

The Department of Health's
Black and Minority Ethnic
**Drug Misuse Needs
Assessment Project**

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Community Engagement

Report 1: The Process



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“Community Engagement is the simultaneous and multifaceted engagement of supported and adequately resourced communities and relevant agencies around an issue, or set of issues, in order to raise awareness, assess and articulate need, and achieve sustained and equitable provision of appropriate services.”

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The Centre for Ethnicity and Health,
Faculty of Health,
University of Central Lancashire

Established in the late 1990s, the Centre for Ethnicity and Health, Faculty of Health, University of Central Lancashire has developed flagship projects and partnerships pursuing high quality, innovative, community-based research and development initiatives, focusing on the health and social care of Black and minority ethnic communities. The Centre currently consists of a multi-disciplinary team with a range of bilingual skills and extensive understanding of the UK’s multi-cultural and multi-faith communities. The Centre’s main activities lie in the fields of drugs and alcohol, mental health, community engagement, racist victimisation, regeneration and health, equality and diversity strategy development, and mental health law. To complement the centre’s research portfolio, teaching and learning activities are in continual development, with the aim of contributing to knowledge, expertise and good practice in the fields of ethnicity and health.

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Note

Some of the data used within this report have been collected from confidential interviews and questionnaires conducted as part of the process evaluation. In these instances the contributions have been attributed to community group project manager, community researcher or DAT Co-ordinator. All other contributions are referenced.

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The Department of Health's **Black and Minority Ethnic Drug Misuse Needs Assessment Project**

Report 1: **The Process**

Section 1

1.1 Introduction

The Department of Health's Black and minority ethnic drug needs assessment project was the largest exercise of its type conducted within England. Consulting over 12,000 people (including approximately 2,000 drug users) within a six-month period, the exercise has gathered the views, perceptions and detailed needs of 30 ethnic and national groups in 47 geographical locations across England on drug prevention, education and treatment. The project, which commenced in November 2000, ended with the compilation of 51 local reports that were disseminated within the communities from which the needs had been assessed. These reports have now been analysed and their summarised findings published in *The Department of Health's Black and minority ethnic Drug Needs Assessment Project - Community Engagement Report 2: The findings*.¹ That report details a rich picture adding to what was an extraordinarily scant evidence base on drug use and Black and minority ethnic communities.

This report outlines the process of conducting the needs assessment project, a process that has become known as community engagement. Radical in its design and ambitious in its scope, the project harnessed the talents of many people, from all walks of life, engaging them with the issue of drug use and also engaging them with those responsible for the design, development and delivery of services. The project aimed to increase community capacity to raise awareness about drug use issues within the participants' own communities, to assess the needs of the communities; and to articulate that need to those responsible for planning services. Crucially, in so doing, the project also engaged service commissioners and providers with the community members that they serve, in some instances introducing them to communities whose existence they were unaware of, increasing their capacity to address diversity, particularly ethnic diversity, within their services.

1.2. What do we mean by engagement?

There can be little doubt that this project was unique in terms of its scale and its subject material. However, the claim that it was radical in terms of its design requires further explanation, for indeed, community consultation, involvement, participation and engagement have been appearing increasingly on the international policy making agenda during the last two decades. In the health and social care field, the World Health Organisation's Ottawa Charter placed community participation at the core of its strategy to achieve Health for All by 2000 and encouraged national governments to strengthen mechanisms for community participation through social policy, legislation and other public means.² In the UK, this theme of

participation or involvement has appeared intermittently in Government policy for the last two decades. The advent of the Citizen's Charter in the early 1990s saw the beginning of a strengthening of the role of public consultation as a tool for service or policy development³ and the current Government's modernising agenda has created a groundswell with the introduction of a number of policy directives aimed at involving the public. For instance, the NHS Plan: A Plan for Investment, A Plan for Reform (2000)⁴, emphasises the need to encourage the participation of the public in healthcare. This strategy of involvement or participation builds on earlier health policies, for example, Our Healthier Nation (1999)⁵ and in cross government strategies such as, the National Neighbourhood Renewal strategy where it is recognised that the most effective interventions are the ones where the community is in the driving seat, with a strong emphasis on Local Strategic Partnerships not only to welcome involvement but to actively seek it out. This drive to involve is most obviously evidenced by the establishment of the Commission for Patient and Public Involvement who recognise that public and patient involvement should be genuine and that those who have in the past been ignored or marginalized should be given a voice:

*"Only by involving local communities can we gain better understanding of how local services need to be changed and developed. By creating local ownership of health services we can improve the quality and responsiveness of those services and reduce health inequalities."*⁶

This national policy and legislation have given rise to a large number of initiatives and strategies to involve, consult, engage and achieve community participation in the decision-making and service development processes. These have been accompanied by a sizeable academic debate on what constitutes participation, involvement and consultation. The debate highlights that these terms are used interchangeably and that consultation, participation and involvement are one and the same thing, although they can differ in degrees of intensity, depth and participation in decision-making.^{7 8 9} The terms are accompanied by tools to achieve participation – models of community empowerment, community capacity building and community development, and diagrammatic depictions examining its nature and depth.

At the risk of adding to the academic debate and in order to distinguish our model from the terms discussed above, the Centre for Ethnicity & Health defines its model of community engagement as:

"The simultaneous and multifaceted engagement of supported and adequately resourced communities and relevant agencies around an issue, or set of issues, in order to raise awareness, assess and articulate need and achieve sustained and equitable provision of appropriate services".¹⁰

Hence, within this model, community engagement is as much about capacity building agencies as it is about capacity building communities. Communities are seen as an integral component

of the policy making process. The process of engagement that seeks to attain community leadership, rather than simply involvement or participation, incorporates a mechanism for sustainability. The definition outlined above has been informed by the process of conducting this project. The project was radical in that it did consult, involve and maximise active participation by communities. The process went further also, by creating the environment where communities with no previous experience in drug use issues, or indeed in research, could *lead* a needs assessment project that would impact on decision making on policy and service delivery issues in the drugs field.

1.3 What do we mean by community?

To add to the complexities inherent in defining the term engagement, the term community in itself raises a number of conceptual problems. Communities are most commonly defined in terms of their shared interests, profession, values or other form of identity. They can also be defined in spatial terms, that is, shared geographical location. In simple terms the community is a body of people with a shared interest and/or geographical location, although a more critical analysis would argue that the factor or factors that unite a body of people to produce a community are counterweighted by a myriad of factors that could serve to separate. People do not necessarily see themselves as part of any community; others see themselves as part of many different communities. Given the fluidity of this concept and the need to strengthen the voice of the community away from the involvement of token service users or perceived leaders of communities, four key determinants of community emerged in relation to this model of community engagement. That the community groups:

- are self-determined as community;
- have access to and the trust of the wider community that they serve;
- are considered and consider themselves disadvantaged or otherwise marginalised in terms of the issue that they will be working with; and
- are willing to engage with the issue and work with statutory services to achieve sustained change.

1.4 Process evaluation

Whilst an increasing number of initiatives involving communities are undertaken in the health and social care field, the evidence base for their success is limited largely to anecdotal evidence. Evaluation appears to be undertaken only sporadically. Where it is undertaken, it is often at the end of the project, an afterthought, conducted by an external body after much of the rich picture that is the process has dissipated.¹¹ However, in contrast to the dearth of literature that examines evaluated projects, there is a plethora of literature that discusses the theory behind evaluation and outlines models, designs and approaches, many of which can only offer hypothetical scenarios of how such approaches could be adopted.¹² Evaluation therefore appears to be a part of the academic debate, seen as necessary in order to build an evidence base for such initiatives – but also acknowledged as complex, challenging and consequently rarely effectively undertaken. Throughout this project, a process evaluation was undertaken, and many of the valuable lessons learned have been incorporated into the community engagement model, lessons

that can be replicated in other areas of research and amongst other disadvantaged communities. The following section outlines the model.

