Report on the Barbados Rapid Assessment Survey on the Extent of Substance Abuse in Communities and for Describing the Relevant Services to Respond to Substance-Related Problems.

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RAPID ASSESSMENT SURVEY

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Executive Summary

Background:

The present study describes results and conclusions from a **Rapid Assessment Survey** (RAS) according to the guidelines of the United Nations Drug Control Programme on the extent of drug abuse in communities, and also describes the relevant services needed to respond to these problems. This RAS has been conducted as part of the **Barbados National Substance Abuse Master Plan 1996-2001** an integrated strategy to minimise drug-related harm in Barbados which focuses on community empowerment.

Methods of data gathering:

***National level*:**

1) Key informant interviews in three sectors:
   Law enforcement, treatment, prevention and social work.
2) Analysis of national statistics.

***Community level*:**

1) Key informant interviews (total of 60) in 6 communities.
2) 300 interviews with drug users and pushers in 6 communities.

Results:

Alcohol, **marijuana** and **crack-cocaine** were identified as the most problematic drugs in Barbados. Dependent on their working sector, different key informants perceived different drugs as most problematic

Treatment and rehabilitation professionals and persons working in the law enforcement-policing sector saw cocaine as the most harmful drug, as this drug was related to most referrals to treatment and to the more severe drug-related crimes in Barbados.

Social workers and prevention specialists underlined the problems related to alcohol because this substance is legal and ubiquitous, and thus overall alcohol was still seen as the most abused drug in Barbados. Its links to social problems, especially family disruption, were highlighted by social workers and prevention specialists.

Almost all persons working on the community level identified marijuana as the drug causing the most problems. It is highly accessible to teenagers and young adults and counteracts any efforts to improve the community situation. Marijuana is seen by users as a means to cope with stress and daily problems. This stems mostly from the social situation characterised by unemployment and poverty.

Community key informants and activists indicate that this escape mechanism centred on the individual and counteracts the efforts to improve the community situation.
On the community level in our Survey, with drug-users and pushers, almost 3/4 of the respondents named marijuana as their primary drug, followed by alcohol with slightly more than 20%, and cocaine with 3%. This result is also a function of our sampling strategy, which relied mainly on sampling from public places within the community.

Average age of onset of drug use was between 14 and 15 years, with no statistically significant differences between the different (primary) drugs.

Key socio-demographic characteristics included:

Male respondents (85%), a median age of 26 with the middle 50% of the sample between 22 and 34 years of age, 41% still living with their parents (next largest group of 23% living

with their partners), a small majority having a partner (58%), about half having at least one child with the majority of these not taking care of their children, at least secondary education (86%), employed (63% with the average salary of those employed being around BDS $16,000 per year with the middle 50% earning between
$7,700 and $18,200). Average spending for drugs per years amounted to $7,280.

The majority of drug-related problems were seen on the community and social level rather than on the individual level. Violence, family and partnership problems, and criminality were seen as sustaining the drug habit and being mentioned most often.

There were clear differences between communities, with a clear indication that more cocaine use leads to more problems, with respect to violence and property crimes.

One of the problems with respect to reducing drug use and drug-related problems will be the clear integration of drug pushers in the communities. Less than 3% of the drug pushers were seen as coming from outside of the community.

Recommendations:

1) The **collaboration and integration** between the three sectors law enforcement, treatment and prevention / social work, should be intensified, and regular meetings on new trends and initiatives should be started on a national level. On the community level, such synergistic activities should be intensified as well.

2) A **data centre on substance abuse** on the national level should be established to provide all partners with up to date information about substance use, substance-related problems, and programs / initiatives. More systematic gathering of drug-relevant data is necessary on different levels, and in almost all sectors.

Specifically relevant seem:

- The establishment of a **small, community-based monitoring system** with input of a few selected communities on local trends, to quickly prepare actions on new trends, and to function as a data resource between active communities.

- A **national school survey on drug abuse**, risk factors to identify information relevant for prevention and education for teenagers. Both suggested measures could be realised almost immediately at rather minimal costs.

  The ideal site for such a centre would be the National Drug Resource Centre of the National Council on Substance Abuse, which currently already serves as a resource centre for other materials and information.

- Efforts on **prevention and education** should be continued with **more emphasis on local problems and local solutions**. This is another reason why a data centre is indispensable.

- The key towards reducing drug-related problems will be integrated initiatives on the **community-level**. These initiatives have to be directed at young people, with no perspectives on gaining employment and escaping the current situation of poverty. At the minimum it should be directed towards offering alternatives to liming on the block (e.g. sports, cultural activities, etc.)

- Currently, there are community efforts underway, and according to key informants some successes have been achieved. What is necessary is to strengthen such efforts by:

1) Selection and dissemination of the most effective or cost-effective initiatives which could only be identified by evaluation.

2) Increasing support for active communities by transferring some resources and responsibilities on the community level.

- **Treatment and rehabilitation facilities should be reorganised and enlarged** with a **shift towards community-based treatment**.

- Community centres like Deacons Farm, should offer the possibility of outpatient treatment (e.g. short treatment based on Cognitive Behavioural-Therapy Relapse Prevention Programs) and counselling, which has proven to be as effective as inpatient treatment for most populations.

- The main inpatient facility should be locally separated from the Psychiatric Hospital. Different models to achieve this transition are outlined. A committee should be established to prepare the necessary **transition as soon as possible**.

- **Law enforcement** activities should be **integrated** into a truly comprehensive national strategy. The main distinction between persons using and trafficking on a small scale to sustain their use on the one side, and persons trafficking on large scale for profit on the other side, should be recognised in all law enforcement activities.
- In order to support the overall strategy with an emphasis on community programming, **community policing** should be a key element in the law enforcement strategies. The local Police Force seems essential in making distinctions between persons using and trafficking on a small scale to sustain their use on the one side, and persons trafficking for profit on the other side. If local Police work hand-in-hand with community activists and centres, the former should be directed toward community alternatives, whereas the latter should be receiving stiff penalties.

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Jürgen Rehm & Arthur Holder

Barbados

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1. Background

The **Rapid Assessment Survey** (RAS) is part of an integrated strategy to minimize drug-related harm in Barbados: the National Substance Abuse Master Plan 1996-2001 Government of Barbados, 1996. Currently it is only available in draft form (see also the National Council on Substance Abuse, 1996).

This plan tries to integrate the work of different institutions at different levels in Barbados including law enforcement activities, treatment, and prevention / social work. It comprises measures for both, demand and supply of illegal drugs.

However, it is fair to say that central to this plan is the implementation of an Integrated Demand Reduction Programme, which focuses on community empowerment.

Whereas the Master Plan puts the emphasis almost entirely on illegal drugs, the overall strategy to reduce drug-related harm in Barbados will include alcohol as well. The reason for this inclusion is given explicitly in the Executive Summary of the Master Plan. Unless alcohol is specifically targeted, the fight against the illegal drugs will continue to be unsuccessful, as it has all over the world.

The RAS has been conducted to inform these activities by:

1) Updating the available statistics at the national level.

2) Conducting key informant interviews at the national level to help interpret the data and to give directions on the implementation of the master plan especially with respect to helping shape future treatment and rehabilitation programs as well as future prevention intervention.

3) Conducting interviews with users and pushers at the local level of six intervention communities to assess the status quo with respect to drug use and abuse on the community level.

4) Conducting interviews with key informants at the community level to round up the picture.

Overall, this will give for the first time an empirically based picture on patterns of drug use and related harm and problems at the community level. It will also give information about national and community service needs. Finally, the RAS will serve as a baseline for evaluating the community measures now implemented in all six communities with "intervention" programmes. Such an evaluation is planned one year after the baseline assessment (e.g. December 1998 and January 1999, Field work). The national level statistics will serve as a control (Rehm & Strack, 1994) in this evaluation.

The RAS has been carried out according to the guidelines set out by the UNDCP, the United Nations Drug Control Programme (UNDCP, without date). According to these guidelines, an RAS may be defined as a method for identifying the extent and nature of social and health problems, and for suggesting ways in which they may be ameliorated.
It involves interviewing key informants, community informants, and drug users and pushers. Its emphasis is on qualitative social science methods and techniques.
The following served as the rationale for conducting the present RAS in Barbados (condensed from the original request for proposals): there is a lack of data and information with respect to the drug problem. This is because of the scarcity of conclusive evidence denoting the full extent and scope of the phenomenon. Several indicators have engendered a general belief that drug use has rapidly increased amongst marginalised youth and that it's closely linked with rapidly expanding patterns of negative behavioural patterns amongst youth in the country, such as increase in violent crime.

However, there has been no comprehensive and on-going assessment of the situation to provide concrete evidence of the full magnitude of the problem. Another deficiency is the vagueness surrounding the incentives or antecedents for drug abuse.

Arthur Holder served as the National Project Coordinator whilst the Consultant engaged by the Government of Barbados to the process, was Dr. Jürgen Rehm.

2. National Level Results

2.1 Background: economic and social situation of the country

Barbados is the easternmost of the Caribbean islands, about 120 km east of St. Vincent and the Grenadines, and 320 km north east of Trinidad and Tobago and covers an area of 430 square km. It serves as a regional transport hub and important tourism centre with good direct transportation to Europe and North America. In 1994, its population was about 262,000 with relatively low growth rates of about 0.5% during the 80s and early 90s. The overall population is quite young with more than 50% under age 30 (reference year 1990).

On November 30, 1966 Barbados severed its colonial status with Britain and became an independent country within the Commonwealth. Its political and legal systems are based on the English traditions (Westminster Form of Constitution, English Common Law).

In the past decades, it has undergone dramatic economical change with tourism becoming clearly the mainstay of economy. Currently, the service sector constitutes more than two thirds of the Barbadian economy. In parallel, the importance of sugar cane has been decreasing, which can be seen by the decline of areas planted, e.g. from 1980 with 16,700 hectares planted to 1992 with 9,200 hectares planted. The closing of sugar plantations has led to cutting workers in rural areas, and thus contributed to a rural to urban exodus.

However, in recent years the output from sugar has been increasing again (Central Bank of Barbados, 1997 a, b). This does not mean that the trend towards employment in the tertiary sector has been stopped since different, capital intensive forms of producing sugar have been introduced, which no longer require much labour.

In terms of the social situation, unemployment soared from 15% in 1990 to over 25% of the average labour force of 126,000 by September 1993, affecting young persons especially hard. Official unemployment rates in 1996 were 24% (Kohler & Moore, 1997).

A social security system established in 1967 provides benefits for sickness, maternity, old age, disability, and pensions. Modern medical facilities are generally accessible, and Barbadians are relatively free from malnutrition and infectious diseases. This situation is also reflected in a life expectancy at birth (1990-95) of 72.9 years for males, and 77.9 years for females, and in the fact that the major cause of death are diseases of the circulatory system.[1]

[1] In fact, life expectancy and patterns of mortality in Barbados resemble very much the patterns of established market economies (Murray & Lopez, 1996, 1997).

2.2 Methods

National level results presented here stem from two main sources:

- Statistics on alcohol and other drugs.
- Key informant interviews with national experts.

The statistics used are listed in Appendix 1 and include police and criminal justice data (seizures, arrests, and imprisonment-rate) as well as treatment data (Psychiatric Hospital, specialized treatment centre).

In the original plan other statistics were foreseen like survey data on all substances, and data on problems for alcohol (e.g. alcohol-related emergency admissions, alcohol-related motor-vehicular accidents). Unfortunately this data does not exist in Barbados (see below point 2.4 *Data requirements for planning*).

