Dealing with Diversity: good practice in drug prevention work with racially and culturally diverse communities

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DEALING WITH DIVERSITY: GOOD PRACTICE IN DRUG PREVENTION WORK WITH RACIALLY AND CULTURALLY DIVERSE COMMUNITIES

FOREWORD

Dealing with diversity: good practice in drug prevention work with racially and culturally diverse communities

Since 1990 the Home Office Drugs Prevention Initiative has been piloting a community-based approach to drugs prevention. In the first phase, 1990-1995, 20 small teams were set up to work with local communities. Their aim was to inform, encourage and support communities in their resistance to drugs misuse. In all, they supported more than 1,500 drugs prevention projects. These projects drew help and support from local business people, voluntary workers and a wide range of statutory and non-statutory organisations.

On 1 April 1995 the Drugs Prevention Initiative began its second phase with the formation of 12 larger teams covering a much larger geographical area in England. These teams have a four-year strategy: to form new partnerships in the community; to build on past experience and to generate new activities.

The work of the teams among communities is building up a pool of experience in drug prevention activity. A priority for the Drugs Prevention Initiative is to ensure that local work is evaluated to see what works and what doesn’t and to share these lessons. Since 1993 the staff of the Initiative have been working with independent experts, to pull together some of the common threads from their shared experience in order to identify the key principles of good practice.

Projects operate in very varied communities, and one very important concern of the Initiative is the need to make drugs prevention approaches relevant to the people they are aimed at. This often means taking full account of racial and cultural diversity. Many different approaches have been adopted by teams, some more successfully than others. In this report, Mark Johnson and Mark Carroll review and analyse the range of experience from the last few years of the Drugs Prevention Initiative and use what they have found, together with what could be found from existing research literature, to draw some conclusions about how best to approach drugs prevention in a racially and culturally diverse society.

The report identifies some of the key issues involved in multi-cultural working, and makes recommendations about such matters as information gathering, project management, gaining credibility, and training, which should be of value not only to the Drugs Prevention Initiative in planning future work, but also to others who are taking forward drugs prevention or other work, such as crime prevention or local regeneration, in the community.

If you would like more information about the Drugs Prevention Initiative or about the work described in this report, please contact the Central Drugs Prevention Unit, Room 354, Horseferry House, Dean Ryle Street, London SWIP2AW, 020 7217 8631, Fax: 020 7 217 8230.

Central Drugs Prevention Unit
Home Office
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EXECUTIVE SUMMARY

1/ This report aims to provide good practice guidance on drugs prevention work in racially and culturally diverse communities.

2/ Its findings are based on:

- a review of the existing literature from the UK and the USA on drug and alcohol-related work with minority ethnic communities; and

- the work of the Home Office Drugs Prevention Initiative (DPI): reports from projects supported by the DPI and visits to ten local drugs prevention teams.

3/ The aim of the report is to draw on the successful strategies and practices of DPI teams and lessons from the literature to identify some of the key elements of good practice.

Findings - key points

- Direct action should be targeted at minority ethnic groups to meet their specific needs.

- At the same time, all activity must take into account the very real diversity in the population in general.

- Minority communities and service providers have needs which must be met if prevention work is to be relevant and effective.

Available information

Actual levels of drug use among minority groups need to be researched. Perceptions need to be discovered, especially amongst those who are not known users.

Recent health promotion work with minorities provides some models for drug prevention.

Reaching communities

Strategies to change attitudes and behaviour must be targeted and culturally appropriate for their intended community.

Service providers need to seek the views of communities and act on their expressed concerns.

The majority white population is also diverse and contains groups who may have particular cultural and linguistic needs.

Services and initiatives must be accessible, which means taking into account suitable hours, transport availability and other relevant circumstances.

Where communities are slow in approaching prevention services, outreach work may be needed.

Involving target groups and communities
Most communities already have useful consultative mechanisms for liaising with minority ethnic groups.

There is a well-developed voluntary sector among minority communities, as well as coordinating and campaigning bodies, in addition to religious, social or issue-based organisations.

Minority representatives should not only be asked for opinions on minority issues but should influence the development of the agenda.

Employing staff of minority ethnic origin may help services to gain the trust of and secure access to minority ethnic communities.

**Staff training/ knowledge/ skills**

Many professionals are ignorant of minority cultures, naming systems and community priorities. An explicit Equal Opportunity Policy for staff and contracts is essential.

All staff should become adept at cross-cultural working.

Staff need to understand the issues of concern to minority ethnic groups as well as having a grounding in specific cultural issues.

**Responding to diversity**

Often, materials used reflect only a monocultural society. Pictures, music or work from other cultures should be used in materials and also the offices from which preventive services operate.

Cultural diversity includes not only language but religion, diet, identity, history and family organisation.

**Sharing information and experience**

There should be channels to encourage staff to share good practice and solutions to difficulties.

It is important to have a central body to help exchange information and support good practice.

**Monitoring and evaluation**

‘Ethnic Monitoring’, a form of audit, can be used successfully with a review process built into its planning. It is now becoming widespread in health and social services.

Consultation and programme planning should be followed by setting objectives, and evaluating targets and processes.
DEALING WITH DIVERSITY: GOOD PRACTICE IN DRUG PREVENTION WORK WITH RACIALLY AND CULTURALLY DIVERSE COMMUNITIES

1. INTRODUCTION

It has long been recognised that British society is not homogeneous but that, in fact, the population draws upon a great diversity of ethnic origins and cultural traditions. This means that for drug prevention services to be effective, professionals must develop explicit strategies for work in a racially and culturally mixed society.

This report aims to discuss the issues involved in this task and to set out a model of good practice based on the knowledge we have so far. It reviews the British experience of prevention work in racially and culturally diverse communities and draws lessons both from home and from work in America, where professionals have been actively seeking solutions for some time (Gordon 1994).

How the study was carried out

The findings of this paper were based on three key elements.

- A review of the existing literature from the UK and the USA on drug and alcohol related work with minority ethnic groups. The literature was supplemented by research findings in the broader field of health promotion where these provided useful models.

- Scrutiny of reports from drug prevention projects supported by the Drugs Prevention Initiative in England, Scotland and Wales. Projects relevant to work with racial and cultural diversity were identified either by drugs prevention teams themselves or from the Central Drugs Prevention Unit database.

- Visits to and interviews with ten drugs prevention teams. Interviews were based on a topic guide developed with staff of the Drugs Prevention Initiative and Home Office race relations advisers.

The ten teams were chosen to reflect the diversity of settings and communities served by the Drugs Prevention Initiative. At each site team members identified projects which illustrated good practice locally or which otherwise merited investigation. In each case projects were chosen to give examples of work with all the major ethnic minority or cultural groups in the area.

The researchers spent a morning with the team being briefed about local activity (sometimes including access to files). They then visited projects to talk to organisers or staff. Where possible, the researchers also visited relevant projects or activities not supported by the Initiative, in order to explore any possible barriers to collaboration.

Note

We are conscious that good practice may have been present in many other locations which we have been unable to visit, and that we may not have described all those projects which we saw.

In general, the identity of those who assisted us with the research has been concealed as a principle of data collection.
How the report is set out

The report begins with a review of research findings on working with racially and culturally diverse communities in the UK and the USA.

The next section, Good Practice I, sets out some of the key issues of drug prevention in diverse societies. These are practical issues, such as language barriers and barriers arising from mistrust, which need to be addressed when planning effective services and projects.

This is followed by a section of recommendations for action, Good Practice II. Recommendations on different issues, such as gathering useful information or gaining credibility among communities, are illustrated with examples of successful practices from projects supported by the Drug Prevention Initiative. These practical examples are highlighted throughout the text in a box.

Finally, a checklist of good practice is presented.

Terminology

There is a great deal of literature debating issues and terminology relating to race, ethnic origin and culture. We have chosen to use the term ‘minority ethnic group’ as a shorthand phrase that encapsulates social differentiation on the grounds of race, cultural difference and religion.

In general this refers to minority ethnic communities and groups largely of African Caribbean and Asian origin, including those of South East Asian origin. Where appropriate, the more specific term is used, using the 1991 Census ‘ethnic group question’ definitions as a standard.

We recognise that there is considerable heterogeneity within any such socio-political grouping, although minority ethnic group concerns are generally considered together because of shared experiences of racism, labelling or marginalisation. Equally, the white sector of society is marked by diversity and contains groups who may suffer discrimination or have particular cultural and linguistic needs: Welsh and Irish concerns have been explicitly noted.

The term ‘minority’ perhaps refers more to an overall societal situation: in certain local cases black or Asian groups may form a majority, but they rarely enjoy political or institutional control. We use the term ‘culture’ to refer to the combination of a number of ‘rules for living’ or means of expressing identity - which may be related to a variety of elements, including language, diet, religion and a shared heritage of common knowledge. Finally, we should observe that there are also issues of gender which merit consideration, although they have rarely been discussed in the literature.
2. REVIEW OF RESEARCH LITERATURE

There is a considerable body of literature on drug and alcohol-related work with minorities available for review. Some of it is devoted to theoretical issues and some describes particular local situations and responses. A good deal of effort has also been dedicated to investigating racial or ethnic variations in drug or substance abuse.

The following points, however, should be borne in mind: research evidence is sometimes contradictory; it is often based on small localised studies and most of it is founded on American experience.

The literature review presented here is supplemented by findings from work in the broader fields of health, social and community work. Developments in health promotion, particularly relating to HIV/AIDS, recognise significant health differentials and thus provide some models for drugs prevention. Similarly, the social work and community development professions have been actively seeking models of anti-racist practice.

