National Council on Substance Abuse

Rapid Situational Analysis

In fulfillment of the UNESCO project 'Towards the Development of Comprehensive Responses to Drug Demand and Harm Reduction in Barbados'

December 2008

United Nations Educational, Scientific and Cultural Organization

This RSA was done by Community Asset Development Consultants (CADCo) on behalf of Barbados' National Council on Substance Abuse (NCSA) as part of UNESCO's drug demand and harm reduction project.

List of Abbreviations

AA	Alcoholics Anonymous
ACMD	Advisory Council on the Misuse of Drugs
BCC	Barbados Community College
BIMAP	Barbados Institute of Management and Productivity
BVTB	Barbados Vocational Training Board
CAN	Citizens Against Narcotics
CBO's	Community Based Organizations
DARE	Drug Abuse Resistance Education
DEA	Drug Enforcement Agency
EDUTECH 2000	Education Sector Enhancement programme
HFLE	Health and Family Life Education programme
IDER	Integrated Demand Reduction programme
MDG's	Millennium Development Goals
MEM	Multilateral Evaluation Mechanism
NA	Narcotics Anonymous
NACD	National Advisory Council on Drugs
NCPADD	National Committee for the Prevention of Alcohol and Drug Dependency
NCSA	National Council on Substance Abuse
OAS	Organization of American States
OECD	Organization for Economic Cooperation and Development
PAHO	Pan American Health Organization
PEC	Poverty Eradication Committee
QEH	Queen Elizabeth Hospital
RBPF	Royal Barbados Police Force
SBS	Special Benefit Services
SJPP	Samuel Jackman Prescod Polytechnic
TVET	Technical and Vocational Education Training
UNDCP	United Nations International Drug Control Programme
UWI	University of the West Indies
WHO	World Health Organization

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Introduction

Background

This Rapid Situational Analysis (RSA) on drug demand reduction and harm reduction in Barbados has been prepared as a project within the framework of UNESCO's commitments towards the realization of globally agreed objectives, particularly with regards to Education for All (EFA) and the Millennium Development Goals (MDGs). The European Commission and UNESCO have been supporting the development of educational strategies, youth empowerment programmes and comprehensive responses to drug demand and harm reduction in various developing countries worldwide since 1998.

The National Council on Substance Abuse (NCSA) is the Government of Barbados' coordinating agency for the national response to substance abuse. The NCSA was therefore critical to the preparation of this RSA in terms of its conduct of ongoing research, its wide knowledge of the stakeholders, and its grasp of the existing situation of substance abuse in Barbados. The oversight and direction of the project was provided by a Steering Committee made up of the following experts:

- Mr. Jonathan Yearwood (Research & Information Officer NCSA, Committee Chairman)
- Ms Laura Lee Seale (Research Assistant (Ag), NCSA)
- Dr. Ermine Belle (Senior Consultant Psychiatrist, Psychiatric Hospital)
- Mr. Erwin Leacock (Principal, Government Industrial School)
- Inspector John Boyce (Royal Barbados Police Force)
- Ms. Paulavette Atkinson (Programme Officer, NCSA)
- Mrs. Selma Greene (Director, Youth Entrepreneurship Scheme)
- Mr. William Gittens (Administrative Officer, Ministry of Home Affairs)

- Mr. Damien Morris (Programme Officer, Barbados Vocational Training Board)
- Mr. Shawn Springer (Representative, Voluntary Counseling and Testing Unit , Ladymeade Reference Unit)
- Ms. Olreka Grosvenor (Ministry of Health)

The overall objective of the study is to:

Reduce vulnerabilities and harm associated with drug use, particularly among youth, ages 12 to 29.

In order to support national movement towards the above objective, this RSA will provide the following:

- An impact evaluation study of the national response.
- A discussion of best practices.
- A discussion of main challenges and barriers to success.
- A discussion of the gaps between policies and practice.
- A detailed inventory of relevant policies and programmes which also serves as a national directory of key stakeholders and service providers.
- Draft recommendations for the way forward.

The discussion and findings of this report are based on

- Previous studies and consultations
- Current data from focus groups, a survey of programmes in schools, a survey of programmes in other government and non-governmental institutions.

Barbados' Context

A full understanding of the drug demand and harm reduction situation in Barbados requires a grasp of its context. This is briefly outlined below.

Geography

Barbados, the most easterly of the Caribbean islands, is situated 74.53 miles east of the Windward Islands and 285.7 miles north-west of Venezuela. It is four and a half hours from New York, five hours from Toronto, and eight hours from London by air. The island is small (166 sq miles) and relatively flat with the highest point reaching 1,104 ft.

Demography

Barbados has the demographic profile of a developed country. The 2007 United Nations Development Programme (UNDP) Human Development Index (HDI) which is based on life expectancy, literacy, education, and standards of living for countries worldwide, places Barbados 31st out of more than 150 countries surveyed.

The resident population reached 274 thousand persons in December 2006, of whom 48.3 percent were male and 51.7 percent were female. The dependent population comprised approximately 22.5 percent of the population under 15 years and 8.5 percent over 65 years. The elderly population (persons 60 years and over) is projected to comprise more than 17 percent of the population by the year 2010.

Barbadians of African descent make up 92 percent of the population. Those of European decent account for 4 percent, those of mixed descent 3 percent, while those of Indian and Asian decent make up the final1 percent of the population.

The population count does not include the number of tourists on the island at any given time, and this consideration must be borne in mind since tourism is the island's leading industry. In fact, tourists increase the number of persons temporarily living on the island by an average of 3,750 persons every two weeks.

Governance

Barbados is an English-speaking, former British Colony that has been independent since 1966. A member of the British Commonwealth, it has a bicameral legislature with separation of powers between the legislative, executive, and judiciary arms. The

Constitution is based on the British style of parliamentary democracy and elections are constitutionally due every five years.

The Governor General as Head of State represents the British Monarch. Executive authority is vested in the Prime Minister and the Cabinet who are collectively responsible to parliament.

The legal system is derived from English common law and statutes. The Courts administer the laws of Barbados which consist solely of local legislation. The judicial system is made up of the Magistrates Court and the Supreme Court, the latter of which includes a Court of Appeal and the High Court. Final appeal from Barbadian courts is to the Caribbean Court of Justice. The Attorney General is responsible for the administration of the legal and judicial system.

There is currently a programme of penal reform and alternative sentencing, which seeks to find creative methods to punish and rehabilitate. This is particularly important since a significant number of first-time offenders are incarcerated for minor drug associated crimes.

Socio-Economic and Cultural Context

It is important that the policies, objectives, and strategies developed to mitigate the negative individual and social impact of substance abuse take into account the social, cultural, and economic context of Barbados. Government's financial commitments to these areas of development are already significant. Therefore, new initiatives that involve further spending will heavily depend on sustained economic growth and external funding.

