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From the Individual to the Community: Perspectives about Substance Abuse Services

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Abstract

This paper argues that substance abuse interventions in distressed African-American communities must be culturally-tailored and incorporate a framework targeting changes in both individual behavior and the community. The current study employed Concept Mapping in conjunction with Community-Based Participatory Research (CBPR) principles to involve 100 community members, substance users, and service providers to examine the role of alcohol and other drugs in distressed African-American communities. Findings reveal the way participants understand the role of drugs and alcohol in their community and their perceptions of substance abuse services. The paper describes a collaborative approach to engage the community in addressing substance abuse.

Keywords

substance abuse treatment; culturally tailored interventions; African-American; community based intervention; community based participatory research; concept mapping

Researchers, service providers, and consumers have typically viewed substance abuse as a medical problem that requires treatment or as a moral problem that requires punishment in the form of incarceration (Larkin, Wood, & Griffiths, 2006; Leshner, 2001). Proponents of the medical perspective argue that addiction is a disease of the brain where the person experiences a compulsion to use substances despite numerous negative consequences (National Institute on Drug Abuse, 2007). Proponents of the criminal justice perspective believe that substance use is a form of criminal behavior that should be punished by incarceration (Porter, Tamm, Lin, Ford, & Iacopino, 2004; Taxman & Messina, 2002). While these are very different frameworks, they reflect a common paradigm: individualism (Ray, 1996). According to this ideology, the individual alone is responsible for his or her plight in life. Therefore, interventions must focus on changing the individual's beliefs, thoughts, assumptions and expectations about the self and his or her social situation. Such a view omits the growing evidence that historic trauma and community-level determinants also have an impact on individual and community health (Dunlap & Johnson, 1992; Leary, 2005; Windsor & Dunlap, 2010).

While there is evidence supporting the effectiveness of many individually focused interventions in reducing substance abuse (Brolin, 2007; Leshner, 2001), some researchers have cautioned against over-generalizing findings of treatment effectiveness, especially when imposed on specific vulnerable groups such as impoverished African-Americans

(Klag, O'Callaghan, & Creed, 2005; Longshore, Grills, Annon, & Grady, 1998; Windsor & Dunlap, 2010). Specifically, such researchers argue that when addressing substance use among vulnerable populations, it is important to understand substance use as a complex phenomenon typically interrelated with poverty, violence, and low social capital. For instance, a Black person living in a distressed neighborhood can change their perspectives and believe that if they work hard enough, they will be able to buy their own home, succeed financially, and be accepted as equals in American society. In other words, they may believe they can live the *American Dream* (Hochschild, 1995). They may experience less psychological distress and attain better coping skills. However, changing their beliefs will not address the poverty, racism, and violence that they may continue to encounter in their neighborhood. As such, simply treating the individual or even the family for substance use does not address the impact of the structural oppressive forces that they may face (Dunlap, Golub, & Johnson, 2006; Windsor & Dunlap, 2010; Windsor, Benoit, & Dunlap, 2010). Structural oppressive forces and their subsequent impact are often evident when the community, not just the individual, is engaged in the research process. Previous research has demonstrated the importance of integrating the worldviews of low-income African-Americans in order to develop culturally-tailored and community-based health interventions in distressed African-American neighborhoods (Pinto, 2009; Schmidt, Greenfield, & Mulia, 2006; Windsor & Dunlap, 2010). For instance, Windsor & Dunlap (2010) found that one of the biggest challenges low income African American women in New York City faced in maintaining sobriety was their inability to leave the communities in which they lived and used drugs. Thus, a culturally-tailored intervention would aim to address these environmental challenges by engaging the wider community in order to facilitate recovery.

In this paper, the authors argue that culturally-tailored interventions aiming to reduce substance abuse in distressed African-American communities must incorporate a broad perspective that targets changes in both individual behavior and in the community itself. Community Based Participatory Research (CBPR) principles have been shown to increase community engagement in research while increasing the quality and applicability of research findings (Minkler & Wallerstein, 2003). CBPR is a framework that calls for community participation at every step of the research process, from question development to dissemination. The first step is to engage representatives of diverse groups in the community early on in the intervention development process. Therefore, the purpose of this study was to engage low-income African-American communities in Newark, NJ to: 1) lay the groundwork to develop effective collaborations between researchers and community members; 2) increase our knowledge of substance abuse and drug traffic in the community from the perspectives of several stakeholders; and 3) explore community perspectives of how substance abuse can be addressed.

Contextualizing substance abuse health disparities in Newark's distressed neighborhoods: The word distressed is drawn from the work of Dunlap, Johnson, & Golub (2006) and refers to a constant struggle with multiple crises precipitated by substance use, drug sales, multiple barriers to consistent employment, poverty, and inaccessibility to effective and affordable healthcare and housing. The current project took place in Newark, NJ because this city has the highest prevalence rates for substance use and HIV/AIDS in the state of New Jersey (Division of Public Health Services, 2008; New Jersey Department of Human Services, 2005).