Section 2

THE CENTRE FOR ETHNICITY & HEALTH'S MODEL OF COMMUNITY ENGAGEMENT

2.1 Introduction

Community engagement is built on the principles of equality and social justice. It acknowledges that barriers to public health and social care services exist for many people and that those barriers are often rooted in the failure of agencies to adequately recognise the complex social, cultural, religious, economic and generational experiences of distinct communities. It further recognises that within some communities there is a lack of awareness about a range of health and social care issues and services. Around some of these issues (for instance, substance use and mental health) and within some communities, stigma and denial exist. Community engagement takes as its starting point the premise that the community itself has the greatest ability to access its own members in order to raise awareness and assess need and that agencies have the responsibility to develop services to meet that need. However, the complete body of knowledge required to develop and deliver services appropriate to the needs of all people, to raise awareness on a range of health and social care issues, to educate, and to disseminate information does not lay wholly with the community or with the agencies. Hence, creating an environment where communities and agencies can share that knowledge will fill the gaps. Through the process of community engagement, social capital¹³ is utilised to effect organisational change. Equitable services, a product of organisational change, are in turn, utilised to increase social capital – a virtuous circle is created.

The Centre for Ethnicity & Health's (CEH) model of community engagement has been developed and tested over a series of projects undertaken by the CEH over the last five years. The model has been used mainly in work with Black and minority ethnic communities and largely around the issues surrounding drug use, mental health and regeneration. The model, covers a five stage process and is made up of the following essential components: **key players**, that is, communities and agencies, who engage together around an **issue**, which in its broadest sense is always barriers to services; equipped with tools & resources, that is, **funding, time, expertise & knowledge** and a framework for the engagement activity. The activity is facilitated by an independent **facilitator**, with the expertise to create the environment in which the engagement can take place. Each of these components is essential to the model's ability to effect sustained change and will be discussed in detail later. The stages are set out in the following sections of this report and a summary appears at the end of this section. But before looking at them this section will end by applying this model to the Department of Health's Black and minority ethnic drug misuse needs assessment project, introducing the issue, the key players and describing the available tools and resources.

2.2. The issue

The link between ethnicity and drug service provision, treatment, education and prevention, does not feature widely in mainstream literature or, until very recently, in local or national policy. Drug services themselves are seen as **“run by white people for white people”**¹⁴ and it was only with the introduction of the current Government’s drug strategy in 1998 that services to specifically address the needs of Black and minority ethnic people became an agenda item.¹⁵ The Government’s strategy Tackling Drugs to Build a Better Britain acknowledged the need for specific support services for **‘Black and minority ethnic populations when they are needed’**, and although this acknowledgement falls far short of aiding services to develop in practice, it does represent a significant sea change in thinking.

This sea change in thought has been evidenced by a small number of high profile research projects that look closely at the issue. The Home Office has funded a national scoping study, of drug service provision for Black and minority ethnic communities¹⁶ and more recently the National Treatment Agency has published a review of the literature (much previously unpublished) that surrounds the subject.¹⁷ The Home Office funded study outlines a number of barriers to drug services for people from Black and minority ethnic communities. The National Treatment Agency study concurs and, importantly, evidences a number of barriers to effectively assessing the extent of their need. Alongside this gathering evidence base, the introduction of the Race Relations (Amendment) Act 2000 and the Human Rights Act 1998 have provided the catalyst for those responsible for the design, development and delivery of services to take positive steps to ensure that their services are appropriate for the needs of all members of the community. This legislation challenges all drug services to eradicate discrimination and disadvantage.

The small, but growing, evidence base reveals a currently unfulfilled need. The project that is the subject of this report, the Department of Health’s Substance Misuse Needs Assessment Project for Black and Minority Ethnic Communities, was established to assess that need.

2.3 The key players

2.3.1 The communities

Forty-seven Black and minority ethnic community groups and voluntary organisations took part in this project. They represented 30 ethnic and national groups, covering a diversity of language, religion, culture, gender, sexuality and age. They approached the project with varying levels of knowledge about substance use. At one end of the spectrum, two of the groups were already providing some form of community based drug service provision within their local areas. At the other end, one group had arisen from a neighbourhood campaign to clear litter and had come together to apply for the grant after finding used syringes amongst that litter. In between, the groups fulfilled various roles within their communities associated with education, childcare, mental health, general health, housing and advice and advocacy. The recruitment and selection procedures for the groups are detailed in section 4 of this report.

2.3.2 The agencies

The key agencies involved with this project were commissioners of drug services at national, regional and local level. From locality to locality, a range of other agencies were included in the project including health, housing, police, probation, education, drug service providers and local academic institutions.

2.3.3 The facilitator

Originally chosen to partner the Department of Health in managing the overall project, analysis of the CEH’s role revealed that along with the expected management functions the CEH also acted as facilitator:

- encouraging inter and intra community participation and networking;
- facilitating the engagement between the statutory and community sectors;
- acting as arbiter and resolving conflicts within the engagement process; and
- advising, guiding and supporting agencies to work with the community groups and vice versa.

2.4 Tools & Resources

2.4.1 Funding

Grants were awarded to the community groups taking part in the project, ranging from £5,000 to £25,000 dependent on the work undertaken. The process of distributing the grants will be detailed within section 4 of this report.

2.4.2 Time

The total timeframe for this project was ten months. The community groups had a maximum of six months and in some instances as little as three months in order to complete their work.

2.4.3 Expertise and knowledge

The project brought together the expertise and knowledge of the communities, the agencies and the facilitator. How this knowledge was shared and how it grew will be discussed in the remaining sections of this report.

2.4.4 Framework for engagement

In this project a needs assessment exercise was the selected framework. Clear aims and goals were set to give the community groups a defined target and to minimise the risk of over reaching or failing. In setting such clear aims, however, the project ran the risk of minimising community responses; in effect, of forcing communities to conform to a way of working that could lock out the community based methods of creating solutions that were essential to the project’s success. A discussion of whether or not the project attained the careful balance necessary to achieve the aims of the

project, within the allotted timeframe, without subsuming community responses, appears in the final section of this report.

2.5 The stages

Community engagement essentially acknowledges that in order for marginalised communities to influence service planning in a way that is meaningful, inclusive and brings genuine, sustainable improvement to their quality of life, a number of barriers have to be recognised and dismantled. These barriers may be real, for instance, where the information

on a service is only available in English. The barriers may be perceived by the community, for instance, only white people attend the service, therefore the service is only for white people. The barriers may be perceived by the agencies, a community does not attend the service, therefore the community does not need the service. The barriers may be visible or invisible to both the communities and to the agencies. Community engagement therefore creates an environment where communities and those responsible for the design, development and delivery of services can work together to recognise and dismantle those barriers. This work is undertaken in a five-stage process:

Community Engagement: The Five Stages

	Summary of action	Barriers to equitable services	Outcome – in relation to DH needs assessment project
First Stage	Identification, negotiation, support seeking, foundation laying. Support and funding secured.	Visible barriers recognised.	Government recognition that drug services have largely developed without consideration of the needs of Black and minority ethnic communities. Adoption of a community led approach to discover community needs. Tenders invited.
Second Stage	Introduction of key players, trust building, joint learning, sharing of knowledge, growth and constant change. Recruitment, selection and training of community groups. Establishment of steering/advisory groups.	Visible barriers begin to be dismantled, invisible and perceived barriers begin to be recognised.	Awareness about drugs and drug service issues raised within Black and minority ethnic community groups. Knowledge of ethnic diversity increased amongst statutory agencies. Capacity of both statutory and community sector increased to enable them to tackle the issue together.
Third Stage	Intense and far-reaching engagement within the community, raising awareness, assessing need. Undertaking framework activity.	Visible barriers further dismantled, invisible barriers begin to be dismantled, perceived barriers gain further recognition.	Awareness raised within wider community. Stigma and denial about drug use begins to be addressed. Community needs expressed. Communication between community and statutory sector ongoing.
Fourth Stage	Needs articulated, action taken – organisational, community and service delivery change effected. Dissemination Implementation.	All key players in the position to work together to dismantle remaining barriers.	Community needs articulated to statutory sector. Generation of community ownership and endorsement of local drug strategies. Community and statutory sector able to work together to implement findings.
Fifth Stage	Sustainability – begin process again, if necessary on secondary issues. Follow-up.	Community and agencies able to prevent further barriers being erected and able to recognise visible barriers on related issues.	Ongoing co-operation and communication between community and statutory sector.

The following sections will move through the stages of this project, highlighting the role of the key players, the value or otherwise placed on the tools and resources and the barriers that were recognised and dismantled throughout the process of the project. The final section will discuss the lessons learned.