Social Context

Education

Education is the largest item of current Government expenditure with BDS $452 million being allocated for the fiscal year 2007 – 2008, that is 15.4 percent of total expenditure. Barbados' education system is modeled after the British system. It produces one of the highest standards of education in the English-speaking Caribbean, with a literacy rate of 99.7 percent.

There are subsidized government nurseries, after which academic tuition is free through to tertiary level. However, only a minority pursues tertiary education. Primary and Secondary education is compulsory until age 16. Post secondary institutions include the Erdiston Teacher Training College, the Barbados Institute of Management and Productivity (BIMAP), the Barbados Community College (BCC), the Samuel Jackman Prescod Polytechnic (SJPP), and the University of the West Indies (UWI), Cave Hill Campus.

In 2006, there were:

- 62 public and 30 private primary schools with a total of 27,997 pupils.
- 23 public and 10 private secondary schools with a total of 21,542 pupils.

Enrolment of Barbadians at Tertiary Institutions for 2006/07 was as follows:

Institution	Male	Female	Total
UWI	1475	3083	4558
Erdiston	50	138	188
SJPP	1524	1248	2772
BCC	1326	2539	3865
Total	4,375	7,008	11,383

There has been a definite trend of greater female enrolment at the tertiary level.

It should be noted that there is also support and coordination of vocational and technical training by the Technical and Vocational Education and Training Council (TVET), and the Barbados Vocational Training Board (BVTB). In addition, schools are available for students with special needs including the deaf and blind, students with learning difficulties, the disabled, and those with dyslexia.

The BVTB offers 26 courses at 17 locations around the island and caters to an average of 1,600 students annually. Other vocational courses are facilitated by TVET in association with various educational institutions.

The primary and secondary schools are currently undergoing extensive physical rehabilitation through the Education Sector Enhancement Programme (EDUTECH 2000). Government has recently introduced measures to ensure that all children are certified at some level before leaving secondary school.

Health

Life expectancy at birth is 76.4 years with infant mortality being 15.9 per thousand in 2006. Although this sector has done well over the years, it is currently undergoing reform to address recent concerns of equity, quality of care, efficiency, and effectiveness in the management of the health services and its finances.

The programmes of the Ministry include:

- Health promotion
- Primary care
- Secondary care
- Tertiary and emergency care
- Mental health
- Geriatric care and assessment
- Rehabilitation services for children and adolescents with developmental disabilities
- Pharmaceutical services.

These programmes are complemented by a vibrant private sector that provides medical services, nursing home care, pharmaceutical services, and complementary and alternative medicine.

Although Barbados boasts of having the most modern health facilities in the Eastern Caribbean, the Government is still heavily investing in the upgrading and maintenance of the present infrastructure. There are two major hospitals and several well-equipped clinics, health centres, and nursing homes.

Health was allocated BDS $369.5 million in 2007/08 or 12.6 percent of total Government expenditure. The Queen Elizabeth Hospital (QEH) which has several

specialist services plus a 24-hour emergency service, the Psychiatric Hospital, the Medical Aid Scheme and the Emergency Ambulance Service account for 32.8 percent of the budget. Primary Health Care Services accounts for 7.25 percent. BDS $39.3 million (10.7 %) was allotted to the pharmaceutical programme and BDS $3.0 million (0.008 %) for the care of the disabled.

Government has committed itself to reducing the incidence of the Human Immunodeficiency Virus (HIV) infection. Acquired Immune Deficiency Syndrome (AIDS) is seen as a major threat to the country's social and economic development. A National HIV/AIDS Commission has been set up to work with government, the private sector, non-governmental organizations (NGOs) and communities, to build awareness and implement prevention and counseling programmes while strengthening treatment and care.

Government is collaborating with the Pan-American Health Organization /World Health Organization (PAHO/WHO) on an initiative to re-orient mental health services away from institutional care while focusing more on community-based care.

Barbados' Special Benefit Service (SBS) provides medication free of cost through participating private pharmacies, to persons over sixty-five years, children under sixteen years, and persons suffering from hypertension, cancer, asthma and epilepsy.

A major constraint to the health sector is the shortage of human resources, especially nurses. As a result, Government is developing short-term and medium-term strategies to address the problems occasioned by the shortage of health-care professionals.

Addressing Poverty

In 2000, Government established a Poverty Eradication Committee (PEC) with the mandate to manage an annually replenished BDS $9 million fund in order to eradicate poverty. Funds are disbursed to NGOs and government agencies that seek to provide financial relief to families while developing programmes for long-term empowerment; $10.3 million was approved for 2007-2008.

The Urban Development Commission (UDC) and the Rural Development Commission (RDC) also address issues of poverty through housing and physical development projects in low-income communities, along with providing financial and technical support to farmers and small and micro-businesses.

There is also a Government funded office charged with the responsibility of achieving the Millennium Development Goals (MDGs).

Law and Order

During the year 2006, the general level of crime increased by 5.3 percent. This was a reversal of the trend seen over the previous three years, where the level of crime had decreased. Crime against visitors increased to 260 cases, 56.6 percent more than the 166 cases recorded in 2005. As in the previous three years, hotel burglary was the most prevalent crime committed against visitors, with 121 cases being recorded, an increase of 65.8 per cent.

The Royal Barbados Police Force (RBPF) is especially focused on continuing its control of crime in the areas of firearm offences, drugs, and drug-related offences.

Economic Context

The Barbadian economy is small, open and market driven, with both the public and private sectors playing important roles meeting the needs of consumers. Since independence, the Barbadian economy has been transformed from an agricultural base to its present service driven status. The principal exports are tourism, financial services, sugar, rum, chemicals, electrical components, and light manufacturing. The principal imports are machinery, food and beverages, and construction materials. The USA, Canada, CARICOM, Japan, and the UK are Barbados' major trading partners. Barbados has its own currency, the "Barbados Dollar (BDS)" which is tied to the US dollar at 2:1 (BDS to US).

Several international economic developments are a cause for concern, these include, but are not limited to; trade liberalization, especially as they relate to arrangements between the European Union (EU) and the African, Caribbean, and Pacific (ACP) States, the initiatives on harmful tax competition taken by the Organization for

Economic Cooperation and Development (OECD), and the recession in the US, which has implications for the global economy.

Against the background of these developments, and constrained by soaring international commodity prices and weak economic performances of its major trading partners, growth of the Barbadian economy slowed to an estimated 1.3 percent during the first six months of 2008, well below the average first-half growth rate of 3.6 percent experienced during the preceding five years.

