, 1954)

In 1957 a social survey in Masterton raised doubt as to how useful information from surveys could be to the community for decision making:

No group of social scientists from Wellington can operate the community for them...

(Robb and Somerset, 1957)

McCreary and Rangihau's (1959) survey results of Ruatahura in 1958 were written in English and in Maori. Meetings were held on the marae to discuss the results, to provide a forum for reaction by the people, and to consider action by the tribal executives.

The Department of Health's Porirua Health Care Service (Keating, 1976) and the Family Growth Study (Reinken and Blakey, 1976) both used public meetings effectively in 1976. In November 1977, the marae setting was again used to help Kara Puketapu in formulating the aims of his community service project which led to the major reorganisation of a Government department. The Mangamahu study (Kaplan, 1979), the Wanganui Health Project (Asher, Fordham and Pitcher, 1979) and the Kawerau Study (James, 1979) also used community feedback sessions to ensure that their data was returned to the people. There was no literature on the actual structure or process of these meetings. One recent exception was the unorthodox approach of Ruth Houghton in doing action research in the Waitaki:

Organising a train trip may be removed from the traditional tasks of community research and social anthropology, but it is an integral part of the responsibilities we have as researchers in New Zealand. The day when Margaret Mead could visit the Pacific and return to New York to write about her work is long gone.

(Houghton, 1981)

This challenge underlined the necessity to explore alternative and creative ways of discussing research findings.

Maintaining communication with a community was a constant challenge to the researcher, especially if he/she did not live in the area being researched. Regular, weekly visits during the field survey established numerous links with informants and living in the community, reading the local paper, socialising in the evenings all added to a sense of being a "part" of Dannevirke. Once the survey was over, time elapsed between visits until the data was collated, printed and the public meeting times could be organised. This time gap was felt to negatively influence the effectiveness of the public meetings.

One of the basic principles of communication has been that communicants must make themselves available to each other. The public meeting was an attempt to do this. E.X. Dance (1970) reported a helical model of communication, which "demonstrates how communication moves upwards and inwards simultaneously - allowing the initiator to be affected by his own past confirmations." Most people had very clear ideas or "past confirmations" of the function and/or process of public meetings. There were four public meetings held in the Dannevirke area over a five-month period. Each meeting took on a different form and evolved in ways unique to the particular locality in which the meeting was held.

First Public Meeting

The first public meeting was held in Dannevirke town

(population 5638*) and truly exemplified this helical process. The Mayor chaired the meeting and the public was invited via the newspaper, interviewers, informants, and by word of mouth. A member of the local Hospital Board, a local G.P., several teachers, Public Health Nurse and a clergyman were among those who attended. The attendance was high (35 people). The meeting was formally opened by the Mayor and although the rules of order were not utilised the atmosphere at least initially, was quite formal (Hall, 1966). There was an advantage in having the Mayor and members of the formal helping system for it demonstrated community acceptance and support of the research. But their presence also set a more formal tone and obviously affected how others in the group communicated. It was also unclear how many of the participants at the meeting had actually participated in the research itself. We were unable to notify the participants individually because of a decision in the research design ensuring confidentiality. This resulted in a higher proportion at the meeting who were just "interested in the research" and had not necessarily participated in it. The expectation of unilateral communication at a public meeting was quite apparent in the initial phase of the first meeting. Many came anticipating a talk from me as the researcher, with formal conclusions and recommendations. The dialogue and interchange that I had hoped for was very slow in coming.

In the second phase, a spirited discussion did evolve, but only after much probing did people feel free enough to involve themselves. Many of those in attendance were there because they were genuinely interested in their community. They expressed concern that there were no Maoris present in the meeting. Even though a special invitation had been sent to a major informal care-giver in the Maori community, their obvious lack of participation in the meeting became an issue of discussion. "How man communicates determines something about socialisation" (Duncan, 1968). It could, perhaps, be said that the symbol

* Department of Statistics, 1976

of a public meeting does not conform to the traditional expectations of a meeting on the marae. The public meeting outside the marae officiated by the Mayor could, in fact, be interpreted as a mono ethnic symbol (Smith, 1973). A lengthy discussion resulted in suggesting a variety of ways to increase communication among all members of the community. This 'selecting out effect' was raised as an issue in all the public meetings. The participants were concerned with not only who came but who did not come and why.

Second Public Meeting

The second public meeting was held at the Weber town hall, a small settlement of 214* people about 45 minutes from Dannevirke. It was a cold and windy night and the community hall was virtually empty for quite a while until three people finally arrived. The paddock next to the hall was quite lively and filled with probably a large percentage of the community's men as it was the last night of the dog trials. The picture of the researcher and three people in a large and cold town hall next to a paddock filled with rejoicing farmers must have conjured up a humorous picture. The researcher had no prior knowledge of the dog trials and the date had been checked with a local who overlooked the potential conflict of dates. Again the newspaper had been utilised as well as local contacts within the settlement. One interesting spin-off from this meeting was that one of the three persons who attended felt the issues were of great enough importance to organise another meeting.

Third Public Meeting

Several weeks later I was recontacted; another meeting at the Weber pub was held, and a group of 18 arrived. Others would have attended, but they voiced objections to meeting in the pub, where alcohol was being served. This meeting had a much different tenor from the first

* Department of Statistics, 1976

and was handled on a much less formal and less structured basis. The researcher opened the meeting and reviewed the major headings in the preliminary report and opened the meeting for discussion. Yet still major communication problems resulted. The group at this meeting wanted to know how things "ought to be" in their community and was not too interested in how they were reported in the basic findings. Several participants wanted direction from the researcher as to what services should be implemented. There was a great deal of frustration expressed in just receiving "information". The role of the researcher as "the expert" again underlined unilateral communication and affected the dialogue. This emphasis on action and "What should we do now?" presented another difficulty for the researcher. The next step of developing services was beyond the scope of the researcher and yet there was an expressed need for someone to take on this leadership role. Accompanying the researcher was the coordinator of the Rural Education Activity Programme (REAP) in Dannevirke County. He offered his community organisation skills to aid Weber in developing some action strategies.

Fourth Public Meeting

The fourth meeting was held in Norsewood, which is a small settlement (479 people*), still highly influenced by their Norwegian heritage. This meeting was, in fact, the least successful with only two in attendance. The two people who came were composed of one who had been interviewed and the other was a District Nurse who had been part of the telephone line to canvass community members to come to the meeting. The newspaper again was used as well as numerous informal contacts. Because this was the last meeting scheduled, there was a significant time lapse between the survey and the actual meeting. This probably was the major factor in affecting the low attendance. Also a School Board meeting was called and seemed to have siphoned off many of the people who were "expected" to attend. One comment made during this meeting was that

* Department of Statistics, 1976

public meetings only "preached to the converted" and that the people who really should be involved are not. The only contact and communication about the research in the Norsewood area was in fact those houses in the sample that were surveyed. Several of our interviewers lived in Weber and in Dannevirke so that the research was much more a part of these communities. The participants of the Norsewood meeting felt that the issues were of great importance to their community and considered organising a second meeting, as in the Weber area, to attempt to involve more people. This second meeting did not eventuate.

Dilemmas for the Rural Researcher

Practical Difficulties

There were numerous practical difficulties that affected the success of public meetings, not the least of which was attendance. One consideration, for example, was what night would offer least competition from the other meetings and community affairs. In Dannevirke alone there were 98 clubs and organisations competing for time. The successful use of communication networks such as the media, informants, mouth to mouth communication, etc. in order to publicise the meeting was both costly and time consuming. Deciding which media to emphasise was difficult to discern for the researcher. And finally, the community's attitude and past experience with public meetings was unknown.

Confidentiality

Confidentiality as described by Babbie existed when "...a researcher is able to identify a given person's responses but essentially promises that he will not do so publicly" (Babbie, 1975). This was distinguished from anonymity where there was no awareness of the respondent available to the researcher. In this project no names or addresses were maintained after the home visit. In fact this may not have been necessary. In all three public meetings

participants stressed that a personal letter advising them of the meeting would have been beneficial and not seen as an invasion of privacy. In the Weber meeting, many examples were given by the researcher to illuminate parts of the survey; these examples were automatically attributed to certain community members by the participants. Babbie addressed this phenomena as "inferred identity" (Babbie, 1975). It was a major consideration in the rural public meeting. Our promises of confidentiality indeed were called to question in a meeting in which the participants knew the other members of the community so well. They informed the researcher that everyone in the area knew who was being interviewed and when the interviews were in process. Our progress throughout the area was monitored via the party line. This frank admittance in their ability to identify individual responses in rural areas presented problems for the researcher, not only in the public meetings but also in the written report.

Political Aspects

Prior to the first public meeting the local M.P. expressed great interest in attending the feedback session, but due to conflicts in schedules he was never able to attend the meetings. The politics of health care and resource allocation in the rural areas was indeed a natural part of the discussion. Although the preliminary report revealed only basic data about the mental health concerns of the county, further analysis would probably enable the breakdown of concerns in specific areas. That there were significant differences within just one county, presented an amazingly complicated challenge in the planning and delivery of services.

The problems of resource allocation in health care then can be resolved only by the exercise in appropriate contexts of professional or political judgement; cooperatively and on the basis of limited information.

(Boyd, 1979)

This quote on the ethics of resource allocation failed to include the consumer and one of the basics of rural community meetings has been an expectation of cooperative development. Yet the actual linkages between the researcher, the community members and the politicians were hazy. At the second public meeting in Weber a lively historical analysis was done on the politicians and their level of responsiveness to the community. Many humorous and not so humorous stories were related about citizens' perceptions of politicians' receptiveness to their ideas and concerns in public meetings throughout the years.

Summary

Overall the public meeting took on many forms in this feedback phase of the Dannevirke Research Project. It succeeded in its basic goal by providing initial information from the survey and established a forum for discussion, although who attended and how they participated varied greatly. Numerous variables affected the successes and probably more questions than answers arose about the use of community meetings in feedback of research findings. Nevertheless, this attempt at providing community dialogue was an important aspect of action-research demonstrating the commitment of the researcher to the community. It also provided a valuable precedent to contradict the "past confirmations" of the research process.

CHAPTER FOUR: THE CONTEXT OF THE SURVEY

Impressions

After spending months in a community as a researcher, certain bold images remain. These are not the images reflected in the individual interviews or from empirical data of the survey. These are the pictures that link the past and the present of a community.

Dannevirke Borough is bisected by the major route between the Manawatu and Hawkes Bay - this route historically opened the 70 mile bush to the Pakeha (see Appendix H). The town cannot escape this main route; the noise of passing traffic fills all the shops. There are familiar names along the route: Williams & Kettle, Hannahs, BNZ, ANZ, Post Office, Mobil, Salvation Army. There are unique shops like the "Colonial Fair Antiques", operated by several industrious farmers' wives and there are closed shops with dust covered names. There is the usual sprinkling of fast food fish and chip shops, tea rooms, all contrasted by a restaurant specialising in Greek food.

Not far off the west side of this main route are the Social Welfare Department, Federated Farmers, the Courthouse, the Police Department. To the east is the library, Senior Citizens, Red Cross and the County Clerk. Church spires are closely huddled around the main route as well: the Catholic, Anglican and Methodist on one side; the Presbyterian, Salvation Army on the other.

Running parallel at first but slowly increasing the distance between State Highway Two at an angle is the railroad line, another major link between the Manawatu and the Hawkes Bay. The ornate grille work on the blue and white Dannevirke station rates a brief stop by the train on its daily return trip. The business section ends but the main route and the train track continue their widening journey through residential homes. The topography becomes hilly farmland

again. The large complex of the hospital appears above the railroad and the Mangatera Hotel provides the last site for food and drink for many more kilometres along the main route.

But before leaving the Borough, another image remains. On Cemetery Road off the main route is an old graveyard surrounded by tall fir trees that seem to perpetually blow at the top and yet keep a windfree space within the grounds. Here recorded on stone are many families and their histories, children who died early on and adults who survived long beyond them. Family trees are outlined here with names meaningless to the interested visitor, but filled with importance to the people who remain in the community.

There are numerous spots in the county that reflect the diversity in this seemingly homogeneous landscape. Scattered settlements of various size are interconnected by curving but surfaced roads. Norsewood, on the main route, has kept alive its Norwegian heritage, with a museum to demonstrate its past and a successful mill crafting jerseys and woollen wear to provide work for the present. Both the museum and the mill bring visitors and travellers to Norsewood. This Norwegian heritage is visibly present in Norsewood whereas the Danish influence in Dannevirke has vanished except in the names of streets. Only one woman in Dannevirke remains who speaks fluent Danish.

From Norsewood on to Uri Road to Porangahau Road and toward the coast there is a quaint hotel, Wimbleton, once a way station for travellers, now only a local "watering spot". Just after Wimbleton is the settlement of Herbertville, in years gone by a bustling seaport, a major pier for offloading wool and meat on ships going from Hawkes Bay to Wellington. The farmer who owns the large sheep station nearby has maintained rich historical material of Herbertville with maps and pictures depicting its high point of development. All that remains now is the hotel, post office and a wind blown beach. The local school is low in numbers and organising a play centre is almost impossible, reflecting the lack of young families in the area.

Moving inland again, leaving the larger sheep stations on the coast, the roads pass infrequent mailboxes of medium sized sheep and cattle farms. In the middle of a paddock looms the impressively large Waihi Falls - a natural wonder of thundering water that seems to be magically hidden. From Waihi there are several directions to turn: one is north to Weber, a friendly settlement with a lively pub and school house; another is south to Pongaroa, a small settlement that belies the fact that it is growing and now has six teachers at the county school. There are numerous young families now in the area reflecting a change in the nature of the settlement. Because the road to Pahiatua was better than the road to Dannevirke in earlier times, many people in Pongaroa still use Pahiatua for their major service centre.

Another part of Dannevirke is what used to be Akitio County until 1976. This is a large geographic area filled with medium sized and large sheep stations, complemented by Akitio Beach which has a small camping ground and numerous summer baches.

On the northern side of Route Two the County runs into the Ruahine Ranges. Here there are many more private bags, closer together, reflecting the high concentration of dairy farms. Here life is dictated much more strictly by the morning and evening milkings.

Following Route Two out of the borough and southwest toward Woodville, the Makirikiri marae sits prominently in the distance. Closer to the county border is the Oringi meat works, a potential addition to the county's job opportunities which promises to bring in new families, and make new demands on housing and services.

The economics of sheep and dairy farming, the different life styles that they reflect, and the stages of family development play a major part in creating the fabric of the various settlements within the county. Different historical and cultural influences also make an impact. Recent economic

developments (the new meatworkers and the redundancies in the woollen mills) affect the work opportunities and dictate migration into the area, as well as contribute to the process of young people remaining or leaving. The evolution of a service centre in Dannevirke Borough was not just due to its central location within the county or due to its position on the main road from Hawkes Bay to Palmerston North.

Brief History

Dannevirke Borough's role as a service centre was not always secure. Historically there was a great deal of competition among various settlements in the "70 mile bush", as the Pakeha settlers moved from the southern Hawkes Bay toward the Manawatu Gorge.

Maori History

In pre-Pakeha days, a huge totara tree named 'Taupa-ki-heretaunga' existed as a natural boundary between the tribes of the Hawkes Bay and those of the Manawatu. The land north of the 70 mile bush was occupied by the Ngati-Kahungura and to the south and through the Gorge there were the people of the Rangitane tribe. Although there was little attraction for the bush as a home, it was a rich food source for visiting parties. There were many battles in the area and one of the most notable took place a few miles from Dannevirke. It was called Umutaoroa, or slow cooking oven, for the great time it took to cook the bodies of the conquered. Eventually the tribal differences lessened and when the first European settlers arrived there were *pas* at Kaitoke, Tahoraiti, Kakoa, Ngatoto, Paehutae, and Okahae at Tiratu (from 'Alpha', date unknown).

The "70 mile bush":

...was representative of most forms of the flora characteristic of the county, the most viable milling timber being rimu, matai and totara. From Takapau to Oringi was a valuable totara belt of varying width, which coincided with the line chosen for a railway.

('Alpha', no date)

The decline in British immigration in the late 1850's and the necessity for hardy settlers who could meet the demands of the dense bush forced the provincial government to recruit Scandinavians. The government was in need of families who would be willing to go inland, build roads, and settle a small block of land with their entire families. Dr I.E. Featherston, the Wellington Provincial Superintendent, in a speech in 1871 highlighted this:

Public Works and immigration must go hand in hand. Nay I will go further and say that government is not justified in undertaking the works I have indicated unless the province is prepared to do its duty in regard to immigration. There is no purpose in preparing a county for settlement unless you are also prepared to bring to it population; and remember this, that capital invariably accompanies and follows immigration.

(Norsewood Pioneer Museum, 1965)

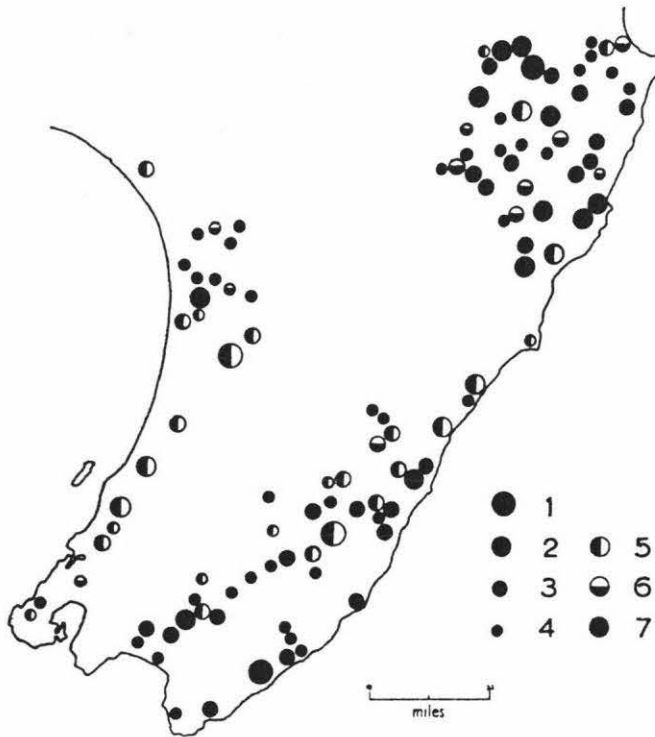
Three settlements were originally planned - two Norwegian and one Swedish - and on 15 September 1872 the 'Ballarat' docked in the Hawkes Bay with Danish families, and the 'Hooding' arrived with Norwegian and Swedish families. The government provided transport from the port of arrival to settlement at two dollars an adult, temporary accommodation at Te Whiti while shelters could be built, and free rations for two weeks (Norsewood: the Centennial Story, Andersen, 1971).

Settlers were allotted 20-40 acre sections emphasising the small family farm and were often encouraged to arrange some small business in the settlement as well (Hamer, 1975).

Prior to the settlement of the interior of the 70 mile bush, most of the farming was done on large sheep stations. The

following maps show the distribution of large stations and bush farms (usually small and family run).

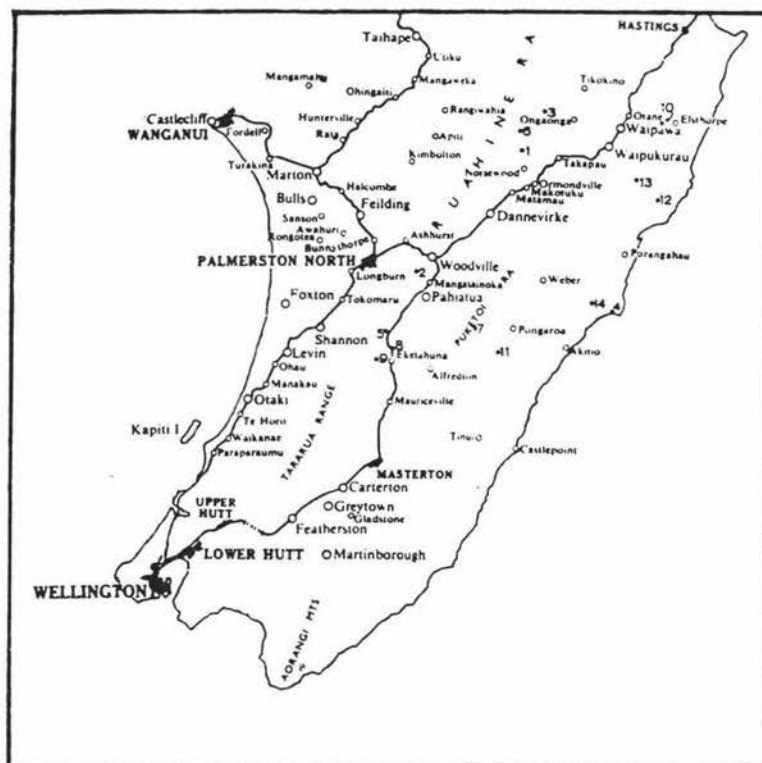
FIGURE ONE
Properties of 5,000 Acres or More 1890



Source: "The Village and the Bush", In Social Process in New Zealand, J. Forster (Ed.), Longman Paul Limited, 1969, p.112.

1. 40,000 acres or more.
2. 20,000-40,000 acres.
3. 10,000-20,000 acres.
4. 5,000-10,000 acres.
5. Company properties.
6. Absentee owners.
7. Private properties.

FIGURE TWO
Location Map



Source: "The Village and the Bush", In Social Process in New Zealand, J. Forster (Ed.), Longman Paul Limited, 1969, p.113.

1. Ashley Clinton
2. Ballance
3. Blackburn
4. Herbertville
5. Hukanui
6. Makaretu
7. Makuri
8. Newman
9. Nireaha
10. Patangata
11. Rakanui
12. Wallingford
13. Wanstead
14. Wimbledon

Franklin's maps bring to life the typology developed by Martin (1983) to demonstrate the connection between the size of the enterprise and the types of control during the late 19th century. The direct control represented social relationships between employer and worker, the indirect represented structural constraints.

FIGURE THREE
Enterprise Size (work situations)

	Small	Large	
Direct	1. Farm as community	3. Paternalist community	Itinerant seasonal labour (swaggers)
Indirect	2. Egalitarian small rural town	4. Occupational community	

Each of the above four cells define a specific type of community that existed in New Zealand in the nineteenth century. Thus far we have focused upon cells one and two - farms and small rural towns - both of which played a key role in New Zealand's development

(Martin, 1983)

It was the struggle to establish this small family bush farm and village settlements that created this historical fabric of Dannevirke Borough and County.

The early settlers faced many hardships including the language barrier, the dense bush, and minimal preparation for what they encountered. Many were not farmers and found that they lacked the necessary skills to clear the land and develop it. Initially, these settlers went to the areas where Norsewood and Dannevirke now stand. But numerous other bush settlements developed in the 70 mile bush. The "break-in-journey points" were often reason enough to start a small community and the distance that could be travelled in a day's journey could define a settlement (Hamer, 1975). A pub, store, previous military position or proximity to timber were reason

enough to develop these settlements. Most of these settlements remained marginal in their economic function and failed to cross the "urban threshold" (Hamer, 1975). Daily life remained focused on local rural interests and their social importance became their primary function (Franklin, 1969).

Although Ormondville was only 14 miles from Dannevirke and four miles from Norsewood, it exemplified the evolution of many bush settlements.

The town in the past supported a butchers shop, bootmakers, blacksmith, saddler, undertaker, solicitor, library, draper, billiard room, three stores, a police station and a court house. Times have changed and most of these services are now centred in Dannevirke. Roothing is good and there are sealed roads in all directions. Sawmilling was a major industry in the early days and over 1000 acres of native bush were cleared. The mill now cuts mainly pine and small dairy farms have given way to the grazing of cattle and sheep.

(Ropiha and Playle, 1978)

Even as early as 1925 numerous other once-busy villages were now settling into a marginal economic function due to change in transport, improved roads, the railway line and the car:

...small centres scattered throughout the countryside were then the rule, but the motor car has killed them. Among them were Woburn, Wimbledon, Herbertville, Wallingford, Wanstead, Patangata, Onga Onga, Tikokino and so on.

(Daily Telegraph, 1925)

The 19th century "break-in-the-journey point" was no longer an issue and other criteria seemed to come into play to aid those settlements which continued to develop into service centres.

Dannevirke is situated very favourably to cope with the trade of the northern part of the 70 mile bush; to the west lies quite densely settled dairy farming land and from the east a number of route ways which penetrate the higher areas converge on the town. When one contrasts

the sites of Dannevirke and Norsewood, founded at the same time, the deficiency of Norsewood's site lies in its too great proximity to the northern border of the bush; so that unlike Dannevirke, which was surrounded by the developing bush community, Norsewood's northern hinterland included the much less densely settled and socially different grazing area which in effect it did not serve. Furthermore, Norsewood was not sited on the railway line and had the competition of nearby Ormondville.

(Franklin, 1969)

There is not total agreement with this analysis. One prediction in 1887 seemed to state eventual fall and decline:

They are inclined to overdo this place [Dannevirke] with shops, and I could not advise any more to start unless they had a little spare cash they were anxious to lose.

(Franklin, op.cit.)

Dannevirke's current status as the service centre for the country disproved this prediction but opened the debate about what criteria were important in analysing a 'successful' rural town. The numerous other settlements in the county that failed to cross the "urban threshold" continued to contribute to the economic and social fabric of the county. But Dannevirke Borough, a Danish settlement, evolved beyond a village to remain the service centre of the 70 mile bush. Location, economic function, historical settlement patterns, cultural heritage, traffic patterns and the "character" of the business community all seemed to be important criteria in the evolution of a settlement to a town.

CHAPTER FIVE: THE FINDINGS

Formal Psychiatric Support for
Dannevirke Borough and County

Prior to 1880 and to the development of major psychiatric hospitals in New Zealand, the mentally ill were categorised with the poor and the criminal and were treated in a similar manner (Jermyn, 1951). With the advent of asylums in the regions (New Zealand was unique in that although it had centralised control of the psychiatric hospitals, the institutions were built in the regions), therapeutic communities were created to protect the patient and to provide a medical laboratory for patients to relearn more rational and orderly behaviour. But the emphasis on asylums separate from other forms of health services in the region created two separate avenues of health care. The individuals suffering from mental disorders were removed from their community and other non-psychiatrically trained professionals had little to do with them once they were referred to the psychiatric hospitals. Family involvement in the hospitalised patients' treatment was minimal as well.

It must be acknowledged however that an unfortunate consequence of central control was that the majority of institutions became largely separated from the main stream of local, social, professional and political life, this isolation was intensified by those very deep seated although largely irrational fears about the nature and complication of all forms of mental illness.

(Government Printing Office,
1969)

This isolation of psychiatric illness from the community was particularly evident in rural areas. Before the development of Manawaroa Centre for Psychological Medicine in the hospital in

Palmerston North in 1970, individuals requiring hospitalisation from Dannevirke Borough and County had to be sent to Porirua and/or Lake Alice Hospital. Hospitalisation virtually severed the patients' involvement with their family and friends in the community until after discharge. Very little follow up services were provided to the patients and their families and liaison with the G.P.s in Dannevirke was quite minimal.

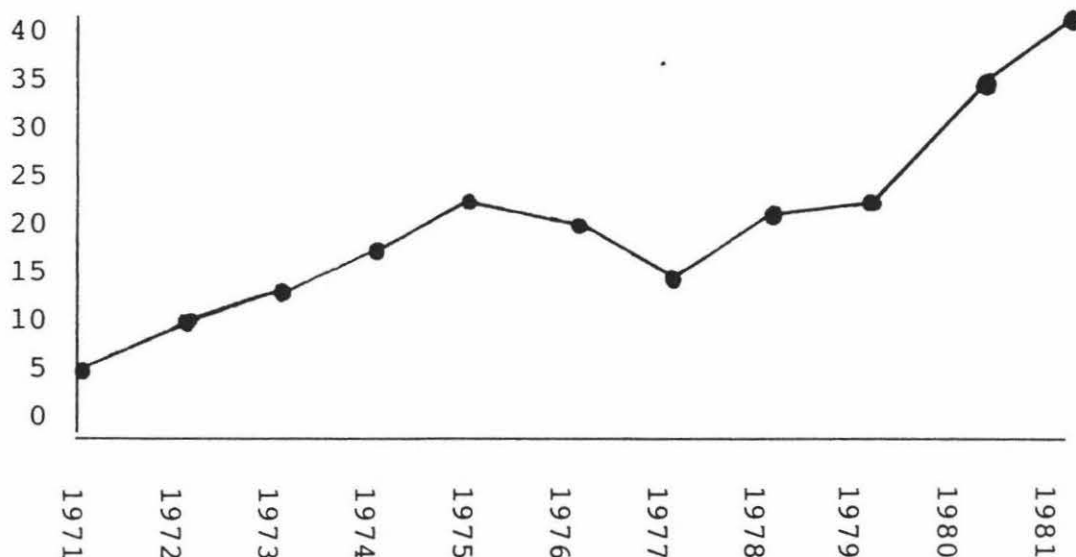
Once Manawaroa was established, it became Dannevirke's major resource for formalised professional psychiatric services, offering inpatient, outpatient, and day treatment services. It does not offer any peripatetic services, satellite clinics, nor does it provide any community education or prevention services for the Dannevirke community. Medical inservice training is available to the G.P.s if they come to Manawaroa and specialised supervision and consultation can be arranged.

Although the outpatient service is utilised by individuals, couples and families from Dannevirke, distance is still an issue, with cost of petrol, driving time, and the psychological barrier of the "Manawatu Gorge" listed as impediments to greater utilisation of the service.

A statistical survey of admissions to Manawaroa from 1971 to 1981 was undertaken to provide a descriptive picture of how Manawaroa has been utilised by the Dannevirke community in regard to their "labelled" mentally ill.

Basic information was abstracted from admission cards to ascertain the diagnosis on admission, the sex, age and race of the patient, marital status, referring physician/or hospital, and length and type of treatment. To ensure confidentiality, no identifying information was released by the hospital, and each patient was given a case number as an identifier. (A breakdown of this material year by year can be found in Appendix I).

Manawaroa Hospital Admissions -
Dannevirke Borough & County 1971-1981



In reviewing the statistics over ten years, the progressive increase in numbers hospitalised is most evident. The number of admissions in 1971 totalled five and the number of admissions in 1981 totalled 37 - an increase of over 600%. This increase is significant considering the relative constant population in the borough and the decreasing population in the county over the last ten years. Utilisation of Manawaroa by Dannevirke Borough and County has definitely increased. There were 212 total admissions during the ten year period but these represented only 147 different individuals. The readmission rate was a little less than one-third of all admissions.

Age

The average of the patient on admission ranged from a high of 41.4 years in 1971 to a low of 25.8 years in 1972. The

youngest admission was age 14 and the oldest was age 80. The average age of admission over the ten year period was 35 years.

Race and Sex

92.5% of all admissions were European, 7% were Maori or part Maori, and .5% Indian. The balance between male and female admissions was almost equal, with 49.5% males and 50.5% females.

In reviewing the diagnostic labels given to the patients on admission, it was difficult to discern patterns. Prior to 1980 the diagnostic classification assigned on admission was not reviewed internally within the hospital, so that the specificity and accuracy of the diagnosis must be questioned. Also the classification system was revised after December 1979, so that the classifications used since 1980 reflect the 9th Revision.* These major difficulties in the record keeping, placed any interpretation of the diagnostic trends prior to 1980 under suspect.

Maori

Taking the above into consideration, there were some interesting statistics to be noted. Of the 7% admissions who were Maori or part Maori, they were much younger than the average admission with an average age of 24.4 years. All but two of the patients were male, and the most common diagnosis was in the 295 Schizophrenic Psychosis classification (N = 15).

European

The European clients were represented almost equally at admission by males and females with the average age of 35 years. Female admissions were most often categorised in two main classifications: 296.1 Manic Depressive (depressive type),

* International Classification of Diseases (Ninth Revision), Chapter V: Mental Disorders. Codes 290-319 inclusive. National Health Statistics Centre, Dept. of Health, 1980.

and 300.4 Neurotic Depression with anxiety neurosis, Adjustment Reaction (brief depressive reaction), and Acute Reaction to Stress the next most utilised. In the years prior to 1980, there were numerous admissions each year without any diagnosis. Women were more often than men in this "no diagnosis" classification.

The male European patient did not appear in any one classification in a regular pattern. In 1980 and 1981 the men tended to be clustered more in the Schizophrenic Psychoses and in the Personality Disorders; this appeared to be the trend in the preceding eight years as well. Forty-five percent of the men were single, whereas only 19% of the women were single.