Section 3

First Stage

	Summary of action	Outcome
First Stage	<p>Identification, negotiation, support seeking, foundation laying</p> <p>Support and funding secured at national level.</p>	<p>Government recognition that drug services have largely developed without consideration of the needs of Black and minority ethnic communities.</p> <p>Adoption of a community led approach to discover community needs</p> <p>Tenders invited</p>

3.1. Introduction

This model of community engagement is essentially about producing equitable services. The first stage is a stage of identification of inequality and seeking support to effect change. This section will detail how recognition by the Government that there were barriers to drug service provision for Black and minority ethnic people led to the adoption of a community led approach.

3.2 Joined up Government

The establishment of the 1998 National Drugs Strategy *Tackling Drugs to Build a Better Britain*, provided the policy starting point for the issue in question. The cross-governmental strategy signalled the high priority Government placed on meeting key aims around drug use. It was accompanied by the publication of the Government's Comprehensive Spending Review in that year, which allocated £188 million over a three-year period to fund additional pro-active work under the drug strategy. This was followed up in Spending Review 2000, which announced increased spending on drug use of over £700 million over the next three-year period.

Within Government there was recognition that the further spending would improve and increase services for those already engaged with them, but those, including Black and minority ethnic communities, that were not accessing services might, if they needed those services, be subject to greater inequality in access than at present. The Government's wider modernising agenda was addressing this area of potential double disadvantage. Black and minority ethnic communities were seen as experiencing a number of inequalities, and action to tackle further social exclusion was recommended in a number of policy areas. This action included designing measures to maximise the involvement of Black and minority ethnic communities. The Social Exclusion Unit and the Policy Action Team on the National Strategy for Neighbourhood Renewal, for instance, published a series of recommendations including:

- Ensuring mainstream services are more relevant to the circumstances of people from minority ethnic communities by, for example, ethnically monitoring outcomes and involving people from Black and minority ethnic communities more in design and delivery
- Implementing programmes specifically targeted at Black and minority ethnic needs.

In addition to this, the Home Office Race Equality Unit had introduced the Connecting Communities Scheme whose main aim was to strengthen the capacity of the Black and minority ethnic voluntary sector to enable it to work effectively with mainstream statutory agencies.

Cross government working and attention to the debate amongst a small but growing number of academics and practitioners, coupled with evidence of the establishment of ethnically specific drug services arising to meet the unmet need of Black and minority ethnic drug users in areas where the population was greater, was the catalyst for the establishment of this project. Cross-governmental working also provided the driver for the community led methods. There was, however, recognition within Government that although Government had the strategic overview necessary to establish the project, it did not have the operational ability to see it through. Therefore a partner would be necessary to work with the Department of Health Substance Misuse Team to undertake this work.

3.3 The tender

In September 2000, the Secretary of State for Health called for tenders for a national project that would assess need around drug treatment, education and prevention within Black and minority ethnic communities. Two issues are worthy of note from the scope of work that was included in the tender document. The first is the simple statement that

*“ drug treatment, education and prevention services have largely developed without recognition of the needs of Black and minority ethnic communities”.*¹⁸

The second issue proposed a solution to the barriers implied in the above statement – that the project designed to assess these overlooked needs should be community **led**. The aims and objectives of the work were set out in the Department of Health tender document as follows:

- to ensure that Black and minority ethnic groups gain a better understanding of drug misuse issues for their communities;
- to establish information networks across participating projects creating linkages both between different ethnic groups and across geographies for the same ethnic groups, in order to encourage information to be shared and gaps in services to be identified;
- to provide capacity building for local Black and minority ethnic community groups to ensure not only the completion of the work, but also an enhanced ability to articulate identified needs to service planners and providers;
- to ensure local health and social care planners and providers are involved in the process in order to enable the development of services that are sensitive to and meet identified needs.

3.4 The proposal

The CEH's proposal was informed by its considerable experience in researching substance use issues within Black and minority ethnic communities. The proposal recognised the diversity encompassed within the term "Black and minority ethnic" and sought to ensure a balance of communities reflecting the population distribution and taking into account distinctive patterns of settlement without neglecting smaller communities, those newly arrived, or communities that had settled in rural areas. It also sought to ensure a balance around prevention, education and treatment projects. Capacity building community groups by way of pre-applicant support, training and on-going support featured widely within the CEH's proposal, as did the acknowledgement that

*"some agencies are viewed with suspicion by potential Black and minority ethnic users."*¹⁹

To overcome this barrier it was proposed that the CEH would work

"in concert with local planners and commissioners so that the work is not set up to face organisational barriers at the outset".²⁰

Of particular relevance was the proposal's plan to ensure ownership of the project by the communities, which noted that

"In essence the projects will be led by, produced by and presented by the community groups themselves with the particular role of the [CEH] being in supporting the processes and enhancing the capacity to ensure successful delivery."

The proposal also recognised that

"The inclusion of DATs and other key health and social care planners from the outset will not only assist in achieving sustainable change within planning and service delivery but will have the added benefit of capacity building for these personnel and agencies in local management and building relationships with Black and minority ethnic groups in relation to drugs."

Essentially, then, the proposal sought to facilitate the engagement of local communities and local service planners to work together for sustainable change.

The CEH proposal was submitted on 25 September, 2000 with proposals being made to undertake work with either 20 or 30 community groups, dependent on the size of the grants made available to fund the overall project. In November 2000 the CEH received approval for its tender and was awarded £500,000 (half the maximum amount available) giving them the go-ahead to recruit 20 community groups.

3.5 Discussion

The first stage of the community engagement model is essentially about support seeking and foundation laying. In addition to the cross-governmental support attained by the Department of Health for the project (the Social Exclusion Unit and the Home Office's Race Equality Unit), the project also had the support of other Government departments with a remit around substance use (the former United Kingdom Anti Drugs Co-ordination Unit, the Drugs Prevention Advisory Service and the Department for Education and Employment). Added to that was the support of non-governmental

organisations, such as DrugScope and the Commission for Racial Equality. Additionally, the CEH had brought on board, in an advisory capacity, the regional drugs agency Lifeline. All of these Government departments and non-governmental organisations brought with them expertise and knowledge to add to that of the Department of Health's substance misuse team and that of the CEH.

This section has seen the engagement of key players at national level and the establishment of the facilitator. The next section will look at recruiting the local key players – the community groups and the agencies.

Section 4

Second Stage

	Summary of action	Outcome
Second Stage	Introduction of key players, trust building, joint learning, sharing of knowledge, growth and constant change. Recruitment, selection and training of community groups. Establishment of steering/ advisory groups.	Awareness about drugs and drug service issues raised within Black and minority ethnic community groups. Knowledge of ethnic diversity increased amongst statutory agencies. Capacity of both statutory and community sector increased to enable them to tackle the issue together.

4.1 Introduction

As discussed in the last section, the establishment of the Black and minority ethnic drugs use needs assessment began, at national level, to dismantle the visible barriers to attaining equitable drug services. Crucial to success at this second stage is engaging the key players (the communities and the local agencies) with the issue and also with each other. Previous work undertaken by the CEH endorses this strategy, noting that for such community based initiatives to be successful, the statutory sector must be fully involved at an early stage.²¹ This section will look at the recruitment and selection of the community groups and the agencies' introduction to the project and to the communities. It will end with a discussion of the development of the CEH's role from manager to facilitator and discuss some of invisible and perceived barriers that gained recognition during this stage.

4.2 Preparing the ground – the management function

From the commencement of the project, the CEH, as joint managers with operational responsibility, had a great deal of preparatory work to undertake in order to speedily and effectively get the project off the ground. Whilst the proposal submitted to the Department of Health had outlined how the CEH would undertake this work, the administrative and managerial implications of actually doing it proved to be a mammoth task. Central to undertaking this work was the assumption that the community groups would need a great deal of support. An operational team was established and a senior staff member from the regional drugs agency Lifeline was seconded to act as a dedicated operational manager. Dedicated administrative staff were also recruited and a

number of members of the CEH's existing team were allocated roles to deal with the recruitment and selection process. In addition, CEH staff were identified and their workloads re-prioritised to allow them to act as support workers to individual community groups once the project was underway.

A campaign to advertise the project was established. The project team set about designing a user-friendly application pack that could be distributed to community groups applying for grants. A help desk was set up in readiness for the enquiries expected once the advertising campaign was underway.

4.3 Engaging the agencies

On 13th November 2000 the Department of Health wrote to all NHS Regional Office Drugs Leads, Drug Action Team (DAT) Co-ordinators and Drug Prevention Advisory Service Regional Managers advising them of the initiative, seeking their support in helping to stimulate applications, and encouraging them to extend that support to successful applicants throughout the period of the project. The agencies were given the help desk details in order that they could raise any queries or concerns about the project or gain further information. Additionally, information was posted on the Department of Health's website and flyers distributed at a London conference 'Enabling Communities'.