Barbados is a regional transport hub with non-stop daily flight services to destinations such as New York, Miami, Toronto, London, and the Caribbean. Further, the Grantley Adams International Airport is a central hub and air link for international air traffic in the Eastern Caribbean – 1.4 million passengers each year. The seaport is one of the most modern in the Eastern Caribbean, and will again be upgraded in the near future. There are regular cargo vessel sailings to North America, Europe, and the Caribbean. In addition, thousands of Cruise Ship passengers visit Barbados each month aboard a number of large luxury liners.

Unfortunately, the same factors that now drive Barbados' thriving economy are central to drug trafficking activity. A reliable and sophisticated communications system, an advanced transportation network, and a strategic geographical location put Barbados high on the list of ideal drug transit hubs.

Cultural Context

The dominant cultural practices are those that are derived from the island's English colonial/African past of enslavement. Alcohol consumption is deeply interwoven in the socialization process. For the poor, the traditional "rum shop" is where older men gather to bond; discuss politics, sports, business, and life in general, while drinking as much alcohol as they can handle in the spirit of competition. The rum shop is where many young men pass through their "rites of passage" to become men.

There are several annual festivals, the largest being the Crop Over Festival. Alcohol consumption is particularly open and prevalent during these events.

The Rastafarian religion and culture is popular among a growing number of youth. The religion traditionally promotes marijuana use as sacred, while denouncing cigarette smoking, alcohol consumption, cocaine and other drugs.

African American and Jamaican ghetto culture is also heavily influencing the fashion, music, and drug use and abuse habits of the youth.

History of Drug Demand Reduction, Harm Reduction and Community Empowerment in Barbados

Since the early 1990s, there has been a tremendous rise in the presence, misuse, and abuse of illegal drugs in Barbados. The Caribbean was identified by the U.S Drug Enforcement Agency (DEA) as a trans-shipment point for international drug dealers. The impact on Barbados meant that a national drug plan was needed to provide a strategy for institutions that were functioning solely to reduce and eliminate these problems.

The Government of Barbados acknowledged the severity of the predicament and began the process of developing a comprehensive national strategy. A new approach was required and this was to be achieved with limited funding. In 1990, the first Master Plan, "Against Drug Abuse - A National Approach" was approved as a policy document for demand reduction.

Early substance abuse initiatives included the Advisory Committee on Drugs (1985), the Psychiatric Hospital Drug Team (1986), the Drug Education Committee (1987) under the Ministry of Health, and the National Anti Narcotics Committee (1987). In 1991, the Government created the National Advisory Council on Drugs (NACD), which divided law enforcement, treatment and rehabilitation, and information and prevention strategies into sub-committees. There was a lack of capacity to implement realistic strategies, and this lead to a rethinking of the approach.

In attempting to reduce the level of legal and illegal drug abuse, the United Nations International Drug Control Programme's (UNDCP) Integrated Demand Reduction (IDER) project was initiated within the context of Barbados' National Drug Strategy.

The IDER approach sought to create an efficient delivery of services to the targeted population by use of a national framework. This framework augmented community empowerment as the social control that is identified often as the key link between education and treatment services. Hence, active participation of the communities in the NACD was of primary concern to develop *"a comprehensive and integrated response."* IDER projects operated in other Caribbean Islands and often involved the design and implementation of diverse projects by CBO's that met various community needs while tackling the drug problem both directly and indirectly.

In 1992, the Government drastically modified its previous top-down policy to reflect a "community empowerment approach." Communities were invited to submit proposals for funding and these were streamlined into policy. This was the start of active community representation. In April 1995, the three-year project entitled "**Assistance to the National Integrated Demand Reduction Programme**", was initiated and funded by the UNDCP and the Government of Barbados (Ministry of Home Affairs) to be managed by the NACD. This was the start of a tripartite programme of cooperation.

Project implementation and the coordination of participating organizations were executed by the National Drug Resource Centre (NDRC[1]). The NDRC was also the secretariat of the NACD and was housed at Trents, St. James. The NACD provided guidance and the policy framework of the NDRC. Under the instruction of the Minister of Home Affairs, the Honourable David Simmons, Q.C. M.P., the NACD was subsumed by the NCSA with the passage of the National Council on Substance Abuse Act 1995-13. This transition facilitated the rapid response that is necessary for an effective system of demand reduction. The lengthy bureaucratic procedures and limited capacity of the NACD proved inefficient. In addition, there was a need for some autonomy.

[1] It should be noted that the name National Drug Resource Centre (NDRC) was relinquished and the National Council on Substance Abuse adopted.

Achievements

The IDER strategy had six major expected end-of-project outcomes aimed at six main target groups. Below is a list of the outcomes.

- The establishment of the NCSA as a permanent administrative, coordinating and data resource centre with trained staff, coordinating and implementing an integrated strategy. The NCSA is currently located in the capital city, Bridgetown.
- A significant improvement in the knowledge and understanding of the drug abuse phenomenon in Barbados using Rapid Assessment Studies.
- The availability of trained peer counselors, educative materials and the establishment of anti-narcotics clubs in secondary schools.
- Demand reduction programmes based on socio-cultural economic activities, established within the six communities identified**.**
- The availability of trained community leaders with capabilities to perform early detection, to provide basic counseling and to assist in rehabilitation.
- Minimal progress in expanding treatment and rehabilitation through the provision of a rehabilitation programme at the island's prisons and the establishment of a half-way house.

The early years of the current decade were used by the NCSA to engage fully with the hemispheric demand and supply reduction initiatives of the Organization of American States (OAS). The NCSA is Barbados' focal point for ongoing work that is evaluated annually by the OAS' Multilateral Evaluation Mechanism (MEM) which tracks and reports on the progress of antidrug programmes by member nations.

More recently (2005-2006), the NCSA has emphasized the following programmes:

Key Population	Type of Programme	Number of participants
Primary 5–11 years old	Various drug education programmes on substance abuse to suit the specific target audience	6162
Primary 5–12 years old	‘‘Children Are People’’ prevention programme focusing on refusal and resiliency skills and healthy lifestyles	320
Primary 10–11 years old	Project S.O.F.T–‘Safeguarding Our Future Today’ is a one week residential camp dealing with drugs and other social issues relevant to adolescent youth	40
Primary 8–9 years old	After-school mentorship programme aimed at improving drug education and life skills	30
Secondary 12–18 years old	Drug education programmes focusing on drug awareness, decision making, healthy lifestyles and self-development	3888
Secondary 13–14 years old	Peer Support Programme –Trains young students to become peer helpers by giving them the skills and knowledge to develop helping relationships with their peers	200
Secondary 15–16 years old	Project X-Change –To empower and educate youth using peer- to-peer education to counteract violence and deviance with wholesome and positive activities	50
Secondary 14–16 years old	Guidance education with a focus on drug education	240
Community based programmes for adults	Drug awareness programmes that include: symposium on Substance Abuse and Violence, and Seminar on the Impact of Popular Music on Drug Use and Risky Behavior.	870
Community based programmes for adults	Various drug education programmes inclusive of parent education, re: drug use and programmes specific to the needs of the community	2112

Study on the Current Situation

Methodology

In order to assess the current situation in relation to previous drug demand and harm reduction surveys, focus group studies were conducted. These qualitative results will be discussed against the background of previous characterizations of the situation in order to assess if there have been any major changes. In addition, surveys of the programmes and policies in schools and other government and non-governmental institutions were also conducted to facilitate the comparison of their results with findings from earlier critical assessments. This information will also form the basis of a national programme to map existing services and their articulation.