Jürgen Rehm and Arthur Holder conducted the key informant interviews in the period from November 26, to December 04, 1997.

They were based on open-ended questions according to three different guidelines specific for the areas of law enforcement (police / justice / customs), treatment, and prevention / social work (see Appendix 2 for a full wording of all the questions).

Key informants were defined as persons who by virtue of their role or community position can provide relevant information on the national level. These ranged from key health professionals, administrative officers, religious leaders, community leaders, through to drug users or ex-users themselves.

Key informants are valued for their access to and knowledge of drug use or drug scene or

other pertinent skills.

The following persons were interviewed as national key informants:

- Police / justice (7 interviews)

- Treatment (7 interviews)

- Prevention / Social work (4 interviews)

Length of interviews varied between 30 minutes and two hours. They were conducted in the institutions where the respondents worked.

An advance letter sent by the National Council on Substance Abuse preceded all interviews. In some cases, upon request of the interviewed persons, the questions were also faxed in advance to allow for preparation.

2.3 Results

History with respect to drug use:

Alcohol, cocaine, and marijuana can currently be seen as the three main substances producing problems in Barbados.[2]

The legal substance, **alcohol**, is deeply routed in Barbados society, as it has been consumed for centuries. Alcohol is also linked to the most important agricultural product of Barbados, sugar cane.

Sugar plantations were introduced to Barbados in the 17th century, and since then, these plantations have been one of the main employers for Afro-Caribbean people during the colonial period and afterwards.

Afro-Caribbean people currently account for more than 90% of the population of Barbados, with rum being part of the Barbadian experience for more than 300 years.

Beer, the other main type of alcohol consumed is more recent. The only local brewery, Banks, was founded in 1961. Other forms of alcohol are available in Barbados but mainly consumed by tourists.

The other two substances became important, but only after political independence in the 60s, when **marijuana** consumption especially, increased rapidly on the island.

[2] Nicotine was mentioned by some key informants as well. While the health-related problems linked to tobacco smoking are tremendous (English et al., 1995), this report is limited to psychoactive substances showing broader social consequences as well.

Experts with respect to its increase cited two seemingly contradictory reasons:

- Following the increase of marijuana consumption in the US in the sixties, its use as did many US trends got adopted by local persons.
- The rise of the Rastafarian religion in Caribbean countries also took place in the 1970s. This rise was accompanied by a different image of marijuana as integral part of the religion, and seen as an almost sacred tool.

Thus, somewhat ironically, the Rastafarian culture with its aim to search for the African-based identity for the region, and the completely opposite cultural universalism of adopting fashionable US trends, resulted in the same consequence: increased acceptance and use of marijuana. Marijuana use has been partially triggered by social problems, especially youth unemployment. It has become the number one drug for adolescents and young adults.

Cocaine was almost unknown in Barbados until the 1980s. Until 1986, there is no evidence of any one cocaine addict being treated at the Psychiatric Hospital, which at the time was the only treatment centre for substance abuse problems in Barbados.

Treatment of persons with addictions (until that year) was distributed 60% for alcohol, and 40% for marijuana. Marijuana treatment was often administered to persons with co-morbid conditions, having paranoia as the main symptom.

Cocaine use quickly increased during the eighties, however, and for the time period between 1986 and 1992, 42% of the persons seen with substance abuse problems by the Drug Rehabilitation Unit of the Psychiatric Hospital used cocaine alone or cocaine and other substances. Alcohol still is the most used substance, however, either alone, or in combinations with cocaine and marijuana (see statistics attached in Appendix 1, especially

Harvey, 1997).

Cocaine in Barbados is almost always smoked in the form of crack. This form of cocaine has been available since 1985, and has been blamed by many as one of the main reasons for the rapid upturn in cocaine use in the island. Sniffing is quite rare, and there are almost no cases of injection of any drug.

A clear contributing factor to the increase in cocaine use in Barbados after the 1980s was the use of the island as a transhipment point for drug-trafficking, and the fact that traffickers are often remunerated with a mixture of cash, cocaine, illegal weapons, and other commodities.

Besides this fact, Barbados as a relatively prosperous island, with an annual transient tourist population of about 1 million, is in itself an attractive market for drug trafficking.

Overall, the experience of Barbados in regards to cocaine seem to parallel the experiences of other English-speaking Caribbean islands (see the reports of Trinidad and Tobago, 1995; or Jamaica, 1996, in their national master plans; for an overview on the region with several case examples see Kohler & Moore, 1997).

Both countries experienced the same upsurge in cocaine use at about the same time period, and the reasons given for the upsurges were similar to those given in Barbados.

According to some experts (both drug pushers and police; see also the results of the drug user survey in point 3 below), **heroin** seems to have reached Barbados as well.

However, its use currently is very, very limited. No treatment has been sought yet for heroin addiction.

Experts including users believe that the aversion of Caribbean people against injection is

protective against further spread of this drug in Barbados.

Unfortunately, there have already been first shipments of Colombian heroin to the Caribbean region[3]. Since historic experiences with countries in Asia using the same argument have been quite negative (Kohler & Moore, 1997) cultural protection seems to be limited at best.

Which substance is causing the most problems in Barbados?

There is some disagreement between key informants working in different areas with respect to the drug causing most problems in Barbados (see Table 1 below).

While the key informants from the treatment sector and from law enforcement almost unanimously saw cocaine as the most problematic drug, persons related to prevention perceived most problems associated to alcohol.

The community persons agreed on marijuana as the drug causing most problems.

Even though the overall numbers interviewed are small except for community key informants, these differences between sectors proved to be statistically highly significant

(**Likelihood ratio Chi^2 = 43.9, df =6; p < 0.0001**), because they are so striking.

[3] Kohler and Moore (1997) cite persons active in the drug field in the Bahamas with the opinion that a Heroin epidemic is ?around the corner? (p. 155). However, they offered no further data to substantiate this judgment.

Table 1: Substances considered to be most problematic in Barbados by employment sector of key informant			
	alcohol	**crack cocaine**	**marijuana**
Treatment and rehabilitation	2	5	0
Prevention/social work	3	0	1
Law enforcement	0	6	1
Community [4]	4	8	50

The different perspectives given in the respective explanations during the interviews can explain this pattern of results. Clearly, persons working in the police force in particular, or in law-enforcement in general, by the nature of their work have more problems with illegal drugs.

This is not to deny the role alcohol plays in certain crimes, but from a legal perspective, where the possession of marijuana or cocaine is a crime, the contributions of alcohol are seen less often and appear to be relatively smaller.

Between the two illegal drugs, most persons involved in law-enforcement see cocaine as more problematic. Problems associated with it tend to be more severe than marijuana.

[4] Results taken from the community key informant interviews (s. 3.2 below).

The legal problems with cocaine also tend to transcend the areas of use or trafficking (e.g. burglary, violence)

Considering treatment, cocaine is linked to much specific treatment in the Drug Rehabilitation Unit of the Psychiatric Hospital, whereas marijuana often is linked to other treatments as a co-morbid condition in this Unit as well as in other wards of the Psychiatric Hospital. Cocaine is also the drug leading to most referrals to Teen Challenge a private treatment centre for addiction-related problems (see below).

The role of alcohol in treatment by the Psychiatric Hospital seems to be perceived as smaller than the statistics suggest (Harvey, 1996, 1997). Thus, alcohol is linked to relatively more treatment in the Psychiatric Hospital but still cocaine is seen as more problematic. However, as discussed below, there is a lot of polydrug-use so that the respective categories overlap.

From a prevention and social work perspective, where most emphasis is laid on the family and social environment of the drug user, it is no surprise, that alcohol is seen as the most problematic drug. Since the prevalence of alcohol misuse is higher than the prevalence of other substance abuse[5], it is linked to more family disruption than the other two drugs.

[5] The prevalence of marijuana use and abuse for teenagers and young adults in Barbados is certainly higher than the prevalence of alcohol use and abuse (see also 3.3). However, alcohol abuse overall, that is for all age classes combined, was seen as more prevalent than marijuana abuse.

Moreover, persons involved in prevention view alcohol as a gateway drug to all addiction in society, and as the key problem to tackle preventively since it is so well rooted in Barbadian society.
Finally, the community key informants and some persons working in the field of the prevention saw marijuana as the most problematic drug. Again, from their perspective, where lethargy and indifference are seen as the biggest barriers towards community empowerment and development, and where marijuana is seen as closely related to such behaviour, the choice seems justified.

As with alcohol, marijuana is also seen as a gateway drug to crack cocaine, and in some groups, a positive image of marijuana as the drug linked to Afro-Caribbean identity, has to be overcome to be effective in prevention.

In comparing substances it should be noted that there is an increasing trend to polydrug use, especially in heavier users. In an analysis of the referrals to the Drug Rehabilitation Unit of the Psychiatric Hospital over a 10 month period ending February 1996, about one third of the patients were polydrug users, and the overwhelming majority of them used all three substances (Harvey, 1997).

Use of all three substances was especially prevalent for young adults in the twenties age-range, also in daily use of persons not seeking treatment, polydrug use is quite common.

Moreover, it is not only the case that the same persons use different drugs at different times, but two kinds of drugs are used on the same occasion.

Specifically, *blackies*, combinations of marijuana and cocaine in the same cigarette, appear to be widespread. Marijuana and alcohol are also often used together, especially in social settings of youth.

Finally, alcohol is used as a depressant to modify the high of crack cocaine. However, the latter combination of drugs has not nearly reached the significance of the other two forms of using drugs together at the same occasion.

Description of drug users:

All experts agreed, that illegal drug use and related problems are most common among males between 16 and 30 from lower social classes (see also the results from the community surveys of drug users and pushers). The trend seems to involve younger persons in drug use. Alcohol seems to be more widespread across different social classes, and affecting much older persons as well. Clearly the treatment statistics support that age differential (Harvey, 1997).

Treatment statistics of the Psychiatric Hospital have their first peak between 16 and 20 years of age, with an average age of 30, and a range between 14 and 69.

Law Enforcement

As already mentioned, cocaine is seen as the most dangerous drug by law enforcement agencies, although all police, prosecution, customs and the correction system claim to spend about equal time and effort on cocaine and marijuana.

Interestingly, a recent report on criminal risk-factors (The National Task Force on Crime Prevention, 1997, p. 85) concluded that illicit drug use emerged as perhaps the single most significant correlate to criminal behaviour and imprisonment. 86% of all the inmates admitted lifetime use of illicit drugs.

Almost all of them used marijuana (98%), of which the majority of users claimed to have used it solely (57%), and 40% used it together with cocaine. Only 2% use only cocaine in

any of its forms (on the history of the relationship between drug use and criminality in Barbados, see Brathwaite, 1996, and footnote 6 on this page).

Overall, almost all persons from the law enforcement sector interviewed praised the current system. They did not foresee the necessity of any major changes in law enforcement to combat drug use and drug-related problems except maybe using more vigilance in enforcing current laws.

This is somewhat surprising, since they all acknowledged an increase in drug-related problems, especially for the young adolescents.[6] But maybe this increase was thought to be completely unrelated to law enforcement issues.

Also, in answering questions about what should happen to persons who had been caught

[6] Historically, class 6 crimes (drug-related crimes, other crimes) between 1960 and 1990 rose from 0.1% to 18.5% of all reported crimes. Moreover, since increases in criminality in general, and dramatic increases in the rate of imprisonment, coincided with the arrival of cocaine and crack cocaine to the island, this arrival is regarded as the main reason to changes in these indicators of criminality (Brathwaite, 1996). In 1990, slightly less than one third of all the persons convicted for imprisonment were under 24 years of age.