Methods

CBPR principles were applied over the course of one year including formulation, data collection, and dissemination of findings (see figure 1). CBPR is a collaborative approach to research that equitably involves all partners in the research process and recognizes the

unique strengths and insights that each brings. CBPR begins with an issue of importance to the community and has the aim of combining knowledge with action to create and achieve social change. Once IRB approval was obtained from Rutgers University, the research team identified groups of potential participants including non-drug using community residents, service providers, and substance users. Purposive or judgmental sampling was used to recruit all participants in each phase of the project. Specifically, researchers collaborated with a service provider at a community based organization providing substance abuse and HIV prevention services and a community resident to identify and recruit the study's sample (n=100). This service provider and community resident joined the research team and participated in all phases of the project. The final research team consisted of two researchers, two service providers, and one community member.

Participants of all racial and ethnic groups were encouraged to participate. Selection criteria included residing and/or working in Newark for at least one year, being older than 18 years of age, and being knowledgeable about Newark's low income and predominantly African-American communities (e.g., living or working in these communities for the past year; interacting with individuals from these communities through work, friendship, etc). Flyers were disseminated at the community based organizations (CBOs) announcing the study and the date and time of group meetings. A cash incentive of \$20 dollars was offered.

Procedures

Concept mapping is a mixed methods approach in which complex qualitative and quantitative data are collected, processed, and displayed into a map that can be easily understood by research participants. Thus this approach can facilitate collaboration between researchers and community members while increasing the trustworthiness of the data. In this project, the process described in Kane & Trochim (2007) was followed. The research team began by conducting three brainstorming sessions (one with substance users, one with community members, and one with service providers) to generate a list of statements that describe the role of drugs and alcohol in Newark's distressed neighborhoods. Once the brainstorming sessions were completed, the research team prepared the final statement list by removing duplicate, confusing, and double-barreled (with dual meaning) items. Research assistants then printed each statement on 3x5 index cards (30 card sets, one for each participant).

Three additional groups of substance users, community members, and service providers were recruited for the sorting and rating phase using the same brainstorming sampling strategy. Sorting and rating in concept mapping can be compared to a factor analysis, the goal is to group the statements according to conceptual dimensions while rating the statements/dimensions according to a predetermined scale. During the sorting, the groups worked individually to sort the statements into piles that made conceptual sense and had similar meaning. Participants were then directed to label each pile. Once the sorting was completed, participants were asked to rate each statement according to their agreement on a five-point Likert scale from completely disagree (1) to completely agree (5).

Results were then presented to a new set of participants in three validation groups including community members, service providers, and substance users so that the group could interpret the maps, discuss potential changes to the analysis, name the different dimensions, and decide on how the maps would be utilized. Recruitment followed the same process used at the brainstorming and sorting/rating phases. Some of the participants had attended the previous brainstorming and sorting/rating phase (approximately 65%), while others were completely new to the project. This was done to increase the trustworthiness of the data by confirming that the findings described the accurate perceptions of participants and that these findings were also applicable to new individuals who live/ work in Newark, NJ.

Once the concept map was completed by incorporating the validation findings (see figure 2), three new focus groups were conducted to explore participants' views regarding substance abuse treatment and related services in Newark's distressed neighborhoods. One group included substance users, the second included service providers, and the third group included community members. Recruitment followed the same procedures used in the previous phases of the study. Focus groups lasted approximately 1.5 hours and with the exception of service providers, participants received a \$20 incentive. Two groups met at the community-based organization and a third at a middle school in the community. Participants were asked to discuss their views regarding the substance abuse treatment programs in the community, including their strengths and weaknesses, community needs, and the role of the community in service provision and advocacy. Digital recordings were transcribed, coded, and analyzed for emerging themes. Inter-rater reliability at 100% agreement was achieved between three coders through various meetings in which a coding tree was developed and refined until everyone was clear on the meaning of each dimension. Emerging themes were then identified and examined by the research team (including the researchers, the service provider, and the community resident). At the end of the project study participants were invited to apply to become members of the Newark Community Collaborative Board- a group charged with the task of considering these research findings in the development of a new culturally tailored, community-based intervention.

Results

A total of 100 people including substance users, service providers, and community members participated in the study. Of the sample, 27% participated in the brainstorming sessions, 30% participated in the sorting and rating sessions (note in multistage clustering a sample of 30 individuals is sufficient for the analysis- see Kane & Trochim, (2007), 18% provided feedback to the cluster map interpretation, and 25% participated in the treatment and needs/strengths assessment focus groups. Overall sample mean age was 44 (SD=9.24) and mean time living in a distressed Newark neighborhood was 12 (SD=17.24) years. Approximately one third of the sample reported current substance use. Substance using participants (N=39) reported having attended a mean of 4.05 (SD=4.14) substance abuse programs in their lifetime. Median annual income was \$20,000. Participants' preferred substances included snorting and injecting heroin (29% and 32% respectively), crack (24%), and alcohol (20%). Table 1 provides participant demographic information by subgroups.