4.4 Recruiting the community groups

4.4.1 Advertising

Advertisements outlining the initiative were placed in a national mainstream newspaper on 15th and 22nd November 2000 and in the Black and minority ethnic press. In addition, flyers were mailed to Black and minority ethnic community groups in 14 towns and cities in England. The project was reported in several local newspapers and on local radio, including coverage on three Black and minority ethnic radio stations.

It was envisaged that there would be as few as 100 applications given the time constraints for returning applications and the perceived disinterest that Black and minority ethnic communities have around the issue of drug use. In the event, the interest shown by community groups was overwhelming and over 500 application packs were sent out. The telephone helpline received over 400 calls in a two-week period. Common queries included "what is a DAT?"; "how can DATs be contacted?"; advice on project outlines; the nature of the relationship between community groups and DATs; advice on budget preparation; and advice on issues surrounding the recruitment and employment of people to work on the project.

4.4.2 Shortlisting

A matrix detailing all completed application forms was compiled. A shortlisting panel screened proposals against a score sheet using the following criteria: organisation and management arrangements; representation of the local Black and minority ethnic community; links with, and understanding of, the local community; the support of the local DAT and / or other statutory planning body; ideas the group had about what they would do and how they would do it; and cost,

value for money, and the likelihood of the project being completed. In addition, applications were matched across geographical boundaries and ethnic groups. The shortlisting panel members were very impressed with the large number of high quality bids and on the strength of this the Department of Health decided to increase the resources, to the maximum amount available under the original tender, to cover funding a larger number of community groups.

Fifty-seven community groups were finally selected for interview following a thorough short-listing process and were broadly representative of Black and minority ethnic populations in England, and their geographical spread according to National Health Service Regions. The intensive selection procedure ensured that the project could potentially proceed with as many as possible of the groups that were invited for interview, albeit with a firm steer to some - for example, those proposals that were over-reliant on external expertise at the expense of community ownership and involvement, those that were over- or under-ambitious, and those with an unrealistic budget.

4.4.3 Interviewing

Interviews were held at regional Home Office Drug Prevention Advisory Service (DPAS) offices where possible. This provided an opportunity for the Black and minority ethnic community groups to learn about the existence and the role of DPAS and vice versa. In total, representatives from 57 groups were interviewed and 48 projects were selected for funding, although one subsequently withdrew. The final 47 Black and minority ethnic groups participating in the project represented 30 different ethnic and national groups, and included one examining the specific drug-related needs of Black and minority ethnic Deaf people and another exploring issues around drugs with respect to the Black and minority ethnic gay, lesbian and bisexual community. Reasons for rejecting proposals at this stage mirrored those described at the shortlisting stage.

Not all of the 47 projects were approved immediately. The interview process was used to capacity build many of the Black and minority ethnic groups who attended. For example, a number of groups attended the interview proposing to give the majority of their grant to external consultants to conduct the research. They were asked to resubmit their proposal, and subsequently identified people from the local community to carry out the task, with external consultants undertaking a background supportive role. The majority of the groups were asked to redistribute the budgeted funding to some extent in favour of employing people from the community to undertake the research, rather than relying on the existing management of the group itself.

4.5 Engaging with the issue: training

Using the principles of rapid participatory assessments²², a research framework was created to encourage and build on the capacity of each community group involved in this project. A two-day training schedule was devised.¹ The first day was based around the UK National Drugs Strategy and basic drugs awareness, and the second day covered research methods. Those attending were provided with a research manual, which provided clear information on the aims of the project, research methods, and the required outputs. Guidance was also given on the community groups' responsibilities as

¹See Community Engagement Report 2: The findings for a fuller description of the training component.

employers and volunteer managers, and on dealing with media interest in their work on the project. As well as training together, representatives from the groups stayed in the same hotel, ensuring that there was ample opportunity for further networking and relationship-building across and between projects. In this way, the groups developed their own peer support and information-sharing networks.

By the end of the training programme, a total of 204 people from the 47 Black and minority ethnic community groups had received formal training. An evaluation of the training sessions was conducted, indicating that the groups saw them as either 'very successful' or 'successful'. Many of those trained returned to the community groups to cascade their training to colleagues. In all 350 people were eventually trained to undertake this work.

4.6 Getting engaged – defining the roles

Although time-consuming, the detailed procedures around advertising, recruitment, selection and training of community groups were considered vital to ensure fidelity of approach and also to ensure that the needs assessments were conducted by capable teams that were representative of Black and minority ethnic groups in England. The procedures also highlighted the manner in which the CEH was beginning to take on the role of facilitator, rather than solely manager of this project. In its efforts to ensure that the community groups led the project, the CEH took on the less authoritarian role of facilitator and concentrated its energies on creating an environment where the community groups and the agencies could work together. This function was not readily or easily understood by all the key players, and this was in part due to the non-realisation of their own roles at this early stage. Despite the user-friendly application packs that had clearly explained the role that the community groups would undertake, as noted earlier, many still arrived at the interviews accompanied by professional researchers or consultants who they intended to undertake the research on their behalf. Buffin notes in his interim report of the project that:

"During the interviews, it was fascinating to observe the reactions of many of the community group representatives as it became clear to them that we actually wanted them to do the work. This approach was clearly unexpected by most groups. There was a dramatic and positive difference in their attitude towards the project when they realised that this was not just another attempt to peer into their communities from outside, but to help them to develop from within. From that point onwards, the groups began to engage enthusiastically in discussion about their own needs for development, instead of simply relating what they thought was expected by the interview team. Whilst many were understandably a little apprehensive about their ability to deliver what was required, most were also excited and inspired at the prospect".²³

In many instances, the statutory agencies also had difficulty in understanding this new dynamic, although they had been given the same information as the community groups. Whilst the majority were supportive, rather than seeing themselves as working with the community groups within this project, the statutory agencies had a range of perceptions about their own role and that of the CEH. Many of these perceptions appeared to be based on the traditional roles and power balances that would normally exist in this relationship. Some saw the community groups as working for the CEH as proxy researchers rather than undertaking research of their own, and others saw the community groups as undertaking research for the agencies, meeting the agencies' priorities and needs,

rather than highlighting the needs of the communities themselves.

4.7 Discussion

The application process clearly generated a large amount of interest. Whether or not applications were successful, this enabled a link to be made between Black and minority ethnic communities and planning organisations such as DATs, with which they had had no prior contact. All those who applied therefore learned about the role and purpose of DATs. DAT Co-ordinators became more aware of the community groups in the areas that they serve and of their perceptions of drug service provision.

The level of response to the advertisement for grants evidenced the interest and relevance of this issue for a wide range of communities, which went against the perceived wisdom at the time. The strength of the applications evidenced that community groups could, with support, undertake this work: their original over-reliance on external consultants supports the notion that there is a lack of confidence within Black and minority ethnic communities and that this is a barrier to participating in planning services.

The application process generated interest and support amongst a number of DAT Co-ordinators who were eager to be involved in the project: some DATs arranged briefing events in order to help stimulate interest amongst Black and minority ethnic groups within their area.

The strategy of ensuring early engagement of community groups and agencies sought to maximise the extent of service change. Whilst the insistence on community groups recruiting people from the wider community sought to maximise the extent of community capacity building by raising awareness and generating a sense of community ownership of the work.

In this second stage, the emphasis was very much on dismantling real and perceived barriers within the community: lack of knowledge about services, lack of awareness about the issue of drugs and lack of capacity to tackle this discrepancy. To a lesser extent, some of the barriers rooted in agencies were also acknowledged: the lack of knowledge about the ethnically diverse communities in their area; the perception that Black and minority ethnic communities had little interest in the issue; and where agencies had offered practical support around the development of proposals for the grants, the realisation of just some of the issues that affect distinct communities and the possible impact these could have on substance use.