Other data on drug-related offences found increases of 74% in apprehension rates for females between 1985 and 1994, with apprehension rates for males for drug-related offences raising 196% for the same time period (Ramoutar, 1996).

for drug-related crime? (J10 in Appendix 2), the overwhelming majority of key informants in the law enforcement sector thought that drug use per se, and drug use combined with trafficking solely to support personal use should not be dealt with in the corrections system, but in treatment.

Apparently however, at present this is not yet always the case, with the stiff sentences sometimes being imposed for small-time users.

It was also astonishing that recent report of the steering committee on penal reform on alternatives to imprisonment (1997) was not discussed at all, even though there was a public hearing on this report, and some recommendations in this report clearly ask for a change in status quo.

The only change with respect to the law enforcement system mentioned in the interviews with key informants from this sector concerned the permission of tapping in order to fight drug trafficking. All other remarks on the several questions concerning necessary change were actually directed toward changes in prevention and education.

Overall, the interviews almost showed an attitude of persons in the law enforcement area as if they were not part of an integrated strategy to reduce drug related problems in Barbados. The authors of this report strongly believe that this attitude should change.

As other examples of national drug strategies have shown (Single & Rohl, 1997), success is contingent on actual collaborative efforts between the law enforcement and health sectors, of course including prevention and education. Collaborative efforts mean more than just national master plans with good intentions on paper. Thus, it is proposed that all three sectors meet regularly, (e.g. every three months) to discuss new trends, to inform about and consolidate initiatives, and to plan future collaborations.

Prevention:

All experts including treatment and law enforcement specialists agreed in the necessity of strong preventive efforts as one of the priorities. Within such a prevention framework should be a regular school curriculum about drug use, including alcohol and tobacco.

Other educational efforts via the media, offering education and alternatives to drug use on a community level, and focused efforts on relapse prevention.

Specifically, three aspects of prevention were mentioned by more than two respondents:

- Recovering addicts should be used more often to describe a more realistic local picture of drug use in Barbados.
- The spiritual dimension of staying away from or recovering from drug use should be stressed within a holistic approach[7].
- The lack of fathers in family education should be taken into consideration.

In conducting the interviews, the consultant often had the impression that prevention was seen as a wonder drug against all drug-related problems. This was true especially for persons not working in prevention, but in law enforcement or treatment.

Unfortunately, recent overviews of the effectiveness of drug education in other jurisdictions do not suggest that education is the panacea.

In short, empirical evaluations have shown that the effectiveness of even the best available education programs to prevent illegal drug use, (see Tobler 1992, in general; see Ennett et al. 1994, specifically for showing minimal beneficial impact of DARE in reducing drug

[7] Spiritual here is not in the sense of one specific religion.

initiation) or alcohol abuse is certainly limited (Edwards et al, 1994).

Moreover, some of the programs used in prevention are imported from the US, and data on effectiveness there may not apply to the culturally different situation of Barbados.

Treatment

With respect to treatment, it became evident that the existing treatment resources are covering only part of the need for treatment. Currently, residential and outpatient treatment are offered only by the Drug Rehabilitation Unit (DRU) of the Psychiatric Hospital and by Teen Challenge, a private organisation.

Both are linked to two specific treatment philosophies: the Psychiatric Disease Model (DRU), and a Christian Model, seeing drug abuse as the result of failing to establish a relationship with Jesus Christ (Teen Challenge).

Overall, both are offering primarily residential therapy, with 12 beds in the DRU, and 32 places supplied by Teen Challenge (data from December 1997). DRU also offers outpatient services for persons with good reasons not to stay inpatient.

Moreover, since no beds are specified for women in DRU, female patients have to either participate in the program either as outpatients, or stay in other wards of the hospital.

This situation may have contributed to the large over-representation of males in the program.[8]

[8] However, since we have no clear population data on substance abuse, the ratio between males and females may just reflect the gender-specific ratio in substance abuse in the community.

The length of the therapeutic programs is quite different with six weeks at DRU, and six months at Teen Challenge. Both, DRU and Teen Challenge offer aftercare, the DRU for six weeks, and Teen Challenge has regular follow-up activities for one year.

While these institutions cover some of the need to treat drug addicts, almost all experts were in agreement that other institutions or other organisation of service delivery were desperately needed to treat alcohol and drug dependence in Barbados.

Most importantly, community based treatment possibilities were suggested which would overcome the strong stigma attached to visiting a psychiatric hospital in Barbados, and to cope with the limitations of a Christian Model for those who share different religious or spiritual beliefs.[9]

Thus, decentralising part of the drug rehabilitation program in Barbados by offering counselling, outpatient treatment and relapse prevention programs at community centres was seen as a cost-effective solution to meet the treatment demands in Barbados.

[9] Some doubt was mentioned regarding the effectiveness of the TeenChallenge model in the specific circumstances of Barbados. However, since this centre has only recently been established, it should be given two years of service to examine the success rates, and discuss effectiveness on a more informed basis.

Three main models were cited. The Substance Abuse Foundation[10] together with Teen Challenge is suggesting a Redemption House as an outreach centre with a wide variety of services (S.A.F. / Teen Challenge, without date). One of these services could be offering drug counsellors and relapse prevention programs on site at different community centres.

Another model mentioned would locally separate the DRU from the Psychiatric Hospital[11], and move it into the community. This newly formed unit should not offer current services but should also form an interdisciplinary group visiting community centres on a regular basis to provide on site one-on-one counselling, and group-therapy like Guided Self Change or Structured Relapse Prevention.

[10] The S.A.F. Substance Abuse Foundation INC. was incorporated in Barbados on December, 6, 1996, as a not-for-profit company by a group of private individuals, many of whom had a substance abuse problem in their own family. It seems to have the support of the Government of Barbados (Kohler & Moore, 1997, p. 10). It is funded by donations from private individuals and corporations, and is registered as a Charitable Organisation with the Department of Inland Revenue. The purpose of the Foundation is to provide long-term residential and other facilities for individuals who suffer from any type of substance use or dependency. The S.A.F. was one of the main motors to bring TeenChallenge to the island as a residential treatment facility (see also Kohler & Moore, 1997; Substance Abuse Foundation, without date).

[11] Please note that a local separation does not necessarily mean an administrative separation. In fact, most persons supporting such a solution did not want to split the DRU from the Psychiatric Hospital.

Such a group could build on the experiences of the Mental Health Team, but use a Social Model of treatment delivery. A third model mentioned would foresee the majority of treatment being offered within community centres with the deployment of almost all resources into these centres, with the exception of psychiatric services for persons with severe mental disorders who should continue to be served in the Psychiatric Hospital. Although the agreement for a more decentralised solution was strong among experts, no concrete initiatives seem to be directed towards establishing such a program. This lack may have to do with the differences in concrete models experts have in mind, and with the perception that it is impossible to obtain the start-up funding for such a program.

Overall, quite a lot of scepticism was mentioned with regard to the government paying more than lip service to initiatives in the addiction treatment field. Many persons have been interviewed for different government initiatives or commissions several times, and although the solution emerging always seemed to be clear and uniform with respect to key characteristics (separating DRU from the Psychiatric Hospital, moving more services into the community), no further action happened.

From our interviews, it became evident that all models suggested in the national key informant interviews again led into this direction. It should be added that interviews with the prevention and law enforcement sector also supported this conclusion.

Therefore, it is suggested that the responsible parties should sit together as soon as possible to start a sound initiative. This would be inclusive of necessary minimal costs, as well as develop different models.

Clearly, the literature shows that well conducted programs for substance abuse on outpatient basis in the community, together with smaller inpatient service delivery for specific indications, are more cost-effective than basing all treatment on a centralised unit centred around inpatient services.

After the initial costs, such a solution may demand equal or even cost less than the current solutions offered to the government, because money could be raised specifically for it. This is especially true if overall social costs are being considered (e.g. Single et al. 1996). Other needs identified beyond the ones already mentioned in the treatment area were 24-hour crisis-intervention programs for addicts[12], a detoxification unit and specific programming including beds for females. All of these services should become part of a new Redemption House (see above), or could be associated to a newly formed community or outreach centre. Also, the need for a halfway house for persons who need longer stay than currently offered, was urgently indicated.

[12] Currently, the DRU can be reached 24 hours seven days a week, but has no formal crisis intervention nor separate rooms or resources for this kind of activity.

2.4 Data requirements for planning

One of the most problematic characteristics of the situation in Barbados is the lack of necessary data for programming and planning in the area of substance abuse.

As shown in Appendix 1, data is scarce and seems to be collected not routinely but for special occasions like Government Commissions, the strategic planning exercise of the National Council of Substance Abuse, or for this Rapid Assessment Survey.

The lack of data makes it almost impossible to properly evaluate large-scale efforts like the National Master Plan, should it be formerly adopted. This consequently leads to a lack of accountability for these efforts.

Barbados will not be able to judge the success or failure of programs or planning activities without outcome evaluations, and no proper evaluation could be carried out without a sound database containing information about relevant outcomes.

Clearly, a truly integrated Master Plan needs an empirical foundation as well as feedback and accountability loops, in order to be monitored and continuously adapted to the needs of the island.

Thus, data from all three sectors (law enforcement, treatment, prevention / social work) should be integrated into one database at the central hub for the implementation of the Master Plan, the National Council on Substance Abuse (e.g. the National Drug Resource Centre).

The latter should be constantly updated, so that all partners can base their strategies and plans on the newest available data from all sectors.

In brief, the database should be composed of:

- Time series on drug-related seizures, arrests and conviction numbers (possession and trafficking), including the most recent updates on all relevant legal statistics.
- Time series on other substance-related legal problems (driving under the influence of substances, alcohol or illegal drugs, accidents related to substance abuse, violence related to substance abuse).

- Relevant treatment and rehabilitation data from all relevant institutions collected in a standardised way.

- Data from general population surveys and school surveys[13] on substance use.

- Including alcohol[14], risk factors, and substance-related harm.

[13] In the current situation in Barbados, a national school surveys on drug use, drug-related attitudes, and risk factors is probably the most important single data source for the following reasons:

- School surveys yield representative results, as schools allow the sampling of all persons living in Barbados up to 16 at rather mininal costs.

- Going into classes with questionnaires specifically construed for school children represents a very cost-effective way to collect reliable and valid data.

- School surveys can provide the information necessary to plan and operationalise effective prevention and education campaigns using local examples and local background. Such an approach has been depicted as necessary to improve effectiveness of these efforts in Barbados, and to escape the entire reliance on North American materials which have been derived in a different cultural and political situation. In addition, given the early average onset of drug use in Barbados (see 3.3 below), the population of school children should be one of the main targets of preventive efforts.

[14] Surveys are all the more important for alcohol in Barbados, as per capita consumption does not allow to evaluate developments and trends because of the high but unknown proportion of tourists' consumption on total consumption.

? Data from a community monitoring system.[15]

? The minutes from the regular meetings of persons from all three sectors on new trends and developments (see above).

The OAS has developed some software tools, EPI-SIDUC, which could serve to establish a first data bank without any additional costs for new programming.