As the Australian experience has found,

"information/knowledge programmes are likely to be more effective if attention is paid to sender, message and context. The senders should be credible and the messages should be relevant to the receiver .... address the values of the audience, be unambiguous, accurate and balanced, and should be appropriate ..." (Reilly and Homel 1988 :5)

These observations were made in respect of age differences. However, the same can be said about other ways of dividing up society. Culture has many parameters and good practice consists in recognising and acting on those issues.

A review of the English language literature undertaken for the Home Office Central Drugs Prevention Unit at the start of the Drugs Prevention Initiative observed that there was little coverage of the implementation of programmes, or of minority groups, or women:

"The literature is characterised by extensive discussion of the concepts underlying these approaches and sometimes rigorous evaluations of outcomes, but with relatively little coverage of the intermediate programme implementation or process stage. Until recently, the literature generally assumed that programmes developed for white youth also provided a model for black and other groups: the literature on prevention issues in relation to females is very thin on the ground." (Dorn & Murji 1992 :4)

While there has been some progress over the period since this report in 1992, these observations remain largely true. Insofar as there is any mention of ethnic minorities in the British literature, it frequently continues to "see black people as merely passive victims of drug and other social problems" (Dorn & Murji 1992 :6) - in which they are not necessarily differentiated from the majority white communities. As Dorn and Murji also state, "virtually all prevention programmes assume something lacking in the population of interest" (:7). Minorities are seen as inadequately integrated and social problems such as drugs misuse are seen to stem from this.
This has not been our understanding or approach, although it is also maintained in the American literature despite the fact that black role models have played a significant role in anti-drugs TV advertising in the United States.

In certain fields of health promotion, most notably HIV/AIDS prevention work, there have been calls for greater attention to be paid to the development of prevention programmes developed specifically for certain ethnic or cultural groups in their countries of origin.

This minority-specific approach would indeed seem to have merit and avoid the ‘deficit model’ described above. In the course of this literature review, few examples were found. However, one study reported on work with Chinese clients in Singapore. The author of that found that drug abusers were less likely to participate in home-based activities or family businesses, and were more likely to be involved in delinquency before becoming drug abusers (Teck-Hong 1992). In this respect, his findings mirror those of American studies, but contain nothing that is particular to Chinese culture, except insofar as failure to participate in family-based activity is more unusual than it might seem in other settings.

Another study reported on the work of the Green December Movement in Pakistan which adopted an explicitly Islamic model (Green being the generally accepted ‘Islamic colour’ and popularly used by Muslim communities in Britain as well as North Africa). Many of its actions seem uncontroversial and familiar to Western eyes, but there are some differences. The most significant is their success in co-opting religious leaders to include drug abuse messages in their addresses to Mosque congregations, and the encouragement of mass actions and youth committees in colleges (Mufti 1986 :125).

Peer-pressure approaches are, it seems, universal but the distinction may lie in the ability to identify appropriate peers or opinion leaders. Projects in Europe working with Muslim groups might find reference to this initiative helpful.

The majority of studies of drug-related action with minority ethnic groups came from the United States of America. Even there, Dorn & Murji reported that "little was known" because "extensively evaluated prevention initiatives have focused mainly on white groups" (:25) although it was suggested that structural factors (such as an earlier school-leaving age) might be significant and that

"Prevention programmes for minorities should focus on social and political factors which will enable people to deal with a system that continually rebuffs them ... Aberrant social behaviour is not the fault of the individual but often caused by the social/political system." (Dorn & Murji 1992 :26)

This is a fairly common theme in American studies, and it is argued that ‘person oriented’ prevention cannot expect to work in low income or ethnic minority communities (Crisp 1980 :18). Communities may be deprived, marginalised and excluded. In the light of this, the issues of income, housing, and other forms of discrimination affecting the community are seen as being proper concerns for drug prevention, and requiring attention before ‘symptoms’ such as drug abuse can be tackled (Orlandi 1986; Payton 1981).

On the other hand, there are some studies, both in Britain (Patel 1993) and the USA (Kaskutas et al 1992) that demonstrate, at least for the case studies they present, the potential of a community-development oriented approach to drug prevention work in culturally diverse settings. Where there have been apparently successful programmes of this nature, the lessons are not always easy
to implement: Maypole in the USA attributed success to one prevention programme because it was less formal than projects working with the white community: "... the program was (thus) an integral part of their community rather than part of the dominant culture" (Maypole and Anderson 1983,1987). The major problem is that most such initiatives are new or short-lived, and

"The Federal Office of Substance Abuse Prevention itself estimates that it takes a full two years for a program to become established enough to produce consistent and valid outcomes" (Kaskutas et al 1992 :171).

Given the sensitivities associated with working in areas of diversity, or with minority groups subjected to high levels of deprivation and exclusion or marginalisation, this may be an underestimate of the time needed - Butt (Awiah et al 1992) writes that it took him six months to gain enough community confidence to commence a research project.

The use of drugs

Little is known about the actual levels of drugs misuse among minority ethnic communities. A very substantial section of the literature is concerned to document the actual (or expected) levels of misuse. A major review of literature on drugs and ethnic minorities at an American research conference in 1983 commented that there was virtually no information on the differential effectiveness of prevention strategies amongst ethnic groups, and demonstrates that the majority of studies were prevalence estimates or devoted to the relationship between drug abuse and criminality (Trimble et al 1984). More recent American studies continue to repeat these patterns and observations (Moore 1992).

Despite evidence to the contrary, a stereotype that minority groups in run-down areas use and sell drugs, persists. This is a prevalent myth even in the British case.

Some minority communities also complain that because of this stereotype, excess attention is given to policing their young people: Mirza and colleagues noted that half of drug-related arrests in Lewisham were of black people, compared to only one in fourteen of drug agency users (Mirza et al 1991). While Crowley et al (1992) reiterate a finding of raised levels of illicit drug abuse amongst Afro-Caribbean (but not Asian) mental health patients, they do accept that this may be partly an artefact of the referral process. In Britain as in the USA, "rarely is information available on drug use amongst those of the minority population who have little or no contact with institutions or agencies" (Payton 1981 :21).

An article in a relevant professional journal, citing such studies as Bean & Pearson (1992) repeats or contributes to this stereotype although hardly justifying it on the basis of the figures it cites:

"The spectre of a violent crack market undermining Britain’s black communities has been revived by research in Nottingham which reported that the "highly visible crack street dealing scene was dominated by Afro-Caribbeans" ... with the growth in crack dealing within the black community came guns and violence." (Druglink 1993 - un-bylined :5).

In fact,

"The assumption that poor people, black people, and other disadvantaged groups are particularly likely to use drugs may be ideologically appealing to some on the basis that it
shows the damage inflicted by poverty and racism; it also reflects and reproduces deep-seated stereotypes: and it completely misses the point as far as prevention planning is concerned." (Dorn & Murji 1992 :26).

What is more, according to nearly all the literature available, it is completely inaccurate. While Burke (1984) appears to argue that marijuana is the drug of preference for black youth in the Caribbean, replaced by alcohol with increasing maturity, and Patel (1988) has pointed to the ready availability of opium in Pakistan village markets, there is more evidence that both alcohol and other drug use is more likely to be linked to greater length of exposure to (and adoption of) British culture (Awiah and Dorn 1992; Clarke 1990; Waterson and Murray-Lyon 1989).

This does remain debated: a recent study argues that although Asian young men had comparable access to disposable income, they were "significantly less likely to engage in risk activities" and dismisses young Asian women as even less at risk because "they had little access to money (and) did not go out" (Brannen et al 1994). Meanwhile, Crowley (1992) found equivalent levels of drug use among Asian, but dramatically higher ones among Afro-Caribbean mental patients.

Other researchers (Ranger 1989) would argue that this is probably an artefact of a racist process. Indeed, the latest research of relevance to this report comes from a prospective study of mentally-ill diagnosed patients in a multi-racial area of London. While cannabis was the main drug of misuse, white clients were the most likely to have been users of this substance, and there was no association between diagnosis of schizophrenia and drug use (King et al 1994:11 17). This also reflects the majority of studies in America, that

"Black youth had ... significantly less use of illicit drugs. Black and Hispanic youth also began marihuana use at a later age than whites and are less likely to become heavy users." (Rebach 1992:27 - based on a meta-analysis of 137 studies).

Mirza and colleagues also comment on the problematic nature of statistical inference, and refer to the "ecological fallacy" (a statistical term indicating a confusion between areas containing high numbers of a category and the expectation that all those in that area are equally at risk of belonging to that category). This meant that their study of known drug users

"made abundantly clear that the high rates of drug misuse ... involve white heroin users living in neighbourhoods of black settlement." (Mirza et al 1991:12).

Similar conclusions were drawn by the Drugs Prevention Initiative study which conducted detailed investigations in four British cities, and paid particular attention to the Afro-Caribbean population of Lewisham and the Asian communities of Bradford. (Leitner at al 1993). While noting that representation of ethnic minorities in its initial samples was sparse and largely confined to those two locations, the addition of a booster sample indicated that both black and Asian groups were significantly less likely than whites ever to have used illegal drugs. They also found whites had generally much greater access to a range of non-prescribed drugs. In this, they consider their work to reflect the findings of other European studies, such as that of Sandwijk et al (1991) in Amsterdam, and to run counter to stereotype:

"Even the black ethnic groups which have previously been seen as prominent in drug usage matched rather than exceeded the majority white groups in terms of prevalence of drug usage." (Leitner at al:31).

