COMMUNITY OPINION ON:

COLLINGWOOD SUBSTANCE ABUSE PREVENTION NEEDS

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ABSTRACT

This study gathered data on: What are the community identified substance abuse prevention needs in a culturally diverse, low income, urban community?

The study focused on the Collingwood area of Vancouver as it is a multicultural,low income, and urban neighborhood.

The study identified community opinion on local prevention needs by interviewing twelve area residents, eleven social service providers, and two distribution employees (total n=25). A content analysis methodology was used to identify ten frequently cited themes under attitudinal and strategic classifications.

The results indicate resident and provider differences. Residents are tolerant and providers view this tolerance as denial.

Residents favor social control and treatment strategies; providers favor attitude change and holistic strategies. Existing resources were seen as fragmented and early prevention education as being central to a comprehensive strategy. The implications of these findings for planners is discussed.

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CHAPTER ONE: INTRODUCTION

This study gathered data on: What are the community identified substance abuse prevention needs in a culturally diverse, low income, urban environment. The study attempts to provide data helpful to local prevention planners and for academic purposes by studying community attitudes towards substance abuse prevention. Other local studies have focused on specific ethnic group attitudes towards prevention needs (Legge, 1989; Urban Native Needs, 1988) or studied smaller non-urban communities (Neilson, C., Morris, B., & Mason, T., 1988; Mason, T., Morris, B., and Neilson, C., 1989; Schultz, L. and Bryne, G., 1989). None have studied multicultural, low income, urban environments. This research attempts to provide exploratory data on that topic.

Importance to Social Work

Urban substance abuse prevention needs were selected for study as social workers are frequently required to deal with substance abuse related problems. For example, child welfare workers must respond to substance

related "parental inability", health care workers to the impact of substance related injury and disease, and justice workers to the results of substance related crime. In addition all three fields need to deal with problems related to Fetal Alcohol Syndrome and Narcotic Addiction Syndrome. Obviously, successful attempts at decreasing and preventing substance abuse will result in a decrease in related problems.

Social service professionals are charged with the responsibility to assist people overcome individual and social problems. Traditionally, drug and alcohol programs have focused on helping those that are addicted or helping those who are affected by someone's addiction. Only recently have we moved beyond helping abusers and their families and attempted to prevent abuse before usage becomes problematic (Ashley and Rankin, 1988).

Definition of Substance Abuse Prevention

Professionals and community members tend to have differing definitions of substance abuse prevention. For some, prevention is primarily an education process that targets children and youth. For others, prevention attempts to decrease the negative consequences of dysfunctional usage. This study defines substance abuse

prevention as any activity designed to hinder or forestall the dysfunctional use of alcohol and other licit drugs, and to obstruct and hinder all usage of illicit drugs.

Extent of the problem

As 10% of adult Canadians can be classified as alcoholic and as 20% experience family or violence problems as the result of alcohol consumption, alcohol abuse must be seen as Canada's number one drug problem (Survey Canada, 1990). While substance use in all categories except cocaine is decreasing, the negative financial and social costs of substance abuse remains a significant concern (Alcohol and Drugs in Canada, 1989).

Many diseases such as, liver failure, kidney disease, and fetal alcohol syndrome are the direct result of alcohol abuse (Liquor Policy Review [LPR], 1987; Alcohol and Drugs in the Workplace, 1987; Alcohol in Canada, 1989).

Many deaths occur due to accidents that result from the physical and mental impairment commonly resulting from substance abuse (Alcohol and Drugs in the Workplace, 1987; Counterattack, 1990). One half of the 747 Canadian drivers killed in road accidents in 1985

had a .15 alcohol level (Alcohol in Canada, 1989). This is twice the legal limit.

The financial costs of substance abuse are not born just by the abuser; rather, the costs of substance abuse also affects the abuser's family and the wider community. Even non-users are affected if only in that they must pay higher taxes to deal with the results of the problem. Alcohol and Drugs in the Workplace (1987) reports that:

> "the negative results of alcohol consumption cost the Province over two billion dollars per annum, five times the amount earned through liquor sales on dealing with the negative results" (p. 4).

The need for the addicted to obtain money to buy illicit drugs leads to increased theft, law enforcement, court, and insurance costs (Wardlaw, 1986).

Besides the health problems associated with substance abuse, the behavioral impairment resulting from abuse has an impact upon the abuser's familial and social environment. The lowering of inhibitions experienced by many substance abusers increases familial and societal violence, and substance abuse is frequently a factor in child abuse and neglect (Ashley & Rankin, 1988; Wachtel, 1989).

Worker productivity and safety is also negatively impacted by substance abuse (Alcohol and Drugs in the Workplace, 1987).

Purpose of the Research

This study attempts to provide exploratory data regarding community opinion on the substance abuse needs in a multicultural, low income, urban community. The actual community under study is the Collingwood neighborhood of Vancouver, British Columbia. This research is a necessary first step in defining local need as it is the first time that Collingwood's substance abuse prevention needs have been examined. It is hoped that the results can be generalized to similar urban areas and be helpful to those interested in substance abuse prevention programming.

Abuse Prevention

Research shows that prevention strategies can discourage use and abuse (Botvin, Baker, Dusenbury, Tortu, and Botvin, 1988; Alcalay, 1983; and Flay, 1986). These programs aim at preventing substance abuse through a myriad of methods. Some attempt to decrease community consumption rates (e.g. the British Columbia

Provincial Government's "TRY Program" and awareness campaign to discourage alcohol consumption by pregnant women). Other strategies attempt to change community attitudes towards use (e.g. The United States Government's "Just Say No Program"). Other strategies attempt to influence children and youth through school and peer group approaches. School based programs such as the Vancouver School Board sponsored Secondary School "Counterattack Club Program" is but one example of a peer based strategy. Traditionally Government has also attempted to influence consumption through public policy and legislation. Legislation passed by both United States and Canadian legislators in the 1930's was a direct attempt to prohibit alcohol consumption. The British Columbia Liquor Control Act prohibits alcohol consumption by those under nineteen years of age and the Canadian Narcotics Control Act and the Food And Drug Act prohibits or controls the consumption of certain other drugs and substances.

While it is difficult to measure the effectiveness of these approaches at reducing consumption, it is interesting to note that alcohol and drug consumption rates have fallen since the mid 1980's. This may indicate that there is a positive relationship between the establishment of many of these prevention programs,

in the late 1970's and early 1980's and decreasing consumption rates starting in the mid 1980's. More research is required, however, before such correlation can be convincingly demonstrated.

Consumer Attitudes

This study focuses on the identification of community attitudes by sampling both professional and resident informants. While professionals are well placed to comment on certain aspects of community need, authors such as Larsen (in Russell, 1990), note that consumer opinion is necessary to counteract "supplier dominated" and incomplete data. This problem is magnified with disadvantaged consumers as they often lack the economic resources to allow choice between services and the political power to influence the actual operation of services. Consumer opinion was sought by this study in the attempt to rectify the imbalance between service suppliers and consumers.

Research Design

The study identified community opinion on local prevention needs by interviewing twelve area consumers (residents, n1=12), eleven social service providers (n2=11), and two distribution employees (n3=2). A

twelve question interview guide containing both common and supplementary subgroup questions were asked. The questions were selected to meet six specific research objectives.

Field notes were transcribed, coded, and grouped using content analysis into significant themes. The themes were then further analyzed and discussed.

Design Rationale

The research used operational inquiry, qualitative methodology, interviews, and content analysis to identify substance abuse prevention needs.

Qualitative methods were used in combination with a needs focused interview guide to identify community prevention themes. According to Patton (1989), qualitative methodology is:

> "particularly oriented toward exploration, discovery, and inductive logic... categories or dimensions of analysis emerge from open-ended observations as the evaluator comes to understand the patterns that exist in the empirical world under study" (p. 44).

The development of the interview guide drew heavily on the work of McKillip (1987). According to McKillip,

need focused research must be designed around two judgements: "(a) services available to a population are (or are not) adequate; and (b) if inadequate, specific actions will correct the inadequacy (p. 7). Given the relationship between "needs" (inadequate services) and specific actions, this study attempts to both identify existing needs and discuss possible actions (strategies) to address those needs.

Due to the needs and solution focus of the research, the study used the five steps of Need Analysis suggested by McKillip (1987). McKillip describes these steps as: 1) the identification of users and uses; 2) the description of the target population and the service environment, 3) the identification of problems and solutions, 4) the assessment of the importance of the needs; and 5) the communication of results.

Due to the absence of previous local research on substance abuse prevention and the qualitative focus of this study, the research design was largely exploratory in nature. According to Patton (1989):

> "responses to open-ended responses permit one to understand and capture the the points of view of other people without predetermining those points of view through prior selection of questionnaire categories" (p. 24).

Given the qualitative and exploratory nature of this study, a face to face, open-ended interview format was selected as the most productive and feasible method to explore these new data. It was also hoped that the sense of human connectedness that can develop in face to face and responsive conversation would have helped to activate research subjects in future prevention efforts.

A content analysis methodology was used to analyze the data. According to Berelson (in Bailey, 1978): "content analysis is a research technique for the objective, systematic, and quantitative description of the manifest content of communication" (p. 276). Bailey (1978) asserts that content analysis "first constructs a set of mutually exclusive categories that can be used to analyze documents, and then records the frequency with which each of these categories is observed in the documents studied" (p. 277).

This data was then analyzed and frequently occurring themes were noted, identified, and discussed.

Definitions

Substance Abuse, Alcoholism, and Addiction: Alcohol and Drugs in the Workplace, in 1987, defined alcoholism as:

"a disease characterized by the repetitive and

> compulsive ingestion of... ethanol (alcohol)... as to result in interference with some aspect of the person's life, be it health, career, interpersonal relationships, or other required societal adaptations. Alcoholism represents a dysfunctional or maladaption to the requirements of everyday life."

Mueler and Ketchum (1987), support the Report's definition. They describe current community attitude toward substance use as being permissive and tolerant as long as one can function appropriately in society.

Need: Neysmith (1983) notes that need can be "conceptualized in a variety of ways but all emphasize its judgemental and relative nature. This must be kept in mind when undertaking a needs study for the purpose of defining and providing services" (p. 8).

The study provides data on normative, felt, expressed, and comparative needs (Neysmith, 1983; McKillip, 1986). Normative needs are those that are typically defined by experts regarding desired professionally acceptable standards. Most normative data was obtained from interviews with local area professionals. Felt needs are those that an individual

believes must be met in order to maintain individually defined standards. Several open-ended questions were selected for use in this study to elicit individual opinion on "felt" substance abuse prevention needs. Expressed needs are typically those that are articulated with regards to specific services. This study asked several questions regarding existing services that were designed to elicit data on expressed needs. Comparative needs are those that compare the individual's perceived needs with those of others. This study collected data on comparative needs by asking a specific question regarding unique ethnic, age, or gender related substance abuse prevention needs.

Obviously, all of the needs identified by this study are subjective in nature and vary between individuals. Neysmith (1983) cautions:

> "these (subjective) factors must be taken into consideration if the information is to be useful and the developed service utilized" (p. 11).

Community Profile

Vancouver, like many other Canadian cities, has experienced considerable change in the recent years. The city has grown from a frontier outpost of largely European and First Peoples residents, into a

multicultural urban center serving a region of nearly two million residents.