[15] Such a national drug monitoring system could be established almost without any additional resources and would help to early detect new trends in substance abuse by transmitting regular telephone information from a selected groups of communities to the national centre on new local trends in substance abuse (e.g. a shipment of Colombian heroin just arrived in our community). The national centre would then be able to distribute this information to other communities to warn them about new developments thus allowing all communities to undertake early programming and other reactions to cope with new developments (see below in point 3.2 as well).

3. Community Level Results

3.1 Background: rationale and selection of targeted communities

The drug problem escalated in Barbados within the 1980s and the government placed emphasis on the eradication of this malaise as one of its priorities. There was criticism from the communities on the approach taken however (which had been quite centralized) and the government was forced to modify its top-down policy to a community empowerment approach.

To this end communities were asked to submit proposals detailing how they would tackle the drug problem in their respective communities in the form of programmes, especially as it related to the at risk young male population.

Thirty-five communities submitted proposals. Based on a consideration of average income, housing, crime rate, occurrence of drug abuse, and the availability of sufficient social infrastructure and community organizations, these proposals were then reviewed by a committee. Six communities were finally chosen for the implementation of this pilot project[16] to use community development in reducing drug-related harm.

[16] The community programs were at the core of the RAS with the following rationale and objectives: whilst there is no reliable data available to estimate the extent of local abuse, indirect indicators demonstrate that drug abuse among certain layers of the society is increasing as is the potential for drug abuse. Without hard figures and research, it is difficult to confirm the belief that young people close to the cutting edge of the ills of society, are the highest group of drug abusers. These six communities were thus selected to conduct a pilot project which would provide some of the answers to problems of drug use and abuse.

The RAS will consider information on drug use and abuse, risk factors and a description of the existing structure of services which are, or, could be, responsible for demand reduction services. The study will provide information for future direction.

The six communities chosen were **City of Bridgetown**, **Deacons Farm**, **Eden Lodge**, **Haynesville**, **Pinelands**, and **Gall & Silver Hill**. Following are short descriptions of all six communities and their programs.

The City of Bridgetown is characterized by poverty, neglect, high drug abuse, crime and unemployment. The community project from the City of Bridgetwon caters to the at risk youth from the city area. Classes are being conducted in basketry, craft, sewing, cake icing, computer applications, screen printing, computer & video repairs.

Deacons Farm, located about 3 km Northwest of Bridgetown, has a population of four thousand persons, of which sixty percent live in low-income housing. Social problems including drug abuse are significant. The development project of this community centers on providing skills-building, computing, home economics, joinery and carpentry, steel pan, dance, boxing, and CXC classes for approximately 300 at risk youth. There is also a youth hostel for local and overseas sporting teams. The Deacons Development Project caters for youth from the Deacons Farm area and neighbouring environment. The old Deacons Primary School was refurbished and now the site consists of 16 class rooms.

Eden Lodge, about 5 km North-west of Bridgetown**,** has a population of about five thousand, characterized by high unemployment among the youth and the absence of adequate educational facilities and other social amenities. The Eden Lodge Community Project consists of the construction of a two storey building offering a wide range of classes in the area computers, small engine repairs, cosmetology, business courses, plus a lawn mower and debushing service, a car valet service, the rental of stalls for community events, an emergency relief programme, and a skateboard park.

Haynesville, located about 8 km West of Bridgetown, has a population of approximately three thousand people with a high percentage of unemployed youth. There is a high

prevalence of drug use and abuse in the community.

The community program caters to approximately 300 at risk youth, and falls under the aegis of the Haynesville United Community Council. It consists of cake & pastry making, sewing & tailoring, computing, and carpentry.

Pinelands, located about can 4km East of Bridgetown, be characterized by problems of overcrowding, high unemployment among the youth, drug abuse and all the social problems that accompany these conditions. The Pinelands Project consists of providing technical and financial expertise to potential entrepreneurs from within the area and elsewhere. This is being effected through a Need Trust Fund which is a revolving form of credit managed by the Pinelands Creative Workshop[17]. The project caters to 150 people.

Gall & Silver Hill, about 10 km East of Bridgetown, has a population of about 6,000 a greater percentage of whom are youth, and plagued by unemployment and drug abuse. The program focuses on the promotion of healthy living for the youth of the area, through developing youth football. The project consists of under 14 and under 16 teams playing in

[17] It seems worth mentioning that the Pinelands Creative Workshop (PCW) has a longer history than the current project. PCW as a non-governmental organisation was started in St. Michael about 4 km east of Bridgetown. It started when the Pinelands Development Council organised a series of workships in drama, dance and arts, sponsored by the Community Development Division (see Kohler & Moore, 1997). From this start the PCW continued to use art forms like drama to highlight problems and point out potential solutions, hereby stressing the concepts of self-awareness, personal growth, community links and networks. In 1997, the PCW has about 95 active members, 70% being female.

various youth tournaments under the auspices of the Barbados Football Association.

The overall goals and objectives of all Community Projects were expected:

- To enhance the community's capabilities to deal with the drug and other related problems by strengthening community action.
- To broaden the impact of the community's initiatives, by providing additional support and resources.
- To determine how the processes used could be refined and disseminated to other communities.
- To initiate community empowerment activities.

The success of all of these projects will be evaluated with another RAS one year after the current one. National trends and statistics will serve as a control group.

3.2 Key informant interviews in the communities

Organisation and setting of field work:

Key informant interviews were conducted in all six selected communities between December 29, 1997 and February 18, 1998.

Ten key informants were selected for each community, with typical key informants being coordinators of community development projects, member of community committee(s), priest, community worker, teacher, youth commissioner responsible for the community, sport coach of local teams, community police officer etc.

Interview training took place on November 29, 1997, at the NCSA and was conducted by Jürgen Rehm and Arthur Holder. It included role-play, mock interviews, background information on the RAS as a whole, and a Q & A session on the scope and technique of key informant interviews. Specially trained interviewers conducted these interviews, with two being assigned to each of the aforementioned communities.

Substances used and consequences for the community:

Table 2 gives an overview of the substances considered the most problematic in the six communities examined. **Marijuana** is clearly considered by key informants as the most problematic drug, on the community level.

Moreover, almost all persons who did not consider it the most problematic drug in the community, mentioned marijuana as another drug causing problems to the community (in total 57 out of 60 informants considered marijuana problematic; see Table 2).

However, there are differences between the communities which proved to be statistically significant[18] (**Likelihood ratio Chi^2 = 43.9, df=6; p<0.0001**). Most strikingly, the role of **cocaine** in the City of Bridgetown seems to be much more pronounced than in other communities.

In the City of Bridgetown, almost half of the key informants saw cocaine as the most problematic drug, while in none of the other communities, more than 20% had the same opinion about cocaine. This could be explained in the fact that the City of Bridgetown is generally considered as one of the centres for cocaine trade on the island.

Table 2: Substances considered by key informants to be most problematic in different communities
(numbers in parentheses indicate substances also considered to be problematic question C3[19])

community	alcohol	crack cocaine	Marijuana
City of Bridgetown	0 (5)	5 (3)	6 (3)
Deacons Farm	0 (7)	1 (7)	9 (1)
Eden Lodge	1 (5)	0 (1)	10 (0)
Haynesville	0 (7)	2 (3)	8 (2)
Pinelands	3 (4)	0 (3)	7 (1)
Gall & Silver Hill	0 (8)	0 (1)	10 (0)

[18] Statistical tests given refer solely to the drug considered most problematic in the community (question C1; for exact wording see Appendix 3).

[19] For exact wording see Appendix 3

When asked about the reasons underlying their answers, almost all people who indicated marijuana as the most problematic drug gave one of the following reasons:

- marijuana is easily accessible and everywhere in the community
- often it is used to tackle problems
- it leads to resignation about the problems facing the community
- marijuana was also mentioned as having a role as a *gateway* drug

For the persons who named alcohol as the most problematic drug in the community, almost the same reasons were given than for marijuana.

Cocaine, on the other side, was more linked to concrete community problems and not to a general attitude of resignation and inactivity.

Specifically, cocaine was seen as causing or triggering violence and aggressiveness in the community, both directly as a consequence in the users, and indirectly because of violence associated with the cocaine market.

Table 3 gives us a look at the same problem from a different angle.
It also underlines the diversity in problems perceived as being related to drug use.

This table summarises the problems key informants were explicitly mentioning as drug related in their specific community.

Table 3: Perceived drug-related problems by community

	City of Bridgetown	Deacons Farm	Eden Lodge	Haynesville	Pinelands	Gall & Silver Hill
violence	5	10	1	4	1	4
burglary, theft, shoplifting	4	3	0	1	0	0
lawlessness[20]	0	1	4	0	3	1
indifference, lack of motivation	0	1	2	0	3	1
family problems including abuse	4	1	0	1	0	0
gambling	0	0	0	3	0	0
absenteeism from secondary schools	0	0	0	3	0	0

Violence is a striking example here. Whereas all 10 key informants from Deacons Farm mentioned violence as a major problem, and 5 informants from Bridgetown did so, this does not seem to be a problem in Pinelands or Eden Lodge (one mention).

Moreover, if the exact answers are scrutinised it becomes clear that most of the informants

[20] This refers to explicit mentioning of the word ?lawlessness? by the key informant.

in Deacons Farm were referring to gang violence, often involving illegal firearms, whereas the one answer in Pinelands was referring to occasional fights, and the answer in Eden Lodge to increase of aggressive behaviour.

Other examples of problems that seem to be more prevalent in specific communities would be drug-related theft, burglary or shoplifting (City of Bridgetown, Deacons Farm) or gambling (Haynesville).

It seems that the four communities where some community key informants mentioned cocaine explicitly as the most problematic drug included:

City of Bridgetown, Deacons Farm, Haynesville; see Table 2 above) or where there were users with cocaine as primary drug (City of Bridgetown, Deacons Farm, Gall & Silver Hill) also seem to have the most legal problems (violence, property crimes, gambling) whereas other community representatives seem to be more concerned with problems like indifference, family problems, etc.

When asked about combinations of drugs being used in the community, mixing alcohol and marijuana at parties or on the block was mentioned most often (by 17 key informants or 28.3%).

The only other combination mentioned was mixing marijuana with cocaine in form of so-called *blackies* (i.e. cocaine laced marijuana joints), which 13 persons mentioned (21.7%). It is interesting to note that all but three of the persons mentioning *blackies* came from the City of Bridgetown and Deacons.

Again this corresponded to the key informants' perception of the most problematic drugs and to the results from the interviews with users and pushers (see Table 4 and section 3.3 below).

Table 4 contains similar information as Table 2, but from the survey of users and pushers (see 3.3 for details). The primary drug of the users and pushers by community confirms the impression of the key informant interviews.

Marijuana was by far the drug of choice, followed by alcohol and cocaine. The specific problems of cocaine in the City of Bridgetown also could be detected on the user side: almost all persons with cocaine as their primary drug come from this community (6 out of 8; see 4). The differences between communities proved statistically significant. (**Likelihood ratio Chi^2 = 50.8, df=20; p<0.001**)

Table 4: Primary substances from the user/pusher survey by community

community	alcohol	cocaine	LSD	marijuana	others
City of Bridgetown	9 (18%)	6 (12%)	1 (2%)	32 (64%)	1 (2%)
Deacons Farm	13 (16%)	1 (2%)	0	36 (72%)	0
Eden Lodge	14 (28%)	0	0	36 (72%)	0
Haynesville	1 (2%)	0	0	49 (98%)	0
Pinelands	15 (30%)	0	0	34 (68%)	1 (2)
Gall & Silver Hill	14 (28%)	1 (2%)	0	35 (70%)	0

Typical drug user in the community:

Almost all the key informants agreed on the portrait of the persons most vulnerable for drug use: young males from the early teens to the late twenties.