Section 5

Third Stage

	Summary of action	Outcome
Third Stage	Intense and far-reaching engagement within the community, raising awareness, assessing need.	Awareness raised within wider community.
	Undertaking framework activity	Stigma and denial about drug use begins to be addressed
		Community needs expressed
		Communication between community and statutory sector ongoing

5.1 Introduction

In all, 12,000 people were consulted during this project, approximately 2,000 of whom were drug users. This large sample is all the more impressive when considered in the light of the lack of drug awareness information that is designed with and for Black and minority ethnic communities, and the perceptions that this information would not be acceptable or is not needed. The barriers of institutional racism and perceptions of racism, divisions within communities and the tension that sometimes exist between community groups and statutory agencies - were all apparent and dealt with - sometimes more satisfactorily than others during this stage of the process. This section will look at the tensions and successes and detail the role of the community researcher and that of the support worker in aiding reconciliation.

5.2 The community researcher

Two-hundred and four people from the 47 community groups were formally trained by the CEH to undertake research within their own communities. The trainees were male and female, representing all age groups and from a variety of academic backgrounds, ranging from those with no formal qualifications to PhDs. They also represented students, unskilled, semi-skilled and professional workers. Their expectations of the project were captured during the training session and revealed that whilst they may be from ethnically diverse communities, age groups and employment backgrounds, their expectations for the long-term impact were similar and fell into the following broad categories:

Raise awareness of drug use issues within community	Strengthen the community voice by implementing the findings of the project	Raise awareness of existence of the community amongst statutory services	Raise awareness of existence of the community group within community
84%	92%	18%	11%

5.3 Engaging the wider community

5.3.1 Access

Strategies to engage with the wider community varied from project to project. Essentially, many of these strategies mirrored those used by professional researchers - one-to-one interviews, focus groups and questionnaires. Many of the projects reported taking advantage of local cultural events such as Melas^{II} and

carnivals in order to access their communities and others staged specific events themselves. In some instances, these events were centred on the project, for instance, public launching of the work. In others, the events were social events designed to appeal to a target audience, for instance a fashion show aimed at attracting young Pakistani women, and incorporating a drug use theme.

A number of access methods were deployed, but the favoured method was clearly the use of existing networks.

"Professional researchers couldn't do the job - the keyword is trust. Often our researchers are interviewing their mates; an outside researcher couldn't have this access." (Community group project manager)

Others also talked of **'trust'** and highlighted the importance of confidentiality, particularly amongst young people around drugs issues, emphasising the fact that the community researchers were not simply community members, but trusted community members.

One community group noted that:

*'...two researchers were engaged initially (in addition to the co-ordinator). Through their networks, they were able to recruit older people, young people, drug users, drug workers and Chinese community workers. However, as the project developed, it became clear that accessing the nightclub scene and parents was proving difficult... In response to this, two further researchers were recruited who had access to parents and subjects involved in the nightclub scene. Had all these contacts and networks not existed, the research would have been near impossible. An outsider coming into the community could not have obtained the in-depth responses that have been accumulated.'*²⁴

A further aspect of successful access and engagement appeared to be skills in using language and media for communication that not only reflected appropriate language and dialect, but also literacy levels and linguistic ability. Seminars, focus groups and questionnaires were designed with this in mind. Professional researchers were criticised by the community groups for their lack of knowledge around language - one group reported that a previous seminar organised by a research consultant and held in their town had been conducted in Hindi to an audience of Urdu speakers.

Knowledge of the community and linguistic ability encompassed more than personal contact and an ability to speak a language; it was also about recognising the fine line between engagement and alienation, especially around such a sensitive issue. Furthermore, it was about being available at times when the community is available and often this was outside normal working hours:

"When you work with the community you have to tailor your work to them ... statutory mainstream work is not always conducive to working with the community." (Community group project manager)

5.3.2 Community politics

The community engagement model, by encouraging community leadership challenges traditional approaches to service planning. This has already been discussed in regard to

^{II} 'Mela' - a South Asian community gathering or festival

the relationship between the statutory and community sectors. However, at this stage of the project, it was noticeable that the model was challenging traditional leadership structures within some communities. This manifested in a number of ways. For instance, a number of the community groups stressed the importance of accessing the whole community and that sometimes community politics gets in the way. One researcher noted in relation to her community that:

"Nearly all statutory organisations gain views from 'community leaders' who are always Muslim males ... the women are completely ignored and their suppression is allowed to continue ... [this project will] ensure all the community benefits and not just the males!" (Community researcher)

In some instances, the project appeared to give the wider community a platform from which to express their dissatisfaction with the status quo. One community group reported the following comment from a focus group:

*"We also feel that our so-called community leaders are using us to get grants and not using the money to be put back into our community – we need to stop the politics around community work."*²⁵

Although expectations of engaging faith leaders were not high in Muslim communities, only one community group reported difficulty in accessing the local Mosque. A number of others reported their surprise at gaining easy access to the Mosques in their area:

"I never expected them to let us in – they've never talked about drugs before, they usually deny that drugs is a problem in our community. Now they're saying 'come to the Mosque, bring your video, run your focus group here – we want to help'. It's unbelievable really." (Community researcher)

5.3.3 Ownership

Alongside good personal contacts, a further positive tool to access and engagement reported by many of the community groups was the community ownership of the project. Many of the groups reported a great deal of interest generated by their projects and talked in terms of the whole community being empowered:

"The whole programme has been devised by someone who cares about people ... everyone feels it is their own project now, this is felt by the volunteers and the participants ... it has changed the attitude to research" (Community group project manager)

This was an opinion echoed by other community groups

"So much research ends up on the shelf, this research is ours and we are using it!" (Community researcher)

"Some people have said how pleased they are to be consulted, they are happy to have a say." (Community researcher)

One community group highlighted three factors in their final report that they felt contributed to community ownership:

'First, although Consultants are academically qualified, many are not involved on a day to day basis with the subject of their studies within their respective communities and are not considered as 'one of us'. The subjects usually know they are dealing with 'strangers' and do not give them the 'real deal'...Second, most studies are not 'user led'. The community

*does not feel that the findings/recommendations of studies conducted will make a difference to their quality of life. For example the respondents felt that addressing drug misuse, although all well and good it was just as important, if not more, to address the underlying causes of drug/alcohol misuse. Some of our respondents felt that external organisations use them more for the benefit of the academics than for their benefit or that of their communities. Third, the respondents felt a sense of 'Questionnaire/Focus Group' fatigue'. We were able to get a high percentage of completed questionnaires returned because our day to day work is client based and we were able to field the questionnaires during 'surgery' with our clients."*²⁶

5.4 Steering groups

The establishment of steering or advisory groups was a fundamental component of the training section of the community engagement model. Community groups were advised to include their local DAT co-ordinator along with representatives from statutory agencies within the drugs and wider health and social care field. The rationale for this was that members of the steering group would be a useful conduit for gaining access to the statutory sector and also would enable the work to be grounded in the strategic planning process. Steering groups were reported as being helpful in accessing many of the statutory agencies, although some groups reported problems accessing schools. One group noted that despite a good contact on their steering group only one in four schools approached would allow them in to conduct their research, from which the group drew the conclusion that:

"Schools won't let you in – they're terrified that their school will become tainted by drugs – they're all so performance driven and dependent on targets. They think that just the suspicion that drugs is an issue will label their school as bad." (Community researcher)

The level of involvement with other agencies varied from project to project. Some organisations had set up steering groups, which they reported as being well attended by statutory and voluntary agencies and the local DAT Co-ordinator. One such steering group visited during the evaluation of the project gave the evaluator the opportunity to observe the exchange of information and expertise between the group. The benefits of having first-hand and speedy information about funding streams were apparent, as was the ability of the community group to feed directly into local service planning. There was, however, some tension evident, interestingly between members of the community group, as to the nature and extent of their involvement with the DAT. For instance, one community group representative expressed a desire for a **'...formal tie in ... equal partners and stakeholders in the strategy'**. Whilst another saw the value of maintaining independence seeing their role as one of **'monitoring the DAT, rather than being part of it'**.

Not all of the organisations were successful in enlisting the support of their local DAT. In some instances this was due to the DAT Co-ordinator's post being vacant, or in another instance the organisation appeared to have relied on existing statutory contacts and resisted attempts to form links with their DAT. Overall, however, only four community groups reported a negative experience with their local DAT:

"They already have a vision of what they want to commission next year so they are not enthusiastic about our work." (Community group project manager)

However, the project leader of this community group acknowledged that

“Before I started working on this project I didn’t even know what a DAT was.” He had already been capacity built to such an extent that he was able to criticise the ethnic composition of the DAT; was knowledgeable about the DAT strategy and its lack of attention to the needs of the Pakistani community; and was continuing his attempts to engage the DAT in the project.