A possible explanation of that stereotype, arising from the 'ecological fallacy' to which we have
already referred, is given when it is observed that "those areas where drug usage clusters tend to be those areas... suggestive of deprivation". (Leitner et al :58). It is also by now well established that areas of deprivation are also highly correlated with (but not caused by) the presence of minority ethnic groups.

Interestingly, the study also shows that white and minority ethnic groups agree to a large extent that increased police activity is neither desirable nor effective as a strategy to reduce drugs use. It is also worth noting that while minority ethnic groups were in general unlikely to have high levels of knowledge about drugs, or to use drug-related services, they were in general better informed about the Drugs Prevention Initiative than white respondents. Indeed, of all groups surveyed, the Bradford Asian group had the highest level of awareness of DPI activity.

Given the timing of the research, low levels of knowledge may not be surprising, but the high level of awareness does demonstrate that it is possible to gain at least an initial impact through the strategies adopted by the DPI teams in the areas of the surveys. To achieve this, it is perhaps not necessary to have detailed information about the prevalence of drugs use. However, this will be essential at a later stage to assess the impact of preventive work, and to target strategy to the best effect.

Earlier data from the British Crime Survey (Mott and Mirrlees-Black 1993) did not address the issue of ethnic drugs use variation. But recently available analysis using the booster sample data of minority ethnic replies provides more evidence that the British experience may parallel that of America. In each of the three ‘lifestyle’ age groups considered, there is a significant gradient in the prevalence of drug taking from the inner-city to rural areas. (Mott and Mirrlees-Black 1995 :16).

However, when the data is analysed by broad ethnic group categories, it is clear that in all but a few categories, the proportion of drug users is consistently higher in the white population and relatively rare in the Asian group. Only amongst Afro-Caribbean males aged 16-29 is there a somewhat higher reported rate of cannabis use. And while Afro-Caribbean females in that age range reported higher use of crack, temazepam and heroin, they were also more likely to report using the fictitious ‘semoron’. (Mott and Mirrlees-Black :54)

While noting the caveat of the authors that "differences between the groups must be interpreted with caution because the numbers of respondents of Afro-Caribbean or Asian origin are small" (Mott and Mirrlees-Black : 18), the rates of reported drugs use among the minority ethnic community are certainly not significantly higher than those of the white group. Taking into account the geographical distribution of the populations, these data would support an interpretation of an overall lower relative risk rate among all minority ethnic groups.

At present there is no other available data on a national scale to confirm or develop these interpretations. The ‘Health and Lifestyles’ survey of the Health Education Authority, which is the most detailed national study of the minority ethnic population presently available, asked only about consumption of alcohol and tobacco products, including information about the use of chewing tobacco and ‘paan’. (Rudat 1994). However, those points may be of value in considering an approach to the use of drugs more generally in a multi-cultural society.

Lessons from health education and health promotion

There is clearly some value in learning from prior experience in health promotion. The Department of Health and NHS have recently been very active in developing their work with
minority ethnic groups. The Government White Paper ‘The Health of the Nation’, (Cm 1986) and the annual report of the Chief Medical Officer (Calman 1992) drew attention to the existence of significant differences in health status associated with racial and cultural diversity in Britain. Particular attention was drawn to variation in preventable disease, such as diabetes, heart disease and stroke. In part this was linked to the provision of health promotion materials.

There has subsequently been a growth of activity in this field by associated professions and agencies. Many of the reports have drawn attention to the need for more research and the lack of evaluative studies (in the USA as much as in Britain: Aguirre-Molina 1990 :795), but there is nevertheless a substantial body of work to consider. That said, as with drug prevention work, there is not always agreement as to conclusions. It is also observed that

"Seemingly the priorities for health education (for minorities) have been birth control, pregnancy and child-care .. . There is a dearth of material adapted for ethnic minorities on the hazards of cigarettes and alcohol ..." (Bhopal & Donaldson 1988 : 138).

and suggested that in many communities a concentration on those priorities is seen more as a form of social control than as an enabling process.

Other researchers have attempted to investigate the response of minority groups to health advice: this has been quite informative in terms of understanding issues of communication. One study followed up an impression that "despite receiving the same (health promotion) as British (i.e. white) diabetics, Asians did not understand it as well" (Hawthorne 1990). The conclusion reached here was that the problem arose from the delivery of inappropriate advice; had it reflected Asian religious and dietary preferences, the population would have been rather more effectively informed.

In general, it is found that Asian groups at least are more receptive than the majority population to professional medical advice, that their cultures are attuned to the prevention of illness, and that it is "low knowledge levels rather than negative attitudes that appear to cause Asians to be at high risk" (Kay et al 1990; Bhopal & Samim 1988). The message is that advice should be attuned to variation in language or culture.

It should also have an understanding that communities that have experienced racism are consequently more than usually suspicious of advice that is didactic and not sensitive to their lifestyles. There are many examples of ‘healthy living’ advice which when carefully examined can be seen to attack cherished traditions and to imply that the problem is one of a ‘pathogenic’ culture - that assimilation (doing what the majority does) would be the best solution. What this fails to recognise is that many people from minority origins have attempted that, and met with rejection: their traditional culture is all they have to give them a sense of value and to resist racism:

"Health promoters need to understand the social history of ethnic minorities ... of which racism is ... perhaps the greatest concern." (Bhopal & White 1993 : 141).

The problem is that there have been many "high profile campaigns against sikur and surma (a food supplement and cosmetic respectively) ... defining Asian people’s health problems in terms of their 'pathological culture’ " (Ahmad 1993 :20).

Such campaigns provoke more resistance than compliance, and may lead not only to rejection of the message but also of the messenger. On the other hand, even with topics as sensitive as
HIV/AIDS, experience

"has shown that suitable workers can access ‘difficult’ areas such as mosques, churches and temples, African-Caribbean estate dwellers ..." (Abdulrahim 1991 :39).

where that suitability means a degree of sensitivity. The same author comments that, contrary to stereotypes which may hinder service planning, some Pakistani youth (for example) do inject drugs or use family planning clinics. At the same time, they receive significantly less information about the generic services available to them, while resources are dedicated to meeting perceptions of special needs arising from genetic, linguistic or cultural specificity.

A more recent two-year research study of the intersection of drug use, HIV/AIDS and community work in an ethnically diverse neighbourhood makes the point that the question of delivering culturally appropriate services "should not be the responsibility of individual workers but of the service planning, development and implementation process ... social and cultural appropriateness should be an integral part of the monitoring and evaluation of services" (Abdulrahim et al 1994 :6). While focused particularly on young people of Greek and Turkish Cypriot origins, the study recommends not only that there should be culturally and ethnically specific work which would also "encourage their uptake of mainstream services", but also that "all specialist drug workers should be formally trained to work within a culturally and socially diverse population" (Abdulrahim et al 1994 :10).

Key messages

The key conclusion from all of these studies is that while ethnic minority communities may have specific needs which should be met, all materials and strategies should reflect the existence of diversity in the population - and should recognise that neither minority nor majority culture and society are static.
3. GOOD PRACTICE I: KEY ISSUES

This section identifies some of the key issues for those planning drug prevention programmes and services. Two sorts of issue were identified when interviewing community groups and practitioners seeking to convey messages about drugs prevention for this report.

Firstly, there are those concerns which are perhaps best described as meeting the needs of communities, although often perceived by providers of services as user problems. These include issues of linguistic diversity, specific cultural or socio-economic constraints on action, and barriers perhaps arising from mistrust.

Secondly, there are the needs of providers, for information, training and enabling to work with diversity, and in making best use of resources.

Issues associated with potential service users

Minority groups are not being reached adequately by drug preventive services and health promotion facilities. The research comes up with few specific reasons for their under-representation. A study of drug users and drug information in Lewisham came to no more specific conclusions than those already advanced by Awiah Butt and Dorn (1990) that:

"if and as other drug-related problems are experienced by black and other ethnic minority people help-seeking is impeded by the perception... that the available services are unlikely to be understanding and sympathetic" ( :8).

The Lewisham authors therefore recommend that a coordinated effort on black outreach work together with the development and extension of ethnic monitoring equal opportunity policies and anti-discriminatory practices is an obvious requirement." (Mirza et al 1991 :17). This also recalls the observation by Awiah et al that the implementation of "equal opportunity policy generally may reduce the pressures for drug use to be converted into drug problems" ( :8).

Most published work in this field makes similar general comments perhaps also reflecting the fact that many of the studies have concerned work with existing drug users rather than preventive activity (Abdulrahim et al 1994).

For specific explanations we must rely upon the views of practitioners at professional workshops and conferences. These are the barriers most often identified by practitioners:

Language Barriers

While the majority of the British ethnic minority population was born and educated in Britain and a substantial proportion including most of the African-Caribbean communities speaks English as a mother tongue there remain a vulnerable minority who can only communicate in Urdu, Cantonese, Bengali or some other language. Few service providers or educators can function in these languages, and there are insufficient translated materials. Not all concepts or technical terms can be directly translated or understood without interpretation.

Materials and locations lacking Black/Asian imagery
Many posters, leaflets and offices reflect only a monocultural society. The use of pictures, music, or scripts (print fonts) from other cultures makes them interesting and relevant to a wider clientele.

**Service provision which is inaccessible**

Many ethnic minority workers are employed in shift work or at times and in occupations which make it impossible for them to attend offices and meetings during conventional office hours. Fewer ethnic minority families have cars. Women may not be able to travel without a family member, or go out at night - and men also may fear racial attacks in certain areas. Muslims may not wish to enter licensed premises whose main function is the sale of alcohol; women may not wish to enter places mainly used by men. Asian youth may have parental restrictions placed on them.