The only disagreement was the starting date, which some key informants believed to be as low as 11 or 12 years, but most used 14 as the lower age limit for drug use. Leaving school

before time, unemployment and poverty were often mentioned as additional risk factors for drug use and subsequent problems. With regard to females, it was clearly mentioned that at this point much less females would be using drugs or showing drug-related problems. However, several key informants mentioned that females would also get involved and follow suit.

Causes of drug use in the community and possible remedies:

Table 5: Perceived social reasons[21] for using drugs
(several reasons possible per key informant)

	counts	percentages
unemployment / lack of jobs	38	63.3%
peer pressure	21	35.0%
poverty	15	25.0%
lack of parental guidance / lack of father	14	23.3%
lack of general education, lack of marketable skills	11	18.3%
low self-esteem	5	8.3%
imitation of bad role models	3	5.0%
last hope	2	3.3%
lack of values	2	3.3%
mentioned once: gambling, Rastafarian religion, disenchantment with system, leaving		

[21] Answer to question C10) What are the community and social factors related to or leading to drug use?

school, lack of drug-specific education

Table 5 gives the perceived social and community level reasons for using drugs. More than 60% of all the key informants mentioned unemployment and the lack of jobs in Barbados as the primary reason.

In the same line are answers like lack of education and marketable skills, and poverty. Concerning the education (mentioned by 18%), it was made clear by the key informants that even though many drug users had finished secondary or tertiary education[22] they could not find any jobs in Barbadian communities, since they had no marketable skills.

Such a situation leads to hopelessness and problems with self-esteem, and the lack of jobs for so many persons in a community, results in poverty both individually, and on the community level (this factor was mentioned by 25%).

Another class of reasons, surrounds peer pressure. Peer pressure on the streets is seen as an important factor to start and to sustain the drug habit (35%). The only other reason mentioned by more than 20% was the lack of parental guidance. While some key informants were non-specific about this factor, others mentioned underlined the lack of fathers in the education of children and the many single-parent families in the community.

It seems interesting that only one person mentioned the spiritual dimension, the Rastafarian religion. Users themselves tended to weigh this influence heavier. But as community activists and most key informants would qualify for this attribute, the Rastafarian religion was not seen as a real cause to start and / or sustain using drugs, but more as ex-post justification for users.

[22] See 3.3 below: in our community sample of drug users and pushers about 3/4 finished secondary and about another 10% finished tertiary education.

What could be done to overcome the drug problem on the community level? Given the perceived causes of drug use listed above (see Table 5) the answers of community key informants are no surprise:

- Improvement of the unemployment situation was predicted to result in a noticeable reduction of drug-related problems.

- Reducing the unemployment rate cannot be solely or mainly done on the community level. Community programs can contribute, however, e.g. by training marketable skill to unemployed youth. Here, Deacons Farm with its program for carpentry is a good example.

- Even in the case of no change in unemployment, it was felt that community programs have an important task to keep the teenager and young adults off the streets, by offering meaningful programs in sports and art.

- Community policing was seen as an effective way to reduce some of the drug-related problems (especially gang violence), but also to reduce open drug use in the streets.

- Finally, it was felt that community centres should also offer help in the form of counselling and advice.

Recent developments in drug-related problems in different communities:

When asked whether the overall amount of drug use in their communities increased, decreased, or stayed the same during the last year, the overall results indicated about the same number for increases and decreases (see Table 6).

However, this overall result is composed of communities where the majority of key informants thought that drug use increased, (City of Bridgetown, Deacons Farm).

A community where the exact opposite was the case (e.g., the overwhelming majority of key informants believed in a decrease of drug use in Pinelands over the last year), and several communities in between.

It happens to be that the only community, where a significant improvement in drug use over the last year was perceived, is also the one community which has the longest tradition of community programs (Pinelands, see also 3.1 above, especially 17).

While one question to key informants is certainly no proof for the effectiveness of these programs, at least it may serve as an indication, that community activities, when offered in an attractive way, may be successful in reducing drug use.

The differences between communities are statistically highly significant.
(**Likelihood ratio Chi^2 = 30.7, df=10; p<0.001**)

A comparison of results to the same question but over a different time span (3 years; see Table 6, values in parentheses) revealed basically the same results except for one community, Gall & Silver Hill. Thus, trends in drug use were seen as being rather stable over the period of the last three years.

Table 6: Changes in the scope of drug use during the last year by community (in parentheses changes over last 3 years)

community	increase in drug use	decrease in drug use	no change
City of Bridgetown	8 (8)	2 (2)	0 (0)
Deacons Farm	8 (8)	1 (1)	1 (1)
Eden Lodge	2 (2)	4 (4)	4 (4)
Haynesville	3 (3)	4 (4)	2 (2)
Pinelands	0 (0)	7 (8)	3 (2)
Gall & Silver Hill	2 (2)	4 (7)	4 (1)
All six communities	23 (23)	22 (26)	14 (10)

3.3 Interviews with drug users and pushers

Methods and field work:

Interview setting and instrument:

In each of the six selected communities, City of Bridgetown, Deacons Farm, Eden Lodge, Haynesville, Pinelands, and Gall & Silver Hill, exactly 50 personal interviews, or 16.7% of the total 300 interviews, were carried out. Interviews were structured and consisted of a set of open and closed question about the interview setting, personal drug use patterns and harm (including questions about alcohol) drug user socio-demographics and social support systems, community dynamics, and questions about a typical drug distributor. The full text of the interview guidelines can be found in Appendix 4 below.

As summarized in Table 7, the overwhelming majority of informants were found in the streets or public places (more than 2/3). The next largest source of referral were snowball referrals, that is, one informant gave the name and address of another potential informant.

Table 7: Referrals to community-level interviews with drug users and pushers

categories	counts	percentages
snowball referral	44	14.7%
knew before	21	7.0%
referred by key informant	11	3.7%
in the streets or other public space	204	68.0%
other (please describe)	1	0.3%
information on referral missing	19	6.3%

In January 1998, 90% if the interviews took place, with 4 being conducted in December 1997, and less than 10% in February 1998. Almost all the interviews were checked for inconsistencies or other problems the same day or the day thereafter.

Interviewers and field work coordination:

12 specially trained interviewers, 4 males and 8 females, conducted the interviews. For reasons of security, there were always two interviewers present at the interview. Most interviewers conducted about 25 interviews, with 44 as the upper boundary and 10 interviews as the lower boundary. All interviewers were specifically trained for this kind of interview to increase consistency across interviewers.

The training sessions were conducted by Arthur Holder and Jürgen Rehm and took place on November 29, 1997, at the facilities of the National Council of Substance Abuse. The training sessions lasted all day and included role-play, mock interviews, advice from ex-drug users, and a general introduction into the study and the community settings. In addition, internal consistency checks necessary to finalize the interviews were introduced and practised. Local fieldwork was coordinated and supervised by Arthur Holder.

Sample description:

About 85% of the persons interviewed were males, and 15% females. Mean age was 27.9 with a standard deviation of 8.1. Median age was 26 years, with 50 % of the persons between 22 and 34 years of age. Almost 90% were in stable, regular living conditions (87.5%) with 8.7% in conditions changing about once a month, and 3.8% having no regular home. 41.3% of the sample still lived with their parents, 8.3% with friends, 23.3% with their partners, and 18.0% alone. The rest had other living arrangements, e.g. with other family.

In terms of close friends, 50% had between 2 and 5 friends, with a median value of 3. The average is about 5 friends because some persons claimed to have 100 friends, which skewed the distribution.

A small majority of those interviewed had a partner (174 or 58.0%). 63.2% of those having a partner claimed the relationship to be good or extremely good. That means that only 36.6% of the overall sample lived in a partnership they considered at least good.

The family is usually another form of social support. Of the respondents 160 or 53.3% of the sample claimed to have at least good relations to their family other than their partner.

About half of the respondents had at least one child and half of these had one child and the other half more than one. One person had 9 children. 43.4% of those with children took care of their off-spring, with the majority of the child rearing being done either by the family or by the partner (multiple answers were possible here).

In terms of education, less than 1% (2 persons or 0.7%) had less than primary education, and about 10% (29 or 9.7%) had primary education only. The overwhelming majority had secondary education (226 or 75.3%), with 32 (10.7%) in post-secondary education (11 or 3.7% missing values).

In terms of employment, 189 persons (63.0%) had employment in the past year, with the majority working the full year (average weeks worked: 42.1 with a standard deviation of 14.8 weeks). Of those, who worked, the average yearly income was around Barbadian $16,000 with the middle 50% earning between $7,700 and $18,200.

In addition to the fact that 37% had no regular work at all, the financial resources from work of the overall sample can be considered quite low. After all, the average spending for drugs per years amounted to $7,280 (see below).

Patterns of drug use:

Table 8 gives an overview of primary drug use in the community. Very clearly, marijuana is the dominant drug with about 3/4 of the respondents indicating it as their primary drug (e.g., the drug they use most often and which causes the most harm). Alcohol is the second most dominant drug named, with more than 20% indicating it as their primary drug. Cocaine was indicated as primary drug only by 8 persons or less than 3% and nobody in our sample named heroin as their primary drug.

Table 8: Primary drugs used in communities

primary drugs used	counts	percentages
alcohol	66	22.0%
cocaine	8	2.7%
heroin	0	0%
LSD	1	0.3%
marijuana	222	74.0%
others (tobacco, pills)	3	1.0%

The age of onset for the primary drug was almost normally distributed with a mean of 14.5 years at onset, and a standard deviation of 3.8 years. There was surprisingly little variation by type of primary drug. Persons with alcohol as primary drugs started on average with 15.2 years, slightly older than marijuana users with an age of onset of 14.2 years, cocaine users

with 15.1 years, and the rest started slightly older (but this group can be neglected with 4 persons in total).

The differences between age of onset of different drugs proved to be insignificant in the overall analysis of variance, and in post-hoc tests between single drug classes. Thus, the slight variation in age of onset could be interpreted as chance, and no systematic differences between drugs could be detected.

The circumstance of first use can be characterized by the following:

- usually with friends, in social situations like parties, hanging out or liming on the block
- persons tried out the drug for the first time because of curiosity or to experiment
- the small minority learned about their primary drug in the family (mostly for alcohol as primary drug) or tried it out alone for various reasons

Other drugs besides the primary drug were used by slightly more than half of the respondents.

Here, the most often named drug was alcohol (96 persons or 32% of the overall sample), followed by marijuana (44 persons or about 15% of the overall sample).

Cocaine (36 persons or 12% of overall sample), whereas only two persons used heroin in addition to their primary drug, two Imps [23] and one LSD.

[23] Imps is a cigarette with punjent odour imported from India. The exact composition of ingredients is unknowm. Imps is presently being used in schools by adolescents and is seen as a precursor to marijuana by experts. It has been arriving in Barbados quite recently, around 1996.

The ages of onset for these additional drugs were comparable to the ages of onset for primary drugs.

For alcohol (15.8 years with standard deviation of 3.4 years) and marijuana (15.4 years with standard deviation of 4.3 years), but higher for cocaine (23.1 years with standard deviation of 5.9 years) and heroin (24.5 years with standard deviation of 9.2 years but based on only two cases).

Patterns of use were daily for all primary drugs, with almost all marijuana users having under 7 joints a day (average around 4 or 5 joints), and a small minority of 10 persons smoking more than 10 joints, with a peak of 45 joints daily.