Concept Map

In concept mapping the concept map displays the quantitative results of the sorting and rating phases (see Figure 2 for the map and Table 2 for sample statements represented in the map). The statements' sorting data are analyzed using multidimensional scaling procedures which derive a stress value as an estimate of the degree to which the map represents the grouping of the data. In order words, it is a goodness of fit measure of the data. High stress values may imply that there was considerable variability in the way people grouped the statements while a lower stress score indicates greater concordance (Kane & Trochim, 2007). In the current study, multidimensional analysis yielded a stress value of .33 indicating the map is acceptable.

The final concept map solution included eight dimensions (see Figure 2): 1) Impact of alcohol as a legal drug in society; 2) Street drugs/ prescription drugs: What's the difference?; 3) The impact of pot on individuals; 4) Street Power Brokers; 5) Police are part of the problem, not the solution; 6) Drug dealers/ drug market/ drug trade; 7) Impact of drugs on the community; and 8) Motivators and aftermath of getting high (see Table 2).

According to participants during the validation group, the dimensions can be grouped into three common themes that depict the role of drugs and alcohol in Newark's distressed neighborhoods (Table 2 displays sample statements from each dimension along with participants' ratings):

1) Impact of specific substances on individuals and communities (dimensions 1, 2, 3, and 8)—This theme reflected the interconnectedness of the impact of substance use on individuals and the community. For instance, participants discussed how the availability and cost of certain substances in the community impacted individual substance use. Prescription drugs are typically preferred by users over illegal drugs because they are safer (one knows the formula for prescriptions, but not street drugs) and less likely to produce severe withdrawal symptoms. However, heroin and other illegal drugs are cheaper. Thus people often turn to illegal drugs or crime when they cannot afford to purchase prescriptions.

2) Drug trade and its players (dimensions 4, 5, and 6)—This theme refers to the main players in Newark's low income and predominantly African-American neighborhoods' drug trade which included drug dealers, vulnerable youth, the police, politicians, business owners, and some corrupt churches and service agencies. They explained that all of these groups benefit from the drug trade at the expense of impoverished youth who get caught in the middle. Politicians develop restrictive policies that serve their individual interests and the police, composed of both honest and corrupt officers, must enforce these policies in the community thus arousing suspicion and fear within the community. For instance, drug policies carry heavy sentences for drug possession. Such policies encourage dealers to exploit vulnerable youth by using them as lookouts and street drug sellers. That way, higher level drug dealers can avoid the risk of heavy prison sentences. Businesses also benefit from the trade as many corner convenience stores serve as storage for drugs while other businesses sell products that are popular in the "flashy drug dealer lifestyle." According to participants, some churches and service agencies in the community are *corrupt*. They explained that these organizations apply for various funding sources claiming to serve those struggling with addiction, while providing questionable and very limited services.

3) Substance use and drug trade impact on the community (dimension 7): This theme reflected the relationship between drug use, trade, and crime in Newark's distressed neighborhoods. Participants talked about their experiences being exposed to drug violence, including witnessing shootings, being interrogated by the police, being afraid to go to certain areas at certain times, and being scared for their children. Participants discussed the disadvantages that impoverished families must face when living in drug infested communities and the implications of racism, discrimination, and lack of opportunities. Participants also discussed a major change in neighborhood culture where the community no longer watches out for the welfare of the children. They explained that in the past, people felt comfortable disciplining their neighbors' children, but currently people are disconnected and afraid.

Focus Groups Findings

While concept mapping generated key dimensions of the role of drugs and alcohol in the community, data from subsequent focus groups were used to identify alcohol and drug use service needs and resources that characterize these communities. Specifically, focus groups yielded an assessment of available substance abuse services in the community, including program strengths and limitations. In addition, focus groups provided implications for developing interventions that include the community in addressing substance abuse in Newark. Four themes that emerged from the focus groups analysis are described below.

Whenever possible, complementary and/or contrasting opinions of community members, substance users and service providers were highlighted.

Substance Abuse Treatment Programs: Strengths and Weaknesses—This theme describes substance abuse services available in Newark and reflected the concept mapping themes of (1) Impact of specific substance use on individuals and (3) Substance use and drug trade impact on the community. According to the participants, services available in the community primarily have an individualistic focus and commonly employ a singular modality. While substance users mainly identified detoxification programs in hospitals, the Salvation Army and Alcoholics Anonymous (AA), providers also noted faith-based programs, long-term residential programs, intensive outpatient (IOP) and Al-Anon for families.

Most participants acknowledged the presence of some outstanding treatment programs in the community. They noted that despite limited funding and resources, there are committed service providers who have vigorously worked to accommodate and provide services for as many clients as possible. For example, providers and users noted the presence of street outreach workers who provide psycho-education on HIV/Sexually transmitted diseases, rapid result HIV testing and clean syringes. Community members also noted the presence of churches and other faith-based organizations that provide immediate transitional housing and treatment services to anyone in need.