**Information which is culturally inappropriate**

References to diet should reflect an awareness that many people nowadays are vegetarian, eat what were once regarded as exotic vegetables and pulses, or observe religious rules in the kitchen (such as the Jewish Kosher or Islamic Halal). Leaflets about the evils of alcohol will be regarded as having little to say to Muslims, while those which discuss tobacco may be seen as irrelevant to most Sikhs.

**Minority ethnic community distrust of white agencies**

It has been suggested that members of minority communities may be unwilling to use services associated with the Home Office, because of its responsibilities for immigration control and policing (Patel 1993). This is not confined to agencies associated with the Home Office: wider concerns about assurances of confidentiality and fears of officialdom have been reported in other studies of health and social work provision (Abdulrahim et al 1994). On the other hand, few community groups interviewed in this study reported the association of the Drugs Prevention Initiative teams with the Home Office as having caused them any problems.

**Denial or fear of admitting need in community**

Many communities have found themselves the focus of unwanted policing or intervention including, for example, the inappropriate use of mental health or social work powers. Others have had cherished aspects of their culture criticised. Because of this experience their members may be reluctant to admit to problems or invite further interventions. It may be that certain problems are not admitted by some leaders because their existence is not compatible with idealised views of what religious norms permit. Individuals can also be aware that their family may be shamed if they are seen to be associated with an anti-social behaviour by seeking help or advice: even given guarantees of confidentiality, "in the geographically concentrated community, no-one is anonymous" (Abdulrahim et al 1994:28).

*It is possible that, as once failure to use the services of the NHS was attributed to ‘newness’ on the part of immigrants to Britain, the challenge of delivering services in a changing and increasingly multi-cultural society has placed strains upon the institutions themselves. They require both information and resources.*

**Service staff ignorance of minority ethnic community issues**

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There is a widespread lack of adequate knowledge about minority cultures, naming systems and community priorities. This may manifest itself in a reluctance to ‘have a go’ and treat minority clients as having generic needs, or in an insensitive treatment of ethnic specific issues. Examples of this might include not knowing that all practising Sikhs are likely to be called Singh (male) or Kaur (female), that Sickle Cell anaemia is a serious and painful condition primarily affecting those of African genetic heritage, or a lack of appreciation of the importance of religion in influencing social and health-related behaviour.

Lack of resources for positive outreach work

The commonest complaint amongst service providers is that they are unable to dedicate resources to seeking out unmet needs, since the majority population keep them sufficiently busy. To provide additional or special services to attract or go out to minority groups is seen as requiring additional funds or staff. This ignores principles of equity (minority groups pay taxes) as well as need, and may be an excuse for not wishing to examine cherished and inefficient ways of working.

Both of these can form barriers between service providers and users. The providers or promoters of services also have their needs, which should be met. These are considered more fully in the next section.

Issues associated with service providers

This section looks at the needs of service providers which must be met before they can deliver effective and appropriate services to minority ethnic groups. In some cases, these issues need to be faced before providers are aware that there are needs in those communities to be met.

A knowledge base

It is clear that the supply of adequate and appropriate information to fieldworkers is an early priority. High quality information about a community is vital to assess need accurately and to shape services appropriately. There are many variations in local situations and resources may be wasted in meeting needs that are not locally felt. The inclusion of an ethnic question in the 1991 Census has moved the debate about local profiling on, but has yet to be fully exploited.

Making connections

Many community work project teams, including those set up for drugs prevention work, are intentionally small and intended to act in a catalytic fashion. It is therefore essential that their ability to form or join networks should be maximised, and that they should be provided with support through those networks, as well] as the means of exchanging experiences and needs with other teams.

Accessing communities

The process of making network connections with official or established groups should be distinguished from the issue of access to (and by) minority communities who are not always as established or integrated into local structures. Not all communities are organised - many may consist of a small number of families who have little contact with each other - such as Chinese restaurant owners who are widely dispersed. Other networks may exist but have single-sex membership.
A history of political marginalisation and exclusion from resources has led to mistrust and other barriers to collaborative working, although there remains a strong willingness to engage in such actions if properly approached. Making initial contact with ethnic minority communities may require special or specific efforts and strategies, using ethnic specific channels (such as radio programmes in Asian languages, ‘Island’ social associations, or a number of temples each serving a sub-set of a religious group). Once contact has been made and rapport established, representatives of those groups may be happier to engage in less focused forums of discussion.

**Multi-cultural working**

There is a slowly growing awareness in many professional sectors that work in a multi-racial, multi-cultural setting requires new skills and ways of proceeding. This is true in respect of national minorities such as the Welsh, Irish and Scots, as well as for black groups. Responsiveness to cultural diversity includes not only an awareness of language, religion and diet, but also of identity, history, and family organisation. Diversity presents opportunities as well as threats, but challenges individuals’ competences and may require structural readjustments. Recognition of this, however, may open up new channels to more than minority clientele. This is because a strategy which explicitly accommodates diversity can make the service more responsive to the whole population.

It is important to recognise that multi-cultural working is not necessarily best served by the addition of specialist and ethnic-specific services: this can lead to marginalisation and abandonment at times of resource constraint. Genuine recognition of diversity can lead to incorporation of a variety of different groups under one umbrella, focusing on shared values and common needs.

**Team composition**

There are obviously issues about the staffing of projects, which are not confined to drugs prevention work. Given restricted resources, an expectation of catalysis and innovative action, and a diversity of settings, it is clearly essential that teams should have access to a variety of skills. This may also raise the question of ethnic matching and equal opportunity in employment. The success of the projects we visited has depended heavily upon the adaptability and personal commitment or drive of workers. This goes beyond the formal qualifications of individuals: the chemistry of teams is as essential a component as more formal skills, but is less easily defined. The ethnic origins of team members will affect the image of teams as perceived by outsiders. On the other hand, evidence collected during the research for this study suggests that image may be as much a barrier in the minds of the team as elsewhere in the views of the community.

**Adding value**

There may be a problem for service providers to prioritise ethnic minority issues within a restricted budget, while ensuring that all communities feel that their needs are valued. Again, this is an issue not confined to a single Initiative. Given the dynamics of all health promotive and drug preventive work, it is clear that actions cannot take place in isolation, or be dependent only upon special funding. Ways are needed to insert the issue into popular discourse and community agendas. Successful strategies will add value to investment by attracting other forms of support or inserting drugs prevention messages into activities which have their own justification and multi-agency backing.
DEALING WITH DIVERSITY: GOOD PRACTICE IN DRUG PREVENTION WORK WITH RACIALLY AND CULTURALLY DIVERSE COMMUNITIES

4. GOOD PRACTICE II: RECOMMENDATIONS

This section draws on the experience of Drugs Prevention Initiative teams and on what is known from the literature to recommend some of the key elements of good practice. It looks at what works in the field of drug prevention based on past experience, at problems and obstacles service providers may encounter and at successful ways of overcoming them.

The American experience

The National Institute on Drug Abuse (NIDA) in the United States published a ‘Guide to Mobilising Ethnic Minority Communities’ which made highly pertinent recommendations and prefigured many of the observations in the previous section. In addition to paying attention to the economic and social situation of minority communities and the need to find alternative means of livelihood for youth in the minority ethnic groups, it emphasised the need for extensive local information prior to embarking on any action plan, listing five key steps:

- Select a community where there is awareness of a problem and the potential for cooperation from the range of local agencies
- Identify community leaders who are capable of getting things done and grassroots supporters who are keen to be involved
- Work within the established structures in the community
- Identify sources of funding - and
- Target a specific neighbourhood (NIDA 1986:13-20).

This does somewhat presume that the informational and training base for such action exists. This may be more easily satisfied in the USA than it is in Britain, where working with racial and cultural diversity is a relative newcomer to professional planning and training.

Nevertheless, it provides a concise summary of desiderata with which we would not dissent in general. The final comment does require some qualification: there are few places in Britain where residential segregation approaches American levels. Such strategies would risk omitting a significant proportion of African-Caribbean and (increasingly) Asian communities, especially those who have managed to achieve a degree of social mobility. The 1991 census shows that there are very few wards or districts where more than half the population is of minority origin, and even fewer places where more than half of a particular minority group lives only within one or two wards. Popular stereotypes may be misleading.

Here we spell out the implications and issues which are most appropriate to the British context, although probably having a wider applicability. Actual examples of good practice are given from projects we visited and are shown in a box. These are not prescriptive and may require considerable adaptation for local needs.

As with other research, we must insist that impact in the terms of satisfactory outcomes is hard to assess because most of the projects are still immature, and it may take three or more years before
a project is sufficiently established to make a long-term impact (Dorn & Murji 1992).

**Information gathering**

There are a number of types of information that will prove essential to the management of any local drugs prevention strategy. Within these it will be necessary to identify particularly the degree to which overall patterns relate to the situation of minority ethnic groups, and gather information relating to those communities. We would identify the following data (not all of which are conventionally available) as being important.

**Statistical**

It is useful to have estimates on local levels of drug use, related crime statistics, and uptake of services broken down by ethnic group. Some may be available from other services (e.g. local drugs prevention teams, Police, and Health Authority sources) although it is important also to consider what is missing from such data, or question why they are not available. Most such data will be problem-based and reflect the priorities of current providers of services.