Marijuana is often consumed with friends or the partner.

Supporting the drug habit:

In terms of money spent for drug use, on average persons spent about ($280) Barbados per 14 days but with a high variability ($670). 75% of the respondents spent 200 or less, and the median value was at $50.

All these numbers are based on a smaller N of 196 who responded to this question with a numeric value.

The rest either did not have to pay for drugs for various reasons (see below), did not know, or answered with qualifiers which could not be translated into numerical values (e.g. it fluctuates between thousands of dollars.)

The money to buy drugs comes in most of the cases from work either as a salaried employee (see above) or doing odd jobs.

Other main sources of income:

Stealing, support from family (62 person or 20.7% claimed family as one of their main sources of income) partner, trafficking (30 person or 10% explicitly stated trafficking as a main source of income), prostitution or sex work (15 persons[24] or 5% stated prostitution as a major income source.

Additionally there are those who just give sex to the drug supplier to pay for their drug supply without regular prostitution). When asked what they are giving up for their drug habit, 60% claimed nothing with the rest stating to relinquish family life, money and food. Again, several persons explicitly mentioned sex.

Drug-related consequences:

When asked about drug-related harm, more than 40% of the respondents claimed to have no negative effects at all. Among the negative effects mentioned, social problems were the most prevalent with around 20%.

These problems included problems with partners and/or the family, problems in the community including being shot at, problems with police, and becoming criminal to support

[24] Since most there are mostly females who prostitute themselves to earn money, and since females were a minority among the drug users and pushers interviewed, prostitution was an income source for 25.6% of all females interviewed. In addition, as stated above, there are some females who pay for their drug supply in sex without earning money through additional prostitution.

the drug habit. Physical problems were the next prevalent category of problems, including hangovers, blackouts, wheezing and nagging cough, but also more severe problems like collapsed bronchial tubes, burned out nose bridge or HIV infections as a consequence of the sex trade to obtain drugs (around 10%).

Mental problems like aggressiveness, negative attitudes, hallucinations, forgetfulness, and loss of control were slightly less prevalent.
On the positive side, there were also about 1/3 who did not claim any positive consequences. Better consciousness, clearer thinking, better awareness, and spiritual reasons were given by about 20%. Slightly less persons claimed a relaxation and meditation as well as taking drugs to cope with stress and problems as the main positive consequence experience from drug use.

Less than 10% gave general well being and a good feeling while using drugs. Other reasons given were less frequent with social reasons, better sex, and relieve from physical problems all being named by 5-10 persons. The physical relief was in all cases associated with asthma.

In the overall balance about half of the drug users think about quitting smoking (143 or 47.7%), and half does not have such a wish (149 or 49.7%), with 2.7% not knowing or refusing. When asked about the main reason to continue, the positive consequences listed above reappear, together with the problem of addiction of the substance, which keeps the respondents from quitting.

In this question, religious reasons for smoking marijuana are cited more frequently (often coupled with subjective feelings greater consciousness and better spirituality).

Social reasons like environment were not mentioned a lot. However, in another question 114 or 38% of the respondents indicated, that most or almost all of their friends were using

drugs, and another 81 or 27% said, that most of their friends were using drugs. Thus, for about 2/3 of the sample the majority of close friends were also using drugs. Only 15 persons or 4% had no close friends using drugs. Moreover, for 43.1% of those, who had a partner, the partner was using drugs as well.

Community dynamics:

About one third of those who answered the question about their own involvement in the community, stated to have no involvement and/or no interest in community activities. Of those interested, the majority participated in some kind of sports, usually football.
In more general terms, the majority perceived problems in the communities. Among those mentioned most often were unemployment, poverty, violence, and problems with the police. Many drug users also claimed that political representation of the community did not succeed in improving the situation in the communities.

In terms of drug use, most persons saw increases in drug use in their community in the last year (197 or 65.7%) or the last three years (223 or 74.7%).

Portrait of a Barbadian drug pusher:

109 persons answered the questions about a typical drug pusher (see Appendix 5, questions D70 onwards). This form of questioning was chosen to create an interview situation of complete anonymity after pilot interviews revealed that persons had problems in answering in personal form even though they identified themselves as pushers before.

About half of the respondents pictured a typical pusher as selling marijuana and cocaine (50 out of 109 persons, or 45.9%), the other half as solely selling marijuana (58 persons or 53.2%) and one person mentioned selling only cocaine.

Of the pushers offering cocaine as well, about 80% (40 or 78.4%) again came from the City of Bridgetown or Deacon Farm, and only one pusher out of 51 selling cocaine came from either Pinelands or Eden Lodge. Heroin or LSD was never mentioned as part of offer from drug pushers.

For some respondents, the pusher also offered alcohol or Imps (see footnote 23 above). Most of the respondents (68 persons or 62.4%) saw the pusher as usually using only marijuana, 16 persons (14.7%) as using cocaine and marijuana, and in 25 cases (22.9%) the pusher was seen as using no drugs at all.
Pushers were seen as having excellent roots in the community (65 of 107 valid responses rated the relationships as very well linked into the community at large),

Another 39 (36.1%) saw linkages only to the drug scene of the community but not to the community at large, and only in three cases (2.8%) the pusher was seen as coming from outside and not at all linked into the community.[25] Given this fact it is not surprising that pushers serve as role model in communities. This data again underlines the fact that drug use and pushing is well established in the contemporary Barbadian communities.

In terms of prices, an ounce of cocaine can be bought on average for $1,150 with the prices between $1,000 and $1,500 being mentioned. Cocaine mainly comes from South America, but some of it is shipped via other Caribbean islands.

Marijuana is mostly sold in forms of so-called 5-bags or 10-bags[26] which indicate the amount of marijuana for $5 or $10. Dependent on availability, the amount of marijuana in a

[25] In some case pushers have been supporting local sports teams, or provided resources for other activities in the community.

[26] This is also called 5-player or 10-player.

5-bag would be more or less. Currently, two spliffs (joints) could be rolled from a 5-bag.

At the time of the survey, an ounce would cost around $175 with some variability between respondents (between $120 and $225), and a half pound would be around $ 900. Both homegrown and other marijuana is offered, with the majority of it coming from other Caribbean islands, most notably St. Vincent and Jamaica.

3.4 Methodological considerations

The current study had a fixed methodology from the outset.
It was a Rapid Assessment Survey conducted according to guidelines of UNDCP, (United Nations Drug Control Programme, without date). Its main goal consisted in giving an empirically based picture on patterns of drug use and related harm and problem on the community level in Barbados.

Other goals concerned the collecting of information about national and community service needs, and the establishment of a baseline for evaluating the community measures implemented now in all six intervention communities (see Point 1 Background above).

At this point we would like to discuss the advantages and limits of the chosen technology, as well as compare it to other possible methodologies. This will be done by discussing two related questions.

? Are there alternative ways to achieve the stated goals?

? What are the limits of the methodology used?

To arrive at the goals, empirical information is necessary on two levels:

- one must quantitatively describe the drug problem in Barbados with respect to incidence, prevalence and other epidemiological key descriptors (Rothman & Greenland, 1998)

- One must qualitatively describe the situation with respect to underlying risk factors and motivations, structure of services, perceived barriers to change, etc.

What alternative possibilities would be in principle available to achieve these goals? One possibility would have been to conduct a representative general population survey in the tradition of the NIDA household surveys in the U.S.

Such a survey would select several thousand households in Barbados, and with trained interviewers would interview randomly selected members of these households with respect their drug use, potential risk factors, etc.

Such a design has the advantage that it allows statistically to conclude from the sample to total population if all persons interviewed answered and if all answer vertically.

In practice however, it has been found (*cite Gfroerer NIDA monograph*) that household surveys severely underestimated use of drugs like heroin or cocaine, (least socially accepted drugs associated with potentially high sentences) in the general population.

Mainly because they do not reach selective drug users as well as the general population, and because drug users do not always answer directly to such survey questions.

The situation seems to be worse for interviews on the phone (for a general discussion of surveys using the phone see Groves et al 1988) because telephone coverage of drug users can be expected to be less than for the general population.

Also because it is harder to get drug users on the phone because of their less regular lifestyle (e.g. Johnson, Houghland, & Clayton, 1989; Aquilino, 1992; Gfoerer & Hughes, 1991). In summary, it can be said that incidence, prevalence or other standard epidemiological indicators of drug abuse and harm cannot be assessed by general

population surveys for drugs like cocaine and heroin.[27]

For alcohol and marijuana, the estimates may be better, but overall consumption for alcohol by survey questions is usually still underestimated by about 40% or more, when compared to sales figures (for a full discussion of assessment of alcohol by different methods see Rehm, in press).
There is no solution to this problem, as other methods for estimating prevalence and incidence of drug use (e.g. capture-recapture, estimates from treatment statistics or from legal infractions) all have problems.

As a result, estimates by different methods differ tremendously, sometimes by the factor of 5 and more (e.g. *IFT* Fahrenkrug et al. 1995). However, this general problem cannot be solved using RAS, as this technique only covers drug users and pushers and no controls from the general population.

Another way to approach the problem of incidence and prevalence would be use of expert judgement. This has proven to be especially helpful to detect new developments but will not

[27] Almost all of the methodological work has been done in societies, where heroin and to a lesser extent cocaine has been the most prevalent ?hard? drugs. That is why these drugs are referred to in this section on methodological considerations. In Barbados, cocaine could be considered as the equivalent to heroin in North American societies with respect to its social status. However, since cocaine has different pharmacological traits than heroin, and since there are differences in the usage (no strict separation of marijuana and cocaine with *blackies,* cocaine laced marijuana joints, being popular on the block at certain communities), such transfers of methodological results are heuristic at best.

give exact percentages for prevalence and incidence (Rehm, Béroud, & Müller, 1994). The RAS in the form of key informant interviews as well as other expert polls used this technique.

Even though it has limits (see Rehm & Gadenne, 1990, for an overview), it is probably the easiest and most cost effective way to obtain a quick overview.

Most problematic among the limits seem the already mentioned impossibility to give exact prevalence and incidence rates, and the potential bias of experts resulting from working in only one sector (e.g. treatment) in generalizing trends for a multi-sectorial problem like drug abuse.

The qualitative problem is even more complex. Of course it would be possible to ask in a representative household sample or in a treatment sample the same questions asked in the RAS, about the qualitative issues mentioned above.

However, at least for cocaine, a household sample could not claim to cover the user-population adequately. Moreover, as cocaine users are only a small minority of the general population, such an approach is not very cost-effective. With regards to the treatment population, another problem persists.

First of all, only a sub-population of drug abusers go into treatment (this is especially true for Barbados, see above).

Secondly, this subpopulation is systematically biased towards more severe cases at the middle stages or at the end of a drug career (see age distribution of the DRU at the Psychiatric Hospital above), or towards the general social classes that consider treatment as valid option.

Thus, this group will not be able to inform prevention in the way and active drug user population could, nor will it be able to inform the reasons, why certain drug users will not seek treatment.

For these practical purposes of prevention and treatment planning, the RAS approach[28] actually is more advantageous since it samples active drug users from a community setting, being at almost all stages of their drug career (with the exception of very severe cases) and most of them not seeking treatment. Since there are treatment statistics[29] in addition to potential gaps, missing areas could be filled in as well.

[28] Actually, without using the label RAS, samples of drug users in the community have recently also be used elsewhere to look into the question why heroin addicts do not seek methadone treatment or as control group to a treatment setting (see e.g. Fischer et al., in press).