Sample

Focus Groups

The focus group interviews were facilitated to glean information from respondents on drug use and the promotion of harm reduction practices. These sessions were conducted in September 2008 with groups of youth drawn from a cross section of organized programmes and institutions. These were as follows:

Voluntary Programmes

Barbados Vocational Training Board: Eight males (16 – 19 years) and 7 females (16 -22 years) presently being tutored at Sayers Court in Christ Church.

Barbados Youth Service: Five males (16 – 22 years) and seven females (16 – 22 years) drawn from the current population of male and female subjects enrolled within the Barbados Youth Service Group.

Pinelands Creative Workshop: Two females (16 – 22 years) and five females (23 – 29 years) drawn from current population of female subjects that participate in activities at The Pinelands Community Centre.

Delinquency Programmes

Edna Nicholls Centre: Seven males (11 – 15 years) and four females (12 years) currently attending the Edna Nicholls Centre in St. Peter.

Custodial institutions

Government Industrial School: Seven males (under 16 years), seven males (under 16 years), seven females (under 16 years) and eight females (under 16 years), all inmates of the Government Industrial School.

Her Majesty's Prisons: Four females (16 – 22years) and eight females (23 – 29 years); seven males (16-22 years) and seven males (23 – 29 years) respondents presently incarcerated at H.M.P. Dodds in St. Philip.

Treatment Programmes

Teen Challenge: Six males (16 – 22 years), five males (23 – 29 years) all of whom are inpatient clients of Teen Challenge Barbados.

Verdun House: Three males (16 – 22) and three males (23 – 29 years) all of whom are inpatient clients of Verdun House.

Schools

Thirty-one public secondary schools were surveyed. Nine schools responded.

Institutions

Thirty-two institutions were surveyed. Twenty-seven Government agencies and four-tertiary non-governmental organizations responded. Those institutions that directly or indirectly seek to reduce drug demand and the associated harms were targeted. These included community, Pan African and cultural groups.

Materials

Questionnaires were used to capture data from the Focus Groups and to survey the schools and institutions. The Focus Group questionnaire comprised 18 questions designed to capture information on drug use, problems with drug use and harm reduction promotion (See Appendix II). The school questionnaire consisted of 13 items which sought to investigate factors such as: drug education programmes, services and activities, as well as staffing and referral systems (See Appendix III). The questionnaire utilized within the governmental and non-governmental institutions

comprised 31 items and requested information regarding the following: the institutions' mandates, guiding legislation, efforts to reduce drug use and promote harm reduction, staffing, referral systems and need for improvements, just to name a few (See Appendix IV).

Procedure

The approach to the analysis of data for this RSA is one which acknowledges that:

- The quantitative data taken from existing studies could be challenged in terms of rigor, and in terms of their comparability with other studies and/or across time periods.

- The challenges to quantitative studies notwithstanding, useful information can be extracted and triangulated with both past studies, and the current qualitative data taken from focus groups with youth, institutions involved in demand reduction, and school administrators.

- In-depth analyses of the early studies cannot be performed because of differences in design but broad comparisons can be made.

Drug-related research has been conducted in Barbados since the 1990s, however, for the purposes of this report, studies from between 2000 and 2006 will be used to build a profile of the substance abuse situation in Barbados. This profile will then be used as a backdrop to evaluate the current situation, as captured through focus groups from several institutions. The types of demand reduction programmes needed should emerge from this analysis.

Results and Discussion

Nature and Extent of Drug Use

The characterization of the drug problem in Barbados as discussed below is drawn from the key findings and recommendations of several NCSA studies. These include:

- Drug and Alcohol Use in Barbados: Its Impact, Factors Related to Use, Available Resources, And Current Interventions. A Rapid Situation Assessment October 1999 to July 2000

- The study of **Drug Use among Arrestees (2002**) which sampled 430 males and females recently arrested. (International Arrestee Drug Abuse Monitoring Survey (I-ADAM)

- The Inter-American Uniform Drug Use Data System's (SIDUC**) Secondary School Survey (2002).**

- **The Global Youth Tobacco Survey (GYTS 2002)**

- The **Relationship between Substance Use and Criminal Behaviour among Juvenile Offenders: A Focus Assessment (2003)**.

- The **Estimation of Costs Attributable to Substance Abuse and Loss of Productivity for Inmates at Glendairy Prison (2004)**.

- The **Relationship between Drug Use and Risky Sexual Behaviour (2005)**, (which sampled 278 subjects either in custody or undergoing treatment)

- The **National Primary School Survey (2006)**.

- The **National Household Survey (2006)**.

- The Inter-American Uniform Drug Use Data System's (SIDUC) **Secondary School Survey, 2006)**, (which sampled 2,220 2nd, 4th and 5th form students from 23 schools).

In every study, Alcohol and Marijuana have been consistently found to be the most commonly used legal and illegal drugs respectively. The 2005 study conducted by the NCSA on the "Relationship Between Substance Abuse and Risky Sexual Behaviour" reported that regardless of age group, the pattern of legal drug use is consistent. Alcoholic drinks, were found to be the most frequently used legal drugs at the age of initiation, this included both "strong" (>6% by content) and "weak" (<6% by content) alcoholic beverages. In the case of strong alcoholic beverages (>6%), 58.8 percent of pre-teens, 62.1 percent of teenagers 13 to 16 years, and 64.3 percent of those who had their first drink later in life, were initiated using alcohol as a legal drug.

The same study reported that regardless of the initiation age for illegal drug usage, the drug first used by the vast majority (98.4%) of subjects was marijuana. Furthermore, the age of initiation for both, alcohol and marijuana was approximately 13 years. By age 16, almost 83 percent of the population studied had experimented with either legal or illegal drugs. This age pattern is seen across every measured demographic. For example, over four fifths (85.1%) of those confined in custodial settings, and more than three quarters (75.4%) of those in non-custodial care, had tried legal drugs by age sixteen. By that same age, more than 80 percent of both those in custodial settings (81.1%) and non-custodial care (84.7%) had already been introduced to illegal drugs.