Good Practice: Where the necessary information was not already available to give accurate estimates of African-Caribbean or Asian community needs, local research projects were set up by several teams. In Bradford and Bristol these were area-based and organised through local community centres.

In Nottingham an action-research project used a community-based agency, that had been originally set up by the Probation service to work with unemployed and at-risk black youth, to explore the feelings of the African-Caribbean groups; in Glasgow a street survey interviewed Asian and white respondents. The use of pre-existing groups who had a research interest provided ready-made partners for future projects. Community organisations were able to provide not only statistics but also local perceptions. The process of the research was seen as being as valuable as the information gained.

**Using the Census:**

The 1991 Census of Population contained a question on ethnic origin, which permits the identification of ten major groupings at a District level, or four broad groups for smaller areas. For each Local Authority, a fuller listing of over 30 categories, as well as detailed birthplace data, can be obtained from published sources.

Local Authority equal opportunity or economic development units and planning departments normally produce bulletins based on these data. Health authorities also have full access to the data and their Public Health departments are expected to make full use of it for planning and annual reports. The data can be used to identify expected levels of demand, or to identify areas which should be targeted for ethnic-specific projects. The collection of service ethnic monitoring data is of little use unless compared to expected levels estimated from the Census.

**Identification of key problems and trends.**

This requires a longer-term approach, or a database maintained over time, and an established baseline.

The use of ethnic monitoring, a record of the ethnic background of users of a service, can be
helpful if compared against appropriate demographic data from the Census. Local analysis, using perhaps the more detailed data in table A of the Census or the age-sex breakdowns also available - will provide estimates of expected levels of minority representation (taking into account the ageing of the population since 1991.) Similarly, such data will provide a baseline against which to consider prevalence estimates from other sources.

Good Practice: While the initial briefings supplied to Drugs Prevention Initiative teams by consultants recruited from local colleges and Universities were not always regarded as an unqualified success, the principle of a research-based overview before starting work has merit.

Consultants collated data from Health, Criminal Justice and Local Authority sources and conducted some interviews with existing drugs workers. In many cases, although cultural diversity was mentioned in the brief, it was left out of the final report: problems also arose in the timing of the work. Nevertheless, the idea clearly stimulated many teams to recruit consultants who conducted more detailed local action research studies prior to developmental activity.

Cautionary Note:

Some teams reported dilemmas when college-based research developed in overly-academic, less practice oriented directions; others had found that community-led projects required very high levels of training and support for both worker and community group. When this was omitted, a report was produced that made useful points but lacked convincing evidence to support its argument.

Building networks

There are existing drug and alcohol prevention networks in most towns. It is clearly important to connect with these and establish explicitly the degree and means by which minority ethnic groups are represented on them. In so doing, it is important to establish which individuals act as representatives because they play an active role in the community, and which have been co-oped from other bodies with no drugs-related role.

Good Practice: the Lambeth team identified a black worker in an existing street-level drug project who had good local contacts as well as credibility in the drug prevention world. He was seconded to conduct a research project and take part in their meetings. His work developed to the point that City Challenge funding was obtained, to set up a major drugs-related project that was black-led but generically focused with him as its leader.

Cautionary examples could also be given of people or agencies which have been invited to attend meetings because their formal status or title indicates a representative role, but who have little interest in the issues of drugs prevention.

Most local authorities have consultative mechanisms for liaison with black and minority ethnic groups in addition to the CRE-funded Race Equality Councils. Many of these will be politically determined. People in such positions will not necessarily have the greatest
credibility in drug prevention fields. They will however have lists of affiliated and special interest groups. Minority ethnic community workers from health, social work, economic or employment fields and criminal justice work may also have their own organisations for support and to exchange information. Many teams found such structures to be useful as a starting point for their mailing lists and consultations. Another team took three years to discover that their City employed ethnic-minority-specific community development workers.

Good Practice: the Wolverhampton team organised a day seminar for all local Asian community workers in order to raise awareness and develop links between agencies and workers. The local Asian Workers Network helped with organisation, provided halal food, interpreters, creche and disabled access, and raised attendance. Similar networks of staff from minority backgrounds exist in many shire counties and urban districts.

Voluntary groups

In many places, the Race Equality Council may also perform a liaison role with the broader voluntary sector. It should not, however, be used as a surrogate for fuller consultation or regarded as representing the totality of the black voluntary sector - it too may have political influences in its composition.

Some Voluntary Service Councils (CVS) have made strenuous efforts to develop links with black voluntary agencies; in others there are Black Caucus or other ethnic minority-led coordinating and campaigning bodies which will be helpful. They exist in addition to councils of mosques or other religious, social or issue-based associations.

Key problems that are identified through such consultative processes will not always be identical either between community groups, or to the initial perceptions of professionals (including staff members). It is important to study the agendas raised through the various bodies consulted, and to consider where and why they may differ - and how consensual approaches may be arrived at.

Good Practice: One City team had initially used the consultative mechanism set up by the local County Council in response to disturbances in the 1980s. This had no credibility within the younger and more radical black communities of the town, and acted instead as a barrier to community contact. Individuals who had been used by the Council were largely self-appointed, uncritical of the official perspective, and politically ambitious. A team member with local knowledge of the history of conflict was alert to the signs of lack of confidence expressed by city-based groups.

When the official representatives failed to deliver expected inputs and access, direct invitations to participate were issued to those community groups which showed a real interest in the issues of concern to the team. These included young people and women, and better access was achieved. The older self-defined leaders may have represented some groups, notably those whose followers supported them because of past benefits: these were not however necessarily those who were of greatest use to the objectives of the drugs prevention team.

Key players or informants
You should consider who are the most prominent activists, workers or representatives from minority ethnic groups active in their areas. These may not be the same people as are represented on the bodies mentioned above: certain cultural groups prefer to retain a degree of exclusivity or are the province of intellectuals and literati who have less immediacy for ‘low culture’ users of the language. We may draw parallels between two cultural groups: in Welsh and Bengali one might draw a distinction between the ‘high culture’ of the Eistedfodd or Dhaka, and the ‘Welsh of the valleys’ or Sylheti.

Good Practice: the Manchester team developed its own procedures to search for partners in the community. A mailing was sent to voluntary organisations identified from the City’s own database of Black Voluntary Organisations. This was followed up by visits from the team leader who spoke at meetings and made informal presentations. A cascade approach identified a number of new groups and built bridges. Offering support to their needs and priorities, together with creative use of the media attention this generated, produced positive results. The team leader summed it up simply: "Interest shows."

Individuals may have been given status or become members of advisory groups for a variety of reasons, and these may not necessarily be relevant to your aims. It is important to consider who has been given legitimacy by statutory organisations. Those who have a reputation for attracting political support, for example, or who have a standing within the religiously observant community, may be of less standing with more alienated or younger groups. Those with greatest links to the ‘Establishment’ may not be so credible within their own communities, but community workers must be aware that one may need to appeal to more than constituency within a community, or use more than one representative from a group. Anyone who insists that they alone can speak for a group is likely to be wrong: the right people will have a multiplicity of links and offer them for use.

The West Glamorgan team sought to work with a variety of representatives of the Welsh language-speaking community. Communities are not homogeneous, and they found that youth workers and church leaders attract different (but equally valid) followings. You must consider which elements of a community are most likely to be interested in, or supportive of, your objectives and work with representatives who give access to them. No single ‘mouthpiece’ is likely to speak for the whole of a community. The image suggested is rather like that of the patchwork quilt: "If you miss a piece there is a hole in the cover you provide, but you must realise that not all the pieces will fit comfortably together".

What are the key concerns and agendas of the different individuals and organisations?

Good Practice: note that there are risks in choosing partners but it requires good judgement and not being afraid to make some enemies in order to gain other allies. There is evidence that divided communities can be brought together around resources. The Lambeth team worked with a multi-faith group, each one of which wanted its own centre and facilities, but all were collaborating for mutual support in dealing with secular authorities! As a general rule, it is advisable to work with organisations rather than individuals, when possible, to permit stability if key helpers move and to avoid personality conflicts.

Management and advisory structures
The formation and running of suitable management and advisory structures - which play distinct roles in assisting the activity of service providers - can have a critical impact on its successful operation. Not only can it provide a source of advice on local political or social sensitivities or cultural specifics and resources: it can also be used to assure observers of the local roots and independence of the work. There are a number of key items to consider. There should be an active relationship with local advisors and stakeholders including the use of co-option and sub-committee working groups as required. A local steering group or advisory panel is desirable for any project, to ensure consultation and community ownership of objectives, providing that this is seen to operate as a genuine partnership following local priorities.

Good Practice: One team began with a strong relationship with its local University. When it became apparent that their interest was excessively academic, the team approached the local Race Equality Council, who took the place of the University on the Advisory Group and implemented a programme of Action Research. Later, an Asian youth worker who possessed necessary skills identified by the group was introduced to the team by one of the researchers (who was unaware of this) and was immediately asked to join the panel.

It is important to ensure that both management and advisory structures are specifically designed to be relevant and appropriate to meeting the team’s agreed objectives. If these include specific target groups, such as youth, or particular minority ethnic communities, then these should be able to see representatives of their interests at management level.

Representatives of such groups will, however, only remain involved and give their legitimacy to the project if they can see that there is a return to the community for their involvement. Many local authority and other agencies seek representatives from minority ethnic groups, and those with the skills and authority to play such a part find considerable demands made on their time.

Relatively small resources, however, may represent a significant return to hard-pressed community groups. The provision of educational materials such as translated leaflets, posters and other resources is always appreciated. Even more significant may be the ability of teams to open doors to other sources of support, such as may be available in the local Training and Enterprise Council (TEC) or through the new arrangements for the Single Regeneration Budget (SRB).