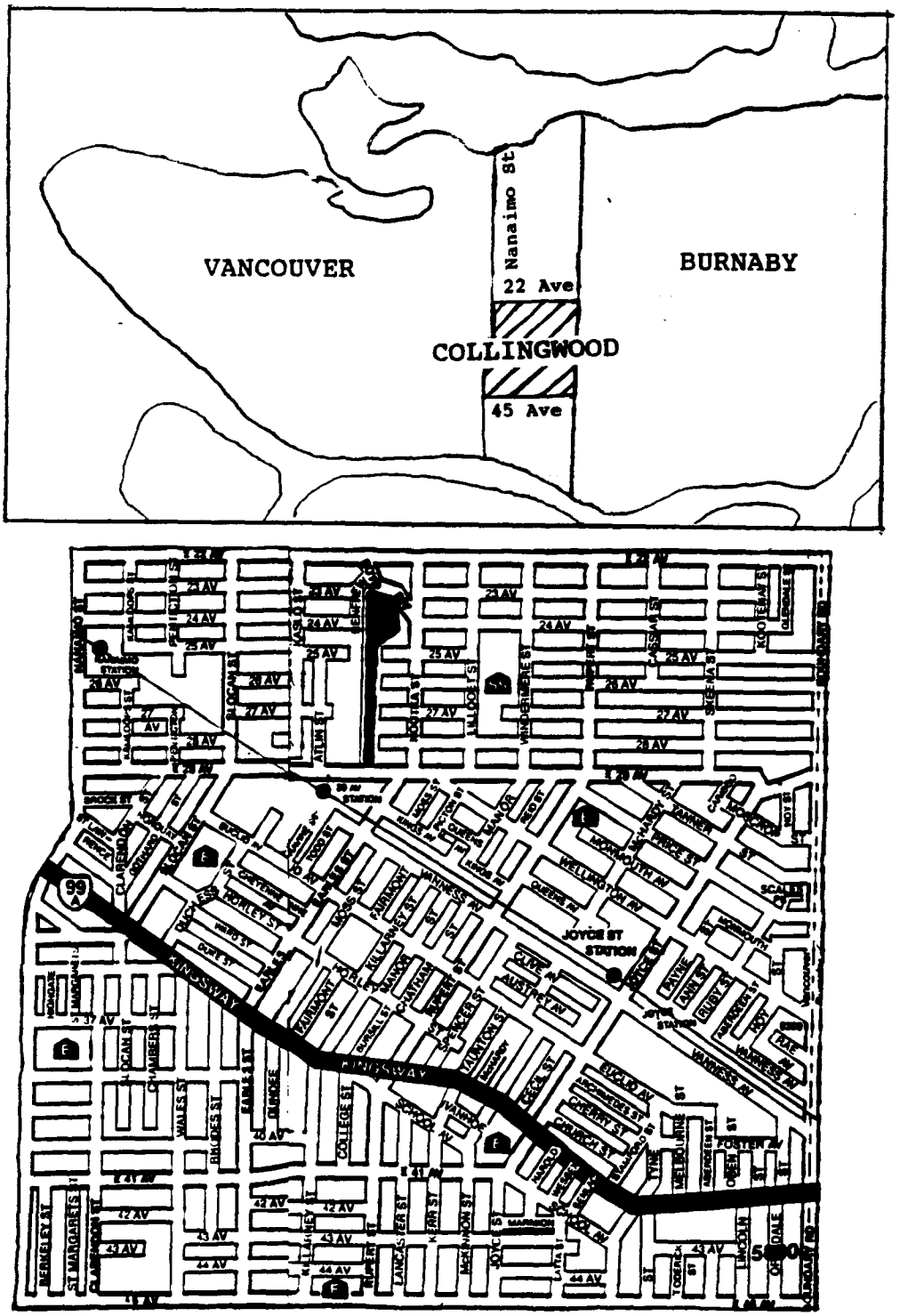
Early immigrants were typically of European background. In recent times however, most off shore immigration is from Pacific rim countries. Vancouver, therefore, is a city in transition and social planners are faced with a myriad of changing social problems.

In terms of substance abuse prevention, very little has been done to study needs in such ethnically diverse urban settings. Most local studies have focused on specific ethnic group prevention needs (Legge, 1989; Urban Native Needs, 1988) or studied smaller non urban environments (Neilson, C., Morris, B., & Mason, T., 1988; Mason, T., Morris, B., and Neilson, C., 1989; Schultz, L. and Bryne, G., 1989).

Collingwood is an approximately eight square kilometre area of Vancouver, B.C. located in the east central area of the City (figure 1). It consists of the area between East 45th Avenue, East 22nd Avenue, Nanaimo Street, and Boundary Road (the boundary between Vancouver and the Municipality of Burnaby).

According to the 1986 Canadian census (Statistics Canada), almost 26,000 people live in Collingwood. Approximately 50% of the population speak English as a first language, 25% speak Chinese or Vietnamese, 13%

Figure 1: Map of Collingwood



speak languages originating in the Indian subcontinent, 5% speak Spanish, and 6% speak other languages. Of all households 70% have children and single parent families represent 14.5% of the population. Of area residents over 15 years old 70% have literacy rates below the grade nine level. Approximately, 16% of area residents are under 12 years old, 16% are aged between 12 and 24, and 68% are over 24 years old while 21% are senior citizens.

In 1986 annual average income of all Vancouver families was $39,9086; the average median was $32,418. The Collingwood average family income was $33,076 and the median family income was 32,418. This data indicates that Collingwood's average family income was $6832 less than the city average and the median $1600 less. Given these below average income levels Collingwood can be defined as being a lower income area.

Summary

Substance abuse has a serious impact on the community. Traditionally, researchers have focused on approaches that have attempted to "pick up the pieces". Only recently have social planners begun to develop organized strategies designed to prevent substance abuse before it becomes a problem.

Most local research on prevention needs have studied suburban or semi-rural environments or specific ethnic groups. Very little research exists on the prevention needs of multicultural, low income neighbourhoods. This study attempts to provide data on these needs.

In the following chapter, relevant statistics, indicating current consumption trends will be reviewed to determine the scope of the abuse problem. This review is followed by an examination of the role of community attitudes upon usage and several theoretical prevention paradigms are presented and discussed.

CHAPTER TWO - LITERATURE REVIEW

Introduction

Three areas of literature were reviewed by this study. Reports and statistics were reviewed in the attempt to understand the extent of the problem. This examination is particularly important to those that must balance competing needs and set spending priorities.

Local studies and articles were examined to understand the impact of community attitudes on identifying substance abuse prevention needs. Understanding community attitude and consumer satisfaction is helpful to those designing programs that reflect community attitudes and to those attempting to influence them. Finally, literature regarding theoretical prevention paradigms was reviewed to provide a theoretical framework to those attempting to develop specific prevention programs.

The Extent of the Problem

This study draws heavily on the 1987 work of J. McKillip, Needs Analysis: Tools for the Human Services and Education. McKillip, suggests that National or Provincial statistics can be used to determine need in

local studies as: "prevalence rates for demographic groups from smaller areas are the same as rates for.... groups on a larger level (p. 45 Holzer, Jackson, & Tweed 1981, in McKillip, 1987)".

The benefits of using this data is that it is readily available, inexpensive, and can act as proxy measures of the local situation or problem (McKillip, 1987).

As few statistics exist dealing specifically with Collingwood substance use and abuse, a variety of consumption, social, legal statistics covering Canadian, British Columbian, and Collingwood patterns and trends have been reviewed as part of this study. A review of these data gives some indication of local trends and patterns.

Also, as Collingwood is a multicultural community, data focusing on Chinese, Vietnamese, Spanish speaking, Indo-Canadian, and Native prevention needs were reviewed and reported. These documents were used to examine the scope of the alcohol and drug problem generally and Collingwood's problems specifically.

The Extent of the Alcohol Problem

Alcohol abuse is the number one drug problem in Canada: 80% of Canadians are drinkers and 10% have

alcohol related problems. In 1986, conservative estimates cited the Canadian ratio between profits from the sales and the money spent to address problems as $3.78 billion vs. $5.25 billion (Alcohol in Canada, 1990).

Some Reports, such as, The Report on Alcohol and Drug Abuse in the Workplace (1987), cited social costs as being five times higher than the money received in income. At the same time, Canada has the eighteenth lowest per capita consumption rates of twenty-eight industrialized countries (Alcohol in Canada, 1990).

Canadian consumption peaked in 1980 at 11.3 litres of absolute alcohol per person per year. This rate fell to 10.2 litres in 1986. This represents an 8% decrease. Since 1986, this pattern of decreasing usage has continued, with the highest decreases occurring in the youngest and oldest groups. While these trends are encouraging, current consumption rates remain almost twice the 1950 (5.9 litre) rate (Alcohol in Canada, 1990).

In 1986, 11% of current drinkers, drink more than four times per week and 6% have more than 15 drinks per week. Approximately 20% of Canadians report experiencing family problems or violence as the result of drinking (Survey Canada, 1990). In 1985, 10.3

million trips per month were made by impaired drivers. Half of these trips were made by 3% of the population. One half of all car fatalities are the result of impaired driving. The 16 to 19 age group have the highest car fatality rates, many of which involved intoxication (Alcohol in Canada, 1990).

Generally speaking, men drink more than women (88% vs. 78%) and men consume more at a sitting. This gap is narrowing as more men are now not drinking or drinking less. Separated, divorced, and single people consume the most alcohol per week. Widows are the least likely to be current drinkers (Survey Canada, 1990).

Higher income and education groups drink more frequently than lower income and education groups, but the lower income and education groups drink more at a single sitting (Survey Canada, 1990).

While declining consumption rates among the young are encouraging, the earlier one starts drinking the greater the likelihood of developing alcohol related problems in adulthood. Unhappily, the first time median alcohol usage in B.C. appears to be decreasing. In 1986, it was 14 years of age; a dramatic decrease from 1956 median age of 18 years of age (B.C. Policy Review, 1987).

B.C. has the highest alcohol consumption rates of

all Canadian Provinces, (1982: 12.5 litres; 1986: 11.2 litres; and 1989: 10.9 litres). These rates indicate a 2.7% decline in average consumption since 1985. (B.C. Liquor Distribution Branch [BCLDB], 1990).

Impaired drivers arrest statistics have fallen by more than 50% since 1977. Vancouver is 8% below the Provincial average in terms of impaired driving charges (Counterattack, 1989).

Collingwood consumption patterns are difficult to determine. The Senlac Liquor Store (located in Collingwood at Kingsway and Senlac Street), sold approximately $10 million worth of product in 1989. This represents an 11% decrease in sales since 1982. This decrease does not necessarily measure local consumption patterns as it does not take into account population growth nor increased non-Governmental outlet "off sales" from other distributors. Senlac statistics indicate that residents prefer beer (7.5% above the provincial average) over spirits (10% below the average) and wine (5% below the average) (BCLDB Annual Reports, 1986 to 1989).

It is interesting to note that Collingwood's preference for beer over wine and spirits may be an indicator of class preference in drinking patterns. The Canadian survey on Alcohol and Drugs (1989) notes that

higher income respondents tended to drink more wine and spirits than low income respondents.

The Scope of the Drug Problem

Licit Drugs Canadians are high users of Prescription drugs (1985: 8% sleeping pills; 6% tranquilizers; 2% pep pills). B.C. and Quebec have the highest provincial usage rates (Drugs in Canada, 1990).

Women use more prescription drugs than men at a ratio of 1.7 to 1 and doctors more frequently prescribe drugs to women than men, even when patients present similar symptoms. In 1982, seniors surpassed middle aged women as the highest prescription drug user group. Lower income groups use at higher rates than higher income groups (Survey Canada, 1990).

Collingwood's lower economic status and high number of single female residents could be indicative of high licit drug consumption rates.

Illicit Drugs Generally speaking, illicit drug use is lower in Canada than the U.S.A. Cocaine and "crack" use is much lower than in the U.S.A. and some research suggests that it is not as large a problem as reported. In 1982, 3.3% of Canadians reported using cocaine at least once in their lifetime: by 1987, 6.1%

reported at least once in lifetime use (Drugs in Canada, 1990).

Use of other illicit drugs is decreasing (usage peaked in the mid 1980's). In 1980, 20% of Canadians reported at least once in lifetime use and 12% were current users. In 1989, 23% reported once in lifetime use and 6% were current users (Drugs in Canada, 1990).

B.C. has the highest illicit drug use of all the Canadian Provinces. In 1989, 9.6% of British Columbians were current users (Survey Canada, 1990).

In 1987, 30% of B.C. adolescents had used cannabis and 14.2% had used hallucinogens in the previous year, and 52% of adolescents claimed that marijuana was fairly easy to get.

A review of B.C. police statistics reveals that heroin charges peaked in 1978, at 0.324/1000 and have declined to a low of 0.087/100 in 1989. Cannabis charges peaked in 1982 at 3.860/1000 and fell to 3.080/1000 in 1989. Controlled and restricted drugs similarly peaked in 1983 and have been decreasing since. Conversely, cocaine charges rose from 0.071/1000 in 1979 to 0.951/1000 in 1989 (B.C. Police Statistical Summary, 1990).

If Collingwood's illicit drug use patterns resemble those reported by these studies, we would expect area

youth to be the largest group of illicit drug users. Their most frequently used drug is likely marijuana. Local use of illicit drugs should be decreasing, although cocaine usage is probably on the rise.

Rationale for Consumer Surveys

According to McKillip, client surveys, due to their exposure to the service, tend to measure client satisfaction and choice. Client surveys are also cited as being particularly helpful when identifying barriers. As the client group targeted in community prevention programs is the residents, "client" related data was obtained from residents and people involved in recovery from substance abuse (e.g. Alcoholics Anonymous).

Also, as is noted by Russell (1990): "only by systematically soliciting client feedback that is comprehensive and informative, can the imbalance in influence between consumers and suppliers of social services be rectified" (p. 44).

McKillip notes that key informant surveys are noted as being normally inexpensive and relatively easy to use, but tend to provide data which is limited and focused on specific agency need.

Local Community Studies

Ethnic Studies Legge's 1989 study used self reported questionnaires and interviews (n=328) with Chinese, Vietnamese, Indo-Canadian, and "Latin" community members (n2=233) and "key informants" (n1=95) to determine B.C. ethnic alcohol and drug education needs. Legge notes that: Chinese men drink frequently but moderately, Vietnamese men drink more frequently and in higher amounts than the Chinese; Latins (Spanish speaking) men were found to be frequent heavy drinkers; and Indo-Canadian men tend to be weekend drinkers (more than four drinks per sitting).