The 2003 study on the "Relationship between Substance Use and Crime among Juvenile Offenders" found that the reasons behind drug use and eventual criminal behaviour may lie in the family and environmental conditions. Unfortunately, uninformed decisions often lead to circumstances that involve drug use, deviant acts, police contact and ultimately incarceration. According to the same study, juvenile delinquents are well versed in what is considered an illegal drug and what are judged to be criminal acts.

Furthermore, it also revealed that there exists a relationship between drug use and criminal activity among the juveniles, who themselves admit that drug use encourages criminal behaviour. Marijuana is reported as the preferred illegal drug among this group, with users indicating that it is taken to attain a high, as well as for medicinal purposes. There is a disdain for cocaine, as it was perceived by the youth to be dangerous and addictive. It is clear that they are aware of the destructive effects of using cocaine. They repeatedly noted that persons who use cocaine are more likely to behave aggressively and

commit violent acts. Alcohol, which is widely used, was also thought to contribute to criminal activity.

In addition, it should be noted that drug use is a significant part of the lifestyle of these youth. Over 92 percent (92.5%) or nine out of every 10 of the delinquents studied reported drug use, of these 80 percent use marijuana and 5 percent use cocaine. The combination of marijuana and alcohol use often leads to criminal and violent behaviour. These activities include fighting, gang warfare, robberies, stealing, making threats of violence and violent behaviour involving the use of weapons.

The findings of the National Primary School Survey reflect the high use of over the counter drugs among students ages 9 – 11 (82.8%) – for example, Panadol and cough syrup. The use of illicit drugs by these children is extremely low, with less than three percent of students reporting use of marijuana (2.8%), crack (1.1%) or cocaine (0.9%).

This study indicated that approximately one in every two children tries alcohol (49.3%) with alcohol use increasing with age. It was also found that alcohol use is more common among boys (53.4%) than girls (45.2%). Approximately one quarter (27.5%) of the students sniff "inhalants" in order to experience the narcotic effects.

Television is the main source of information on drugs (80%) for the students participating in the Primary School Survey. There is, however, a lower reported use of information by the students of the NCSA's Drug Education programme (68.6%) and the Royal Barbados Police Force DARE (Drug Abuse Resistance Education) programme (60.7%). The limited use of formal or informal peer-group discussions in primary schools regarding drugs should also be noted. Just under one half (48.3%) receive information on drugs from their friends.

According to the Primary School Survey student opinion is split over the number of times one can use drugs before becoming addicted. Just over four in every ten (44.1%) believe that drug addiction is possible even with occasional use; while 40.8 percent are of the view that one has to be a frequent drug user to become addicted. This confusion differs across age groups. More of the students under eleven years of age, as compared to those 11- years and older, believe that drugs must be taken numerous times before one can become addicted.

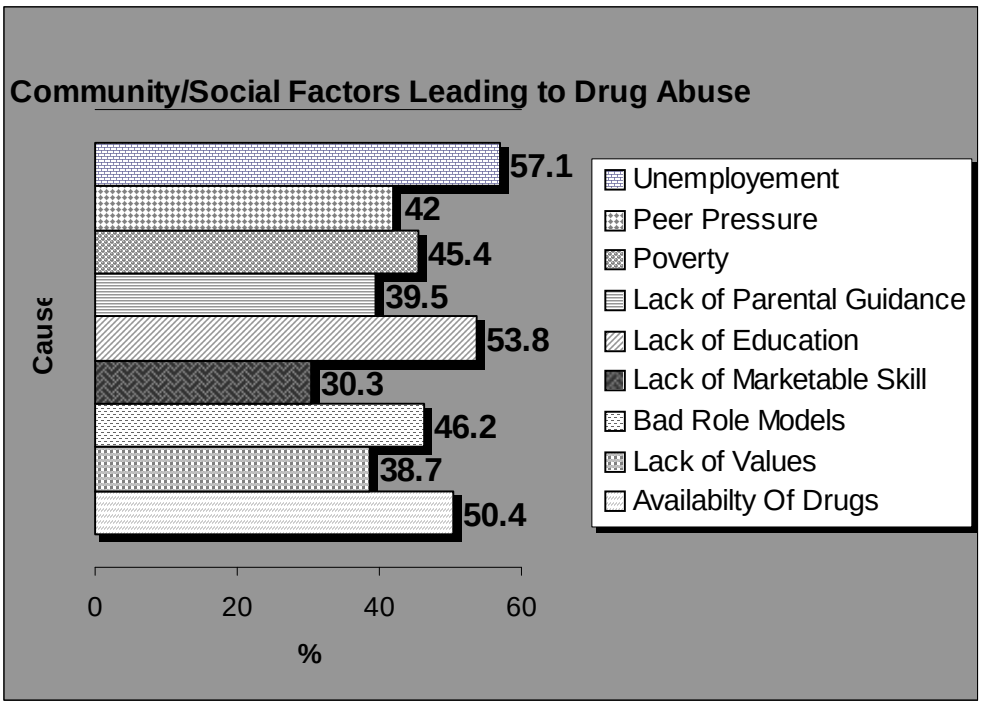
Information coming out of the Rapid Assessment Survey 2000 study (RASII) indicated that the majority of students felt that the problem of drug use in schools was getting worse. This same study also revealed that approximately 51.7 percent of the community-based key informants, 51.4 percent of the drug users and 72.2 percent of the out-of-school youth felt that drug usage in their communities had worsened over the past two years. The primary drug of choice was marijuana at 75 percent, alcohol at 19 percent was the legal drug of choice and cocaine was the drug of choice for a relatively small segment of the population at 6 percent. The use of heroin and others as choice drugs proved non-existent at the time of this study. An estimated 89 percent of students experimented with alcohol, and 50.7 percent of these had taken a drink within the past year. One–half of the students below the legal drinking age of 16 had drunk in the past year.

The Rapid Assessment Survey (RAS) II survey was conducted between October 1999 and July 2000. The methodology employed used the six communities from phase 1 (Pinelands; Deacons; Haynesville; Eden Lodge; Silver Hill; The City), plus an additional six communities (Sayers Court, Christ Church; Ellerton, St. George; Redman's Village, St. Thomas; Belleplaine, St. Andrew; Bayville, St. Michael; Maynard's, St. Peter). Secondary data from the first study, that is, RASI, were used while primary data were collected from various groups, some of which included national and community key informants, drug users and pushers, out-of-school youth, participants in the community projects and student focus group discussions.

These analyses have indicated several concerns, including the fact that: 50 percent of the participants in the community projects knew where to buy drugs; and there was an absence of any affiliation with some type of organization by 74.1 percent of drug users and 73 percent of out-of-school youth.

On average, marijuana users spent BDS$81.00 a week on drugs as compared to BDS$140.00 in the previous RAS. The average amount spent by cocaine users was BDS$229.00, more than double the amount spent on any other drug. The primary source for money came from salaries, followed by families and friends. Only a small percentage of persons admitted to using illegal means such as stealing and prostitution.