5.5 The role of the support worker

“The support mechanism has been crucial ... in the past the Health Authority has put money into community led projects, but the support has not been there, the projects have failed and the community has been left with the feeling that they were set up to fail”. (Community group project manager)

Two Project Support Teams, consisting of a total of 13 workers were established - one to cover the projects in the North of England, and one to cover the South and Midlands. Project support workers were required to offer a significant level of support to the communities, but to stop well short of doing the work that the communities were learning to do themselves. The project support workers visited 'their' projects for half a day once a fortnight and were available at other times by telephone and/or email contact. They had a number of key responsibilities, which began immediately after the selection process, including helping projects to identify who they sent to the training session; accompanying those people to training at the university and providing or organising further training sessions if requested; helping projects to develop their research project; supporting the chosen methodology; acting as resource for information about drugs and relevant organisations; ensuring that projects were linked into local planners and Drug Action Teams; and monitoring projects on an on-going basis. A planning and evaluation tool was developed, with the dual purpose of assisting the support workers in undertaking their tasks and also aiding the community groups to track the progress of their projects.

The groups required varying levels of support, in different areas of their work on this project, ranging from guidance on their research instruments and sampling strategies, to advice on managing the project budget. Carrying out the work in the allotted time was a significant problem for some groups, and several reported that they could not have completed their projects had it not been for the assistance of their support worker.

‘The entire project was guided and supported by the Support worker. Regular meetings were held with the support worker by the volunteers. The meetings were crucial in the smooth running of the project, it included structuring the work, overcoming research problems encountered, asking questions about the project such as; what the group has covered?, what it will be doing next?, who will be doing what?, time management of the project. Further help was given in identifying what needs to be incorporated in the project report.’²⁷

5.6 Discussion

The third stage of this process highlighted intense engagement, both between the agencies and the community groups and also between the community groups and the wider community. Barriers to effective consultation included

stigma, which was evident within both the community and statutory sector; community politics; and realpolitik within agencies. Central to overcoming the barriers within the community was the deployment of trusted community members who could undertake the research in a culturally sensitive manner and the utilisation of steering groups to facilitate access to the statutory sector. During this stage of the process, awareness around the issue was raised within the wider community, generating community ownership of the project but also raising expectations for statutory services to implement change. The consultation of 12,000 people evidences the manner in which these barriers were overcome. The final barriers surrounding implementing the findings will be discussed in the next section

Section 6

Fourth Stage

	Summary of action	Outcome
Fourth Stage	Need articulated, action taken – organisational, community and service delivery change effected Dissemination Implementation	Community needs articulated to statutory sector. Generation of community ownership and endorsement of local drug strategies Community and statutory sector able to work together to implement findings

6.1 Introduction

At this penultimate stage of the process many of the community groups were well aware that their success in accessing and engaging the community had resulted in a considerable amount of responsibility to ensure that the findings of their research did not **‘end up on the shelf’**. Along with the 12,000 people that had been consulted, community groups also reported a vast array of positive media coverage by local press, local radio and three of the groups reported having TV coverage. As one community organisation, nearing the end of their project noted:

“We live in this community, if the research is ignored it will be damning for us all”(Community researcher)

This section will look at dissemination and implementation and the efficacy of the mechanisms incorporated into the project for achieving sustainability.

6.2 Recall events

In July and August 2000, events were held at the University of Central Lancashire, marking the end of the project and signalling the way forward. The events’ main aims were to give the community researchers a friendly platform from which to disseminate their findings, to discuss exit strategies and to further strengthen the communication network that had been so important throughout the project. The events were held over two days with the first day consisting of presentations from the CEH management team giving feedback on the project, congratulating the groups on their work, and encouraging them to take it forward. Senior members of the Department of Health also attended the events and gave presentations, informing the community

groups of forthcoming funding streams and how they could take advantage of these. The second day consisted of small group presentations by the community groups to their peers and CEH team at which they gained feedback on their findings and in effect rehearsed for the local dissemination events they were planning.

6.3 Reports

Each of the community groups produced a report of their work (in some instances more than one report was produced). Groups had been issued with advice and guidance on the compilation of their reports and a help desk had been set up during the report writing stage. Along with the useful information contained within the report, community groups spoke of a particular value and symbolism associated with the reports. This value was seen in relation to the joint badging of the report with the Department of Health and the University. To some of the community groups, this joint badging extended official status amongst statutory agencies to the work that had been conducted. The report also symbolised the work and provided, in the words of one community group member:

"A showcase for our organisation, concrete evidence that we did it and can do it again." (Community group project manager)

And in the words of another:

"It's a great tool for beating over the heads of planners". (Community group project manager)

6.4 The role of the DAT Co ordinator

As noted in section 4, statutory agencies were seen from the outset as being critical to the success of this project and the engagement of DAT Co-ordinators in particular was seen as essential. All of the community groups began their projects with the written support of either their DAT Co-ordinator or a local strategic health agency. However, the level of support given in reality varied greatly from project to project.

Forty of the community groups responding to a question asking about the relationship with their local DAT Co-ordinator during the lifetime of the project, responded in the following broad categories:

Relationship not forged	Relationship deteriorated	Relationship good	Relationship strengthened
4	1	9	26

DAT Co-ordinators were seen to have contributed to the project in a number of ways: encouraging community groups to apply, initial support, introductions to other agencies, provision of extra training around drug misuse issues, sitting on steering groups, offering guidance on methods, assisting at the report writing stage, attending local dissemination events, and, in some instances, funding those events.

This level of support is remarkable when one considers the lack of prior information that DAT Co-ordinators received about the project and the speed with which it was initiated. As one DAT Co-ordinator who had played an active role in the project noted:

"DATs are already pushed to the limit therefore their involvement has to be realistic and within their own

priorities. I have to say I felt slightly coerced into this project." (DAT Co-ordinator)

Few DATs refused to take part, and although their level of involvement varied, a number seized the initiative with both hands:

"The DAT Co-ordinator was a member of our steering group. They also sent us the original bid information and encouraged us to apply. They fully supported the project throughout, helping both professionally and practically. The other members of the DAT team also fully supported the project. The project was viewed with respect and importance and the DAT Co-ordinator anticipated acting on the findings and recommendations from the beginning." (Community group project manager)

"The local DAT Co-ordinator has been involved with the needs assessment from the beginning of the initiative as a member of the steering group. This has enabled the results to be included as part of the DAT template and for the steering group to be formally recognised with some members now part of other DAT sub-groups. The DAT has also made further funding available to carry on and expand the work already started through the needs assessment process." (Community group project manager)

"They supported us at the beginning ... then they were involved in our steering group. Later they set up a consultation group – we are the main player in it. In the future they are initiating a post which will deal with Black and minority ethnic issues." (Community group project manager)

For those community groups that had secured DAT engagement, sustainability of their project was greatly enhanced. Community groups were asked whether their findings had been incorporated into their local DAT plan: 20 said it had, 8 said it had not, whilst 12 did not know.

Interviews with DATs support this evidence, with DAT Co-ordinators speaking of the general influence of the needs assessments on informing issues of ethnicity and diversity within their overall plans and in some instances advising of more specific issues, particularly in relation to young people and substance use.

6.5 Partnership and joint working

Along with the vital relationship with DATs, community groups also spoke of a range of other relationships that had developed within the course of the project that had the potential to sustain the work. Partnerships had been developed with Primary Care Trusts, Local Authorities, Health Action Zones, Youth Offending Teams, Police, Probation, social services, local drug service providers, youth services, schools, Crime & Disorder Partnerships, local voluntary organisations and with the other community groups that had worked on the project. On average, the community groups reported adding three agencies to their existing network.

6.6 Local dissemination

Within six months of the end of the project, the majority of community groups (34) had publicly launched their needs assessment reports in community settings. Many of these events had been attended by DAT Co-ordinators. Indeed, some DATs had funded and helped with the arrangements for the events.

"We organised a high profile launch for the report in partnership with local DATs. There has been a remarkable improvement in the contacts that we have recently forged with local DATs. There is a possibility that local DATs will come together to jointly fund a long-term project with us." (Community group project manager)

The events had also been attended by a range of other health and social care planners and providers along with members of the community, local political leaders and in some instances Members of Parliament. Those community groups that had not held events mostly advised that they were intending to do so in the near future.