Chinese people are perceived as not tolerating drunkenness; Vietnamese and Latins accept occasional inebriation. All groups view teen and female intoxication as being unacceptable and cite single men as being most in need of prevention services.

Illicit drug use was not reported as a major concern in any group except the Latins. Spanish speakers were particularly concerned about substance usage among youth.

Generally, these groups saw the need for a range of prevention services in English as well in their native languages. As Collingwood has significant percentages of the ethnic groups studied by Legge, we can speculate

that the area shares many of these consumption patterns.

Native people are seen as needing culturally sensitive approaches that recognize the unique problems faced by Native people (Native Needs, 1988).

Suburban and Rural Studies Mason, Morris, and Neilson (1988), studied the Squamish area's Alcohol and Drug Program needs by surveying community informants (n1=498) and interviewing Health, Justice, and School professionals (n2=42). The authors found that existing programs were effective but insufficient to meet community needs. Youth and family services were identified as being the greatest need. The study notes that most alcohol and drug problems are life-style related and that community attitudes that tolerate or encourage alcohol and drug abuse need to be changed.

Mason et al. suggest that more youth orientated non-substance related recreation programs are especially needed. This could explain why usage is high among youth in the northern Regions where recreational options are fewer. Generally, the study found that more effort should be put towards awareness and education campaigns to confront denial and raise "the public conscience" about the effects of substance abuse. The authors also suggest stricter enforcement of existing laws.

Neilson, C., Morris, B., & Mason, T. (1989), interviewed and surveyed a random sample of area residents (n1=190) and selected key informants (n2=44) to study the Whistler area's alcohol and drug prevention needs. The study included several informants involved in the distribution of alcohol in their key informant group.

The study found that a majority of respondents believed that alcohol abuse was a significant problem for the community. Approximately 25% of respondents reported that some member of their family had a problem with substance abuse.

Neilson et al. report boredom and isolation as being the major causes of substance abuse. Increased recreation and social activities were the most often cited solution to alcohol and drug problems. Teens and youth were seen as being the most in need of non-drug related social activities. Increased education and awareness, psychological services, and law enforcement were also reported as being significant substance abuse prevention needs.

Schutz, L. & Bryne, G. (1989), studied substance abuse prevention needs in Port Moody, Port Coquitlam, and Coquitlam (Tricities). The study used thirteen professional group meetings and a mail out parent

survey (n2=232) to identify youth substance abuse needs in the Tricities.

The study's results were used to make eleven specific recommendations regarding potential solutions to youth substance abuse prevention needs in the Tricities. The study identified the following: (1) further research in non-suburban, non-middle class communities, (2) development of the local task force, (3) increased government funding, (4) target the entire community for awareness campaigns, (5) personalize the impact of the problem, (6) focus on education and prevention, (7) increase community involvement, (8) concentrate on elementary schools, (9) comparative studies, (10) use former users in publicity campaigns, and (11) more prevention program volunteers.

While these non-ethnic focused studies do provide interesting data, their relevance to Collingwood must be balanced against differences in the communities studied. Both the Squamish and Whistler areas are much more rural than Collingwood. Further, Whistler is a resort community that promotes, according to the study's authors, a "party atmosphere" focusing on the "weekend crowd". This party and tourist community focus, encourages the community to have a tolerant attitude towards alcohol consumption and intoxication.

The Tricities study, focused exclusively on youth needs in three suburban communities. This study notes that one of the limitations of their study was the "middle class" demographics of the sample. The youth focus and its middle class nature limit the relevance of the Tricities study to Collingwood's needs.

Community Tolerance towards Consumption

In order to interpret community opinion on substance abuse prevention it is helpful to understand community and consumer attitudes and tolerance levels. Ashley and Rankin (1988), provide a conceptual framework for understanding the attitudinal diversity regarding acceptable alcohol consumption. The authors conceptualize community attitudes as falling into four categories: (1) morally wrong, (2) disease, (3) integration, and (4) population consumption.

The morally wrong to consume model is held by certain religious groups such as Baptists, Mormons, Muslims, and Sihks. For these groups the consumption of alcohol is viewed as being sinful, therefore, any consumption is unacceptable and wrong. These groups tend towards prohibition and abstinence as being the preferred prevention approaches.

The disease model, held by groups such as Alcoholics

Anonymous, view addiction as being a disease, therefore, they tend to view prevention efforts as needing to focus on high risk groups. Individuals who view substance abuse as a disease tend to view prevention as encouraging those predisposed to addiction to abstain or to encourage those effected by the disease to seek treatment at its early stages.

The integration model defines alcoholism as the "failure to integrate alcohol use into everyday functions of society." The integration model is frequently used by those who drink alcohol but who also tend to view addiction and alcoholism as a moral weakness. The authors argue that this model has led to society tending to ignore increasing health and social costs as it presumes that the majority can drink alcohol without becoming addicted. They note that this model has dominated North American policy making since the mid 1940's. The ideas represented by the integration model also lend support to the functional definition of alcoholism expressed by writers such as Mueler and Ketcham (1987).

The population consumption model focuses on the community. The central thesis is that if average population consumption rates are decreased the hazardous results of over drinking will also be decreased. Smart

(1987), points out that decreasing provincial consumption rates in Quebec, Ontario, and Alberta, between 1974 and 1983, have resulted in a decrease in alcohol related problems in Quebec and Ontario.

We can expect community opinion on substance abuse prevention to reflect individuals holding each of these beliefs towards prevention. Researchers, therefore, must attempt to be aware of the prevention orientation of the data source, as that attitude will color and bias the data and will influence their perception of possible solutions.

Prevention Paradigms and their Implications

McKillip (1987), argues that there is a relationship between how one defines needs and the resulting solutions. Further, he asserts that the identification of needs inevitability leads to an examination of services designed to met those needs. As these two "judgements" are interrelated, a comprehensive literature review must discuss both dimensions to achieve a complete understanding of the issue.

This next section discusses the theoretical paradigms frequently used by prevention planners. In recognition of the interrelationship between the definition of need and the resulting prevention

approach, examples are provided for each paradigm discussed.

Johnston, Amatetti, Funkholder, and Johnston, (1988); discuss nine theoretical paradigms commonly used when addressing substance abuse prevention needs. These theories are: (1) social learning, (2) cognitive dissonance, (3) developmental, (4) behavioral intention, (5) social development, (6) health behavior, (7) drug involvement stages, (8) deviant response, and (9) sensation seeking.

Social learning theory sees drug using behavior as being learned through the influences of reward, punishment and social modeling. When attempting to influence usage decision making towards non-use social learning theory frequently uses a team or group approach (often involving "near peers" and other modeling relationships) in the attempt to establish non-using norms. For example, public education campaigns that use cultural trend setters to promote a non use message, abstinence support group programs such as Alcoholics Anonymous, and the school based "Dry Grad Program" use a social learning prevention approach. Public education campaigns that stress the negative consequences (e.g. imprisonment), of substance abuse is another example of the use of this approach.

A social learning approach is most frequently used by contemporary substance abuse prevention planners (e.g. if you drink, don't drive).

Gullotta and Adams (1982), note that the goal of prevention education is to increase social learning and knowledge, in the hope that this will result in increased manifestation of the desired behavior. They further note that apparently successful educational approaches include multifaceted features beyond strict educational tools. They assert, therefore, that substance abuse education programs: "need to utilize every available tool, while using multiple theoretical perspectives to achieve some degree of success" (p. 418).

Coombs, Santana, and Fawzy (1984), suggest that drug use is a learned behavior that occurs with youth raised in a variety of social conditions. They assert that educating parents how to have more positive interactions with their children will result in increased child self-esteem and increased determination to resist pressure to use from drug using peers.

Strickland and Pittman (1984), integrate peer based social learning and media exposure to reduce substance use. The authors argue that these two theories are related and that we must have a more comprehensive

explanation of adolescent problem drinking if we want to reduce it.

Alcalay (1983) found that the most prevention focused media campaigns seek to increase knowledge or to change behavior and attitudes, in the hope that behavior will change as a consequence. Alcalay argues that this assumption is now being challenged by researchers. She asserts, rather, that these campaigns tend to reinforce already accepted behavior. She argues that the media does not change the behavior of those who have already come to the decision to use. She also notes that one weakness of mass media campaigns is that they do not allow feedback nor interaction. This lack of interactiveness and the tendency to view the individual as an object and not unique human being, lessen the impact of the message being communicated.

Cognitive dissonance theory holds that what one's beliefs and attitudes are reflected in one's behavior and that when they are not, the individual experiences a certain "cognitive dissonance" that he or she will attempt to eliminate. Prevention programs using this theoretical perspective tend to "cognitively inoculate" individual community members largely by promoting verbal non-use messages. For example, public education

campaigns that promote the message that "cool" people don't use drugs is an attempt to associate popularity and social desirability with drug abstinence. In this example, cognitive dissonance theorists would hold that if the individual comes to believe that being "cool" and using drugs are incompatible, people desiring to be "cool" will have to say no to drugs or else their "coolness" would be in question.

Interestingly, Williams, Ward, and Gray (1985), found the "credibility" of the communicator to be the most significant factor in accepting a non-use message in one school based prevention program.

The United States Government sponsored "Just Say No" campaign is one well known example of the use of this approach.

Frequently, social dissonance programers will back up the non-use message with the teaching of refusal skills. One method of teaching refusal skills is for the teacher to verbally describe a drug taking social situation and help individuals identify strategies that they can use to avoid usage. The teacher may also use role play techniques to provide the student an opportunity to practice using these techniques.

Gullotta and Adams (1982), discuss using a similar approach with youth. The authors attempt to promote

feelings of self worth as a means of reduction of the likelihood of substance abuse. While a myriad of self worth techniques exist, programs using this tool attempt to reinforce and strengthen the individual and his or her environment rather than focus on stemming the supply of the substance.

Developmental theory conceptualizes human life as being organized around meeting certain age appropriate behavioral, social, and intellectual goals.

Developmental theory holds that prevention programs should be designed in recognition of the developmental place of the target population. For example, children eight to twelve are typically seen as not being able to think abstractly, therefore, substance abuse prevention programs designed for this age child should be concrete and give a non-ambiguous non-use message.

Ericksen (1956), viewed adolescents "as impatient idealists" who are in search of identity; their question being "who am I?" Prevention programs aimed at teenagers using this approach attempt to help youth form positive non-use identities around their ideals.

Oeting and Beauvais (1986), take a developmental orientation when they discuss drug use and the peer identification process in adolescence. They point out that understanding and using the adolescent's peer group

as a change agent is an important factor in understanding and preventing usage.

Behavioral intention theory suggests that a person's attitudes, beliefs, sense of normalcy, and expectations can be used to predict the likelihood of that person demonstrating a specific behavior. Behavior is seen as being influenced by a number of variables that link together to produce a specific behavior. Johnston et al. (1988), suggest that the predictability of a specific behavior is influenced by four central criteria; (1) the nature of the action, (2) target, (3) context, and (4) time. An individual will be influenced by all of these factors and a change in any one of them may have significant impact on the behavior. For example, if the nature of the action is intoxication, the target is alcohol, the action is driving a car, and the time is rush hour, an individual may not choose to drive a car. However, if the time variable is changed to four a.m., the same individual may choose to drive.

Also, behavioral intention theory highlights the importance of social norms of influencing behavior. For example, one social group might perceive it to be acceptable and normal to drink and drive (e.g. people living in isolated locations) while another group does not (e.g. people living in high traffic volume areas).

Knowing and attempting to influence a group's sense of normalcy can therefore serve as a valuable prevention technique. For example, people living in isolated areas could be informed about the higher number of single car accidents and deaths resulting from impairment.

Gullotta and Adams (1982), suggest that efforts that attempt to change normative (accepted community levels of tolerance) drinking and drug taking behaviors, such as media campaigns, education, and legal fiat, are three commonly used community mobilization tools.

The social development model uses attachments between individuals and other social units to influence substance usage. Ideally, social development theory seeks to create a positive peer group while at the same time it ensures that society provides a clear and consistent messages about usage and abuse. This approach is frequently used by social minorities, such as the native peoples, as a central prevention philosophy.

Gullotta and Adams (1982), cite natural care giver and self help groups as social units that can influence substance abuse prevention. These groups typically organize around a specific problem in the attempt to solve it. Mothers' Against Drunk Drivers (M.A.D.D.) and the "Dry Grad Program" are examples of use of this

approach. Gullotta and Adams note that these types of programs provide a good starting point in the development of a comprehensive prevention program. They caution, however, that a comprehensive program must be built around a combination of research, theory, and practise in order to minimize substance abuse in society.

Health behavior theory views substance abuse prevention as part of a larger health strategy that stresses the benefits of having a holistic perspective on the impact of an activity upon an individual's social environment and his or her physical and mental health. Prevention techniques using this orientation tend to promote health-enhancing behaviors that include the individual's entire behavior repertoire.

