

Exploring community responses to drugs

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1 Introduction: the appeal of community

Although appeals to 'community' are far from new they have come to be made with increasing frequency. Over the last ten years or so, 'community' has become something of a policy buzzword which has been attached to a diverse range of ideas and initiatives (Crawford, 1999). The increased use of this term has been evident in the drugs and alcohol fields. 'Communities' provide one of the four key elements of the national drugs strategy and, according to the Prime Minister, Tony Blair (Central Drugs Coordination Unit, 1998, p. 1):

This strategy is an important step forward in developing a cooperative approach. But the fight is not just for the Government. It is for teachers, parents, community groups, those working in the field and everyone who cares about the future of our society. We owe it to our children to come up with a truly imaginative solution and create the better Britain they deserve.

In reality, however, attempts to include the wider community in drugs and alcohol policy are in their infancy and various factors have been identified which militate against such involvement. According to a recent article which appeared in *Druglink*,¹ one of the main problems to be faced is how to build an effective framework for community engagement (McIntyre, 2003). If community involvement in drugs initiatives is to become more effective and transparent, it suggests, the following questions will have to be answered.

- What defines a community?
- How are communities identified?
- Which sections of the community are engaged?

- What are the processes by which they become involved in particular programmes?
- How much power will they actually possess?

Defining community

One of the first questions to be addressed is what does the term 'community' mean. Although the answer may appear to be straightforward, it has been hotly disputed. Some critics have completely rejected the term on the basis that it is meaningless, while others have complained about the laziness with which it is sometimes used (for discussion see Crawford, 1999; McLaughlin, 2002). If the term 'community' cannot be defined then obvious difficulties flow from this. For all the work that is being carried out with communities, it has been suggested that 'nobody is quite sure of their exact location, except that they are based somewhere outside town halls, police stations and government offices' (McIntyre, 2003, p. 19).

Although references to 'community' are often vague, definitional difficulties have perhaps been overstated. General definitions have been developed which satisfactorily identify the core elements of the term. Communities are made up of associations or groups of people focused around certain interests, characteristics or identities – including lifestyle, culture, religion, ethnicity, sexuality, occupation, place of residence and so on – and are based on relationships of friendship and care (Wilmott, 1984; Hoggett, 1998; Crawford, 1999; Rose, 1999). Far from being meaningless, 'community' describes a form of social

organisation which is treated as real by a great many people and exercises a strong emotional pull (Crawford, 1999). This was evident from the preliminary interviews conducted as part of this study. When asked to define 'community', interviewees tended to talk about its ambiguous and contested nature and yet, when asked which communities they belonged to, talked in fairly concrete terms:

What does community mean? Right, so there's the technical, multiple definitions that academics come out with and then there's the notional, emotional, definition. All the practical definitions I use in my everyday work are to do with communities of similarity – all the basic stuff, we all drum together, we all eat in the same place, work in the same place, we have a shared experience that we draw on ... then there's the romantic or romanticised definition of community and it's that community that I refer to when I say I belong to the black community. It doesn't stand up to scrutiny but it exists none the less and it's emotional.

(Drug service manager, London)

None of this should be taken to imply that involving communities in public policy is straightforward. Considerable difficulties have been identified in this area and it is these that we now turn to.

Working with community

There is a very extensive literature on community engagement and some key themes were identified which helped to shape this study as it progressed. Recent political developments have been strongly influenced by

the idea that the state is no longer able to meet all society's needs for order, security, health and productivity and should no longer be responsible for doing so. With this shift, the idea of the welfare state is giving way to the idea of the facilitating state or the enabling state. The community – in the form of individuals, firms, organisations, localities, schools, parents, hospitals, housing estates – is expected to provide 'partners' in the process of government and take greater responsibility for meeting society's needs (Rose, 1999). However, some critics have argued that, for all the talk of devolution and partnerships, power continues to be centralised and channelled through bureaucratic structures and local professional networks. Power relationships, they suggest, are often ignored within such structures and little, if any, recognition is given to differences between partners (Crawford, 2001; Newburn, 2003).

Studies of local partnerships have raised concerns about the use and abuse of the term 'community' (see, for example, Crawford, 2001). According to some critics 'community' is a romanticised notion which may be used cynically to create an illusory image of harmony and consensus. Stanley Cohen (1985) has argued that because the term 'community' is free of negative connotations, it can be used to justify almost anything and is often used to repackage and justify existing practices which may have become widely discredited. It has often been suggested that the term 'community' is used simply to provide 'window dressing' and to elicit support, without meaning anything substantial about the way in which an initiative is implemented. In this context, two questions become key.

- What is it that the community is being engaged to do?
- Which communities are being engaged?

These questions came to prominence in the United States during the late 1960s and early 1970s. ‘Citizen participation’ provided a key impetus for community work during this period and was based on the idea that communities are best served when every citizen participates directly in making decisions that affect them. In an influential review of this approach, Sheri Arnstein (1969, p. 216) declared:

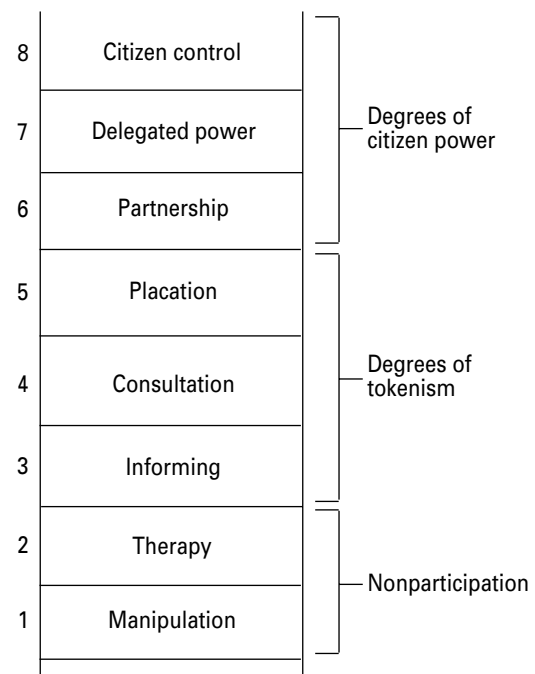
The idea of citizen participation is a little like eating spinach: no one is against it in principle because it is good for you. Participation of the governed in their government is, in theory, the cornerstone of democracy – a revered idea that is vigorously applauded by virtually everyone. The applause is reduced to polite handclaps, however, when this principle is advocated by the have not blacks, Mexicans, Puerto Ricans, Indians, Eskimos, and whites. And when the have-nots define participation as a redistribution of power, the American consensus on the fundamental principle explodes into many shades of outright racial, ethnic, ideological, and political opposition.

According to Arnstein, citizen participation is often an empty ritual because it does not involve a redistribution of power. In illustrating this point, she developed a ladder of participation which progressed from manipulation, where the real aim is ‘education’ or ‘cure’, through to citizen control, where ‘have not citizens’ obtain the majority of decision-making seats or full managerial power (see Figure 1). According to Arnstein it is only at the level of placation that citizens begin to have

some degree of influence although tokenism is still apparent. While consultation can provide a legitimate step toward full participation, it remains just a ‘window-dressing ritual’ unless it is combined with other modes of participation. At the level of partnership, power is redistributed through negotiation and trade-offs between citizens and power holders.

In Britain, concerns have been raised about the way in which some groups tend to be excluded from community partnerships. Adam Crawford (1999) has argued that the ability of some interest groups to organise around and define certain issues is of crucial importance in attaining a voice and that the exclusion of disorganised interests is felt particularly sharply by those who are already politically marginalised and socially disadvantaged: i.e. the unemployed, the homeless, black people,

Figure 1 Arnstein’s ladder of citizen participation



young people etc. Because of these processes of exclusion, 'community' is often used in ways which reflect the values and interests of powerful social groups. According to Nikolas Rose (1999, p. 476), British communitarian thinking has taken on an explicitly Christian character which ignores important social tensions, including those based on 'race', sex and social class: as a result a 'single set of moral principles are proclaimed as if they were self-evidently universal and applicable to all communities of reason and rectitude'.

Because of such concerns, considerable attention has been given to the ways in which community involvement may be made meaningful. According to Crawford (1999), community initiatives must make it clear how they come to know what the community wants and, as part of this process, they must engage with the inherent difficulties associated with the aim of genuine representativeness. Similar concerns were raised by recent research into community-based restorative justice programmes in Northern Ireland. This research focused on the idea of legitimacy and identified seven essential elements which provide the basis for claiming that the programmes are genuinely community-based (Mika and McEvoy, 2001).

- *Mandate* is the broadly based licence for the programme and may be secured through research/audit to ascertain needs and resources and through local consultation.
- *Moral authority* refers to the basis upon which the community accepts and recognises the power and authority of the

programme. It is said to grow out of genuine and diverse participation of all segments of local communities and, in the context of Northern Ireland, involvement of ex-prisoners and ex-combatants was considered to be highly suggestive of moral authority.

- *Partnership* is the sense in which the initiative emanates from the community, empowering and building capacity, applying local resources to the ends of antisocial crime control and prevention, addressing the needs of victims and offenders and working constructively with other community groups, associations and organisations.
- *Competence* involves the deliberate and long-term development of appropriate skills among individuals and organisations and includes training opportunities etc.
- *Practice* involves the establishment of standards for justice processes, protection of participants and responsiveness to the community.
- *Transparency* requires mechanisms for public scrutiny, local management and control and opportunities for public input.
- *Accountability* refers to ongoing programme monitoring and evaluation to ascertain compliance with published standards as well as programme impact and effectiveness.

The place of community in the national drugs strategy

In the context of official drugs policy, the notion of community has been strongly linked to well-established concerns about law enforcement.² The communities element of the national drugs strategy is dominated by a variety of criminal justice-led initiatives, which aim 'to protect our communities from drug-related antisocial and criminal behaviour' (Central Drugs Coordination Unit, 1998, p. 3). Some of these initiatives have been considered 'innovative', including arrest referral schemes and Drug Treatment and Testing Orders, although traditional policing activities predominate. Police-led efforts to disrupt drugs markets are central to this element of the strategy and considerable emphasis is placed on 'promoting effective action by the police, and other partners, to drive out dealing and drug markets' (Drugs Strategy Directorate, 2002, p. 38). A similar orientation is evident in the Communities Against Drugs (CADs) initiative which was introduced in 2001 as part of the ongoing 'war' against drugs. More than £200 million was set aside to disrupt drugs markets, tackle drug-related crime and strengthen communities. This money has been used to fund high-visibility policing, anti-drugs education and action to tackle drug-related antisocial behaviour (Drugs Strategy Directorate, 2001a).

Both the communities element of the national strategy and the CADs initiative give a leading role to the police, the prison and probation services supported by other key partners including housing and the employment service. Despite the emphasis that

is placed on locally defined solutions, official policy is driven by central government in the form of the national drugs strategy and is implemented / managed by Drug Action Teams and Crime Reduction Partnerships.³ While some emphasis is placed on wider community involvement, such involvement must be consistent with the aims and structures laid out by official policy. Within this context, attempts at wider community engagement have tended to focus on the 'moral' community. Local partnerships have been developed through CADs, for example, based on investment in residents' and community groups to provide information about drug supply and to build up a dialogue with the police and other agencies (Drugs Strategy Directorate, 2001b).

Aims and methods of the research

Very little research has been conducted into community responses to drug and alcohol issues (but see Duke *et al.*, 1996; Hastings *et al.*, 1996). Our study aimed therefore to shed light on the processes by which local communities may be involved in the drugs and alcohol fields. In seeking to fulfil this overall aim, we sought to:

- 1 provide an overview of community responses to drug and alcohol use
- 2 begin an in-depth account of the development of community responses to substance-related problems
- 3 identify facilitating and inhibiting factors to effective community responses
- 4 provide examples of promising approaches.

The study was based on a survey and a small number of case studies. Because of the exploratory nature of this study, preliminary interviews were conducted with seven key informants prior to the survey in order to identify the key issues to be covered. The main aim of the survey was to identify community responses, map their key characteristics and consider the influences on their success or failure. Alongside these areas, consideration was also given to respondents' attitudes to the role of community in the drugs and alcohol fields. The survey covered a representative sample of 37 Drug and Alcohol Action Team (DAAT) areas in England and Wales and was administered mainly over the telephone.⁴ Although a structured questionnaire was used, respondents were also encouraged to expand on their answers and their additional comments were noted. Within each area, DAAT co-ordinators provided the first point of contact and a wider sample was generated through 'snowballing' techniques.⁵ Responses were received from 34 of the 37 areas and a total of 155 people participated in the survey, at an average of just under five per area. Most survey respondents had some kind of professional involvement in the drug and alcohol fields and less than one in ten described themselves as community activists or volunteers (see Appendix 2 for details).⁶

The case studies focused on specific projects rather than geographical areas and provided an opportunity for a more detailed consideration of the issues that emerged from the survey. This element of the study was conducted in three

areas selected on the basis of the survey returns. Attempts were made to cover a reasonable geographic spread and include different types of community and community response, although these concerns had to be balanced by practical considerations: one of the case studies was conducted in a London borough, one was conducted in a suburban borough in south east England and the other was conducted in a northern city. The case studies were based principally on qualitative interviews with key stakeholders. Across the three areas, 47 interviews were conducted with professionals involved in the development of local drugs strategies, community workers, other professionals, volunteers from the local community and local residents. In addition, members of the research team organised a group discussion with community volunteers in one of the areas, attended relevant meetings and collected relevant reports. For each area we aimed to develop a detailed account of the response, its organisation and its history; locate the response within the broader drugs strategy for the area; and, as far as possible, assess local reactions to the response. Further details about the fieldwork are provided in Appendix 2.

Although this study set out to examine issues relating to drugs and alcohol the community initiatives that were identified were primarily concerned with drugs. The apparent lack of alcohol-focused work may reflect the route that we took into local communities, starting with the DAATs, but there was also some evidence that it was driven by funding priorities.

2 Professionals and the community

Interviews with key informants highlighted the importance of relationships between professionals and the wider community and this provided a key focus for both the survey and the case studies. The survey examined respondents' attitudes to community involvement in the drugs and alcohol fields and sought to identify the key characteristics of community responses in these areas. It also began to consider the factors associated with success and failure. The vast majority of survey respondents were either working directly in the drugs and alcohol fields or in some other related area (e.g. housing, nursing or policing). Slightly more than one in five were youth and/or community workers, including a small number of community activists, or were employed in some other community-focused role (e.g. community health development officers and community safety co-ordinators). The results of the survey are discussed below in relation to three main themes: attitudes to the role of community; the nature of community responses; and the perceived effectiveness of community involvement.

Attitudes to the role of community

How should communities be involved? What should they be expected to do? How much power should they be given? What role should professionals be given? These are just some of the questions that arise from the apparently simple idea of involving communities in public policy and they highlight the issue of governance. According to professionalised models of governance, policy and practice are considered to be the responsibility and realm of trained professionals and there is little room for

involvement of individuals outside of these professional circles. Alternatively, it is sometimes argued that initiatives should be 'community led': that is, the aims, methods and practices should be selected by the community and professional involvement should be facilitative rather than directive. There is, of course, considerable room for manoeuvre between these extremes as professional groups may develop structures to facilitate joint working with the community. Under these circumstances important questions arise about the limits and purpose of community involvement. Is the community viewed as simply having a sensitising role and as fitting into a structure which is largely set by professionals or does its role extend to decision making and accountability?