However, despite the presence of such programs and initiatives, participants noted that the majority of available treatment programs are characterized by structural gaps and limitations that curb their efficacy. For example, participants stated that accessibility to available programs is often limited by the type of insurance that an individual has. The following statement by a provider demonstrates this:

If you have insurance, Medicaid, or something, if you're a sniffer or heroin addict you can get methadone. Um, other forms of treatment, well first starting off with detoxes, there are 12 step programs that you can go to. There are a few faith-based organizations that will help you out. Most of those (treatment programs) are asking money for them (services). Service availability depends on the type of insurance that you have. Now the insurances are being coded to state whether you are eligible for substance abuse treatment so your co-pay could range from 100 dollars to um like 15 dollars a week if you're going on the methadone or Suboxone program.

Participants noted that accessibility to treatment services is also limited to certain types of addictions. The following statement from a service provider shows how it is easier for an individual with a heroin addiction to receive treatment than for one addicted to cocaine:

It's a little easier to get help if you are going for heroin than cocaine because heroin...because heroin and alcohol you need to have a medical detox because it is more of a physical dependency where cocaine is said to be more of a mental addiction.

In addition to restricted access to treatment services, participants noted the emphasis on pharmacological interventions as another limitation of available service provisions. Participants discussed the employment of one-dimensional treatment modalities, namely the use of pharmacological interventions. Community members questioned the effectiveness of methadone treatment for heroin addiction. They argued that methadone was another form of addiction, and that the aim of effective treatment should be to avoid any type of dependency. In the voice of a community member, "When they go to methadone clinics it's because they can't afford the heroin, so they know they can go there and that just eases the pain and keeps the sickness off." Community members felt that pharmacological interventions should be

used only in severe cases. Service providers and substance abusers, on the other hand, offered a different perspective. They stated that methadone programs as well as pharmacotherapy are important interventions in that they help stabilize the addicted person and reduce crime and blood born disease transmission rates. However, some individuals in these groups acknowledged that pharmacotherapy alone is not enough:

I hear plenty of people come in and say once I get the meth or Suboxone I'll be alright. No they are not going to be alright because you can still continue to do the same things.

The absence of diverse and effective treatment modalities was also a noted limitation of available service provisions. Community members expressed grave concern for the absence of what they perceive to be the most important and effective treatment modality that is ironically the least available in Newark: residential treatment. Participants noted that in addition to being sparse, existing residential rehabilitation centers in Newark tend to become overwhelmed with client demand. They explained that when it is cold, homeless substance users are more likely to seek shelter in residential treatments as a way to stay warm. A substance user said, "At this time of year rehabs are very crowded 'cause nobody wanna run around the streets and try to chase and get high."

Another missing component in existing service provisions as noted by the community members is the lack of behavioral treatment available for nicotine or marijuana smoking. They argued that this may be due to community denial that these substances are also drugs. They noted that the only treatments available for nicotine use are pharmacological and often only accessible by those with health insurance:

Like she said there are places where weed isn't considered an abuse so you can't get treatment for that. So it has to be cocaine, or heroin, or you have to be an alcoholic. Somebody who has to drink alcohol 24/7. But the weed is just as addictive as...I mean I'm a smoker...And if I say I wanted help smoking it's give me your insurance card, give me a prescription for that thing with one side effect or another... You know, it's really no treatment for a smoker. Or they don't have a facility for smoking that I know of. And you get sent out of town for alcohol.

Barriers to Substance Abuse Treatment—Community members mentioned that one critical barrier to treatment may be substance users' difficulties in finding motivation to change. Establishing trust and changing their views are challenging tasks in treatment. The following statement from a community member who works at Newark's school system illustrates this issue:

We have to try to change the mindset of some of our parents who are not addicted but may just be using and abusing. They think it's okay to get high. If they go to work every day or even if they don't, they think it's okay. As long as they think it's okay they're gonna continue to do the same thing no matter what their child says, it's not going to work. [...] we have to build trust with our parents saying "we're truly here to help you, not to hurt you." And that's difficult to do.

As discussed in the previous theme, two additional barriers to substance abuse treatment are lack of insurance and restricted treatment access due to type of addiction. Participants in all three focus groups mentioned that a major obstacle in obtaining access to substance abuse treatment is the fact that many poor individuals have serious difficulties getting identification cards. Participants explained that in New Jersey, people must have a valid identification card in order to obtain services. However, they explained that obtaining an I.D. card can be an expensive and cumbersome process:

When we deal with clients who are HIV positive most of them have a problem getting I.D. They are homeless and have no I.D. at all. The process for them to get their I.D. takes forever so they really have a problem with documentation.

Other community level barriers included transportation and the lack of a continuum of care where the individual is supported in maintaining sobriety. Participants believed that individuals should first be able to go through detoxification and then to a residential treatment program. Upon their completion of the program, these individuals should be given access to information and support services to maintain their sobriety. A community member said:

As far as the community here, I think that this community as a whole needs more facilities, it's a lot of facilities in New Jersey but not so much as in Newark and in the greater Newark and Clinton Hill area. And then we find a lot of times that it is a lot of waiting list especially for long term treatment. Like you go into the detox that's when they a lot of times, 9 out of 10 detox just doesn't cut it, especially if you been a drug user for multiple years you know you need further treatment. Then to learn about the disease itself because it's just not the drugs, it's the lifestyle and everything else that goes with it so you know they need long term treatment.