Swisher (1984) used cognitive approaches and a social alternatives program to influence adolescent usage. He found that information alone was not effective in reducing teenage usage but that this approach must be reinforced by involvement in a non-use social alternative group. Swisher adds that this combined approach was successful and "cost effective."

Drug involvement stages theory views initiation to drug usage to be predictable given the presence of a number of situational, interpersonal, and psychological

factors. Understanding and manipulating these factors is seen as being essential when influencing usage or behavior change. Approaches using this orientation focus on early education aimed at gateway target drugs such as cigarettes or alcohol.

Botvin, Baker, Dusenbury, Tortu, and Botvin (1988), conducted a three year, large sample study of effectiveness of a school based prevention program in reducing cigarette smoking. The program resulted in a significant reduction in cigarette smoking in the prevention program group.

Deviant response theory views drug use and alcohol abuse as a manifestation of an individual trying to gain status within a deviant subgroup. This usage is seen as being an attempt to boost self-esteem. It is interesting that some people seem to reject socially acceptable methods of increasing self esteem while embracing other "deviant" methods of accomplishing the same goal. This is a complex question which could easily become the topic of a separate thesis.

Sensation seeking theory holds that an individual has a need for sensory stimulation, and that substance use provides one opportunity to meet this end. This theory is often used by those who point out that the number of people reporting drug use decreases after age

thirty and that young men have higher sensation seeking levels and alcohol consumption levels than young women.

The Role of Public Policy in Prevention

Public policy attempts to influence consumption by using Government regulatory means to control consumption. Johnson et al, argue that alcohol related problems decrease as the price for alcohol increases. They assert that by raising the minimum alcohol purchase age, shortening the hours of sale, and other distribution controls results in a general decrease in alcohol related problems.

MacDonald (1986) notes that changes in legislation in four American States designed to provide more convenient access to wine (sales in retail stores), resulted in a modification of consumption patterns. While wine sales increased, beer and hard liquor sales remained about the same. MacDonald concludes that consumers did not switch from beer and spirits to wine, rather the amount of wine that wine drinkers drank simply increased.

Smith (1986) notes that the number of alcohol related traffic problems and accidents increased in four Australian States in the six years immediately following the lowering of the drinking age from twenty to

eighteen. The Task Force on Substance abuse in the Workplace (1987), notes that while raising the drinking age in B.C. would probably decrease the number of alcohol related problems among young drinkers, the Canadian Charter of Rights and Freedoms, which sets the age of majority at nineteen makes such a move impossible.

Casswell (1985) discusses some of the "organizational politics problems" that acted as barriers to public efforts to stabilize or reduce alcohol consumption rates in New Zealand. Among the greatest opponents to these efforts were the "alcohol industry, the advertising industry, and sporting organizations." These groups all rely on alcohol sales as a source of income. Pressure from these groups tended to create political resistance to the establishment of programs designed to decrease alcohol consumption.

Finally Johnston et al. (1988) suggest that a holistic approach that coordinates general health promotion activities, programs for targeted groups, media persuasion campaigns, and public policy in common strategy is needed. They conclude that: "a rational prevention policy will have hundreds of items in it... they will all have to be done (p. 584)."

Summary

The literature clearly demonstrates that alcoholism and substance abuse is a serious and costly social problem. A number of theoretical paradigms exist regarding substance abuse prevention and it has been suggested that multiple aspects of these paradigms need be organized into effective prevention program.

The following chapter will describe the steps and theoretical framework used by this study to identify community prevention needs.

CHAPTER THREE - METHODOLOGY

Purpose

The question posed in this study was, what are the community identified substance abuse prevention needs in a culturally diverse, low income, urban environment. This data was collected to assist in the development of an effective substance abuse prevention strategy for communities exhibiting these characteristics.

As part of the larger research question six more specific areas of investigation were addressed.

i) to what extent is the community aware of existing substance abuse prevention programs?

ii) what are the ways and means that community members consider existing prevention services might better meet the area needs?

iii) what are community member perceived barriers, strengths, and gaps in existing substance abuse prevention efforts?

iv) what are current substance abuse prevention needs as identified by local professionals, distributors, and community residents?

v) what are the target groups for future substance abuse prevention efforts?

vi) what are community priorities as identified by community members?

Sample Selection

This study used a small purposefully selected sample (n=25). McKillip (1987) argues that in even in small scale limited surveys, samples should be selected that provide a variety of perspectives. He labels this method as "purposeful sampling". Purposeful sampling uses representatives of various subgroups and attempts to measure variability and not central tendency.

Consumer (resident) and supplier (service providers and distributors) opinion was solicited in recognition of the importance of balancing community input in prevention planning.

Each group was considered to have a different perspective on substance abuse prevention.

Two criteria were used to define the resident sample population: nineteen years of age, and principle domicile maintained in Collingwood.

Recruitment of volunteers through posters located at central community facilities was unsuccessful.

Subsequently, two local community service committees, the Area Services Committee and the Collingwood/Champlain Heights Community Substance Abuse

Prevention Committee (C.C.H.C.S.A.P.C.)., and three substance abuse community services, Alcoholics Anonymous, Narcotics Anonymous, and Alanon were contacted to ask for their assistance. All of the organizations contacted were asked to publicize the need for subjects and to ask interested potential subjects if their name and telephone number could be given to the researcher. These organizational contacts then gave these names to the researcher, who subsequently contacted them by telephone. Twenty-one potential resident subjects were identified in this manner.

Of the 21 residents, 12 were selected for interview if the subject met one or more of the following criteria: first language other than English, young adult age group (under 35), former substance abuser, male (to balance female predominance in the client group), and residence in the less densely populated and commercial southern third of the study area (different community focus towards the Champlain Heights area).

The final group of twelve subjects was therefore purposefully selected around five variables: language, age, gender, recovery, and place of residence. The final sample selected included all the E.S.L. (3), all under thirty-five years of age (3), and all recovering (1) subjects. Four men were selected to add gender

balance and one resident who lived near in the southern third of the area (see Appendix B: Resident Characteristics).

Social Service Providers Selection

Total sample of service providers was eleven (n=11). The sample included five categories: social service workers, school, medical, police, and recreation. These categories were selected as they represent major prevention groupings for services listed in community service directories and this study sought to select two representatives each category.

The central selection criteria used for service providers was employment in an agency included in at least one of the five service categories. In order to identify these services providers, the Area Services Committee was approached and asked to assist in participant identification. Explanatory Letters (Appendix C) were circulated at one of the Committee's regular meetings.

The service providers responding to this request were asked to briefly describe the substance abuse prevention aspects of their work and were assigned to one of the service categories. As a result of this process seven service providers were identified either

through volunteering themselves or by discussing the study with their colleagues. This group contained two social service workers, two recreation workers, one medical worker, one school representative, and one policeman. In order to complete the sample, the researcher then directly approached relevant agencies: 4 medical clinics, 2 school counselling offices, and the local police detachment.

These agencies were initially contacted by telephone and follow up Explanatory Letters sent to agreeing agencies.

One school subject and one medical worker were identified as a result of these contacts. A second police subject could not be recruited and was replaced by a child protection worker.

After this sample was selected, it was noted that the absence of a multicultural perspective was an significant deficit. It was decided that a multicultural service provider be added to the study.

The final service provider sample (n=11) consisted of: three social service workers, two recreation workers, two school workers, two medical workers, one police worker, and one multicultural worker (Appendix D: Service Provider Characteristics).

Distributor Selection

Distributors of intoxicating substances have regular contact with users and abusers, therefore their opinions are useful when examining the area's prevention needs. While distributor input is helpful, it is also open to bias as the distributor makes money from sales. He or she may not want to encourage a decrease in consumption as that will impact upon profit.

The original study targeted five types of local distributors: liquor store employees, pharmacists, licensed premises employees, licensed restaurant servers, and drug traffickers. These classifications were chosen as they represent the five main distribution occupations occurring in Collingwood.

The other selection criteria was that the subject's work site or distribution point must be physically located in Collingwood.

Due to the limited resources available, the study, targeted a subject sample to include one distributor from each distribution classification for inclusion in the study.

Subjects from this group proved to be the hardest to recruit. No distributors were recruited using community posters or third party recruitment methods. Due to this lack of respondents, three licensed premises, three

licensed restaurants, one retail liquor outlet, and three pharmacies were targeted for special recruitment. The managers of these outlets were directly approached and the researcher explained the research project.

If the manager was not available, the researcher explained the project to the presenting employee and left a copy of the explanatory letter for the manager to read.

Recruitment efforts for the drug trafficker category, due to the illegal nature of that activity, presented special recruitment problems. The researcher attempted to recruit traffickers by word of mouth, guarantying anonymity.

Two residents said that they knew a drug trafficker and said that they would approach him or her regarding participation in the study, none came forward.

A hotel manager and a pharmacist agreed to participate in the study (n3=2) as a result of these efforts. Due to the small number of identified distributors and the similarities of this group to service providers, their data was collapsed into the service provider data and subsequently treated as one unit of analysis (n2=13).

Summary of Subject selection

The study targeted three sample groupings: consumers (residents), providers, and distributors. Each group was selected on the basis of having different perspectives on area needs.

Consumer selection attempted to select a cross section of twelve subjects using linguistic, age, gender, recovery, and geographic criteria. Eleven service providers were selected using service classifications, and two distributors were selected based on their work environment (Hotel and Pharmacy).

In total twenty-five (n=25) subjects were included in the final sample.

All respondents were required to sign a permission to be interviewed form before being interviewed (Appendix E: Permission to be interviewed).

Measures

As very little data exists on what are the substance abuse prevention needs identified by community members in a culturally diverse, low income, urban environment, an unique interview guide (Appendix F: Interview Guide) was developed. The interview guide was organized to obtain data on each of the study's objectives. All 3

sample groups were asked to respond to each of the objectives in a slightly different manner in each of the interview guides.

All respondents were asked to specifically provide data on each objective as follows:

(1) community awareness of substance abuse programs; service providers (see #3), residents (see #13), and distributors (see #24).

(2) how existing prevention programs might better meet area needs; service providers (see #8), residents (see #19), and distributors (see #21).

(3) community barriers and strengths; service providers (see #12), residents (see #16), and distributors (see #23).

(4) prevention needs; service providers (see #9c), residents (see #17), and distributors (see #21).

(5) target groups; service providers, residents, and distributors were all asked the same "target related" question (see #3).

(6) community priorities: service providers (see #9a), residents (see #18), and distributors (see #25).

All respondents were asked a number of common questions regarding the nature community problems associated with substance abuse (see #1), the

seriousness of substance abuse problems (see #2), specific group needs (see #3), and acceptable alcohol consumption levels (see #4).

Development of Questions

The development of the Interview Guide questions drew heavily on the questions asked on five other local studies (Legge, 1988; Legge, 1989; Mason et al., 1988; Neilson et al., 1989; Schutz & Bryne 1989). The questions asked in these other studies were transcribed and relevant questions grouped around this study's objectives.

The questions were then modified, reworded, or collapsed together to increase their clarity and relevance to the study. A group of selected questions were then pretested with one resident and one service provider. After the interview process the pre-test subjects were asked about the questions' effectiveness at gathering data on the objectives under examination. Based on this feedback, some questions were again reworded or collapsed together; while others were rejected as being inappropriate.

These questions were then divided into three categories: common, supplementary, and descriptive.

Common questions were asked of all the respondents

and were designed to gather data on four core issues and related objectives: neighborhood substance abuse problems; the seriousness of these problems; which individuals and community groups have special prevention needs; and acceptable usage levels (see #1 to #4).

Different supplementary questions were asked for each of the three respondent groups. These questions were designed to gather data on issues that arise due to their residence or employment in the community.

Descriptive information was collected on a face sheet and in questions asked in the interview guide itself. The face sheet was developed specifically for this study and it was designed to collect largely demographic data.

Reliability and Validity

Miles and Huberman (1984) argue that: "Qualitative data... are a source of well-grounded, rich descriptions and explanations of processes occurring in local contexts" (p. 15). They continue by noting that qualitative studies have a certain quality of "undeniablity". Similarly, Bailey (1978), asserts that first-person accounts of events or feelings have a certain "face validity." While face validity on interview data can be damaged by the respondents

ulterior motives (such as pleasing the interviewer with perceived correct answers). However, in needs assessments, "content (face) validity is normally sufficient."

The researcher attempted to increase face validity of this study by: paraphrasing and probing subject responses and by maintain a non-judgemental and curious attitude.

Paraphrasing is a technique whereby the interviewer repeats back the theme or idea expressed by the respondent in the interviewer's own words. Typically, the paraphrased statements represent the interviewer's interpretation of the subject's remarks and can be asked in a curious manner. For example, a subject made a long statement regarding the undesirabilty of allowing a number of well dressed youths with pagers to hang around a local convenience store. The interviewer paraphrased this as: "so you see a lot of these kids at the store?" The subject answered "yes". The researcher also suspected, due to the inflections and non-verbal language used, that the interviewee had suspicions regarding these youth. The researcher subsequently probed with: "do you suspect that they are involved in some kind of problem behavior?" The subject again responded in the affirmative and continued on to

describe his concerns about "gang activity."