The perceived role of community

Respondents to the survey were presented with a series of statements about what the role of community should be in the drugs and alcohol fields and about the strengths and weaknesses of community involvement. They were asked to agree or disagree with each statement. The statements and the responses they elicited are shown in Table 1.

Widespread support for community involvement was evident, particularly in the form of consultation. The vast majority of respondents agreed that the community should be consulted about what services are doing. This reflected a fairly widely held belief that members of a community are best placed to identify their own needs. Similar sentiments were evident in the more extreme, and somewhat less widely held, view that professionals do not really know what the

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Table 1 The perceived role of community (%)

	Disagree strongly (-2)	Disagree (-1)	Neither/ nor (0)	Agree (1)	Agree strongly (2)	Do not know (-)	Mean score ^a
Communities should be consulted about what services are doing	*	1	2	41	55	*	1.5
To be done properly, community-based work takes up a lot of time and resources	0	5	5	33	56	1	1.4
Greater investment should be made in developing community initiatives in the drugs and alcohol fields	0	1	7	49	42	*	1.3
Communities have the right to expect that their needs will be met by those who are paid to provide services	2	9	11	51	27	0	0.9
Members of a community are best placed to know what that community needs	1	13	25	43	16	2	0.6
There is a lot of talk about community action but the system works against it	2	21	18	43	14	3	0.5
'Community' is just one of those buzzwords people use without really thinking about what it means	7	20	10	49	15	0	0.5
Services should be led by what the community wants them to do	3	28	30	28	10	*	0.1
Community responses ensure the interests of marginalised groups are taken into account	9	35	18	23	13	2	0.0
Professionals don't really know what the community needs	5	45	20	23	7	0	-0.2
People with drug and/or alcohol problems need to be protected from the community	11	51	23	11	1	3	-0.6
Work with people who have drug and/or alcohol problems should be left to professionals	20	48	19	9	3	*	-0.7
Professionals should not interfere with whatever it is that communities want to do	16	60	16	3	1	3	-0.9

* = <1

n = 150-154

^a The mean score is based on the numeric codes which denoted the response categories and which are shown in brackets e.g. disagree strongly was denoted by the value -2.

community needs. Support for community involvement was not limited to the role of consultation, as more than two-thirds of respondents rejected the suggestion that work with people who have drug/alcohol problems should be left to professionals.

Although there was widespread support for community involvement, respondents highlighted a number of difficulties which they felt such approaches generated. While some of these difficulties were related to the nature of community, others focused on the risks that community involvement might pose. Respondents felt that community consultation exercises tend to be dominated by specific interest groups and this reflected concerns about the divided nature of communities and the unrepresentative nature of community 'representatives'. Such concerns were apparent from the ambivalence that respondents showed to the suggestion that community responses ensure that the interests of marginalised groups are taken into account (see Table 1):

A lot of the stuff on community involvement assumes that communities always want to do the right thing. A few people who stand up in a meeting and say we represent the community, and I've seen this a lot with black groups, and the more you think about it the more you think, well who do you represent other than yourself – what is your constituency?

(Drug/alcohol service manager)

Communities can represent the interests of marginalised groups but again it depends if they're inclusive. Usually they take account of the strongest members of the community, not necessarily the smaller groups, the loudest voice is always heard.

(Service commissioner)

Particular concerns were expressed about the influence of reactionary elements of the community and the likely demand for punitive responses. Such anxieties often focused on the dangers of vigilantism, although there was little support for the suggestion that people with drug/alcohol problems need to be protected from the community (see Table 1). The emphasis that was placed on popular punitiveness and vigilantism appeared, in part, to reflect an underlying sense of unease about the possible loss of professional autonomy. Even where punitive responses were not anticipated, for example, concerns were expressed about the type of initiatives that communities might favour:

I've had experiences where they've said this is definitely what we want and I know from experience and research that it's a really shite idea. The example was a group that wanted a drug rehab in the area for black and minority ethnic users but they wouldn't use it because they don't want to be seen as drug users and don't want to be known in their area. I'm for consultation and it shouldn't just ask and ignore what people say, which happens a lot but there can be difficulties with it.

(Drug/alcohol service manager)

The idea that community involvement poses risks to professional autonomy raises fundamental questions about responsibility and power. The vast majority of respondents emphasised the importance of professional responsibility. This was reflected in widespread support for the welfare principle, whereby communities have the right to expect that their needs will be met by those who are paid to provide services (see Table 1). While

respondents were fairly evenly divided over whether services should be led by what the community wants, they quite clearly rejected the suggestion that the community should be left to do what it wants without professional ‘interference’ (see Table 1). In seeking to reconcile the principles of professional responsibility and community involvement, many respondents focused on the notion of ‘partnership’. For some, this meant professionals providing a ‘safety net’:

It's difficult because often the community has that 'not in my back door' mentality and that would skew what we would normally do. In communities we have to accept that there is a massive prejudice against drug users. I'm in favour of community involvement but there need to be protective mechanisms put in place.
(DAAT co-ordinator)

If they say they want to lock up all drug users or run all drunks out of town well you can't do that. Community views are part of what's needed but they need to be filtered by professional opinion.
(Drug/alcohol service manager)

For others, partnership meant rethinking the way in which professional power is exercised. Specific concerns were raised about the way that professional decision-making processes exclude communities:

Health and social services planners often talk their own language and tend to plan based on what they already know. There's talk about including communities but the way that decisions are made excludes them, almost unconsciously.
(Drug/alcohol service manager)

And this reflected the broader issue of tokenism. Most respondents agreed that while

there is a lot of talk about community action, the system works against it and most also agreed that ‘community’ is just one of those buzzwords people use without really thinking about what it means. Similar concerns were reflected in relation to resources, with the vast majority of respondents agreeing that community work requires considerable time and resources if it is to be done properly:

A lot of things fall down because of a lack of time and money, it's about tokenism. We all say we involve the community and then we go and do these tokenistic things – public meetings and consultation – but we don't go through a process where we educate the community, we don't think in terms of long-term investment to make the community more effective.
(DAAT co-ordinator)

The ‘appropriateness’ of community involvement

Survey respondents were asked how appropriate they felt community involvement was in relation to a variety of activities and areas of work. Their responses are summarised in Table 2 and, in many ways, confirm and clarify the patterns described above. The principle of community involvement was generally well supported and there was little evidence of outright opposition. At worst, the overall judgement appeared to be that community involvement was, or was close to being, ‘fairly appropriate’ in any given activity or area. Quite marked variations were evident across the range of activities and areas, however, and these variations showed that support for community involvement was limited in some very significant ways.

Table 2 'Appropriateness' of community involvement (%)

	Not at all appropriate (0)	Fairly appropriate (1)	Very appropriate (2)	Do not know (-)	Mean score
<i>Activities</i>					
Consultation about development of services/initiatives	*	23	77	*	1.8
Delivery of services/initiatives	3	62	35	*	1.3
Evaluation of services/initiatives	6	37	55	3	1.5
Fundraising for services/initiatives	12	44	41	4	1.3
Management of services/initiatives	18	61	16	5	1
Commissioning services/initiatives	21	52	22	5	1
<i>Areas of work</i>					
Education/prevention	1	34	64	*	1.6
Diversionary activities	3	33	64	*	1.6
Support for users and family/friends	5	27	67	1	1.6
Campaigning	3	34	59	5	1.6
Aftercare and relapse prevention	15	44	37	4	1.2
Law enforcement	37	38	18	7	0.8
Delivery of treatment	37	43	14	7	0.7

* = <1 n = 150-154

- Consultation was considered to be most appropriate for community involvement.
- Management and commissioning were considered to be the least appropriate.
- Fundraising and delivery of services were in an intermediate position.

The ambivalence that was evident in relation to fundraising reflected the widely held view that the state should be responsible for providing services. A similar judgement was evident in relation to the delivery of services which, many respondents felt, required professionalism. The influence of such judgements was apparent from the way that respondents' attitudes varied according to the different areas of work. Support for community

involvement was strongest in relation to those areas which are less tightly professionalised such as drug education/prevention, diversionary activities, support for users, family and friends, and campaigning. Much greater ambivalence was evident in relation to other areas, which reflected a respect for professional expertise and an emphasis on professional responsibility:

It depends what you mean by treatment – it's certainly appropriate in terms of rehab and supporting people back into work and the community but if you're talking about formal medicalised treatment it's difficult because there's expertise involved.

(Drug/alcohol service manager)

Support for community involvement was weakest in relation to the delivery of treatment, while the medical dimension of aftercare and relapse prevention helps to explain the ambivalence that was evident in relation to this area of work. Although there was some support for the idea that the community may act as the ‘eyes and ears’ of the police, respondents tended to be wary of over-involvement in this arena as they felt that law enforcement was rightly the responsibility of the police and the courts and were loath to encourage vigilante-type action.

These findings point to a consistent pattern. While there was widespread support for the general principle of community involvement, such support fragmented and dissipated at the suggestion of reduced professional power/ autonomy. Thus community involvement was least widely supported in relation to those areas of work that are most tightly professionalised and those activities which involve most decision-making power. Overall, then, respondents favoured a sensitising and gap-filling role for the community which could be easily integrated into a professionally structured framework.

Competing visions of community involvement

Respondents’ attitudes to the role of community varied markedly according to the nature of their involvement in the drug and/or alcohol fields. As an initial step, the individual statements about community involvement were grouped together based on their underlying factors (see Table A3.1, Appendix 3). Four factors were identified – a pro-community factor, a tokenism factor, a resources factor and a welfare factor.

The most striking differences were evident between service commissioners, planners and policy makers on the one hand and youth and/or community workers on the other (see Table A3.2, Appendix 3).

- Youth and/or community workers were, by some distance, the strongest supporters of community involvement. They were also among the strongest supporters of the welfare principle although they tended to be fairly ambivalent in this regard. Strong support for community involvement and moderate support for state provision may be understood in terms of a ‘community rights’ perspective. According to this perspective the community has the right to be extensively involved in public policy but also has the right not to be involved. A broadly similar perspective was shown by drug/alcohol workers and those in other community-related positions.
- Commissioners, planners and policy makers tended to be ambivalent about community involvement and the welfare principle. They were, in addition, less worried than youth and/or community workers about tokenism and were less convinced of the need for resources. This combination may be understood in terms of a ‘community as resource’ perspective, according to which the community should not rely on the state to meet its needs but should be actively involved in ways which are largely defined by the state.

A similar pattern was evident in relation to the perceived appropriateness of community involvement (see Table 3). While there was broad agreement that community consultation was highly appropriate, marked differences of opinion were evident in relation to other types of activity. Youth/community workers consistently favoured much more extensive community involvement than did respondents in any of the other categories. They were, for example, two-and-a-half times as likely as commissioners, planners or policy makers to support community involvement in management and three-and-a-half times as likely to support community involvement in commissioning.

These different conceptions of power are likely to cause tensions in any attempts at partnership working, and it is notable that those with greatest responsibility for the development of local strategy (i.e. commissioners and policy makers) strongly favoured a 'sensitising' role for the community. It follows from this that, in practice, there are likely to be limited opportunities for what Arnstein (1969) described as 'genuine participation'.

The nature of community responses

Four-fifths (80 per cent) of survey respondents identified a community response to drugs and alcohol in their area and, on average, they described three such responses. In order to develop a detailed profile, respondents were asked a range of questions about the community response that they knew best and these questions focused on the nature of the activities that responses were involved in and the nature of community involvement.

Area of work and type of activity

Illicit drugs provided a far more substantial focus for community responses than did alcohol: 81 per cent of the responses identified by respondents had a strong focus on drugs compared with 31 per cent with a strong focus on alcohol. In those cases where alcohol provided a strong focus, it tended to be part of a broader focus which included drugs. Almost all (91 per cent) of the initiatives which had a strong focus on alcohol also had a strong focus on drugs. The case study work indicated that the dominance of illicit drugs was in part, at

Table 3 'Appropriateness' of community involvement by nature of involvement in drugs and/or alcohol fields (% who considered community involvement to be 'very appropriate')

	Consultation	Delivery	Evaluation	Management	Commissioning	<i>n</i>
Service commissioner, planner or policy maker	79	24	55	14	14	42
Drug/alcohol worker	70	41	48	30	15	27
Youth/community worker	81	67	81	33	48	21
Other – community related	92	17	33	8	17	12
Other	72	30	52	6	22	49
All	77	34	55	16	22	151

least, driven by national policy and reflected particular difficulties securing funding for alcohol-focused work (see Chapter 3).

The activities that community responses tended to be involved in broadly reflected respondents' attitudes to the appropriateness of community involvement. Less tightly professionalised areas of work provided the most frequent focus for community responses and, notably, there was relatively little evidence of involvement in law enforcement.

- 65 per cent of respondents identified responses with a focus on education and prevention.
- 60 per cent identified responses with a focus on support for users, family and friends.
- 53 per cent identified responses with a focus on diversionary activities.
- 41 per cent identified responses with a focus on treatment.
- 40 per cent identified responses with a focus on aftercare and relapse prevention.
- 36 per cent identified responses with a focus on campaigning.
- 26 per cent identified responses with a focus on law enforcement.
- 18 per cent identified responses with a focus on some other area.

The activities that initiatives tended to be involved in were reflected in the groups on which they focused. Young people provided one of the main focuses for community responses (65 per cent of responses included such a focus)

and this reflected the emphasis on education, prevention and diversionary activities. Drug users/people with drug problems and family/friends of people with drug/alcohol problems also provided a common focus (70 per cent and 51 per cent focused on these groups respectively) and this reflected the emphasis on support, treatment and aftercare/relapse prevention. Conversely, people who sell drugs provided a relatively unusual focus for community responses (only 23 per cent of initiatives included such a focus) and this reflected the weak orientation towards community involvement in law enforcement.

Nature of community involvement

Assessing the nature of community involvement is a difficult and delicate task. According to Cohen (1985, p. 160), analysts 'who mount research projects to determine whether an agency is "in the community" or not should know that they are busy with magic, not science'. Our attempts to quantify the nature of community involvement focused on the following dimensions:

- location of the response
- involvement of paid professionals and unpaid volunteers
- governance arrangements and the role of the community in decision making
- involvement in partnerships
- funding arrangements.