This theme reflects a disjunction between community members and substance users in that these groups had different ideas about substance use and services. Users seemed to view services mostly as medical detoxification, where they go to get clean. Residential services were seen as unattainable for many. Some noted trying to gain access to such programs for shelter during cold months. Users also requested more individual counseling and complained that most interventions were delivered in group format and were short term. Service providers discussed a wide array of services that users did not mention. Both service providers and users viewed pharmacotherapy as a helpful form of treatment. Community members focused their recommendations on increasing the number of available long term residential services and reducing pharmacotherapy interventions.

Structural Issues: Individual versus Social Responsibility—Participants in all three focus groups discussed the role of individual responsibility in the recovery process, highlighting concept mapping themes (1) Impact of specific substance use on individuals and communities and (3) Substance use and drug trade impact on the community. Participants expressed that substance use and recovery are a personal choice, one that it is largely dependent on self-determination and will. The following quote from a substance user reflects some of participants' views on individual will power and determination to get clean: "Bottom line is: [...] Am I ready to stop using drugs? If you're not really ready we can sit there and bullshit you and talk all the good talk we want." Despite the emphasis placed on self-determination, participants posed questions regarding recovery while also acknowledging the overwhelming strength of addiction. Another substance user said:

It doesn't matter how much willpower an individual has. It's almost impossible you know the addiction is so much bigger and so much stronger than it used to be. No matter how determined you are how much willpower you have its no, you're no match.

A controversial theme that emerged in all groups was the balance between providing useful support to recovering individuals while not enabling them. Some providers and substance users believed that users typically become too dependent on others. According to these participants, recovery includes becoming independent and productive. One provider said;

You have a lot of people that have been scheming and conniving and have always depended on someone to do things for them and when they get clean they look for

someone to do something for them also. Getting clean to me means become a productive member of society and stop being so dependent upon the system.

Many providers, community members, and drug users disagreed. They expressed that it is imperative to find a balance in providing some social support while encouraging the individual to become independent. For instance, participants discussed the role of services, such as social security, section 8 housing, and unemployment insurance. Social Security is important because after completion of substance abuse treatment, individuals in recovery need to reenter the community and find a means to support themselves. Section 8 housing provides people with transitional housing so that they have time to reestablish themselves. Lastly, securing meaningful employment was considered the most important step in sustaining recovery. Thus, people in recovery need to develop work skills and receive community support when searching for employment as mentioned by a substance user:

Give us a job give us a job, hire us just to see how it work out you know what I'm saying? Hire us just so we can, you know, have something to do, we don't be just sitting home and we don't have nothing to do.

Another important issue discussed regarding social responsibility in the recovery process was the criminal justice system and existing drug policies. Community members, drug users, and most service providers did not believe drug users should be sentenced to prison. They supported the idea that substance abuse is a disease and users should receive treatment, not punishment:

If you have a drug addiction problem, we would go in front of the judge and say "look, jail isn't the answer. We would like to send him to a long-term program for treatment and we would like your honor to consider working with us. And by turning him over to us, letting us refer him out as opposed to us sending him to jail. That's the right thing to do because you're trying to address the issue, the drug addiction, not just keep locking people up.

Proposed Solutions to Substance Use and Drug Trade in Newark—This theme addressed solutions to issues raised in all concept mapping themes. Participants were asked to discuss solutions to the issues identified in the concept mapping phase of the project. Service providers and community members thought the most important step would be to increase the number of residential treatment facilities in Newark and expand the scope of services. They suggested services should be available to substance users and their families. One provider said, "Family counseling for the whole family, because in the community here you find out that it's not just a me thing or you think it's an entire family thing." One community member added that services must be comprehensive, "You have to address the homelessness, mental health, employment, everything. And that's the problem with a lot of these programs."

Like in the concept mapping theme (2) Drug trade and its players, all participants expressed frustration with Newark's long history of government corruption. They believed that the government benefits from the drug trade and chooses not to address the issues they identified. A community member expressed this by saying,

"We could fill this whole building with people who share these concerns, but until our government recognizes the fact that... I don't care what anyone says. Our government can look in the future 10 years from now, they can put people on the moon... Why can't they stop drugs from coming into this country?"

Another community member commented: "A lot of the drugs and some big politician gets a cut of the money. They don't want to stop it no matter what we do."

Drug users shared similar views: What I really do believe, that if we wanted to if this government wanted to stop drugs from coming in, I'm pretty sure we could. But we don't and there are many reasons why. Now forget the fact that it is destroying families its killing children its destroying families but money is being made through drug addiction ok? And that's the number one thing.