As is demonstrated in this example, paraphrasing allows the interviewer the opportunity to validate or clarify interpretation of the opinions expressed by the subject and to reject incorrect interpretations. Probes can be used to tease out the accurate meaning of ambiguous verbal and non-verbal language and to encourage the subject to provide more clarifying data.

Non-judgemental paraphrasing and probing were also used in situations where the researcher had reason to question the data being provided. For example, one distributor said that he never had a problem with people trying to pass fraudulent prescriptions. The researcher probed with: "so there has never been one case?" This question lead to the subject clarifying that, "yes, people tried from time to time but they tended to stay away from his store."

As the above example illustrates, curious non-judgemental questioning can be used to softly challenge suspect data and obtain insight into the possible hidden motives. As Holsti (in Bailey, 1978) notes:

> "content validity is usually established though the informed judgement of the investigator. Are the

> results plausible? Are they consistent with other information about the phenomena being studied (p. 289)."

Patton (1990) states that qualitative methods are useful and frequently unavoidable when acceptable, valid, and reliable measures do not exist. In these situations, Patton suggests that gathering descriptive information is more appropriate that using untested qualitative measures, even though the validity and reliability of those results are suspect.

Some limitations of this study include the use of a single measure, the Interview Guide, and the reliance on community opinion as the major source of data.

According to Patton (1990) and McKillip (1986), qualitative data obtained by single measures such as interview guides, are typically weak in terms of their reliability and validity.

Miles and Huberman suggest that there are three typical biases frequently found in qualitative studies which involve field work data collection mechanisms (such as in anthropological studies). Holistic fallacy (1) refers to the tendency of interpreting events with more congruence than is the reality. This typically results from "lopping off the loose ends" that do not

fit with the other data (such as excluded outliners). Elite bias (2) is the over weighting of data from "high-status" informants and underrepresenting data coming from lower-status informants. "Going native" (3) (losing objectivity) refers to a process whereby the researcher is coopted into the perceptions of local informants. The authors note that these tendencies correspond to three research related judgemental heuristics: representativeness, availability, and weighting.

This study attempted to minimize the impact of "more congruence than is the reality" and over-weighting by selecting three different sample classifications and including a varied profile in selected subjects. The use of a common data analysis methodology and the inclusion of all data for analysis also increased validity.

The researcher further attempted to maintain objectivity by spending time away from the site and discussing the research project with non-involved (hopefully more objective) colleagues.

Data Analysis

Given the exploratory nature of the study and the use of qualitative open-ended questions, this study used

a content data analysis methodology.

Content Analysis: Nan (1976) describes content analysis as: "any methodological measurement applied to a text for social science purposes. Or, any systematic reduction of... recorded language, to a standard set of of statistically manipulable symbols representing the... frequency of some characteristics" (p. 217).

Nan continues that these units can be "semantic units" typically consisting of words or groups of words containing similar content. These groups are typically called themes. The researcher using this approach, can study the frequency of the appearance of certain words or themes occurring in a text or texts. Nan notes that thematic coding minimizes the problems associated with simply counting words appearing in different contexts and, consequently, provides more meaningful data.

Bailey (1978), describes the goal of content analysis as taking a verbal, nonquantative document and transforming it into quantitative data. Bailey describes the first step of the content analysis process as the construction of mutually exclusive and exhaustive categories that can be used to analyze the data. The second step is to record the frequency with which the semantic unit appears in the document. Bailey suggests that the categories are developed by examining the

documents to ascertain common elements. He notes that: "only by letting the categories emerge from the documents... can the goals of mutual exclusiveness and exhaustiveness be met" (p. 279).

Bailey describes a theme as the "moral, purpose, or goal of a document or portion of a document" (p. 281). He cautions that as a theme does not have a spatial boundary and is somewhat subjective in nature, it will tend to have low intercoder reliability.

Patton (1990) notes that: "Content analysis requires considerably more than just reading what is there. Generating useful and credible qualitative findings through observation, interviewing, and content analysis requires discipline, knowledge, training, practice, creativity, and hard work" (p. 11).

Analysis procedure: McKillip suggests a five step procedure is useful when analyzing data. Step one involves typing out interview transcripts, including the identity number of the respondent. In step two a portion of the responses are examined and tentative categories identified. McKillip notes that answers should be placed in mutually exclusive categories (only placed once) and that it may be helpful to break some answers into smaller units prior to categorization.

Step three involves writing a definition of each

category. In step four, responses and categories are to be second rated. Step five involves reorganizing the responses and categories based on the feedback of the second rater.

In this study, step one involved transcribing interview notes immediately after the interview. Whenever possible, these notes contained direct quotations of the key phrases and words used by the respondent. Where this was not possible (e.g., the response was too long winded), paraphrasing techniques were used to summarize the opinions expressed. Frequently, these paraphrased summaries were checked for validity. This would be done by asking the respondent, during the interview, if a certain paraphrase adequately described the stated opinion. These quotes and paraphrases were then transcribed (Appendix G: Sample of Interview Notes) and used as the primary data from which the results were drawn.

The interviews were not audio recorded as it was believed that recording would increase recruitment difficulties and inhibit some respondents from answering questions fully.

Over thirty semantic unit categories were developed from generating a list of frequently occurring themes and the responses were placed into appropriate

categories. Semantic themes cited by three or more respondents were considered to be significant and were reported as results.

Based on discussions between the second raters and the researcher, the semantic unit categories were collapsed together into ten macro themes and regrouped under two broad classifications (attitudes and strategies).

The data was interpreted using this conceptual paradigm.

Summary

The methodology used in this study included using an open-ended interview guide to interview a total of twenty-five substance abuse consumers, service providers, and distributors regarding their opinions on local substance abuse prevention needs.

The resulting data was analyzed using content analysis techniques to identify significant community themes.

In the following chapter the thematic results of this study are presented.

CHAPTER FOUR - PRESENTATION OF FINDINGS

Introduction

The data elicited by this study was analyzed using a content analysis. Two broad thematic classifications emerged: attitudes and strategies. A total of ten specific themes were identified and assigned to one of these classifications. Each classification contained at least four themes.

The four attitudinal themes were: (1) the right of the community to limit individual alcohol consumption; (2) the definition of substance abuse is related to the social context; (3) substance abuse and the criminal subculture; and (4) the need to change societal attitude.

The six strategic themes were: (5) the absence of government commitment towards prevention; (6) the fragmented prevention services system; (7) the role of advertising and promotion on consumption; (8) the costs of abuse; (9) the need for a for a continuum of service; and (10) the existence of Collingwood as a distinct community.

This Chapter will present these attitudinal and strategic themes using actual quotations wherever possible, to illustrate the significant semantic units

used to identify the theme. To be considered significant a theme will have been cited by at least three respondents.

Attitudes

Attitudinal themes address the importance of individual and community values and beliefs in identifying substance abuse prevention needs. The social context within which a behavior occurs tends to define whether that behavior is normal or deviant. Identification of community attitudes is therefore central to understanding the nature of community prevention needs.

Interestingly, residents and service providers tended to have differing attitudes regarding substance abuse prevention. For example, there was a striking difference regarding the seriousness of the problem. Residents were more tolerant of usage unless they were personally affected by abuse whereas service providers tended to be concerned about the costs of usage and substance abuse. Further, many providers tended to label community tolerance as "community denial".

These attitudinal themes and resident and provider opinions are presented in more detail in the following section.

1) "If substance use does not affect me it is none of my business": The most significant theme to emerge involved the right and responsibility of the community to limit individual alcohol consumption. The majority of residents tended to agree with the respondent who stated, "if substance use does not affect me it is none of my business." Another resident similarly commented, "drinking is O.K. if it does not interfere with your life or someone else's." A minority of residents favored complete abstinence, believing that any consumption was too much. The majority believed that occasional use, sufficient to induce intoxication, was acceptable. As one resident put it: "a certain amount of drinking and intoxication is seen as being normal."

Even respondents who supported abstinence did not favor complete prohibition, they tended to agree with one respondent who believed that we do not have "the right to limit other people's choices."

Conversely, service providers were typically deeply concerned about the extent and impact of substance abuse and much more prepared to be proactive towards preventing usage. For example, the child welfare worker claimed that substance abuse is behind 95% of her cases "in one way or another"; the doctor claimed that most of his case patients' deaths are the result of

"life-style diseases", and the youth worker who said that "most of the children" involved in her agency's programs were involved in problematic substance usage. These beliefs reflected in increased commitment towards prevention planning.

2) Substance use is part of the social context:

The majority of both resident and service provider respondents believed that a definition of what constitutes substance abuse is determined in large part by the social context within which the consumption occurs. This social context includes; individual genetics, family of origin experiences, poverty, social isolation, childhood trauma, developmental place, available recreational pursuits, social pressures, and cultural values.

Many respondents believed individual genetic heritage was a predisposing factor. This belief is demonstrated in the statement made by one resident: "alcoholism runs in families... most alcoholics I know come from drinking families." Several respondents noted family of origin experiences and life experiences as also being predisposing factors. As a service provider stated, "substance abuse does not exist by itself: social isolation, poverty, physical and sexual abuse,

and other forms of trauma are all mixed together... you can't just isolate it (one factor) out of the individual's context."

The notion that substance abuse was an attempt to deal with stress was also cited by many respondents. For example, single parents living in poverty were identified by a significant number of respondents as having special problems. One resident summarized this belief by commenting: "single parents just need something to get them through the day... they are down on life. It helps them forget for awhile... they have trouble facing life's pressures."

Many respondents cited the belief that a decrease in the social pressures arising from poverty would decrease substance abuse. As one resident put it, "we need to help people solve day to day problems... especially economic ones." Several respondents noted the need for increased child minding and day care in this context.

Several respondents stated that other social factors and contexts encourage substance abuse. Youth were seen as being particularly vulnerable to the influence of substance using peers. As one service provider noted, "sometimes kids use drugs to be cool for their friends."

Another service provider noted the absence of

non-drinking social centers for adults: "the bar is the only available social outlet, if you like to listen to music, dance, and meet people... where else is there to go?"

There was a high level of agreement by both residents and service providers that the cultural values of the new Canadian groups had an impact on area substance abuse. The non-substance use values of groups such as the Sikhs and the negative social stigma placed on drunkeness by groups such as the Chinese were commonly cited as being positive community influences.

Several respondents noted that these groups also have special problems. One resident believed that, "it is hard for many of them... they come from societies which support total abstinence. When they get to Canada they experience a sort of cultural pull from their more Canadianized drinking peers."

Another resident expanded on this theme by noting: "sometimes you see guys in turbans drinking in their cars in the alley... it looks like they're drinking in secret... if they wear a turban they are not allowed to drink you know."

3) Substance abuse and criminal subcultures: Most residents suggested that there was a relationship

between substance abuse and "criminal activity" of all kinds.

Predictably, hotel bars, and social clubs were cited as being noisy ("you hear them half way down the block sometimes... especially around closing time"); violent ("there are often fights in the parking lot"), and centers for other sorts of drug abuse ("when I wait at the light to cross the street, I can smell the pot drifting from the parking lot").

The Aerial Light Rapid Transit (A.L.R.T.) stations, certain convenience stores, the adult format Haida Cinema, the pool hall, and Collingwood Park were all cited as being substance abuse problem areas. The exact relationship of these areas to substance abuse is however unclear. While these sites were mentioned by a significant number of residents, the problems involve a wide range of criminal and antisocial activity of which alcohol and drug related problems are only a part.

Certain convenience stores were noted as a problem because, "there are a lot of well dressed kids always hanging around... I wonder where they get the money from?"

Another resident noted that the "expensively dressed young men with pagers that you see around (the store)... are probably gang involved."

A service provider stated: "teenagers tend to scare away some people from places such as Recreation Centers... their rough housing and tough look are particularly difficult for our seniors to take."

A significant number of residents criticized the liquor store for "tolerating bootlegging to minors. One resident reported that he, "parked at the Safeway parking lot on two successive Friday nights and... saw lots of teen vehicles and bootlegging going on."

Another resident, noted that in spite of existing bootlegging problems, "the store really tries to keep things clean and under control."

The Haida Cinema was criticized for the "bad crowd" that is attracted to its "adult format" films.

Collingwood Park and the alleys around the Park were cited as being a "drug drop area" and as having "a lot of open drinking in the summer."

Several locations were cited as being a substance abuse problem area because of the presence of visible cultural minorities. For example, Collingwood Park was seen as being a problem by one resident because of the "number of old Sikh men that sit around the wading pool." It should be mentioned that the pool in question is no longer in use as a wading pool.