In the first instance, respondents were asked what it was about the initiative they identified that made it a community response. Their answers indicated that community involvement

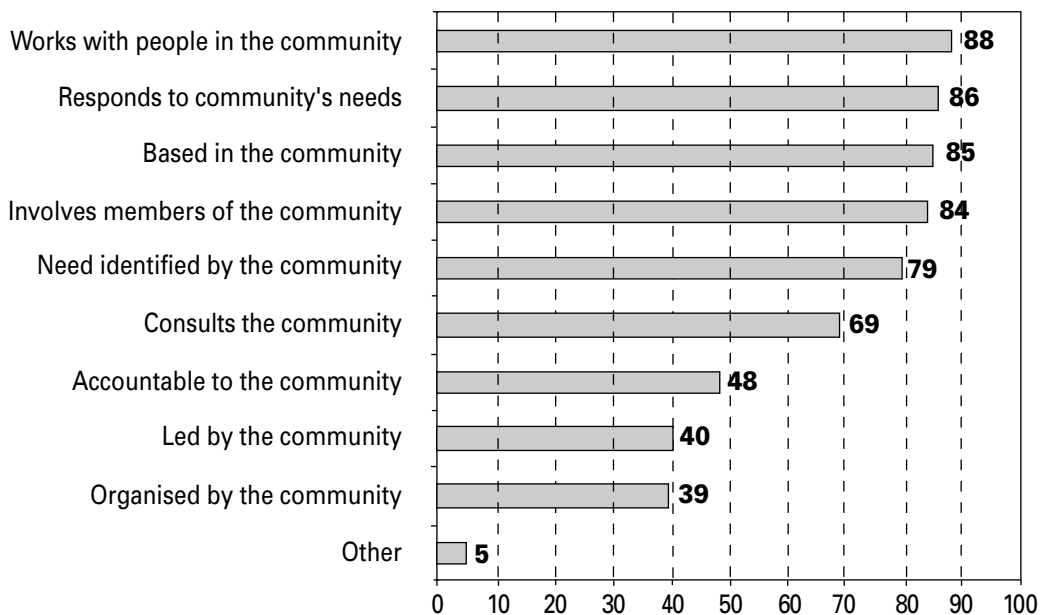
tended to take fairly passive and diluted forms (see Figure 2). While it was commonly asserted that these initiatives were located in the community and responded to the needs of the community, fewer than half of them were considered to be accountable to, led by, or organised by the community. This suggests a limited degree of community involvement in governance and formal decision making, which was confirmed by other elements of the survey. There was, for example, a clear trend towards informal community involvement. While more than two-thirds of the responses were said to consult the community, only half (52 per cent) appeared to have carried out a formal community consultation exercise. Other, less formal, forms of contact included outreach work (62 per cent), promotional events (59 per cent), public meetings (58 per cent) or some other

community-focused activity (32 per cent), including capacity building and support group meetings.

The initiatives identified by the survey were fairly evenly divided between those with a focus on a neighbourhood or ward and those with a focus on a borough or city (42 per cent and 40 per cent respectively, leaving 5 per cent with a national focus and 14 per cent with some other focus). While some of these responses were based in state institutions, such as schools and hospitals, others were based in more informal community settings.¹

- 34 per cent were based in a community project.
- 30 per cent had their own premises.
- 21 per cent were based in a drugs and/or alcohol agency.

Figure 2 The makings of a 'community' response (%)



n = 117

- 12 per cent were based in schools.
- 11 per cent were based in a youth project.
- 10 per cent were based in participants' homes.
- 9 per cent were based in a church or places of worship.
- 6 per cent were based in a GPs' surgery.
- 5 per cent were based in a tenants' / residents' association.
- 2 per cent were based in a hospital.
- 29 per cent were said to be based on outreach.

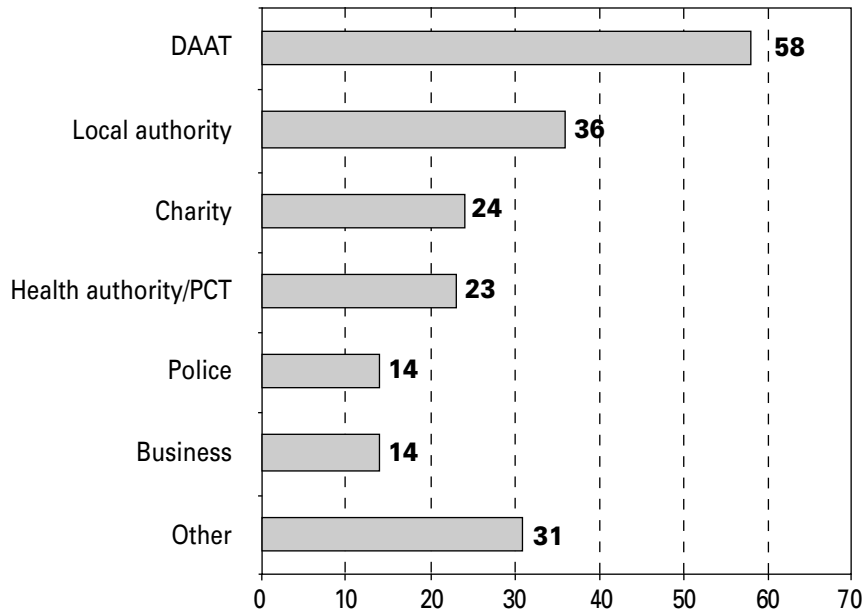
Relationships with professionals have been identified as a key dimension of community responses and it was clear that professional interests were well represented in the initiatives identified by respondents:

- *Professionals versus volunteers:* the vast majority (88 per cent) of initiatives rested on some degree of paid professional involvement and approximately half (49 per cent) were professional-led compared with slightly less than two-fifths (38 per cent) that were volunteer-led (the balance between volunteers and paid professionals was unclear in 13 per cent of cases).²
- *Management structures:* three-quarters (77 per cent) of the initiatives had a management committee or a steering group (14 per cent did not and in 9 per cent of cases respondents were unsure).

While there was evidence of widespread community involvement in these bodies, professionals in the field were the single most frequently represented category. Professional representation was evident in 76 per cent of cases where such structures existed, compared with 64 per cent for members of the community, 58 per cent for individuals from community organisations, 41 per cent for representatives of funding bodies, 39 per cent for staff representatives, 32 per cent for service users, 23 per cent for elected representatives (such as local councillors and school governors) and 20 per cent for people with drug/ alcohol problems.

- *Partnerships:* the vast majority of initiatives were working in partnership with at least one other agency and the most common partners were provided by professionally dominated bodies such as DAATs (71 per cent of initiatives were working in partnership with a DAAT), local authorities (60 per cent), the police (60 per cent) and the primary care trust/ health authority (51 per cent). Organisations with stronger roots in the community provided less common partners – other community projects (39 per cent), residents' /tenants' associations (32 per cent) and faith communities (27 per cent).
- *Funding:* nearly all of the initiatives received some form of funding and the prominence of statutory partners reflected their role as funders (see Figure 3).

Figure 3 Sources of funding for community responses



n = 111

A typology of community responses

The individual measures described above suggested that respondents included some very different types of initiative under the umbrella of ‘community response’. Community involvement appeared to be very passive in some initiatives but active in others; some initiatives were led by paid professionals, while others were led by unpaid volunteers; and some initiatives were based in state institutions, while others were located in less formal community settings. We felt that these variations probably reflected some fairly fundamental differences in orientation and were keen to consider how they fitted together. The initial analysis of the survey, supported by the qualitative fieldwork and the existing literature, generated a series of ideas which guided this more detailed analysis.

Drawing on these various sources, we developed the following typology of community responses.

- *Community outreach*: professionals who usually work from a central / institutional location may conduct ‘outreach’ work in the community. Such initiatives are based on expert knowledge, the aims are defined at the outset and there is little, if any, room for involvement of those outside the professional group. In this context the term ‘community’ is used to describe the location of work and, at its simplest, means that the initiative is not based in a (state) institution such as a hospital or a school.

- *Professional network*: within official policy discourse the term 'community' is used primarily to refer to professional networks made up of agencies which are responsible for co-ordinating efforts around the goals set by central government. DAATs and Community Safety Partnerships provide examples of such a structure. Based on expert knowledge and professionally defined codes and protocols, these networks often leave little room for involvement of those outside the professional group. The use of the term 'community' in this context may be considered little more than window dressing as such networks provide a framework within which well-established professional practice is presented. A slight variation is achieved when 'community representatives' are included in the network, although they are often given little more than a sensitising role as professional knowledge continues to be prioritised and strategic decision making continues to be the responsibility of professionals.
- *Community partnership*: where community members and professionals come together on a more or less equal footing, a community partnership is formed. Discrete forms of professional expertise are valued but are located within a broader set of parameters which reflect community views. Community members have genuine influence and are actively involved in decision-making processes.

- *Grass-roots community initiative*: a grass-roots community initiative may be created when members of a community come together over a particular issue which they consider important. The initiative unfolds as the group continues to meet and is not defined by professional interests although in time it may evolve into a community partnership. Examples of grass-roots initiatives include user/ carer support groups.

In seeking to apply these categories to the survey, they were defined by the following characteristics.

Community outreach programmes:

- depended totally or mainly on paid professionals
- were based in the community but were not organised or led by the community, and
- were based on outreach work.

Professional networks:

- depended totally or mainly on paid professionals
- worked in partnership with other professional agencies, and
- were not organised or led by the community.

Community partnerships:

- were based, in part, on the activities of paid professionals but depended mainly on the activities of unpaid volunteers, and
- were organised or led by the community.

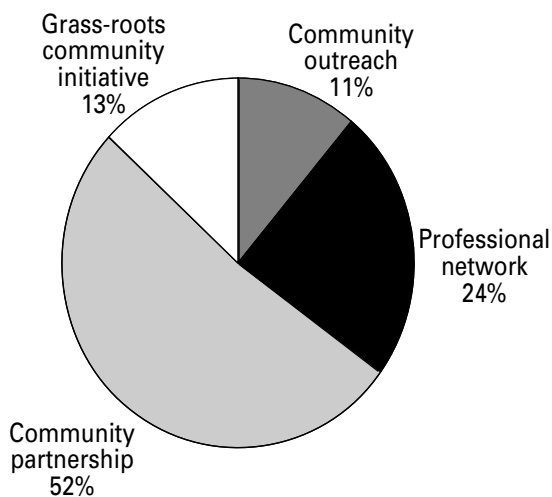
And grass-roots initiatives:

- did not depend at all on the activities of paid professionals, and
- were either led or organised by the community or depended totally on the activities of unpaid volunteers.

Approximately one in ten of the responses identified by the survey took the form of community outreach services and included, for example, a home-based detoxification programme (see Figure 4). All of the services in this category also met the criteria for a professional network and, in total, this type of response accounted for a little over a third of those identified by the survey: nearly three in four (71 per cent) of these networks were said to involve members of the community. Community partnerships made up the largest single category and accounted for slightly more than half of all responses. Grass-roots community initiatives, by contrast, were relatively unusual and accounted for approximately one in eight of the identified responses.

The ability to organise around particular interests requires resources and the relatively small number of grass-roots initiatives reflects the tensions that have been noted between ‘voluntariness’ and community (Crawford, 1999). Community action is often weakened because it is unable to mobilise resources above and beyond those which can be procured on a voluntary basis. Where grass-roots initiatives do get off the ground, moreover, they may seek funding in order to stabilise their positions and, with this move, they may evolve into community partnerships. These pressures were highlighted by a user/carer group which had

Figure 4 Type of community responses



n = 99

been offered, but refused, statutory funding on the grounds that it wanted to maintain its independence.

Grass-roots community initiatives had a very distinct profile in terms of the areas of work that they focused on and, once again, this appeared to reflect ideas about professionalism. While they were, by some distance, the most likely to focus on campaigning, they were the least likely to focus on the delivery of treatment and law enforcement. Grass-roots initiatives focused on campaigning at one-and-a-half times the rate of community partnerships and professional networks; on the delivery of treatment at a third of the rate of community partnerships and professional networks; and on law enforcement at half the rate of professional networks.³

The low level of grass-roots involvement in law enforcement is particularly noteworthy given the way in which official policy links the notion of community to crime/policing and

given the fears that respondents expressed about vigilantism. Only two out of the 13 grass-roots initiatives identified by the survey included a focus on law enforcement and they both did so alongside a range of other activities. In addition, the survey did not identify any cases of vigilante activity and, in the few instances where communities had mobilised against drug users and dealers, they appeared to have worked through official channels. One of the grass-roots responses included a focus on crime prevention/neighbourhood watch, for example, while another had 'reclaimed' a pub which had become a centre for drug-dealing activity and then went on to organise a petition against a proposal to open a drug treatment facility nearby.

Membership of community partnerships and professional networks

While community partnerships and, to a lesser extent, professional networks provide channels for community involvement, important questions arise about their membership. Disadvantaged and marginalised groups may find it difficult to access such structures because they lack the resources to organise around issues and influence agendas (Crawford, 1999). Even where they do organise, such groups may not be readily absorbed into existing structures. Partnerships and networks are shaped by important processes of inclusion and exclusion as illustrated by a recent Department of Health Community Engagement programme. The aim of this programme was to engage 'community/voluntary groups' in 'community-led needs assessment' and one of its specifications was that participating groups had to be willing to work with their local DAAT (University of

Central Lancashire, 2003). Such criteria may mean that radical or critical elements of the community are filtered out of the process and that those elements that are deemed to be 'acceptable' are selectively promoted at the expense of those that are deemed to be 'unacceptable'.

In this context it is worth noting that the involvement of users and carers in decision-making forums has not been a high priority in the drugs field (Mason, 2003).⁴ The survey highlighted some such involvement in management committees and advisory groups, but it was not evident equally across the different types of response. Overall, approximately one in three (31 per cent) of the community responses we identified had a management committee or steering group which included service users and/or people with drug and/or alcohol problems.⁵ However, community partnerships were approximately twice as likely to have developed such forms of representation as either professional networks or grass-roots initiatives (43 per cent compared with 24 per cent and 17 per cent respectively). The apparent lack of user involvement in grass-roots initiatives may reflect a limited capacity for self-organisation and/or a reluctance among commissioners to fund user-led initiatives. It may also reflect a degree of antagonism between drug users and the wider community. In addition, the absence of user representation from three-quarters of the professional networks says something significant about the way in which users' roles are generally defined. Where user and carer involvement was most central to what initiatives were doing it tended to take the form of self-help and support. Only rarely did it focus on influencing decision making among

commissioners and local policy makers. A small number of cases were identified where attempts were being made to increase the involvement of these groups in such decision-making forums but they were typically in the early stages of development and, from a professional perspective, were presented as a risk:

In bringing forward the opinions of service users about existing services and needs for new services, they [members of a user forum] have been listened to and services are being set up.

There was a willingness to take risks, to provide something relevant; it's about trusting and believing in people that they can do things for themselves. Collaboration with the DAT has been key and ... professionals have been very willing to involve service users and this has been a big plus point. It's a partnership thing really.

(Facilitator of a user forum)

'Effectiveness' of community involvement

Respondents' feelings about the effectiveness of community responses were explored in general terms and in relation to the specific community initiative that they identified. Marked differences were evident in these two areas of assessment. In general terms, respondents displayed considerable doubts about the effectiveness of community involvement and, on average, rated it as no more than fairly effective in any of the areas we identified (see Table A3.3 in Appendix 3). Community involvement was typically considered to be less effective than it was appropriate across a range of areas, except law enforcement where it tended to be rated as fairly appropriate and fairly effective. While community involvement

was widely supported as a principle, these judgements imply criticism of the way in which the principle is put into practice. Doubts about the effectiveness of community involvement often reflected beliefs that it is typically tokenistic. Community consultation was singled out for particular criticism in this regard as respondents expressed reservations about untargeted approaches, preferring instead a tighter focus on key stakeholders such as drug users, their families and friends:

The issue of community development in drugs and alcohol, in terms of getting people's involvement and commitment, you need to think hard about how and not just look at the bog standard community consultation. You need to work with small groups in informal settings who might otherwise be excluded. You can't just expect people to come to meetings because they've seen a flier and you can't treat those who turn up as being representative when they're obviously not. You need to work harder and explore the issues further than people often do.
(Member of Community Safety Team)

Respondents' assessments of particular community initiatives were considerably more favourable than their general assessments. None of them rated the specific initiative they identified as 'not at all effective' and almost equal numbers rated them as 'fairly' or 'very' effective (40 per cent and 41 per cent respectively, with 3 per cent unsure and 17 per cent indicating that it was too early to say). This poses the question, what was it about these initiatives which made them effective? In answering this question respondents identified several key themes, including:

- openness and commitment among professionals to the contribution of the community
- responsiveness to the needs of the community
- the delivery of concrete outcomes.