As for the reasons why persons who used drugs continued to use, it was found that the type of drug used influenced the results. Cocaine users suggested addiction, marijuana users suggested relaxation and meditation, while alcohol drinkers said they just enjoyed



the feeling. These differences were also reflected in the desire to quit. Forty-eight percent of the entire sample had no desire to quit in the past year, seven out of ten cocaine users (70%) continuously contemplated quitting as compared to 19.4 percent for marijuana and 39.6 percent for alcohol.

The RAS 2000 study also revealed that "approximately 22 percent of the students surveyed had experimented with illegal drugs at some point. There was a significant age related trend for users increasing from a low of 0.8 percent in persons 10-12 years old to 9.1 percent in persons 13-15 years old and even further to 15.8 percent in students 16 years and older. Those in the oldest group were 22 times more likely to have smoked than those in the youngest group".

Possible influences on student usage were looked at in both the Youth Survey (SIDUC 2002) and Global Youth Tobacco Survey (GYTS 2002), and a significant association was observed between parental drinking, drug use and subsequent use by the adolescents.

Students with a parent who had a drug problem were 2-3 times more likely to drink and smoke.

When compared to persons who refrained from substance abuse, persons who smoked cigarettes were nine times more likely to have smoked marijuana, and persons who drank alcohol were ten times more likely to have smoked marijuana. This was clear evidence of the need to incorporate alcohol and cigarettes in all prevention education programmes. These programmes should commence at primary school level, when children are most likely to take their first drink.

Other highly-affected groups included young males, and persons from lower socio-economic areas where social factors such as selling and usage are observed on a daily basis.

Harms Associated with Drug Use

The study on the Relationship between Drug Use and Risky Sexual Behaviour was conducted in 2005 and focused on persons either in custody or undergoing treatment. This study was able to scientifically document the widely held belief that many drug users involve themselves in high-risk behaviour, especially high risk sexual activities. The Barbadian population is among the top ten countries in the Commonwealth Caribbean mostly affected by HIV and AIDS. The first two AIDS cases were reported in 1984, and by 1996 the cumulative total of reported cases was 762, increasing to 1,425 by June 2001 in a population of approximately 270,000 persons. By that date also, the cumulative total of persons who had tested positive for HIV was 2,474 and the number of persons who had died of AIDS was 1,111.

In 1985, the Advisory Council on the Misuse of Drugs (ACMD) stated: "The spread of HIV is a greater danger to individual and public health than drug misuse". Accordingly, we believe that services which aim to minimize HIV risk behaviour by all available means should take precedence in development plans. The report goes on to say that "there needs to be changes in professional and public attitudes to drug misuse and that we must be prepared to work with those who continue to misuse drugs." Not to do so would "have a major effect on ability to contain the spread of HIV".

The HIV epidemic in the Caribbean is associated with high-risk sexual behaviours, such as early initiation of sexual activity, multiple sexual partners, other risky sexual behaviours, as well as drug abuse. Youth may become particularly vulnerable to HIV infection through impaired judgment and unprotected sex that could follow moments of clouded consciousness associated with drug and alcohol abuse.

A critical portion of the assessment of the patient who uses illegal drugs is a determination of the immediate and long-term drug use – related risks he or she may face. HIV infection is particularly important in this regard. It is important to note that for many drug users, sexual acquisition of HIV infection is every bit as much of a threat as needle-borne acquisition. However, in the Caribbean, transmission by contaminated injection equipment is not reported to be common.

The use of crack cocaine is an important indicator of risk for HIV infection through its association with unsafe sexual behaviour. Crack smokers were shown to have prevalence levels of HIV infection as high as those of drug injectors, reported due to both the frequency and the high risk of their sexual encounters.

Due to the inhibiting effects of many drugs, the stimulant effects of others, and the relationship of drug procurement to risky sexual behaviour, drug use is linked to HIV infection in many ways other than needle use. For the patients, who are known to be HIV negative in the past, or for those unaware of their infection status, drug use and sexual practices must be explored.

The high prevalence of HIV is therefore linked to a transfer of fluid, either through sexual behaviour or through the use of unclean needles. Drug users are therefore at a high risk of contracting HIV either through their habits or through their behaviour. Thus, it is necessary to also investigate the at-risk behaviour of persons living with HIV. The 'high risk behaviour' is defined as the use of drugs through the exchange of needles and unprotected sex**.**

The use of licit and illicit drugs in Barbados and the expense of maintaining a constant supply of drugs can mean that theft and prostitution are often used to finance a habit. This brings drug users constantly into contact with the criminal justice system.

According to the 2003 study of the Relationship between Substance Use and Criminal Behaviour among Juvenile Offenders, this link between drug use and risky sexual behaviour is more pronounced among persons who were involved in exchanging drugs for sex, who never used condoms or were inconsistent in condom use, had multiple sexual partners, used legal and illegal drugs, had sexual partners who used legal and illegal drugs and were opposed to using or did not like using condoms.

There is a high incidence of promiscuous sexual activity particularly in the areas of multiple sexual partners and inconsistent condom use. Although eight in ten persons have already had sex by the age of sixteen, it is the associated behaviours in these areas that provide some cause for concern, primarily:

Forty-five percent (45%), particularly males in the under 45 age category admit to having multiple sexual partners. Alarmingly, among the 18-25 age group, this is the case for 2 out of every 3 persons (66.7%). Three out of every four sexually active people practice unprotected sex, either frequently or infrequently. The incidence of this practice is particularly high among the 18-25 age demographic. People who use drugs with sex are six times more likely to be involved in drugs-for-sex exchanges (30.8% versus 5.0%).

Close to 90 percent of those using drugs with sex either never use or are inconsistent in their condom use as compared to over 61 percent (61.6%) of those who did not. Just under half of these people have multiple sex partners as compared to 31 percent (31.0%) of those who do not practice this habit. Eight in ten have sexual partners who used legal drugs and close to three quarters of partners also use illegal drugs. Significantly higher proportions of sex with drugs users are opposed to using or do not like using condoms (57.4% vs. 38.4%).

Data from the Youth Health Survey reveal that 2.2 percent of the students surveyed suffered an accident or injury because of drinking or using drugs, and 1.7 percent had suffered from some other health problem.

Information from Tamarind House, the Drug Rehabilitation Unit of the Psychiatric Hospital, stated that between the years 1996-1998, of the 1207 admissions, 36 percent was for marijuana, 28 percent for alcohol, and 10 percent for cocaine. Additionally, 27 percent were treated for poly-drug abuse. Estimates from Teen Challenge placed the

percentage of admissions due to cocaine at about 70 percent. The ages of persons treated at the Drug Unit ranged from mid-adolescence to 65 years. One of every two admissions (50 %) was someone between the ages of 20 - 34 and 29.6 percent were in the 35-44 age ranges. The age-related results at Tamarind House pertaining to alcohol indicated that 44 percent were between 35 - 44, 36 percent between 45 - 64; 13.4 percent were for persons less than 35.