It appears that in the minds of many residents the

presence of groups of young rambunctious people dressed in one or another manner, groups of turbaned old men, and X-rated film patrons are frightening in and of themselves. This feeling may have more to do with fear of different kinds of people than it does with substance abuse. This theme was less strongly expressed by service providers.

4) A change in societal attitude is needed: Most service providers discussed the need to change societal attitude as being one of the most important aspects of substance abuse prevention. One service provider suggested that "society needs to change its pattern of acceptance and encourage taking responsibility. We need to confront denial and overcome stigma and shame."

Another service provider commented, "we must get people to recognize the problem, as a problem, before we can mobilize them to fight it."

Several service providers held beliefs similar to one respondent who noted, "we all have compulsive behaviors to deal with... we must teach kids that seeking help for them is O.K. and normal."

The majority of residents did not express the need to change societal attitudes; rather they favored prevention services for children and youth and treatment

and enforcement approaches for adults.

Strategies:

Six significant themes emerged that identified areas of potential strategic action for planners. These themes point to the need for increased government financial and legislative commitment towards prevention, holistic thinking when providing treatment related services, and the need to examine the notion of what constitutes a community when developing prevention services.

5) "Government should put it's money where it's mouth is": Most service providers and many residents were critical of government commitment towards prevention. For example, one service provider suggested that "the Government has a high financial interest in alcohol sales... to decrease sales will reduce revenue." Several respondents believed that: "Government should direct the money from alcohol sales back into prevention and treatment programs." One resident stated: "they (the Government) should put their money where their mouth is."

These sentiments were related to the second strategic theme of "fragmented resources."

6) "Fragmented... under coordinated and under-funded resources": A significant number of service providers believed that the existing resources system was "fragmented and under funded."

Generally, respondents were either not aware of many of the existing prevention programs or were critical of at least some aspects of them. Prevention programs were seen "as having a too limited definition of abuse and prevention." One service provider described the delivery system as being "physically and structurally isolated from the community".

By contrast, the privately sponsored Alcoholics Anonymous was viewed by all of the respondents as being a much valued and successful treatment resource. It was described in terms such as: "its a mainstream resource", "the only thing that works in the long run," and "that is where I'd tell a friend to contact if they needed help." One service provider added, however, that "A.A. isn't for everyone." This respondent continued: "the spirituality aspect of it is a problem for some people."

A significant number of respondents favored raising the drinking age, however many also believed it would be "impossible to enforce" or that it "would only deal with the symptoms."

Public schools were the second most frequently cited potential prevention resource. As one respondent put it, "they have a captive audience and we must start young." Both resident and provider respondents believed that "prevention programs should be built into the school curriculum starting at the lower grades." One respondent noted, "schools must go beyond just telling kids to say no... they should teach life skills, decision making, refusal skills, and legal outcomes." Another stated that, "education is our strongest weapon... it is the only way to stop the problem."

A service provider noted however, "Schools are being asked to do so much these days... they are already overloaded with non-academic needs."

Alcohol and drug clinics tended to be seen in a positive light ("good counsellors"), but they were also criticized for having "long wait-lists", "limited office hours", and as being "too far away."

Most residents cited the police as being an important prevention resource and as "doing a good job under the circumstances". Most critics cited low staffing levels and increased work load as limiting the police role in prevention. As one service provider noted, "the police budget has not kept up with increasing population growth and increased demands on

police time." Another provider stated, "the police are too busy flying from call to call... there is little time left for prevention."

Several residents wanted increased police presence and visibility. As one resident put it, "I wish that they would get out of their cars and walk around more."

Interestingly, none of the respondents spontaneously mentioned the British Columbia Government's "TRY" campaign as a prevention resource. The researcher did, however, ask many respondents a probing question about TRY near the end of the interview. Once this probe was asked, approximately seventy percent of respondents stated awareness of the program and could identify at least one aspect of it. The television commercials, posters, and telephone line were the most frequently noted TRY services.

A significant number of respondents appeared to be critical or cynical about the TRY program. As one service provider noted, "to just say no makes it seem too easy and leads to blame... the approach is all wrong, it implies a lack of moral fiber in substance abusers." Another service provider said flippantly: "TRY, try what?"

7) "Advertising makes too big a deal of it": Many

respondents in both groups commented on the role of advertising and promotion on increasing consumption. Several respondents believed that advertising and manifestations of popular culture (such as television and films), leave the impression that "everything good that happens, happens with a drink in hand." One service provider echoed this sentiment by stating: "advertising makes too big a deal out of it... to be sexy etc. you must use alcohol."

This belief lead several respondents to call for increased legislative restrictions on alcohol and drug advertising. This sentiment was echoed by one respondent who stated: "we need to present drinking in a more balanced way... it is now largely promoted in a positive manner."

Respondents holding these views tended to favor the promotion of public education campaigns, increased control of advertising, and increased prevention related political lobbying with policy and decision makers.

A resident suggested: "we have got to make those who make big dollars from sales pay, for prevention programs."

8) Substance abuse: health, family, and social costs: Most service providers believed that substance

abuse results in a wide range of health, family, and social problems. They also noted that the general public and the government tend to minimize these costs. One of these many cited problems was the high financial cost of treating substance related health problems. As one service provider pointed out: "alcohol related diseases are a central factor in very many emergency hospital admissions."

The nature of this relationship was echoed by one health service professional, "between ten and twenty percent of my patients have a substance abuse problem, not including tobacco related problems." He continued, "life-style diseases are the greatest killers."

Poor personal relationships, decreased school and work performance, and family violence and break-up were all cited as social costs by a large number respondents. One child protection worker stated that substance abuse was "behind 95% of child protection cases in one form or another." Several residents noted that women are "particularly vulnerable to violence as the result of a spousal substance abuse." As one resident put it, "some people seem to think that the man is king and that women are nothing, women in these situations often get beat up when the man drinks."

A significant number of respondents tended to

believe that substance abuse is becoming more of a problem for women. As one respondent noted, "women are now being portrayed as drinkers... as a role model for what a modern women is."

A service provider noted that prescription drug misuse and abuse was an increasing problem for older women: "a lot of older women are dependent on their husbands to get their emotional needs met, therefore, widowhood brings increased risk of substance abuse." One recovering alcoholic noted that, "female alcoholics and drug addicts suffer more than men because of increased shame and social stigma. Men are seen as letting off steam... it is different for women."

Young people were also identified as having special needs. Children in substance abusing families were cited by a significant number of respondents as having unique problems. As one school based provider noted, "these kids (living with alcoholic parents) are reluctant to talk about their problems out of fear of opening the family closet... this inhibits them from seeking help."

Another service provider noted, "the majority of the kids in our programs have some degree of alcohol or drug usage that gets them into trouble sometimes."

A long term resident noted that, "kids walk a fine

line... they have to be friendly to local drug types, while at the same time, not become involved in their antics."

The need to educate parents was a frequently cited prevention need. As one service provider stated, "we must remind parents what it was like to be a teenager." Another suggested that, "parents ideas come from thirty years ago and they are no longer relevant to the current context." Still another respondent noted, the need to educate both parents and teachers to "identify substance abuse problems and what to do once they have."

Generally speaking, the respondents saw the need for more "grassroots" family and children's social alternatives and services. One resident summed it up as "we need a place where parents can go for help with their kids."

9) "A continuum of services available to everyone": Service providers frequently cited the need for multidimensional prevention strategies. As one provider stated, "we need to develop programs that honor and value all people and offer a continuum of services available to everyone." Or, as another provider put it, "we need a network of counselling and a coordinated strategy."

Another service provider stated that we should "draw on existing resources more fully... operate community events and engage in more outreach." Still another respondent stated that "we must have a multicultural focus and use non-traditional approaches in new types of resources." One provider suggested that there needs to be "more social permission to disclose our own (service providers) problems."

Several service providers cited the need for higher standards (qualifications and training) for prevention workers and the need for increased evaluation of existing programs. For example, one service provider stated: "many programs for kids are run by bigger crooks than the kids are." Another service provider believed that "in order for programs to be effective, staff have to have a professional attitude and be paid well."

Several service providers were critical of simple campaign approaches: "they (public campaigns) would only help to a point... if the causes of substance abuse are low self-esteem or a family that doesn't care, education won't help."

One respondent involved in recovery stated, "you can't educate addiction away... I am not sure that addiction can be prevented... the best we can hope for is that people seek help sooner, before they have lost

everything."

10) Collingwood, a community of communities?

Several themes emerged regarding the absence of a shared sense of community identity and values, and the impact of the transitional nature of the community on substance usage. This theme lead many respondents to question if Collingwood is really a distinct community.

One frequently cited theme was the belief that Collingwood lacks cultural homogeneity and a commonly shared sense of history. Collingwood is seen as being a cultural mosaic. One respondent suggested that Collingwood is not really a community of "people living and doing things together." A service provider believed that Collingwood was "really just a bunch of parking lots off of Kingsway." Many of these respondents tended to view area residents as moving into the area due to the availability of affordable housing, and not because of the community's ambience and perceived desirability. For these respondents, Collingwood is, at best, "a community of communities."

Many respondents questioned the existence of Collingwood as a distinct community and consequently questioned the feasibility of developing community based prevention strategies.

A second related theme was that Collingwood is viewed as being "a launching pad for new Canadians." Typically residents were described as "arriving from overseas... buying a house... establishing themselves... and then moving on as soon as their economic situation permits."

Many respondents argued that this results in an absence of commitment to the long term interests of the community.

Longer term residents expressed the belief that Collingwood was a community but now it no longer is. A resident noted that "thirty years ago, we used to know everyone and drop by to visit... now we don't even know our neighbors... we certainly don't socialize with them." Another resident put it as, "I used to know all the stores and go to shop in them, now I don't even know what to do with the products that they sell in them." Another resident stated, "people now go downtown to shop... going downtown used to be such a big deal."

Many longer term residents were saddened by recent changes to the area. Several were concerned about the impact of increasing numbers of Non-Christian, Non-Caucasian, and Non-English speaking residents. As one resident noted "we used to be lily white... now there are mostly dark faces on the streets." Another

stated that "we were a working class Irish Catholic community... it is sure not that way now!"

Several respondents cited increasing population density and changes in the transportation system as negatively impacting on the area's sense of identity. One respondent said, "the Skytrain has sure changed things, more noise, more people, and more negative action on the streets." Another resident noted, "we used to walk or take the tram... now when people visit they are usually from other areas and they come by car."

Many respondents did not view Collingwood as a single and well defined community, many identified the need to develop a sense of community as an essential first step in the development of any neighborhood based prevention programs. One respondent put it as, "the community needs to be strengthened first... then we should focus on specific problems." This opinion was echoed by another respondent, who stated, "a mobilized local community is the key... identify a specific issue and stick to it."

In recognition of Collingwood's multicultural make up, several respondents cited the need for programming in different languages.

Summary

This chapter has used an attitudes and strategy classification system to present the ten most significant themes that emerged from the data. These themes have demonstrated the importance of values and culture in establishing levels of community tolerance and denial about substance usage. They also describe the costs of the resulting abuse and the impact of government priorities on existing resources and consumption.

In the next chapter, the implications of these results will be discussed.

CHAPTER 5 - DISCUSSION

Introduction

This chapter discusses the implications of the community identified substance abuse prevention themes for planners. Resident and service provider opinion is compared and a number of important attitudinal and strategic issues are discussed. The limitations of the study and the implications for future research are also examined.

Implications of Attitudinal Themes

Most of the residents had a relatively tolerant attitude towards substance usage. Many service providers believed that this tolerance was in fact denial. These attitudinal differences create a dilemma for planners. Do they support a tolerant position towards substance abuse or work towards challenging alleged community denial?

As approximately eighty percent of Canadians drink alcohol (Survey Canada, 1989) it is not surprising that the majority of residents believed that alcohol use is acceptable to "occasionally have fun," "to celebrate a festive occasion," or "to enhance a meal or some other social occasion."

This tolerant attitude represents a local manifestation of what Ashley and Rankin (1988) label the integration model. Individuals holding this view, conceptualize abuse as a failure to integrate alcohol consumption into day to day life. Further, once consumption becomes problematic (failure to integrate), residents tend to view substance abusers as either being somehow morally deficient or as having a disease. Those holding the morally wrong model tend towards control and punishment as preferred prevention techniques; those holding the disease model support treatment and early intervention. As Ashley and Rankin note the integration model has led to society largely being tolerant of consumption, ignoring prevention measures, and the costs associated with usage and abuse.

Abstinence based approaches ("there wouldn't be any problem if people never touched the stuff"), will predictably meet with resistance from drinking community members and it is unlikely that abstinence approaches would be effective.

Also, as is discussed by Meichenbaum and Turk (1987), nonadherence to medical treatment is typically estimated to be in the 30% to 60% range. We can speculate that nonadherence to non-medical drug and alcohol programs will be even lower, especially

by those who are addicted. Predictably the more that one challenges so called "social drinking" and "denial" the more one will meet resistance by those who drink or use drugs.