For those most directly involved in community work these ingredients were underpinned by a developmental focus based on capacity building and community involvement in decision making:

We start from where people are and not where other people think they are ... [and] we don't run away at the first problem ... Local people are the experts and should have a voice. A good proportion will say 'you should throw the whole lot of drug users in the river' and we'd look at that. They have to come to the conclusion that it's not realistic. We'd look at it – we'd ask them how many of the people they know have tried drugs, how would they feel about a person who had experimented with a spliff once being thrown in the river? It's a big difference coming to the conclusion that it's ridiculous rather than being told by a professional not to be ridiculous.
(Drug/alcohol service manager)

Conclusions

In considering the conclusions of this chapter, it is important to remember that the respondents to the survey were mainly professionals or others identified by professionals as being involved in community-based activities. These conclusions are of interest, however, because they highlight the views of those who are most directly involved in developing community involvement and partnership activities.

- The principle of community involvement was widely supported by survey respondents, although it was generally balanced by an emphasis on professional responsibility. Possible tensions between these two positions tended to be resolved through an emphasis on 'partnership'.
- Respondents identified a number of difficulties, or potential difficulties, with community involvement. Some of these difficulties were related to the nature of community (e.g. concerns about the unrepresentative nature of community 'representatives'), while others were based on the risks that community involvement might pose to professionals. Concerns were expressed about the dangers of popular punitiveness and vigilante-type responses and, more generally, about the potential loss of professional power and autonomy.
- Respondents also emphasised the dangers of involving the community in ways that are tokenistic. And the implications of these dangers were highlighted by judgements about the effectiveness of community involvement. Respondents' ratings of specific community responses tended to be much more positive than their general ratings and this reflected a belief that community involvement is often undermined by tokenism.
- In spite of these concerns about tokenism, many respondents sought to resolve the potential risks associated with community involvement by falling back

on models of engagement which give away little decision-making power to the community and within which community involvement is limited to a 'sensitising' and gap-filling role.

- Support for community involvement was strongest in relation to those areas of work that are least tightly professionalised (e.g. education/ prevention and campaigning) and was weakest in relation to those areas that are most strongly professionalised (such as treatment and law enforcement). In addition, while there was widespread support for community consultation, there was much less support for community involvement in management and commissioning.
- Attitudes to the role of community varied markedly according to the nature of respondents' involvement in the drugs and alcohol field. While community workers/activists favoured more active and extensive forms of community involvement, those in commissioning and policy-making roles tended to favour more passive and limited forms of engagement.
- Respondents' concerns about professionalism were reflected in the type of activities that community responses tended to focus on. The responses identified by the survey were most active in those areas of work that are least tightly professionalised and were least active in those areas that are most tightly professionalised. While there was

considerable evidence of community involvement in education and prevention, for example, there was much less evidence of community involvement in law enforcement.

- Very different types of initiative were included under the umbrella of 'community response'. The most common response took the form of community partnerships, which accounted for slightly more than half the total. While such responses depended, in part, on the activities of professionals, they appeared to involve a genuine degree of power sharing with the wider community. Grass-roots initiatives also provided the basis for active forms of community involvement, although they were fairly unusual. Elsewhere, the term 'community' was used to describe less active forms of community involvement. Approximately one in ten of the responses were professionally led outreach services and, in this context, the term 'community' appeared to describe little more than the location of the service (i.e. it was not based in an institution). A further one in four responses took the form of professional networks, which involved the community in fairly passive ways if at all.
- While community partnerships and, to a lesser extent, professional networks provide channels for community involvement, important questions arise about their membership. There was, for example, little evidence that users and

Exploring community responses to drugs

carers were being included in strategic decision-making structures. Although a third of the initiatives could point to user involvement in management committees

and steering groups, such involvement tended to be concentrated in community partnerships and was much less evident in professional networks.

3 Involving communities

In the previous chapter, based on the survey, we identified the relationship between professionals and the wider community as a key dimension of community responses.

Community involvement was most commonly facilitated through partnerships with professionals and, to a lesser extent, through involvement in professional networks. The extent to which power was shared with the community was also identified as a key dimension and a range of potentially competing influences were identified. Support for the principle of community involvement was balanced by an emphasis on professional responsibility, while concerns about tokenism were matched by unease about the possible loss of professional power and autonomy. The projects selected as case studies provided an opportunity to explore these issues in greater depth and are discussed on the basis of the following dimensions and themes:

- their location
- the nature of the response
- the nature of professional involvement
- partnership as risk and trust
- community responses and community values
- legitimacy and the construction of 'community'
- the dynamic nature of community involvement.

While the first and second of these dimensions/themes are primarily descriptive, those that follow are essentially analytical: that is, they provide the basis for classifying

community responses and understanding the way in which they unfold.

The location of the case study responses

The case studies were undertaken in three DAAT areas – London Town, Suburban Town and Northern Town – and were tightly focused on a small number of initiatives. Considerable care was taken to establish the local policy context in each area although this did not amount to a detailed inventory of community involvement and we did not attempt to provide a comprehensive overview of the approach adopted by each DAAT. Initiatives were selected for the case studies on the grounds that they offered examples of different approaches, in markedly different types of community, and because, in some instances, considerable thought had been given to how the community might be involved.

London Town is located in the north of the capital and is among the ten most deprived boroughs in the city, although it divides into two distinct parts. The west of the borough contains high-status residential districts and 'village-like' shopping. There is very little unemployment and residents are relatively affluent. The east side contains areas of marked deprivation which have endured high levels of unemployment over many years. The borough has a large number of single people and, like much of the capital, there is a relatively high turnover of residents and the population is ethnically diverse, with an estimated 180 different language groups. African-Caribbean people make up the largest 'minority' group and account for one-fifth of the population, although there are also sizeable Greek, Turkish

Cypriot, South Asian and Irish communities which have been joined more recently by Kurdish, Somali and Kosovan refugees and asylum seekers. Official indicators point to a relatively high crime rate and recent concerns have focused on drug-related crime, particularly that associated with crack cocaine, and gun-related violence. Drug-related 'turf wars' between different ethnic groups provided a major cause for concern during the case study period.

Suburban Town is a predominantly affluent borough, although it does contain two wards with deprivation scores above the national average. The Bernard Green Estate forms one of the most marked pockets of deprivation in the borough and provided the focus point for one of the case study initiatives. Built in the 1960s and 1970s, this estate has become geographically and socially isolated from the rest of the borough. Transport links are poorly developed and commercial activity has found it difficult to thrive. A quarter of children on the estate come from households receiving income support and more than half of those aged under 11 years qualify for free school meals. Black and minority ethnic groups account for slightly less than a third of the estate's population, which compares with slightly less than a quarter of the population in the borough as a whole (plus a fifth who are Jewish). Bernard Green has also become home to increasing numbers of asylum seekers and refugees, including some highly qualified individuals who have become actively involved in the life of the local community. The estate has achieved a certain degree of notoriety within the borough and some residents spoke of the stigma that was attached to living there. While residents and professionals often

indicated that this reputation was undeserved or exaggerated, some did speak of the 'ghetto-like' situation and of being scared to go out after dark. Drugs were clearly implicated in this situation. The chair of the Residents' Committee felt that drug dealing was the main problem on the estate, having been displaced from a neighbouring area. A recent Crime Audit confirmed that the estate was one of the borough's six hot spots for drug-related crime.

The Northern Town case study concentrated on Eastdon, a highly deprived part of a once thriving industrial city. Traditionally dependent on the city's heavy industry for employment, Eastdon has endured severe economic hardship and social exclusion since this type of work virtually disappeared. By 2001 the four wards which make up the area were all included among the 8 per cent most deprived wards in the country and one was ranked among the 1 per cent most deprived. With an overwhelmingly white population,¹ Eastdon is dominated by one of the largest public housing estates in Europe; there are very few local amenities and those that do exist face an uncertain future. The area has also become physically and socially isolated from the rest of the city: levels of car ownership are low, public transport links are poorly developed and, according to community workers, local people make little use of the city centre and few people move into or out of the area. Within the city, Eastdon has acquired a reputation for high levels of crime and drug use. According to drug workers and local residents, the area has had an identifiable heroin problem for ten years or so, while crack was said to be emerging as a significant problem. Despite its obvious difficulties, those connected with Eastdon were

careful not to portray an overly bleak view of it. A certain degree of pride was evident in the way that local people had withstood the hardships they faced and this was accompanied by a degree of resentment at the way in which the area was often portrayed. Eastdon was widely considered to have a strong community ethos.

The nature of the responses

In terms of our earlier typology, most of the case study responses fitted into the community partnership category. However, one of the London Town initiatives took the form of a professional network, while the others started out as grass-roots responses. The detailed case study work highlighted the dynamic nature of community involvement (see below) and made it clear that 'community partnership' is an umbrella term which covers considerable variety. The London Town case study focused on three main initiatives.

- *Communities Against Drugs*. London Town received funding through the CADs initiative and was recently designated as one of 30 'vulnerable' areas which were to receive continuing support. The money was managed by a professional network made up of the police, the DAAT and the council and is an example of a 'top-down' government-led initiative. Community involvement and engagement are central to the stated strategy of strengthening communities, and funds have been used to support a community empowerment initiative and a 'small grants' programme. The community empowerment

programme provided training to potential community leaders; the 'small grants' programme offered support to 'hard to reach' groups, including some black and minority ethnic groups and newer immigrant groups. Most applications received by this programme were for awareness workshops for young people and parents and seven projects were funded, including one which aimed to raise awareness of drug issues among French-speaking black groups through the use of leaflets and a video.

- *The Unity Association*. This partnership between the faith, voluntary and statutory sectors is led by a minister from a local church. Focusing on the concerns of local black and minority ethnic communities, and other communities, it aims to promote peace and good citizenship, to restore a sense of community in the borough as a whole, to involve all communities in making the borough a safer place and to work closely with young people. An official launch was held in July 2001 and the Association went on to organise a 'peace week', which culminated in a march for peace. Its core activities focus on providing prevention/education and diversion for young people (including a video project and a drama production for schools), promoting a borough-wide publicity campaign, producing a newsletter and providing drug education for community elders. At the time of the case study the Association had three members of staff – the lead minister / chief executive, a strategy

development manager and a project manager – and two additional (part-time) members of staff were being recruited.

- *Critical incidents.* Shortly before the fieldwork began, two critical incidents occurred in the east of the borough which focused attention on the policing of local drugs markets. The first occurred in Forest Road, which contains an active night-time economy based on a series of restaurants and unlicensed social clubs. This area has seen long-standing ethnic tensions between the Turkish Cypriot and Kurdish communities and the incident was said to be the result of a ‘turf war’ between rival drug gangs: 40 people were seriously injured, three were shot and one was killed. A series of police raids followed and a public reassurance campaign was launched which saw a mobile unit located in the area for the next ten weeks. A strategy group was already being formed before the incident, partly because of lobbying from a local residents’ group. The incident strengthened the case that the residents’ group had made for action and the strategy group provided a forum where members of the residents’ group came together with councillors, neighbourhood officers, police and local traders.

The second critical incident took the form of a police-led operation against an open crack/cocaine market in North Avenue. The operation involved 300 police officers and was used as an opportunity to engage with the local community.

Following the incident the police increased their presence in the area, the council reclaimed premises and banners were erected asking residents to supply information and intelligence: ‘We just kept up the activity so that they [drug dealers] knew it was still too hot for them to return’ (police officer). A police-initiated public meeting was well attended by residents and traders and this encouraged the police, the Neighbourhood Development team, the council and a local Grant Trust to establish the North Avenue Improvement Group which was chaired by a local resident and member of the Grant Trust.

The Suburban Town case study focused on a community engagement programme on the Bernard Green Estate. The example chosen is just one of a number of activities in the area and does not reflect all the work of Suburban Town’s DAAT member agencies. This programme was funded by CADs and was part of a broader strategy aimed at reassuring local people and reducing fear of crime. An undercover police operation had targeted crack and heroin dealers who were operating openly on the estate. Arrests had been made and a police office had been established on the estate, in order to let ‘people know that drugs couldn’t come back again’ (professional, Suburban Town). Following this action, the local Police Superintendent, the DAAT co-ordinator, the CADs programme officer (a serving police officer) and the local health and social care commissioner promoted the community engagement programme in a deliberate effort to build partnerships with local people. The

programme was designed to encourage communities to help themselves and sought to attract a wide range of interests. A not-for-profit consultancy, which specialised in citizen-led initiatives, was commissioned to facilitate the programme and locally recruited 'spark-plugs' were supported with small investments to deliver projects 'that quickly add up to stronger communities and greater local capacity'. Initially, £50,000 was set aside to support approximately 20 projects, each lasting three to six months, and the ideas for the projects came from the spark-plugs (not from the funders). While the consultants acted as intermediaries, 'investors' were expected to be closely involved in the process and to meet with the spark-plugs in order to shape and implement their proposals. One of the core aims of the programme was to move from embryonic idea to funded project in one day. Thereafter, honours, awards and celebrations provided a key forum through which links between investors and spark-plugs were maintained.

The Suburban Town case study focused on the first phase of the programme, during which five projects were supported (one did not get off the ground and the money was returned). Most of these projects focused on diversionary and educational activity, reflecting widespread concerns about antisocial behaviour by young people.

- A music project and a social club were established with the aim of providing alternatives for young people who were spending time on the streets drinking; the social club regularly attracted 70 young people.

- An information technology training project aimed to help ex-offenders into employment. The project successfully placed eight ex-offenders in jobs and there was some talk of improved police–community relations.
- An environmental project successfully engaged a core of ten young people in reclaiming a pond on the estate and this was well received by local residents.

We did not attempt to evaluate the gains that the projects brought about but there was substantial anecdotal evidence that some valuable outcomes had been achieved through these activities. Investors were pleased with the results and indicated that they would consider replicating the programme in other areas.

The Northern Town case study focused on the Northern Town Drugs and Alcohol Project (NTDAP) which grew out of a community consultation event organised in 1996 by the DAAT, with the support of a local GP, the Youth Service, the police and local community projects.² Representatives from a range of key agencies came together with local residents and members of a carers' group (Relatives of Substance Misusers) and a broad consensus emerged in favour of a multi-agency approach. Three main areas of work were identified – education and young people, crime and safety, and health service provision to users, carers and the community – and a few months later a part-time community development worker was appointed to find joint ways of working with local community groups. By the time of the case study, NTDAP had evolved into a well-established drug education and treatment

service. The community development worker was employed on a full-time basis and had been joined by a project manager, a project administrator, an education worker, two nurse specialists and a substance misuse counsellor; partnerships had been developed with nine of the area's ten GPs; work was being conducted in local schools; and the project's work with carers, families and friends of drug users had been recognised by the National Treatment Agency. Funding for these services had been raised from various sources, including the health authority, the police and the local education department. By the time of the case study, the treatment component was being supported by the DAAT while the community development and education components were being financed through regeneration money. Project staff were not employed directly by NTDAP but by 'partner agencies'.