Referrals

Of the 212 admissions during the ten years, nearly 50% of the referrals came from the same two general practitioners in Dannevirke Borough. Three other Dannevirke G.P.s accounted for 35%, and the Dannevirke Hospital Superintendent for less than 5%. The rest of the referrals came from other doctors serving as locums in the Dannevirke area. In the earlier years, 1971-1976, the places listed most frequently for previous treatment were Porirua, Kingseat, Hastings, and Ashburn Hall. From 1976 onwards only Manawaroa was listed as the last previous treatment centre.

From these basic statistics it was apparent that utilisation of Manawaroa by Dannevirke physicians as a formal psychiatric support had greatly increased since 1971. Two of the five doctors in the borough consistently referred more patients than the other three. These two physicians may have referred more patients because of their own interest in psychiatric illness, the community seeing them as a psychiatric resource, or an unusually high percentage of mental illness in their two practices.

The Maori clientele tended to be rarely hospitalised and those who were referred were young and seriously mentally ill.

Women were referred as much as men but seemed to fall more heavily into categories reflecting mood disturbance, affect imbalance, and depression. The older (65 and over) patients all tended to be European, who were widowed, divorced, or widowers. With the improved record keeping since 1980 more detailed case analysis could occur allowing the development of a more accurate picture of the target populations being referred.

Despite the increasing number of admissions, it still only reflected those few individuals within Dannevirke Borough and County who were seen to need professional psychiatric services which could not be provided within their community of residence. There were still many individuals receiving help within the county and borough from other human service professionals and/or informal support networks of friends and relatives. To begin to describe these formal and informal networks is the focus of the next two sections.

Case Studies of Formal Caregivers

Although the census of formal caregivers in Dannevirke Borough was not a large number (5 General Practitioners, 5 clergy, 1 school counsellor, 1 school principal, 1 Public Health Nurse, 1 Police Chief, 1 Department of Social Welfare social worker, 1 Maori Community Warden), the diversity of the group presented problems in analysing their responses to the open-ended interview questions.

The assumption behind this phase of the investigation was that there was "truth" to be discovered in the perceptions and actions taken by these formal caregivers. But the dilemma was how to analyse their responses and organise them into some manageable and meaningful format. In reading and rereading the transcripts I began to note a certain "topography" in the conversations - a topography with definite boundaries which began to reflect areas of allegiances and areas of similar

perceptions. It was important to note that the time limit on the interviews and the fixed number of topics queried created some limitations on the direction of discussion and the length of responses. Despite these limitations an interesting pattern of similarities and differences evolved.

In the search to make some sense out of this topography of social perception which the formal caregivers had of mental illness, I began to analyse the responses using some of the principles of lexicology, the sociological discipline that examines key words which are characteristic of a given society or area. These key words were embedded in a network of subordinate words which depended on the key words: mental illness was certainly an example of a key word in our 20th century society. Latouche and Matore (Arnoux, 1982) list the components of a key word:

1. It belongs to a notational field limiting its acceptations.
2. It has a past, it remembers that to say it carries the trace of past social settings.
3. It has an exponent or social weight.
4. Our awareness of its changes.
5. It is a social fact.
6. There is no thought without words, at least as a first approximation.
7. It appears at the same time as the concept.
8. It expresses the consciousness humans have of things.
9. It spreads across a population only if it corresponds to a need. Its use is intimately linked to people's behavior.

The various vocabularies used in discussing the subject of mental illness in a rural environment seemed to continually contain these components: the history of the mental health movement, the impact of asylums and institutions, the

negative and positive connotations of words used in relation to mental illness, and the relationship of practice behaviour to a corresponding need in the general population.

Each professional caregiver defined boundaries which encompassed their perceptions and practice behaviour in relation to mental illness. Their personal life experience, education and professional development combined in a way which provided a unique, individualised understanding of mental illness. But at the same time, each professional group reflected shared agreement on numerous aspects of mental illness and the delivery of service to the community. This created a different set of boundaries, reflecting professional allegiance.

First, each professional group will be discussed in relation to their similarities and differences within the profession. Then the relationship among caregivers and between caregivers and their clientele will be discussed.

The General Practitioner

Dannevirke is unique in that although all the five G.P.s are in separate private practices - a format common to most rural areas - it also has a general hospital and all of the G.P.s are on staff.* So not only does it have a fair number of G.P.s for the population, it has a hospital as a major medical

*

This is not common practice. Out of the 1800 in full-time general practice in New Zealand, only 302 have a part-time hospital appointment (West, 1975).

resource for the county. The hospital is a common meeting ground for the practitioners and ensures the medical community of ongoing communication and shared practice.

All the general practitioners stated that they fulfilled the "gatekeeper" role to health care services in the Dannevirke Borough and County. They perceived this to be part of their function as a G.P. and also felt that their patients came to them for this service.

They felt people came to them first - often with a medical complaint that was seen as necessary to gain access to discuss with the doctor an emotional or psychological problem. One G.P. expressed some concern about how he was used for all kinds of problems. He wondered if people turned to him out of habit and if his area of jurisdiction extended beyond his effectiveness. The G.P. might not be the appropriate person for some emotional problems but the rural environments lacked many of the mental health services of an urban environment (e.g. A.A., Marriage and Family Guidance, church social services).

Once the area of concern (non-physical) was clarified, then a treatment plan was formulated and could include counselling, some medication, a brief stay at the Dannevirke Hospital or if necessary referral to a psychiatric specialist or to psychiatric hospitalisation at Manawaroa. The G.P. felt he was the link to specialist treatment outside the community, but they all preferred to treat within the community if possible.

The percentage of mental illness (or non-physical problems) treated in the practice varied from estimates of 10% up to 25%. The definition of mental illness was broad and included

a variety of presenting symptomology. But all stated that a significant percentage of their patients reflected "stress", "depression" and dysfunction in their daily lives from emotional or psychological origins.

The areas most commonly identified by the G.P.s as mental illness were the depressed and/or isolated housewife, the overstressed businessman, the alcoholic, the lonely, aged population, and the adolescent schizophrenic. The Maori population was seen not to experience mental illness in the same form, and as a group they more often reflected social problems stemming from structural problems in society (e.g. poverty, unemployment, housing), although drinking problems, unemployed youth, and wife abuse among the Maoris were brought to the G.P.s attention. The Maoris were seen to respond to stress differently and perhaps to handle their problems "amongst themselves and in their own ways". Some frustration was expressed with the lack of Maori response to preventive medicine, especially with inoculations for children. It was acknowledged by the G.P.s that both Pakehas and Maoris utilised other people in the community, often alongside the service they were receiving from them.

If more was required than counselling and medications on an outpatient basis, the G.P.s had a functional relationship with the hospital and its superintendent. The Dannevirke Hospital was used for respite - in the psychopedic ward and in the general medical ward for problems with alcoholism, depression and suicidal ideation. This use of the facility allowed for a most helpful "time out" and maintained the patient in the local community. The G.P.s stated the further afield the patient was referred the less successful the follow-up and exchange of information. All the G.P.s felt that the service received from Manawaroa was quite satisfactory. The biggest

problem seemed to be the geographical/psychological barrier of the Gorge and the travel time for outpatients or for the families of inpatients. During the research period petrol restrictions and carless days were in effect. Both were worries for referring outside the community. Several G.P.s also commented on their reluctance to "interrupt" the psychiatric consultation which may have hindered better follow up and they underlined a lack of face-to-face contact with the psychiatrists and staff at Manawaroa. Lake Alice was used rarely and care there was seen as adequate but discharge plans for aftercare were not communicated back to the G.P. in charge.

Although all the G.P.s felt they were the major source for treating mental illness, they listed numerous other people in the community who were helpful. The Public Health nurse and District nurses were seen as a vital link to families especially for follow up in relation to medication and visiting isolated segments of the population (e.g. aged in homes or flats, farm families), the police were identified as essential in helping with domestic violence. The G.P.s were mixed in their reliance on the clergy. Some saw the clergy as helpful for their own parishioners, others saw them as not particularly helpful in dealing with mental illness. There was only one social worker in the community at the Department of Social Welfare and he was relatively new, so that he was not mentioned as a potential resource. (One G.P. had used the social worker for marital counselling after he discovered he was a trained Marriage and Family Guidance counsellor as well).

All the G.P.s mentioned their own collegial support as a major asset. Locums were rarely used in Dannevirke as the local G.P.s covered for each other. One area of minor difficulty was when a patient wanted to change doctors. It could be uncomfortable for the previously treating physician and for the new G.P. who was being consulted.

The G.P.s practising in Dannevirke all had long histories in rural practice. Four of the five have been in Dannevirke for

15-30 years. One doctor had only been practising there for less than five years and was referred to as "the new doc".

Several of the G.P.s practised in areas "more rural" than Dannevirke, areas where they were the only doctor* and where the closest general hospital was over 140km away. All had experience in home visiting over many miles, but now most consultations were done in their surgeries. They all lived in their surgeries or on the same ground and shared the common experience of always being seen to be available or on duty. This created the dilemma of being needed vs. being used and abused. Being always on call was seen as a potential stress to themselves, their wives and children. They chose to practice in Dannevirke because they enjoyed the rural lifestyle, liked having some other G.P.s in the area, and enjoyed the part-time appointment to the hospital. The lack of competition for patients was stated by several of the G.P.s as to why they preferred rural practice to urban practice.

In addition, the G.P.s mentioned they enjoyed having the ability to see several generations come into the world and develop. Also as a result of treating the entire family they obtained a more comprehensive understanding of the patient and their environment.

Professional isolation was experienced, especially when specialists were essential and their services were unavailable in the local community (e.g. halfway house for young adults with a major mental illness). But overall all the G.P.s felt quite satisfied with their practice and their lifestyle. Preventive programmes for mental illness were not seen as viable for the rural area. Several G.P.s equated prevention with control from outsiders who didn't understand the community. The lack of sufficient numbers was most often stated as the reason why preventive programmes or alternative forms of mental health services could not be established.

* One G.P. described different types of rural stress: he talked of the chronic "anxiety" of wives in mining towns on Widows Lane reflecting the dangers of the one occupation town vs. the lonely widows of farmers now living in Dannevirke Borough.

The crisis in general practice is manifest in...our helplessness in determining how to use developing social services without being pushed out of primary care. In great measure the fault lies with us.

(Carson, 1971)

Public Health Nurse

There were two public health nurses in Dannevirke and I was able to interview one of them. She defined her role as a nurse in an independent fashion. Although based in a building on the Dannevirke Hospital grounds, her employer was the Department of Health. She defined her mission as prevention and not curative, so she was not dependent on referrals from the local G.P.s and used the local "grape vine" to intervene. She differentiated her role from the District Nurse, a hospital employee who must wait for referrals by the G.P. This does not mean the PHN was completely autonomous because she was involved in the local medical community and had rapport with all the G.P.s. She described the G.P.s as excellent in their medication follow-up for people experiencing psychiatric problems. But she felt that this was often not enough. Most of the local G.P.s had not received a great deal of training in treating psychiatric illness and there was no ongoing inservice training available locally. So the level of expertise for handling the more difficult psychiatric cases was not increasing. She felt her own training was inadequate at times and she travelled to Palmerston North for supervision every six weeks. On a more frequent basis she consulted with a PHN whose greater depth of experience aided in increasing her own skills.

The PHN received referrals directly from Manawaroa and Lake Alice. She then made home visits to assess their readjustment to community life. She ensured the medications were being taken appropriately and was the liaison with other necessary support services. At least 10% of the people on her caseload she defined as experiencing psychiatric problems. These problems included alcoholism, often unacknowledged as a problem by the patient. Linkage with Manawaroa was quite

satisfactory except with those clients that Manawaroa felt unable to help or could no longer help. Although a small number, these people were often left "to sink or swim" and she questioned if this was truly 'community' mental health. It was these people and their families who seemed to suffer the lack of alternate services in a rural community. The majority of her clients were women who fell into two distinct categories: the elderly Pakeha, and young Maori or Pakeha woman with small children.

Although she defined the rural community as having great tolerance for individual differences, she found in practice the rural community perspective was "narrower" than the urban in perceiving problems and solutions to them. Because of rural traditions and a strong "memory" and knowledge of people and their behaviour, greater deviancy was not actually allowed and restricted alternate ways of viewing and resolving problems. She felt women were particularly vulnerable in rural areas because employment opportunities were limited and there was minimal acceptance of women in different roles. In her view, the traditional role of the G.P. as the professional who decides for the client was maintained.

Although she found the G.P.s most helpful, she felt a rethinking of the "helping process" was essential to explore other ways of dealing with psychiatric and emotional problems.

The PHN had only been in Dannevirke for 18 months but she was quite supportive of initiatives in preventive programme development. She felt that prevention was not the recruitment of more professionals but better coordination of existing professional and lay people in community so that new solutions could be achieved. She noted teamwork, in the form of a community mental health committee, might aid in delivering better services locally and ensuring better peripatetic services from the Hawkes Bay, Palmerston North and Wellington. Teamwork would also minimise the sense of professional isolation that occurred in the rural environs: the interchange of different professional groups could expand the perspective

of mental illness. The preventive programmes she listed were many and varied. Education programmes were needed for young mothers both in antenatal and postnatal care of babies and toddlers; sex education for adolescents and some sort of family clinic for contraception was essential; she felt many young persons were uncomfortable approaching their family doctor for these concerns. Preventive programmes to deal with retirement and widowhood were also included in her list because she felt loneliness could be a problem for elderly rural women.

The Clergy

The ministers of the five largest churches in Dannevirke were interviewed (Catholic, Anglican, Presbyterian, Methodist, Salvation Army). The more traditional churches in New Zealand have been experiencing a declining membership and Dannevirke was no exception. The Presbyterian church in Dannevirke did a survey of its membership and found a significant decline in its membership, especially among the younger families in the community. The fundamentalist/pentecostal churches were showing an increase in membership but I was unable to interview these particular denominations. A representative of the Mormon church was interviewed but not as an identified church professional. He was contacted as a major resource for the Maori community. The Ratana church and specifically Maori backed sects were not included and reflect in some ways a monocultural analysis of the role of the church. The effect of races worshipping separately is important but not within the purview of this particular research.

One of the most striking differences between the G.P.s and the clergy was the transient nature of the clergy's position in the community. The Catholic priest had just arrived, the Methodist had only been there two months, the Salvation Army minister had been there four months but was getting married soon and would probably leave and join her husband's church. The Presbyterian and Anglican ministers had been there several years, but all had ministered in numerous other communities, both urban and rural and expected this pattern would continue.

Although they were mobile, all the clergy interviewed felt the parishioners were used to the "comings and goings" of ministers. Each described a period of orientation and accommodation as they learned about their parish and the congregation grew to know them. Four of the five clergy saw themselves "assigned" to the Dannevirke community and one felt he was "led" or needed in a spiritual sense.

The clergy met regularly in a Ministerial Fraternal Support group. Attendance was voluntary and did not include all ministers in the community. The previous Catholic priest had refused to belong and the effectiveness of the group was being challenged by some newer clergy. They expressed a need for mutual support and for a united forum to speak to community problems, wider than their respective denominations. But contrary to the following quote, ecumenism has not taken a firm foothold in the rural churches of Dannevirke:

This 'ecumenism' - one element in homogenization to which urbanised societies are subject has reached into the world's rural areas and made it difficult if not impossible for specific churches to preserve their high degree of congregational and theological ethnocentrism.

(Smith and Zopf, 1970)

The clergy all lived alongside their churches except for the Salvation Army clergywoman. She lived a few streets away but had her office in the church. They all commented on the value of being accessible and visible to the community but they also felt the resulting lack of privacy and the invasion of people and problems into their private lives. One minister commented that it was ironical that he and his family actually had to go away from the borough to obtain some private time.

The majority of the clergy interviewed felt that most people experiencing mental illness would consult their G.P.s first. If they had not consulted the G.P., the clergy would refer them on to their G.P.s if they felt more than spiritual counselling was needed. One minister felt it was quite important to help the person reframe the problem, especially

if the problem was defined as an individual dysfunction, when in fact it could be due to a societal dysfunction (e.g. unemployment). This reframing would then aid them in making a more appropriate referral. Several ministers felt they should be utilised as part of a community team approach in dealing with mental illness and communication problems. But most of them felt they were not utilised by the G.P.s in this manner. The majority of their work was with the people of their own denomination. The Ministerial Association was helpful in supporting a minister coping with a difficult problem and in clarifying if other churches were involved.

All the ministers were quite used to utilising the Department of Social Welfare's social workers and felt strong links with the new full-time social worker at the Dannevirke office. Because the social worker was a marriage guidance counsellor, they were referring marital problems to him. One minister felt well trained to do marital counselling for his own church and another said his predecessor had been involved in marriage guidance and had developed a reputation as a "counsellor" inside and outside his congregation.

None of the clergy had been to Manawaroa to observe or meet the staff but all had experienced some parishioners being sent there as clients. One minister expressed concern about follow up especially with parishioners who were discharged to their homes in rural areas with three months of medication and no follow up. This minister organised "lay people" with similar experiences to visit the parishioners at Manawaroa and follow them up at home after discharge. Several of the ministers' wives were quite active in areas of counselling and saw a role for themselves working alongside their husbands.

The advantages of rural life were identified by the clergy most often in relation to the disadvantages of urban life. It was less materialistic, less sophisticated, the pace of life was slower. The reduced population meant people knew each other and their contacts were deeper - meaning they crossed each other's paths in many ways and in many different roles.

The medical community was seen as highly accessible and the G.P.s "were always available - even on weekends." The ministers felt their transiency could be an advantage because they were not biased by history or long association. Although all the ministers felt they must use sensitivity and time effectively to enter a rural community and "earn their right" to be involved in people's lives.

The clergymen compared the disadvantages of rural life with the advantages of urban life. Confidentiality was seen as a constant problem in rural communities: anonymity was impossible. One minister stopped driving his car and walked to home visits so his parishioners could not be identified as being visited by the minister. The lack of specialists especially in psychiatric and psychological difficulties was cited as problematic, often forcing people to travel outside the county.

Young people were identified as extremely vulnerable to the lack of resources. Shrinking employment opportunities meant the "cream" of the youth were moving to large urban centres. The clergymen said certain streets in town were easily identified as trouble areas, so that certain families and individuals became stigmatised.

Although networks of support were visible and helpful, the clergymen noted they could be restricting as well by prohibiting a person from seeking help outside his family and friends. The numerous clubs were also seen a mixed asset because the main supporters were torn by loyalties and responsibilities to the competing organisations. Change was seen to come slowly to the rural communities with the same people being called on to initiate change. The Maori community until recently was seen to suffer from the "in-between" status of the larger tribes in Hawkes Bay and in the Manawatu. The ministers tended to divide the Maori population into Mormon and non-Mormon.

Prevention was seen as a negative imposition of programmes

from outside the community. All seemed concerned with youth and families but were unsure as to how best to support family life. One minister suggested the establishment of a semi-communal accommodation centre for young people staffed with existing G.P.s, ministers and guidance counsellor and social worker. The programme could offer emergency support, community education and enrichment. Several ministers suggested involving more of their parishioners in community action but felt that social action for improving mental health was a difficult task. During the research, one of the ministers refused to give a service at the Anzac Day ceremony, questioning the continuance of Anzac celebrations. The ministers reflected different views on healing and what level of interventions were both effective and appropriate for their church.

School Principal and Guidance Counsellor

The impact of the school on a rural community is particularly influential, beginning in pre-school and continuing through kindergarten, primary, intermediate and secondary. Due to time and resource constraints, the secondary school guidance counsellor and principal of Dannevirke High School, which serves both the borough and county of Dannevirke were interviewed. This selection obviously excludes valuable input from the numerous teachers, principals and teacher aids involved in all other levels of education. It did provide, however, valuable insights into the mental health and illness concerns of youth in the secondary school.

It was difficult to combine the interviews of the principal and the guidance counsellor in that their roles were dramatically different. The principal was an administrator and adjudicator who did some counselling. The guidance counsellor did counselling, both academic and psychological. Dannevirke High School has a well developed counselling network which has been evolving over the last six years. This created difficulties in discussing the principal and guidance counsellor views in isolation. The school has "buffer zones" composed of various teachers with different levels of

expertise in counselling, recreation and sport. There were group tutors, house leaders and guidance coordinators. The principal's encouragement and endorsement of the guidance network and the guidance counsellor have been vitally important to the network's successful development. The principal in his counselling role was often asked to deal with truancy and the numerous problems related to truancy, but not generated by the school itself. Many of the issues behind truancy were related to problems in the young person's home life. There was often fear of school and especially with Maori parents, school was not necessarily seen as a positive experience. Pregnancy most often marked the end of Maori girls' schooling but not so with the Pakeha girl.

The principal felt that rural life had many advantages. The slower pace and sports-minded community of parents made them available for support for the school's activities. In his eyes having a residential and day school made the High School an important centre for community activities - pulling in the more rural families as well as the families in the borough. He acknowledged that there were some disadvantages for the rural area offers fewer opportunities for musical and cultural experiences. Also he noted the great pressure experienced by some of the teaching staff who became the primary resource for some of their students, due to the lack of other services for youth in the community. The principal was aware of more marital pressure on both his staff and in the community in the last two years. As an important and a visible member of the community he was also aware of the difficult pressure experienced by his children and children of other professionals attending Dannevirke High School. There were no alternate schools available unless the parents wanted to send them to a private school outside the county.

Prevention was seen as important but not in the form of a community mental health centre with specialist staff and programmes. He was adamant that Dannevirke did not need another agency but needed further coordination of existing helping personnel (e.g. clergy, Department of Social Welfare

social workers, schools, parents, G.P.s and police). A community worker could be helpful to facilitate this process but he felt the secondary school in a rural community was ideal for establishing a centre for moral education, values clarification and increased understanding in family life.

The guidance counsellor had only been at the Dannevirke High School for two years but had established a place in the guidance network and created community networks to aid students in resolving numerous difficulties. His rapid assimilation in the community was aided by his wife's role as the Public Health nurse. Most of his counselling was only with the youth but some families were involved. It was hard to engage families during the day due to work schedules and conflicting commitments. He counselled a small number of students who were referred back from Manawaroa after a serious suicide attempt or a psychotic episode. In 3rd and 4th forms many of the problems evolved from complex family relationships and/or concern with sexual relationships. Since 30% of the students were bused into school he also dealt with loneliness among teenagers living miles out from the school. Other problems included delayed grief reactions to parents' separation, serious illness or death of a family member.

Staff also saw the guidance counsellor as a resource and used him for their own marital difficulties. The guidance counsellor had regular meetings with the social worker from the Department of Social Welfare and established a good relationship with the police and several Maori wardens.

The guidance counsellor viewed the Maori youth as not having as many "personal hang ups" as the Pakehas. Their problems seemed to him to be more in the realms of anti-social behaviour and social and economic deprivation. Alcohol was noted as a serious problem for both Pakeha and Maori youth. Often young people were at the pubs with their parents. Drugs such as marijuana, heroin, and prescription medications were not noted as major issues.

One of the advantages of the rural community the guidance counsellor noted was the presence of several strong Maori community officers and unpaid volunteers in the local Tu Tangata programme. Several major conflicts of local "gangs" had been defused by these community officers. Cooperation among professionals was described as quite good. The G.P.s were not seen as a major resource to many of the young people because their problems were not medically related.

The guidance counsellor felt the primary disadvantage in the rural setting was in dealing with more difficult psychiatric problems and/or complicated family problems. The guidance counsellor was aware of his own lack of psychiatric expertise and it was difficult to obtain supervision and further education. He commuted to Manawaroa every two weeks for supervision with a psychologist. Peripatetic services were minimal. They had only one visit from Psychological Services in the last 18 months, and the community had just received a full-time social worker from the Department of Social Welfare. Probation and Maori Affairs Officers were infrequent visitors. Being the only guidance counsellor in the community engendered professional isolation and loneliness and access dilemmas. The constant pressure to be available impinged on his personal and private life.

Prevention was identified by the guidance counsellor in a political/structural manner. He felt a Ruahine Region needed to be established so that the gaps in service created by being in between Wellington, Hawkes Bay and the Manawatu could be resolved.

Social Worker

Social workers preparing for service in rural areas need a special understanding of the structure of social welfare in rural communities. In many cases the organization of service differs markedly from the structure of services in large cities. Perhaps the most important difference is the small number of agencies and professionals.

The rural worker needs special skill in working with a scarcity of services and with hidden, undefined, and informal services.

(Ginsberg, 1976)

The Department of Social Welfare is the only agency in Dannevirke with a full-time social work position. This position was previously only a two day a week part-time assignment from the Palmerston North office. Pressure from the Dannevirke community and growing awareness by the Department of Social Welfare of the unique demands with a rural office, initiated this shift in manpower. During the research an additional social worker from the community was hired, bringing the staffing complement to two social workers and a secretary. Although the number of potential clients was smaller in a rural catchment area, travel time in the large geographical area was time-consuming. Because the social worker does much of his work in home visits, a larger staff establishment was required. Also, once the position became full-time, a substantial number of Dannevirke County clients being served by other counties were transferred to the Dannevirke office. These clients lived in areas bordering other counties and had been receiving services from the offices closer in driving time. An added complication was that many clients serviced by the Dannevirke office of the Department of Social Welfare were also involved with numerous other agencies in Palmerston North, Hastings, Pahiatua and even Wellington. The rural social worker in the Department had to be generically trained to do a multitude of tasks required including a wide range of counselling, adoption proceedings, foster care recruitment, transport for state wards, and advocacy work on behalf of economically oppressed individuals.

The social worker was instrumental in providing access for the researcher to many key persons in the community. In his short time in Dannevirke he had developed a working rapport with the police chief, the school guidance counsellor, the Public Health nurse and several ministers. His ties with the local G.P.s were increasing as were his contacts with local politicians and borough and county bureaucrats.

The social worker highlighted the professional differences he had encountered working in the rural community. Most of his experience as a social worker had been in an urban environment, although years earlier he and his family had experienced isolation and extreme demands of rural missionary work in the Phillipines. Despite this experience, there were still many adjustments he had to make in his role as a social worker and as a member of the rural community.

The most immediate change for him was his constant visibility and availability as the only social worker in the community. Although his home was a good distance from his office, private and professional life became intermingled with clients stopping by his home or calling him after hours. This placed a great deal of stress on his wife and privacy seemed to be difficult to achieve.

He also faced professional isolation. To obtain supervision he had to travel to Palmerston North, 60 kilometres away. The time spent in the Palmerston North office was often essential for the numerous administrative issues of running a branch office. Many rural assignments were still seen administratively as temporary, and he felt he had to continually validate the full-time status by clarifying the differences in rural practice.

Mental health problems surfaced in a variety of ways. Many of his clients were living under the pressure of limited financial resources, inadequate housing and under-employment. Solo mothers and their children were especially vulnerable. State wards and/or children needing foster care were often in need of immediate care. This often placed pressure on the same "caring people" time and time again to provide assistance.

Some clients experiencing severe emotional problems required the coordination of numerous professionals. Distance and travel time complicated community care, but he and the Public Health nurse would alternate weekly home visits to outlying areas such as Pongaroa. He also had access through the

Department of Social Welfare to a psychiatrist at Manawaroa and could arrange consultations. But this often meant providing transport and accompanying the client to Palmerston North.

The social worker found his experience in Wellington dealing with the city's wide range of health services and specialists made him aware of opportunities which were unavailable or unfamiliar to the rural community. Although the rural area has many informal supports and could respond quickly in times of a crisis, it did lack specialists in such areas as psychological testing, hearing and vision complications, temporary refuge for wife and child abuse and support programmes for more chronic problems (e.g. alcoholism, psychiatric disorders). The social worker had to facilitate referrals to the necessary resources outside the borough and county.

Within the borough and county, the informal networks of concerned friends and neighbours could be a mixed blessing for the functioning of the social worker. He obtained information in a collateral manner that could be quite helpful in resolving certain problems in another area. Calling a neighbour of a client without a phone in an outlying farming settlement could save a fruitless two hour drive, but it also alerted the party line neighbours that a social worker was involved. He found confidentiality in the strictest sense dysfunctional and anonymity impossible. On the other hand, being new to the community had been quite helpful. For instance, when a new client said, "I guess you know all about me," he could say, "No" and offer that person new and unbiased counsel.

The Maori community had developed separate supports of its own that the social worker found essential. He described the Maori community as divided by their religion - Mormon and non-Mormon - each section with identifiable people with mana who could be quite helpful. The different maraes sought him

out and invited him to visit and to discuss how they could work together. In working with the young people at the high school, the social worker and the counsellor relied on two Maori lay persons to defuse some difficult confrontations.

Despite the advantages and disadvantages of the Dannevirke community, the social worker stated there was a need for creative programmes of prevention tailored for rural mental health needs. Improving the coordination of services by professionals, especially for shared clientele, needed to continue. The confusion over what geographical centre houses what service needed clarification with a directory of existing services for professionals and the citizens of the community.

The social worker noted the need for speciality psychiatric and psychological services on a more regular basis, especially with the more difficult cases. Ongoing training for the local professionals in community mental health care and ongoing family life education for people in the community were suggested. Prevention that included improving employment opportunities in the rural areas (especially for women), was cited.

The social worker found rural practice quite challenging. It demanded different skills from those he had utilised in an urban environment.

The personal qualities most frequently listed as desirable were good communication skills and the ability to function independently and to have good interpersonal relationships. Other qualities listed were the ability to relate to minority groups and youth; to work with community organisations such as churches, schools, and granges; to tolerate isolation while still remaining visible to the community; and to develop trust and a sense of helpfulness.

(Gertz, et al, 1975)

Senior Sergeant

The police sergeant in the Dannevirke office seemed quite surprised that I wanted to interview him in relation to mental illness in the rural areas. After he began discussing his views on working in the community, it became evident that he and his staff were making numerous interventions with all types of people who were experiencing extreme emotional difficulties.

His experience ranged from being a rural community's only constable to being part of a large urban police force. This breadth of experience provided him with information to compare these other settings with his present position in the Dannevirke community. Although he saw Dannevirke Borough and County as basically rural he felt the availability of numerous professionals, the hospital, and good access roads were a sharp contrast to other communities that he described as isolated or "most rural".

The people who were most obviously suffering from mental illness came to police attention through direct contact on the streets of the borough, from concerned neighbours and/or from the social worker or G.P. who felt someone was potentially dangerous to themselves or others. Their interventions included ensuring the safety of other family members and providing transport to a psychiatric facility if necessary. But the police were also involved in domestic disputes, either in homes and flats or in pubs. These situations were difficult and actually offered some danger to the policeman who intervenes. Often the excessive use of alcohol complicated the situation. A high percentage of their interventions successfully defused the situation and the people involved were not referred to other agencies or professionals.

The advantages of a rural community were obvious to this policeman. He was privy to a great deal of background information from friends and family so a house call was not an adventure into the unknown (as it could be in an urban environment). The stresses facing the local people were

known and their family, friends and employers were accessible to the policeman. Difficult neighbourhoods were easily identified and patrolled. High visibility in the rural community made the policeman a part of the existing services and his presence became familiar. Making rounds to the local pubs while on duty provided another side of a policeman; he was approachable for other than just criminal acts or violations of the law.

Disadvantages in the rural community were often an extension of the advantages. By being so familiar, the policeman's own personal life was difficult to separate from his professional. His own conduct when out in public was always under scrutiny. When pressure mounted, his ability to find privacy for himself and his family was more difficult in a rural setting. The sole constable did not even have other policemen for support. In an urban environment, he could socialise outside his assigned territory. There was also a danger in smaller communities of labelling certain young people, families, streets as the "trouble makers" and not allowing room for changed behaviour. "Rural memories" were quite longstanding so that reputation could be hard to negate. This "reputation" could also accompany the policeman, and time was essential to build trust with the community, especially if the previous policeman was ill-regarded.

His relationship with other professionals in the community varied, but he had established close contact with both the local G.P.s and the hospital. He described the emergency services of the hospital as quite helpful when confronted with a psychological problem after hours. The police chief acknowledged the social worker was new, but felt he worked closely with the police and because their offices were adjacent to each other, informal conversations concerning various difficulties were possible. The social worker's services were described as most helpful especially since he was now available on a full-time basis. Coordination with Probation and Maori Affairs was still an ongoing problem. Some of the local Maori elders and the new Tu Tangata programme

had been quite helpful in dealing with some of the Maori community who viewed police intervention as not helpful.

The police chief cited alcoholism as a major problem in the Dannevirke community. Closely aligned to the drinking problem was the lack of employment and formal recreation opportunities for young people. Preventive programmes (e.g. job schemes, youth centre) were needed in the rural areas to improve the situation. The police chief queried whether or not there was a clear distinction between the way a rural or urban community tolerates deviance. In both urban and rural environments, what was a criminal act and what was an act due to mental illness was difficult to discern at times. He felt that continued education in the field of mental health and communication skills could be most helpful to the police.

It is essential the police officer be taught how to deal with the mentally ill. It is particularly important that they be given adequate instruction in the management of suicidal persons. Since in many cases the police officer is one of the first contacts of potentially delinquent children, he should receive instruction...in dealing with them.