In expressing their frustrations with politics, corruption, and living in communities historically neglected by the government, participants discussed the importance of stepping into their roles as stakeholders for the betterment of their community. Though participants admitted that change won't come easily or overnight, they resolved to do so by taking on the community in a more manageable way- block by block. This meant taking on grass roots efforts, meeting one's neighbors, creating coalitions, and organizing their communities, block by block. One community member explained:

Because there are those things all over the world. Then, why for these four blocks nobody saw drugs on those blocks? Because that community came together and decided that these four blocks will go untouched. So even if it just starts with block by block...If we built the school up, we have the power to change the city.

Inspired by the previous participant, another community member provided an example of how community action can result in real change:

That's what it's about. Taking it block by block. Remember the one you told me about where they jumped the guy when the school was letting out? Right in front of the school. So I spoke to the kids who clock out there [drug dealers]. And I said "yo I heard that somebody got a beat-down during the time the kids were coming out of school and I heard it was awful." I was like "listen I'm gonna tell you guys right now, I'm good with everybody but that can't go on no more. When the kids are coming and going from school you all have to fall back. Because you can't do that. Somebody watched over you to get you to the point that you got to grow up [...] I knew those kids when they were growing up. [...] So they're sensible now.

Participants in all groups agreed that real change would require commitment and perseverance from a variety of groups within the community. Participants discussed the benefits of involving substance users in community action. A community member said:

Right, and helping them [substance users] learn how to do: it is by engaging them in doing it. I try to encourage a lot of the shelters and continuing care programs to do the same thing. I'm like look "you have to get your clients involved" because most of them have never done anything. They had substance abuse problems they just chased all day every day. Get them involved with the daily running of the facilities. Make them feel needed, responsible and so forth. That helps them come around and get together.

Discussion

Findings from the concept mapping phase revealed dimensions that describe the role of drugs and alcohol in the community according to substance users, service providers, and non substance using community members who participated in the study. Their perspectives provide insight on the impact and dynamics of substance use and drug traffic at the individual, community, and policy levels in Newark, NJ. For instance, participants discussed the relationship between individual responsibility and social responsibility. On one hand, all participants agreed that substance users are responsible for their sobriety and that it is incumbent upon them to seek treatment and make "good choices." However, participants also recognized that the community in which they live contributes to the "bad choices" they sometimes make. Even if an individual takes the initiative to seek treatment, Newark has

waiting lists which can take as long as six months. The individual's recovery process is further hindered by the fact they continue to live in a neighborhood with high drug activity and little community support. Thus making continued substance use a viable option while waiting for treatment.

All participants acknowledged the presence of strong and effective treatment programs in the community, however they emphasized the dire need to increase funding and resources to enhance and expand service provisions. In particular, participants overwhelmingly agreed that the community would benefit from individualized, long-term residential treatment targeting specific substances and accessible to individuals regardless of addiction type. Other research on low income African-American families in New York has reported similar findings. Dunlap et al (2006) found that marijuana users often felt discouraged attending substance abuse treatment because they felt their experiences and treatment needs were different than the needs of individuals dependent on cocaine, heroin, and/or alcohol.

Participants also noted that individually focused treatments are not enough. Concept mapping findings reflect the impact of substance use and drug trade on the community. As such, focus group findings included the need to develop community-based interventions to support persons in recovery while simultaneously combating drug traffic and strengthening the community. For example, a critical barrier to maintaining drug-free lifestyle lies in the fact that the majority of substance users who undergo treatment return to the same distressed environment in which they used drugs. Research has identified this issue as a major obstacle in maintaining sobriety among those who attend treatment (Allen, 1995; Windsor & Dunlap, 2010). Participants mentioned the need for accessibility to a continuum of services that not only provide individual and group treatment, but also support services upon completion of treatment. These support services, such as housing, job placement, and health care would ease the transition for individuals back into the community. Findings support previous research on the benefits of comprehensive services (Ducharme, Mello, Roman, Knudsen, & Johnson, 2007; Marsh, Cao, & D'Aunno, 2004; McLellan et al., 1998) .

Recommendations for Practice and Policy

This paper emphasizes the importance of community engagement in research while fostering community cohesion and developing meaningful health interventions, policies, and services. Findings revealed the distrust that community members, service providers, and drug users have for the government and the police force in Newark serves as a significant barrier to community involvement in addressing substance use and the drug trade. Although participants agreed that drug and alcohol have deleterious consequences on the community, they questioned the government's motivation in addressing this issue. African-Americans often report feeling suspicious of governmental or formal institutions because of historical abuses they have endured (Dunlap & Johnson, 1992). Such distrust creates major obstacles for both the government and the community. However, as this project has demonstrated, community members have a sincere desire to help make their community a better, more livable place. Therefore, it is critical to foster a working relationship between community members, the government, and the police force based on mutual trust and united by the common goal of addressing drug use and traffic in Newark's distressed communities.