The Consumption Model In spite of the predictable resistance that prevention planners will have to face from "social drinkers", planners will have to change the community's tolerant attitude in order to significantly reduce drug and alcohol problems in society. Perhaps, the most effective way to do this without alienating those who hold to the integration model is to promote what Ashley and Rankin have labelled the consumption model.

The consumption model leads to attempts at reduction of average consumption rates in the belief that such a decrease will result a decrease in substance related problems. This approach does not demand abstinence, rather it encourages limiting frequency and amounts consumed. This approach permits planners to engage in public education campaigns that highlight the dangers of usage (i.e., drinking and driving, workplace intoxication, and drinking during pregnancy); while at the same time rending support to abstinence, control, and treatment strategies.

Such an approach maximizes the opportunities to

garner broad based community support and enhance the likelihood of adherence. For example, planners using a consumption approach could argue, that product promotion advertising should be controlled or at least balanced with prevention orientated advertising.

The impact of promotional advertising on consumption rates can be seen by comparing Canadian consumption rates. Canadian consumption patterns increased dramatically from the early 1950's. This is also the period when the population was exposed to increased alcohol and drug advertising.

It is also interesting that consumption began to decrease after the mid 1980's which is the period immediately following increased restrictions on alcohol and drug advertizing. It must also be noted that the current trend towards decreased average consumption may have other sources than just advertising controls and increased prevention programing. For example, there has been an increased emphasis placed on general health promotion campaigns such as Participaction.

Theoretically, as consumption related approaches gain community support and credibility, they will have the secondary benefit of confronting issues such as community denial.

Planners must not simply rely on large scale attitudinal campaigns as the only method to reduce consumption rates. Planners should also pressure government to reduce the accessibility of alcohol through limiting the opening hours of distribution points, limiting the number of distribution points, and through the provision of more resources towards enforcement of existing laws. They should encourage prevention and treatment approaches that target individuals and groups and work towards inclusion of prevention components into existing programs.

Substance abuse and the criminal subculture Many respondents associated substance abuse with a criminal subculture and identified a number of subcultures as target groups requiring special prevention services. There was a tendency for respondents to suspiciously associate certain visible groups with substance abuse (i.e., "adult movie" viewers, well dressed teenagers, and turbaned old men). This tendency appeared to be associated with fear of being harmed by one of these groups' members or simply fear of the unknown.

Planners must be cautious, therefore, when developing programs designed for alleged high substance abuse groups. They are well advised to verify that substance abuse is in fact a problem before targeting

these groups for special attention. Planners should include cross cultural dimensions into their strategic plans.

"Walk the walk" Planners will also have to encourage change on a more personal micro level. They must model appropriate attitudes and behavior and encourage others to do the same. For example, one modelling technique can be as simple as starting with non-alcoholic beverages when listing the drinks available to guests at a social function. As people involved in the twelve step movement remind us, "we must walk the walk and not just talk the talk."

Strategies:

While changing community attitudes is the most important prevention need, a comprehensive prevention program must develop specific strategies designed to assist members of targeted groups. Community members identified six strategic themes. The implications of these themes are discussed in the next section.

Causation One strategic implication was that planners should identify the factors that lead to substance abuse and then develop programs designed to minimize those factors in high risk groups. As one respondent put it, "in order to stop it you got to find

out why people get hooked in the first place."

While no definitive causation exists research and community opinion agree that a number of biological, environmental, and social factors appear to be predisposing variables. These causation theories must be critically examined by planners before being accepted as popular belief is not always complete nor accurate. For example, respondents tended to believe that socioeconomic status impacted upon substance abuse. The belief was that the more affluent were under less economic pressure, therefore, the poor have more need drink to escape from life's pressure. According to a 1989 Canadian Survey, the rich drink more frequently but consume less at a sitting than do the poor.

While, this data does support reported self-medication/social escape drinking patterns by the poor, it also indicates that the affluent also have substance abuse needs that are particular to their socioeconomic class.

Planners interested in a comprehensive prevention approach must therefore critically review causation related research before committing large sums of public money on prevention programs.

Developmental Place Planners should develop prevention programs that are developmentally appropriate

for targeted populations. For example, the tendency for illicit drug usage to peak at age 18, the tendency for average alcohol consumption rate to decrease with age, and the tendency towards increasing seniors prescription drug usage rates (Survey Canada, 1990) are of obvious significance to planners. Not only should these groups be targeted for special programing, the programing must also be appropriate to the developmental place of the group to be effective.

Interpersonal and family implications While substance abuse was cited as being a problem in many ways, its impact on interpersonal relationships and family life was the most frequently cited problem theme. If planners want to address family related substance abuse prevention needs, they will have to struggle with some basic ethical decisions. Planners will have to decide to what degree the state or community has the right or responsibility to intervene with substance abusing families or individuals.

For example, if we are to accept this study's data that "it (substance abuse) is behind ninety-five percent of child protection cases, in one way or another", then we must decide if the community has the right to intervene and remove children from substance abusing parents, and if so, at what point? Further, do we have

the right to accept children living in substance abusing families into prevention or "survival" programs without their parents' permission? Do the benefits of such actions warrant the possible negative impact on the child's relationship to his or her family and parents?

Do we have the right to prevent a fetal alcohol birth by somehow ensuring that pregnant women don't drink, or don't drink beyond a certain limit? This would be difficult without containment. Do we have the right to restrict people from drinking alcohol in their own homes if they tend to resort to family violence when drunk?

As consumers did not view limited alcohol use as being overly problematic, they tended towards non-interventionism in favor of individual rights. Planners and legislators may, therefore, need to educate and convince the consumer group that the substance abuse problems are serious enough to challenge individual rights in favor of community rights. Intervention limitations must be established that encourage a maximum amount of family and system related outreach; while respecting the general rights of individuals and families to privacy.

<u>"Fragmented... under coordinated and under-funded resources"</u> Planners wanting to identify ways and means

that existing programs might better meet community needs should address the perceived fragmentation of services. According to respondents, planners must work towards strengthening community networking and coordination efforts. This can be accomplished by supporting local initiatives such as the Area Substance Abuse Committee and the Area Services Network.

Local coordination groups must develop a broad definition of substance abuse and accept the use of a variety of approaches including both treatment and prevention strategies. They should lobby with local, Provincial, and Federal Government agencies for increased funding, integration of services, health promotion and substance abuse awareness campaigns.

Generally speaking, planners must take a holistic approach to substance abuse prevention. Local prevention programming should assist and support already existing programs, target specific groups and needs, and encourage the development of a sense of community.

Besides organizing on a neighborhood level, planners should assist ethnic organizations and affinity groups to develop culturally appropriate, area wide prevention programs.

Government Commitment Many respondents were cynical about government commitment towards funding

prevention programming. Planners holding this view should publicize the health, social, and financial repercussions of alcohol abuse and challenge the notion that the revenue government receives from alcohol sales covers these costs. Generally, planners should encourage government to direct more funds towards prevention programs, arguing that a general decrease in consumption will result in lessened long term social and financial costs.

Minimally, planners should lobby government to redirect "profits" from alcohol sales towards prevention programming. Government should also require beverage alcohol companies to match the money spent on product promotion with money targeted for prevention orientated publicity campaigns.

"A continuum of services" A significant number of service providers cited the need for a multidimensional approach to substance abuse and "a continuum of services available to everyone."

Planners should conceptualize substance abuse prevention as being relevant to every community member and develop a range of strategies targeting the entire community. Public media campaigns, legislative change, support to existing prevention groups, services to people negatively affected by substance abuse, need to

be supported, as do programs designed to help people solve social and economic problems, deal with emotional and psychological stress, and help involve people in health enhancing behavior.

Several service providers noted the need for planners to normalize the need to seek help and ensure that prevention and treatment programs are accessible to all. Planners should encourage alcohol and drug professionals to engage in more outreach, decentralize their various helping systems directly into the community, and provide more flexible working hours.

Generally, planners should view substance abuse as being the result of a number of interrelated factors. A comprehensive prevention program would require strategies that address all of these factors. As Johnson et al. (1987) remind us: "a multifaceted approach is necessary as no single model will be effective for all audiences."

Limitations of the study:

This study contained a number of limitations that negatively affected the reliability and validity of the data. One limitation of this study was the use of a single measure, the Interview Guide, and the reliance on community opinion as the major source of data.

According to Patton (1990) and McKillip (1986) qualitative data obtained by single measures such as interview guides, are typically weak in terms of their reliability and validity.

A study's reliability can be made more robust, through the use of a range of triangulation techniques. One technique frequently used by needs assessments such as those of Mason et al. (1988), Neilson et al. (1989); and Legge (1989) is to use two operational measures to measure the same concept. Typically, qualitative studies use a quantitative measure to increase reliability.

Due to limited financial, personnel, and technical resources the study did not use this method of triangulation. The study's use of a single measure and the absence of a second measure and/or other methods of triangulation, supplies data that has weak reliability across populations and that possesses only a certain face validity.

Another major limiting factor is that the interviews were not audio recorded; rather a field note taking system, relying on note taking ability and memory, was used to collect and transcribe the data. Errors of memory, recording and transcribing will all tend to weaken the reliability of the data.

Another limitation affecting reliability is that all of the respondents were a minimum of 19 years of age, therefore, the opinions expressed directly by children and youth are not included in the findings.

It is also important to note that the inability of the study to recruit individuals who admit to currently abusing alcohol or drugs and the high number of residents abstaining from the consumption of alcohol (six abstainers) tend to limit the study's validity.

Finally, the small sample size (n=25) and non-random sample selection process does not meet the requirements of statistic probability. The use of a purposeful selection process, while not increasing the study's statistical reliability, does provide a wide range of informants from differing perspectives and, therefore, increases the study's internal reliability.

Purposeful sampling limitations also exist, which further erode the study's reliability. Resident subjects tended to be older, Caucasian, and English speaking. E.S.L. subjects were under-represented in the resident sample. Further, as the researcher only speaks English and as the resources available to the project did not permit the engagement of bilingual research staff, the language of the interview was English. Non-English speaking respondents are not, therefore,

adequately represented in the sample.

Implications for future research:

This study provides exploratory data on the little researched topic of neighborhood substance abuse prevention needs. Future studies should use a larger sample and several measures, including some form of quantitative survey, to further explore the themes identified by this study. A new study should also collect base line data, useful to those that want to test the eventual effectiveness of a locally developed strategic plan.

Conclusion:

This study gathered and analyzed data on: what are the community identified substance abuse prevention needs in a culturally diverse, low income, urban environment? The results indicate there are several differences between resident and service provider attitudes towards substance abuse. Residents tend towards tolerance of "functional" substance abuse. Service providers label this tolerance as denial and place a higher priority on prevention. Service providers would describe the greatest prevention need to be a change in community attitude. Residents tend to support increased law enforce and punishment,

improvement in the social condition, and/or treatment as being the most significant prevention needs. Both groups identified early-school based prevention strategies as being needed.

Service providers suggested the need for a continuum of services that respond to a broad range of human need. Generally they cited the need for increased government support of prevention programs, programs designed for specific target groups, and a dual definition of what constitutes community (geographic and affinity).

This study attempted to provide data that will help to shape future research. Obviously, more research is required before the a truly comprehensive strategy can be designed and developed.

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Appendix A: Certificate of Approval

The University of British Columbia
Office of Research Services

B90-358

BEHAVIOURAL SCIENCES SCREENING COMMITTEE FOR RESEARCH AND OTHER STUDIES INVOLVING HUMAN SUBJECTS

C E R T I F I C A T E of A P P R O V A L

INVESTIGATOR:	Russell, M.
UBC DEPT:	Social Work
INSTITUTION:	Collingwood Neighbourhood House
TITLE:	Community opinion on substance abuse prevention in Collingwood
NUMBER:	B90-358
CO-INVEST:	Hetherington, T.
APPROVED:	JAN 21 1991

The protocol describing the above-named project has been reviewed by the Committee and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

THIS CERTIFICATE OF APPROVAL IS VALID FOR THREE YEARS FROM THE ABOVE APPROVAL DATE PROVIDED THERE IS NO CHANGE IN THE EXPERIMENTAL PROCEDURES

Appendix B: Resident Characteristics

res.#	sex	age	yrs.	occ.	m.s.	recruit	lang.
1.	F	33	10	clerk	M	5	E
2.	F	24	17	day care	S	3	E
3.	M	64	64	retired	M	3	E
4.	F	35	22	housewife	M	5	E
5.	M	45	45	retailer	M	2	E
6.	M	47	41	unemployed	M	4	E
7.	F	50	10	p/t teacher	S	5	O
8.	F	53	32	office wker	S	4	E
9.	F	43	>1	office wker	S	1	E
10.	M	38	5	com. wker	M	4	O
11.	M	71	17	retired	M	4	E
12.	F	38	18	clerk	M	5	O

KEY

res.# - resident number.
sex - sex of the resident: M = male; F = female.
age - age of resident.
yrs. - number of years of area residence.
occ. - occupation of resident.
m.s. - marital status: M = married; S = single.
recruit. - agency that recruited resident:
1 = Alcoholics Anonymous
2 = The Collingwood Business Association
3 = The Collingwood United Church
4 = The Collingwood Neighbourhood House
5 = The Nisha Family and Children's Services.
lang. - first language spoken: E = English; O = Other.