(WHO Technical Report 223, 1961)

Maori Community Leader

The last caregiver to be interviewed was a man not qualified by any professional degree or training. His personal mana for a large portion of the Maori community in Dannevirke made him instrumental in providing help to individuals and families in an informal manner. He often saw Maoris who would not approach Pakeha professionals in the community. He was always available and would visit people in their homes, saw people in his own home or met with young people in the school. He also worked with professionals in the formal helping system; he was a resource for the Department of Social Welfare's social worker and the school guidance counsellor in helping Maori young people. He acknowledged his Mormon faith may have kept him from reaching some of the Maoris in

the community but he contended that he had contact with several other informal Maori caregivers in the community who could respond to these people.

This interview was much harder to summarise for the discussion went far beyond the 30 minutes and included his wife and son. He wanted his wife and son present because, "They believe in what I do" and also because they experienced the pressure his constant availability to others placed on their own lives. This was not a concern over a loss of privacy, but an awareness of the loss they experienced with his nearly constant involvement with others.

I was also concerned that being an American and a Pakeha might stand in the way of the interview. Once my lack of knowledge of the Maori was acknowledged, it seemed to provide a focus for the session, with the family attempting to clarify how they perceived mental illness and the Maori response to it. The other linkage seemed to be my familiarity with the Mormon church in the United States.

His responses to people suffering from emotional distress were varied, from providing aid directly (e.g. organising temporary housing with relatives for a woman whose husband was being physically abusive), to spending several hours in silence with an individual, offering spiritual support. Some people needed referral on to a Tohunga, especially if the illness were seen to result from a violation of *tapu*. He felt strongly that the Maoris viewed mental illness differently from the Pakeha and therefore would be reluctant to confide their concerns to a Pakeha professional. Although he felt relations between Pakeha and Maori were fairly good in Dannevirke, he felt there were still numerous differences that were not fully understood. The Maori often knew more about the Pakeha way of doing things than the Pakeha knew about the Maori. He had strong concern for the young rural Maoris faced with bleak employment possibilities, incomplete schooling and the attraction of urban life.

In working with a potential gang problem at the high school, he used his knowledge of the young people's *whakapapa* to defuse extreme antagonism between two groups who actually were distantly related. Prevention for him was in Tu Tangata and the revival of Maoritangi. He felt the strength of the Maori community coming together would benefit all Maoris but especially the younger generations. The marae was also a resource to the community but young people had to learn its value.

Various local historical differences needed to be resolved to provide a more united Maori community in Dannevirke. Small communities could stigmatise people quickly and make it difficult for growth to occur. He argued for resources that would allow the Maoris to resolve their own dilemmas and against the creation of new services or agencies for them.

He was not naive to the anger and the sense of despair expressed by some young Maoris, but his strong Christian faith provided him with a positive approach to problem solving. Mental health concerns were not unique to the urban Maori, but the rural community has some distinct advantages. He delineated them as the ready accessibility of family and tribal support, the numerous sport and civic clubs, and the cooperation that is potentially available to a small community. He underlined potentially for he felt it was a process that did not occur naturally.

The Maori may take pride that there are certain illnesses and certain conditions basically specific to himself. He takes pride in his family loyalties, his tribal traditions and hospitalities.....Putting it another way, the Maori believes he is in some way specifically and indefinably different from the Pakeha. The Maori believes he has subtle differences which cannot be understood or communicated to any non-Maori.

(Gluckman, 1976)

Summary

The topography that surfaced from these interviews formed identifiable patterns in the helping community. The patterns were influenced by the definition of sub-communities and the professional allegiances that they reflected. All the G.P.s saw the Dannevirke Borough and County as their catchment area, but within that greater boundary their specific practices formed mutually respected and supported sub-systems. Even to the extent that locums were not actively used. An occasionally disgruntled patient who changed doctors did not disrupt their ability to work together. The hospital as the institution that crosses over all their individual practices, served as a meeting point for collegial support and continued professional challenge. There was minimal contact with other medical personnel outside Dannevirke, limited mostly to professional referrals or consultations with specialists in the Hawkes Bay and the Manawatu. The G.P.s felt that the community expected them in the main to be responsible for ensuring their physical and mental health. For the most part the physicians concurred with these expectations and accepted the blurring of their professional and private lives in the rural community. The Maori community was seen to operate on its own in relation to some physical health problems and to many mental health concerns.

The clergy defined their areas of responsibility by their congregations and on a denominational basis. Although there was an interfaith council it seemed to provide more collegial support and cooperation than ecumenical action. Mental illness was seen as the major responsibility of the G.P., but spiritual support was seen to be their responsibility especially in relation to their respective congregations. The blurring of private and professional lives was unique to the rural community and caused some difficulties. Lack of understanding between the Maori and Pakeha community and within the Maori community itself, caused problems to be viewed in separate ways. Specialist mental health services were missing in the local community and the clergy were dependent on G.P. referral to resources outside the community.

The school principal and guidance counsellor defined their area of responsibility as all secondary students in the community. Although some parents were involved, most of their caring involved young people. They relied on their own internal guidance network and interacted with the social worker, public health nurse and police chief. Informal Maori caregivers were utilised by the school principal and guidance counsellor because the Maori youth problems were identified as being different from those of the Pakeha.

The social worker defined his community as all clients of the Department of Social Welfare but he expanded his role to interact with others in need of referral, advocacy, protection and counselling. He linked his clients to specialist mental health services and worked with informal Maori caregivers in the community who were necessary to bridge the Pakeha-Maori gap. He saw the Maori community divided by religious beliefs. The blurring of his professional and private life was a source of stress.

The Public Health nurse operated between the doctors, the social worker and the hospitals. She defined her area of responsibility as all who are referred and anyone else she felt in need of her support, medical evaluation or specialist psychiatric care. She saw the G.P.s as the major providers of care for the mentally ill, although she questioned if they were the most appropriate for all areas of mental illness.

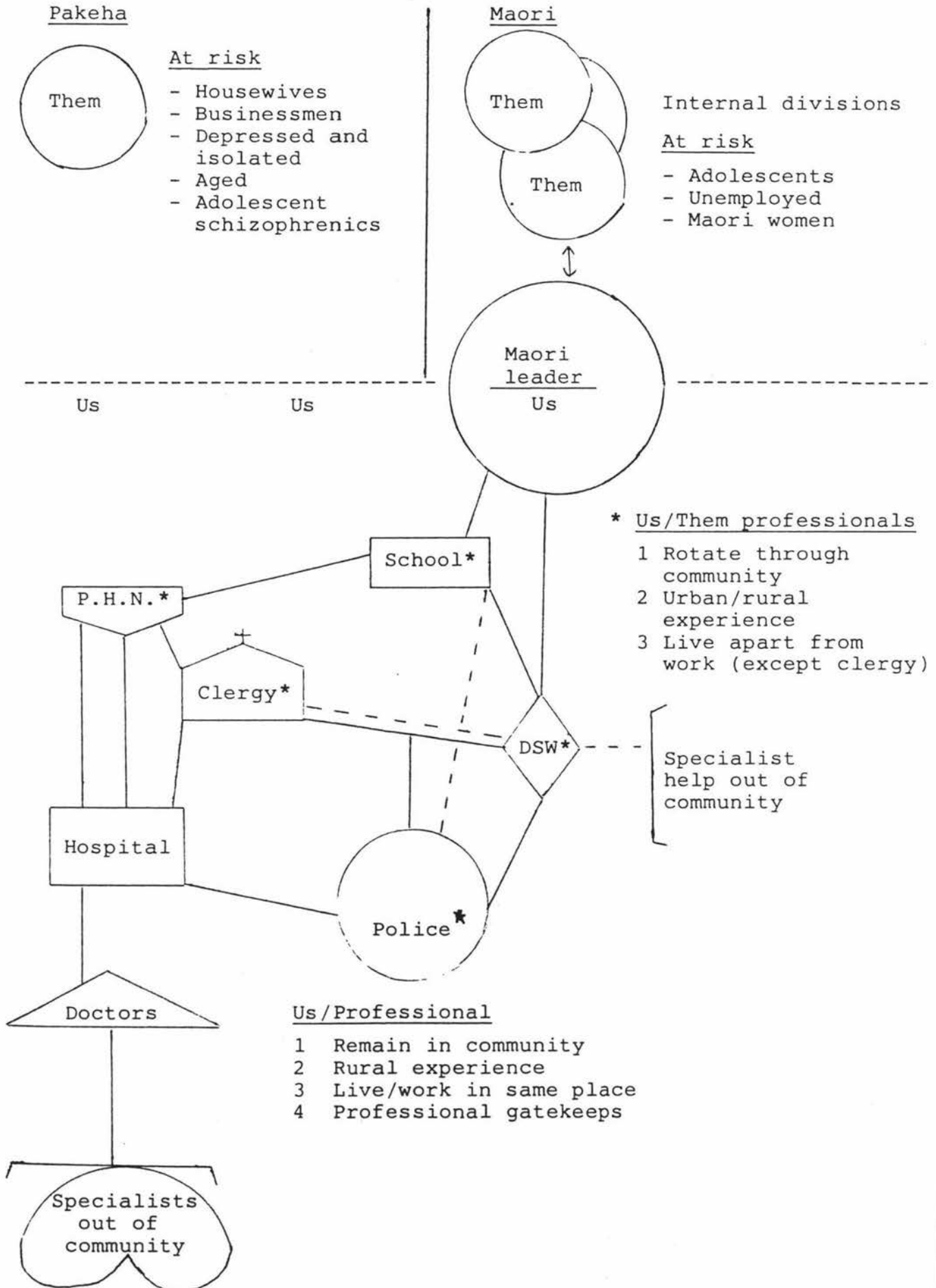
The police chief was the community's agent of control but his role involved him in dealing with people in severe emotional distress. He worked with the hospital, the G.P.s and the social worker. He saw differences in how the Maori community experiences mental illness.

The non-professional caregiver saw his main responsibility as the Maori community. Mental illness was defined differently and he cited the Maoris' historical problems as different from those of the Pakehas. Religion he felt divided the Maori community as well as historical tribal differences.

There was agreement that the populations at risk were young people, women and the aged. Maoris tended to be at risk due to societal and economic inequities. Pakehas seemed to reflect the stress of business and competition. Alcoholism and family abuse were reflected in both Maori and Pakeha. Chronic mental illness in adolescents and young adults was cited as a serious problem for rural areas, with limited specialist resources.

Attached is a graphic representation of the helping networks. In the figure, the doctors identified most strongly as the "Us" professionals, clearly delineating themselves as separate from the patients they serve. Yet their strong professional commitment, their sense of responsibility and accessibility to the community combined to make them the gatekeepers to service both within the community and to speciality services outside the borough and county. In the figure the "Us/Them" professionals (social worker, clergy, etc.) identified themselves as an important part of the community but their relationship was based on their time limited assignment to the community. The Maori leader did not identify himself as a professional and saw himself as an indigenous caregiver. The Pakeha and Maori community were seen to have some basic similarities in areas of psychological and emotional risk. The unique differences are represented in Figure Four.

FIGURE FOUR
Helping Networks - Formal Caregivers' Viewpoint



Community Survey

One of the major goals of the survey was to establish certain characteristics of the Dannevirke area and of the people who lived there. A variety of questions were used to elicit respondents' perceptions of various dimensions of their lifestyle, including the advantages and disadvantages of living in a predominantly rural area, the adequacy of services, participation in voluntary associations and the kinds of support networks which existed.

Rural Lifestyle

The sample population was epitomised by its stable and local character. Nearly all (93%) of the respondents had been born in New Zealand. Of those who had been born overseas, the majority were from the United Kingdom. The essentially 'local' nature of the sample is revealed by the fact that 75% of the respondents had lived in Dannevirke for more than ten years and 52% of these respondents had lived in the borough/county all of their lives.

A large majority (89%) of the sample described their lifestyle as "enjoyable". Table Seven provides data which describes the perceived advantages of residence in the survey location.

TABLE SEVEN

Perceived Advantages of Rural Living (Percent)*

Dimension	%
Community spirit	30
Healthy environment	29
Access to services	28
A good place to raise children	24
Friendliness of residents	24
Open space	23
Honesty and morality	4
	(N = 207)

* Respondents listed more than one advantage

Respondents' specification of these advantages frequently used the city and an urban environment as a point of comparison.

Although the perceived advantages seemed to outweigh the disadvantages (34% of respondents said there were no disadvantages), the data shown in Table Eight indicate that there were problematic areas for respondents.

TABLE EIGHT
Perceived Disadvantages of Rural Living (Percent)*

Dimension	%
Lack of services and difficulty in access to services	28
Travel time to services and friends	26
Lack of entertainment and cultural events	21
Higher cost of living (transport)	12
Lack of job opportunities	7
Small population restricts freedom (no privacy)	6
Small population limits business growth	4
	(N = 207)

* Respondents listed more than one

Respondents also used urban comparisons when specifying disadvantages. Certain disadvantages such as the lack of services, time spent on travel, travel costs, and the lack of entertainment were seen as "givens", the realities of living in a rural area. Despite these disadvantages, the respondents did not see themselves as isolated. Even families in the most remote farming areas in the county were satisfied with their ability to reach services and friends. Less than 10% of the sample was dissatisfied with the conditions of the roads and less than 5% did not have anyone in their home who was unable to drive. A family vehicle was available

to 90% of the sample, so that the lack of public transport in the county and the borough was not a major obstacle to their ability to "get around". But availability did not necessarily provide access for all. Eighteen percent of the sample reported difficulty in visiting friends and in travelling to services when they wanted because someone else in the family had the vehicle.

Channels of Communication

Another factor in rural life has been the "backwater" effect: the presumed effects of being cut off from the life outside, from national and international events. In Dannevirke Borough and County television and radio have, however, minimised the effect of geographical distance from main centres and nearly all the respondents had access to both. Table Nine describes respondents' potential access to these media. The patterns of actual use of radio and television were not clarified in the present study.

TABLE NINE
Access to Television or Radio and Reported
Quality of Reception in Dannevirke Borough
and County (Percent)

	Access %	Quality of Reception	
		Poor %	Fair %
Television	96	16.5	83.5
Radio	99	19.0	81.0
(N = 207)			

Limited reception was more of a problem for respondents living in the county affecting the availability of certain programmes.

The radio and television were important in linking the community to the world beyond the area surveyed; however the newspaper has a much longer history of performing many of these communication tasks in a rural community. Most (90%) of the respondents read the Dannevirke Evening News regularly. This paper was comprised of local news and some syndicated columns. Newspaper selection from outside the community indicated both regional affiliation and national interests. The Hawkes Bay Herald was read by 20% of respondents, the Daily Telegraph by 18% and The Dominion, the most frequently read newspaper after the Dannevirke Evening News, was read regularly by 36% of the respondents. The Manawatu Evening Standard was not available for regular distribution in Dannevirke Borough and County.

Ninety-seven percent of all respondents had a phone in their household, which they listed as the most frequently used method of contacting others. The party line, a waning aspect of rural life, still played a major role in Dannevirke. Respondents with party lines (33% had party lines, and of those with party lines 65% had three or more households on the same line), stated the party lines were important links to their neighbours.

The mail was identified as another important channel of communication, especially for those respondents with family living beyond a local phone call or short drive. Although 54% of the respondents received mail twice or more a week, a significant 23% received less than one letter per week. Although no conclusions could be drawn based on data generated by the survey, there was some indication that even infrequent letters provided essential emotional support. Immigrants who were part of the survey described the mail as providing major links with family and friends from "home".

Networks

Rural areas have been characterised by interrelated social and family networks. Table Ten delineates one measure of

these social networks: the club and voluntary association memberships of the respondents. Dannevirke has over 100 civic, sport, cultural, and recreational groups (Appendix J). Seventy-five percent of the respondents belonged to at least one club or organisation, with sports clubs registering the highest membership.

TABLE TEN
Respondents Reporting Membership to
Civic, Sports, and/or Cultural Clubs (Percent)

No. of clubs	%
No clubs	24.1
One club	20.2
More than one club	55.7
Total	100.0%
	N = 203

A small percentage of the respondents were involved in four or more organisations, which suggested a degree of overlapping of membership. Comments made by respondents supported this overlap and inferred that in a rural community the same minority provided the leadership and continuity in various clubs and organisations.

Group pursuits were not the only measure of involvement. "Self-centred" leisure activities were identified by many of the respondents. Gardening, domestic hobbies and crafts (bottling, sewing, weaving), tramping and jogging were all listed as important activities.

Visitation patterns with family, friends and workmates was another way of identifying networks of support. Respondents ranked visiting as the second most common way of contacting people. In the survey, respondents were asked who they contacted and how often, and as well, who contacted them and how often. Responses were computed into a visiting score which combined all contacts to provide a general picture of

the amount of stated interaction. Table Eleven shows the visitation patterns of the respondents.

TABLE ELEVEN
Combined Visits of Family, Friends, Workmates
and Others (Percent)

No. of visits/week	% involved in visiting
Daily	7.2
2 - 3 week	59.0
Once a week	27.0
Less than once a week	6.8
Total	100.0%
	N = 207

Although 66% of the respondents were actively involved and stated a high degree of interaction with a variety of people, slightly less than 7% of the respondents appeared to be isolated socially, i.e. less than one visit per week. The relationship between the degree of social involvement and psychological well-being will be addressed in the following section.

Membership patterns in clubs and visitation patterns of family and friends were two types of networks which appeared to provide social and emotional support for respondents. These networks had identifiable 'social boundaries' beyond which contact became less evident. In a rural context, the stability of the community and the small population which increased individual visibility facilitated this process of identifying these social boundaries.

Boundaries

Another way of defining boundaries and patterns of interaction was the use of service centres. The respondents were asked to list the town they most often used for services (business, medical, social). Table Twelve lists the towns identified as service centres for the households included in the survey sample.

TABLE TWELVE

Towns Most Often Used by Respondents for Services (Percent)

Town	%
Dannevirke	89.8
Palmerston North	7.8
Waipukurau	1.9
Other	.5
Total	100.0%
	N = 207

Dannevirke Borough was listed by 89.8% of the respondents as the most frequently used centre for their emotional, social and physical needs. A few respondents who identified Dannevirke Borough as their service centre, also stated that they used another centre due to family tradition or strong ties to a physician or lawyer. It is also worth noting that until recently the road to Pahiatua was better than the road to Dannevirke. As a result some Pongaroa residents had stronger ties in Pahiatua.

Regional affiliation and regional boundaries was a lively topic during the period of the survey, since the Government as part of its overall policy for regional development had recently announced plans for Dannevirke Borough and County to be part of the Manawatu. Geographical barriers such as the Manawatu Gorge, and socio-cultural links associated with historical patterns of settlement seemed to be major factors on respondents' perceived regional affiliation. Table Thirteen lists the regional boundaries chosen by respondents when they were asked to identify the region they identified with most closely.

TABLE THIRTEEN
Respondents Choice of Regional Boundaries -
Only One Choice (Percent)

Region	%
Southern Hawkes Bay	42.5
Ruahine	17.9
Dannevirke (Borough and County)	16.9
Hawkes Bay	14.0
Manawatu	6.8
Other	1.9
Total	100.0%
	N = 207

Respondents' perceptions of regional boundaries appeared to have been altered dramatically by the Government's decision to include Dannevirke Borough and County in the Manawatu region. This discrepancy underlined the misrepresentations that can occur in assigning rural boundaries and allocating services from a national plan that has not adequately taken into consideration historical ties and established service centre patterns.

Dannevirke demonstrated an identifiable rural lifestyle, characterised by strong linkages between families and friends. The phone, visiting and the mail were utilised to maintain contact. Radio, television and newspapers reduced the, geographical isolation and most respondents expressed a high degree of satisfaction with their rural life.

The next section will explore their sense of psychological well-being and attempt to define more clearly the mental health of a rural community.

Well-Being

The notion of well-being, a hotly debated and complex concept, was derived largely from research focused on social indicators.

Just as economic indicators were used to monitor the progress of the economy, social indicators were employed to monitor social concerns and changes. These two basic types of indicators, the "objective" and the "subjective" measured different areas: the objective indicators measured such things as mortality and crime rates while subjective indicators measured individual feeling about life experiences. The Bradburn Affect Balance Scale (Bradburn, 1969) and the 3-Point Happiness Question (Gurin, Veroff and Feld, 1960) were used in the present survey to obtain a measure of respondents' well-being. These established scales were used because they allowed comparison with an international survey (Andrew and Withey, 1976) as well as with results obtained from New Zealand research (Chamberlain, 1982).

Happiness

The 3-Point Happiness Question enabled respondents to give a direct report of their happiness. Although this type of self report rating could be subject to some distortion, previous research (Bradburn, 1969) indicates the item is reliable and valid. Table Fourteen reports the results from the analysis of respondents' answers to the question: Taking all things together, how would you say things are these days - would you say you are: very happy, pretty happy or not too happy?

TABLE FOURTEEN
3-Point Happiness Question (Percent)

Degree of Happiness	%
Very happy	29.8
Pretty happy	62.0
Not too happy	8.3
Total	100.1% N - 207)

Questioned in this manner, 30% of the respondents reported feeling very happy, 62% reported feeling pretty happy and

8% stated that their lives were not too happy. These results were similar to those found by Andrew and Withey (1976) and Chamberlain (1982) in his survey conducted in Palmerston North. The similarity of this rural response to Chamberlain's urban survey was contrary to the expectation that rural respondents would be happier. The relationship between expressed feeling of happiness/unhappiness and population density became more obvious when intrarural differences were explored.

Table Fifteen shows a statistically significant relationship between place of residence and respondents' assessments of their happiness. The majority of the respondents (62%) who described themselves as "very happy" lived in the county, while the greatest percent of respondents (71%) who described themselves as "not too happy" lived in the borough.

TABLE FIFTEEN
Place of Residence and Happiness (Percent)

	% Very Happy	% Pretty Happy	% Not Too Happy
Borough	38	50	71
County	62	50	29
Total	100%	100%	100%
	N = 61	N = 127	N = 17
Total N = 205			
Chi ² = 6.19557		df = 2	p < .045

The high percentage of unhappy respondents in the borough might be explained by the disproportionately high number of low income earners, a high percentage of women living on their own, and the high proportion of unemployed residing in the borough.

Bradburn Affect Balance Scale

Bradburn (1969) viewed psychological well-being as a function

of two independent dimensions: positive and negative affect. Both were considered essential to developing a valid and reliable measure of this complex concept. The Bradburn Affect Balance Scale measured the difference between the scores of the positive and negative indices to indicate the individual's current level of psychological well-being. Table Sixteen reports the respondents' responses to the Affect Balance Scale.

TABLE SIXTEEN
Affect Balance Scale Responses (Percent)

Positive Affect	% Responding Yes
Excited	61.8
Proud	46.9
Pleased	72.9
On top of the world	42.5
Things going your way	67.6
<u>Negative Affect</u>	
Restless	16.9
Lonely	16.4
Bored	19.8
Depressed	14.0
Upset	14.5

Although the largest percentage reported feeling positively (e.g. 73% pleased, 62% excited), 14% to 20% of the respondents also reported negative feelings. The measure of well-being used in the present study was a composite of these negative and positive feelings. In Table Seventeen an eleven point scale is used to indicate the distribution of respondents' composite scores of positive and negative feelings.

TABLE SEVENTEEN
Affect Balance in Percent

Negative						Positive					
- 5	- 4	- 3	- 2	- 1	0	+ 1	+ 2	+ 3	+ 4	+ 5	
0	.5	1.0	3.5	3.5	10.4	17.9	19.9	15.9	16.4	10.9	
N = 207											

An examination of the distribution of scores in Table Seventeen indicates that the positive scores far exceeded the negative scores, with over 80% of the respondents falling on the positive side of the scale. This distribution of scores indicates overall, a high sense of well-being among the sample population. However, slightly more than 10% of the scores reflected a neutral position, that is, respondents reporting an equal distribution of positive and negative feelings. Almost 9% of the sample reported a predominantly negative score. This distribution of affect balance scores closely parallels the findings reported by Chamberlain (1982) in his survey of an urban population. It is significant to note that the proportion of respondents who reported negative scores (8.5%) was consistent with the reports of the General Practitioners in Dannevirke Borough who estimated that about 10% of their consultations involved mental health issues or concerns.

When the sample of respondents was divided according to locality the relationship between well-being and place of residence became significant. Table Eighteen shows the results of this analysis.*

* The Bradburn Affect Balance Scale is normally from 1-10 but for cross-tabulation, the well-being scores were collapsed into Low (0-3), neutral (4-7) and high well-being (8-10).

TABLE EIGHTEEN
Well-Being by Place of Residence (Percent)

Place of Residence	Well-Being		
	Low	Neutral	High
Borough	80	53	36
County	20	47	64
	100%	100%	100%
	N = 10	N = 104	N = 87
Total N = 201			
Chi ² = 10.3	df = 2	p < .05	

Of the respondents who reported high well-being, a greater percent (64%) resided in the county, whereas the majority of the respondents (80%) who reported a low level of well-being lived in the borough. This dissociation between well-being corroborated the findings from the three-point happiness question.

The data generated by both scales suggested significant intra-rural differences, however more detailed comparative studies will be required to substantiate this intriguing set of results.

Intra-Rural Differences

There were numerous other significant relationships which demonstrated borough/county differences. An analysis of the distribution of incomes among respondents indicated that income earners were disproportionately distributed with the higher income levels being concentrated in the county: 68% (N = 16) of those earning \$20-\$24,999 and 95% (N = 21) of those earning \$25,000 or more. Respondents living in the borough were much more likely to be lower income earners: 70% (N = 40) of those earning less than \$4,000.

Employment opportunities between the two localities also varied

as did the rate of unemployment with the greater number of opportunities for employment and the higher incidence of unemployment occurring in the borough.* Not unexpectedly, the relationship between the low level of well-being reported by unemployed respondents was statistically significant ($\text{Chi}^2=30.49$; $p < .001$). Unemployed respondents also reported a statistically significant degree of worry about their physical health ($\text{Chi}^2 = 15.58$; $p < .001$).

The relationships between well-being to various independent socio-economic variables such as education, income and race were not statistically significant. A similar non-significant relationship between gender and well-being was established, however it was interesting to note that among those respondents who reported low well-being, females outnumbered males four to one. A high proportion of female respondents indicated concern about the lack of employment opportunities for them in the rural environment (particularly in the county area). More specifically, 63% of the females reported worrying a great deal. Widows were disproportionately represented in the borough sample and when compared with the remainder of the respondents living in the borough, represented the highest incidence of low well-being.**

Another interesting intra-county difference worth noting was the relationship between the distribution of well-being scores and type of farming. While the relationship between well-being and the actual size of the farm was not statistically significant, there appeared to be a relationship between well-being and farm type (i.e. sheep, sheep and beef and dairy). Among those respondents who reported high well-being, 85% ($N = 46$) were either sheep or sheep/beef farmers, whereas only 11% ($N = 6$) of the dairy farmers reported high

* At the time of this study Dannevirke Borough and County had a total of 48 registered unemployed.

** It is important to note that the Bradburn Affect Scale and questions concerning "worry" or "feelings" may be sexually biased. It may be easier for women to agree to these feeling questions than men, especially if the roles of male/female are more strictly held in a rural environment. This needs further investigation.

well-being. This difference was statistically significant ($\text{Chi}^2 = 59.89$; $p < .001$).

The unique pressures on the male and female respondents who were dairy farming were emphasised by numerous respondents. The particular nature of these stresses and their consequences warrants further research, especially since it may well be related to the productivity and efficiency of farmers.

Networks and Well-Being

Informal networks have been described as providing two different types of support: the ongoing nurturance and stimulation necessary to maintain well-being and/or a buffering effect necessary to cope with personal or community crisis. Compared with urban communities, rural communities have been credited with close and supportive networks which "take care of their own" when trouble or adversity occurs.

People who have ready and meaningful access to others, feel integrated into the system, and are satisfied with their role seem better able to cope with the impact of life events.

(Myer, 1975)

In order to explore this proposition further, the relationships between membership in clubs and organisations and the visitation patterns with family and friends were cross tabulated with the Bradburn Well-Being scores.

Membership in Clubs

There were numerous clubs in Dannevirke and the reported levels of membership were very high: 58% of the respondents were involved in at least one sports club and 44% of those respondents were involved in more than one organisation. When the membership patterns of respondents were examined a statistically significant relationship between club membership and psychological well-being was discovered. The data corroborating this relationship are summarised in Table Nineteen.

TABLE NINETEEN
Membership in Clubs by Well-Being (Percent)

Membership in Clubs (Sports and civic and cultural)	Psychological Well-Being		
	Low %	Neutral %	High %
None	10	29	19
One	70	18	18
More than one	20	53	63
	100%	100%	100%
Total N = 197	N = 10	N = 102	N = 85
Chi ² = 19.19405		df = 4	p > .001

The results shown in Table Nineteen indicate a positive relationship between high membership of voluntary associations and a high sense of psychological well-being. The techniques for data gathering used in the survey did not, unfortunately, permit an examination of the possible association between the effects of membership on respondents' well-being. Examination of these enhancing or 'buffering' consequences require further detailed research.

Visitation Patterns

Examination of the association between patterns of visiting and measures of well-being did not result in any statistically significant associations. The different categories of target groups for visits (i.e. family, friends, workmates) were also analysed separately. The only target group to demonstrate a statistically significant relationship to well-being was the family: the lower the frequency of visits from the family, the lower the level of well-being reported by respondents.

Table Twenty reports the results of the analysis of the association between family visitation and well-being.

TABLE TWENTY
Family Visitation by Well-Being (Percent)

No. of visits per week by Family	Well-Being		
	Low %	Neutral %	High %
None	12	32	31
Less than once a week	50	27	33
Once a week	38	21	31
Two/three times a week	-	20	5
	100%	100%	100%
Total N = 144	N = 8	N = 75	N = 61

Chi² = 11.17670

df = 6

p > .04

The data shown in Table Twenty appeared to provide support for the proposition that social isolation, especially from family is a significant factor in an individual's low sense of well-being. In this regard, it was noteworthy that after the general practitioner, the family was listed by the respondents as the most helpful source of support with problems involving alcohol dependency, psychiatric illness, and marital relationships. Hence, those individuals who had infrequent contact with family lacked a significant source of informal support. The possibility of support (i.e. club membership, high number of visits from family and friends) does not, however, explain how the utilisation of these supports in times of personal crisis actually helps individuals and the groups to which they belong.

Mental Illness

Mental illness is an extremely difficult concept to define. In the Wanganui Health Survey (Asher et al, 1979) it was found that 20% of those reporting health problems, stated their major concern was mental health. Their definition of mental health problems ranged from chronic psychiatric illness, childhood behaviour problems, problems of aging, alcohol and drug dependency, to marital and family problems. This transposing of the term 'mental health' to 'mental illness'

complicates the problem of defining mental illness. The diversity of conditions subsumed by the concept of mental illness increased the range of people and professionals who may define themselves as involved in the mental health field in either a therapeutic or preventative role. Howitz's (1977) research on pathways to psychiatric treatment indicated that recognition of a psychiatric problem was likely to occur within the family and that self-labelling and labelling by a spouse occurred before any subsequent labelling by a professional. In order to explore these possibilities further specific items were included in the survey. Specifically, the respondents were asked to describe their conception of mental illness, who they would turn to for help in a crisis, what the major problems were facing the community and what services were available to resolve these problems.

The pattern of respondents' definitions of mental illness are summarised in Table Twenty One. These conceptions, though colourful and varied, tended to fall into three major categories. Less than 5% of the respondents included mental retardation in their definition, which suggested an inclination to make a clear distinction between mental illness and mental retardation.

Seeking to establish respondents' perceptions of mental illness proved difficult. Indeed, it was the question in the interview schedule which produced the highest percentage of "don't know" replies. It was not clear why, but numerous respondents stated the following: "It was too difficult" or "Ask a professional person". The overall pattern of replies suggested that recourse to professional help was the most appropriate response and that they were not "qualified" to answer.

TABLE TWENTY ONE
Categorisation of Respondents' Conceptions
of Mental Illness (Percent)

Definition of Mental Illness	% of Sample
<u>Disease</u>	
Mental illness is a psychiatric disease (i.e. depression, psychosis)	39
Mental illness is genetically transmitted	23
<u>Social Issues</u>	
Mental illness is social stress	29
Mental illness is an "inability to cope"	33
<u>Hackneyed Expressions</u>	
Terms used to describe mental illness with assumed understanding of the meaning (i.e. "around the bend", "nuts")	21
<u>Don't Know</u>	6
(N = 207)	

Pathways to Help

When asked to list, in order of preference, who they would seek for help, if mental illness was a problem for themselves or a family member, 57% of the respondents indicated that the General Practitioner was the most appropriate resource. Twenty-six percent of the respondents indicated their relatives and 8% listed the clergy and friends. Respondents clearly endorsed the General Practitioner as the "gate keeper" to the professional, caregiving system in the rural community. The low percentage of respondents who would turn to the clergy

for assistance seemed to reflect the tendency of respondents to define mental illness primarily as a medical problem.