6.7 Discussion

For many of the community groups and agencies participating in this project, this stage, rather than being the end, was only the beginning. Reports on drug use, containing recommendations of appropriate responses to the needs of communities had been successfully produced. These reports had been disseminated both within communities and to mainstream health service planners. The community groups and the agencies that they had engaged with had all learned a great deal about the service needs of the communities and developed a greater understanding of each other and demonstrated, in many instances a willingness to work together co-operatively on this issue. The ultimate goal of this project however, was the possibility of sustained change to planning processes to ensure the ongoing development and provision of appropriate services through mainstream funding streams. At this stage, those community groups that had successfully engaged with agencies were in a position to work together to achieve that goal.

Section 7

Fifth Stage

	Summary of action	Outcome
Fifth Stage	Sustainability – begin process again if necessary on secondary issues. Follow-up	Ongoing co-operation and communication between community and statutory sector

7.1 Introduction

At the outset of this report it was contended that the process of conducting this needs assessment was as, if not more, important as the findings. The findings, however, contribute to the process. Indeed, their successful implementation into local service design, development and delivery validates the process. In addition, the process, designed largely to capacity build communities to enable them to undertake the work, had a number of unexpected outcomes. This section is based on extracts from the community groups' reports and on interviews and questionnaires conducted six months and twelve months after the project ended, in order to measure its longer-term impact.

7.2 Individual impact

At an individual level, in addition to learning about the needs of their communities, project participants gained knowledge and understanding of drugs and drugs related issues; research skills; interview skills; management experience; knowledge about the work of Drug Action Teams; time management skills; and communication skills.

'I found that I greatly benefited from the training days at Preston which built on my basic drug knowledge. I thoroughly enjoyed conducting the needs assessment itself. I worked with some groups that I already knew of and also managed to develop links with many new groups. I facilitated focus groups, carried out one-to-one interviews, carried out questionnaire drops and did some work around participatory appraisal.' (Community researcher)

Forty-five people (22%) of the 204 that were trained to undertake the work were reported as having secured employment in the health and social care field following the project. This success was attributed to their involvement in the project and the skills and knowledge gained. Others had gone on to further and higher education and some spoke of taking up careers in the drugs field in the future.

'Being involved in the Black and minority ethnic needs assessment helped me to further develop my skills in the drugs field. I am much more interested in this work and I will hopefully carry on to develop this and to do some work in this field in the future.' (Community researcher)

Some spoke of personal growth in terms of the issue and the value of achieving an insight into a previously unacknowledged subject:

'Coming from an Asian background there is so much the community hides from others when keeping the truth from all, even family. To know there were agencies and professionals was some what a surprise to myself; just talking to certain individuals made me aware that it could be dealt with (drugs) in so many different ways leading also to so many different outcomes! All in all I believe I was somewhat ignorant and really didn't know about the goings on around me, but since being involved in the assessment team, it has increased my insight into what is going on in the black communities, acknowledging its here and happening!' (Community researcher)

Grown confidence was a widely reported legacy of the project

*'...local black women and men, who "know" and are trusted in the community, have conducted the research. Furthermore, by undertaking the work they have gained many new skills, knowledge, experience and confidence... The project has given the individuals involved the opportunity to train and develop their own personal skills as well as empower themselves with the confidence to convey their own experiences around issues concerning drugs, not only to their family and friends, but also to local people and local organisations and groups in their community.'*²⁸

7.3 The impact on the community groups

At an organisational level, community groups reported that the process allowed them to establish better links with their communities:

"The project has also given YAP [Youth Awareness Programme] the opportunity to develop its capacity and infrastructure to be more active and effective in providing for the needs of the community it serves and supports its future development".²⁹

Others spoke more specifically about how the project had aided the community group to raise their profile within their communities and with funders; to recruit and retain new volunteers; to network with other groups; to demonstrate competence at project and research management; and to develop partnerships. Significantly, 22 of the community groups reported embarking on new areas of health and social care related work within six months of ending their project. All of them attributed this diversification, to the new skills developed and partnerships made as a result of the project.

7.4 Community impact

At the community level, the process had the advantage of being able to ensure the ownership of the project by the community, thereby gaining their trust and support and allowing a sensitive subject to be more openly discussed.

*'Undertaking such a project has been a unique challenge not only for the organization and its staff but also for the community, who have had to address the sensitive issue of drugs for the first time in such details.... The individuals from the project team were able to further build their relationships with the community by being constantly involved in discussions and meetings throughout the course of the project. This aspect was unique in building further trust amongst the community, because of the sensitive nature of the discussions.'*³⁰

*'The project was very much a community based engagement project with special emphasis on recruiting and empowering community talent.'*³¹

*'...training young people...has the added value of strengthening their skills and experiences. The use of researchers and facilitators drawn from the local community resulted in gaining the support and approval of the community and also built up the capacity within the community'*³²

*'The communities themselves had to overcome the taboo nature of the subject and be willing and able to talk openly about the drug problems. Had the trust between the YCA [Yemeni Community Association] and the community, not being established, it would have meant that the crucial data collection aspect of the survey would have been unobtainable. It was because the trust and the work of the YCA was generally recognized amongst the community members, that the survey was able to target a good cross section of the community, including women.'*³³

*'This approach was well received within the community and it helped to create the necessary environment for trust and co-operation from the respondents.'*³⁴

7.5 Impact on service development

The impact of this project on the individual, the community and the community group has in itself impacted on service development. The recruitment of more people from Black and minority ethnic communities into the health and social care field in general, and into the drugs field in particular, is one of the most significant outcomes of this project. In addition, a number of the community groups now have formal representation on Drug Reference Groups and other DAT

sub-groups. In Hackney, a Black and minority ethnic forum has been established by the DAT in conjunction with four of the community groups that conducted work in that area. In Manchester, two of the community groups have been successful in establishing a Manchester Drug and Race Unit. In London, five of the community groups are working with the Greater London Authority on a project to build the capacity of refugee and asylum seeking communities around drug use issues. In all, twenty-six of the community groups reported (six months after completion of their projects) that they were working in partnership with local DATs or other agencies to take forward their findings.

7.6 Discussion

This section has highlighted a number of positive and sustainable changes that the project has made at an individual, organisational, community and service level. Throughout this report it has been contended that the process of assessing need and creating an environment where those needs can be articulated to service planners is the way forward towards achieving equitable services. Whilst the success of this project has been considerable, a number of valuable lessons have also been learned to inform the way forward and these will be outlined in section 8 of this report.

Section 8

Conclusion and way forward

8.1 Introduction

This project has been subject to a process evaluation. One of the most frequently asked questions of the evaluator has been **"Was the project a success – did any of the groups fail?"** The preceding sections of this report clearly highlight that the project was a success. None of the groups failed. Each one undertook the work and completed it on time. Some were more successful than others in engaging with statutory services; some more successful than others in engaging with their own communities. All of them raised awareness within their communities, assessed their communities' needs and their communities now own a report from which they can continue to articulate those needs to service planners. In keeping with the ethos of the project, the evaluation has also been participatory and in the judgement of those who participated – the communities, the agencies and the facilitator – this project has been a success. However, a number of valuable lessons have been learned and this concluding chapter will summarise these, offering the consensus of opinion of those who participated in the evaluation of the project and highlighting those lessons by examining the component parts of the model.

8.2 Lessons learned

8.2.1 Community groups

- It is the belief of those that participated within the evaluation of this project that the community leadership was essential to accessing the wider Black and minority ethnic community. This wide consultation has resulted in a

greater local knowledge of the needs of distinctive Black and minority ethnic communities and collectively has provided the evidence for a national report that will make an effective contribution to a scant evidence base on this subject.