It should also be remembered that the selection of advisors or partners for a steering group requires more than the scrutiny of a curriculum vitae or competences of the individual. Their ability through their presence to project a particular image of the Drugs Prevention Initiative and its projects is as valuable as their professional role in contributing to the scrutiny and management of the group. This projection may also arise from their links with other agencies and resources.

It would be good practice to approach the selection of steering group members in the same way as recruitment of staff. The design of a person specification, including the skills and attributes which are seen as desirable to assist the team, may make the search easier. It also avoids the danger of including minority ethnic representatives in a tokenistic fashion.

Good Practice: the West Glamorgan team recognised the need to reflect the cultural diversity
of their area. In this case, the target group was a national and linguistic minority. They therefore approached a director of a Welsh-language television company to join their advisory group. A spin-off was enhanced media coverage.

It should be noted that minority community representatives who feel that they are occupying a tokenistic position soon become disillusioned. They should be valued and asked for opinions not only on racial and cultural issues. They will have their own forms of expertise, whether from personal or occupational background, and this skill should be recognised. Nor should their role be responsive: they must be allowed to influence the development of the agenda from the perspective of their own community - and not expected to be the only ones carrying that responsibility. As one person said to us, "They leave it all to the Black in the comer."

Minority consultative committees may be set up to supplement the work of the steering committees or advisory groups. This may permit a larger number of community representatives to meet than could otherwise be accommodated. It may also bolster confidence among groups, and meetings could be held at times or places more convenient to its membership than those preferred by professional committee members. While such a policy may demonstrate openness, it must not be allowed to develop into marginalisation. At least one representative should be a voting member of the main steering committee, and resources allocated to support the work of the consultative committee.

Attention has to be paid to the timing of meetings, their location, or the costs of attending, if women, part-time or shift workers, and unemployed representatives of community groups are to be encouraged to participate and be retained. It should be remembered that as a result of historic discrimination in education and the labour market, relatively few minority ethnic community members are likely to be in the types of paid employment where travel and absence costs will be met by employers. This is not to say that such individuals do not exist, although many of them are already heavily committed to management roles in community group activities. In this case, the use of consultative projects or regular public meetings might be considered.

Relations with (and role of) a central team

The researchers found a positive attitude towards the ways in which the Drugs Prevention Initiative had functioned, particularly relating to the role of the Central Drugs Prevention Unit. While the terminology and formal organisation referred to here was specific to the work of the Home Office Drugs Prevention Initiative, the lessons do have a wider relevance. There is clearly value in having a central team or co-ordination function. Its strengths can be seen in particular relating to:

- Facilitating exchange of information and support on good practice - including maintenance of databases of resources and the supply of training materials and research-based information.

Good Practice: the existence of working groups which brought together members of different teams to discuss issues of common interest was itself beneficial. Consideration of the ‘position
papers’ which were drawn up for each group demonstrates a high degree of commonality in their content. Each one refers to the need for clarity over targeting and the definition of clear and specific objectives, which may differ between client groups or community segments - and calls for research to support this. Greater exchange or linkage between groups, and care to include explicit reference to Race and Cultural Diversity in the other topic groups would be a good idea in future.

**Encouraging and validating innovative activity** - and explicitly recognising the uniqueness of local situations through delegation where possible.

**Liaison with other national bodies managing networks of related groups.** The Central Drugs Prevention Unit and any other central bodies might consider developing links with groups such as Sia (the national black voluntary sector development agency) or the National Black Caucus, as well as agencies such as the Health Education Authority and the Commission for Racial Equality.

**Staffing**

The work of Ghosh (1984) in the field of alcohol prevention found that "in order to gain credibility, trust, and attract people to your service it is evident that you need wherever possible to employ black workers ... as generic workers ... the make-up of the staff team should reflect the cultural diversity of the local population". A similar point is made by Patel (1993:43). The picture in drug prevention work is more complex, since teams are covering larger areas and may be themselves smaller than most local health promotion teams. With small numbers of staff it is impossible accurately to reflect the real diversity of a local population and therefore cross-cultural working is inevitable.

Staff from minority ethnic backgrounds are, of course, used to working across cultures. What emerges from the work of the Drugs Prevention Initiative in its first phase, however, is that while the presence of black and Asian staff was a factor in the ability of service providers to gain credibility and trust from, and secure access to, minority ethnic groups, it was not usually an overriding one.

A point made in a study of Haringey is valid: "Clients should be provided with the choice of a drug/health worker from their own ethnic group" wherever possible, but this need may be met by recruiting and maintaining a pool of specialist ethnic minority origin workers "available on a sessional basis if required to meet relatively uncommon language needs" (Abdulrahim et al 1994, :10). This is not, however, a substitute for the employment through proper equal opportunity procedures of staff from minority origins in generic posts.

The existence of team members from minority ethnic groups has given communities a greater level of initial confidence in approaching the Initiative, even when (as has often been the case) the original approach has been to a white member of staff. It is also true to say that the preference of many minority groups is to work with staff from the same origin as themselves, for various reasons including shared languages or other cultural understandings, saving time on explanation. However, many of the teams without staff members from minority ethnic communities have been successful in gaining the support and confidence of such communities. The reasons for this lie partly in changes in the situation and in minority ethnic organisations since the early 1980s when Ghosh conducted his work, but also in the skills that Drugs Prevention Initiative team members have been able to deploy or develop.
Over the last ten years, minority ethnic organisations have become more experienced and adept in adapting to a funding culture which is predominantly white-led and managed. The experiences of the 1980s, in dealings with the Inner City Partnership and other Urban Programme schemes, were highly influential as a learning process. In order to ensure survival subsequently, community organisations have had to be able to develop funding applications in collaboration with not only national and local government, but also initiatives such as Safer Cities, Taskforce, and the private sector (including the TECs through the reformed Section 11 and Ethnic Minority Grant procedures). The Home Office, through Voluntary Services Unit and other support for the minority ethnic voluntary sector, has played a significant role in this. Even if the results of co-working have not always been positive, the greater familiarity with the ‘formal sector’ acquired has itself increased confidence in assessing the potential of the Initiative.

Gaining credibility

The first task of any agency pursuing drugs prevention work is to establish credibility among those communities with which it wishes to work. The essential elements of this credibility appear to be:

A visible commitment to working with the (specific) community. This can be demonstrated in a variety of ways. Note that sponsorship can bait the hook and obtain initial credibility, but a deeper relationship will be required subsequently and promises made must be kept.

Good Practice: the Manchester team launched its publicity campaign for European Drug Prevention Week 1994 at the premises of the Greater Manchester Bangladeshi Association, rather than using the expected City Hall facilities. In addition to the usual civic dignitaries, the community group’s own officers shared the limelight and were able to make useful contacts.

Another team gained very visible publicity by sponsoring a community football team - their logo was displayed on team shirts for a season.

A sophisticated understanding of the issues facing the community is essential. We have already drawn attention to issues of racism and of stereotyping: it is essential to display an awareness of these, alongside recognition of other issues seen to be of primary importance to the particular communities.

An ability to listen positively is an asset. The role of drugs prevention teams is to facilitate appropriate community response to actual and potential drug misuse. They should use the expertise within communities to make sure the means of communication in both directions are appropriate, recognising heterogeneity in minority ethnic community groups.

A willingness to take action on the concerns of that community is necessary. Concern and sensitivity without action are unlikely to achieve credibility. The primary concerns may not initially seem to relate to drug prevention work, but meeting those needs may open doors to go further.

Good Practice: American experience suggests that any support for employment related projects is likely to achieve results.
Birmingham Asian families were worried about the safety of their children after school. A Drugs Prevention Initiative-funded worker was able to organise early evening youth activities in a community centre using its facilities and mixing traditional youth club work with some educational and poster-designing activities which raised drug-related knowledge.

The Bristol drugs prevention team collaborated with the local Training and Enterprise Council to develop a project which would provide career counselling and increase employment prospects for young people who were not reached by conventional employment training initiatives, through a community voluntary group.

The Birmingham team was approached by a church-based project set up to support the families of prisoners, particularly working with black people. The origin of the project had been the realisation that disproportionate numbers of black people were being imprisoned, and that existing services were not providing counselling, financial help or training to their families. It also helps with transport for prison visits, holidays and respite care for children and carers. The team was able to part-fund a worker on the project.

The most effective introduction is a track record of previous activity. While we have noted that time is required to gain credibility and produce results, it is not simply time serving, being in an area, that matters. A history of relevant action will gain respect. Minority ethnic groups are linked into community and professional networks that are extremely good at conveying both positive and negative messages about the effectiveness and sensitivity of individual staff and projects.

Team building

The success of project and team activity depends heavily upon the quality and collaborative working abilities of individual staff. Recruitment and subsequent retention of staff should be explicitly considered as part of the overall programme planning. While we have drawn these conclusions from observation of the working practices of the Drugs Prevention Initiative teams, the principles hold true for other agencies in cognate areas of work.

An explicit Equal Opportunity Policy for recruitment and promotion procedures is essential.

Staff with a locally-grounded community development background have significant advantages in securing confidence of local groups - and bring valuable information resources.

Individuals must feel comfortable in working with, and be able to establish the confidence of, minority ethnic groups.

Team leaders need skills in managing diversity, and multi-cultural teams. Personal difficulties here will not only affect the internal efficiency of the team, but will be seen externally as reflecting a lack of commitment to their needs and concerns.