Characteristics Summary

Average age = 54.1
Average length of area residence = 23.5
Total females = 7; total males =5.

Total English as first language = 9; total English as second language = 3.
Recruitment source totals: 1 = 1; 2 = 1; 3 = 2; 4 = 4; and 5 = 4.

Appendix C: Explanatory Letter

COMMUNITY OPINION ON SUBSTANCE

ABUSE PREVENTION IN COLLINGWOOD

The Collingwood Champlain Heights Community Substance Abuse Committee is sponsoring research on substance abuse prevention in the Collingwood area. Our intension is to identify existing substance abuse prevention needs in the Collingwood area and make recommendations regarding future substance abuse prevention efforts.

As part of this process, we are completing a number of interviews of area residents, drug and alcohol distributors, and professionals, to obtain opinions on local substance abuse prevention needs. From these interview results we will develop a questionnaire style needs assessment and make recommendations regarding the future development of a local prevention strategy.

We have asked committee members to help us recruit subjects for this project. We have asked them to pass this letter on to people that they believe are interested in the topic and who may be willing to be interviewed. Obviously, as you are reading this letter, one of our members believes that you may be willing to be interviewed.

Confidentiality Guaranteed. The identity of selected respondents will be known only to the researcher. Upon selection, all subjects will be issued an identity number and this number will be the sole means of linking your identity to your responses. In this way you will be assured that your identity will remain confidential to the researcher, Tom Hetherington.

Selection and Interview Process: If you are interested in being interviewed, please contact the researcher, Tom Hetherington, by telephone. Selected subjects will recontacted by the researcher by telephone and an interview time and place arranged.

Interviews will not be tape recorded and you retain the right to refuse to participate or withdraw at any time without jeopardy. The interview will take less than one hour to complete. You will not receive any financial remuneration for your involvement.

Remember we are investigating substance abuse prevention. Prevention means: promotion of a healthy life-style without dependency on alcohol and drugs.

For more information contact: Tom Hetherington at 251-5849.

Appendix D: Service Provider and Distributor Characteristics.

s.p.#	sex	age	employment
1	F	33	youth and family
2	F	45	child protection (MSS)
3	F	53	church adult outreach
4	F	34	multicultural worker
5	M	55	police
6	M	54	high school counsellor
7	M	42	elementary school counsellor
8	F	36	nurse
9	M	61	recreation manager
10	F	26	recreation worker
11	M	27	medical doctor
12	M	41	hotel employee
13	M	45	pharmacy employee

KEY

s.p.# - respondent number.
sex - sex of the respondent
age - age of the respondent.
employment - nature of work in Collingwood.

Summary of Service Provider and Distributor Characteristics

Total females = 6; total males = 7.
Average age = 42.5 years.

Appendix E: Permission to be interviewed

I understand that the Collingwood/Champlain Heights Community Substance Abuse Prevention Committee is interviewing local community members on the question of "what constitutes an effective substance abuse prevention program for the Collingwood area?" I realize that these interviews will be used to develope a "strategic plan" designed to meet these prevention needs.

I also understand that these interviews will be used in a University of British Columbia, School of Social Work research project. This project is being supervised by Dr. M. Russell and the results will be used by Tom Hetherington as part of his Masters of social work thesis. I agree to permit my interview to be used for this purpose.

I understand that my identity will be known only to the researcher and that I will be issued an identity number. This number will be the sole means of linking my identity to responses. I have been assured that, my identity will be kept in confidence, by the researcher, Tom Hetherington.

Interviews will not be tape recorded and I retain the right to refuse to participate or withdraw at any time without jeopardy. I understand that the interview will take less than one hour to complete and that I will not receive any financial remuneration for my involvement. I further understand that I can contact the researcher at any time should I have any questions or concerns regarding the research. This contact can be made by contacting Tom Hetherington at 251-5849.

Remember we are investigating substance abuse prevention. Prevention means: promotion of a healthy life-style without dependency on alcohol and drugs.

[ ] I assure that:

I have volunteered to be interviewed without coercion or promise of reimbursement;

I have received a copy of this consent;

and I agree to be interviewed.

[ ] I do not agree to be interviewed.

SIGNED: _____

DATE: _____

Appendix F: Interview Guide
COMMUNITY OPINION ON SUBSTANCE ABUSE PREVENTION IN COLLINGWOOD.

FACE SHEET

Interview # _____

Date _____

Occupation _____
Age _____
Male_____ Female _____.
Location of Interview_____

1. Do you live in Collingwood (between 22 Ave. to 45 Ave. and between Nanaimo and Boundary, Vancouver)?

YES NO

2. Do you work in the Collingwood area (between 22 Ave. and 45 Ave. and between Nanaimo and Boundary, Vancouver)?

YES NO

Interviewee's ethnic background _____.

Interviewer's Comments

COMMON QUESTIONS

1. In what ways does substance abuse present difficulties for Collingwood residents? (Provide examples only if necessary. i.e., family problems, violence).

2. Do you think the problem is:

a) Alcohol:
Is: not serious [ ] Minor [ ] Moderate [ ] Serious [ ]

b) Illicit Drugs (e.g., marijuana, cocaine, heroin)

Is: not serious [ ] Minor [ ] Moderate [ ] Serious [ ]

c) Prescription Drugs:

Is: not serious [ ] Minor [ ] Moderate [ ] Serious [ ]

3. Who is affected by substance abuse and in what ways?

NOTE TO INTERVIEWER: fill in the information on those groups mentioned by the interviewee. If after probing, the respondent is having difficulties answering, ask: "Would any of the following groups be affected?" and read the list.

who is affected by substance abuse	substance & in what way
i) families	-
ii) single people	-
iii) single parents	-
iv) youth	-
v) elderly	-
vi) men	-
vii) women	-
viii) other	-

4. What do you consider to be acceptable personal drinking habits? What should be acceptable community levels?

SERVICE PROVIDER QUESTIONS

5. Briefly summarize the nature of your work (or of your agency's work). Do you specialize in a particular area or work with particular kinds of people?

6. What programs or services are offered by the agency (ask for brochure if possible).

7. Are you aware of any alcohol/drug prevention programs that are available in the Collingwood area?

If yes, what are they?

NOTE TO INTERVIEWER: ask questions regarding content, methods used, which ones seem to work best, for what populations?

8. How could existing programs be improved?

9. What kinds of programs are needed? (if necessary, PROBE for opinions on increased community education, increased law enforcement, legislative change [some sort of prohibition and/or control] or development of other health promoting alternatives? If the respondent cites non-educational programs probe for more detail.)

a) Who should such programs be designed for?

b) What information should be included in education focused programs? (if necessary, PROBE about alcohol and drugs, available resources, legal implications, life-styles training, aids for parents)

c) What problems/issues/concerns should be addressed? (provide examples only if necessary, peer pressure, intergenerational conflict.)

10. Which individuals and/or organizations could effectively deliver the programs? (Provide examples only if necessary i.e., community organizations, immigrant services, schools, doctors, alcohol/drug agencies, media, etc.)

a) Please explain why you believe they would be effective?

11. What community strengths and resources will aid in developing local alcohol and drug prevention programs?

12. What are the barriers to the development of an effective substance abuse prevention program in Collingwood?

COMMUNITY RESIDENT QUESTIONS

13. What services and resources currently exist to meet the alcohol & drug related needs in Collingwood? What do you know about them? How did you find out about them?

14. Do you think that the general public is aware of these services? Why/why not?

15. Who would you turn to if someone you knew wanted help with an alcohol or drug problem?

16. What are the barriers to the development of an effective substance abuse prevention program in Collingwood? What implications does the multicultural nature of Collingwood have upon substance abuse prevention?

17. Are there any particular areas of the community where substance abuse appears to be particularly problematic? Why?

18. What are some possible solutions to alcohol and drug problems in Collingwood? (if necessary PROBE for opinions on increased community education, increased law enforcement, legislative change [some sort of prohibition and/or control] or development of other health promoting alternatives? If the respondent cites non-educational programs probe for more detail.)

19. Which individuals and/or organizations could effectively deliver the programs? (Provide examples only if necessary i.e., community organizations, immigrant services, schools, doctors, alcohol/drug agencies, media, etc.)

DISTRIBUTORS QUESTIONS

20. Briefly summarize for us the nature of your work (or of your agency's work). Do you specialize in a particular area or work with particular kinds of people?

21. As someone who is involved with the sale or distribution of alcohol or drugs, what do you see as being some of the substance abuse issues that are particular the your work situation?

22. Do you see a need to change the control regulations of your business in order to minimize the potential of substance abuse by your clients? Why/why not?

23. What are the barriers to the development of an effective substance abuse prevention program in Collingwood?

24. Who would you turn to if someone you knew wanted help with an alcohol or drug problem?

25. What are some possible solutions to alcohol and drug problems in Collingwood? (if necessary PROBE for opinions on increased community education, increased law enforcement, legislative change [some sort of prohibition and/or control] or development of other health promoting alternatives? If the respondent cites non educational programs probe for more detail.)

26. Which individuals and/or organizations could effectively deliver the programs? (Provide examples only if necessary i.e., community organizations, immigrant services, schools, doctors, alcohol/drug agencies, media, etc.)

CONCLUDING COMMON QUESTIONS

27. Do you have any other suggestions or comments you would like to make?

28. We are interested in hearing what other community members think about this subject. If you know any other community members that could agree to an interview or want to be involved in the work of the committee, please ask them to contact our office.

Appendix G: Sample of interview notes

RESIDENT
female, 24, recreational/day care worker. Lives with parents. Resident in area 17 years. Christian, United Church.

1. DIFFICULTIES?
- "prevalent in low income areas." "income has relationship to problems." "more need for out reach."
OTHER?:
- people now tend to "stick to themselves now." "they don't know their neighbours." I heard evidence of substance abuse.
CHANGES OVER TIME?
- "dramatic increase of substance abuse in schools." "increased violence in isolated incidents."

2. PROBLEM IS?
i) alcohol is MINOR.

ii) illicit drugs is SERIOUS.
- "drug drops in area." "I don't know how much stays in the area."

iii) prescription drug abuse level is NOT KNOWN.

3. WHO IS AFFECTED?
i) YOUTH? "focus should be on them." "educate parents to educate their kids."
ii) OTHER? "the entire community." "the neighbourhood has a bad reputation." I see "more negative action on the streets."
NEGATIVE ACTION?
7/11, gangs and threats. "Collingwood Park is a drop area (according to friend who lives across the street)."

3a. WHAT IS ACCEPTABLE USAGE?
- "We all need to be aware of our limits and live within them."
- "drinking is O.K. if it does not interfere with your life or the lifes of others."
- illicit drugs are not O.K. as they are "addictive."
- prescription drugs are "necessary for some people, sometimes however they are over prescribed"
WHY?
- doctors sometimes prescribe them "to get patients off their backs."

4. SERVICES IN AREA?
- "no special programs." A.A.

5. IS THE GENERAL PUBLIC AWARE?
"In metro Vancouver, yes." I am not aware of any neighbourhood programs. "we like the idea but not in my backyard."

6. WHO WOULD YOU TURN TO?
"yellow pages or agency services book to identify agencies." "N.D.P. Community Handbook."
TRY PROGRAM?
- "I don't know much about it." "I think it says that community should take more responsibility."

7. BARRIERS?
- "fear of getting involved."
WHY?
- "some seniors are afraid of drugs and won't go near them." its is "scary as people get hurt sometimes." "emotionally taxing." "lack of community spirit."
IS COLLINGWOOD A COMMUNITY?
- no. Collingwood "is not community of people working together."

MULTICULTURAL?
- no. "no obvious substance abuse in E.S.L. families at preschool." different for Caucasians - "more physical abuse." "of 12 Caucasian families in preschool 3 had substance abuse problems and 2 may have had problems."

8. PROBLEM AREAS?
- "Killarney Park ice rink is a drop off point."
MR. SPORT?
- "they are usually so drunk that they are not scary."

9. SOLUTIONS?
- "education is the strongest weapon." "maybe more policing might be effective but it will probably just cause the problem to move." "an attitude change is necessary".
ATTITUDE CHANGE?
- for example: "educators need to take a stronger stance." "not taking action means acceptance."
LEGISLATIVE CHANGE?
- "present laws are O.K." "the more you say know the more they will say yes."
YOUTH?
- "more recreational alternatives." the goal should be

"getting kids to do things for themselves." They "need to develop more self esteem."

WHO SHOULD DELIVER PROGRAMS?

- "Community Centers, Parks and Recreation, Schools, and the Church, but not many young people go to these places".