A significant majority of respondents (73%) indicated that mental illness should be treated locally and in so doing reflected their belief in community based care for the mentally ill. Nevertheless, there was also an awareness that some problems were too severe to be treated locally and required specialist care which was, unfortunately, presently unavailable in the community.

When respondents were asked if there was anyone they would avoid when experiencing mental illness, 10% of the respondents replied that they would avoid contact with friends and some family members. Combining the "other" category of people to avoid, 31% of the respondents were aware of non-professional people in the community with whom they would not feel comfortable sharing their mental health problem. This particular response suggested a need to explore further why those particular people were seen as disruptive in the help-seeking process.

Several respondents also stated that they would utilise two or more persons at the same time (i.e. the General Practitioner and their spouse). This combining of sources of help was clarified further when discussing alcohol problems. Respondents listed numerous areas in their lives affected by excessive drinking: finances, health and marital relations. The "ripple effect" frequently associated with alcohol dependency was also perceived as occurring with mental illness. Accordingly, numerous respondents acknowledged the value of multiple supports when trying to cope with alcohol and mental health problems.

Figure Five depicts the respondents' description of pathways to help for problems which were defined as mental illness. The most noteworthy feature of the diagram was the centrality of the General Practitioner's role as the primary caregiver and also as the key agent in referrals to specialist services.

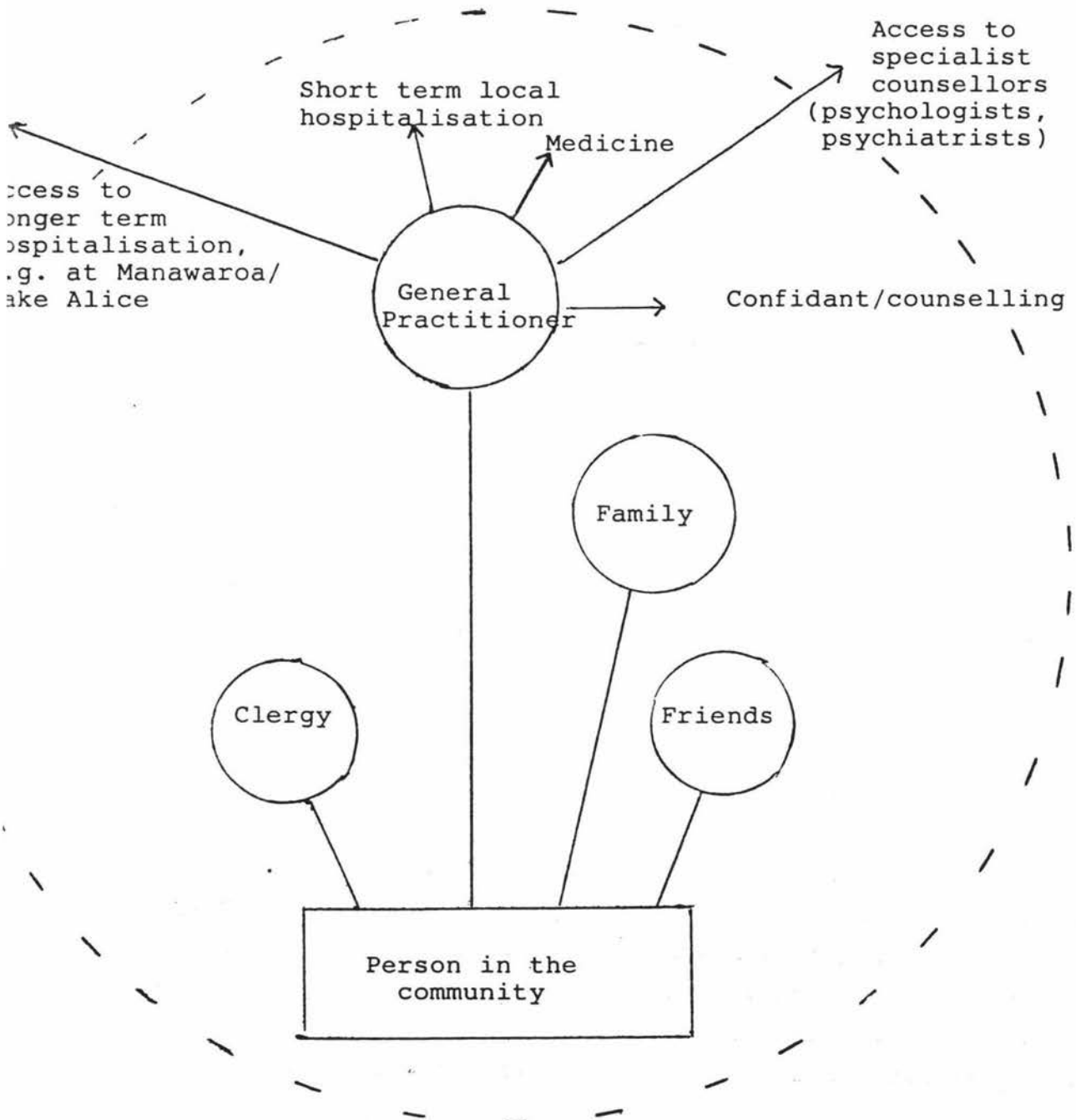
This particular pattern does, of course, do no more than affirm the existing dominance of medical personnel in the diagnosis and treatment of mental illness.

FIGURE FIVE

Respondents' Description of Pathways for Help with Mental Illness

Problems Include:

- biological/genetic disorders
- emotional conflict
- social/relationship problems



Problem Identification

Respondents were also asked to identify those problems which they believed occurred most frequently in the community.

Table Twenty Two summarises the problems identified.

TABLE TWENTY TWO
Problems Identified by Respondents (Percent)

Problem	%
Marriage and relationship problems	58
Alcohol and alcoholism	51
Youth and delinquency	50
Unemployment	46
Shifting	37
Loneliness	35
Misuse of prescribed medicines	24
Drug abuse (other than alcohol)	23
Depression	23
Racial issues	19
(N = 207)	

Marriage and other human relationship problems, alcohol abuse, youth problems were all stated as primary concerns. Unemployment was seen more as a potential problem that was, at the time of the survey, affecting other communities more than Dannevirke.

Service Delivery

After identifying major problems in their community, the respondents were then asked to describe the requisite services that were available in the Borough and County. The only service that seemed to be well known by respondents by Alcoholics Anonymous. The General Practitioner was listed as the most appropriate resource for all problems, whereas the clergy were mentioned only as a resource for marital problems,

'religious' concerns and loneliness. The policeman was seen as helpful for dealing with delinquent behaviour. But because so few respondents chose to complete this question, it was difficult to code this question. Most respondents were unaware of existing services and stated "I guess I'd find out when I have the problem". The study did not explore how respondents might obtain this information when necessary, nor how they would use the services that already existed in the Borough.

In the community feedback sessions the problem lists were discussed to provide information for the community and to assess their relevance for respondents in the Borough and the County. As in the survey, the citizens demonstrated an ability to identify and agree upon common problem areas, but they were not familiar with many of the existing formal networks of support in their community. Respondents also experienced difficulties when preventive services and/or specialised mental health services were discussed. Some wanted the researcher to provide ideas for new services, others felt there was no need to establish services until the problem became evident in their own families; others wanted services tailored to their respective localities. Future research would be beneficial in exploring models for citizen participation in needs assessments, policy development, programme implementation and evaluation of mental health services in rural communities.

CHAPTER SIX: CONCLUSIONS

In assessing the mental health of a rural community the challenge was to develop methods of investigation which accurately reflected the existing networks of social support in a relatively circumscribed geographic locality. There were two major concerns which informed this survey. The first subsumed two general questions: (i) How did rural people define mental illness, and (ii) What were the informal and formal networks of support that existed in a rural area which did not have formalised psychiatric or community mental health services. The second concern involved an analysis of how professionals working in the human services viewed their roles as caregivers. The field techniques used to generate the data included a number of approaches, complemented by a basic descriptive information about Dannevirke Borough and County. The three components of this study were as follows:

1. Formal Networks of Support (the Hospital);
 A ten year statistical analysis of inpatient referrals from Dannevirke Borough and County to Manawaroa Psychiatric Unit, Palmerston North Public Hospital (1971-1981).

2. Formal Networks of Support (the Professionals);
 Sixteen indepth interviews with the professional community (formal caregivers) in Dannevirke Borough.

3. Informal Networks of Support (the Survey):
 A household survey in the borough and county of 207 respondents.

Community feedback sessions were also organised to share preliminary findings from the survey with members of the different localities within the borough and county. This public dialogue was an initial attempt to make available

findings from the empirical and hermeneutic analysis to obtain critical feedback and action from members of the community.

Formal Networks of Support: The Hospital

Since 1976 Manawaroa Psychiatric Unit in Palmerston North has become the major inpatient resource for Dannevirke Borough and County. Utilisation of the unit during the period 1971-1981 increased 600%, indicating a definite need for inpatient care. Dannevirke Hospital provided adequately for short-term hospitalisation but patients requiring longer term care were referred to Manawaroa. All referrals came through the General Practitioners. Although the general practitioners reported they were "pleased" with the service, Manawaroa staff provided minimal supervision and ongoing community education for the formal caregivers, thereby intensifying the professional isolation identified by all the professionals as "a major concern".

Distinct inpatient patterns defined by age, race, sex and diagnosis were identified. Further research would be necessary to clarify these patterns and their implications.

Formal Networks of Support: The Professionals

Three major issues were continually mentioned in the interviews with the professionals: confidentiality, access to professional care, and interdisciplinary communication. All the professionals had received their education in urban areas. The G.P.s had practiced primarily in rural areas whereas the other professions had work histories of both urban and rural experience. Yet all professionals agreed that the realities of practice in a rural area had not really been addressed in their pre-service training.

(1) Confidentiality

Confidentiality has been the time-honoured cornerstone of

the doctor-patient relationship. This ethic has been reinforced in the field of mental health by the tenets of psychiatry. Other professional groups have also sought to adhere to this principle of confidentiality of personal exchanges concerning interpersonal or intrapsychic dilemmas. This assumption of confidence facilitated the exchange and encouraged the person to seek help when they knew their confidence was protected.

Yet in this study, both in the interviews with the professionals and in the research process itself, the "sharing" of information seemed to occur relatively freely, albeit with discretion, in the rural environment, especially within the same professional groups. The referral process required information exchange and in Dannevirke where daily business was closely monitored through observation and overlapping networks, the ability to maintain strict confidentiality was compromised. Professionals interviewed in the research varied in the extent to which they felt comfortable with this process. The social worker, who was new to the community, felt his lack of prior knowledge helped his clients. They perceived themselves as "starting fresh" because he did not know "their history". Nevertheless, the General Practitioner stated his patients liked the fact that he knew their families intimately; there was then, no need to "explain everything" when there was a problem. There were indications that once the sharing of information occurred various types of informal supports were initiated in the community. These apparent differences in both the process and content of confidentiality between the urban and rural settings has received inadequate attention in the literature.

(2) Access to Professional Care

The professionals interviewed in the survey identified a variety of pathways to care in the community (see Figure Four) however, all agreed that the general practitioner was the "gatekeeper" for people experiencing mental illness. Ten to twenty percent of patients reportedly came to the general practitioner with a medical problem which subsequent

discussion revealed was in fact simply an entree for seeking help for an emotional or psychological difficulty. Active outreach and preventive mental health programmes were not provided by the professionals because they shared the expectation that residents would know when and how to seek the appropriate resources. One exception to this was the Maori caregiver who actively promoted alternate pathways to care for his people.

The professionals acknowledged that informal networks and folk healers were used in conjunction with the existing formal supports. However, most of the professionals did not actively use these existing informal supports by integrating them into their treatment approach.

The professionals in Dannevirke described two work related stresses which they felt were more common in a rural environment: role convergence and professional isolation. The distinction between private and public life was blurred in this rural community. Their high visibility as professionals made them "always accessible" for service and their private lives were subject to constant community scrutiny. Isolation from others in the same profession was of particular concern to the one-of-a-kind professionals (e.g. school guidance counsellor, social worker). Lack of supervision, ongoing inservice education and specialist education contributed to a sense of professional stagnation. Finally, the lack of professional consultants and peripatetic specialists created hardship when dealing with different psychiatric problems.

(3) Interdisciplinary Communication

Professional parochialism and the lack of attention to interdisciplinary communication in professional education is not unique to rural practice. What was different for rural practitioners was that because of limited professional resources, those who were in rural practice providing human service resources were, perforce, constrained to work as closely as possible with each other, a reality which they had not been properly prepared for in their pre-service education. Although on one level the professionals in

Dannevirke worked quite well together, the potential for more creative responses to community mental health problems seemed to be impaired by the jargon, values and perspectives unique to their respective professional training and development. The tendency to place most mental health problems in a medical context, precluded other professionals from greater involvement. Interdisciplinary tensions were further complicated by intradisciplinary ones. The clergy in Dannevirke offered an excellent example of ecumenical power being restricted by strict parish boundaries and inter-denominational differences. Even though volunteers and "natural helpers" were well known to exist in the community, the professionals - medical and non-medical alike - were not clear about the best way to actively communicate with them or maximise their participation in and contribution to the total caregiving facilities in the community.

Informal Networks of Support: The Survey

In this study the Borough and County of Dannevirke were defined as a rural community. The rural-urban debate has tended to portray the rural community as a homogeneous environment with three distinguishing characteristics: a sparse population, large geographical area, and an agricultural economic base. While Dannevirke satisfied these criteria, the present research findings demonstrated that it could not be defined as homogeneous, especially since historically, and to the present day, the population has been settled in geographically and culturally diverse settlements with a plurality of economic, political and social linkages. This study showed the term rural referring to the spatial allocation of population was insufficient to capture the rich and complex fabric of the people and their relationships.

Rural communities have been described as isolated, but this has not been demonstrated in this study.* Television, radio,

* Sense of isolation due to geographical distance is different from feeling lonely. Although most respondents did not describe themselves as isolated, 45% of the respondents reported that they "least enjoyed time spent alone".

newspapers, excellent roads, and branch stores of major chains linked Dannevirke residents in similar ways to more urban dwellers. The major area of worry delineated by 42% of the respondents was concern over the world situation, reflecting the residents' contact with national and international news. A clearcut division between what is rural and what is urban was not easily discerned.

(1) Well-Being

Using the 3-Point Happiness Question (Gurin, Veroff and Feld, 1960) and the Bradburn Affect Balance Scale (Bradburn, 1969) as a measure of psychological well-being, a majority of the rural respondents reported that they were happy (92% N = 207) and reported a high sense of well-being (42% N = 207). In fact, when asked to list any disadvantages to rural life, 34% of the respondents stated there were no disadvantages at all.

However, when the Well-Being scores of the borough and county respondents were compared, a statistically significant difference resulted. A higher percentage of respondents in the county reported higher levels of well-being while those in the borough reported a greater percentage of low well-being ($\text{Chi}^2 = 10.3$ $p < .05$) demonstrating intrarural differences.

Rural areas have been depicted as having strong support groups; Dannevirke was no exception. The community offered over 100 cultural, civic and sports clubs. A high percentage (78%) of the respondents belonged to one or more of these clubs. This high degree of involvement when crosstabulated with well-being using Bradburn's Scale, reflected a statistically significant relationship between high membership in clubs and a high sense of well-being ($\text{Chi}^2 = 19.19$ $p > .001$). This seemed to indicate the "buffering effect" group membership could provide, but the quality of membership and its function in aiding people in emotional distress would require further study.

Interaction between family and friends was measured and those

respondents who reported low visitation from family also reported a low sense of well-being ($\text{Chi}^2 = 11.18$ $p > .04$). Increased visitation did not result in a high sense of well-being, indicating that lack of family support did not necessarily contribute to a higher sense of well-being. Further research was indicated to test multiple membership, quality of group interaction, and family/friend visitation patterns.

(2) Mental Illness

Although the respondents were basically happy and reported a high degree of psychological well-being, 8-10% of the respondents reported feeling unhappy. These figures corresponded with the general practitioners' reports that 10% of their practice involved mental health concerns.

Mental illness was defined clearly by the respondents but covered a wide range from serious psychiatric illness to alcoholism to marital problems. The respondents identified the general practitioner as the primary "gatekeeper" in the community for mental health needs with family and clergy as secondary supports (see Figure Five).

Easy access to the general practitioner was seen as a strength in their community. Local treatment of mental illness was favoured by all respondents but they were aware of the limited specialist services in their community and acknowledged that treatment outside the community was necessary in some cases.

Questions concerning prevention and the development of new services proved to be quite difficult. Although gaps in the services were easily identified by the respondents (i.e. no halfway house for young people with psychiatric disorders) and problem areas were specified (i.e. unemployment, divorce, truancy), the way in which a rural community could respond to these concerns was unclear.

Recommendations for Practice

In reviewing the findings of the study the following

recommendations were formulated. Although these recommendations are specific to Dannevirke, they contain implications for mental health practice in other rural areas of New Zealand.

1. Manawaroa as the inpatient psychiatric facility for Dannevirke needs to develop policy for its rural catchment area taking into account their unique requirements.
 - a) With the increasing use of inpatient care, a regular peripatetic psychiatric service should be investigated for Dannevirke. This would provide direct service on an outpatient basis in the community as well as consultation for the professionals in Dannevirke.
 - b) Better utilisation of Manawaroa would result from cross-fertilisation of staff and "open days" where all Dannevirke professionals could come to the facility to observe the various treatment resources and personnel available. Conversely, Manawaroa staff should accept the responsibility for familiarisation with the borough and county they serve.
 - c) Ongoing education and supervision in psychological medicine and community mental health care could emanate from Manawaroa, lessening the sense of professional isolation and stagnation expressed by the Dannevirke caregivers.
2. Within the Dannevirke community there exists numerous resources - both formal and informal - for the provision of improved mental health services.
 - a) A community mental health advisory council should be formed comprised of professionals, "natural helpers", and consumers to ensure the integration of mental health care into the total health care system. This council could also ensure the intra-rural differences were recognised in policy development and service delivery.

- b) The interfaith support group as an ecumenical body has a unique opportunity to move beyond its individual parishes and provide a forum to challenge the community structures which may be contributing to the mental ill health of the residents.
 - c) The high school with its established guidance network offers a central location for family life education. The importance of all the schools at the interface between home and community makes them a potential forum for discussing identified problem areas.
 - d) The maraes of the community offer another central meeting place with a structure developed for problem solving within the Maori community. Diversion programmes such as Matua Whāngai and alternate work schemes would provide Maori youth with numerous alternatives.
 - e) Women's mental health was identified as a major concern. Workshops for career planning for rural women, a women's health collective, and networks of concerned rural women could offer mutual support and challenge.
3. Positioned between two major population centres has numerous implications for service delivery in the Dannevirke Borough and County. Agencies servicing this area need to be made accountable and develop policies which reflect the ongoing needs of the community. Irregular and inconsistent services from major departments are not acceptable to a rural community and agencies such as Maori Affairs, Department of Social Welfare, Probation, and Psychological Services need to review their policies for serving areas with small populations.
4. Prevention needs to be examined in a rural context. Creative programmes using the media would enable "tailored" education for rural mental health problems.

The existing informal supports of clubs and family offer built-in prevention, but there is still a proportion of the population who feel isolated and experience a low sense of well-being.

Policy Implications

The romanticisation of the "rural community" inferred that the rural context was safer, more supportive, more stable, and therefore, more conducive to better mental health than the urban environment. Yet the literature on the rural-urban debate and psychiatric impairment in a rural context challenged the simplistic nature of the romanticised conception of the benefits of the rural environment, and raised numerous contradictions. Because of the paucity of research into mental health in rural areas in New Zealand the realities of provision are far from clear; moreover the nature of the unique services these communities have developed remains uncharted, in any rigorous empirical sense.

This gap in information has serious implications for policy development and service delivery planning in the field of rural community mental health. If the rural-urban distinction is based on distorted conceptions of "community" then the development of services based on these assumptions could negatively affect the existing supports systems.

Every piece of social policy substitutes for some traditional arrangement, whether good or bad, a new arrangement in which public authorities take over, or at least in part, the role of the family, of the ethnic neighbourhood group or the voluntary association. In so doing social policy weakens the position of these traditional agents...

(Glazer, 1971)

This was particularly true in rural community development where Long's (1977) "neo-revolutionary modernist developmental perspective" emphasised the transfer of professional skills from the "modern urban" sector to the less skilled and technologically deficient "traditional rural" sector. In

mental health care, this transfer of services and skills was not completely negative because rural communities gained certain specialised psychiatric services which were previously unavailable. But the cost factor led to the weakening and/or dissolution of existing helping networks. This study has identified numerous informal supportive networks in the Dannevirke Borough and County and although their role in buffering the effects of mental health crises varied, their presence was an important facet in a community which lacked the repertoire of services associated with an urban environment.

The respondents in the household survey favoured care for the mentally ill within their own community wherever possible. This preference has implications, especially if consumer input into rural mental health care planning is to be taken into account, authentically. Historically, services for psychiatric care in New Zealand developed separately from other health care services. Because health care planning is now proceeding on a regional basis, an integrated, community perspective which includes consumer input would be essential to ensure the appropriate development of mental health services in rural areas.

Developing appropriate services for a mentally healthy community has numerous implications for the providers and consumers. In determining what is "mental health" two powerful treatment ideologies have been in conflict: the therapeutic or clinical treatment of the individual versus the structural change interventions based on community development models.

The basic question that must be resolved is whether the community mental health centre as it operates in a specific community is a personal service system, a public problem-solving system, or a public health system.

(Whittington, 1975)

This quote underlines the debate which is relevant to rural communities, and to those professionals and consumers involved in mental health care.

Numerous rural-urban differences were revealed in the findings from the present survey. While it is not possible to establish the bases of these differences, unequivocally, a number of underlying factors may need to be taken into account. For example, the continuing effects of the historically uneasy alliance between local and central government, and the continuing trend to centralise and rationalise the allocation and distribution of diverse kinds of resources should not be overlooked.

Implications for Research

This descriptive study was an initial foray into a largely unexplored area. Very little research has been done on rural social support systems and their implications for community mental health services. The findings of the present research suggest a number of avenues for further research:

1. Further comparative research should be done on social indicators in rural and urban communities.
2. Sexual bias of subjective social indicators needs to be researched. Reporting states of feeling may be easier for women than men and result in a disproportionate number of women reporting low well-being.
3. Recent research indicates that the quality of social interaction is as important as, and independent of, the quantity of interaction. More research is needed on networks of support and how they are utilised in a rural community.
4. Comparative analysis of support groups in rural and urban areas would help clarify their respective roles in buffering people in times of crisis.
5. Research into cross-cultural differences in perceiving and treating mental illness would clarify the role of "natural helpers" as well as clarify the use of formal resources by different ethnic and cultural groups.
6. Comparative analysis of community mental health services

which are now in existence in New Zealand would delineate their response to their rural catchment areas.

7. Research into alternate organisational structures which have been developed to meet the needs of rural communities in the delivery of human services would provide models unique to the New Zealand context.
8. Research into the interaction of local and national decision-making and how it affects the distribution of health care services would provide information on policy development for rural mental health care.
9. Analysis of the "rural content" in professional education process would provide information on the current training of formal caregivers.
10. Indepth interviews with the identified mentally ill in rural areas would provide information into their treatment and the gaps in services. These people are often the least powerful in the caregiving process and their experiences need to be heard.

New Zealand has prided itself in the provision of equitable provision and delivery of health care services. The development of mental health services that are separate from other health care services has resulted in inconsistent and, in some respects, inadequate services for the rural sector. The challenge will be to build on the existing formal and informal supports and to create more comprehensive responses to the particular mental health needs of rural communities. Overcoming the present dearth of research aimed at analysing the empirical realities of rural life is an essential prerequisite to rectifying these inequalities. Findings from the present research is a modest contribution to the establishment of base line data on rural pathways of support. The findings, although tentative, are thought-provoking and have implications for further research and policy development.

Research project will be based on Dannevirke County

A group of sociology students and nurses under the direction of Massey lecturer in social work Randolph Herman will be making an extensive survey in both the county and borough areas over the next nine weeks.

The Dannevirke Community support research project is funded by the Mental Health Foundation. Town and country residents will be sampled to assess the levels of health and support services in a rural community.

The survey will study the formal and institutional level of health care available plus the more informal aspects, such as neighbour support.

Already interest has been expressed further afield on the value of such surveys which give a clearer picture of various communities round the country.

The emphasis is placed purely on collecting information, not providing solutions to aspects of problem areas revealed by the study.

Though the emphasis is on health, Mr Herman said in Dannevirke yesterday that a great deal of information regarding other community services such as communications, access, and their part in overcoming rural isolation, would likely come to the fore.

One of the things that has drawn the team to Dannevirke is its geographical position on the edge of Hawke's Bay, Wairarapa, and the Manawatu regions. He said he had already discovered Dannevirke's judicial and social welfare services were based on Palmerston North while educational, Housing Corporation and Rural Banking headquarters were established in Napier.

The need for specialist medical services for areas such as Dannevirke district had already become apparent elsewhere, particularly in the mental health sphere and the availability of these will also be looked at by the team.

Mr Herman expects to bring down a report based on the team's findings following random surveys of complete households involving all members 16 years and over.

The research team will arrive in Dannevirke on Tuesday afternoons and remain until Thursdays and has established a headquarters in Federated Farmers offices, Gordon Street.

Mr Herman (left) with two of his students, Mrs Barbara Scarfe and Murray Walker, studying a map of Dannevirke County before undertaking their survey. — News Photo.



SURVEY MOVES INTO COUNTRY

Sociology students at present engaged on a health and support services study in Dannevirke Borough and County, move from town to country this week.

The team, under Massey lecturer Randolph Herman, is on a total nine week project funded by the Mental Health Foundation. It has worked in Dannevirke for the past three weeks and transfers its attention to the Weber-Ti Tree Point-Wimbleton-Herbertville districts in the next week or so extending from there to cover the remainder of the Dannevirke County.

Marital pressures pose major social problem in S.H.B.

Pressure on marriage relationships topped the poll of social problems listed by Dannevirke people involved in a survey conducted by Massey University last year. Assessing the social needs and support systems available in both urban and rural areas was the object of the survey encompassing five per cent of the population over a three month period.

University lecturer Randolph Herman presented his preliminary report to about 30 people in Dannevirke last night.

He warned the findings could have major implications for future planning and claimed that while results of the research revealed needs, it was up to the community to provide the answers.

Respondents listed marriage and relationship problems as the greatest social ill in the community (58 per cent). Not far behind was alcohol and alcoholism (51 per cent), youth and delinquency (50 per cent), and unemployment (46 per cent).

Isolation and loneliness drew top billing from 35 per cent and Mr Herman said findings showed this response was significant, contrasting with the general view that rural life involved less hassle and the presence of friendly people.

The claim was backed up by the meeting with the comment there were a lot of very lonely people in and around Dannevirke.

MISUSE OF DRUGS

Of other problems listed, misuse of prescribed drugs was pointed to by 24 per cent, drug abuse other than alcohol by 23 per cent, depression, 23 per cent, and racial issues by 19 per cent.

Mr Herman said the issue of race problems was difficult to define, with many respondents disclaiming the presence of racial issues because there was no racial violence.

Others in the survey, however, listed examples to prove the actual presence of racial issues in the community.

He pointed out a significant concern for unemployment problems and said the highest rate of unemployment was among Maoris and the young. "Therein lies future racial tension," the lecturer said.

The world situation was listed by 42 per cent of the respondents as their greatest worry, while 36 per cent expressed concern for their children's future. Twenty-four

per cent listed work as top of the list, while 23 per cent claimed lack of money was still their prime worry. Mr Herman said that 25 per cent overall said they worried a lot while 30 per cent claiming they worried more last year than the year before.

The survey revealed the mean income sample was \$6356 — below the national average — with 21 per cent earning less than \$4000 per annum but 20 per cent of the sample earned \$20,000 or more.

Mr Herman said the relationship of income and the perception of social problems was an important issue, as was the relationship of income and access to formal and informal networks of support.

"Life is okay in Dannevirke," however, was the greatest impression the survey team picked up over the three months. Seventy-three per cent of respondents said they were pleased they had accomplished something in life, while 68 per cent said things were going their way.

Feelings of boredom were listed by 19 per cent, loneliness by 15 per cent, and depression by 14 per cent. Mr Herman said these percentages were still significant, even if they seemed small.

He claimed there were gaps in the support systems required to meet the need of the community, but he thought the district was generally well off in this respect. He said Dannevirke was well served in the medical field with five doctors and a hospital, advantages many rural communities elsewhere did not have.

He also praised the support provided by sports organisations and clubs, with which the community was well served.

MUSCLE

"It will depend on how much muscle the community has as to what it can achieve in meeting future needs," Mr Herman said. The survey covered 110 households and everyone over the age of 16 years was surveyed.

Mr Herman said the survey reflected a stable population with 75 per cent of the sample having lived in the area longer than 10 years. Forty-four per cent of this figure have lived here all their lives.

Mr Herman discovered that the largest age group in both borough and county was the five to 14 years range, which could also have some significance for future planning. The next largest group was the 40 to 59 sector. Mr Herman was also dragged into the regional issue and he claimed it was controversial. Fifty-six per cent of respondents stated allegiances to Hawke's Bay or S.H.B. 18 per cent to the Ruahine concept, with only 6.8 per cent identifying with Manawatu. Seventeen per cent want Dannevirke to stay as it is.

Dannevirke was also listed as the centre used mostly for services by 89.4 per cent of participants.

The provision of services in the future was thrashed out following the presentation of the report and Hospital Board chief executive Eric Kells warned that hospital services would not be broadlined. "We will not get any more funds than we get now," he said, and we have to use only what we get."

Bandwagons were wheeled out as representatives of the schooling system, medical profession, nurses, teachers, and others suggested trends and solutions.

Employment and creation of jobs to retain the young were concerns of many. It was suggested by one speaker that the greed of two-income families and the numbers of married women in the workforce blocked employment opportunities in the area.

"Just trying to make ends meet," was the answer thrown back. Consensus of opinion was hard to achieve and Mr Herman was unable to offer assistance.

"We have highlighted our findings and the needs felt by your community," he said. "You will have to find the ways to meet them."

Mr Herman will return to outline further analysis of the survey, including the views of the professional groups in the community and to make some conclusions.



Massey University

PALMERSTON NORTH, NEW ZEALAND

TELEPHONES, 69-099, 69-089.

In reply please quote:

DEPARTMENT OF SOCIOLOGY - SOCIAL WORK UNIT

Dear

My name is W. Randolph Herman and I am a lecturer from the Social Work Unit at Massey University.

I have just received a small grant from the University to begin a research project in Dannevirke borough and county. I am currently waiting for approval for a grant from the Mental Health Foundation so that I can conduct a survey in your community concerning the formal and informal networks of care for the mentally ill.

At your convenience I would like to meet with you for 30 minutes and ask some questions concerning your perceptions of mental illness and the resources available for treatment in your community.

I look forward to meeting you and discussing these issues.

Sincerely,

W. Randolph Herman
Lecturer.

APPENDIX C

QUESTIONS FOR PROFESSIONAL CAREGIVERS

1. When someone comes to you or is referred with a mental illness, what do you do?
2. Define mental illness.
3. What percentage of your practice has to do with psychological/emotional problems?
4.
 - a) What other organisations and/or people in the community do you see as helpful in dealing with mental illness?
 - b) What organisations or people outside the community do you see as helpful in dealing with mental illness?
5. Where were you trained and in what kind of communities have you practised?
6. What are the advantages to working and living in a rural community, if any?
7. What are the disadvantages to working and living in a rural community, if any?
8. What mental health preventive programmes would benefit this community?

APPENDIX D

DANNEVIRKE COMMUNITY RESEARCH PROJECT

GUIDE TO INTERVIEWER

Gidday,

I am _____ and this is _____. We are from Massey University and are conducting research on the existence of helping patterns in the Dannevirke Area. People get support in many ways and we are interested in how people do this.

Your household has been selected randomly and your co-operation in answering the questions will aid us in obtaining information on how helping services are provided in rural areas. The interview will take approximately half an hour and we would like to interview each member of the household over 12 years of age. The information you provide will be used in writing a report but your names and any identifying information WILL NOT BE USED. After the survey is completed we will feed back this information to you and to the community.

A. SOCIAL CONTACTS

1. Were you born in New Zealand?

(0) Yes (If YES, answer (d) only)

(1) No (If NO, answer (a) through (d))

If NO (a) where were you born? _____

(b) where have you lived? _____

(c) how long have you lived in New Zealand? _____

(d) how long have you lived in Dannevirke?