Other situational barriers to treatment access included lack of program availability, transportation, health insurance, and difficulties obtaining identification cards. Policies must be developed to address these barriers. For instance, the City of Newark can waive the fee for obtaining identification to low-income residents while simplifying the process. Participants suggested that the city should use some of the vacant buildings in Newark as residential substance abuse programs and shelters for low-income individuals. Federal funds can be obtained to help start up these facilities and implement evidence based programs.

Study Limitations

While this study was successful in engaging community members in research and producing useful results, it includes a few limitations. Although concept mapping employs qualitative research techniques, in-depth information is lost in the structured methods employed in the brainstorming sessions. Thus, in the current study, additional focus groups were conducted after the concept map was developed to enrich the data and explore service provision in Newark. Typically in CBPR, a community member is included in the analysis process. However, since the analysis can be modified in the map interpretation step of concept mapping, community members were not included in the analysis or data entry tasks of the current study.

Due to methodological limitations findings can only be generalized to the study sample and within the boundaries of Newark's distressed communities. Moreover, because of the limited sample size and lack of random sampling, this study reflects the views and insights of a modest portion of Newark's population. Consequently, it does not provide an exhaustive account or assessment of available service provisions and limitations in Newark. For instance, perspectives from government representatives and youth are lacking. The majority of the participants in the present study were already actively engaged in the community and committed to social change. More research needs to be done on effective methods of engaging diverse groups and disengaged individuals to increase the effectiveness and sustainability of future community-based treatment programs.

Conclusion

Findings suggest that community collaboration can provide invaluable insight in understanding the role of substance abuse in distressed communities while identifying innovative solutions. However, how can one engage the community and together, develop, implement, and evaluate potential solutions? CBPR coupled with concept mapping were a useful method in starting the dialogue, defining the problem, and identifying solutions. Findings from this project were presented at a political State of the City address by our partner community resident. We have used these findings to inform the development a new community based intervention to reduce substance use in Newark, NJ. Social workers and community organizers have successfully utilized a variety of community mobilizing techniques (e.g. building coalitions, conducting town-hall meetings, testifying in public hearings, writing letters to elected officials, knocking door to door to disseminate information) to collaboratively define and address community challenges. It is time that proposed solutions to substance abuse move beyond individual focused approach or punishment to combine psychotherapy and/or pharmacotherapy with community building, mobilizing and advocacy. Distressed communities need meaningful job opportunities, safety, a sense of belonging, and ownership in order to prosper. Empowering individuals to address these structural issues while working on their recovery side by side with their fellow neighbors may be powerful and innovative solution in the field of substance abuse.

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Data from this study have been previously published as a policy brief at the Center for Behavioral Health Research & Criminal Justice Research at Rutgers University. The policy brief was a short publication aiming to discuss the research findings implications to policy in the city of Newark, New Jersey.

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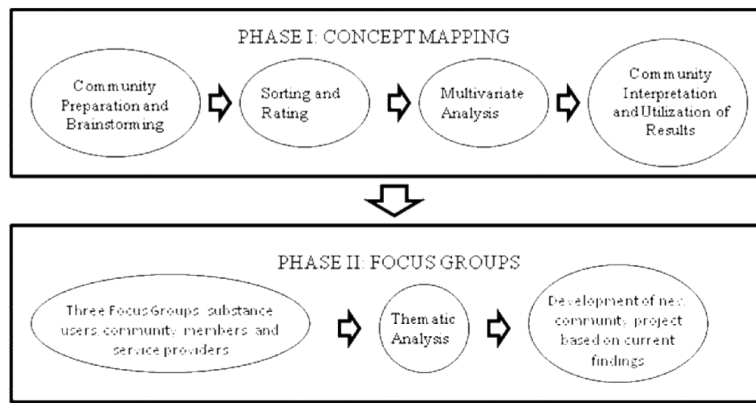


Figure 1.
Project Process

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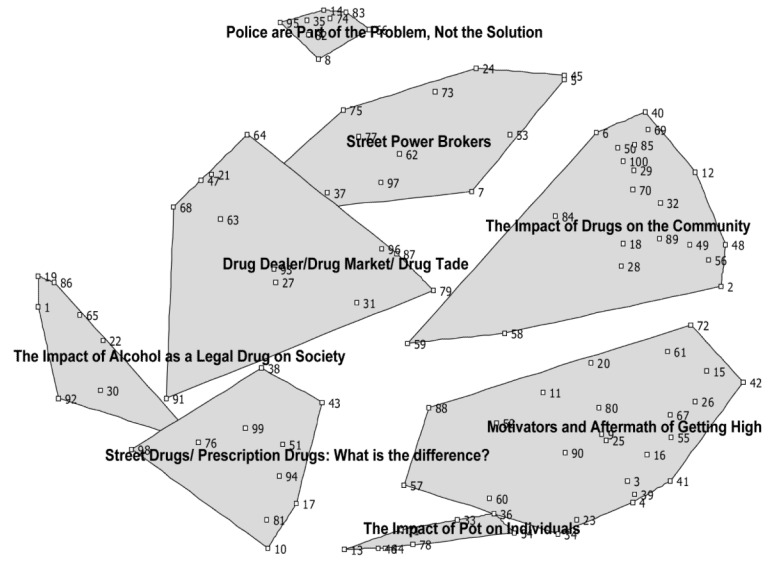