[29] In Barbados, systematic treatment statistics do not exist as yet (only the individual work of Harvey, 1996, 1997 for the DRU). However, such statistics are potentially available for future planning.

The final question concerns the generalisation of the data from six communities to Barbados as a whole. Clearly, there was no formal probabilistic sampling either of the communities or of the persons within communities.[30] Thus, there is no formal, (e.g. statistical) inference possible from the six communities to Barbados as a whole.

There is reason to believe that the picture derived from these six communities in important ways can be generalised to Barbados as a whole. However, since the results of the six communities clearly fitted and supported available national statistics, they were in overall agreement with the expert judgements of the national key informants.

The lack of employment and perspectives leading to liming on the block and smoking of marijuana certainly would be a feature which is true for almost all communities in Barbados plagued with unemployment, especially youth unemployment.

Other social and psychological mechanisms[31] were peer pressure and low self-esteem. In a situation where complying with the rules (e.g. attaining a secondary education) does not seem to help attain jobs, the cultural acceptance of alcohol and marijuana (based on the Rastafarian religion) can be expected to be generalised in Barbados society.

Other features, which have been found only in particular communities (e.g. gang violence related to illegal weapons in Deacons Farm, the cocaine situation in the City of Bridgetown) seem to be more specific arising from additional factors not common in most Barbadian communities.

[30] For future RAS in societies like Barbados, where drugs are often used on the block openly during the day or in the evening, a probabilistic sampling frame of times and places within the communities may be considered. However, such a form of probabilistic sampling would not allow any conclusions on the whole of Barbados, it would just ensure that the results are representative for the selected communities.

[31] See Gadenne (1984) or Aronson et al. (1990) on the scientific logic underlying the tranfer of mechanisms or laws.

However, the underlying mechanisms for these phenomena as well can be transferred, once the additional factors (availability of cheap cocaine, availability of role models to escape the situation by trading cocaine, etc.) are present in other communities as well.

3.5 Overall conclusions from the community level

Taken together, the results from the community level suggest the following:

On the background of a problematic economic and social situation with a large minority of young adults finding no salaried employment, marijuana has become the drug of choice to cope with the situation. It is mainly been used because subjectively it helps to cope with stress and problems, and because it relaxes.

Moreover, it is routed in the Rastafarian identity and religion which became popular in Barbados in the 1970s, and which is quite accepted by the teenagers and young adults, and which considers marijuana as a sacred tool. Thirdly, marijuana is easily accessible in all communities in Barbados.

Marijuana has become part of the public life in communities. It is often smoked openly while liming on the block or at parties. This is also the way school kids can make their first experiences with the drug. Marijuana is often mixed with alcohol and in some areas, so called *blackies*, marijuana joints laced with cocaine, have become popular.

In poor neighbourhoods, where the average earning of those employed are not that high (Barbados $16,000 on average) the costs of drug use lead to other forms of acquiring financial resources, including trafficking and stealing. Prostitution was also an option mainly for females.

From the point of view of community activists and programmers, marijuana is the most problematic drug, as it is seen as leading to indifference and inactivity in the community.

They want to cope with the problems by providing training of marketable skills or, at a

minimum, by providing alternatives to just hanging around and smoking marijuana.

In order to carry out such a program, they have to be given more resources and more responsibilities. This includes the transfer of police resources to allow community policing. Current experiences with this form of policing have been quite positive.

In addition to marijuana, cocaine and alcohol are seen as the biggest problems in communities. Cocaine was more prevalent in the City of Bridgetown, Deacons Farm, and to some degree also in Haynesville.

It was seen as leading to more criminality in these communities, especially violence including gang violence and property crimes.

4 Conclusions and Recommendations

- The **collaboration and integration** between the three sectors law enforcement, treatment and prevention/social work, should be intensified, and regular meetings on new trends and initiatives should be started on a national level.

  This recommendation has been derived from the national key informant interviews, especially from the fact that the persons from different sectors had no knowledge about problems or key initiatives of the other sectors.

  On the community level, such synergistic activities should be intensified as well. However, currently at least in some communities there are some integrated effort, albeit without the treatment and rehabilitation sector.

- A **data centre on substance abuse** on the national level should be established to provide all partners with up to date information about substance use, substance-related problems and programs / initiatives. More systematic gathering of drug-relevant data is necessary on different levels and in almost all sectors.

<u>Specifically relevant seem:</u>

- The establishment of a **small, community-based monitoring system** with input of a few selected communities on local trends to quickly prepare actions on new trends and to function as a data resource between active communities.
- A **national school survey on drug abuse**, risk factors to identify information relevant for prevention and education for teenagers.

Both suggested measures could be realized almost immediately at rather minimal costs.

The community-based monitoring system stems from the idea that certain developments take place earlier in some communities than in others. If relevant information is shared and properly disseminated, this may lead to earlier implementation of preventive efforts, or of efforts to minimize drug-related harm (e.g. when new and more dangerous patterns of drug use are observed. Warning other communities of these things may lead to successful action and stop such patterns at that point.

In the current situation in Barbados, a school surveys on drug use, drug-related attitudes, and risk factors is probably the most important single new data source for the following reasons.

- School surveys yield **nationally representative results**, as schools allow the sampling of all persons living in Barbados up to 16 at rather minimal costs.

- Going into classes with questionnaires specifically construed for school children represents **cost-effective way to collect reliable and valid data**.

- School surveys can **provide the information necessary to plan and operationalize effective prevent.** Such an approach using local examples has been depicted as necessary to improve effectiveness of these efforts in Barbados, and to escape the entire reliance on North American materials which have been derived in a different cultural and political situation (see recommendation 3). School children are the **right target group for such an effort as the average age of onset for marijuana, alcohol and cocaine use alike is between 14 and 15 years**.

The ideal site for such a centre would be the National Drug Resource Centre of the National

Council on Substance Abuse, which currently serves as a resource centre for other materials and information.

- Efforts on **prevention and education** should be continued with **more emphasis on local problems and local solutions**. This is another reason why a data centre is indispensable.

- The key towards reducing drug-related problems will be integrated initiatives on the **community level**. These initiatives have to be directed at the young persons with no perspectives to gain employment and to escape the current situation of poverty. At the minimum it should be directed towards offering alternatives to liming on the block. (e.g. sports, cultural activities, etc.)

  Currently, there are community efforts underway, and according to key informants and the empirical results of the RAS, some successes have been achieved. What is necessary is to strengthen such efforts is:

  1) Selection and dissemination of the most effective or cost-effective initiatives which could only be identified by evaluation.
  2) Increase support for active communities by transferring some resources and responsibilities on the community level.

- **Treatment and rehabilitation facilities should be reorganized and enlarged** with a **shift towards community-based treatment**. Community centres like Deacons Farm should offer the possibility of outpatient treatment (e.g. short treatment programs based on the principles of cognitive behavioural theory like Guided Self-change, or on relapse prevention) and counseling which has proven to be as effective as inpatient treatment for most populations.

The main inpatient facility should be locally separated from the Psychiatric Hospital. Different models to achieve this transition are outlined above. A committee should be established to prepare the necessary **transition as soon as possible**.

- **Law enforcement** activities should be **integrated** into a truly comprehensive national strategy. The main distinction between persons using and trafficking on a small scale to sustain their use on the one side, and persons trafficking at large scale for profit on the other side, should be recognized in all law enforcement activities.

- In order to support the overall strategy with an emphasis on community programming, **community policing** should be a key element in the law enforcement strategies.

  Local police force seems essential in making distinctions between persons using and trafficking on a small scale to sustain their use on the one side, and persons trafficking for profit on the other side. If local police works hand in hand with community activists and centres, the former group of drug users should be directed toward community alternatives, whereas the latter should be receiving stiff penalties.

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Appendix 1: Statistics and Documents available

The following statistics and documents were the basis of the report made available.

Statistics:

- statistics on drug crimes for period 1980-1995 (cases brought, persons charged, age distribution, nationality, finding)
- statistics on drug offenses for period 1980-1995 (cases brought, persons charged by drug and offense)
- selected treatment statistics of the Psychiatric Hospital (prior to 1986, and 1986-1992)
- statistics as part of the Master Plan

Documents:

National Strategic Plan 1996-2001 (draft form)

National Substance Abuse Master Plan 1996-2001 Government of Barbados (draft form)

Alternatives to Imprisonment in Barbados - Report of the Steering Committee on Penal Reform (March 1997)

Report on the Barbados Rapid Assessment Survey on the Extent of Substance Abuse in Communities and for Describing the Relevant Services to Respond to Substance-Related Problems. First Phase: National Level October - December 1997 - prepared by Jürgen Rehm and Arthur Holder (National Council on Substance Abuse, January 1998)

Report on Criminal Risk Factors - prepared by the National Task Force on Crime Prevention, Office of the Attorney General, Barbados (June 1997)

Appendix 2:
Guideline for key informant interviews - national level

Objectives:
To get a full picture of drug misuse (including alcohol) in Barbados, and the different services, organizations, institutions and individuals engaged in delivering programmes to prevent, reduce or treat drug misuse.

Police / Justice:

Name of organization where the key informant works:

Key informant function in the organization:

Date of interview:

Interviewer name:

Date of finalization:

J1) What is the most problematic legal or illegal drug in Barbados?

J2) Why is this drug the most problematic? What are the main problems caused by the use of this drug?

J3) What is the drug that is related to most measures of law enforcement in Barbados?

J4) What are other drugs causing problems in Barbados?

J5) Are there new trends of drug-taking behaviour in Barbados? If yes, which?

J6) Which persons are most vulnerable for drug use here?

J7) What can be done better to reduce or minimize drug-related problems from a perspective of law enforcement?

J8) Are there any initiatives in that direction? If yes, please describe.

J9) What are the main barriers and facilitators for improving the situation from a law enforcement perspective?

Barriers:

Facilitators:

J10) What should happen to persons who had been caught for drug-related crime?

J11) Is prison the best way for re-socialization and deterrence, or should there be alternative forms of correction?

J12) Does the police have links to the community? If yes, how do these links operate?

J13) What should happen in society as large to reduce drug-related problems?

J14) Are there any other comments you would like to make about the drug-related problems in Barbados?

Collect any available recent data on the problem; ask for other potential key informants on the problem; ask specific questions relation to the function of the key informant.

Guideline for key informant interviews - national level

Objectives:
To get a full picture of drug misuse (including alcohol) in Barbados, and the different services, organizations, institutions and individuals engaged in delivering programmes to prevent, reduce or treat drug misuse.

Treatment:

Name of organization where the key informant works:

Key informant function in the organization:

Date of interview:

Interviewer name:

Date of finalization:

T1) What is the most problematic legal or illegal drug in Barbados?

T2) Why is this drug the most problematic?

T3) What is the drug that is related to most treatment in Barbados?

T4) Could you please give a percentage of the proportion of treatment for this drug in comparison all drug treatment in Barbados?

T5) What are other problematic drugs in Barbados?

T6) How are the two or three most problematic drugs applied? (e.g. smoking, sniffing, orally, etc.)

T7) Is there a tendency for polydrug use, that is, to use more than one drug on the same occasion? If yes, which drugs are used on which occasions?

T8) Are there new trends of drug-taking behaviour in Barbados? If yes, which?

T9) Which persons are most vulnerable for drug use here?

T10) What can be done better to treat drug-related problems?

T11) Are there any initiatives in that direction? If yes, please describe.