Supporting team members. Team staff must be enabled or empowered and supported to counter changing situations or new challenges - they cannot be expected to possess all the necessary skills. There are a number of mechanisms which might supply these internal needs:

There should be opportunities and channels to encourage the sharing of good practice and the resolution of difficulties. Staff should be encouraged to network with colleagues.
Good Practice: the Birmingham team had held a ‘Think & Link’ day at which staff were able to get away from the pressures of the office and brainstorm to clarify their objectives, build a common purpose, and develop an action plan based upon these. Themes included: who are our customers; how do they see us; what do they expect from us; action plan; development of a formal mission statement.

Expert advice or consultancy could be identified locally or nationally, to provide advice or guidance and facilitate exchange of experience. This would enable staff to locate expertise that was not held internally, and offer a sounding board for ideas.

It may be helpful for team members to have access to networks outside the Home Office and Drugs Prevention Initiative, and gateways to seek such support. Many staff have these from previous work experience and professional or community associations, but these should be valued as part of their contribution to the work of the team as a whole. Structures to facilitate such access should be developed, and may be assisted by independent external inputs. An active search for such connections is preferable to reliance on chance or personal knowledge.

Training

The question of what training should be undertaken (or undergone) by staff raises the question of the objectives of the training, what it is expected to achieve, and how its impact can be measured. Different models of training have been tried in the past, and are currently in fashion (Wrench & Taylor 1994). Race Awareness Training and Anti-Racist Training both seek to affect the attitudes of participants, but are frequently divorced from an awareness of their professional training or behaviour. It is expected that once the training has influenced beliefs and attitudes, participants will be able to change their own actions. The ineffectiveness of these approaches has been demonstrated by a number of commentators. The alternative model of multi-cultural training, however, has its own risks including a belief that provision of information alone can change deeply-ingrained values; and may be subject to the criticism that it generates false expectations and reinforces stereotypes.

All staff may benefit from training in the use of ethnic monitoring service delivery.

Good Practice: one team was aware of a need for training to develop its ability to work with racial and cultural diversity. It arranged a course with professional external race trainers. Although its experiences were disappointing, certain lessons were learned. It is very important to be clear about the processes and outcomes of different types of training, and to seek advice or references from others who have used such trainers.

The training required by staff should meet three objectives:

To enable participants better to understand what issues are of concern to minority ethnic communities, especially as they relate to drug prevention issues and to locally significant groups.

To continue to develop the skills of staff in implementing quality community development programmes, while acknowledging that this can only be achieved though the recognition of
racial and cultural diversity.

To enable participants to prepare and implement action plans for work with hard to reach communities.

Specific training might also be made available to senior staff in aspects of the management of multi-cultural staff teams, and in the implementation and operation of equal opportunities in staff recruitment and selection.

**Supporting projects**

The explicit strategy of the Drugs Prevention Initiative has been one of indirect action, through giving support to projects run by other groups. Not all groups, particularly those run by minority communities, have extensive experience or resources in meeting the requirements of formal audits and form-filling, and few have prior knowledge of drugs-related project work.

Service providers can provide extensive help at little cost in supporting and developing applications from new groups.

Service providers have an important role to play in catalysing support from other statutory sector agencies, when required, to overcome any lack of skills or expertise amongst minority ethnic groups in managing projects.

Community groups may need drugs information training.

**Good Practice:**

The Bradford team produced a card-file pack, ‘A DIY Guide to Drugs Prevention’. It contained extensive information both on running a drug prevention project and about drug-related topics. Descriptions of drugs, case studies, and contacts for specific support as well as practical answers to common queries were given in a form which could be updated or added to easily. One case study described how "Mohammed, a member of a local mosque" set up a project.

There may be a role for Drugs Prevention Initiative teams to play, in collaboration with other community development agencies, in supplying or supporting training for community groups.

It should not however be assumed that minority groups are lacking in professional skills and access to other talents of value for drugs prevention work.

**Good Practice:**

The Greater Manchester Bangladeshi Association was set up in 1985 and has conducted research-based surveys of community need, run positive action vocational training courses in information technology, and receives significant funding through tender-tested contracts. It is connected to the Internet computer communication system, and chaired by a JP: its director was a senior manager in a local industrial company.

**Setting objectives**

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The work of the Drugs Prevention Initiative to date has been intentionally developmental and therefore designed to ensure that innovation was not programmed out. This has meant in many cases a preference for responding to locally expressed needs and initiatives. While responsiveness is a virtue, for any programme, it is also necessary to have an agreed set of objectives and priorities to ensure that key issues or groups are not excluded de facto by pressures of other demands. There are particular problems in areas where minority groups have a lower profile. That said, there are examples of work in places such as Newcastle or Brighton, where minority ethnic groups form a smaller proportion of the population than the national average yet it was still found possible to incorporate an awareness of their needs in planning and practice.

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**Good Practice:** The Brighton team made an early and well-publicised decision that it would publish a brochure on its work in all major languages used locally, including braille. Language schools and foreign students are an important part of the local economy, and this decision received wide publicity, making an initial impact on minority communities who could see that their existence and interests were recognised by the team.

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A suitable procedure should be followed to set priorities and objectives that explicitly recognise the needs of minority groups and issues of cultural diversity:

A draft plan can be developed from the information gathering process, focusing upon the expressed concerns identified.

The consultation process should use a variety of the identified forum/s and key players, as well as established local procedures and public meetings.

It is critical to gain agreement from, and engage the active support of those people identified as being best placed to make the work plan meaningful.

In setting objectives it is necessary to avoid using or reinforcing stereotypes. Good Practice may include setting objectives that meet the needs indirectly.

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**Good Practice:** several teams selected priority areas for their work which were known to have major concentrations of minority population, rather than specifying communities in racial terms, to avoid this labelling problem. This is not without its problems unless it is known for sure that all the population of interest does live in a single area, or that others are catered for in some other way. The use of Census data and other forms of local knowledge (referred to earlier) are critical in this process.

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Geographical targeting may also reinforce stereotypes: teams in large cities were able to include both areas which were notorious and others which were not thought to have a problem. Those who attempted to avoid targeting obvious areas which were also associated with minority ethnic populations risked leaving such communities out of all provision. A
flexible approach, using local groups with wider catchments or specialist media as well as areas, may help strike a balance.

Objectives should be agreed and finalised following the above process.

Both reactive and pro-active strategies should be used: where a potential target community is identified but is slow in approaching the Drugs Prevention Initiative for support or preoccupied with other work, outreach work might be necessary.

Good Practice: the Birmingham team identified a need to work with the Chinese community but was aware of a reluctance to recognise a problem within the group. They approached a linkworker employed at the long-established Chinese Community centre with a proposal to develop an audio-tape that would help parents discuss drugs issues with their children. This was met with enthusiasm and a collaborative project emerged which attracted the involvement of activists and community members.

Publicising objectives

While the team and its advisors require the stimulus of the target-setting process, it is equally important to gain community support and confidence by publicising those objectives, to draw in further participants. This will maintain momentum, and prevent stagnation - and requires active promotion.

In devising a promotional strategy, it is important to recognise the diversity (cultural, linguistic and political) within communities.

Good Practice: several teams made use of a specially designed logo or identity to ensure their material and projects they support were locally recognisable. The Bradford team overprinted all leaflets with a three triangle symbol and used this extensively. The Welsh team materials had a Celtic knot-work logo; Welsh-language stickers had a novelty value which led to a wide initial uptake by community activists.

Different communities may respond to different elements or opportunities of the action programme.

There are a variety of media which can and should be used, including (but not only) those specifically targeted at particular minority ethnic groups. Different age groups will listen to programmes which may not appeal to their parents (or children!).

It is important to have identified the key opinion formers within communities who may be found in diverse roles according to the community. In some places, professionals or community workers may have the greatest influence; in others it may be religious leaders or business people.

Use should be made of these key individuals, once they have been identified and found, to reflect or affect community views. They should be represented on the management and advisory structure.
All projects should be designed in accordance with the general principles of equality of opportunity and cultural diversity, so that generic projects also reflect a diverse target population and display the openness of the team.

Despite that, there remains a need for projects that are culturally specific, to reassure threatened groups or meet needs which cannot be catered for in larger settings (e.g. for Muslim women observing purdah). Some generic projects which are well designed and could be meeting the needs of minority ethnic groups are held in locations which are perceived as threatening because of fears of racial attack. There is also an information gap as well as disparity of status and resources which require positively targeted action rather than generic provision to overcome.

Good Practice: the Bristol team published a leaflet giving details of all its projects, including contact telephone numbers to allow follow-up enquiries. This was designed to be accessible and widely distributed.

Many other teams produced Annual Reports in various attractive formats, giving due prominence to activities with minority groups, and using pictures as well as text - showing minority participants in project activities.

Engaging communities in action

Small Drugs Prevention Initiative teams on their own can only accomplish a limited amount, as can any other local service providers. High levels of success have been achieved by reacting to offers or requests for help from community based groups. It is, however, essential that reactive strategies are used positively, and that staff actively seek out opportunities to react, in keeping with their identified objectives. The style of their procedures will assist in this:

A facilitative rather than a didactic style generates greater co-operation.

Communities have a great deal of expertise within them which can be harnessed to get messages across.

Good Practice: in Bradford a project called Black against Crack made use of a printer who was a member of the group and developed innovative foil-printed plastics, biros etc. and striking imagery to spread their message and existence.