(0) Under 6 months

(1) Under 12 months

(2) Under 5 years

(3) Under 10 years

(4) 10 years or more

(5) All of life

2. Has this been your permanent address for the last 5 years?

(0) Yes

(1) No

If NO (a) how many times have you shifted in the last 5 years? _____

3. How do you like living in Dannevirke?

(0) Dislike very much

(1) Dislike

(2) Neutral

(3) Like

(4) Like very much

If DISLIKE (a) where would you prefer to live? Why? _____

4. What do you see as advantages, if any, of living in rural areas?

5. What do you see as disadvantages, if any, of living in rural areas?

6. Currently there is discussion as to which region Dannevirke will fall under. Of the following regions which do you feel most a part of?

- (0) Dannevirke
- (1) Hawkes Bay
- (2) Southern Hawkes Bay
- (3) Manawatu
- (4) Ruahine
- (5) Other (Specify) _____

7. Could you list in order, from the least to the most often, the following towns you would go to for services? (e.g. medical, social, shopping)

- (0) Dannevirke
- (1) Palmerston North
- (2) Napier
- (3) Hastings
- (4) Waipukurau
- (5) Other (Specify) _____

8. Could you list any sports and recreation clubs you belong to? (e.g. rugby, darts, etc.)

(GUIDE TO INTERVIEWER: Code frequency of attendance by (0) weekly, (1) monthly, (2) yearly, for questions 8, 9, and 10)

	NAMES	FREQ. OF ATTEND.	OFFICER
1			
2			
3			
4			
5			
6			

9. Could you list any civic organisations you belong to? (e.g. Lions, Rotary, P.T.A., etc.)

	NAMES	FREQ. OF ATTEND.	OFFICER
1			
2			
3			
4			
5			
6			

10. Could you list any cultural clubs (and societies) you belong to? (e.g. Opera Society, Rose Society)

	NAMES	FREQ. OF ATTEND.	OFFICER
1			
2			
3			
4			
5			
6			

(Questions 8, 9, and 10) (a) When I read these names back to you, can you tell me how often you attend each one, and if you hold an office?

11. Are there other recreation activities that occupy your time? (e.g. knitting, tramping, hunting, etc.)

People get support in different ways. The following questions look at how you contact people.

12. What way would you most commonly make contact with people?

- (0) Visits
- (1) Letters
- (2) Phone
- (3) They visit
- (4) Meet on street
- (5) Club Meetings
- (6) At work
- (7) At the Pub
- (8) Other (Specify) _____

13. In an average week, who contacts you and how often?

(GUIDE TO INTERVIEWER: WHO i.e. family/relation, friend, acquaintance
 HOW i.e. visit, phone, letter, meet on street
 HOW OFTEN i.e. once a week, twice a week, etc.)

	WHO	HOW	HOW OFTEN
1			
2			
3			
4			
5			

14. In an average week, who do you contact and how often?

	WHO	HOW	HOW OFTEN
1			
2			
3			
4			
5			
6			

15. Do you have a telephone?

(0) Yes

(1) No

If YES (a) Are you on a party line?

(0) Yes

(1) No

If YES (b) how many parties?

(0) One

(1) Two

(2) Three

(3) Four or more

(c) how often does your phone go out of order?

Comment _____

16. How often do you receive mail?

(0) Not at all

(1) Once a week

(2) Twice a week

(3) Three or more times a week

16a. How do you receive your mail?

(0) Town delivery

(1) Rural delivery

(2) P.O. Box

(3) Private Bag

(4) Other (Specify) _____

17. Do you have a television?

(0) Yes

(1) No

17a. Do you have a radio?

(0) Yes

(1) No

17b. Please comment on the reception quality of each.

Television _____

Radio _____

18. What newspapers do you read regularly?

(0) Dannevirke paper

(1) Hawkes Bay Herald

(2) Daily Telegraph

(3) Evening Standard

(4) Dominion

(5) New Zealand Herald

(6) Truth

(7) Other (Specify) _____

19. How many in your household can drive?

(GUIDE TO INTERVIEWER: Transport is essential in rural areas)

(0) None

(1) One

(2) Two

(3) Three

(4) Four or more

19a. Do you see the condition of your roads affecting your ability to make contact with people and services?

(0) Yes

(1) No

Please comment _____

20. Do you have access to the following forms of transport?

(0) Family/private car

(1) Public transport

(2) Taxi

(3) Friend's car

(4) Other (Specify) _____

Comments _____

20a. Do you feel your access to transport affects your ability to contact people or services?

(0) Yes

(1) No

If so, how? _____

21. Please tell me how far in miles or kilometres (specify which) and travelling time (one way) and, if applicable, in what town, the following are from your home. If because of steep grades it takes longer to travel one way than the other, give average time. (GUIDE TO INTERVIEWER: Show Card 1)

SERVICE	DISTANCE	TIME	TOWN
Your nearest neighbour			
Your nearest centre with a general store, a post office and garage			
Your nearest doctor			
Your nearest general hospital			
Your nearest maternity hospital			
Your district health nurse's base			
Your nearest police station			
Your veterinary surgeon's clinic			
Your nearest primary school			
Your nearest secondary school			
Your nearest hotel			
Your church			
Dannevirke (centre)			

22. May I ask you to describe your present state of health? Is it -

- (0) Always good
- (1) Usually good
- (2) Variable
- (3) Usually poor
- (4) Always poor
- (5) Don't know

23. Compared with a year ago would you say that your health is -

- (0) Better now
- (1) Worse now
- (2) The Same
- (3) Don't know

B. STYLES OF COPING

24. (GUIDE TO INTERVIEWER: Many people in New Zealand drink)

Could you tell me if you now drink, or have ever drunk, alcohol?

- (0) Yes - now
- (1) Yes - used to
- (2) No - never
- (3) Don't know

} If either of these, proceed to question 28.

25. When you drink, who would you most likely drink with? (e.g. alone, family, spouse, parents, work mates, friends, etc.)

26. Some people worry about their drinking even though they may not drink that much. Do you worry about your drinking at all? How much?

(0) A lot

(1) Sometimes

(2) Little

(3) Never

(4) Object

27. Do you feel your drinking is creating, or has ever created, any difficulties for you?

(0) Yes

(1) No

(2) Object

If YES (a) in which of the following areas have these occurred?

(0) Your health

(1) Your friendships and social life

(2) Your marriage

(3) Your home

(4) Your financial position

(5) Looking after yourself and providing for your own needs

(6) Being able to care for your family

(b) which of the following people have been or are helpful?

(0) Spouse (husband/wife)

(1) Relative

(2) Friend

(3) Neighbour

(4) Clergy

(5) District Nurse

(6) Doctor

(7) Social Worker

(8) Other (Specify) _____

(c) which of the following people did you not find useful?

(0) Spouse (husband/wife)

(1) Relative

(2) Friend

(3) Neighbour

(4) Clergy

(5) District Nurse

(6) Doctor

(7) Social Worker

(8) Other (Specify) _____

28. Has anyone else's drinking ever created any problems for you?

- (0) Yes
- (1) No
- (2) Object

If YES (a) in which of the following areas did these occur?

- (0) Your health
- (1) Your friendships and social life
- (2) Your marriage
- (3) Your home
- (4) Your work
- (5) Your financial position
- (6) Looking after yourself and providing for your own needs
- (7) Being able to care for your family

29. In general, do you worry a lot or not very much?

- (0) A lot
- (1) Not very much
- (2) Never

30. Would you say you worry more now than you used to or not as much as you used to?

- (0) More
- (1) About the same
- (2) Not as much
- (3) Never

31. During the past few weeks have you worried about any of the following?
(GUIDE TO INTERVIEWER: Show Card 2)

- (a) Not enough money
- (b) Financial debts
- (c) How things are at work (or your spouse's work)
- (d) Getting along with wife/husband/boy or girlfriend
- (e) Moving ahead in the world
- (f) Your children
- (g) Sexual problems
- (h) People you have trouble with
- (i) Your health
- (j) Things happening in your neighbourhood
- (k) The world situation
- (l) Growing old

	YES	NO
(a)	<input type="checkbox"/>	<input type="checkbox"/>
(b)	<input type="checkbox"/>	<input type="checkbox"/>
(c)	<input type="checkbox"/>	<input type="checkbox"/>
(d)	<input type="checkbox"/>	<input type="checkbox"/>
(e)	<input type="checkbox"/>	<input type="checkbox"/>
(f)	<input type="checkbox"/>	<input type="checkbox"/>
(g)	<input type="checkbox"/>	<input type="checkbox"/>
(h)	<input type="checkbox"/>	<input type="checkbox"/>
(i)	<input type="checkbox"/>	<input type="checkbox"/>
(j)	<input type="checkbox"/>	<input type="checkbox"/>
(k)	<input type="checkbox"/>	<input type="checkbox"/>
(l)	<input type="checkbox"/>	<input type="checkbox"/>

32. Now, let's talk about something else. We are interested in the way people are feeling these days. During the past few weeks did you ever feel -

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

- (a) Particularly excited or interested in something
- (b) So restless that you couldn't sit long in a chair
- (c) Proud because someone complimented you on something you did
- (d) Very lonely or remote from other people
- (e) Pleased about accomplishing something
- (f) Bored
- (g) On top of the world
- (h) Repressed or very unhappy
- (i) Things were going your way
- (j) Upset because someone criticised you

33. Now we want to shift to things you enjoy. Here is a list.
(GUIDE TO INTERVIEWER: Show Card 4)

- | | |
|---|---------------------------------|
| 1. Work on Job | 5. Hobbies or recreation |
| 2. Taking care of house | 6. Time spent with husband/wife |
| 3. Getting together and doing things with friends | 7. Doing things with children |
| 4. Participating in clubs | 8. Time spent alone |

(a) please tell me which one gave you the most enjoyment in the past few weeks?

(b) which one did you next enjoy?

(c) which one did you least enjoy?

34. Taken all together, how would you say things are these days?

- (0) Very happy
- (1) Pretty happy
- (2) Not so happy

35. Compared with life today, how were things four or five years ago?

- (0) Happier then
- (1) Not so happy then
- (2) About the same

36. Think of how your life is going now. Do you want it to continue in much the same way as it's going now; do you wish you could change some parts of it; or do you wish you could change many parts of it?

- (0) Continue the same
- (1) Change some parts
- (2) Change many parts

37. An area of concern to many people is mental illness, but mental illness means different things to different people. How would you define mental illness?

38. If you or a member of your family or a friend experienced mental illness, who would you turn to?

38a. Who would you avoid (for the time being)?

39. If someone were to need intensive psychiatric treatment (e.g. hospitalisation) would you rather see them cared for in -

(0) Local hospital/clinic

(1) Sent away

Why? _____

40. Mental illness is one problem, there may be many others. Could you rate the following in terms of how common you think they are in the Dannevirke area?

(GUIDE TO INTERVIEWER: Show Card 5)

NOT COMMON (0)	COMMON (1)	HIGHLY COMMON (2)	NOT A PROBLEM (3)	PROBLEM
				(a) Alcoholism
				(b) Drug abuse
				(c) Medication overuse
				(d) Delinquency/youth problem
				(e) Marriage problems
				(f) Racial conflict
				(g) Depression
				(h) Suicide
				(i) Unemployment
				(j) Shifting
				(k) Loneliness
				(l) Child abuse
				(m) Other (Specify)

40a. Of these listed problems, what services are you aware of that exist in Dannevirke?

PROBLFM	SERVICES
(a) Alcoholism	
(b) Drug Abuse	
(c) Medication overuse	
(d) Delinquency/youth problem	
(e) Marriage problems	
(f) Racial conflict	
(g) Depression	
(h) Suicide	
(i) Unemployment	
(j) Shifting	
(k) Loneliness	
(l) Child abuse	
(m) Other (Specify)	

C. DEMOGRAPHIC MATERIAL

41. What ethnic group do you feel you belong to?

(0) European

(1) Maori

(2) Pacific Islander

(3) Other (Specify) _____

42. What is your marital status?

(0) Single

(1) Married

(2) Widowed

(3) Engaged

(4) Separated

(5) Divorced

(6) De facto

43. Sex?

(0) Male

(1) Female

44. In what year were you born? _____ (Age _____ For interviewer only)

45. Do you live in the -

(a) County

(b) Borough

(If County, answer (c) through (f))

(If Borough, answer (f) only)

(c) what kind of farm is this? (e.g. dairy, sheep, mixed beef-dry stock, pig poultry, cropping, etc.)

(d) what size is it? _____ (acres or hectares)

(e) what type of ownership? (e.g. jointly with spouse, or family, partnership, company, trust, etc.) (If not an owner clarify position)

(f) if female, what part do you play on the farm/in the household?

(0) Paid

(1) Unpaid

(2) Outside work

List duties and responsibilities _____

46. Could you look at this card and tell me what your main occupation is?
(GUIDE TO INTERVIEWER: Show Card 6)

(0) Employer of labour

(1) Self-employed

(2) Wage or salary earner

(3) Seasonal worker

(4) Student

(5) Homemaker

(6) Unemployed

(7) Retired

47. Are you presently working full-time or part-time?
(GUIDE TO INTERVIEWER: If answer (3), go to Q.49)

(0) Full-time

(1) Part-time

(2) Not applicable

(3) Unemployed

48. Do you have any other part-time jobs as well?

(0) Yes

(1) No

(2) Not applicable

49. (For respondents currently unemployed) Have you ever been in paid employment?

- (0) Yes, full-time
- (1) Yes, part-time only
- (2) No previous employment
- (3) Not applicable

50. What was your previous job? (If any) _____

51. What is your major source of income?

- (0) Salary/wages from employment
- (1) Income from business/farm
- (2) Interest and rents
- (3) Superannuation
- (4) State benefit (Sickness, unemployment, DPB, ACC)
- (5) Receipts from boarders
- (6) Rely on spouse/parents for support
- (7) Other (Specify) _____

52. How many years did you spend at secondary school? _____ Years

53. What was your highest school examination qualification?

- (0) None
- (1) Proficiency examination
- (2) School Certificate in 1 - 3 papers
- (3) School Certificate in 4 or more papers
- (4) University Entrance
- (5) Higher School Certificate
- (6) Bursary or scholarship
- (7) Other (Specify) _____
- (8) Not applicable

54. Have you gained any qualifications since leaving school?
(GUIDE TO INTERVIEWER: If NO, go to 0.55)

- (0) Yes
- (1) No
- (2) Not applicable

54a. What qualifications do you have?

- (0) Commercial qualifications (e.g. Pitmans)
- (1) Professional qualifications (e.g. Teaching)
- (2) Technician's Certificate
- (3) Trade Certificate
- (4) University Degree
- (5) Other (Specify) _____

55. How would you describe your religious beliefs?
(GUIDE TO INTERVIEWER: If NONE, go to 0.58)

- (0) None
- (1) Some belief
- (2) Fairly strong
- (3) Very strong
- (4) Don't know
- (5) Object
- (6) Not applicable

56. Do you belong to a religious group?

- (0) Yes
- (1) No

56a. Which group do you belong to?

- (0) Anglican
- (1) Presbyterian
- (2) Roman Catholic
- (3) Methodist
- (4) Baptist
- (5) Ratana
- (6) Latter Day Saints (Mormon)
- (7) Other (Specify) _____
- (8) Object

56b. Is there a church in this area for you to practise in?

- (0) Yes
- (1) No

If NO, where do you go? _____

57. How much do you think your religious views affect certain areas of your life?

	CONSIDERABLE	SOME EFFECT	NONE
(a) General health			
(b) Choice and use of food			
(c) Choice and use of alcohol			
(d) Friendships			
(e) Social life			
(f) Sexual life (e.g. contraception)			

58. (GUIDE TO INTERVIEWER: Finally, one more question)

It would help me to have some information on income in this household. We do not wish to know the exact amount, but could you look at this card and tell me into which of these groups your total annual household income falls?
(GUIDE TO INTERVIEWER: Show Card 7)

- (0) \$0 - 1,999
- (1) \$2,000 - 3,999
- (2) \$4,000 - 5,999
- (3) \$6,000 - 7,999
- (4) \$8,000 - 9,999
- (5) \$10,000 - 11,999
- (6) \$12,000 - 13,999
- (7) \$14,000 - 15,999
- (8) \$16,000 - 17,999
- (9) \$18,000 - 19,999
- (10) \$20,000 - 24,999
- (11) \$25,000 - 29,999
- (12) \$30,000 +



58a. If your income is seasonal (farmers), how do you view your financial status?

(GUIDE TO INTERVIEWER: This brings us to the end of the questionnaire. Thank you for your time and your thoughtful consideration of the questions.)

APPENDIX E

APPENDIX

Index of Intercoder Agreement

(a) Index of intercoder agreement ()

$$= \frac{PO - PE}{1 - PE}$$

where PO = percentage of judgements on which two analysts agree when coding the same data independently.

Pe = per cent agreement to be expected on the basis of chance (formula given below).

= ratio of actual difference between obtained and chance agreement to the maximum difference between obtained and chance agreement.

(b) Expected per cent agreement (Pe)

$$Pe = \frac{k}{\sum_{i=1}^k p_i^2}$$

where k = total number of categories

pi = proportion of the entire sample which falls in the ith category.

(c) Sampling error of

$$= \frac{Po}{1 - Pe} - \frac{Pe}{1 - Pe}$$

(d) Variance of sampling distribution

$$= k^2 \cdot \frac{1}{1 - Pe} \cdot \frac{Po \cdot Qo}{N - 1}$$

Where Qo = 1 - Po

N =

(e) Results: Index of Intercoder Agreement = .867

APPENDIX F (i)

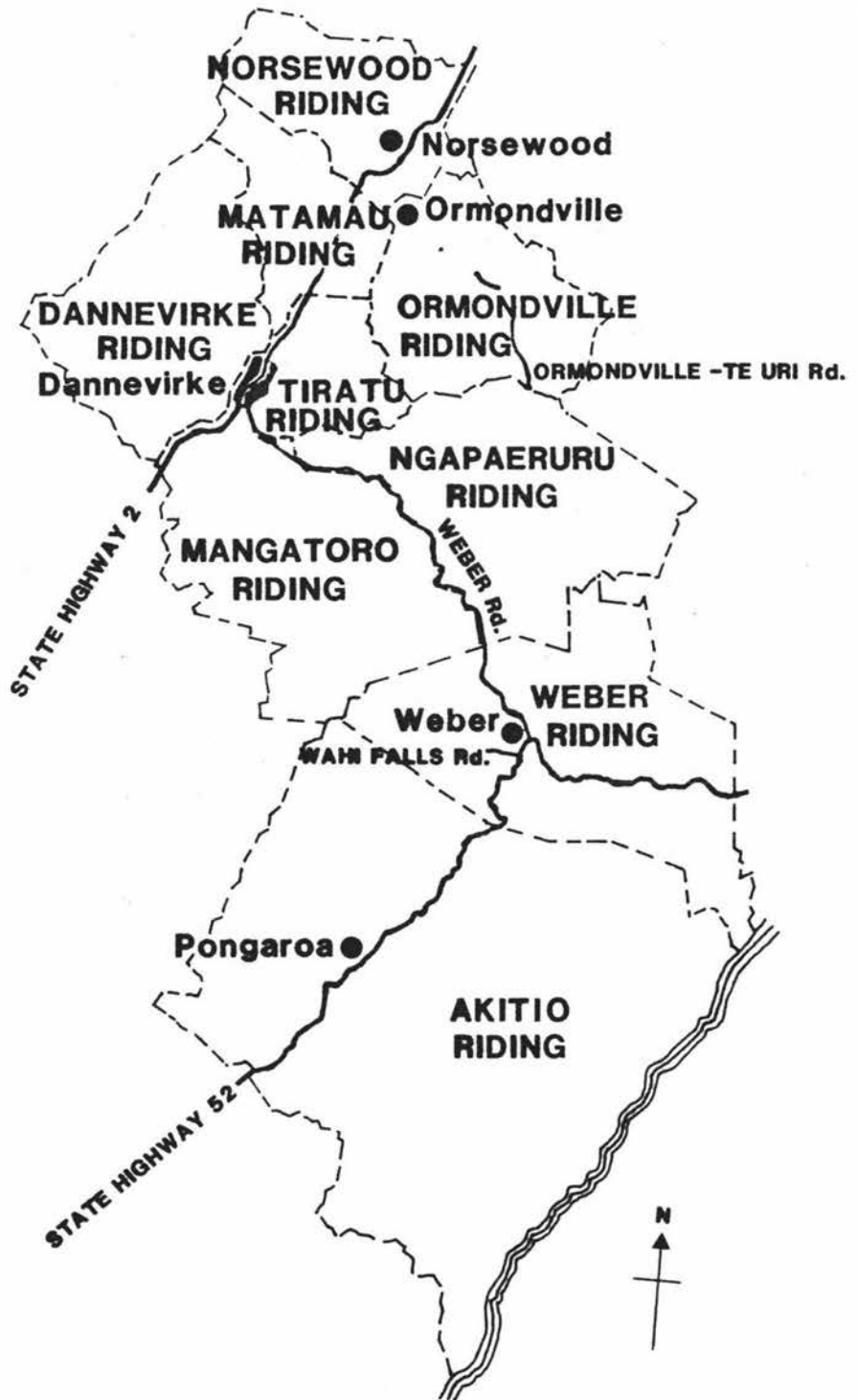
1976 CENSUS OF POPULATION & DWELLINGS
 POPULATION AND DWELLING DETAILS BY MESH BLOCK AND AREA UNITS

HAWKES BAY STATISTICAL AREA				Unoccupied Dwellings					In course of erection	
				Popula- tion	Occupied Dwellings	Tempor- rarily	Unten- anted	Bach	Houses	Flats
A/V	Dist/Sub.	Dist.	Mesh							
457	125	01	01	2	10	1				
	Dannevirke B		02		4					
			03		1					
			04							
			05	98	33	1	1			
			06	141	48	1	2			
			07	21	5					
			08				1			
			09	58	22					
			10	77	29	3				
			11	136	50	1	1			
			12	174	52		3			
			13	92	33					
			14	95	34					
			15	16	5					
			16	87	26	2	3			
Total Subdistrict 01				1,039	352	9	11	-	-	-

APPENDIX F (ii)

1976 CENSUS OF POPULATION & DWELLINGS
 POPULATION AND DWELLING DETAILS BY MESH BLOCK AND AREA UNITS

A/V	Dist/Sub.Dist.	Mesh	Unoccupied Dwellings					In course of erection	
			Popula- tion	Occupied Dwellings	Tempor- arily	Unten- anted	Bach	Houses	Flats
451	25 07 Dannevirke C	01	87	33	1			6	
		02	69	18	1	2			
		03	86	19		4			
		04	44	12	1	4			
		05	34	10					
		06	18	7		1	1		
		07	80	28	1	1			
		08	21	6					
	Total Subdistrict 07		479	146	4	13	-	1	6
	125 08	01	53	16		7	1		
		02	74	28		4			
		03	19	9		2			
		04	8	3					
		05	66	20		1			
		06	41	13		1			
		07	123	32		1			
		08	74	19					
	Total Subdistrict 08		458	140	-	16	1	-	-



Dannevirke County Ridings

From Dannevirke County Council Plan 689

APPENDIX G

HOW PEOPLE SUPPORT EACH OTHER
IN A RURAL TOWN AND COUNTY

— A PRELIMINARY REPORT —

By: *W. Randolph Herman*
Lecturer, Social Work Unit
Massey University

PART I: SOME FACTS ON DANNEVIRKE BOROUGH AND DANNEVIRKE COUNTY

"The 70 mile bush, sometimes referred to in early documents as 40 mile bush, or even the 90 mile bush, stretches from the Ruataniwha Plains in the North to the Ruamahanga in the South, a distance of about 75 miles. The district which it formerly covered is situated in a great geological depression on the eastern side of the Tararuas and Ruahine Mountains which form a part of the main axle range of the North Island of New Zealand. The bush was representative of most forms of the flora characteristic of the country, the most viable milling timber being rimu, matai and totara. From Takapau to Oringi was a valuable totara belt of varying width, which coincided with the line chosen for a railway. About 20 miles from its northern boundary the bush became less dense and the low hills east of where Dannevirke now stands were covered with fern and manuka scrub." (Dannevirke - the founding of a bush settlement by "Alpha")

WHY COMMUNITY RESEARCH?

In the last few years there has been an increased interest in pursuing descriptive and empirical evidence of social life in rural New Zealand. Although the vast majority of the population now reside in urban areas, New Zealand's national wealth is still largely dependent on the rural environment. Rural activists have underlined the importance for politicians, planners, and providers of social services to be aware of their unique needs. The amount of rural research in New Zealand is growing; Rural Change in the Banks Peninsula,¹ the research in the Mangamahu Valley,² the National Survey of Rural Women in New Zealand,³ and the Health Study in the Wanganui Region⁴ are just some of the major attempts of compiling baseline information. It is essential to have as much information as possible in planning for the development and provision of services. The 1977 Planning Act underlines and requires communities to implement a social services planning package. This emphasizes the necessity for information to be garnered and redistributed, not only to local and central Government authorities but to the people of the community. Statistical material becomes meaningless if it is not relevant to those people who participated and were involved in the research.

The Mental Health Foundation of New Zealand provided a grant in March 1980 to look at a rural community and examine how services are perceived to be provided on a formal and informal basis. Before planning the provision of services, it is essential to know what in fact is operating in the community. The study is an attempt to discern the kind of support available and in some instances not available, in a rural community in New Zealand.

WHAT IS RURAL?

Rural is most often defined by what it is not. The 1979 New Zealand Year Book states *"an urban population has been defined as that of 24 defined main urban areas, plus that of all boroughs, towns, districts, communities, district communities and townships of 1,000 and over."* That which is not defined as urban is then classified as rural. Nor can rural be totally equated with farming because of the interlocking networks with the small district communities, townships and boroughs. Therefore Dannevirke borough and county, although not meeting the exact requirements by the census definition, does manifest concerns which are not urban in nature.

WHY DANNEVIRKE?

One of the questions that was most often asked of the field researchers was "Why did you pick on Dannevirke? Do you think we are crazier than the rest of the country?" It was a reasonable question by any community being researched. Dannevirke was selected for numerous reasons, but not because it had any more problems than any other rural area.

Its population was under 10,000 and it covered a large geographical area. This area encompassed dairy farming, sheep farming, sheep and beef farming, as well as a significant borough population. Dannevirke's geographic boundaries came between two major population areas. This 'in-between' position provided potential for confusion in the delivery of services. Services for the Dannevirke area now presently come from the Hawkes Bay, Palmerston North and even Wellington. The 'in-between' status is not uncommon for a rural area and seems to underlie a major difficulty in service delivery.

In my work with the Social Work Unit with Massey University I had become acquainted with Dannevirke through students who had worked with the Social Welfare Department. It was essential that if research were to be done in a community by 'outsiders' that the researcher had respondents within the community who could aid and facilitate the field research.

Lastly, of a more practical nature, access into Dannevirke was relatively easy from Palmerston North. As in any research there were budget limitations. Rural research was expensive due to the large geographic areas and the amount of travel that was required in interviewing.

SAMPLE

According to the 1976 census Dannevirke borough has a population of 5,638 showing a 5% increase in population since the 1971 census. Dannevirke county has 3,655 people showing a 5.9% decrease in population since 1971. In reviewing the census statistics it is interesting to note that both in the borough and county the largest age group was the 5-14 category. This large block of youth both in the borough and the county has major implications for future planning. The next largest group in the borough and the county is the 40-59 age group, but in the 65 and older group there is a difference in the borough and county. The borough shows 65 and older as being the next highest group, and this was reflected in the large number of senior citizens and widows who were interviewed in our sample in the borough. This sharp difference in age population may reflect patterns of handing over farms and desire to be closer to services, especially health related, as persons become older.

There are 2,829 households and the field researchers attempted to see a representative sample of occupied households in the borough and county. Distance, weather, and limitations on the numbers of researchers and cars restricted the number, but nevertheless we were able to contact 110 households, which approached a 5% sample. Everyone in the home over 16 years of age was interviewed, and the mean number of persons interviewed was 2.3 per household.

The sample reflected a stable population for the main part. 90% were born in New Zealand, and of those not born in New Zealand a higher proportion of those were living in the county. 75% of the sample have lived in Dannevirke for more than 10 years and of that group 44% have lived in Dannevirke all their lives. As in other studies mobility is indeed an issue for the rural area, as much as for the urban area. In our sample 37% had moved at least once in the last 5 years. This is slightly higher than the national average. The sample showed 47% male and 52% female in the borough, which is almost the same as those in the census figures. This percentage is almost reversed in the county with more males than females.

The ethnic breakdown of the sample was 90% European, 9% Maori and 1% other. This seems to be fairly close to the census figures, although if Maori and Maori descendent figures are combined the census shows almost a 20% Maori population in the county. This would indicate that the percentage of non-Europeans in the county sample is low.

The mean income of the sample was \$6,356, lower than the national average. It is interesting to note that 21% were earning less than \$4,000 but it also showed that 20% earn \$20,000 or more. This seems to underline polarity in the rural environment with a large percentage of people in the high income bracket and a large percentage in the low income bracket. The relationship of income

and the perception of social problems is an important issue, as is the relationship of income and access to formal and informal networks.

THE SURVEY

The actual field research took place in Dannevirke from June to August 1980. The research team included three social work students, Murray Walker, Karen Walsh and Barbara Scarfe, and there were numerous community people who helped us. To name a few, it is important to include Dr Mulvihill, Superintendent of the Dannevirke Hospital Board, and Ces Taylor, Grace Benson, Jennie Taylor, and Edith Nicoliason, without whose assistance we could not have interviewed as many families as we did. John Robinson, social worker from Department of Social Welfare, Mrs Burnside of the Federated Farmers, and the County and Borough Clerks who were all extremely helpful in facilitating the project. We came to Dannevirke every week and spent two days and one evening living in the Galloway House at the hospital, and used the Federated Farmers facilities during the day. We had an extremely low rate of refusal, which reflects the high number of homes in which we were welcomed. One of the questions most often asked by the respondents before allowing the field worker to enter his home was "What are you going to do with this information?" It was important for us to clarify to all those who participated that this information indeed would come back to the community in a public forum. It was quite common for respondents to comment that other researchers had been by and they had never heard anything or any more of the project.

Confidentiality, of course, was another issue. No names or addresses were utilised, and the Lions farm map was used to pinpoint farms within the riding. No permanent record was kept of any respondents' names, addresses etc. The only identifying factor was the geographic area, either the borough or the county.

The sample was a random sample, meaning that everyone had an equal chance of being selected. We divided the borough into statistical areas that the Department of Statistics used in developing the census. The borough has six statistical areas and we sampled from each of these. In the county we used voting ridings as geographic boundaries for the sample.

Future public meetings will be held in different areas around the county to allow people in the outlying areas to participate. The research did show some distinct differences within these areas and it is hoped that these meanings will allow further discussion.

SUPPORT SYSTEMS

It is important to define the terms that are the cornerstones of the research project. The Dannevirke study is based on the discovery and description of support systems. For this study a support system was defined as the interaction of individuals, groups, and organisations which provide support and communication.

There are many assumptions of how rural support systems operate and how life in rural New Zealand 'really is'. Rural life is typified as having a slower pace, less hassle, friendly people, in contrast to the urban life which is depicted as fast, unfriendly, 'dog-eat-dog'. These assumptions are powerful and often not backed by empirical facts. Yet planning and service delivery has often been found to be based on these assumptions. Often the obvious is

overlooked and reconsideration of the assumption is essential.

It is often assumed that in rural communities everyone knows each other, and looks after each other. The anonymity and isolation of urban life is supposedly non-existent in rural life. Therefore, if this be true, the need for formalised services such as Marriage and Family Guidance, Probation Departments, Welfare Services, would not be as essential as they would be in an urban environment. The informal system that exists in a community may provide the kind of services that people need to help them deal with the numerous crises of everyday living. Even in rural New Zealand, physical and social change is being experienced at a more rapid pace. The social and psychological well-being of individuals in the community is therefore an issue of major importance. This study attempted to look at those systems (individual, group, or organisation) which are available or not available to the members of the borough and county.

MENTAL HEALTH

Mental Health is an extremely difficult concept to define. It is quite common for the term 'mental health' to be transposed to 'mental illness', complicating the definition further. For example, in the Wanganui Health Survey it was found that 20% of those who reported health problems, stated their major concern was mental health. But their definition of mental health problems ranged from chronic psychiatric illness, childhood behaviour problems, problems of ageing, alcohol and drug use to marital and family problems.⁵

The Dannevirke study was designed to explore the relationships between an individual's definition of mental health and his involvement in formal and informal social support system. If people are part of an active support system this may aid them in dealing with social and psychological problems, or in fact, it could deter people from getting 'professional help'.