The statistics for marijuana-related problems indicated that over two-thirds (69.5 %) were experienced by people between the ages of 20-34 years and another 14.9 percent by people less than 20 years. Less than one of every ten (6 %) marijuana-related clients were over 35 years. As with marijuana, two of every three (64.7%) admissions for cocaine-related problems related to people 20-34 years. The second largest group (31.9 %) was people between the ages of 35-44 years.

At the Drug Rehab Unit for the period 1996-1998, 71 females were treated, 52.1 percent for alcohol, over 15 percent (15.5%) for marijuana, more than 5 percent (5.6%) for cocaine and just over one quarter (26.8%) for poly-drug use. This accounted for only 11 percent of alcohol-related admissions, just fewer than 3 percent (2.6%) for marijuana admissions, just over 3 percent (3.4%) for cocaine admissions and almost 6 percent (5.9%) for poly-drug admissions.

In 2005, the Drug Rehab Unit had ten new patients, eight men and two women. Overall, total admissions were 26 men and two women.

Substance Abuse and Delinquency

While the causal connection of drugs and alcohol to criminal behavior is complex, crimes of violence consistently show relationships with the use of these substances as found in the research on the 2002 study of Drug Use among Arrestees. Drug users report frequent fights between users and pushers. Key informants report cases of burglary, theft and shoplifting (57.1%), and prostitution (43.7%). This study also revealed that 17 (1%) students were confronted by police for drugs and/or alcohol, while 51 (3%) students had at some time become violent while using alcohol and/or drugs.

Prison officials estimate that perennially, from 45 - 55 percent of all admissions to the prison is the result of drug-related cases, such as possession, selling and trafficking. In

addition, upon further counseling of inmates, it is believed that due to the abuse of drugs, an estimated 80 percent, or 4 out of every 5 incarcerations involve drugs in some capacity. This was supported by a 1997 study of Criminal Risk Factors among Prison Inmates, where illicit drug use emerged as the single most significant correlation to criminal behaviour and imprisonment. Of those that were interviewed, 23.4 percent reported that the main reason for committing crimes was to support a drug habit, while 4.7 percent revealed that it was due to the psychoactive effect of drugs and/or alcohol. 86 percent of the men in that study used illicit drugs with one-half of those being marijuana users and 42.6 percent poly-drug or cocaine users. This was expected to continue and increase without a proper system of treatment and rehabilitation.

Statistics from the Royal Barbados Police Force (RBPF) indicate that between 1992 and 1998, the number of drug cases more than doubled from 500 to 1094. The majority was attributed to marijuana, measuring an increase from 319 in 1992 to a maximum of 818 in 1998. Cases brought for trafficking increased by 261 percent during the same period. The number of cases that involved cocaine increased by 11 percent. The demographics indicated that males accounted for over 80 percent of all cases.

Comparison of Barbados' Drugs Profile with 2008 Focus Group Results

The focus group results confirm to a large extent the foregoing drugs profile of Barbados.

Dominant Drugs

The focus groups revealed that alcohol and marijuana were the most prevalent drugs tried, being used or known to the focus groups. The participants overwhelmingly indentified alcohol and marijuana as their drugs of choice. Some did not even consider these substances to be drugs. Very few considered using or used crack cocaine, ecstasy or pills. Inhalants were never mentioned.

Drug Awareness Education

Most of the focus group participants received some level of drug awareness education either at the primary school level, through the media, from the NCSA, or through their current programmes.

Reasons for Drug Use

Some young people who participated in the focus groups reported that they tried or use drugs for comfort, to alleviate boredom, to relieve stress or to relax and meditate,

to enhance sex, to retaliate, through peer pressure or on their own volition, as a result of seeing friends indulge, being unemployed, through curiosity, through intrigue developed from discussions during incarceration about how drugs make you feel, for religious purposes, and for entertainment. In the case of marijuana, its low cost and easy availability were also given as reasons.

Perceptions of Harm

Participants considered drugs other than marijuana such as cocaine, crack cocaine and ecstasy as "dope," a coded term for a "harmful drug." Crack cocaine is spoken of as an especially serious drug that is avoided by the youth since they have witnessed crack addicts becoming "paros."[2] There also appears to be a cautious approach to mixing marijuana and alcohol, cocaine and marijuana or experimenting with other mixtures which may also include horse hair or prescription pills. Though prescription pills were not called "dope," it was generally felt that they were dangerous. Mixtures with energy drinks, most of which contain caffeine, were also mentioned.

Some participants displayed a broad and in-depth knowledge of the legal and illegal drugs and their forms of use and abuse, but this was not matched by a symmetrical and equally broad and deep understanding of the possible harm. The harmful effects were usually couched in vague terms and the use of slang.

There is some skepticism about the damage that can be caused by marijuana. In the case of alcohol, it would appear that participants viewed harm to be associated with extreme and frequent use or alcoholism. Most did not consider themselves to be alcoholics or addicted to any other drug. The research highlights a strong relationship between parental and home use of alcohol and marijuana and strongly held beliefs that marijuana and alcohol are not drugs.

Encouragingly, focus group participants often reported that they would discourage the use of drugs by younger members of their families and included cigarettes in this list.

[2] "Paro" (an abbreviation for paranoid) is a local term for a drug addict, more often than not homeless, impoverished, desperate and willing to beg or commit petty crimes for money to purchase drugs.

Challenges and Barriers to Success

The following critical assessment of the drug demand reduction situation in Barbados was prepared after several meetings in 2001 with the following experts:

Paulavette Atkinson	Programme Officer, National Council on Substance Abuse
Victoria Beecher	Clinical Director, Verdun House
Dr. Ermine Belle	Senior Consultant Psychiatrist, The Psychiatric Hospital
Tessa Chaderton-Shaw	Manager, National Council on Substance Abuse
Pernell Clarke & Sean Daniel	Research Officers, National Council on Substance Abuse
Cheryl Corbin	Project Officer, Forensic Sciences Centre
Danny Gill	Former Chairman, National Council on Substance Abuse
Wendy Green	Consultant, Community Asset Development Consultants
Wendy Greenidge	Drug Education Officer, National Council on Substance Abuse
Edwin Harewood	Assistant Comptroller, Customs and Excise Department
Maryam Hinds	Director, Barbados Drug Service
Ishmael Morris	Deputy Manager, National Council on Substance Abuse
Deryck Murray	Consultant, Community Asset Development Consultants
Desmond Sands	Senior Analyst, Anti-Money Laundering Authority
Cheryl Willoughby	Community Programme Officer, National Council on Substance Abuse

The following areas were found to be of concern at the beginning of this decade.