A Wolverhampton music project recruited a part-time youth worker whose hobby was running sound systems at social events. This developed into a major activity as it attracted young people wishing to break into the music industry.

In Brent a youth centre drama workshop based on getting rid of drug dealers came to the attention of the local drugs prevention team: funding for the video-taping of this event led to the development of a video-production company using the skills that emerged.

Services should be organised to enable outreach and visits to community settings for initial discussions.
Staff should seek to encourage access to their offices by community groups in order to draw them in and break down barriers.

Good Practice: one city-centre based team offered its offices for community meetings of groups which were met through participation in local consultative and coordinating networks. Visitors could hardly fail to see the display of posters and other audio-visual material collected through a project which the team had supported and were able to learn "that we were doing real things".

While in the past some voluntary organisations run by minority ethnic groups have felt that they were set up to fail, exercises designed to salve consciences by asking for low standards are equally demeaning.

Staff can provide from their own resources particular assistance in the formulation and development of submissions.

Good Practice: the Brent team, having decided in principle that they would only part-fund projects in order to ensure support and longer-term commitment to projects by other agencies, created an Information Pack containing advice for groups on how to prepare a bid for funding. Other teams reported helping groups with repeated revisions of bids to City Challenge and similar sources.

Adding value

A further aspect of adding value may be the potentially untraceable later impact of the involvement of community-based workers in Drugs Prevention Initiative activity. Dorn and Murji have observed that in school-based projects, it is frequently the case that it is those involved in the delivery of educational projects who have gained most: "it is the teachers who learn, the peer-counsellors that change" (22). On a number of occasions we met ‘graduates’ of Drugs Prevention Initiative-funded projects who were determined to use the training and experience they had gained in subsequent community-development type projects, and permeate their youth work with drugs-related advice.

We found, particularly amongst the older organisers of many ethnic minority community groups, a reluctance to seek out drugs-related projects for participation, perhaps in case this led to stigma being attached to their community. An alternative explanation of this reluctance may be that "Not all black people were over-excited by wanting to talk to the Project about developing services for drug users ... the majority of black people had other more worrying concerns such as high unemployment, ... poor housing and education" Patel 1993 :40). There is also a desire among many minority ethnic youth (most particularly Asian girls, perhaps accentuated by parental pressure) to attend culturally specific activities. The generation of a cadre of drugs-aware community workers who go on to work in community-generic projects and thereby infuse those activities with their drugs prevention knowledge will have a longer-term payoff analogous to the part-funding of workers in existing youth work.
Working to a plan

Following the development of agreed objectives and management structures, individual members and teams will find it helpful to have a suitable workplan against which to compare activity and progress. This should be structured in terms of those objectives:

Targets may include identification of communities in terms of Geography (specific areas), Settings (users of particular facilities), Community (perhaps based around a common cultural identity), Age or Status (as in definition of at risk groups), or explicitly intended to be inclusive. We have noted earlier the problems associated with some of these.

Wherever possible, the administrative procedures for grant application and management should be simplified. They are necessary, and can provide groups with a framework to design and guide their projects, but should not demand impossible levels of administrative competence or be rigidly enforced.

Timescales for projects should be associated with activities and objectives, even if interpreted sympathetically to take account of unforeseen circumstances.

Performance Indicators or agreed programme milestones should be formulated at an early stage.

Producing appropriate materials

Greatest impact is achieved by materials (whether posters, leaflets, audio-visual media or T-shirts) that enable sections of the public to identify with them. This is inherent in the production of youth materials but should be more widely considered.

Translation of leaflets into the languages of minority groups may not necessarily be essential, in terms of literacy, but supplies immediate visual evidence of the team’s awareness of the group’s existence. The written languages of many ethnic minorities use distinctive scripts - such as Devanagri (Hindi) or Gurmukhi (Sikh Punjabi), and Muslims prefer to use decorative forms of the cursive Arabic script in place of pictures. A handbook by Collins, Tank & Basith (1993) contains examples and useful additional information.

Provision of simultaneous translation (i.e. parallel texts) in leaflets (or on posters) makes the material of double or greater value, since not only is it accessible to those literate in Welsh, Hindi, etc: it can be shared by family members and used to provoke discussion or for the teaching of the language to younger people.

Good Practice: with Drugs Prevention Initiative funding, the translated leaflets published by the Institute for the Study of Drug Dependence have been made widely available with a Drugs Prevention Initiative logo: these carry a dual text with the minority language on the top of each page duplicated in English below.

There are other sources of ready-translated texts: for example, HIV/AIDS and accident prevention workers have used Hong Kong produced Chinese materials which are readily acceptable to British Chinese families, many of whom maintain strong links with Hong Kong.
Good Practice: support for local teams was made available through the central organisation of a specialist Non English Language Materials group. This helped to gather, collate, analyse and share information and produce guidelines on materials in languages other than English. The group recognised the needs of Welsh and other European language speakers, and others facing communication barriers through deafness, blindness and literacy problems. Collaboration led to the development of agreed principles, ways of minimising production costs, and sharing of information as well as support for the Institute for the Study of Drug Dependence leaflets and distribution of other types and sources of material.

The physical environment of an office itself can send important messages to visitors. This will require attention to the type of building as well as its location. Attention also needs to be paid to the layout of the office, the posters and other decoration, and external notices.

Good Practice was hard to find here as teams were heavily constrained by the lettings policy of their sponsor and landlords. Many had been unable, or restricted in their ability, to advertise their presence at the entrance to buildings. The Wolverhampton team had developed an attractive display which included many pictures of minority groups and settings based on their supported community projects. This was set up on permanent exhibition in their offices.

**Evaluating outcomes**

All activities should incorporate a procedure for evaluation, as part of their development. This provides reassurance, prevents repetition of errors, and has a learning function for all involved which may be in itself a positive outcome. Good evaluation should not be threatening to participants. Design and implementation is itself a developmental process. Indeed, the setting of objectives which is crucial to evaluation, is also a part of the process of a well-run programme but it is frequently overlooked in the rush to be responsive or to meet deadlines! Few teams or projects had set up their own performance indicators or measurable milestones.

Ethnic Monitoring, which is a form of audit or evaluation when used properly and with a review process built into its planning, can be used successfully. It is now becoming widespread in health and social service provision, as well as in schools and colleges, and colleagues in these services may be able to assist in establishing appropriate targets or standard levels.

Good Practice: the Bradford team used a monitoring form for all their contacts and activities. This requires a conscious recording of information about users and enables analysis of ethnic, linguistic, gender and spatial dimensions of approaches made by users, and projects supported.

Methods and responsibilities should be agreed in advance of commencement of the work programme. It is important to be clear what is being evaluated, and not to imply that it is the organisation or minority group that is under scrutiny. Evaluation should follow principles that make it supportive and a joint learning process. Responsibility should be shared, or a mutually acceptable scrutineer who is agreed to be independent may be sought to conduct the exercise.

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A study from America describes the development of a community-based, ethnically matched programme of drug prevention work. This required collaboration between a community activist group and the police, who had "sharply divergent views and values". The ‘formative evaluation process’ attached to a pilot project provided the opportunity for debate and constructive criticism and played a significant role in the establishment of the final programme (Kaskutas 1992).

Good Practice: One team conducted an evaluation of a project that had been supported in its area. The community forum responsible, which was an alliance of over fifty groups, had no previous experience of supporting research. While concluding that the research study itself ‘had not been a success as is traditionally defined’, the evaluation was able to highlight successful elements to assist projects and give the participants greater confidence in the future. Sharing this with the forum facilitated the relationship between the team and the community groups, and validated some of the key messages that had been contained in the original. The most important broader insight was probably the need for greater professional (Community Drugs Team or drug-advisory) support for community-based workers who may have necessary access and insight to work locally, but little technical knowledge or awareness of danger. The community forum had never previously employed a worker, and also learned necessary management skills.

The objective of evaluation is to provide a review of both processes and targets in the light of prior and subsequent information. This may reveal that certain groups or objectives have been overlooked, or that earlier intentions were misplaced, and should be fed back into planning of future phases.

Community groups should be asked to set out their own objectives, so that these can be incorporated into the target setting process. They will be more supportive of recording, and enabled to learn from and apply the lessons of evaluation in their own activities as well as being better able to criticise the activity of statutory or established bodies.
5. A CHECKLIST OF GOOD PRACTICE

Gather information about the area before you start

Look at the statistical data on the presence of ethnic minority populations before you take any action

Use only reliable data - assess your sources and use grass-roots information wherever possible

Maintain your databases long term and be alert to trends and changes

Use existing networks for drug & alcohol prevention

Seek allies working with minority ethnic groups in other fields, such as health promotion and community work

Value those who play an active part in the community, but work with organisations rather than personalities

Look for ethnic minority-specific networks & structures

Give minority communities a share in management

Use the resources and skills available in minority communities

Make partnership real and avoid tokenism

Share information with colleagues and use their good ideas

Appreciate that good ideas may not be transferable to your local situation

Observe Equal Opportunity practice in employment

Give your staff the opportunity to develop the necessary competences to support the broader strategy through training

Ensure staff maintain continuous links with community projects to give them support as necessary

Be prepared to accept different perspectives, and act on them by committing resources

Remember that minority groups also share common interests with the majority and do not only have special needs

Set targets that reflect local needs and priorities

Monitor activity and evaluate it by agreed standards

Keep communities informed of all your activities
Ensure materials you use are appropriate and reflect diversity

Assert the value and integrity of diversity

BUT

Be prepared to make mistakes and learn from them
REFERENCES AND SELECTED BIBLIOGRAPHY


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