T12) What are the main barriers and facilitators for improving the situation in treatment?

Barriers:

Facilitators:

T13) What should happen to persons who are in treatment to reduce the chances of relapse?

T14) Is aftercare well developed?

T15) Do the treatment centres have links to the community? If yes, how do these links operate?

T16) What should happen in society as large to reduce drug-related problems?

T17) Are there any other comments you would like to make about the drug-related problems in Barbados?

Collect any available recent data on the problem; ask for other potential key informants on the problem; ask specific questions relation to the function of the key informant.

Guideline for key informant interviews - national level

Objectives:
To get a full picture of drug misuse (including alcohol) in Barbados, and the different services, organizations, institutions and individuals engaged in delivering programmes to prevent, reduce or treat drug misuse.

Prevention / Social work:

Name of organization where the key informant works:

Key informant function in the organization:

Date of interview:

Interviewer name:

Date of finalization:

P1) What is the most problematic legal or illegal drug in Barbados?

P2) Why is this drug the most problematic?

P3) What is the drug that is related to most preventive measures in Barbados?

P4) What are other problematic drugs in Barbados?

P5) How are the two or three most problematic drugs applied? (e.g. smoking, sniffing, orally, etc.)

P6) Is there a tendency for polydrug use, that is, to use more than one drug at the same occasion? If yes, which drugs are used on which occasions?

P7) Are there new trends of drug-taking behaviour in Barbados? If yes, which?

P8) Which persons are most vulnerable for drug use here?

P9) What are the major social factors related to drug use?

P10) How can they be turned into preventive initiatives?

P11) What can be done better in the area of preventing drug-related problems?

P12) Are there any initiatives in that direction? Please describe.

P13) What are the main barriers and facilitators for improving the situation in prevention?

Barriers:

Facilitators:

P14) What should happen to persons who are already taking drugs?

P15) Is social work sufficiently linked to the community? If yes, how do these links operate?

P16) What should happen in society as large to reduce drug-related problems?

P17) Are there any other comments you would like to make about the drug-related problems in Barbados?

Collect any available recent data on the problem; ask for other potential key informants on the problem; ask specific questions relation to the function of the key informant.

Appendix 3: Guideline for key informant interviews local level

Community name:

Key informant function in the community:

Date of interview:

Interviewer name:

Date of finalization:

C1) What is the most problematic legal or illegal drug in your community?

C2) Why is this drug the most problematic?

C3) What are other problematic drugs in your community?

C4) How are the two or three most problematic drugs applied?

C5) Is there a tendency to use different kinds of drugs together? If yes, which and in what settings?

C6) Are there new trends of drug-taking behaviour in your community? If yes, which? (timeline: last year)

C7) Has drug use increased, decreased or stayed the same during the **last year** in this community?

9 increased **9** decreased **9** stayed the same

C8) Has drug use increased, decreased or stayed the same during the **last three years** in this community?

9 increased **9** decreased **9** stayed the same

C9) What persons are most vulnerable for drug use here?

C10) What are the community and social factors related to or leading to drug use?

C11) Can community and social factors be changed to **prevent or reduce** drug use in the future in this community? If yes, how?

C12) What are the major problems related to drug use in your community?

C13) What could be done to reduce or minimize these problems?

C14) Are there any initiatives in that direction? Please describe.

C15) What are the main barriers and facilitators for improving the situation in your community?

Barrriers:

Facilitators:

C16) Are there enough and adequate facilities for social and medical assistance in the community? If not, what is missing most?

C17) What should happen in society at large to reduce drug-related problems?

C18) Are there any other comments you would like to make about the drug-related problems in your community? What is special about drug use in your community?

Informant specific questions.

Appendix 4: Guidelines for interviews with drug users and pushers community level

D1 community name:

9 Deacons Farm **9** Eden Lodge **9** Pinelands

9 City of Bridgetown **9** Gall & Silver Hill **9** Haynesville

D2 how found:

9 snowball referral

9 knew before

9 referred by key informant

9 in the streets or other public space

9 other (please describe)

D3-5 date of interview:

day: ***8 8*** month: ***8 8*** year: ***8 8***

D6 interviewer:

number: ***8 8***

D7-9 date of finalization:

day: ***8 8*** month: ***8 8*** year: ***8 8***

Personal drug use (including questions about alcohol)

D10 primary drug (drug which is linked to most problems and / or which is used most often)

9 alcohol **9** cocaine **9** heroin

9 LSD **9** marijuana **9** others

if others, please name

D11 age of onset for primary drug (age of first use of primary drug)

8 8 years

D12 circumstances of first use (please describe)

D 13-18 other drugs used:

9 alcohol **9** cocaine **9** heroin

9 LSD **9** marijuana **9** others

if others, please name

D 19-24 age of onset for these drugs (please put age in front of all drugs applicable)

8 8 alcohol ***8 8*** cocaine ***8 8*** heroin

8 8 LSD ***8 8*** marijuana ***8 8*** others

D25-30 circumstances of first uses (please describe)

D31 current patterns of use (how much and at what time, if too problematic describe last two weeks)

D32 how much spent on drugs during the last two weeks (in $ Barbados, if drugs were obtained other ways e.g. by own trafficking, prostitution, estimate value on the street)

8 ***8 8*** $Barbados

D33 how was this money obtained:

D 34 what is given up to consume drugs:

D35 negative consequences or expected negative consequences (personally experienced)

D36 positive consequences or expected positive consequences (personally experienced)

D37 thoughts of quitting (describe)

9 yes **9** no

D38 what is the main reason for continuing drug use:

Drug user socio-demographics and social support:

D39 age: 8 8 years **D 40 sex:** **9** male **9** female

D40 living place:

9 regular **9** often changing (e.g. every month) **9** no living place

D41-45 current living circumstances (please mark all that apply)

9 with parents **9** with friends **9** with partner or own family

9 alone **9** other, please describe

D46 how many close friends:

8 8 number

D47 proportion of close friends also using drugs:

9 all or almost all **9** majority **9** minority **9** none

D48 partner:

9 yes **9** no

D49 partner into drugs:

9 yes **9** no

D50 relationship to partner (please describe)

9 extremely good

9 good

9 ok

9 some problems

9 lots of problems

D50 own children:

8 8 number

D51-55 who takes care of them (please mark all that apply}

9 self **9** partner **9** parents / other family **9** friends **9** others

if others, please describe

D56 relationship to family other than partner:

9 extremely good

9 good

9 ok

9 some problems

9 lots of problems

D57 schooling (indicate highest completed degree)

9 less than primary school

9 primary school

9 secondary school

9 post secondary education

D58 employment (how many weeks or months of the last year with paid work; only fill in one!)

8 8 weeks **8 8** months

D59 income derived:

8 8 8 thousand $Barbados

D60-64 other sources of income (mark all that apply)

9 trafficking **9** prostitution **9** family / partner support

9 support from state (welfare, etc.) **9** other support (please describe)

Community dynamics:

D65 activities:

D66 perceived problems in community:

D67 perceived areas of discord in community:

D68 has drug use increased, decreased or stayed the same during the last year in this community:

9 increased **9** decreased **9** stayed the same

D69 has drug use increased, decreased or stayed the same during the last three years in this community:

9 increased **9** decreased **9** stayed the same

Questions about a typical drug distributor:

D70 personal drug use:

9 usually uses all the drugs he / she sells

9 uses only drugs considered less harmful (no cocaine, no heroin)

9 uses no drugs

D71 linkage to community:

9 very well linked into the community at large

9 not very well linked into the community at large, but linked into the drug scene of community

9 not at all linked into the community, comes from outside

9 others, describe

D72-76 type of drugs sold (check all that apply)

9 cocaine **9** heroin

9 LSD **9** marijuana **9** others

if others, please name

D77-86 how much sold per drug (usual quantities / price)

Substance	**quantity**	**price**
Cocaine		
Heroin		
LSD		
Marijuana		
Others (specify)		

D87 hours per day spend to sell drugs:

8 8 hours

D88 any problems (e.g. police, fights among drug pushers, etc.)

D89 where did the drugs come from:

Appendix 6: Steps and timetable of the RAS

Goals:

First stay from September 28 - October 1, 1997

- To interactively finalize the work plan for the Rapid Assessment Survey (RAS) in Barbados.
- To make contact with the leaders of the six intervention communities.
- Inform about the goals and the scope of the RAS.
- Test the feasibility of all the planned assessment within the RAS.
- Gather background information in the intervention communities to improve and focus the standard UNDCP assessment instruments to the specific local situations in Barbados.
- Gather preliminary information on the scope and current status of the intervention projects.

Subsequent detailed work-plan for the RAS submitted between October 97 and May 1998.

1) National Level

a) Assemble statistics on Alcohol and other Drugs including:

Police and criminal justice data (seizures, arrests, imprisonment)

Treatment data (psychiatric hospital, specialized treatment centre, others)

Taxation and production data (for alcohol: per capita consumption)

Survey data (all that is available: Youth Commissioners' Survey)

b) Conduct expert interviews with persons from:

Police / justice (5 interviews)

Treatment (5 interviews)

Prevention / social work (5 interviews)

c) Data analysis and final report on phase 1:

Working steps:

a) Materials assembled by National Council on Substance Abuse by 12-15-97.

b) Final interview-guidelines ready by 10-15-97.

c) Last of 18 interviews with national key informant conducted by 12-04-97.

d) Interim report on national level finished by 01-01-98.

e) Revisions made after comments by Board and national key informants and finalized by 01- 31-98.

2) Local level of community interventions (6 intervention communities)

a) Select interviewers, prepare guidelines for interview.

b) Train interviewers and local research leaders.

c) Conduct key informant interviews at local level (10 per community for a total of 60 key informant interviews).

d) Conduct drug users / pusher population interviews at local level (50 per community for a total of 300 interviews with the drug user / pusher population).

e) Coding and checking.

f) Data analysis.

Working steps:

a) **Interviewers selected by 11-15-97.**
b) **Interviewing guidelines for community key informant interview and for drug user / pusher population interviews developed by 11-15-97 and finalized after pilot interviews by 11-28-97.**
c) **Full day training session for community interviewers held on 11-29-97.**
d) **Community key informant interviews finished by 02-18-1998.**
e) **Community interviews with drug users and pushers finished by 02-18-98.**
f) **Coding of interviews finished by 05-15-98.**
g) **Analysis of the interviews for final report finished by 05-20-98.**
h) **Final report on RAS: 05-23-98, revision if necessary by 06-30-98.**

List of deliverables Jürgen Rehm:

Dates indicate delivery of the final products.

Detailed working plan:	10-01-97
Interview guidelines national key-informant interviews:	10-15-97
Other assessment instruments:	11-15-97
Training of research leaders and interviewers:	12-05-97
Progress report:	12-31-97
Report on national study:	01-31-98
Draft final report:	05-18-98
Final report:	05-23-98

List of deliverables Arthur Holder:

Dates indicate delivery of the final products where he has primary responsibility.

Selection of local interviewers:	11-15-97
Contribution to all assessment interview guidelines:	
Contract with interviewers:	11-24-97
Supervision of collection of statistical data:	12-15-97
Supervision of national key informant interviews,	
Finished by:	12-15-97
Supervision of local key informant interviews, finished by:	02-18-98
Supervision of drug user population interviews	
Finished by:	02-18-98
Contribution to final report:	05-23-98

Ongoing for all part of the study:

Liaison with Community Projects with fieldwork, as well as liaison with the Consultant.