Even within the county of Dannevirke there were numerous area differences in how people defined problems and identified sources for help in resolving these problems. This project is an attempt to look at one county and how that county says who it is collectively and how it provides for those it claims to be its own.

RESEARCH FINDINGS

REGIONALISATION

The identity of a community is a complex process, one which is influenced by history, physical geography, and psychological boundaries.

An interesting historical note is that in pre-Pakeha days, a huge totara tree named 'Tapu-ki-heretaunga' existed as a natural boundary between the tribes of the Hawkes Bay and those of the Manawatu.⁶ Historical boundaries, such as the great totara, play a subtle but important part in present day boundary definitions.

How people perceive their geographical boundaries can determine their use of services. Therefore, it was important in this survey to examine people's subjective sense of geographical allegiance. The issue of regionalisation was, and is still, quite an issue of controversy. Recently the area of Dannevirke has been assigned to the Manawatu Region. The findings of this survey tend

to show a much different picture. Of the sample, 56% stated they felt allegiance to Hawkes Bay or Southern Hawkes Bay, 18% to the Ruahine district, 17% say that they wanted Dannevirke to remain as it is, and only 6.8% felt any identification with the Manawatu. This was consistent with another question that asked "which city was used most often for services, health, welfare, and social?" - 89.4% of the respondents said they felt Dannevirke was indeed the centre for this.

COMMUNICATION

Contacts between people can be a way of measuring networks of support. The Dannevirke study showed numerous ways in which people communicate. The phone was listed as the most common way of contacting people. 97% of the people in the sample had a phone, with 32% possessing a party line. But of the 32% who were on the party line 14% had four more on their line. A number of respondents commented that the party line ring was a welcomed reminder of neighbours. 5% of the respondents did communicate actively through letters, which underlies the subtle support systems from friends and relatives either outside of Dannevirke County, within the country of New Zealand, or even farther afield outside of the country in other areas of the world. 54% of the respondents got mail delivered twice or more a week. But a significant 23% reported getting less than 1 letter per week. 42% were contacted daily to 2-3 times a week by relatives, and another 25% was contacted at least 2-3 times a week by friends. This pattern interestingly changed when respondents were asked how they contacted other people - only 30% contacted their relatives daily to 2-3 times a week, and less than 15% contacted friends 2-3 times a week.

One of the things that affects rural as well as urban life is the media, and the effect of instant communication. The presence of modern communication is in most of the households in Dannevirke, with 93% of the respondents having television, and 90% having radio. Over 80% of the homes stated reception was good; 11% stated their TV reception was only fair because they could only receive one channel. Several households constructed unusual structures to improve television transmission.

90% of the respondents read the Dannevirke Evening News regularly, with 20% reading the Hawkes Bay Herald, and 18% reading the Daily Telegraph. Only 2.4% of the sample read the Manawatu Evening Standard. Newspaper selection may be another indicator of regional affiliation.

Mobility and access to service is an issue in a rural environment. In the Wanganui study the greatest obstacle in obtaining services was distance and the issue of driving. In the Dannevirke study less than 10% felt that the conditions of the roads limited their ability to get to services and friends. 90% of the respondents stated they had a household vehicle. But 17% stated that their ability to visit or obtain services was affected by lack of access to the family vehicle. Many commented that if costs for petrol increased it would severely inhibit their mobility.

STATE OF HEALTH

The Dannevirke study undertook to assess the statements of well-being and health using subjective measurements, that is recording the stated opinions of the respondents. Consumer opinion and consumer perception of the delivery of services is now recognized as a legitimate and significant area of social research. 87% of the respondents stated that they are usually-to-always in good health with 12% stating that they had variable-to-poor-to-very-poor health. These findings are very similar to those found in the Wanganui study.

WELL-BEING

In order to get a complete picture of well-being, it is important to measure not only the negative feelings, but also the positive feelings. Mental health is not a static concept and it is important to attempt to capture the interaction of the individual's life situation and his own sense of psychological well-being.

In response to the question "How much do people worry?" 25% said that they worry a lot, with 30% saying that they worry more now than they did a year earlier. Table 1 lists the concerns of the people of the borough and the county.

TABLE ONE: *Areas or "worry" delineated by respondents*
(Respondents could indicate as many categories as appropriate)

<i>Areas of worry/concern</i>	<i>% of sample who worried</i>
World situation	42% *
Concern about children	36%
Things at work	24%
Not enough money	23%
Growing old	17%
Concern about health	15%
Concern about sexual problems	5% **

*This may reflect the access that the population has through radio and television to local and world news.

**One respondent did not think that anyone would truthfully answer the question "Do you worry about sexual problems?" Although 5% may not be an accurate response it does underline (1) that there is concern on some people's part related to their sexual life, and (2) that these kinds of questions are very difficult to ask and obtain valid answers.

It was then asked "What things make you feel good?"

TABLE TWO: *Areas of "feeling positive" delineated by respondents*

<i>Positive feeling</i>	<i>% of sample who had positive feelings</i>
Pleased that they had accomplished something	73%
Felt things were going their way	68%
Felt excited and interested in something	61%
Felt proud because someone complimented them	47% *
Felt on top of the world	42%

*If someone had accomplished something and was pleased about it, and had been complemented about it, it may reflect their involvement in a system greater than themselves.

Table 3 reflects negative feelings. These negative feelings do not necessarily negate the overall sense of well-being. Their importance rests on their possible consequences for the community.

TABLE THREE: *Areas of "feeling negative" delineated by respondents*

<i>Negative feeling</i>	<i>% of sample with negative feelings</i>
Feeling bored and disinterested	19%
Feeling remote or lonely	15%
Feeling depressed	14%
Feeling upset due to someone else's criticism	14%

Tables 4 and 5 list activities least and most enjoyed in the week prior to the interview.

TABLE FOUR: *Three areas least enjoyed by respondents*

<i>Areas not enjoyed</i>	<i>% of sample who enjoyed least</i>
Time spent alone	45% *
Time spent caring for the house	36%
The job	10%

*In a rural area where it would be assumed that people like being 'alone' a large percentage responded that this was not enjoyable.

TABLE FIVE: *Three areas most enjoyed by respondents*

<i>Areas of enjoyment</i>	<i>% of sample who enjoyed most</i>
Being with friends	26%
Being with their spouse	25%
The job	17%

Overall, 91% of the respondents stated that they were pretty-to-very happy with their status of life, and 24% felt that things are actually happier now than they were 4 years ago. 51% of the respondents stated that they wanted things to continue the same, but there were 41% who would like to change some parts of their lives, and 7% wanted to change many parts of their lives.

MENTAL ILLNESS

The project was interested in looking at indices of mental health, but it was also interested in looking at how people in the community defined mental illness. The question was open-ended and numerous categories resulted from the respondents' explanations.

TABLE SIX: Three major groupings of definitions provided for Mental Illness - respondents listed more than one area.

Definitions of Mental Illness	% of sample
<i>DISEASE</i>	
Mental illness is psychiatric disease (i.e. depression, psychosis etc.)	39%
Mental illness is genetically transmitted	23%
<i>SOCIAL ISSUES</i>	
Mental illness is social stress	29%
An inability to cope	33%
<i>HACKNEYED EXPRESSIONS</i>	
Terms used to describe Mental Illness with assumed understanding of meaning (i.e. 'around the bend', 'nuts' etc)	21%
<i>DON'T KNOW</i>	
	6% *

*This question was the only one that received a significant number of respondents replying "I don't know".

When asked who they would turn to first for help with mental illness, a resounding 57% said they would turn to their General Practitioner, 26% said they might turn to relatives, and 8% would turn to friends and the clergy. It is interesting to note that in the Wanganui study when people were asked where they would go to treat a disability which did include physical as well as mental problems 58% said they would go to their General Practitioner or Private Specialist.⁷ This seems to underline again the role of the General Practitioner as the 'gate-keeper' in the professional system for help. The low percentage of people who said they would turn to their clergy for assistance with mental problems may indeed reflect how people define a problem. If the problem is defined as a medical one then the doctor and medical profession would be seen as the most appropriate resources. 75% of the respondents felt that mental illness should be treated locally with only 25% saying it should be treated out of the community. This seems to support the principal of community mental health care. Those who stated that mental illness should be treated locally usually added that if it could not be taken care of 'satisfactorily' then the person should be seen elsewhere.

PROBLEMS

The respondents were asked to identify their perceptions of the most common problems in the Dannevirke community.

TABLE SEVEN: Problems delineated by respondents as highly common in Dannevirke area - respondents listed more than one problem area

Problem in Dannevirke	% of sample who stated highly common problem
Marriage and relationship problem	58%
Alcohol and alcoholism	51%
Youth and delinquency	50%
Unemployment	46%
Shifting	37%
Isolation and loneliness	35%
Misuse of prescribed medicines	24%
Drug abuse (other than alcohol)	23%
Depression	23%
Racial issues	19%

The four most frequently identified problems in Dannevirke were marriage and relationship problems, alcohol and alcoholism, delinquency and unemployment, the next most frequently raised was shifting and isolation and loneliness. Isolation and loneliness can well be related to shifting. Racial issues was a difficult question and many people qualified their responses. For example one Maori respondent said "Yes, it was a problem" but "well, I wouldn't say its a racial problem, but when I worked on a crew the Pakehas would be served tea inside and I was served tea outside", and many people when saying "no, there weren't any racial problems in Dannevirke" said "there's no violence around here".

Child abuse was not identified as a common problem. What degree of discipline constituted abuse was discussed frequently.

The respondents were asked what services existed in Dannevirke borough and county for the above stated problems. The only service that seemed to be well known was Alcoholics Anonymous, and most respondents were unaware of where to go for the various problems. Many said "I guess I'd find out if I had the problem". There were no indications of the process by which they would obtain this information.

ALCOHOL CONSUMPTION

One problem area that was examined in detail was alcohol consumption. 82% said that they now drink, 7% used to, and 11% have never drunk alcohol. A survey conducted by the National Alcohol Society and Drug Dependence stated that there are two groups in particular that have come to the notice of professional agencies - these age groups are the 15-24 group and those in their 40's.⁸ It is interesting to note that the large bulge of population within the borough and the county were in the same age groupings. This may be an issue in planning for services. The one service that seemed to be most readily stated

by respondents was Alcoholics Anonymous. In the Dannevirke study, most respondents said they drank with a spouse or friends, but a significant 2.5% said that they did drink alone. When asked if drinking created a hardship for themselves 9% stated that it did and related the hardship to their friends, their health, and their ability to care for their family. When asked if someone else's drinking was causing a hardship for them, a much larger 23% of the sample responded "yes" and said these hardships seemed to affect friendship, home life, marriage and caring for the family. 16% of the respondents who said that someone else's drinking had created problems for them also stated that drinking was a problem in two or more areas. In other words, drinking affected home life and ability to care financially for their family underlining the complexity in alcohol related problems. When asked who was most helpful with alcohol related problems, spouse and relatives were listed.

RELIGIOUS BELIEFS

52% of the respondents said they had some or no religious beliefs, and 45% said they had a very strong religious belief. 60% said they belonged to a religious group, 37% said they did not belong. The following table reflects how religion was stated to affect their lives.

TABLE EIGHT: *Areas in which religion affects the lives of respondents*

<i>Areas affected by religion</i>	<i>% of sample responding</i>
General health (mental health included)	20%
Choice of friends	17%
Social life	13%
Use of alcohol	11%
Sexual life	12%

ROLE OF WOMEN

In the Dannevirke study 64% of the women interviewed stated they had no major responsibilities outside of their home. They were then asked to list what duties they did in the home and the activities ranged from farm work and household and family care, to book work, and care for the elderly.

76% of the women stated they were not paid for the work they did, even though many of them saw themselves as vital to the maintenance of the farm or household. Many commented that employment opportunities were difficult to find, especially ones that might fit in with their other responsibilities. In the National Study on Rural Women, 60% of the women interviewed in the Southern Hawkes Bay area felt that there was little or no employment opportunities outside of their own home.

More women than men reported discontent in caring for the home, placing numerous other activities as more enjoyable.

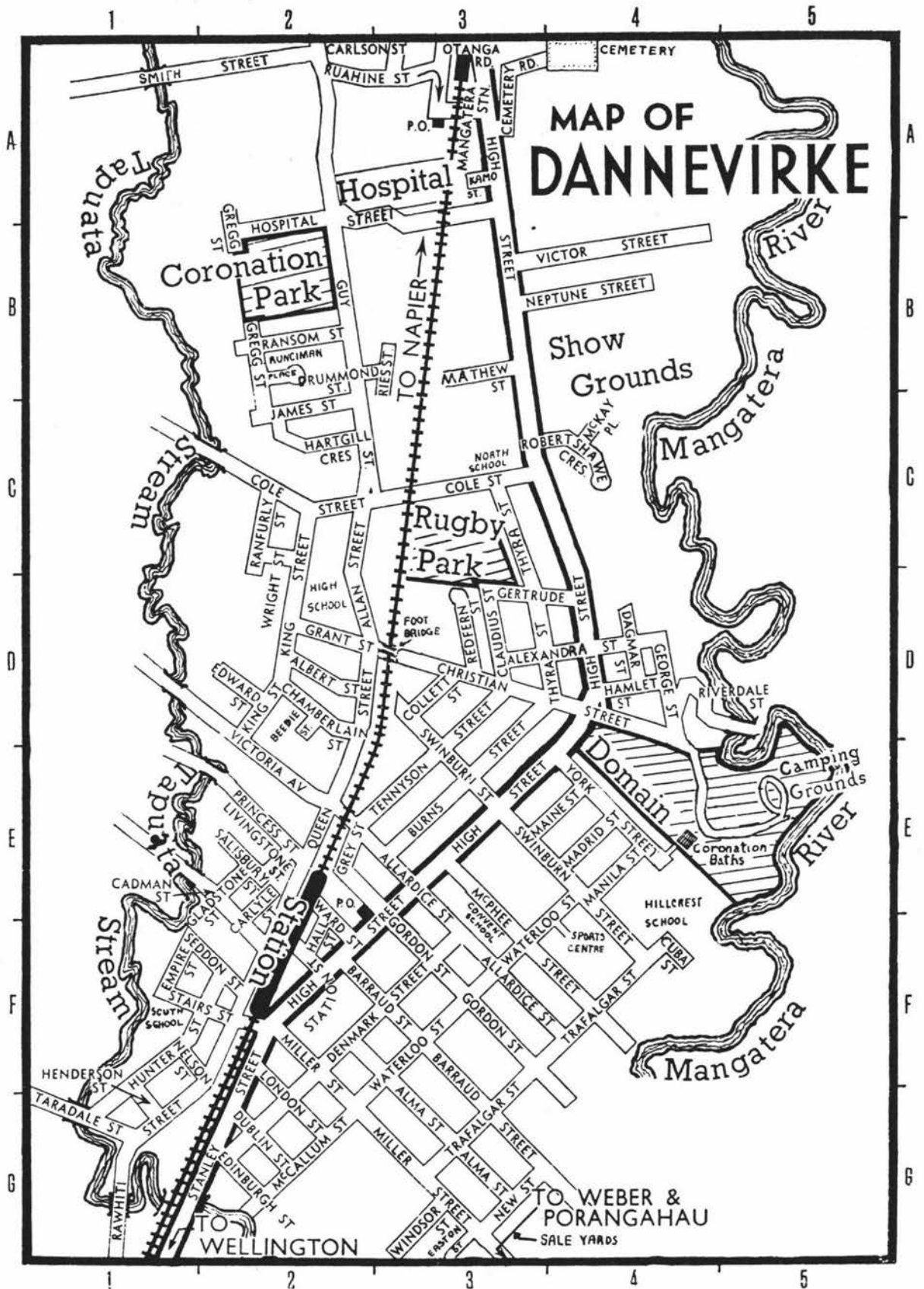
SUMMARY

There is a great deal more demographic material which may be of interest but is not within the purview of this preliminary report. Further statistical analysis and a more in-depth report will be forthcoming. The major focus of this preliminary report is to give feed-back to the community as soon as possible and to examine areas that may be of interest to the community.

In a major sense, the continuing discussion in the borough and county in the material presented represents the most significant part of the study. This will allow real clarification to take place on how Dannevirke Borough and County people take care of each other.

REFERENCES

1. Sparrow, Mary et al., *Banks Peninsula 1977, A Rural Survey*, Studies in Rural Change, No. 2, Christchurch N.Z. 1979.
2. Kaplan, Paul F., *Social Aspects of Productivity: Hill-Country Sheep-Beef Farms in the Mangamahu Valley*, Department of Sociology, Massey University, 1979.
3. Gill, Tiiti et al., *The Rural Women of New Zealand: A National Survey*, University of Canterbury Press, 1975.
4. Asher, Bruce et al., *Health in the Wanganui Region: A Survey of Behaviour and Opinions*, Massey University, 1979.
5. Ibid.
6. "Alpha", *Dannevirke - the Founding of a Bush Settlement* (Dannevirke County Council).
7. Ibid. *Health in the Wanganui Region...*
8. Morton, Joyce M. *Survey of social work agency involvement with problem drinking*, IN: N.S.A.D. Monograph, No. 2, 1973.



APPENDIX I

REFERRALS TO MANAWAROA INPATIENT FACILITY FROM
DANNEVIRKE BOROUGH AND COUNTY 1971-1981

1971

Sex	Classification No.	Diagnosis (primary)	No. in that Diagnosis
F	300.4	Depression neurosis	1
F	300.0	Anxiety neurosis	1
F	301.6	Personality disorder (Asthenic)	1
M	295	Schizophrenia	1
M	N.D.	No diagnosis given	<u>1</u>
Total			5

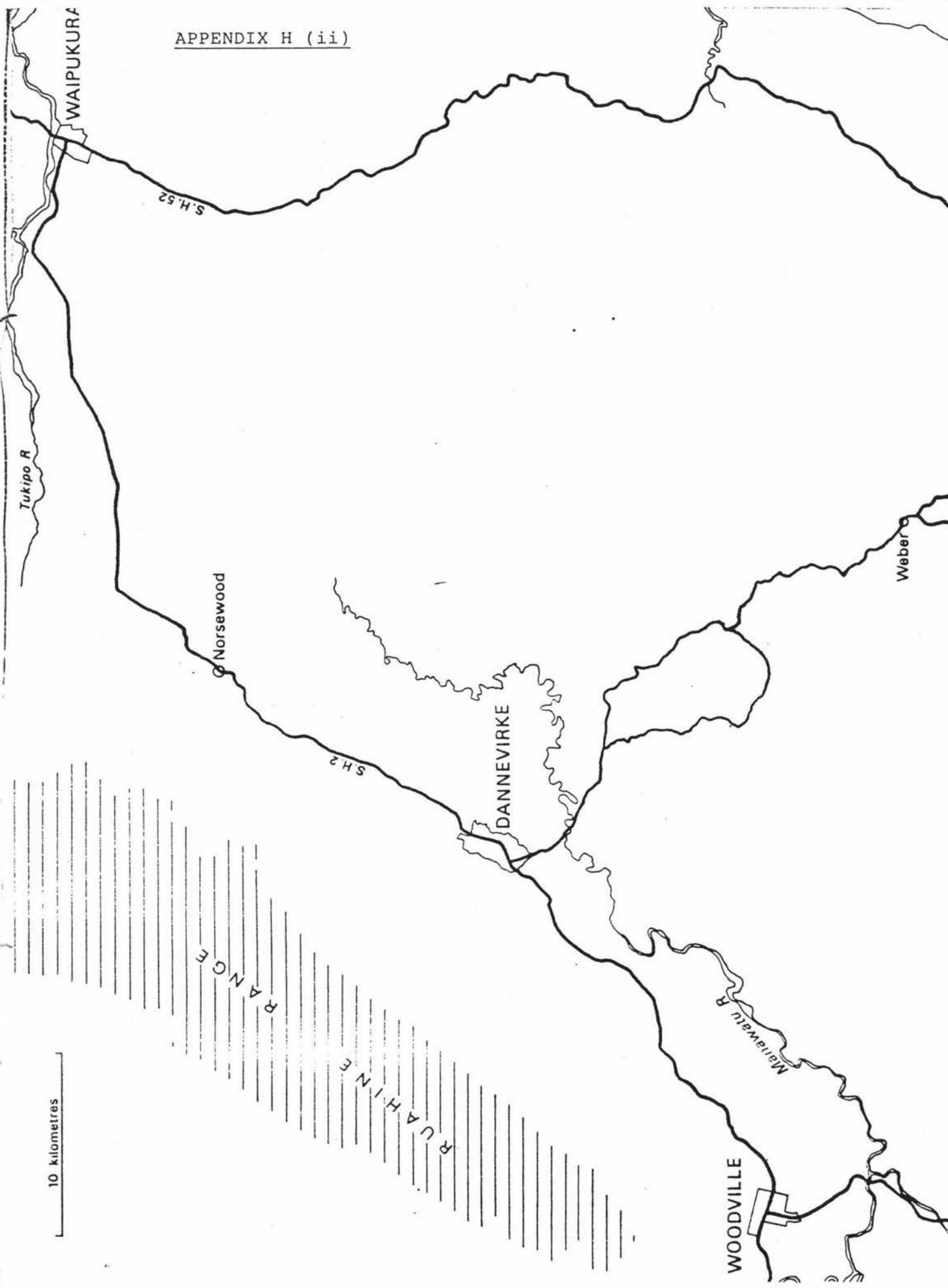
1972

M	310.0	Borderline Retardation	1
M	307	Transient Situational Disturbance	1
M	302.8	Sexual deviation	1
M	301.8	Personality disorder	1
M/F	300.4	Depressive Neurosis	2
F	300.1	Hysterical Neurosis	1
M	298.0	Reactive Depressive Psychosis	1
F	295.7	Schizophrenia (Schizo- affective)	1
M	295	Schizophrenia	<u>1</u>
Total			10

1973

M	310.0	Borderline Retardation (following intoxication)	1
M	301.8	Personality disorder	1
FFF	300.4	Depressive neurosis	3
M	300.0	Anxiety neurosis	1
F	298.0	Reactive Depressive Psychosis	1
M	295.8	Schizophrenia (other)	1
F	295.4	Acute Schizophrenia episode	1
FMMM	N.D.	No diagnosis given	<u>4</u>

APPENDIX H (ii)



10 kilometres

RANGAHINE

RANGAHINE

WOODVILLE

Mairāwatu R.

DANNEVIRKE

Norsewood

Weber

WAIPUKURUA

Tukipo R.

S.H.52

S.H.2

Appendix I (Contd.)

		<u>1974</u>	
<u>Sex</u>	<u>Classification No.</u>	<u>Diagnosis (primary)</u>	<u>No. in that Diagnosis</u>
FFFFFFMM	300.4	Depressive neurosis	8
M	300.3	Obsessive-Compulsive neurosis	1
F	300.0	Anxiety neurosis	1
F	298.0	Reactive Depressive Psychosis	1
M	295.8	Schizophrenic, other	1
MF	295.7	Schizo affective type	2
FF	N.D.	No diagnosis given	<u>2</u>
Total			16

		<u>1975</u>	
F	301.9	Personality disorder (unspecified)	1
F	301.6	Personality disorder (Asthenic)	1
M	301.1	Personality disorder (effective, cyclothymic)	1
FFFFM	300.4	Depressive neurosis	5
M	300.3	Obsessive-Compulsive neurosis	1
F	300.1	Hysterical neurosis (anorexia)	1
FFMM	300.0	Anxiety neurosis	4
M	297.1	Paranoid states (involutional paraphrenia)	1
M	296.2	Manic-depressive psychosis (depressed type)	1
F	295.6	Residual Schizophrenia	1
FM	295.4	Acute schizophrenia episode	2
FMM	N.D.	No diagnosis given	<u>3</u>
Total			22

Appendix I (Contd.)

1976

Sex	Classification No.	Diagnosis (primary)	No. in that Diagnosis
M	310	Borderline retardation	1
FF	307.0	Transient situational disturbance	2
M	301.8	Personality disorder (other)	1
FFFF	300.4	Depressive neurosis	4
FFFFM	300.0	Anxiety neurosis	5
M	297.1	Paranoid states (involutional paraphrenia)	1
MM	296.2	Manic depressive psychosis - depressed	2
FM	295.4	Acute schizophrenic episode	2
F	N.D.	No diagnosis given	<u>1</u>
		Total	19

1977

FFFF	300.4	Depressive neurosis	4
MF	300.0	Anxiety neurosis	2
F	298.0	Reactive depressive psychosis	1
M	296.2	Manic depressive psychosis - depressed	1
M	295.9	Latent schizophrenic	1
M	295.6	Residual schizophrenic	1
M	291.2	Alcoholic psychosis - hallucinosiis	1
M	295.4	Acute schizophrenic episode	1
MMM	N.D.	No diagnosis given	<u>3</u>
		Total	15

Appendix I (Contd.)

				<u>1978</u>
Sex	Classification No.	Diagnosis (primary)	No. in that Diagnosis	
F	301.6	Personality disorder (Asthenic)	1	
M	301	Personality disorder	1	
FFF	300.4	Depressive neurosis	3	
F	300.3	Obsessive-Compulsive neurosis	1	
F	300.0	Anxiety neurosis	1	
M	296.2	Manic depressive psychosis (depressed)	1	
M	295.6	Residual schizophrenic	1	
M	295.3	Schizophrenic, paranoid type	1	
F	295.4	Acute schizophrenic episode	1	
FFFFFFMM	N.D.	No diagnosis given	<u>9</u>	
Total			20	

				<u>1979</u>
F	307	Transient situational disturbance	1	
M	301.2	Personality disorder (schizoid)	1	
FFMM	300.4	Depressive neurosis	4	
M	300.3	Obsessive-Compulsive neurosis	1	
FF	300.2	Phobic neurosis	2	
F	300.0	Anxiety neurosis	1	
F	296.3	Manic depressive psychosis (circular)	1	
FMM	298.0	Reactive depressive psychosis	3	
M	296.2	Manic depressive psychosis (depressed)	1	
M	296.1	Manic depressive psychosis (manic)	1	
M	295.6	Residual schizophrenic	1	
M	295.4	Acute schizophrenic episode	1	
F	294.4	Psychosis to childbirth	1	
FM	N.D.	No diagnosis given	<u>2</u>	
Total			21	

Appendix I (Contd.)

1980

Sex	Classification No.	Diagnosis (primary)	No. in that Diagnosis
M	301.6	Personality disorder (Asthenic)	1
M	300.4	Depressive neurosis	1
M	300.3	Obsessive-Compulsive neurosis	1
FF	300.0	Anxiety neurosis	2
F	298.0	Reactive depressive psychosis	1
F	296.3	Manic depressive psychosis (circular)	1
MM	296.2	Manic depressive psychosis (depressed)	2
F	296.1	Manic depressive psychosis (manic)	1
M	295.4	Acute schizophrenic episode	1
M	295.3	Schizophrenic, paranoid	1
F	295.2	Schizophrenic, catatonic	1
M	295.0	Schizophrenic - simple type	1
F	294.4	Psychosis in childbirth	1
		Subtotal	15
		(using pre 1980 classifications)	

1980 (contd.)

M	317	Mild mental retardation	1
M	301.8	Personality disorder (other)	1
M	301.4	Personality disorder (amankastic)	1
MM	301.3	Personality disorder (explosive)	2
FF	300.2	Phobic state (neurosis)	2
F	300.1	Neurosis (hysteria)	1
FMMM	300.0	Anxiety neurosis	4
M	298.0	Non-organic psychosis (depressive)	1
M	296.3	Manic depressive psychosis (circular)	1
M	296.1	Manic depressive psychosis (depressed)	1
M	295.4	Acute schizophrenic episode	1
FM	295.3	Schizophrenic - paranoid	1
M	N.D.	No diagnosis given	1
		Subtotal	19
		Total	34

Appendix I (Contd.)

1981

Sex	Classification No.	Diagnosis (primary)	No. in that Diagnosis
F	310.0	Non-psychotic, organic brain damage (frontal lobe syndrome)	1
FM	309.1	Adjustment reaction, prolonged depressive	2
FF	309.0	Adjustment reaction - brief depressive	2
F	308.0	Acute reaction to stress/ disturbance of emotion	1
M	302.8	Sexual deviation (other)	1
M	301.8	Personality disorder (other)	1
M	301.7	Personality disorder in sociopathic/asocial	1
M	301.9	Personality disorder (explosive)	1
FFFFM	300.4	Neurotic depressive	5
FF	300.3	Obsessive-Compulsive neurosis	2
F	300.1	Neurotic hysteria	1
FFMM	300.0	Anxiety neurosis	4
F	298.3	Non-organic psychosis - acute paranoid reaction	1
M	296.4	Manic depressive psychosis (circular - mixed)	1
MM	296.2	Manic depressive psychosis (circular - manic)	2
FFFMM	296.1	Manic depressive psychosis (depressed)	5
MM	295.4	Acute schizophrenic episode	2
M	295.3	Schizophrenic - paranoid	1
M	295.0	Schizophrenic - simple	1
MM	N.D.	No diagnosis given	<u>2</u>
Total			37

Sport & Recreation Directory

AMATEUR RADIO CLUB Contact: Dave Turner, Phone 7990

ANGLING CLUB Contact: E. Job, Phone 6312
Aim: Fostering kinship of fellow anglers and clubs. Conservation of trout and river habitat. Preservation of species by rearing fish at local hatchery. Guidance of new anglers, young or not so young.

ART GROUP Contact: M. Wood, Phone 7444
Meetings 1st Saturday every month, 9.30am-3.00pm at High School Art Room.

ATHLETIC CLUB Contact: R. Goggin, Phone 7760
Season begins November through to March. Seniors, 11 years and over, at 7pm on Thursday nights at the Domain. Also participate in League meetings throughout Hawkes Bay and Manawatu. Juniors, up to 11 years, meet Mondays at 6pm at the Domain.

BABY SITTING CLUB Contact: Mrs C. Olsen, Phone 8939
Formed by parents who babysit for each other in one another's homes. Payment by hours to be returned, rather than money. Meetings held now and again in members' homes.

BADMINTON CLUB Contact: J. Lamason, Phone 8229
Meet 7pm Wednesday nights at Sports Centre. Ladies can also play Monday 1.30pm-3pm and Wednesday 9.30-11am. Ladies contact, Mrs R. Clatworthy, Phone 7987.

BALLET SCHOOL Contact: Miss J. Irvine, Phone 6132
A wide range of classes is available at the Studio, 6 Allardice Street. Boys and girls accepted from 5 years of age upwards. Hobby classes for students and adults in Modern Jazz, etc.

BASKETBALL Contact: M. Ngatuere, Phone 8349
Meet Sports Centre Tuesday and Thursday 6-10pm. Friday evening, school children 6-9.30pm. Annual Tournament once a year. Affiliated to NZ Basketball Federation.

BOWLING CLUB Contacts: Women Mrs R. Gowan, Phone 6148
Men, Earle Johnson, Phone 8745

BIRTHRIGHT (DANNEVIRKE) INC. Contact L. or N. Feck, Phone 7914
To supply a service of advice, guidance and financial assistance to children and their mothers or fathers in circumstances where the support and guidance of a mother or father is no longer available.

BOXING CLUB Contact: G. Gilmore, Phone 8851
Meet Tuesday and Thursday at Sports Centre from March to September, Mainly children. Trips to other clubs and competitions entered into.

BUSINESS & PROFESSIONAL WOMEN'S CLUB

Contact:

Contact: Mrs G. Taylor, Phone 8501

Meeting 1st Wednesday of month at Merrylees Hotel for dinner at 6.30pm, meeting to follow. International organisation open to all women gainfully employed. 20 percent of club membership can comprise of women not working. New members welcome. Aims: to encourage women to be active in local, national and international affairs.

BRIDGE CLUB

Contact: Mrs D. Riddell, Phone 7268

Meet Monday and Thursday 7.30pm, Friday 1.30pm, at the Concert Chambers. Learner's class: 12 week course usually starting June.

CANINE OBEDIENCE CLUB

Contact: Mrs M. Thompson, Phone 8673

Meet 7pm Tuesday evenings during school term at Kennel Club Hall, Showgrounds. Train dogs in general obedience according to the rules of the NZ Canine Obedience Assn. A fully qualified instructor is available.

CAR CLUB

Contact: R. Turner, Phone 8891

Meet 2nd Tuesday each month at Hard of Hearing Rooms, McPhee Street. Films are shown and visitors talk on big racing events. Also organise car trials and hillclimbs and car gymkhanas. Visitors welcome.

CHAMBER OF COMMERCE

Contact: J. Nixon, Phone 7533

CHURCH WOMEN'S FELLOWSHIP GROUPS

Contacts: Respective Vicars

CHESS CLUB

Contact: J.S. Phillips, Phone 7862

In recess at present due to lack of members. Anyone interested contact as above.