Figure 2.
Final Cluster Map

Table 1

Demographics of Participants (N=100)

Demographic	Overall Sample (%)	Drug User	Community Member	Service Provider
Role in Project	100%	41%	29%	30%
Completed at least HS or GED	90%	76%	97%	100%
Employment				
Full Time	46%	0%	65%	89%
Part time	5%	5%	0%	7%
Unemployed	49%	95%	35%	4%
Female	58%	53%	64%	59%
Ethnicity				
African American	71%	76%	75%	59%
Black Caribbean	15%	11%	16%	18%
Hispanic	1%	0%	0%	4%
White	11%	13%	6%	15%
Other	2%	0%	3%	4%
Currently unmarried	79%	87%	73%	74%
Currently uses substances	32%	76%	3%	7%
Drugs currently being used [*]				
Marijuana	7%	5.3%	0%	19%
Snorted Heroin	17%	42%	0%	4%
Injected Heroin	14%	37%	0%	0%
Crack Cocaine (smoked)	13%	32%	0%	4%
Cocaine (inject/ snort)	12%	29%	0%	4%
Smoked nicotine	14%	24%	3%	15%
Alcohol	20%	26.3%	21%	11%

* Percentages do not add to 100% because the same person may have reported using several substances

Table 2

Selected statements according to each dimension and overall agreement rates

<i>Cluster 1: Impact of Alcohol as a Legal Drug in Society (8 statements)</i>		
<i>Statement Number</i>	<i>Statement</i>	<i>Agreement Rating Average</i>
30	Alcohol increases risk behaviors such as unsafe sex and sharing needles	4.67
65	Alcohol is so prevalent it gets normalized and overlooked	4.43
92	The impact of alcohol is as destructive if not more destructive than drugs	4.37
Cluster Stats:	Mean (SD)	4.15(0.32)
<i>Cluster 2: Street Drugs/ Prescription Drugs: What's the Difference? (9 statements)</i>		
<i>Statement Number</i>	<i>Statement</i>	<i>Agreement Rating Average</i>
17	Pills are just as popular as heroin	4.33
51	Kids are huffing (using inhalants)	3.90
43	Kids as young as 12 are using leak (marijuana joint dipped in embalming fluid)	3.80
Cluster Stats:	Mean (SD)	3.67 (0.45)
<i>Cluster 3: The Impact of Pot on Individuals (8 statements)</i>		
<i>Statement Number</i>	<i>Statement</i>	<i>Agreement Rating Average</i>
33	People use pot to get high	4.57
54	Sometimes when people smoke pot, they want to use other drugs (it is a gateway drug)	4.43
13	People tend to believe pot is not harmful	4.33
<i>Cluster 4: Street Power Brokers (12 statements)</i>		
<i>Statement Number</i>	<i>Statement</i>	<i>Agreement Rating Average</i>
7	Drug dealers are hiring kids as runners to protect themselves from being arrested	4.73
97	Some people trade their welfare checks in corner stores for drugs and cash	4.63
53	The government has the power to clean up the drugs	4.50
Cluster Stats:	Mean (SD)	4.17(0.39)
<i>Cluster 5: Police are Part of the Problem, Not the Solution (8 statements)</i>		
<i>Statement Number</i>	<i>Statement</i>	<i>Agreement Rating Average</i>
35	Some police officers are involved in the drug trade	4.60
8	The police moves the drug trade from place to place, but they do not fully address it	4.43
83	Cops are practicing racial profiling.	4.37
Cluster Stats:	Mean (SD)	4.02(0.62)
<i>Cluster 6: Drug Dealers/ Drug Market/ Drug Trade (11 statements)</i>		

<i>Statement Number</i>	<i>Statement</i>	<i>Agreement Rating Average</i>
87	The drug market provides children with false promises of wealth	4.37
68	Dealers buy some jewelry, they buy things, but there is no economic security	4.33
96	Adults who exploit children selling drugs can receive heavier prison sentences	4.33
Cluster Stats:	Mean (SD)	4.06(0.31)
Cluster 7: Impact of Drugs on the Community (20 statements)		
<i>Statement Number</i>	<i>Statement</i>	<i>Agreement Rating Average</i>
69	People know that there are places in the community that are dangerous and should be avoided	4.70
18	Drug culture creates negative role models for the youth	4.53
32	Drugs increase gang activity	4.33
Cluster Stats:	Mean (SD)	4.23(0.26)
Cluster 8: Motivators and Aftermath of Getting High (24 statements)		
<i>Statement Number</i>	<i>Statement</i>	<i>Agreement Rating Average</i>
11	Some families get high together	4.57
67	Drug withdraw makes people more irritable	4.57
90	Some drug users who recover can learn important lessons through their drug use	4.57
Cluster Stats:	Mean (SD)	4.23(0.26)