Although the initiatives included in the case studies differed from one another in many ways, they all concentrated on illicit drugs rather than alcohol. This was, to some extent, driven by local and national spending priorities. A number of respondents in Suburban Town felt that alcohol was as much of a problem as illicit drugs, if not more so, but because the community engagement initiative was funded by CADs it had to be principally drugs-focused. Similarly, while a community consultation exercise in Northern Town highlighted a demand for an alcohol counsellor, funding for such a post was not forthcoming and, as a result, a joint drug and alcohol post was established, funded by the local DAT.

The nature of professional involvement

All the case study areas had active professional networks which were responsible for applying national policy to the local context. The precise membership of these networks varied although the DAAT and the police played a leading role in all three areas. As the key local decision makers, these networks helped to set the parameters within which community involvement was developed. They were also directly involved in all of the case study responses although the extent and nature of their involvement varied. Important differences were apparent in the orientation of local drugs policy and the style of community engagement.

London Town's drugs strategy was led by a professional network centred around the DAAT, the police and the voluntary sector. The police played a leading role in the CADs initiative and in the various partnerships within the borough. Their role was defined primarily, although not exclusively, in terms of law enforcement:

Obviously our main role with the community is enforcement under the government drug strategy ... [we do this] by tackling the class A drugs dealers very aggressively ... and in London Town, this, at the moment, is predominantly crack cocaine ... We have devised a policy and a strategy with the community ... Simply crack cocaine users we treat more as victims. Crack cocaine sellers and people who provide opportunities for sale or use, we treat as criminals ... We [aim to] make London Town a hostile place for all drug users and drug dealers to operate. The tactic that we use predominantly is 'stop and search' on an intelligence-led, focused basis.
(Professional, London Town)

The police did step outside of a strict law enforcement role. They were actively involved in 12 schools in the borough, running swimming clubs, basketball clubs and football teams. Moreover, in order to cement their partnership with the council, two police officers worked permanently as ‘ambassadors’ within the main council Administrative Centre. These officers provided a link with the council, local councillors and the general public. Nevertheless much of this activity was framed within a law enforcement agenda. Thus, for example, the police spoke of the way in which fear and indifference create a ‘wall of silence’ in communities and much of their community-focused work was undertaken with this in mind.

While law enforcement was a key priority in all of the case study areas, the police appeared to be more active in stepping outside a strict enforcement role in Northern Town and Suburban Town. The case study initiatives in these areas included a greater emphasis on welfare-based approaches and, in Northern Town, the willingness of the police to work flexibly was highlighted:

In the early days there might have been some tension in the way that things were dealt with, but yet again through the partnership working, the police have come to understand the approach the community would prefer and have adapted to that. Now much of that is down to personalities because obviously whoever’s in charge of the district or a particular area does have quite an influence on how it’s policed ... the person who was [involved with NTDAP], he was actually chairing the steering group, the inspector up

there, his approach was such that he was very community orientated.

(Professional, Northern Town)

The way in which professionals engaged with communities also varied and three main styles were identified.

- *Professionals as sponsors.* Professionals identify individuals in the community whom they feel they can trust and effectively promote them and their activities. Within this style, professionals tend to take an arm’s-length approach to the day-to-day activities of the community response and so issues of trust and recruitment are key.
- *Professionals as ideas brokers.* Professionals identify an approach to community involvement which is implemented by a third party who acts as a mediator between professionals and the community.
- *Professionals as nurturers.* Professionals identify an approach to community involvement and are actively engaged in its implementation. This is the most ‘hands on’ of the approaches and ownership issues are key.

The boundaries between these styles are not absolute and may become a little blurred. It was evident from the case studies that professionals need not stick rigidly to one particular role and that their role may be redefined as community initiatives and relationships develop.

Examples of sponsorship were evident in London Town, where the CADs ran community

empowerment initiatives and the 'small grants' programme provided mechanisms for mentoring potential community leaders and supporting community groups. This process was well illustrated by the Unity Association, whose relationships with professionals in the borough involved a degree of mutual courting and grooming. The lead minister was something of a 'moral entrepreneur' who was clearly considered to be a valuable resource by local professionals and, while the Association was rooted in an identifiable community, it moved quickly towards a community partnership approach. Its immediate origins lay in a breakfast meeting hosted by the lead minister at his church and attended by representatives of different faith groups, the council and the police. At the official launch of the Association, religious leaders, members of the local community, politicians and a local police representative signed a 'peace pledge', whereby they promised to work together to achieve peace and reduce violence in the borough. Following the launch, the Association drew up a business plan and developed an increasingly prominent role, both within the borough and beyond.

- The lead minister was integrated into local professional networks, becoming the chair of the DAAT's Communities and Availability Task Group.
- A police-initiated community-focused gun-crime initiative was handed over to the Association and, as a result, the lead minister became involved in 'Operation Trident'.³
- A group of local black churches applied for funding through the Association so

that they could send two people on an NVQ drugs course.

- The role of the lead minister was highlighted by David Blunkett, the Home Secretary, at a local event: 'I would like to thank [the lead minister] for the tremendous contribution he makes locally and across London, and in contributing to the Home Office with his support' (*London Borough Advertiser*, 1 October 2003⁴).

The Bernard Green community engagement programme in Suburban Town highlighted the role of professionals as ideas brokers. The programme grew out of the concerns that a core group of local professionals had about the tokenistic nature of much community work. This group was committed to finding better ways of working with the community and a not-for-profit consultancy which specialised in community engagement was commissioned to help with this process:

I got really fed up with going to meetings and people talking about things they were doing to the community. No one had got their head around the idea of getting the community to do it for themselves. I've got the [name of consultants] to do what they call [name of programme]. We're focusing on a particular estate and it provides a way of getting money to individuals in the community.

(Professional, Suburban Town)

Under the approach that was applied on the Bernard Green Estate, professionals were expected to devolve power to the spark-plugs and to avoid the temptation of 'micro managing'. Their role was defined as one of

‘investors’ and they participated in the programme by attending meetings with the spark-plugs and attending celebrations and awards ceremonies. By bringing spark-plugs and investors together, both could question the other on the same day and decisions could be made quickly. The potential management void was filled by the consultants, who identified the spark-plugs and then set targets, key steps and milestones. While illustrating the role of professionals as ideas brokers, the Bernard Green community programme also demonstrates the fluid nature of professional involvement. In time, some of the investors came to be much more closely involved in the life of the programme than was formally required of them. They tried, for example, to secure funding for projects which were considered to be valuable and, in this way, their role came to involve a greater degree of nurturing. It was notable, however, that these relationships could be broken when key professionals moved on to take up posts elsewhere.

The nurturing role was also apparent in Northern Town, where it appeared to be part of a broader trend. Neighbourhood-based work has provided an important focus for the city’s local authority for some time. The city council has developed an Area Action Strategy which aims to involve local people in decision making, improve relationships between the council and local communities and provide a framework for local regeneration and for attracting funds. Twelve Action Panels have been established across the city which involve local councillors, panel representatives and panel partners, and meetings are open to the public. Some decision-making responsibility is being devolved to the

panels and they are consulted about major policies and plans relating to their area. In addition, Eastdon has attracted £20 million of regeneration money for the period 1999–2006, drawn primarily from the Single Regeneration Budget (SRB). Seven theme groups have been established, including one which focuses on community empowerment, and the strategy is being overseen by a board which includes eight community representatives.

The immediate origins of the Northern Town response lay in the work of the then DAAT co-ordinator who was interested in piloting a multi-agency approach to drugs work which brought together local agency workers with community groups. Although she had a general framework in mind, the specific nature of the project was negotiated through a process of ‘community development’:

[The initial consultation event] was very open ended, just sort of what do we think the problems are, what do we think the answers might be, who else needs to be involved. It was kind of let’s kick it off, fairly open. And I suppose in my head at the time, I didn’t really have a particular agenda ... I just saw myself as a bit of a neutral broker really, sort of facilitating it, to set up a dialogue in the area from which would grow something ... I think from that there was an agreement that certain key issues emerged, and there was an agreement that we would have some kind of subgroup structure.

(Professional, Northern Town)

Although the nature of the project emerged through negotiation, the DAAT co-ordinator was heavily invested in the process of its development and went on to sit on the steering group. While no longer involved, her previous

role and sense of ownership were evident from her description of the project as 'my baby'.

Other styles of professional involvement were evident in the case studies which blurred the distinction between professionals and community members. There were several instances where professionals, as community members, acted as an intermediary between professional and community groups. In London Town's North Avenue a member of the council neighbourhood management team told us how her neighbours, who were involved in the neighbourhood watch group, had sought to use her as their voice: 'they [the police on this occasion] will listen to you, love, because you're from the council. Because, you know, they won't listen to us'. There was some suggestion that the role of professionals as community members may be particularly important in relation to mobilising black and minority ethnic groups (see also Federation North West, 2002). A local government official in London Town felt that the more recently established minority ethnic groups tended to be 'very suspicious' of professionals who they saw as 'authority figures'. The role of minority ethnic professionals was highlighted by the Forest Road incident as the council executive lead for community safety was a member of one of the local ethnic groups and played a crucial part in the development of the response.

Community partnerships as risk and trust

According to Mary Douglas (1986, p. 1) 'writing about co-operation and solidarity means writing at the same time about rejection and mistrust'. We have already seen, in the previous chapter, that community involvement was seen to pose

risks to professionals. The notion of risk was also highlighted by the case studies, although it took a somewhat different form. While survey respondents focused on the risks posed by 'reactionary' elements of the community, the case studies highlighted the risks of working with groups, such as problem drug users, that may outrage public opinion. The case studies also showed that community involvement poses risks to the community and highlighted the importance of trust as a basis for working with risk (see also Wilcox, 1994; Southwell, undated).

Notions of risk and trust were central to the development of community responses in all three case study areas although the way they played out varied markedly. The variations that were evident in this regard reflected the style of community engagement that professionals adopted. As already noted, the sponsorship style depends on identifying community leaders who can be trusted and this was best illustrated by the Unity Association. Thirty police officers joined the peace march which was organised by the Association in what one described as 'a fantastic show of solidarity between the community and the police and the council, everybody'. Another officer praised the Association for 'chipping away' at the 'wall of silence' in a culture that 'won't inform'. For the local professional network, partnership with the Association involved very little risk as the lead minister was clearly considered to be someone they could do business with:

We've got some fantastic community leaders, people like [the lead minister]. Through people like him we've built up a whole network of interested people from within all different communities that are represented in the borough.

(Professional, London Town)

In Suburban Town the community engagement programme was, with some justification, presented by the core professional partners as an 'innovative' programme which they framed in terms of 'risks' and 'trust':

I had the autonomy to take some risks and not have auditors on my back all the time about spending ten pence of £10 ... [which means] we can put money into the hands of these people, not micro manage the money, not be completely risk averse as we generally are in the public service ... If I look back, the one thing that absolutely struck me was that it was the laying out of trust with the concrete element behind it. So whether or not it's pound notes or computers or something else, take it, use it, we trust you. And then they will deliver.

(Professional, Suburban Town)

Although it was acknowledged that the risks posed by the programme were limited by the amount of money involved, the consultants also played an important role as risk managers. In particular, they helped to build trust between investors and spark-plugs by encouraging professionalism among spark-plugs and community awareness among professionals. Talk of devolving power to the community was reflected in the development of the programme. Projects were designed and implemented by local residents with the support of the consultants and investors did not intervene to change the focus of the projects, although they had some reservations about the strength of the focus on young people. Equally, however, the parameters within which the programme operated were set by CADs and, ultimately, investors retained a degree of control over the allocation of resources. It was notable that none

of the funded projects were run by drug users or carers, although no attempts had been made to exclude them from this role. Indeed, some investors indicated a willingness to recruit users as spark-plugs and reported other instances where this had happened. Nevertheless, it remains the case that funding user-led projects raises potentially controversial and thorny issues for professionals, including some that relate to the provision of direct cash payments to users.

The risks that community involvement posed to the community were highlighted by the Northern Town case study. The trust that the DAAT co-ordinator showed in the community was not immediately reciprocated and a generalised suspicion of professionals formed an important part of the backcloth to this initiative. By working through local community workers and existing networks, by engaging diverse groups and by demonstrating commitment to the process, however, the DAAT co-ordinator began to create a level of trust:

They talked about starting off a project ... they'd have some community work to develop it and I got cross at that meeting actually because I thought oh, they're going to go off and they're going to steal our ideas because that's what normally happens to us ... [But] Sue Edwards says to me 'well I'm going to be on one of the working groups to look at how we proceed' and I felt better about that because she was a worker at a project where I was on management, and I knew she would act with integrity, and also she'd work from a perspective of the community having a voice and a say in the process, so that felt better. But I didn't know the Drugs Action Team, I didn't know, you know. It's like any other

organisation that's come here and not worked with us but done things to us ... there was quite a lot of suspiciousness about things being parachuted in, perhaps lasting a year or two and then disappearing off the face of the earth again.
(Local resident, Northern Town)

Across the case study areas issues of risk and trust were felt particularly sharply in partnerships with the police and this helps to explain the low level of community involvement in law enforcement. In London Town the early meetings of the Forest Road Strategy Group were said to be shrouded by a fear of reprisals: 'Some traders declined to participate – some long established, like estate agents. So there was obviously still some fear – they had previously had windows broken'. Some of the community representatives were said to be suspicious of traders' possible hidden agendas and were very uncomfortable about identifying themselves. The initial meeting was deemed a success, however, as bonds of trust were fostered between community groups, residents, professional groups and the 'authorities'.

The risks posed by partnerships with the police were also evident in the other case study areas. On the Bernard Green Estate, in Suburban Town, residents who co-operated with the police were sometimes labelled as 'informers'. Similar sensitivities were aggravated early on in Northern Town, where it was felt that the police expected the project to pass on intelligence information. Concerns were raised that this expectation jeopardised the relationship that the project was seeking to build with the wider community and, as a result, the police were said to have adjusted their role in the project.

Community responses and community values

Official drugs policy is underpinned by a straightforward moral position: that is, drug use is wrong and should be stopped principally by the mobilisation of the law against possession and supply. Such thinking dominates the community element of the national drugs strategy and the CADs initiative, although other elements of the strategy place greater emphasis on welfare approaches based around treatment and education. Given the focus of official policy, the extent to which communities support law enforcement-led approaches is a key issue.

A degree of community support for law enforcement was evident across all of the case study areas and was most clearly evident in response to the critical incidents in London Town. Local people in both the affected areas had been concerned about drug-related activity prior to the incidents and expressed frustration at what they considered to be the unresponsiveness of local officials. The critical incidents highlighted the seriousness of the problems and strengthened the case for intervention:

We had been trying very hard to alert the powers that be, both the police and the council, to the fact that this was going on. And I must say that we haven't always met with the success that we might have hoped. We've been told that we're being alarmist, that 'where's your evidence?' – which, of course is very easy for them to say and very hard for us to prove ... And so that was where, tragically, the events of last November did actually highlight that there really was a very serious problem.