CINE CLUB

Contact: Mr S. Crouch, Phone 8139

Meet last Wednesday each month at different members' homes. Hire films from National Library. Show own slides and films.

COMMUNITY DAY NURSERY

Contact: Katrina Imrie, Phone 8843

Open from 8-5 every week day. The Day Nursery is run by a parents' committee not only for the working mother, but the mother who needs an hour or afternoon's break, or has to attend that important appointment.

CO-ORDINATING COMMITTEE

Contact Mrs Adrian, Phone 5524

Joint committee of Women's Institute and Women's Division, Federated Farmers. Run projects and Education Days on behalf of the two women's groups.

C.W.I. (S.H.B. Fed. Country Women's Institute) — All Groups

Contact: Mrs L.M. Speedy, Pres., Phone Weber 534

Mrs F.M. Broome, Sec., Phone Weber 3311

C.W.I. is a very active organisation open to all women without distinction. Monthly meetings are the chief programme aiming to contain "something to hear, something to see, something to do." The Institute is a happy, friendly society, working for the good of its members and its community, and anyone is welcome to attend meetings.

CRICKET CLUBS

Contact (All clubs, all grades): G.H. Rees-Jones,
Phone Motea 829

CRICKET SUPPORTERS' CLUB (Central Districts) Contact: J. Dobson,
Phone 7123

CRIPPLED CHILDREN'S SOCIETY Contact: L. Jones, Phone 7178
Associated with Manawatu Crippled Children's Society.

CROQUET CLUB Contact: Mrs C. Stephens Phone 7322

CYCLING CLUB Contact: D. Stephens, Phone 8824
Meets each Saturday from April to October. 42 members, 18 active riders.
Organised rides on roads in S.H.B. 3rd Saturday in May, Annual Open Road
Race.

DANNEVIRKE HIGHLAND PIPE BAND Contact: Mr I. McDonald,
Phone Work 8039, Home 7684

Meet for practice once a week on Wednesday at 7.30 under the Grandstand at
the Showgrounds. Learners the first hour, and more advanced then on.

DARTS CLUB Contact: W. Anderson, Phone Home 8521, Work 7741
Hold a dart competition starting mid-March until finished. Open to any team of
six or more, with entry cost of 50c per player. Played weekly on Thursday
nights at different venues. Excess money donated to charity.

DEERSTALKERS ASSN. Contact: R. Aplin, Phone 7870
Monthly meeting for guest speakers. Talks on conservation, streams, safety,
bushcraft, etc. Education for juniors. Assistance to NZ Fire Service and Search
and Rescue.

DOG TRIAL CLUB Contact: Gordon Kerr, Phone 8457

DRAMA SOCIETY Contact: Mrs Gay Edgecombe, Phone 7705 bus, 7789 res
Mr Maurice Millar, Phone 6208 bus, 7027 res

The Drama Society presents four or five seasons every year in the Little
Theatre, Allardice Street. A junior and intermediate group also meet on a
regular basis.

DRESSAGE CLUB Contact: Mrs Pam Barnett, Phone Motea 737
Meet at Dannevirke or Woodville courses. Are organised through the NZ
National Horse Society with the National Instructor. Meetings are also held at
the convenience of the President, Eric Ropiha, who is the local instructor.

DRUIDS LODGE Contact: Mr K. Mildon, Phone 7654
Friendly Society — open to men and women over 16 years.

EVERY BOY'S & GIRL'S RALLY Contact: Mr R. Ebbett, Phone 7650
(All groups)

Venue Gospel Hall, Burns Street. Aims: To build strong Christian character
and self reliance.

FLYING SCHOOL Contact: Colin Sandrbook, Phone 5435 priv.,
6116 Aerodrome

Operates from public aerodrome just off main Highway 1 mile south of
Dannevirke. Two aircraft are available for flying instruction, joyrides or charter
to any licensed airfield in New Zealand.

FREE KINDERGARTEN Contact: Supervisor, Phone 6130
Morning and afternoon sessions every week day. You are welcome to observe the sessions in progress.

GIRL GUIDE ASSN. Contact: Mrs Menzies, Dist. Commissioner, Phone 8497
Dannevirke District has five units catering for girls aged 7-19 years. Brownies, 7-10 years, Guides 10-14 years, Ranger Guides 14-19 years. All groups follow an eight point programme which covers Service to the Community, Out of Doors, Promise and Law, Developing your Mind, Health and Fitness, Hobbies, Homemaking and International Service. Leaders are always needed so that more girls may join this expanding unit.

GLIDING CLUB Contact: B. Chesterman (Instructor), Phones 25-840, or 28-706. Club Captain —Phone Waipukurau 1203

GOLF CLUB Contact: B.J. Stott, Phone 8624
Men's Competition Day —Saturday, Ladies' Competition Day —Wednesday, Full Year Round Programme. Resident Professional: B. Doyle. Golf Course: Phone 8149, P.O. Box 102.

GUN CLUB Contact: Phone 7741 bus, 8521 res.
Secretary Mrs M.E. Jane, Phone 7352

Meet at 1pm at Laws Rd property on the 2nd Sunday in every month, except September. In April a special day for duck shooters' practice. Visitors and new shooters welcome.

GYMNASTIC CLUB Contact: I. McNae, Phone 7547
Meet at High School Gymnasium on Fridays. 3 sessions: 4-6pm for 6-9 year olds; 6-8pm for 10-12 year olds; 8-10pm for seniors. It is for recreational gymnastics, with the emphasis on competitive gymnastics. There are two groups within the club, the first where children attend for enjoyment and fitness, and the second where girls' and boys' gym squads are formed to be coached to compete on a nationwide level.

HARRIER CLUB Contact: R. Goggin, Phone 7760
Cross country runs each Saturday. Road runs during lambing season. Differing grades: Seniors, 20 and over; Juniors 18-20 years; Colts, 14-18 years; Midgets 8-14 years; Ladies 14 and over; Girls, 14 and under.

HEARING ASSOCIATION Contact, Mrs J. Spencer, Phone 7284
Hearing Association Rooms, 19 McPhee Street.
Executive meets monthly. Lip reading and auditory courses conducted. The organisation is for the welfare and rehabilitation of those with impaired hearing. Membership is solicited from normal hearing people as well.

HIGHLAND PIPE BAND See Dannevirke Highland Pipe Band

HOCKEY ASSOCIATION See Ruahine —Dannevirke Women's Hockey Assn.

HOCKEY —MEN'S Contact: Gerald Thompson, Phone Weber 819
Meet on Tuesday evenings for practise at Coronation park where they have their own facilities. Have two teams, and one High School team.

HORTICULTURE SOCIETY Contact: Mrs F. Massie, Phone 7516
Meetings 2nd Wednesday each month at 7.45pm, at Knox Hall.

HUNT CLUB Contact: Huntsman, Phone 7417
Meets from Eketahuna in the South to Waipukurau in the north, April to July, three times a week during the season. There is no age limit.

INDOOR BOWLS Contact: C.G. Hall, Phone 8543

INTERNATIONAL TOASTMISTRESS CLUB (Dannevirke)

Contact: Fran. Manahi, Phone 8668
Meetings, 2nd and 4th Tuesday of each month at the Mangatera Hotel Lounge. Visitors are cordially welcome. Major emphasis is placed on Communication and Speaking, Leadership training and Parliamentary procedure. Toastmistress helps its members to grow more poised and articulate and develop confidence to deal with all spheres of living.

JAYCEES Contact: Tony Rhodes, Phone 7678
Jaycees meet on the 2nd and 4th Monday of the month at the Mangatera Hotel. Membership is open to everyone in the 18-40 age group and encourages self improvement. Jaycees are proud to publish this booklet.

JUDO CLUB Contact: C. Bond, Phone 5781
Meet at Lower Domain in own building. Divided into two groups, Primary meet Monday 7-8pm, Secondary and Senior, Thursday 7.30-8.30pm.

LIONS CLUB Contact: Mr J. Kernaghan, Phones 7624 or 8730
The Lions Club of Dannevirke meet on the second and fourth Wednesday of the month at tea meetings, held at Merrylees Hotel. The club is one of four service clubs in the town, and has a very keen membership.

LOYAL DANNEVIRKE LODGE Contact: V. Blackford, Phone 7265
Meet Manchester Unity Hall every 2nd Thursday. Approximately 400 members carry out ritual meetings concerned with the welfare of their members.

MODEL RAILWAY CLUB Contact: S.E. Darlington, phone 8039 day,
8919 night
Meet Dannevirke Showgrounds on Monday nights. A common meeting ground to share knowledge and experiences. The club has its own model railway.

MUNICIPAL BAND Contact: Barry Tougher, Phone 8852
Meet on Thursday nights in the Band Room, Allardice Street, Open to both sexes, from 10 years of age upwards. Tuition given and instruments provided. Play in concerts, contests and community projects.

NETBALL ASSN. Contact: J. Tucker, Phone 6296 (after 6pm)
Meetings at Hard of Hearing rooms the last Thursday of month during season. Senior —from Secondary School onwards. Everyone graded into teams from which rep players are picked.

OLD ACQUAINTANCE CLUB Contact: Mrs Howse, Phone 8986
Meet at Rooms, 23 Allardice Street, for over 50s. Mondays — 500 Tournaments; Tuesdays — Indoor Bowls; 2nd and 4th Wednesdays — Euchre Tournament; Thursdays — Friendly Cards and Talks; Last Friday of month — social. Indoor Bowls other Fridays. Bus trips organised at least yearly.

OPERATIC SOCIETY Contact: Mrs D. Anderson, Phone 8941
Meet at the residence of the Secretary or President 3rd Tuesday of month. Have at least one show a year, usually in April. Hire the set and costumes. During the year have groups visit to sister societies.

ORCHESTRAL SOCIETY Contact: Mrs W.J. Wakely, Phone 7218
Meet fortnightly. Players are from all age groups, with wide range of abilities. Have one concert a year, and play for their own entertainment. Must be able to read music to join.

PLAY CENTRE (Makirikiri) Contact: Supervisor, Phone 7891
Open Tuesday, Wednesday and Thursday from 9am-12am for children from two and a half to five years of age. Pre-school experience for both parents and children.

PLUNKET MOTHERS' CLUB Contact: Mrs Colleen Stephens, Phone 7322
Meet 4th Wednesday of month. Meetings involve business, then a speaker or demonstration, finishing with supper. Provides an opportunity for young mothers to meet and exchange ideas.

PLUNKET SOCIETY Contact: Mrs Colleen Stephens, Phone 7322
Meet at the Plunket Rooms, 2nd Tuesday of month, alternating morning and evening. A business organisation to administer the local branch. A Community Health project.

PONY CLUB Contact: Mr K. Reisima, Phone 8264
Meet at the Showgrounds fortnightly, October to May. Instruction given to pony and horse riders under 21 years of age. Organised games and gymkhanas.

RED CROSS Contact: Ruby McMillan, Phone 7234
Mostly welfare work, Meals on Wheels, also Hospital Library and Canteen.

REFEREES ASSN. Contact: D. Massie, Phone 8266
This is a very active club, meeting fortnightly on Tuesday nights. New members are always welcome.

RETURNED SERVICES' ASSOCIATION Contact: J. Dobson, Phone 7123

RIFLE CLUB (Dannevirke — Large Bore) Contact: Mrs H. Streater,
Phone 7867

ROAD SAFETY ASSOCIATION Contact: Mrs V. Fryer, Phone 7938
Monthly meeting 1st Tuesday in month. Discuss all aspects of road safety and danger points.

ROSE SOCIETY (S.H.B.) Contact: L. Hermanson, Phone 5794
Meet 1st Thursday every second month. Speakers and bus trips, and visits to private gardens. Also attend Rose Convention.

ROTORACT

Contact: Miss J. Ellis, Phone 5793

This is a service club, sponsored by Rotary, for the 18-28 year olds. Activities include fund raising for local and overseas projects and community service. Meetings are held fortnightly on Monday at the Masonic Hotel Lounge.

ROTARY INTERNATIONAL

Contact: Mr A. Law, Phone 25-808

ROYAL FOREST & BIRD PROTECTION SOCIETY

Contact: Mrs Jan Drake, Phone 8809

With its 25,000 members, it is the oldest, largest and most influential conservation group in New Zealand. S.H.B. Branch meets in Hearing Association Rooms every 3rd Thursday at 8pm, with an outing to places of interest on the following Sunday. Programmes for year are available.

RUAHINE-DANNEVIRKE WOMEN'S HOCKEY ASSN.

Contact: Mrs Webber, Phone 6174

Eight Senior teams. Primary hockey played Saturday mornings. Most schools contribute teams, plus combined country team.

RUAHINE SCOUT ASSN.Contact: Mr C. Lyttle, District Commissioner,
P.O. Box 83, Dannevirke, Phone 7117**RUGBY LEAGUE**

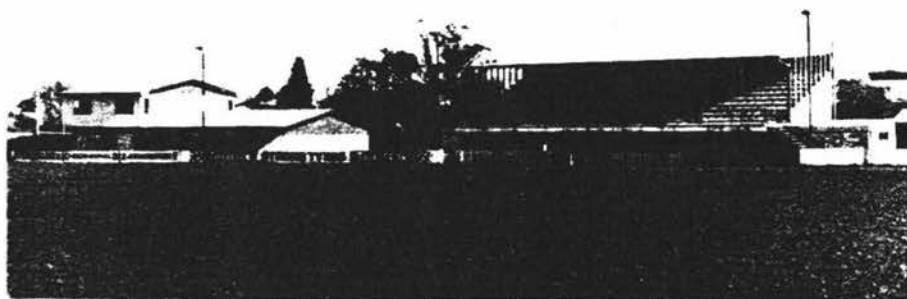
Contact: R. Leishman, Phone 7332

Meet for practice Mondays and Wednesdays at Showgrounds. Competition games in Dannevirke and Palmerston North. New grounds in process at Coronation Park.

RUGBY —SUB-UNION

Contact: J. O'Meara, Phone 7418

There are four senior clubs in Dannevirke who play in competition with teams from the Central and Southern Hawkes Bay areas. Aotea, W. Karaitiana, phone 7607; Excelsior, Mrs G. Murphy, phone 7206; Ruahine, W. Gimblett, phone 7886; Old Boys, J. Kerr, phone Motea 896.



Rugby Park.

SAVE THE CHILDREN FUND Contact: Mrs J. Drake, Phone 8809
The S.H.B. Branch is affiliated to the British Commonwealth, with headquarters in London. Its aims are to arouse interest in the needs of deprived children throughout the world, and raise money to support the S.C.F. Medical and Welfare teams currently working in 26 different countries.

ST JOHN'S AMBULANCE Contact: R. Johnson, Phone
Meet at the Hall in Queen Street. Cadets every Wednesday, 6.30-7.30, starting at 11 years of age. Seniors, 16 years and up, meet every 2nd Wednesday night. Committee, meet 2nd Monday of every month. They are desperately short of manpower, uniform and committee, and would welcome new volunteers.

SCOTTISH COUNTRY DANCING Contact: Mrs G. Cox, Phone 7405
In recess, contact as above.

SCOTTISH SOCIETY (S.H.B.) Contact: I. McDonald, Phone 7684
An Ingleside (Family Gathering) is held every other month on the 4th Saturday, when there is entertainment for the whole family, mostly dancing, with the Highland Pipe Band in attendance.

SCOUT ASSN. See Ruahine Scout Assn.

SCRAMBLE CLUB Contact: Alistair Jackson, Phone 7649

SLOT CAR RACING Contact: Keith Benbow, Phone 3864
The meetings are held at Barraud Street, on Tuesday and Thursday nights from 7-9pm. The track has been in operation for about 10 years.

SOCCER Contact: N. Girvan, Phone 8428

SOLO PARENTS Contact: J. Shuker, Phone 7241
Meet once a month in one another's homes on the last Thursday in the month. New members welcome.

SOUTH SCHOOL SOCIAL CLUB Contact: Mr V. Blackford, Phone 7285
Bowling Club mainly. Meet 7.30 Tuesday nights at South School. 1st Tuesday of month for Tournaments. Other clubs are also invited.

SPCA Contact: Mrs E. Edwards, Phone 7403
There are 40 branches of SPCA in New Zealand. The Dannevirke branch started 20 years ago. The two inspectors for Dannevirke have to cover a wide area, and all calls handled very tactfully. Meetings are held the 1st Monday of month in Council Meeting Rooms.

SPINNING CLUB Contact: Mrs Judd, Phone 8100
Society for Spinning and Weaving meet every Friday, 10am-3pm and have alternate Fridays for spinning and weaving. Open every 2nd Saturday, 10am-2pm. Purchased their own cottage at 30 McPhee Street five years ago.

SWIMMING CLUB Contact: Mrs M. Doyle, Phone 8810
Club nights: Tuesday 7pm, competition night; Thursday 7pm, coaching. Open for practise 6.30-8 every morning. Usually run "Learn to Swim" courses for young children.

TABLE TENNIS CLUB Contact: T. Clarke, Phone 8943
Meet Monday 7.30-11pm at North School Hall. 25 members. Play neighbouring clubs for Ray Fremantle Shield once a year.

TENNIS CLUB Contact: Lorraine Akast, Phone 7710
The Tennis Club, which is at the Sports Centre, has 5 grass and 4 hard courts. Its season is from mid-September to Easter. Club Day is Sunday from 1.30pm, and Ladies' Day Wednesday mornings. As they are affiliated to the Manawatu Association, inter-club is played throughout Manawatu.

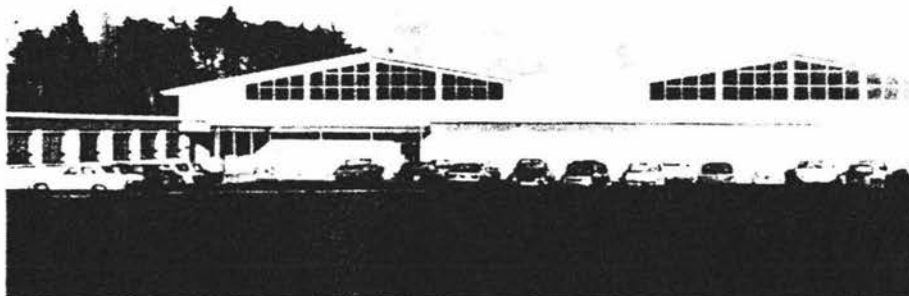
TOWNSWOMEN'S GUILD Contact: Mrs V. Fryer, Phone 7938
All welcome. Meet at Old Acquaintance Hall 2.30pm first Wednesday each month. Affiliated to the "Associated Country Women of World" and assist in local and national projects.

TRAMPING CLUB Contact: Mrs Allan, Phone 7022
Meet every 2nd Thursday of every 2nd month. General business is discussed and reports are read from previous excursions, and future excursions organised. Any age group welcome.

TRINITY COLLEGE OF MUSIC Contact: Mrs N. Menzies, Phone 8497
No meetings involved. Organise music exams, both practical and theory, within the area.

WEIGHT WATCHERS Contact: Lois Ferrick, Phone 7558
Meet Wednesdays at 1pm and 7pm for weigh-in. It is an international association. They have a planned eating programme with no exercising. Open to all age groups from children upwards with a need to lose 10lb and over.

WOMEN'S DIVISION FEDERATED FARMERS Contact: Mrs J. Adrian,
Phone 5524
Eleven branches within the area, each meet monthly. General business is discussed and usually a speaker is present. This organisation is involved with various community projects, in particular their own housekeeping scheme. Branches from Waipukurau to Woodville.



New Zealand Wool Spinners Ltd

BIBLIOGRAPHY

- Abbott, M. Community Mental Health Services in New Zealand:
1983 Report and Reactions. ISBN0-9597664-1-3.
- 'Alpha' Dannevirke: The Founding of a Bush Settlement.
Unpublished paper, no date.
- Amyot, A. and Messier, M.
1973 "The travelling teams: ways of organizing community
psychiatry in a rural and isolated region."
Canadian Psychiatric Association Journal,
Vol.18, No.2, pp.123-131.
- Andersen, A.C. Norsewood: The Centennial Story. Publisher
1972 A.L. Andersen.
- Anderson, D.B. "An operational framework for working with
1976 rural families in crisis", Journal of Marriage
and Family Counseling, Vol.2, No.2, pp.145-154.
- Andrews, F.M. and Withey, S.
1976 Social Indicators of Well-being. Penguin,
New York.
- Angerman, A. A Review of Mental Health Services for Women
1976 in Craig, Colorado. Summer Study Programs
in Rural Mental Health, Wisconsin.
- Arnoux, L. Energy Within Without. 3129 Energy Uses and
28.8.82 Lifestyles. New Zealand Energy Research and
Development Committee Publication.
- Arutumian, C., Kroll, J. and Murphy, S.
1976 Source Book of Programs: 1976. Community
Mental Health Centers, American Institute for
Research, Palo Alto, Ca.
- Asher, B., Fordham, F. and Pitcher, D. Health in the
1979 Wanganui Region, A Survey of Behaviour and
Opinions. Massey University.
- Babbie, E. The Practice of Social Research. Wadsworth
1975 Publishing.
- Bachrach, L.L. "Characteristics of Federally Funded Rural
1974 Mental Health Centers in 1971". (Statistical
Note 101, NIMH), Washington, D.C., U.S. Govt.
Printing Office.
- Bartoletti, M.D. "Family life centers for rural and semi
1975 rural communities," International Journal of
Social Psychiatry, Vol.21, No.1, pp.27-36.
- Beaglehole, E. Mental Health in New Zealand. Price
1958 Milburn, Wellington.

- Beattie, J.A. Labour as a Constraint to Increases in
1978 Agricultural Production, M.A. Thesis, Massey
University.
- Beck, G.D. "Developing a social service department in
1973 a rural general hospital," Hospital and Community
Psychiatry, Vol.24, No.12, pp.842-843.
- Bedford, R. (Ed.), (also Anne Gilles)
1979 Studies in Rural Change. Department of Geography,
University of Canterbury, Christchurch, No.1-4.
- Beisen, M. "A study of personality assets in a rural
1971 community," Archives of General Psychiatry,
Vol.24, No.3, pp.244-254.
- 1974 "Components and correlates of mental well-being,"
Journal of Health and Social Behaviour, Vol.15,
No.4, pp.320-327.
- Benoit, R. and Roy, C.
1974 "Psychiatry in rural Canada - an experience
in Southwest Saskatchewan," Information
Psychiatrique, Vol.50, No.5, pp.537-540.
- Bentz, W.K. and Edgerton, J.W.
1970 "Consensus on attitudes toward mental illness:
between leaders and the general public in
a rural community," Archives of General Psychiatry,
Vol.22, No.5, pp.468-473.
- Bentz, W.K., Edgerton, J.W. and Hollister, W.G.
1971 "Rural leaders' perceptions of mental illness,"
Hospital and Community Psychiatry, May, pp.27-29.
- Benvenuti, B., Galjart, B. and Newby, H.
1975 "The current status of rural sociology", Sociologia
Ruralis, 15, 1-2, 3-21.
- Bischoff, H.G.W. Rural Settings: A New Frontier in Mental
1976 Health. Summer Study Program in Rural Mental
Health Seminar, Madison, Wisconsin.
- Blake-Palmer, G. Honest Prejudice and Unnecessary Deviations;
1962 Their Influence on the Form of Mental Health
Programmes. Nelson, Stiles and Company.
- Bloom, J.D. and Richards, W.W.
1974 "Alaska native regional corporations in community
health," Psychiatric Annals, Vol.4, No.9,
pp.67-75.
- Blum, H.F. "Sociology of mental illness." In Deviance
1970 and Respectability: Social Construction of
Moral Meanings. Basic Books; New York.
- Bowles, R.T. Social Impact Assessment in Small Communities.
1981 Toronto: Butterworth.

- Boyd, K. The Ethics of Resource Allocation in Health Care. Edinburgh University Press: Edinburgh.
1979
- Bradburn, N.M. The Structure of Psychological Well-being. Aldine: Chicago.
1969
- Bradburn, N.M. and Caplovitz, D.
1965 Reports on Happiness: A Pilot Study of Behavior Related to Mental Health. Aldine: Chicago.
- Bradburn, N. and Sudman, S.
1980 Improving Interview Method and Questionnaire Design. Jossey-Bass.
- Broadbent, J. The Japanese Community Power Structure as Template for Social Movement Formation.
1982 Doctoral Thesis, State University, New York.
- Bronfenbrenner, U. The Ecology of Human Development.
1979 Harvard Press, p.29.
- Brown, D. and Wadwell, J.
1981 New Directions in Urban-Rural Migration - Turnaround. Academic Press.
- Brown, G.W. and Harris, T.
1978 Social Origins of Depression: A Study of Psychiatric Disorders in Women. Tavistock Publishers.
- Bunce, M. Rural Settlements in an Urban World. Croom-Helm Ltd., pp.23-83.
1982
- Butterfield, S.H. "Rural development: why it is hard for developing country leadership to get started," International Development Review, Vol.19, No.1, pp.8-12.
1977
- Buxton, E.E. "Delivering social services in rural areas," Public Welfare, No.31, No.1, pp.15-20.
1973
- Callen, K.E. and David, D.
1978 "What medical students should know about psychiatry: the result of a survey of rural GPs," American Journal of Psychiatry, Vol.135, No.2, pp.243-244.
- Campbell, G.H. The Family and Farm Development on the Central Volcanic Plateau. M.A. Thesis in Geography, University of Auckland.
1970
- Cant, R.G. Case Study in Outmigration. Proceedings 5th New Zealand Geography Conference.
1967
- Cant, R.G. "Research in progress: towards a rural ecology for New Zealand," Pacific Viewpoint, Vol.15, pp.68-74.
1974

- Canterbury Regional Planning Authority, The Non-Settlement
1980 Area: Distances Between Settlements and the
Extent and Nature of Controls. Regional Policy
No.5, Control of Urban Form, Technical Report
No.2.
- Caplan, G. Support Systems and Community Mental Health.
1974 Behavioral Publications: New York.
- Caplan, G. and Killilea, M. (Eds.)
1976 Support Systems and Mutual Help. Grune and
Stratton: New York.
- Carlyon, J.T. Aspects of Rural-Urban Relationships. M.A.
1967 Thesis, Dept. of Geography, Victoria University.
- Carruthers, G.E., Erickson, E.C. and Renner, K.N.
1975 Delivery of Rural Community Services: Some
Implications and Problems. New Mexico State
University, Agricultural Experiment Station.
- Carson, S. "The General Practitioner as the Leader of the
1978 Health Team", In The General Practitioner and
His Role in New Zealand Today and Tomorrow.
(Edited by J.G. Richards), Longman Paul.
- Chamberlain, K. Perceptions of Well-being in Palmerston
1982 North. Occasional Papers in Psychology, No.8,
Massey University.
- Chen, P.C.Y. "Classification and concepts of causation
1970 of mental illness in a rural Malay community,"
International Journal of Social Psychiatry,
Vol.16, No.3, pp.205-215.
- Cohen, J. "Effects of distance on the use of outpatient
1972 services in a rural mental health centre,"
Hospital and Community Psychiatry, Vol.23,
No.3, pp.27-28.
- Commission for the Environment. Results of a Questionnaire
1979 Survey of Rural Needs and Services. Commission
for the Environment: Wellington.
- Congalton, A.A. (Ed.) Hawera - A Social Survey: A Report
1954 of a Community Venture. Hawera Star Publishers.
- Coulton, C. "Person-environment fit as the focus in health
1981 care," National Association of Social Work,
U.S.A.
- Coward, R.T. Considering an Alternative for the Rural
1978 Delivery of Human Services: Natural Helping
Networks. Purdue University, Indiana.
- Craig, T. Social Work in Primary Health Care: A New
1980 Zealand Study. Health, Planning and Research
Unit, Series No.6, Christchurch.
- Crawford, C. "Organisation of Health Services for Rural
1976 Areas", Rural Health Services: Organisation,
Delivery and Use. Edited by Hassinger and
Whiting, Iowa Press.

- Crenson, M.A. "Social networks and political processes in urban neighbourhoods," American Journal of Political Science, Vol.22, No.3, pp.578-594.
1978
- Crick, B. In Defence of Politics. Penguin.
1964
- Cullis, J.G. and West, P.A.
1979 The Economics of Health. Martin Robertson.
- Cummings, E. and Cummings, J.
1957 Closed Ranks. Cambridge Harvard Univ. Press.
- Cutler, D.L. and Madore, E.
1980 "Community-family network therapy in a rural setting," Community Mental Health Journal, Vol.16, No.2, pp.144-155.
- Dance, E.X. "A Helical Model of Communication," In Serenl, K.K. and Mortenson, G.D. (Eds.) Foundations of Communications Theory. Harper and Rowe: New York, pp.103-107.
1970
- Davenport, J. and Davenport, J.
1982 "Utilizing the social network in rural communities," Social Casework, February.
- Davis, J.A. Education for Positive Mental Health. Aldine: Chicago.
1965
- Davis, P. Health and Health Care in New Zealand. Longman Paul.
1981
- de Lacey, A. (Ed.) Choices: A Newsletter for Community Health Projects. Management Services and Research Unit, Dept. of Health, Vol.6.
1980
- Department of Health "Report of the Department of Health,"
1977 and Appendix to Journals of the House of Representatives
1978 of New Zealand, Vol.II.
- Dickie, M.I. "Social work in general medical practice."
1975 Unpublished paper, Department of Health.
- Dissmeyer, R. Peri-Urban Land Use: Manukau City. BTP
1981 Research Essay.
- Dow, A. "Wanganui Probation Office: a rural study." Massey
1980 University Social Work Unit, unpublished report.
- Drey, K.V. "The social work generalist in a rural context: an ecological perspective." Journal of Education for Social Work, Vol.16, No.3, Fall.
1980
- Dulaney, P.E. and Words, J.
1975 "Patient neighbour: a dilemma of the community mental health nurse," Journal of Psychiatric Nursing, Vol.13, No.4, pp.18-21.

- Duncan, H.D. Symbols in Society. Oxford University Press:
1968 London, pp.21-23.
- Dworkin, E.P. "Implementation and evaluation of a clergy
1974 in-service training program in personal
counseling," Journal of Community Psychiatry,
Vol.2, No.3, pp.232-237.
- Dyck, G. and Ediger, E.
1977 "Community mental health movement success -
a rural center." In W.E. Barton and C.J. Sanborn
(Eds.) An Assessment of the Community Mental
Health Movement. Lexington Books.
- Dyce, T. "Community in New Zealand." Opportunities for
1979 Change. Community Forum Inc., Vol.1.
- Dyer, M. In Support Systems and Mental Health - an inter-
1976 disciplinary exploration, G. Caplan and
M. Killilea (Eds.). Grune and Stratton:
New York.
- Economics Division of Agriculture and Fisheries
1977 Economic Review of New Zealand Agriculture.
1978 Wellington.
- Editorial "Stopping local rot: current comment," The
1978 New Zealand Farmer, Vol.19, p.6.
- Edwards, A.R. and Wilson, P.R.
1979 Social Deviance in Australia. Cheshire.
- Etwell, E. "Client counseling: the farm management -
1982 personal problem interaction," New Zealand
Agricultural Science, pp.153-154.
- Eyles, J. and Woods, K.J.
1982 The Social Geography of Medicine and Health.
Croom Helm Ltd.
- Fenby, S.L. "Social work in rural setting," Social Work,
1978 Vol.23, pp.162-163.
- Fisher, S. and Greenberg, R.
1977 Scientific credibility of Freud's theories
and therapy, Basic Books.
- Foley, D. Neighbours or Urbanites. Dept. of Sociology,
1952 Rochester: New York.
- Ford, T.R. "Rural Poverty in the U.S." In Rural Poverty
1969 and Regional Progress in an Urban Society.
Washington D.C.: U.S. Chamber of Commerce.
- Foster, F.H. Mental Hospital Admissions and Release Data:
1962 Cohort Study of First Admissions. Department
of Health: Wellington.
- Franklin, S.H. "The village and the bush: the evolution
1969 of the village community." In Forster, J.
(Ed.) Social Processes in New Zealand, pp.112-113.