- Capacity building and strengthening community groups was an essential requirement to ensure community leadership of the project. This capacity not only enabled the groups to undertake the project, but also ensured sustainability in the future. There are now community groups whose knowledge and skills around substance use issues have grown and who are, in many instances, now operating as gateway or referral services to drug agencies.
- Building the capacity of community groups also raised their expectations about delivering drug services themselves. In some instances, where this service delivery has involved peer education, awareness raising and resource development there is evidence to show that partnerships have been developed with local commissioners and planners to undertake this work. Some disappointment has been evident, however, amongst some of the groups, who wanted to provide more specific treatment services or those who had been unable to develop close links with mainstream services. Future projects should address this issue and ensure from the outset that community groups are aware of what they can realistically hope to achieve.
- Community groups also spoke highly of the transferable skills gained through undertaking the project. They anticipate these will strengthen the service they offer to their communities on a day-to-day level. Future projects could aim to enhance these skills through the provision of accredited training.
- A lower level of support for groups had been originally anticipated than eventually proved necessary. A high degree of support was required and this varied from group to group dependent on past experience, existing research skills, knowledge of the subject and links with agencies. Community groups who had intended to employ professional researchers and aid them with access to the community, were faced with the additional pressure of recruiting and offering day-to-day support to people from the wider community. Whilst none of the community groups regretted this strategy, and a number valued the role of the support worker in easing any difficulties that arose, it was suggested that extra time should have been allocated to deal with the recruitment of community members and the extra support that they needed.
- Both the community groups and the statutory agencies noted the value placed on recruiting people from the wider community. A significant measure of the success of this project has been the finding that 22% of those trained to undertake the work have gone on to find work in the drugs and wider health and social care field. Others reported that they had gained sufficient confidence to enter into further and higher education. Recruiting people from the wider community has introduced them to career opportunities that they may not otherwise have considered and also introduced agencies to a pool of potential recruits who they may not have otherwise targeted in recruitment strategies. Future projects should aim to build on this success by emphasising the opportunities for enhancing career development through participation in the project.
- The community groups strongly valued the project's overall success in considering ethnic diversity in its widest form,

that is, not just concentrating on the larger Black and minority ethnic communities, but addressing the needs of smaller, lesser known communities. Many of those representing small communities attached a value simply to 'getting their voice heard'. Almost all of the groups attached a value to the networks that they had built with the other groups participating in the project, which they found useful in collecting and sharing information, peer support and in some instances partnership development on follow-up work. A small, but significant number mentioned that working with the other community groups had reduced the stigma of drug use that they may have felt had they been undertaking the project in isolation.

8.2.2 Agencies

- Whilst the majority of DAT Co-ordinators were supportive of this work, lessons can be learned from those that did not or could not participate. A small but significant number of DAT Co-ordinators commented that they had no prior warning of the initiative and would have been more willing to help had they been given fuller information. A small number reported feeling confused about the roles of the community groups and the CEH and unsure about where they fitted in. It was noted that in most instances where the community groups' findings had been fed into the local DAT Plan, DATs had been actively involved from the outset of the project, in some cases stimulating the grant application from the community groups and in all cases being involved in steering group membership or some other form of advisory role. A key lesson learned, therefore, is that DATs and other agencies cannot be expected to participate in a community engagement exercise without consultation. Future projects should ensure that DAT Co-ordinators are fully involved from the outset whilst maintaining the community led ethos of the project.
- DAT Co-ordinators and other service planners also need support from the facilitator in the engagement process. Whilst this was extended when requested, it is recommended that future projects should formalise this arrangement.
- A small number of DATs spoke of disappointment in terms of the focus of individual needs assessments and also of the particular community that was the subject of the research. This disappointment was articulated in terms of other communities being a higher priority in a particular area. The majority of these DATs nevertheless felt the exercise was valid and useful and had introduced them to community groups whose existence they would otherwise have been unaware of. A key lesson learned has been that the project has in some instances broadened the horizons of the planning system and that by focussing solely on DAT priorities, DATs would have missed an opportunity to engage with communities who had not already come to their attention.

8.2.3 Facilitator

- The facilitator added an extra dimension that helped to break down traditional power balances that can often destroy relationships between the community and statutory sector. The facilitator cannot force statutory agencies to participate, nor can it force community groups to conform to the statutory services expectations, but it can create an environment where they can work together and alleviate many of the tensions that arise. In this project, the

facilitator focussed heavily on the needs of community groups. Future projects should ensure that the needs of agencies are given greater attention in order to improve the engagement process.

- The facilitator also had a role around building a communication network. In this project, the network, although informal, was particularly valued by the community groups. An attempt to introduce an electronic discussion group was largely unsuccessful, but the personal contacts made through training sessions, regional events and recall days have been enduring. Future projects should attempt to build on the success of this informal networking with the introduction of a paper newsletter (as well as electronic media) that is circulated to all participants in the project
- The facilitator also took a strategic overview of the long-term impact of the project. A number of schemes were devised to harness the enthusiasm and energy created by the project and submitted to potential funders. Additionally, the strategic team assisted individual community groups with the development of bids to take their work forward and alerted the community groups to potential sources of funding. This area of work could be developed and enhanced in future projects. .

8.2.4 Time

- As mentioned at the outset of this section, all of the projects finished on time. However time was the main source of contention within the overall project. The short time-scale and the increased numbers of groups involved in the project, placed pressures on many of the participants. Community groups expected to have six months to complete their work. In reality, the longest project was six months with some having little more than three. The key lesson learned is that time is needed at the outset of the project to establish relationships between the key players and to define their roles. A timeframe should then be set and adhered to.
- The timing of the project was viewed as positive in terms of the national policy context. The Race Relations (Amendment) Act 2000 had recently been introduced and local agencies were aware of their duty to ensure the appropriateness of their services. It was anticipated that the Spending Review 2000 would make available the funds to implement, where appropriate, the findings of the local projects. This fitted well with one of the objectives of this project, which was to enhance the possibility of sustained change to local planning processes to ensure the ongoing development and provision of appropriate services through mainstream funding streams rather than the use of short term funding.
- As well as considering time in the context of the duration of the project, future projects should also consider whether it is the right time – whether the engagement coincides with major religious festivals, school holidays, etc., and if they do, then the time allotted should be adjusted accordingly.

8.2.5 Funds

- In this project, grants were paid directly to community groups who were encouraged to recruit members from their own communities to undertake the work rather than employ external consultants. This strategy has had a

number of successful outcomes. Community groups report that their organisations are now seen as a place of opportunity within the community; the people that were recruited have reportedly maintained their connections with the community group.

- The strategy of paying community members had a number of advantages at the individual level. Participants in the project reported feeling valued and useful; receiving payment for work appears to have increased the confidence of many of the community researchers to undertake further education or work in related fields. Rewards for community participants are usually largely emotional and symbolic as compared to health professionals and managers for whom participation has tangible professional advantages.³⁵ Future projects should continue this successful strategy.

8.2.6 Expertise & knowledge

- This project has entailed a steep learning curve for all key players. All have gained new skills and knowledge that they can use in other areas of work. DATs in particular have placed a high value on the project's contribution to their knowledge base around community participation. Community groups report increasing their skills, knowledge and confidence around research techniques, drug use issues, partnership working and project management. The facilitator, through documenting the process, has been able to develop a model of community engagement that can be transferred into other areas of need.
- It was considered a missed opportunity that the training programme for the community researchers was not accredited and future projects should give community researchers the option of taking an accredited route.

8.2.7 Framework

- The framework used in this project was a needs assessment exercise. The importance of setting clear aims and goals was seen as essential in order to maintain focus and deliver something at the end of the project. The process of conducting the needs assessment has had, a number of unexpected outcomes. However, a high value has been placed on the production of the end of project reports. This value has been expressed by community groups and by agencies. Along with those agencies that have reported implementing the findings or undertaking some form of follow-up work, agencies also report using the local reports as reference points for bid applications, reports, etc. Many of the community groups spoke in terms of the report being a showcase for their work, a tool to use in future funding bids; and the joint badging with the Department of Health and UCLan added kudos to their work. Future projects may have a different framework, but the value of a report or other concrete evidence of participation in the engagement process should be recognised and incorporated into their project plans.

8.2.8 Conclusion

Fifty-one needs assessment reports have been produced by this project, detailing the specific cultural needs of a diverse range of Black and minority ethnic communities. Individually, these reports are unlikely to have much more than local impact, but as a collective body of information, the contribution to the evidence base is highly significant. Of further significance are

a number of outcomes that have been born of the process: the impact at the individual, community group and community level along with the impact on organisational change in the design, development and delivery of drug services.

The key to the success of this project appears to have been the top down approach, together with grassroots community leadership. The Department of Health was not simply the funder of this project. As mentioned at the outset the Department of Health was the catalyst and the instigator of the community led approach. Throughout the project, the Department of Health gave significant commitment to the project and contributed to its design, development and delivery. In addition, the community groups attached a symbolic value to the Department of Health's involvement in the project, in terms of giving them credibility both amongst their communities and also amongst the statutory sector.

The Department of Health has signalled its commitment to this work by establishing a further three-year community engagement programme. This programme will be accompanied by an enhanced evaluation framework that will incorporate strengthened mechanisms for measuring the programme's effects on building community capacity and assessing its impact on service change.

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