(Community volunteer, London Town)

In both areas, official responses to the critical incidents appeared to be welcomed. According to one of the police officers involved in the North Avenue operation: 'We had a standing ovation from the public as we arrived ... almost unheard of!'⁵ And a Forest Road resident noted: 'You couldn't go down at any time without seeing a policeman, which was wonderful actually, I thought, and a lot of residents did'.

The fieldwork in Suburban Town and Northern Town highlighted a more complex set of community values. Community members in these areas described the harms that they felt resulted from drug use and expressed a clear sense of grievance against users and dealers. There were many 'bad' tales of drug users, focusing on crime and antisocial behaviour, and concerns were frequently expressed about the inappropriate disposal of injecting equipment near children's play areas and in residential areas:

People who are drug addicts don't care. If they're on benefits they will spend their benefit on drugs and then when that runs out they will steal, shoplift, prostitute or whatever to get the money.
(Local resident, Suburban Town)

Although such tales were frequently told they did not provide the sole basis for community values. Crucially, 'bad' stories were matched by 'sad' stories:

We do know of two families sadly. There was a young girl who used to help us ten years ago. Very nice, outward-going, about 14 years old, cheerful, lovely-looking and she actually died. Got involved with drugs and died of a drugs overdose. Just before she died of a drugs overdose, her child was about to be adopted by her sister. We

know of someone else – a grandparent who is looking after her grandchildren because her daughter is a heroin addict – on that level it's just heartbreaking isn't it?

(Local resident, Suburban Town)

These contrasting stories, along with the proximity of drug use, produced complex responses. Community values in both Eastdon and Bernard Green reflected a double bind which is likely to face high-crime communities. On the one hand there was clear sense that something had to be done:

There's a drug problem everywhere but if you go up posh area, they lock their door to it, they won't admit it, whereas Eastdon, they know it's a problem and they're open to it, aren't they? ... And running them [users] out of the area doesn't work 'cause they've got to go somewhere. Somebody somewhere has got to deal with them. Why not here?

(Community volunteer, Northern Town)

On the other hand, some elements of these communities raised concerns about the harms that resulted from official enforcement-led responses. According to one of the spark-plugs on the Bernard Green Estate, seeing the police 'harassing your neighbours' did no benefit to the community. Similarly, it was said in Eastdon that police 'harassment' of local users had created resentment, particularly among relatives and carers. And yet local residents were also said to be frustrated by what they perceived to be a lack of police response to demands to 'take out' dealers. While these views reflected the distinctions that people drew between users and dealers, they also reflected other influences. A mother, and wife of a one-time heroin addict,

who was involved in the local user / carer group, spoke of being scared to let her children play in the park in case they picked up discarded needles, but insisted that ‘druggies ... [are] just normal people’ and highlighted the lack of drug services in the area. She also spoke of her resentment of dealers who target young children or use them as ‘runners’ and reflected on the way in which heroin had affected her relationships:

Two of places I lived in, a lot of people around about were on heroin and I lost a lot of my stuff by accepting them into me home, trying to help them, thinking I were helping. While all along my jewellery were going bit by bit, and you learn by mistakes and you learn to spot who will and who won't.

Q: *So how do you feel about that now, looking back?*

It's just part of life, isn't it, you learn to live, you know I trusted people and I shouldn't have trusted them. So I'm more wary now.
(Community volunteer, Northern Town)

For the community members who became involved in the responses in both Eastdon and the Bernard Green Estate, these tensions and ambiguities tended to be resolved through an emphasis on building social cohesion. The Eastdon initiative focused on welfare-oriented responses such as treatment and education and the volunteers favoured conciliatory forms of control:⁶

[P1]: *Well locking them [dealers] up and throwing the key away doesn't work ... They learn more inside than they do out ... They need education, real proper education, because they don't know what they're doing now with drugs ... They rip*

families apart, totally rip families apart. And I think if they had to do a year of being in school, literally, being made to do it and learn it eventually they'd come out and it'd be in their heads, they wouldn't think of going back. Well I don't think they would ...

[P2]: *I think they ought to be made to look after people that they've damaged ... I mean it's like this thing where, you know, you have criminals who go face to face with the people that they've stolen from or what have you ... I know a young lad that were in rehab and he actually did that and he said it really, really helped him meeting the person. It were a car crash weren't it, or something?*

(Community volunteers, Northern Town)

Similarly, the initiatives on the Bernard Green Estate included a strong focus on building social cohesion, by encouraging ex-prisoners back into work and engaging young people in community work. Crucially, while some residents on the estate simply wanted to get rid of drug users, others were more sympathetic and inclusive and it was from this group that the spark-plugs emerged:

I met this guy. He had just come out of prison right so because I'm so friendly to everyone I was just talking to him then he started saying to me 'oh you know I've just come out of prison' and I said 'what did you go to prison for?' and then he said 'I was caught drug trafficking' – 'you are selling drugs!' I said 'that's terrible isn't it' and so he said 'yes' ... so he would come to my house. That guy the way he approached me it really touched my heart. I knew there was a lot of people like him who wouldn't have anyone.
(Community volunteer, Suburban Town)

Legitimacy and the construction of 'community'

Attempts to build cohesion depend, in part, on the way in which the notion of community is constructed. Official policy tends to see cohesion as being developed through exclusionary processes. According to this vision drug users are seen as being outside of the community (hence the lack of emphasis on user involvement) and consensus is developed by excluding dissonant voices (Crawford, 1999). A much more inclusive vision of cohesion is offered by the idea of legitimacy, as moral authority is seen to emanate from diverse participation (see Chapter 1).

Case study responses in London Town and Suburban Town tended to be driven by specific interest groups. The Unity Association grew out of a black church initiative and most of Suburban Town's first group of spark-plugs were black Christians, including evangelical ministers, although one was a white woman originally from the East End (she too was a firm Christian). Despite the feeling among the police that they had made contact with 'new' elements of the community, most of the first-wave spark-plugs had been community activists for some time and had already received money from a variety of funders.⁷ In addition, some doubts were expressed about the moral authority of working through 'community leaders':

As soon as someone in the community springs up as a leader there is so much antagonism to them ... self-appointed leaders have a really tough time in Bernard Green ... they are seen as getting above themselves ... [but] the local authority likes working with community leaders. It

makes it much easier for them ... they love it ...

[but] it is actually quite divisive.

(Community member, Suburban Town)

A much broader participatory base was developed in the Northern Town case study and this reflected the particular emphasis that was placed on issues of legitimacy. An initial mandate was established through official indicators, baseline research, a community drugs audit and a community consultation exercise. From this starting point, a broad-based partnership was established which combined community influence with an extended professional network.

- The core of the project's decision-making structures was based on a professional network which included representatives from the primary care trust and each of the employing agencies (e.g. the DAAT, an alcohol service and a voluntary community health service).
- A steering group provided the main formal link between the project and the local community and, in addition to the partners, consisted of other professional and community stakeholders. The group was chaired by a local police officer and included a project worker from the local Relatives of Substance Misusers group, NTDAP project staff and three community representatives who provided links with the project volunteers, a local carers' group and the local tenants' and residents' association.
- At the time of the case study, the project had 12 active volunteers drawn from a range of different interest groups in the

local community, including teachers, youth and community workers, students, the unemployed, parents, relatives/ carers and ex-users.

- The project had strong links with a local user group which was part of a DAAT-led city-wide initiative to increase levels of user involvement. This group had a dual function, serving as both a support group and a key stakeholder in the project, and was consulted about future developments. Providing that users had achieved a certain degree of stability, it was suggested that the stakeholder role helped to reinforce the process of recovery, particularly in the longer term:

If we're not going to be involved in drugs we need to be involved in something, a constructive role in society plays a massive part in relapse prevention and it gives some people a purpose, there's elements of redemption ... for people who might have done some [bad] things in the past, this feeling that we're putting something back helps improve self-esteem and self-worth.
(Ex-user, Northern Town)

The user group was regularly attended by one of the project's community representatives who provided a link with the steering group. In addition, some of the paid workers spoke of relatives who were, or had been, addicted to heroin.

- Formal mechanisms were developed to ensure wider community input, including annual community consultation events, local surveys and independent evaluations.

Community influence was evident from the way in which the response had developed. Much to the surprise of the then DAAT co-ordinator, the project did not follow the community safety agenda which dominated professional concerns, and local people, including members of the relatives' group, played a key role in ensuring that treatment formed a core part of its activities. Community concerns were also reflected in the emphasis that was placed on partnership and sustainability. Project staff were employed by 'partner agencies' and worked through the existing community infrastructure (e.g. GPs' surgeries and schools). By working in this way, and by providing training for residents and professionals, they aimed to promote sustainable interventions.

Community influence was also reflected in, and facilitated by, the role of the community worker. A local woman was recruited to this post who had little relevant professional experience but very strong local ties and considerable experience as a 'community activist'. As a resident in the area for nearly 30 years and as someone who had been actively involved in the local church and tenants' association, she brought a detailed knowledge of the area, provided important channels of communication with the local community and played a key role in shaping the project:

One of the people that helps with the organisation does live in the community, has faced problems and knows where the community is coming from. She relates well with other members of the community and will try to get the views of the people in the community and push them forward.
(Community volunteer, Northern Town)

If it hadn't been a community member that started it off it would have been different ... there's a passion there, there's an absolute passion, you know, we're not just here working to do us jobs and then we can all bugger off and leave Eastdon and go home. This is somebody who is actively, you know, is passionate and loves this community, all its negatives and its positives, and is dedicated to working with those people and has had links with many people in lots of these groups, you know, for many years ... I think to be honest if it wasn't for Dianne and having a good community development base to start with, I think the ethos of having it as a community project would have just got lost.
(Project worker, Northern Town)

While professionals had, as one of the workers put it, 'come in on community terms', the community component of the project ensured that the project continued to have a strong community ethos which extended into, and shaped, even its most tightly professionalised components. As one of the nurses reflected:

I'm very proud to work with this project ... [because] we work within the community and that works very well ... it's developed over time looking at what the community have asked for ... At first it took me a while to get my head around working in this kind of project when I expected to be working in a community drug team which is all nurses and social workers. But on saying that I wouldn't go back ... I couldn't work the way they work, I like how we work here. I wouldn't want to go back to seeing everybody in the office, nobody does visits. Here, you know, they know you, everybody knows. It's like you can park your car here and they'll make sure nobody will do anything, because they know who you are.
(Project worker, Northern Town)

In spite of this ethos, power relationships within the project were complex and contested and there were clear tensions between professional and community modes. The broad parameters within which the project operated may have been negotiated with the community but the workers had considerable autonomy in their day-to-day work (this was particularly the case for those involved in treatment). In addition, sharply differing views were apparent concerning 'boundaries' and relationships with clients and the wider community. Workers with a background in nursing and social work tended towards a 'professionalised' model which was strictly governed by protocols and procedures, while the situation was somewhat more blurred for those directly involved in community development (see 'The dynamic nature of community development' below).

While these tensions may be an inherent part of multi-agency working and community partnerships, they were largely managed and resolved through an emphasis on accountability. Accountability provides one of the most important checks on the exercise of power and establishes obligations to explain or justify behaviour or decisions (Roche, 2003). Within the project, power and influence were widely dispersed and numerous channels of accountability were established.

- Managerial accountability was based on routine monitoring by funding agencies and the primary care trust.
- Professional accountability was built into the fabric of the partnership. Individual members of staff were line-managed by their employing agency and were subject to their policies and protocols. Where

appropriate, they also received external 'clinical supervision'. These mechanisms were fundamental to the workings of the partnership as they provided the basis for managing risk and enabled professional agencies to trust the community.

- There was a strong ethos of internal accountability within the project as members of staff felt accountable to one another. Staff meetings and the steering group provided the key forums through which internal accountability was achieved.
- Accountability to the wider community was provided through a range of formal and informal mechanisms. The project held annual consultation events and regularly participated in local democratic structures such as Area Panels and the SRB Health and Social Care Thematic Working Group. In addition, the project's relationship with the wider community generated informal opportunities for providing accounts. During one fieldwork visit, for example, a trip to the local supermarket led to a five-minute conversation about the project between the community development worker and a local city councillor.

The dynamic nature of community involvement

The nature of a community response, like the style of professional involvement, may change over time. Just as, for example, the style of professional involvement may shift from nurturing to sponsoring, so grass-roots

initiatives may evolve into community partnerships. The dynamic nature of community responses was particularly evident in London Town and Northern Town.

The three case study responses in London Town were located on different points of the typology of community involvement and, in different ways, they all illustrated the dynamic and shifting nature of community responses.

- The CADs initiative was, in essence, made up of a professional network although moves had been made towards a community partnership approach, particularly in relation to the Unity Association.
- The Unity Association, by contrast, started out as a grass-roots initiative but through involvement with local professional networks had moved towards a community partnership. Professionals had remained at arm's length from the day-to-day running of the project, however, and saw their role as providing financial and professional support rather than taking leadership and control.
- A similar but more marked shift had taken place within the critical incident responses. These responses had begun as grass-roots initiatives but had quickly developed into community partnerships which were largely reliant on professional support and appeared to be evolving into professional networks.

The evolution of the critical incident responses highlighted the importance of boundaries between community and

professional responsibility. Such issues were highlighted by a local newspaper, who raised questions about the extent to which the 'community' is responsible for determining 'the solution' and implementing policy (*London Borough Advertiser*, 1 October 2003). As we have already seen, local people in both the affected areas had been concerned about drug-related activity prior to the incidents and this had provided the basis for some early grass-roots activity. Both incidents highlighted the need for something to be done and brought local people and professionals together. Following the initial crisis response, moves were made towards establishing permanent structures which would improve communication between local people and the police and the council. These responses yielded clear benefits, including heightened levels of trust between participating groups, but they did not provide the basis for sustainable community involvement. By the end of the case study period it was unclear whether the Forest Road Strategy Group would continue to attract representatives from the different interest groups. Attendance at the North Avenue Improvement Group had also tailed off and a decision was taken to integrate the group into the infrastructure that was emerging around regeneration efforts in the area, although concerns were expressed about the lack of public interest in these structures.

Community involvement in these responses may be understood in terms of a campaigning exercise as once official responses had been assured, local residents turned their attention to other priorities. Both the Forest Road Strategy Group and the North Avenue Improvement Group quickly shifted their focus away from drugs and onto more general 'crime and grime'

issues: 'At the moment things like wheelie bins and rubbish are a very hot issue' (local resident/chair of the Community Safety Partnership). Continued action over the original problems appeared to be considered the responsibility of professionals, and residents in North Avenue expressed disappointment when the strong police presence was reduced.

The dynamic nature of community involvement was also highlighted by the Northern Town response. During the initial consultation stage of this initiative, bonds of trust began to develop between professionals and the wider community but there came a point at which something tangible had to be put in place if these bonds were to be maintained. At this point the project manager, the nurses, the education worker and the administrator were appointed, followed by the substance misuse counsellor. With this transition the project experienced a process of professionalisation. Having ensured a professional response, community members appeared to respect the professional autonomy of the incoming workers and the community development function went from being central to being fitted around the, now, core activities of treatment and education.