- Freidson, E. Profession of Medicine. Dodd, Mead and
1975 Company: New York.
- 1973 (Ed.) The Professions and Their Prospects.
Sage Publications.
- Froland, C. "Kinship and social networks, social support
1978 and health," Social Science and Medicine,
Vol.12B, pp.273-280.
- Gans, H.J. "Urbanism and suburbanism as ways of life"
1962 In Rose, A. (Ed.) Human Behaviors and Social
Processes. Boston: Houghton Mifflin,
pp.625-648.
- Gardner, W. "Small rural properties: part three.
1978 Provision of public services and rural residential
living". Town and Country Planning Division.
- Georges, R.A. and Jones, M.O.
1980 People Studying People. University of California
Press: Berkeley.
- Gertz, B., Meides, J. and Pluckham, M.
1975 "A survey of rural community mental health
needs and resources," Hospital and Community
Psychiatry, Vol.26, pp.816-819, December.
- Gill, H. and Gill, T.
1975 "New Zealand rural society: a framework study,"
New Zealand Agricultural Science, Vol.9,
pp.60-68.
- Gill, P.K. People and Places, Choice of Rural and Urban
1976 Residence in New Zealand. M.A. Thesis in
Sociology, University of Canterbury.
- Gill, T., Koopman-Boyden, P.G., Parr, A.R. and Willmott, W.E.
1976 The Rural Women of New Zealand, a National
Survey (1975). Women's Division of the Federated
Farmers of New Zealand, Wellington, New Zealand.
- Gilles, A. Alternative Employment Opportunities in Rural
1979 Areas in New Zealand. Technical Paper 4/79,
Research and Resource Report, Economics Division,
Ministry of Agriculture and Fisheries.
- 1979 A Northern Wairarapa Hill Community in 1979.
Economics Division, Ministry of Agriculture
and Fisheries, Wellington.
- 1979 "Rural social issues," People and Planning,
pp.4-5. 12 December.
- 1979 The Social Situation of New Zealand's Rural
Population: Policies for Rural Social Development.
Technical Paper 4/79, Economics Division,
Ministry of Agriculture and Fisheries.

- 1979 Rural Social Development. Paper presented at ANZAAS Conference. January.
- 1979 "Social research and planning requirements for rural development," Studies in Rural Change No.1. Bedford, R. (Ed.), Christchurch.
- Gilligan, J.F. and Wilderman, R.
1977 "An economical rural mental health consumer satisfaction evaluation," Community Mental Health Journal, Vol.13, No.1, pp.31-36.
- Ginsberg, L.H. Education for Social Work in Rural Settings.
1969 Council for Social Work Education - 17th Annual Program Meeting, Cleveland, Ohio.
- 1979 "Rural-urban migration and social networks." International Journal of Comparative Sociology, Vol.20, Nos.3-4, pp.241-252.
- 1976 (Ed.) Social Work in Rural Communities: A Book of Readings. Council on Social Work Education, New York.
- Glazer, N. "The limits of social policy," Commentary, Vol.52,
1971 p.51.
- Glendinning, D. "A place in the country," People and Planning.
1979
- 1978 Why Did They Leave Eketahuna? Wairarapa Education and Rural Services Committee Report, Masterton.
- Gluckman, L.K. Tangiwai, a Medical History of 19th Century
1976 New Zealand. Whitcoulls: Auckland.
- Goldberg, D.P. The Detection of Psychiatric Illness by
1972 Questionnaire. Oxford University Press: London.
- Goode, W.J. Community Within a Community: The Professions.
1969 From The Concept of Community. Minar, D.W. and Greer, S. (Eds.), Aldine Publishing Co.
- Gore, S. "The effect of social support in moderating the
1978 health consequences of unemployment," Journal of Health and Social Behavior, Vol.19, No.2, pp.157-165.
- Granovetter, M. Getting a Job: A Study of Contacts and
1974 Careers. Harvard University Press.
- Grant, V.L. Some Effects of Geographic Isolation on Education:
1978 Kaikoura High School and Community. Thesis for Education degree at Massey University.
- Graves, G.D. "A survey toward community attitudes towards
1971 mental illness," Australian and New Zealand Journal of Psychology, Vol.35, pp.18-28.

- Gray, R.M. and Reinhardt, A.
1977 Prevalence of Psychiatric Impairment in Rural and Urban Communities. University of Utah, Salt Lake City.
- Gurian, H. "A decade in rural psychiatry," Hospital and Community Psychiatry, Vol.22, No.2, pp.56-58.
1971
- Gurin, G., Veroff, J. and Feld, S.
1960 Americans View Their Mental Health. Basic Books: New York.
- Hall, R. Continuity and Change in a New Zealand Rural Community - Research in Progress. Sociology Department, Canterbury University.
1979
- Hall, L. Meetings - Their Law and Practice. McDonald and Evans: London.
1966
- Hamer, D.A. "Towns in 19th Century New Zealand",
1975 New Zealand Journal of History, Vol.13, April.
- Harris, G.T. A Socio-economic Study of Farm Workers and Farm Managers. Agro-Economic Research Unit, No.115.
1980
- Harris, K.R. The Christchurch Rural-Urban Fringe. A
1975 Detailed Study of the Changing Uses of Land on the Edge of the City and Attempt to Develop a Predictive Model. M.A. Thesis, Geography Department, University of Canterbury.
- Hassinger, E.W. and Whiting, L.R.
1976 Rural Health Services: Organization Delivery and Use. Ames, Iowa: Iowa State University Press.
- Heberlein, T. Density, Crowding and Satisfaction: Sociological Studies for Determining Carrying Capacities. United States Department of agricultural Forest Service.
1977
- Heenan, L.D.B. "Demographic condition of New Zealand rural society". In New Zealand Rural Society in the 1970s. (Ed.) D. Bedford. Studies in Rural Change, No.1, Christchurch, New Zealand.
1979
- Hellu, T. Restructuring the Health Service. American Temple Foundation.
1978
- Henderson, G.D. The Impact of Skifield Development on Methven. M.A. Thesis, Department of Geography, University of Canterbury.
1976
- Henderson, J.H. Return to Open Country: People and Places Out of Town. Reed: Wellington.
1975
- 1974 Open Country Muster; People and Places out of Town: A Fifth Selection. Reed: Wellington.

- 1971 Our Open Country; People and Places Out of Town: Fourth Selection. Reed: Wellington.
- Herjanic, B.M. "A rural versus urban children's mental health clinic population," Journal of the American Academy of Child Psychiatry, Vol.11, No.3, pp.583-584.
1972
- Herman, W.R. "How people support each other in a rural town and county." Unpublished, preliminary report.
1981
- Higgins, J. "The unfulfilled promise of policy research," Social Policy and Administration, Vol.14, No.3, Autumn.
1980
- Hinkle, J. and Ivey, A.
1969 "Rural attitudes toward mental health: a brief report," Mental Hygiene, April, Vol.53, pp.295-297.
- Hinkle, J.E., Cole, C.W. and Oetting, E.
1968 "Research in a community mental health center: a framework for action," Community Mental Health Journal, Vol.4, No.2, pp.129-133.
- Hornblow, A.R. Empathic Abilities of Medical Students. Ph.D. Thesis, Monash University.
1977
- Horwitz, A. "Social networks and pathways to psychiatric treatment," Social Forces, Vol.56, No.1, September, pp.86-105.
1977
- Houba, A.M. Rural Planning in the County of Hokianga. Dip.T.P. Research Essay, Department of Architecture Library, Auckland University.
1979
- Houghton, R.M. An Extension of Community Research: The Waitaki. New Zealand Association of Social Anthropologists, Hamilton.
1981
- 1980 Lower Waitaki Communities Study; Interim Summary Report. Town and Country Planning Division, Ministry of Works and Development, October.
- Human Services Bibliography Series, No.2, August.
1976 "Needs assessment: project share." P.O. Box 2309, Rockville, Maryland, U.S.A.20852.
- Hunter, A. Symbolic Communities. University of Chicago Press.
1974
- Husaini, B. et al "The stress-buffering role of social support and personal competence among the rural married," Journal of Community Psychology, Vol.10, No.4.
1982
- Irey, K.V. "The social work generalist in a rural context: an ecological perspective," Journal of Education for Social Work, Vol.16, No.3, Fall.
1980

- Isherwood, M. "Factors in general practitioner prescribing,"
1980 Health Planning and Research Unit, Christchurch.
- James, B. "A report to the Kawerau Community." University
1979 of Waikato, Hamilton.
- Jeffery, M.H. and Reeve, N.E.
1978 "Community mental health services in rural
areas: some practical issues," Community Mental
Health Journal, Vol.14, No.1, pp.54-62.
- Jermyn, R.L. Treatment of the Mentally Ill in New Zealand
1951 1840-1880. M.A. of Arts Thesis in History,
Victoria University.
- Johnson, H.W. (Ed.) Rural Human Series. Peacock
1980 Publications.
- Johnston, R.J. "But some are more equal - who gets what,
1975 where, and how in New Zealand," Geography,
Vol.60, No.4.
- Jones, J.D., Wagenfeld, M.O. and Robin, S.S.
1976 "A profile of the rural community by mental
health center," Community Mental Health Journal,
Vol.12, No.2, pp.176-181.
- Kadushin, C. Why People Go To Psychologists. Atherton:
1969 New York.
- Kamien, M. "The social role of the community psychiatrist
1975 in rural Australia: from rejection to acceptance,"
Australian and New Zealand Journal of Psychiatry,
Vol.9, No.1, pp.15-20.
- Kaplan, P.F. Social Aspects of Productivity: Hill-country
1979 Sheep-Beef Farms in the Mangamahu Valley.
Survey Report, Department of Sociology, Massey
University.
- Keating, E.C. Health in Porirua: The Porirua Health
1976 Care Survey. Government Printing Office.
- Keller, S. The Urban Neighbourhood. Random House: New York.
1968
- Kelly, M. "How Waimaha saved its community care," New Zealand
1979 Farmer, No.18.
- Kennedy, D. "Dr Kennedy speaks to Dr Srole's findings," Rural
1978 Community Mental Health Newsletter, Vol.5, No.1,
November-January, pp.19-20.
- Keskiiner, A., Zalzman, M.J., Ruppert, E.H. and Welt, G.A.
1972 "The foster community: a partnership in
psychiatric rehabilitation," American Journal of
Psychiatry, Vol.129, No.3, pp.283-288.
- Korte, C. and Milgram, S.
1970 "Acquaintance networks between racial groups,"
Journal of Personality and Social Psychology,
Vol.15, pp.101-108.

- Krupinski, J. et al A Community Health Survey of the Rural Town of Hayfield, Victoria. Mental Health Special Publication, No.1, Melbourne.
1970
- Ladewig, H. and McCann, G.C.
1980 "Community satisfaction: theory and measurement," Rural Sociology, Vol.45, No.1, pp.110-131.
- Land Use Seminar, Department of Geography, University of Canterbury. Rural Depopulation and Resettlement. Department of Geography, University of Canterbury.
1980
- Langner, T.S. "A twenty-two item screening score of psychiatric symptoms indicating impairment," Journal of Health and Human Behavior, Vol.3, No.4, Winter.
1962
- Laosa, L.M., Burstein, A.G. and Martin, H.W.
1975 Mental Health Consultation in a Rural Chicano Community: Crystal City. Educational Testing Service, Princeton.
- Lawrence, P.J. Mental Health and Community. Canterbury Mental Health Council. Caxton Press.
1963
- Lee, N.H. The Search for an Abortionist. University of Chicago Press.
1969
- Leininger, M. "Some anthropological issues related to community mental health programmes in the United States," Community Mental Health Journal, Vol.7, pp.234-241.
1971
- Lewis, O. Life in a Mexican Village. University of Illinois Press, p.435.
1949
- Liazoz, A. "The poverty of the sociology of deviance: nuts, sluts and perverts," Social Problems, Vol.20, pp.103-120.
1972
- Lin, T.Y. et al "Ethnicity and pattern of help seeking," Culture, Medicine and Psychiatry, Vol.2, pp.3-13.
1978
- Lister, R.G. "Rural settlement in New Zealand," Rural Settlements in Monsoon Asia. Proceedings of I.G.U. Symposium at Varanasi and Tokyo, (Ed. R.L. Singh), Varanasi: Geographical Society of India.
1972
- Littlejohn, J. Westrigg. Routledge and Kegan Paul: London.
1963
- Litwak, E. and Szelenyi, I.
1969 "Primary group structures and their functions: kin, neighbours and friends," American Sociological Review, Vol.34, pp.461-481.
- Lloyd, D.W. A Preliminary Review of Rural Social Conditions With Particular Reference to the Manpower Position on Farms. Wellington: Agricultural Production Council.
1974

- Lofland, J. Analyzing Social Settings: A Guide to Qualitative Observation and Analysis.
1971 Wadsworth Press: California.
- Long, N. An Introduction to the Sociology of Rural Development. Tavistock Publications: London.
1977
- Lopata, H.Z. "Contributions of extended families to the support systems of metropolitan area widows: limitations of the modified kin network," Journal of Marriage and the Family, Vol.40, No.2, pp.355-364.
1978
- Lynn Smith, T. and Zopf, P.E. Jr. Principles of Inductive Rural Sociology.
1976 F.A. Davis Co.
- McAllister, J.J. and Lindsay, J.S.B. "Psychiatric illness in general practice: a survey of opinions," New Zealand Medical Journal, No.82, pp.155-158.
1975
- McArthur, J. "Rural return," Straight Furrow, 2 November.
1979
- McClatchy, D.B. Report of a Survey of Farm Labour in Patangata County, Hawkes Bay. Agricultural Economics Research Unit, No.34, Lincoln College.
1966
- Macionis, J.J. "The search for community in modern society: an interpretation," Qualitative Sociology, Vol.1, No.2, pp.130-143.
1978
- McCreary, J. and Rangihau, J. Parents and Children of Rutahura. School of Social Science, Victoria University.
1959
- McDonald, C.W. "The nature of, quality of care and changes required in mental health services in the Horowhenua community: a proposed research project." Unpublished Paper, Department of Psychology, Massey University.
1980
- McKinley, J. "Social networks, lay consultation and help seeking behaviour," Social Forces, Vol.51, pp.275-292.
1973
- McLean, J. The Future for New Zealand Agriculture: Economic Strategies for the 1980's. Planning Council, Government Printer.
1979
- Mahoney, S.C. and Hodges, A. "Community mental health centers in rural areas: variations on a theme," Mental Hygiene, Vol.53, No.3, pp.484-487.
1969
- Marans, R. Basic Human Needs and the Housing Environment.
1975 Ann Arbor Institute for Social Research.

- Marks, R. "Research reporting," Social Work Research.
1975 (Ed.) Polansky, N.A. (Revised edition).
University of Chicago Press, pp.284 ff.
- Martin, J. "God made the country and man made the town,"
1983 In Shirley, I. (Ed.) Development Tracks.
Dunmore Press, p.99.
- Martinez-Brawley, E.E. "Historical perspectives on rural
1980 social work," Journal of Education for Social
Work, Vol.16, No.3, Fall.
- 1980 "Rural sociology and rural social work: an
historical essay," Journal of Sociology and
Social Welfare, Vol.7, No.4, pp.546-560.
- Mathiew, T. "What does Levi-Strauss mean by a model?"
1982 Journal for the Theory of Social Behaviour,
Vol.12, No.2, July, p.173.
- Matus, R. and Neuhring, E.M.
1979 "Social workers in primary prevention: action
and ideology in mental health," Community Mental
Health Journal, Vol.15, No.1, pp.33-40.
- Maughan, G.W. and Ward, A.B.
1978 Farm Production in New Zealand: An Analysis
of Incentives and Disincentives. Department
of Agricultural Economics and Farm Management,
Agricultural Policy Paper, No.2, July.
- Mayer, W. "Treasurers and trials of the complete community
1972 psychiatrist," Exchange, Vol.1, No.2, pp.7-8.
- Mazer, M. People and Predicaments. Harvard University
1976 Press: Cambridge, Mass.
- Mellor, W.A. and Bell, R.A.
1974 "Assessment of needs: an epidemiologic survey,"
Southern Health and Family Life Studies, Vol.1.
- 1974 "Outcare appraisals studies: continuity of
care," Southern Health and Family Life Studies,
Vol.3.
- Mermelstein, J. and Sundet, P.
1973 "Community control and the determination of
professional role in rural mental health,"
Journal of Operational Psychiatry, Vol.5,
No.1, pp.3-12.
- Michaux, M.H., Pruijm, R.J., Foster, S.A. and Chelst, M.R.
1973 "Relatives' perceptions of rural and urban
day center patients," Psychiatry, Vol.36, No.2,
pp.203-212.
- Moar, T. "Farm Workers Association," New Zealand Farmer,
1978 Vol.15, p.33.

- Monia, S. Retirement Subdivisions in Franklin County.
1981 BTP Research Essay, Department of Architecture
Library, Auckland University.
- Morris, J.L. and Cant, R.G.
1966 The Nature and Extent of Farm Labour Shortage
in Cheviot County, Canterbury. Agricultural
Economics Research Unit publication, Lincoln
College.
- Mountfort, D.L. "Rural-residential zones", Paper Dip.
1978 Town Planning, Auckland School of Architecture
Library.
- Murphy, H.B.M. "The meaning of symptom-check-list scores
1978 in mental health surveys: a testing of multiple
hypotheses", Social Science and Medicine,
Vol.12, pp.67-75.
- Myers, J.K., Lindenthal, J.J. and Pepper, M.P.
1975 "Life events, social integration and psychiatric
symptomatology", Journal of Health and Social
Behaviour, Vol.16.
- Naftulin, D.G., Donnelly, F.A. and O'Halloran, P.B.
1974 "Mental health courses as a facilitator for
change in a rural community", Community Mental
Health Journal, Vol.10, No.3, pp.359-365.
- Newby, H. Community. Study Section 20, Open University.
1980
- New Zealand Census of Population
1976 New Zealand Department of Statistics, Vol.1A.
- New Zealand Department of Health
1968 National Health Statistics Census of Mental
Hospital Patients 1966. New Zealand Government
Printer.
- New Zealand Government White Paper
1974 A Health Service for New Zealand. New Zealand
Printing Office.
- Norton, W. and Benson, R.
1980 "More on the Myth of Rural Tranquility", American
Journal of Sociology, Vol.85, No.4, pp.956-958.
- "Norsewood Pioneer Museum", Norsewood Pioneer Museum Society
1965 Inc.
- 'Norwester' "Planning regulations can strangle rural
1979 development", New Zealand Farmer, No.2.
- Oeser, O. and Emery, F.E.
1957 Social Structure and Personality in a Rural
Community. Studies of Social Behaviour,
Department of Psychology, University of Melbourne.

- Olmsted, D.W. and Smith, D.L.
1980 "The socialization of youth into the American mental health belief system", Journal of Health and Social Behavior, Vol.21, June, pp.181-194.
- O'Reilly, C., Fenwick, P. and Kuiper, A. (Eds.)
1979 Immigrant Women. Christchurch Branch of Society for Research on WOMen in New Zealand.
- Ozarin, L.
1983 "Mental health services in rural America", Hospital and Community Psychiatry, Vol.34, No.3.
- Pahl, R.E.
1966 "The rural continuum", Sociologies Ruralis, Vol.6, Nos.3-4, p.28.
- Park, J.
1982 Doing Well: An Ethnography of Coping. A Report to the Social Science Research Fund Committee, Department of Anthropology, Auckland.
- Parr, A.R., Koopman-Boyden, P.G. and Thorns, G.K.
1975 Rakaia: A Study of a Rural Community (mimeographed), Department of Psychology and Sociology, University of Canterbury, Christchurch, New Zealand.
- Pearson, D.
1980 Johnsonville: Continuity and Change in New Zealand Township. Allen and Unwin.
- Perez, L.
1979 "The human ecology of rural areas", Rural Sociology, Vol.44, Fall.
- Perrucci, R.
1974 Circle of Madness. Englewood Cliffs: Prentice Hall.
- Phillips, P.L. and Clancy, K.J.
1970 "Response biases in field studies of mental illness", American Sociological Review, Vol.35, No.3, June, pp.503-515.
- Pincus, A. and Minahan, P.
1973 Social Work Practice - Models and Methods. Peacock Publications.
- Polansky, N. and Williams, D.P.
1978 "Class orientation to child neglect", Social Work, Vol.23, No.5, September.
- Porirua Community Health Service and Department of Health
1976 Health in Porirua. Porirua Health Care Survey, Government Printer.
- "The prevalence of psychiatric disorders in urban vs. rural settings". Proceedings of 5th World Congress of Psychiatry, Mexico City, Mexico, November.
1971
- Pryde, J.G.
1981 A Survey of the Health of New Zealand Farmers October-November 1980. Agro-Economic Research Unit, No.118.

- Rangitikei County Council
1979 "Papers from a rural development seminar",
Huntermville.
- Ranstead, J. "Old MacDonald had a wife", Broadsheet Magazine,
1977 No.53, October, pp.22-28.
- Raphael, D.P. Problems of Political Philosophy. MacMillan:
1972 London.
- Redfield, R. "The Folk Society", American Journal of
Sociology, Vol.52, No.3, pp.253-308.
1947
- Reinken, J. and Blakey, V.
1976 Family Growth Study. Department of Health
Special Report Series No.48.
- Rennie, N. "Timber goes with meat and wood from the
1979 Gisborne hills", The New Zealand Farmer, Vol.22,
p.29.
- Reul, M.R. "Territorial boundaries of rural poverty:
1974 profiles of exploitation", Center for Manpower
and Public Affairs, Michigan State University
Extension Service.
- "A review of hospital and related services in New Zealand",
1969 Government Printing Office.
- Reynolds, R.C., Barks, S.A. and Murphie, A.H.
1976 The Health of a Rural County: Perspectives
and Problems. Gainesville: University of
Florida Press.
- Richards, J.G. "The general practitioner and the community",
1978 New Zealand Medical Journal, pp.358-360.
- Riggs, R.T. and Kugel, L.F.
1976 "Transition from urban to rural mental health
practice", Social Casework, Vol.57, No.9,
pp.562-567.
- Ritchie, I. "Planning for productive land uses", People
and Planning, 12 December, pp.8-9.
1979
- Robinson, D. and Henry, S.
1977 Self Help and Health: Mutual Aid for Modern
Problems. Martin Robertson & Company: London.
- Robb, J.H. and Somerset, A.
1957 Report to Masterton Result of a Social Survey.
Masterton Printing Co. Ltd., May.
- Robinson, J.C. "An analysis of rural depopulation and
1975 its associated causes and effects with particular
reference to a coal mining region. M.Phil.
Thesis. University of Waikato.
- Rockoff, M.L. "Techniques in rural health care", Commitment,
1977 Fall, pp.24-29.

- Rogers, E.M. and Burdge, R.J.
1972 Social Change in Rural Societies. 2nd edition,
Englewood Cliffs, N.J.: Prentice Hall.
- Rojek, D.G., Clements, F. and Summers, G.F.
1974 Community Satisfaction in a Rural Setting:
Dimensionality and Correlates. Working Paper,
Center for Applied Sociology, Wisconsin
University.
- Rootman, I. and La Fave, H.
1969 "Are popular attitudes toward mental illness
changing?" American Journal of Psychiatry,
pp.261-265.
- Ropiha, D. and Playle, F.O.
1978 101 Years of Ormondville. Published by
Ormondville Centennial Committee, May, p.5.
- Rueschmeyer, D. "Doctors and lawyers: a comment on the
1965 theory of professions", The Canadian Review
of Sociology and Anthropology, Vol.I, pp.17-30.
- Runyon, R.P. Winning with Statistics. Addison-Wesley
1977 Publishing Company.
- Sanders, I. Rural Sociology. Prentice-Hall.
1977
- Sanjek, R. "A network method and its uses in urban
1978 ethnography", Human Organization, Vol.37,
No.3, pp.257-268.
- Scherer, J. "Why talk about community", Contemporary
1972 Community, Sociological Illusion or Reality?
Tavistock Publications, pp.1-12, 130-132.
- Schodek, K., Liffiton-Chrostowski, N., Coleman Adams, B.,
1980 Minihan, P.M., Yamaguchi, J.
"The regulation of family involvement in
deinstitutionalization", Social Casework.
- Schoff, H.G. Rural Settings: A New Frontier in Mental
1976 Health. Paper of Summer Study Program in
Rural Mental Health Services, Madison, Wisconsin.
- Schur, E.M. Labelling Deviant Behavior. Harper Row.
1971
- Sennett, R. The Fall of Public Man. Cambridge University
1977 Press, p.339.
- Shupe, A.D. Jr. "Development of mental health services
1974 away from existing community institutions
in rural areas: the case of the Japanese
Kumia", Community Mental Health Journal, Vol.10,
No.3, pp.351-358.
- Simpson, T. The Road to Erewhon: A Social History of
1977 the Formative Years in New Zealand 1890-1976.
Beaux Arts: Auckland.

- Smith, B. "Forestry and rural social change". Background
1980 paper for LUAC Seminar, Rural Depopulation
on Resettlement, University of Canterbury, May.
- Smith, B.L. Trans-Racial Communication. Prentice Hall, Inc.
1973
- Smith, T.L. and Zopf, P.
1970 Principles of Inductive Rural Sociology.
F.A. Davis Co: Philadelphia.
- Snow, L.F. "The religious component in southern folk
1977 medicine", In Traditional Healing: New Science
or New Colonialism. Singer, P. (Ed.), Oweni,
New York, London: Couch Magazine Ltd.
- Social Science Fund Committee Newsletter, Vol.2, No.1,
1981 May, ISSN.0111-3674, p.1
- Somerset, H.C.D. Littledene, Patterns of Change. Wellington:
1974 New Zealand Council for Educational Research.
- Soreff, S. and Hymoff, I.
1976 "The practice of dynamic psychotherapy in
a circumscribed community", American Journal
of Psychotherapy, Vol.30, No.4, pp.658-665.
- Sorokin, P.A. and Zimmerman, C.C.
1929 Principles of Rural and Urban Sociology.
New York: Henry Holt, pp.466-467.
- Sparrow, M., Grigg, R., Marshall, K. and Menzies, G.
1979 Banks Peninsula 1977 - Studies in Rural Change -
No.2. Rural Development and Extension Centre,
Lincoln College.
- Srole, L. "Urbanization and mental health: some
1972 reformulations", American Scientist, Vol.60,
No.5, pp.576-583.
- Stacey, M. "The myth of community studies", British Journal
1969 of Sociology, Vol.20, No.2, pp.134-147.
- Stein, M. The Eclipse of a Community. Harper: New York.
1964
- Stephenson, J. "The East Coast - a forest too far?",
1979 New Zealand Listener, 15 December.
- Stimson, V.G. "Social care and the role of the general
1977 practitioner", Social Science and Medicine,
Vol.II, pp.485-490.
- Strachan, J.E. The School Looks at Life: An Experiment in
1938 Social Education. New Zealand Council for
Educational Research.

- Summers, G.F., Seiler, L.H. and Hough, R.L.
 1971 "Psychiatric symptoms: cross-validation with a rural sample", Rural Sociology, Vol.36, No.3, pp.367-378.
- Swenson, C. "Social networks, mutual aid, and the life model of practice", In Social Work Practice: People and Environments, an Ecological Perspective. Germain, C. (Ed.), New York: Columbia University Press.
- Task Force of Social and Human Sciences Sub-Commission,
 1981 National Commission for Unesco. Challenges to the Social Sciences in the 1980s - Professionalization of the Social Sciences in New Zealand. UNESCO Publication.
- Thio, A. "Class bias in the sociology of deviance",
 1973 American Sociologist, Vol.8, pp.1-12.
- Thoits, P.A. "Life stress, social support and psychological vulnerability: eipdemiological consideration",
 1982 Journal of Community Psychology, Vol.10, No.4.
- 1983 "Multiple identities and psychological well-being: a reformulation and test of the social isolation hypothesis", American Sociological Review, 48.
- Thompson, M.G. "A systems approach to delivery of mental health services in North Halton County, Canada",
 1975 Journal of Child Psychiatry, Vol.14, No.2, pp.292-305.
- Timms, N. and Watson, D.
 1978 Philosophy in Social Work. Routledge and Kegan Paul Ltd.: London.
- Torry, D.T. "Mental health services for American Indians and Eskimos", Community Mental Health Journal, Vol.6, No.6, pp.455-463.
- Town and Country Planning Division, Ministry of Works and
 1980 Development. Background Paper for the LUAC Seminar on Rural Depopulation and Resettlement. University of Canterbury, Ministry of Works and Development.
- United States Department of Health, Education and Welfare.
 1972 Reporting Health Events in the Household. Department of Health, Education and Welfare Health Series, No. (HSM) 72-1028, Series 2.
- Valenzuela, W.G. and Hallamore, A.G.
 1979 "The 'good neighbour network': gatekeepers to a rural mental health support system", Psychosocial Rehabilitation Journal, Vol.3, No.3.

- Vellekoop, C. Migration Plans and Vocational Choices of Youth in a Small New Zealand Town. New Zealand Education Studies, Vol.3, No.1.
1968
- Wagenfeld, M.O. "Cultural barriers to the delivery of mental health services in rural areas: a conceptual overview". Paper presented to Conference on Rural Community Mental Health, NIMH, Rockville, Md., U.S.A., May.
1977
- 1979 "Psychotherapy in rural areas", In Handbook of Rural Community Mental Health. Keller, P.G. and Murray, J.D. (Eds.), Human Sciences Press: New York.
- 1981 (Ed.) New Directions for Mental Health Services. Jossey-Bass Inc.
- Wagenfeld, M.O. and Robin, S.S.
1975 The Social Worker in the Rural Community Mental Health Center. Rural Sociological Society Annual Meeting, San Francisco.
- Wairarapa Community Action Programme.
1978 Proceedings of the Seminar on Rural Communities with Dwindling Populations. Eketahuna County and Community Research and Development Group and CAP.
- Warren, R. The Community in America. Chicago: Rand McNally.
1963
- Webb, S.D. and Collette, J.
1977 "Rural-urban differences in the use of stress - alleviative drugs", American Journal of Sociology, Vol.83, No.3, pp.700-707.
- Westermeyer, J. and Pattison, E.M.
1981 "Social networks and mental illness in a peasant society", Schizophrenia Bulletin, Vol.7, No.1, pp.125-134.
- Wheeler, P.B. "The communal character of scattered rural settlements in New Zealand". Reprinted from New Zealand Agricultural Science, Vol.14, No.3, pp.118-122.
1980
- 1979 Images of Rural Areas. Discussion Paper No.15, Geography Department, University of Otago.
- Whittington, H.G. "Survival strategies for community mental health centers", In Community Mental Health. Bellak-Barton (Ed.), p.27.
1975
- Wilcox, A. Rural Residential Living. BTP Research Essay, Department of Architecture Library, Auckland University.
1979
- Willis, E. A Study of the Contributions of Family Labour on Dairy Farms in South Taranaki, New Zealand. B.A. (Hons.) dissertation in Geography, Victoria University of Wellington.
1973

- Windle, C. and Scully, D.
1976 "Community mental health centers and the decreasing use of state mental hospitals", Community Mental Health Journal, Vol.12, No.3, pp.239-243.
- Wing, J.K. and Hailey, A. (Eds.)
1972 Evaluating a Community Psychological Service. Oxford University Press: London.
- Women's Division Federated Farmers
1975 "The Rural Woman". Paper presented for United Womens' Convention, Wellington. (Edited by J. Talbot).
- World Health Organization
1961 "Programme development in the mental health field:", WHO Technical Report 223, p.34.
- W. Richmond Ltd. and Dawn Meat NZ Ltd.
1979 Pacific Freezing at Dannevirke. Hastings, April.
- Wright, G. "Eketahuna - no mythical hicksville", Straight Furrow, 5 October.
1979
- Yeakel, M. and Ganter, G.
1975 "Some principles and methods of sampling", Social Work Research. Polansky, N.A. (Ed.), University of Chicago Press (revised edition), pp.92-108.
- Young, D. "A small town staying alive", New Zealand Listener,
1980 28 June.
- Young, M. and Willmott, P.
1957 Family and Kinship in East London. Routledge and Kegan Paul: London.
- Zmaniecki, F. The Social Role of the Man of Knowledge.
1968 Harper Torch Books: New York.
- Zusman, J. "Program evaluation and quality control in mental health services", In Progress in Community Mental Health. Bellak, L. and Barten, H. (Eds.), Vol.III, Brunner and Mazel: New York.

LIBRARY CLEARANCE

1. (a) I give my permission for my thesis, entitled
..... FORMAL AND INFORMAL SUPPORT SYSTEMS IN A RURAL TOWN AND COUNTY
.....
.....

to be made available to readers in the Library under the conditions determined by the Librarian.

(b) I agree to my thesis, if asked for by another institution, being sent away on temporary loan under conditions determined by the Librarian.

(c) I also agree that my thesis may be copied for Library use.

2. I do not wish my thesis, entitled
.....
.....
.....

to be made available to readers or to be sent to other institutions without my written consent within the next two years.

Signed *W. P. H. Hearn*

Date *26/1/84*

Strike out the sentence or phrase which does not apply.

The Library
Massey University
Palmerston North, N.Z.

The copyright of this thesis belongs to the author. Readers must sign their name in the space below to show that they recognise this. They are asked to add their permanent address.

Name and Address	Date
.....
.....
.....
.....
.....