During the case study there were signs that the project was entering a second transitional phase as the delicate balance of power which had emerged following the expansion of the project appeared to be under threat. A residential trip for volunteers and users which had been planned as part of the community development work was postponed because some of the workers in other parts of the project felt there were insufficient protocols to manage the potential risks. What seemed, from the

outside, to be a fairly routine disagreement became a focal point for competing anxieties which appeared to hinge on two related factors. The first concerned the broad thrust of the project. According to one set of views the project required a period of consolidation in which less emphasis was placed on innovation and more emphasis was placed on strengthening existing partnerships and sharing lessons. According to the other set of views the project had become unnecessarily risk averse and 'middle class'. The second factor concerned the community development role. On the one hand it was felt that this role had become too diffuse, while on the other it was felt that competencies which had previously been accepted were now being questioned. By the end of the case study, the immediate future for the community development role appeared to be one of role clarification in which co-ordinating the volunteers, working with carers and user involvement, came to provide the key focus. What was less clear, however, was where long-term funding would come from for this role.

Conclusions

- The case study projects show how partnerships are built between professionals and local communities. Different styles of community engagement were identified including the professional as sponsor, the professional as ideas broker and the professional as nurturer.

- Distinctions between professionals and community members can become blurred. Professionals as community members may play an important role as intermediaries and this may be particularly important in relation to black and minority ethnic communities.
- Issues of risk and trust are central to partnerships between professionals and the community. Power relations lie at the heart of these risks for both groups. Professionals risk losing power and influence, while communities risk being involved in ways which do not grant them power and influence (i.e. in ways that are tokenistic).
- Various risk-management strategies were identified. Professionals as sponsors focused on recruiting 'low-risk' partners who could be trusted to work within the parameters set by official policy; professionals as ideas brokers worked through intermediaries who helped to build trust; and professionals as nurturers adopted a developmental approach which included an extensive trust-building phase early on.
- The legitimacy of community responses depends in part on diverse participation. Approaches which focus on 'low-risk' partners run the risk of excluding key stakeholders, including users and carers. The legitimacy of the case study responses was developed most fully in the context of a nurturing relationship with local professionals.

- Diverse forms of participation may be achieved through multi-agency working and community partnerships. While such approaches have inherent tensions they may be managed effectively though a dispersal of power and diverse forms of accountability.
- Community values are complex and subtle and support for law enforcement-led approaches should not be assumed. Community values are particularly ambiguous in disadvantaged communities, reflecting the proximity of problematic drug users as neighbours, husbands etc. In this context, community volunteers clearly favoured approaches which sought to build social cohesion and police involvement in community partnerships depended on stepping outside of a strict enforcement role.
- Involvement in law enforcement poses particular risks to community members and this helps to explain the low level of community involvement in this area. Elements of the community which engage in law enforcement risk jeopardising their relationships with the wider community and run the risk of reprisals. Boundaries between community and professional responsibility are particularly sharp in this area. Those case study responses which focused on law enforcement took the form of campaigning and, once an 'appropriate' professional response had been assured, community interest moved on to other areas.

4 Conclusion: influences and alternatives

The term ‘community’ has come to be used with disconcerting frequency within the drugs field. Superficially, at least, there is widespread support for the principle of community involvement but there is little agreement as to what this might mean or what form it should take. In this, the drugs field is far from unique. Indeed one of the main messages to emerge from this study is that much of what has been learnt about community engagement in other areas applies equally to the drugs field. Community involvement, we have suggested, raises difficulties for professionals and the community. In particular, it presents both interest groups with risks that are related to the distribution of power. Faced with these risks many professionals appear to fall back on models of community engagement which give away little decision-making power and within which the community is limited to a ‘sensitising’ and gap-filling role. Community workers and community activists, by contrast, tend to support much more active forms of participation.

There are, it seems to us, potential difficulties with both of these positions. Passive forms of community involvement can easily feed concerns about ‘tokenism’ and run the risk of alienating and frustrating community members who feel disempowered. Equally, however, approaches that rely on intense levels of community involvement may break down because community members are not prepared to take on responsibilities which they see as rightly belonging to professionals. The tensions that are apparent between tokenism, on the one hand, and exploitation, on the other, produce genuine dilemmas which cannot be resolved through simple formulaic solutions. Quite

different approaches were evident in the various case study responses, each of which enjoyed some success in engaging community stakeholders. Common themes were apparent, however, which have important implications for policy and practice. Community involvement, it seems, depends upon the ability to manage distinct, and sometimes competing, interests and demands. It follows from this that an ongoing process of negotiation and review is required which includes, at an early stage, an explicit focus on building trust between stakeholders and gaining agreement over respective roles and responsibilities.

Rethinking the role of community

This study suggests that there is a need to rethink the community element of the national drugs strategy. Official thinking ties the notion of community to law enforcement and criminal justice interventions and, where wider community engagement is envisaged, it tends to be limited to supporting such initiatives. Our research indicates that, in practice, formal community involvement rarely focuses on law enforcement and is much more likely to focus on education/prevention, support for users and carers and campaigning. This reflects a variety of influences which should provide the starting point for future community engagement initiatives.

- Community values are complex and diverse. On the one hand, a considerable degree of anxiety about drugs and drug-related crime was evident across a range of communities, often focusing on the activities of dealers and associated gun

crime. These anxieties provide a basis for mobilising communities to improve the quality of life in their local neighbourhoods.

- On the other hand, anxieties about drugs and drug-related crime do not necessarily translate into widespread support for enforcement-led responses. Ambiguity was particularly marked in disadvantaged communities, reflecting the proximity of problematic drug users as neighbours, relatives and friends etc. In this context, community responses tended to focus on welfare approaches and on promoting social cohesion. Police involvement in such initiatives depended on sometimes stepping outside of a strict enforcement role.
- It was noticeable that many of the community volunteers we came across during this research were members of faith communities and churches, whose motivation sprang from their beliefs, values and convictions. Others were motivated by immediate personal experiences, often as carers and users. Meaningful community engagement depends upon the participation of diverse groups, including those who often find themselves at the margins of mainstream social, economic and political life.
- Communities may not always be able or willing to take on roles which they may feel rightly belong to professionals. Prevailing notions of the facilitating state, whereby the community is expected to take on greater responsibility for the

delivery of services while being directed from the centre, bring an obvious potential for exploitation. Communities may lack the resources for such a role and may be unprepared to fill the gaps left by the state. Such dynamics may be felt particularly sharply in relation to law enforcement. This is, after all, an area which is widely considered to be the responsibility of professionals and community involvement has to contend with obvious risks, such as the threat of reprisals. It is notable that the case study responses which focused on law enforcement concentrated on campaigning, with the aim of ensuring an 'appropriate' professional response.

For these reasons, the drugs strategy should not tie the notion of community so tightly to criminal justice interventions but should focus more on welfare-based approaches with the aim of promoting inclusive forms of social cohesion. The expanded notion of community engagement we are proposing would allow due weight to be given to public health concerns and to the harms associated with alcohol. It would also encourage greater consideration of the legitimacy of so-called 'community' responses. The application of this label to professional networks is inadequate and even a little misleading, while attempts to involve the wider community which are limited to 'respectable' stakeholders lend a very limited degree of legitimacy. Genuine legitimacy requires diverse participation which includes socially excluded and marginalised groups, such as drug users, problem drinkers and their carers.

Consolidating partnerships

Community involvement may typically be based on a 'sensitising' and gap-filling role but this does not mean that appeals to 'community' can be dismissed as empty rhetoric. It is evident from this study that a considerable amount of activity is being undertaken to develop and extend professional networks and to encourage community partnerships. Building on and consolidating these achievements requires measures to strengthen both communities and the infrastructures which underpin sustainable community involvement.

While sustainability may not be important where community action focuses on mobilising an 'appropriate' professional response, it is likely to be a key issue in most cases. The important contribution that professionals can make in this regard is evident from their role as sponsors, ideas brokers and nurturers.

Within these roles, professionals must be prepared to address issues of risk and trust which are, almost inevitably, going to arise. From a professional perspective, successful engagement with communities demands an element of risk taking and risk management. Examples of such practices include:

- listening and responding to community voices
- developing trust between different groups in the community
- developing trust between professionals and the community
- working through established community networks

- devolving funds and decision making to the community
- building capacity and fostering the skills needed for leadership roles etc.
- encouraging participation in existing decision-making structures
- involving previously excluded groups, e.g. drug users and carers.

In the context of community partnerships involving a range of professionals and community interest groups, the development of trust may be facilitated by dispersing power throughout the structure of the partnership and establishing diverse forms of accountability.

Ways forward?

Widespread drug use has given rise to a seemingly intractable set of problems dating back to the middle of the last century and there is little sign that these problems are abating. Despite the best efforts of the police and the medical establishment, illegal drugs continue to be readily available and widely used. Even when the police are able to identify and arrest major drug-dealing operations this has little, if any, discernible impact on price and availability (Drugscope, 2004; see also Lee and South, 2003). The scale of the problem can be gauged from estimates which indicate that illegal drugs account for approximately 8 per cent of world trade, which is more than that in iron and steel and about the same as that in textiles (Elvins, 2003). Under these circumstances it is important to retain a sense of realism about what community responses can be expected to

achieve. In the search for solutions it is all too easy to lose sight of modest yet worthwhile achievements. Bearing this in mind, we think there are two approaches that are worth exploring further: these are multi-component community strategies and restorative justice. In different ways, both approaches address some of the tensions that we have identified.

Multi-component community approaches

Multi-component community strategies emerged from the health field and focus on the whole community rather than on a specific target group. The aim is to achieve an aggregate-level outcome through a programme of co-ordinated action which impacts upon community structures, cultures and economic and physical conditions as well as individual behaviours. In relation to drug use, this means changing the structures in which drug use and drug-related risk behaviours occur, thereby reducing the related problems in ways that are likely to be sustainable. Previous initiatives, including the Drugs Prevention Initiative and CADs, have sought to mount a 'comprehensive' approach to tackling drugs by setting local drugs problems in the context of wider community problems. However, the multi-component community approach is distinct because of the way that it conceptualises the problem and because of the kinds of action it requires in relation to design and implementation.

Multi-component strategies are based on a particular approach to 'community'. Drug prevention programmes have generally viewed communities as catchment areas consisting of a collection of different target groups that can be identified and 'treated' without changing

community structures and without affecting individuals outside the target groups. By contrast, multi-component approaches based on systems theory see communities as dynamic systems of interaction where the problem is created by the system rather than by 'problem' individuals. The aim, therefore, is to identify where the system is malfunctioning and to correct it. In discussing such an approach to alcohol-related harm, Holder (1998, p. 10) notes that:

To develop effective community-level prevention, policy makers must understand how each of the community's subsystems influences alcohol use and thus contributes to alcohol-involved problems.

Multi-component approaches are informed by theories of behavioural change which operate at the level of the individual, the situation and the environment. According to Pentz (1996), these different levels of theory should be integrated throughout the various stages of conceptualisation, design and implementation. Drug prevention programmes based on such an approach, she notes, typically use multiple channels which represent each level of influence. For programmes aimed at young people this means working with schools, parents, community organisations, mass media and policy makers. In addition, each channel should be used in sequence in order to maximise initial learning, boost learning effects, diffuse prevention support and maintain public interest.

Multi-component approaches are further distinguished by the following characteristics:

- identification of problems defined at local levels

- identification, mobilisation and co-ordination of appropriate agencies, stakeholders and local communities
- clearly defined aims, objectives, indicators and measures of effectiveness for the programme as a whole
- ideally, the inclusion of evaluation of the programme from the start.

Community mobilisation and involvement are considered essential to the success of this approach. As such specific initiatives may be undertaken:

- to strengthen collaborative networks between professional groups, community groups and drug user groups
- to mobilise local activity or support existing activities led by non-professionals
- to use local media to raise awareness or modify attitudes towards drug use and drug users
- to improve job opportunities and housing for drug users and their families by gaining the support of local employers and housing authorities etc.
- to revise policing and criminal justice approaches.

In essence, multi-component programmes aim to strengthen the preventive, 'therapeutic' function of community systems, while reducing those aspects which might be termed 'anti-therapeutic' and which create or sustain the problem.

Restorative justice

Restorative justice has been one of the most influential developments in 'crime control' over the last decade and has provided an important focus for those interested in reforming the criminal justice system (Crawford and Newburn, 2003). While challenging assumptions of professional expertise and monopoly, this approach emphasises the value of knowledge and skills that exist in the community.

- Crime is mainly considered to be a violation of people and their relationships, rather than a violation of the state.
- The primary focus shifts away from punishing the offender to righting wrongs and healing damaged relationships.
- Reparation or making good by the offender to the victim is key.

Restorative justice rejects the punitive orientation of the 'just deserts' model in favour of a therapeutic approach which aims to heal hurt and injustice by encouraging participants to enter freely into a process of making amends (Braithwaite, 2001). Reintegrative shaming plays a key role in this process and is 'disapproval dispensed within an ongoing relationship with the offender based on respect ... where forgiveness, apology and repentance are culturally important' (Braithwaite, 1993, p. 1). In practice, restorative justice seeks to turn traditional observers of the criminal justice process into active participants and typically involves victims and perpetrators alongside their family and friends, community volunteers

and various professionals (Roche, 2003). Victims are given an opportunity to describe the harm they have suffered, while offenders are encouraged to explain their actions and to begin making amends. This process is undertaken in various forums, including family group conferences, healing and sentencing circles, victim and offender mediation, citizen's panels and community boards.

The contribution that restorative justice may make to the drugs field has recently been clarified by one of its leading exponents. According to John Braithwaite (2001, p. 229), the foundations for a restorative approach are provided by the observation that substance use can be, but is not necessarily, a source of profound injustice:

If substance abuse is part of the story of injustice, part of what is important to understand to come to terms with the injustice, then both the substance abuse and the injustice it causes are likely to be among the things participants will wish to see healed in the restorative process.

Restorative processes require that those who are hurt by substance use are given a chance to explain their hurts and discuss the problems they would like to see solved. They are triggered when substance use becomes serious enough to cause 'real' crime such as burglary, assault or drink-driving. Crimes that have a victim provide an opportunity for loved ones to confront the substance users' victimisation of themselves and the collateral victimisation of their family. In other words, a restorative strategy exploits criminalisation to challenge both the harm that results from substance use and the substance use itself. At the same time, these harms are not to be treated in isolation.

Restorative processes approach offences in a dynamic way and seek to set them in context. As a result the wrongs that the 'offender' has done to their family and community should be considered alongside the wrongs that the community and family have committed against the 'offender'. In this way the boundaries between 'victim' and 'offender' may begin to blur (Roche, 2003). Thus, for example, one of the things that participants in restorative processes may wish to see healed are the hurts and injustices that arise from attempts to punish substance use (Braithwaite, 2001).

An important element of Braithwaite's (2001) argument is that restorative processes can support rehabilitation. Being confronted with the genuine harms that result from substance use by family members and loved ones in a supportive context may help to sustain and reinforce users' motivation to change. Opportunities for making amends may also play an important role in the process of recovery. This is evident from the Twelve Steps programme practised by Alcoholics Anonymous and Narcotics Anonymous: at step eight members 'made a list of all persons we had harmed and became willing to make amends to them all'; and at step nine they 'made direct amends to such people wherever possible, except where to do so would injure them or others' (<http://www.alcoholics-anonymous.org>; <http://www.na.org/basic.htm>). Making good in this way may help users to find their redemption narrative and create a new identity which is not based around substance use (Maruna, 2001). The process of making good may also provide the basis for mediation between users and the wider community and for healing broader social divisions. As well as

supporting users' recovery, for example, there are a range of activities which could provide the basis for making amends to, and being forgiven by, the community. These might include clearing public spaces of drug-using paraphernalia, engaging with treatment programmes, participating in support groups, working as peer educators, delivering drugs education in schools or youth settings, volunteering at local drugs agencies and participating in DAAT forums. Such activities may, in other words, be framed explicitly in terms of reparation.

Restorative justice holds out the prospect of control and regulation while building social cohesion. This is reflected in its concern for the welfare of both 'offender' and 'victim'. Such an orientation may be considered particularly relevant to the drugs field because it has the potential to fuse the notions of care and control. Moreover, while the restorative justice literature has concentrated on substance use there is no obvious reason why this approach should not be extended to cover supply. There was, for example, clear support in one of the case study areas for the application of restorative-type procedures to drug dealers.

Community responses in context

With the shift from welfare state to facilitating state it seems likely that the role of community will continue to be emphasised in official drugs policy. While this will almost certainly bring greater opportunities for future community involvement, these opportunities may come at a price. Above all else perhaps, the 'responsibilities' of the community must not be allowed to eclipse the responsibilities of the state. This is particularly important as the problems associated with drugs are felt most

sharply by those communities which are least able to generate resources and mobilise themselves. It is, moreover, highly likely that any approach to communities which treats them as though they are free-standing entities will provide a limited solution at best. As illustrated by the multi-component approach, community engagement can, and arguably should, be located within a broader perspective which addresses the wider social forces that affect communities and leave them vulnerable to drug-related problems. These might include housing allocation policies, employment policies, transport policies; the impact of poverty and relative disadvantage; and the effects of economic, social and geographic isolation.

Partnerships between professionals and the wider community can play an important role in this context, reducing the isolation of community responses and going some way towards ensuring that the state continues to fulfil its responsibilities. Prevailing approaches to such partnerships reveal a number of problems, however, which relate to both their conception and operation. It is our contention that existing approaches need to be rethought and restructured in order to support more meaningful and legitimate forms of community engagement. The emphasis on community involvement in the drugs and alcohol fields should shift away from primarily law enforcement and criminal justice interventions towards building social cohesion. In addition, there needs to be a greater degree of power sharing with the wider community and a more inclusive approach which incorporates those elements of the community that are often marginalised, including drug users and their carers.

Notes

Chapter 1

- 1 *Druglink* is a magazine produced by Drugscope, the UK's leading independent centre of expertise on drugs (see: www.drugscope.org.uk).
- 2 For a brief summary of official drugs policy please refer to Appendix 1.
- 3 Drug and Alcohol Action Teams (DAATs) are primarily responsible for implementing and managing the national drugs strategy at a local level and bring together representatives of local agencies, including the health authority, local authority, police, probation, social services, education and youth services, and the voluntary sector. Representatives from these agencies also make up Crime and Disorder Reduction Partnerships (CDRPs) which were established by the 1998 Crime and Disorder Act to reduce crime and disorder. CDRPs are responsible for managing CADs. From April 2003 many partnerships merged CDRPs and DAATs.
- 4 Although designed as a telephone survey, this component of the study included a postal element. Individuals who proved difficult to contact by telephone were sent a copy of the questionnaire by post and were asked to complete and return it. In addition, some respondents preferred to complete the questionnaire themselves and return it by post rather than complete it as part of a telephone interview.
- 5 Each respondent was asked to provide contact details for the community responses in their area and were asked to suggest any other individuals who should be included in the survey.

- 6 This proportion may be a result of the way in which respondents were identified.

Chapter 2

- 1 Respondents could select more than one option.
- 2 This was assessed by comparing the level of volunteer input with the level of paid professional input. An initiative was considered to be volunteer led if it was totally or mainly dependent on the activities of volunteers and only slightly or not at all dependent on the activities of paid professionals. Similarly, an initiative was considered to be professional led if it was totally or mainly dependent on the activities of paid professionals and only slightly or not at all dependent on the activities of volunteers.
- 3 In terms of their focus on law enforcement, community partnerships were closer to grass-roots initiatives than to professional networks. With this one exception, however, community partnerships were very similar to professional networks in terms of their focus.
- 4 The national drugs strategy and the CADs initiative place very little emphasis on user and carer involvement. Neither form of involvement is mentioned in the communities section of the national drugs strategy, although an example of user involvement is noted on page 62 of the *Updated Drug Strategy* (Drugs Strategy Directorate, 2002). Nor is there any mention of user or carer involvement in any of the examples of local partnerships highlighted in

the CADs literature (Drugs Strategy Directorate, 2001b).

- 5 Initiatives where the respondent did not know if there was a management committee or steering group were excluded from this analysis.

Chapter 3

- 1 The only reliable information available regarding ethnicity relates to children attending local authority schools. In Eastdon, 94 per cent of the children attending such schools were white, which is much higher than the city average.
- 2 There was evidence of similar processes in the other case study areas. A community drugs project was established in Suburban Town, for example, several years prior to this study: prevention and treatment (with community involvement) have been priorities there for some time.
- 3 Operation Trident is a Home Office initiative aimed at tackling gun crime in black communities.
- 4 The name of the newspaper has been changed in order to protect the anonymity of those involved.
- 5 Public support for police action was corroborated in other accounts of events although the press did not report the incident positively.
- 6 The labels 'P1' and 'P2' have been used to distinguish between different respondents.
- 7 The organisers reported that a wider range of people were involved in the later rounds of the programme.

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Appendix 1

Drugs policy

The government's national drugs strategy is outlined in two key documents – *Tackling Drugs to Build a Better Britain: The Government's 10-Year Strategy for Tackling Drug Misuse* (Central Drugs Coordination Unit, 1998) and the *Updated Drug Strategy* (Drugs Strategy Directorate, 2002). It aims to reduce the harm that drugs cause society and has four main elements:

- young people – preventing today's young people from becoming tomorrow's problematic drug users
- reducing supply – reducing the supply of illegal drugs
- communities – reducing drug-related crime and its impact on communities
- treatment and harm minimisation – reducing drug use and drug-related offending through treatment and support; reducing drug-related death through harm minimisation.

The Home Office drives the delivery of the drug strategy at the ministerial and official level, in partnership with the Department of Health, the Department for Education and

Skills, HM Customs and Excise, the Office of the Deputy Prime Minister and the Foreign and Commonwealth Office. In 2001 the government established a special health authority, known as the National Treatment Agency (NTA), to drive the delivery of treatment services throughout England (www.nta.nhs.uk).

At the local level the national drugs strategy is implemented by Drug Action Teams (or, in some cases, by Drug and Alcohol Action Teams). DAATs bring together all the local agencies involved in tackling 'drug misuse', including the health authority, the local authority, the police, probation services, social services, education and youth services and the voluntary sector. They also work with Crime and Disorder Reduction Partnerships (CDRPs) to help the police and communities tackle local drug problems and associated crime (www.drugs.gov.uk). DAATs and CDRPs are being encouraged to go beyond merely working together and to actively merge their systems.

The NTA and drug teams in the regional government offices are responsible for monitoring the effectiveness of local delivery by DAATs.

Appendix 2

Methods

The survey

The survey sample was selected on the basis of a random stratified sample which was designed to provide a good geographical spread. DAATs in England and Wales were divided into nine broad regions using the standard regional classification. The first DAAT to be sampled was selected using random numbers and then every fourth case was selected.

Survey respondents tended to be concentrated in the age range 40–59 and were divided fairly equally between males and females. Very few individuals from black and minority ethnic groups were included in the survey (see Table A2.1).

As noted in the main body of the text, most respondents had some kind of professional involvement in the drugs and/or alcohol fields (see Table A2.2).

The case studies

Although the case study fieldwork produced a reasonably diverse sample of interviewees, our attempts to access local residents enjoyed limited success. In one of the areas fieldwork was seriously delayed by the need to gain ethical approval from the local NHS trust and insufficient time was left to access the wider community. In a second area, negotiating access

Table A2.1 Demographic profile of survey participants

Age (%)	
20–29	9
30–39	22
40–49	36
50–59	32
60+	2
Mean (in years)	44
Median (in years)	45
Sex (%)	
Male	45
Female	55
Ethnicity (%) ^a	
White	95
African Caribbean	2
Asian	2
Other	1

n = 148–154

^a The white category is made up of ‘white British’ (92%), ‘white Irish’ (2%) and ‘white other’ (1%); the African Caribbean category of ‘black Caribbean’ (1.3%) and ‘black African’ (0.6%); the Asian category, of ‘Pakistani’ (1.3%) and ‘Asian other’ (0.6%); and the other category of ‘other’ (0.6%) and ‘mixed – white and black Caribbean’ (0.6%).

Table A2.2 Nature of respondents' involvement in the drugs and alcohol fields^a

	%
Service commissioner, planner or policy maker	29
Drug/alcohol worker	18
Youth/community worker	14
Other – community focused	8
Other	33

n = 154

^a The category 'Service commissioner, planner or policy maker' includes DAAT chairs, DAAT co-ordinators, employees of the Drug Prevention Advisory Service (DPAS) and respondents who described themselves as service commissioners. The 'Youth/community worker' category includes the small number of respondents who described themselves as community activists or volunteers. The 'Other – community focused' category was made up of respondents who worked in a community-oriented position but did not describe themselves as a youth and/or community worker and included community services managers, community health development officers, community outreach development leaders, community safety managers/co-ordinators and DAAT community support workers. The 'Other' category was fairly evenly divided between the statutory and non-statutory sectors (these two groups made up 12 per cent and 11 per cent of the total sample) and covered a variety of specific occupations including police officers, doctors, nurses, housing officers, education officers, mental health officers, probation officers, project managers and a publican.

to the wider community through professional gatekeepers proved difficult and time consuming. Across the three case study areas data collection took the following form.

- *London Town*: qualitative interviews were conducted with three police officers, three council officials, the DAAT co-ordinator, three specialist drug/alcohol workers, two members of the young people/education team, two voluntary sector workers, two members of a resident/community consultation group and an academic running leadership training in the area.
- *Suburban Town*: qualitative interviews were conducted with four professionals involved in the development and

management of the local drugs strategy (including the DAAT co-ordinator), with the manager of a local drugs agency and with two volunteers in this agency.

Additional qualitative interviews were conducted with two consultants involved in community development in the area, seven volunteers from the community, one local community police officer, two officials from the local residents' association and one local councillor.

- *Northern Town*: qualitative interviews were conducted with six project workers directly involved in the case study project and with three current or past members of the DAAT. In addition, a group discussion was conducted with five volunteers from the case study project.

Appendix 3

Survey analysis

Variations in respondents' attitudes to community involvement were assessed on the basis of an initial factor analysis. This form of analysis aims to identify the general principles or factors around which people's attitudes are organised. All of the attitudinal statements were included in the initial analysis although two items were subsequently dropped. Both items – 'People with drug and/or alcohol problems need to be protected from the community' and 'Community responses ensure that the interests of marginalised groups are taken into account' – had proved conceptually problematic (respondents had difficulty answering them) and neither of them fitted clearly into any of the general factors. Once these items were excluded, four factors were identified (see Table A3.1):

- a pro-community factor made up of normative statements in support of community involvement
- a tokenism factor made up of empirical statements indicating concern about tokenism and/or scepticism about the role of professionals
- a resources factor made up of statements indicating that community involvement should not be seen as a cheap option

- a welfare factor made up of normative statements indicating support for the idea that the state should meet the needs of its citizens.

Factor scores were computed by adding together respondents' scores on each of the relevant items and dividing by the number of items included in the factor. This gave the average item score on a given factor. A score of -2 indicated that a respondent strongly disagreed with all of the statements on that factor, while a score of +2 indicated that they strongly agreed with all of them. The highest score was evident in relation to the resources factor, indicating that the vast majority of respondents agreed with the statements included on this factor (the average score on this factor was 1.38). More moderate agreement was evident in relation to the pro-community factor (0.34) and the tokenism factor (0.25), while considerable ambivalence was apparent in relation to the welfare factor (0.08). Respondents' scores varied according to the nature of their involvement in the field and pointed to quite different conceptions of community involvement (see Table A3.1)

Table A3.1 Respondents' attitudes to the role of community (principal component analysis – varimax rotation)^a

	1 Pro-community involvement	2 Tokenism/ scepticism	3 Resource intensive	4 Welfarism
Communities should be consulted about what services are doing	0.71	-0.06	0.14	-0.03
Professionals should not interfere with whatever it is that communities want to do	0.61	0.33	-0.20	-0.18
Services should be led by what the community wants them to do	0.61	0.01	0.15	0.21
Members of a community are best placed to know what that community needs	0.77	0.02	0.31	-0.11
There is a lot of talk about community action but the system works against it	0.11	0.58	0.49	-0.21
Professionals don't really know what the community needs	0.22	0.63	0.28	0.15
'Community' is just one of those buzzwords people use without really thinking about what it means	-0.18	0.79	-0.07	-0.02
Greater investment should be made in developing community initiatives in the drugs and alcohol fields	0.17	-0.003	0.77	0.07
To be done properly, community-based work takes up a lot of time and resources	0.09	0.13	0.64	0.06
Work with people who have drug and/or alcohol problems should be left to professionals	-0.27	-0.17	0.09	0.71
Communities have the right to expect that their needs will be met by those who are paid to provide services	0.30	0.29	0.01	0.73

^a Factor loadings show the correlations between a given item and a given factor and for each item the highest loading is shown in bold as this highlights the factor to which it belongs. The factor analysis model was conducted using both orthogonal and oblique rotations. The results were highly consistent and the results from the orthogonal rotation have been used as they may be interpreted more easily (Kline, 1994).

Exploring community responses to drugs

Table A3.2 Mean factor score by nature of involvement in drugs and/or alcohol fields

	Pro-community	Tokenism/ scepticism	Resource intensive	Welfarism	<i>n</i>
Service commissioner, planner or policy maker	0.32	0.18	1.18	-0.05	42
Drug/alcohol worker	0.41	0.27	1.58	0.15	27
Youth/community worker	0.84	0.75	1.55	0.14	21
Other – community related	0.39	0.56	1.54	0.08	12
Other	0.11	0.16	1.34	0.10	49
All	0.34	0.25	1.38	0.08	151

Table A3.3 Respondents' perceptions of the effectiveness of community involvement (%)

	Not at all effective (0)	Fairly effective (1)	Very effective (2)	Do not know (-)	Mean score
<i>Activities</i>					
Consultation about development of services/initiatives	27	47	19	7	0.9
Fundraising for services/initiatives	36	35	16	13	0.8
Evaluation of services/initiatives	37	39	14	10	0.7
Delivery of services/initiatives	40	45	7	8	0.6
Management of services/initiatives	53	25	10	11	0.5
Commissioning services/initiatives	56	24	7	13	0.4
<i>Areas of work</i>					
Education/prevention	26	46	20	10	0.9
Diversionary activities	28	44	18	10	0.9
Support for users and family/friends	23	45	21	11	0.9
Law enforcement	30	32	20	18	0.9
Aftercare and relapse prevention	35	32	13	20	0.7
Campaigning	46	28	6	20	0.5
Delivery of treatment	53	16	7	23	0.4

n = 147-150