Health

There was a need to develop a public health prevention policy that targets the entire family and recognizes addiction as a health-related issue, and to inform the development of specific prevention programmes that emphasize health. Existing facilities and resources needed to be fully utilised while optimising the design and implementation of new programmes. For example, various governmental institutions that fall under the Ministry of Health can assist in the delivery of drug prevention services. Although there were resource persons available at the QEH and the Psychiatric Hospital, as well as community health nurses at the polyclinics, a challenge was presented by the fact that health professionals have minimal experience in drug prevention.

A lack of communication on the nature of available programs and resources was a severe planning constraint. It was therefore important to implement ongoing strategies, and set up systems that facilitate the development of a register of available human and other resources, and to promote closer inter-agency coordination.

Formal Education

Guidance counselors in secondary schools delivered some drug prevention education formally, and resource persons from the Psychiatric Hospital provided limited training. In addition, Drug Education was one component of the Health and Family Life Education (HFLE) programme currently being phased into the primary school curriculum. Officers from the RBPF also facilitated the Drug Abuse Resistance Education (DARE) programme in some primary schools on a very limited scale.

At the time, the drug prevention education offered by the NCSA at the primary, secondary, and tertiary levels was not regarded as a primary component in student development. As a result, very limited time was allocated to deal with the subject as part of the curriculum. It was thought that a method of integrating drug prevention issues into the curriculum should be developed. Students would have been assessed based on their knowledge of drug abuse and credited accordingly.

Few opportunities for drug addiction training were available to resource persons who could teach drug prevention. This contributed to the lack of expertise and the limited

number of available resource persons. It would have been necessary to create an awareness of the issues involved by those responsible for formal training. Training programmes were especially needed for specialization in the field of substance abuse prevention for various target groups, for example, those who interact with persons at risk.

Informal Education

From time to time, NGOs, churches, and other groups utilized trained drug prevention resource personnel from various agencies. They made direct contact with members of the various groups and used didactic material that has high visual impact. Unfortunately, the material, its graphics and its delivery were not always relevant to the local population. In addition, support mechanisms were needed for those who were trained as peer supporters.

There was a lack of will to place anti-drug materials and displays in all areas where people congregate and are at risk, for example, bars, nightclubs, and beaches.

Awareness Campaigns

There was a need to coordinate awareness efforts by an umbrella body to be more effective. The awareness campaigns were generally under-financed, lacked trained personnel, and suffered from poor communication and networking. The early campaigns included those by NGOs such as Citizens against Narcotics (CAN) that focused on illegal drugs and became less prominent by the beginning of this decade, and the National Committee for the Prevention of Alcoholism and Drug Dependency (NCPADD) which is still promoting the introduction of the Breathalyzer test in Barbados. There was also a sustained anti-tobacco awareness programme by various agencies. However, there was insufficient information, even with this narrow focus. The base of information needed to be broadened to deal with all addictive drugs.

Awareness campaigns in relation to treatment and rehabilitation were inadequate and rarely reached or involved the target groups in question. Existing programmes needed strengthening and adapting to adequately meet the needs of all the target populations, including the youth. The use of positive role models coupled with the use of recovering addicts with lengthy “clean time” needed to be employed.

Key Populations

Community programmes often lacked trained personnel and failed to attract "at risk" groups. The government's community centres were not fully accessible and closed at specific times. Vigorous drug awareness programmes needed to be developed in all institutions. Vulnerable persons also needed to be motivated.

Assessment and Referral

Several programmes already provided some level of assessment and/or referral. These included:

- Alcoholics Anonymous (AA)/Narcotics Anonymous (NA)
- Centre for Counseling and Addiction Support Alternatives (CASA)
- Churches
- Counselors and Therapists (Private)
- Division of Youth Affairs
- Family services (Probation Department)
- Family programmes (Royal Barbados Police Force)
- Guidance Counselors at schools
- Juvenile Liaison Scheme (RBPF)
- NCSA
- National Committee for the Prevention of Alcoholism and Drug Dependency (NCPADD)
- Medical practitioners
- Parent Education for Development in Barbados (PAREDOS)

- Royal Barbados Police Force (RBPF)
- Polyclinics
- Detox Unit at Psychiatric Hospital
- Teen Challenge
- Verdun House

Referrals and assessment were hampered by the lack of inter-agency coordination. Training was thought to be a high priority to build capacity at both the professional and volunteer level.

It was believed that the delivery of referral services was best carried out by an agency with some autonomy and supplemented by the network providing information on treatment services that are available to the community. A system for adequate follow-up needed to be developed. Of top priority were the development of an assessment system for coordination of referral services and the standardization of referral instruments.

Full psychological and medical screening was only accessible for clients at the Drug Rehabilitation Unit and this vital service needed to be offered at all treatment and rehabilitation facilities. It was imperative, therefore, that each client would receive a full psychological and medical screening and follow-up during the assessment process.

At the time, it was proposed that consideration be given to ensuring that reciprocal referrals are made at an inter-regional level. It was clear that enabling legislation would have been necessary to address fully the above concerns.

Current Challenges and Barriers

Challenges and Barriers identified during the November 2008 Consultation

This RSA benefitted from a national consultation held in November 2008. The following experts presented and responded to several queries from the participants.

Institution	Name	Presentation Topic
The Psychiatric Hospital	Dr. Ermine Belle (Senior Consultant Psychiatrist)	"To what extent do approaches to health and general well being reflect the principles of harm reduction?"
VCT Unit, Edgar Cochrane Polyclinic	Mr. Shawn Springer	"To what extent are current approaches to reducing risks associated with HIV transmission compatible with the principles of harm reduction?"
The Psychiatric Hospital	Dr. Ermine Belle (Consultant Psychiatrist)	"To what extent do current approaches to drug treatment in Barbados reflect the principles of harm reduction?"
Judiciary	Justice Faith Marshall-Harris	"Approaches to the Sentencing of Drug Users within the Criminal Justice System"
Royal Barbados Police Force	Inspector John Boyce	"Current Approaches to Drug Education within the Royal Barbados Police Force: Implications for Harm Reduction"
Government Industrial Schools	Mr. Erwin Leacock (Principal)	"Current Approaches to Juvenile Reform: Implications for Drug Education"
The Barbados Vocational Training Board	Mr. Raphael Cave (Director)	"The potential impact of drug use on vocational training."
NCSA	Ms. Paulavette Atkinson	"Discuss the community approaches to drug education and harm reduction."
Barbados Association of Principals of Public Secondary Schools	Mr. Matthew Farley (Public Relations Officer)	"Facing the Challenges of Drug Use in Schools: The Need For a Comprehensive Referral System"

Even though the NCSA has made great strides in the areas of research, informal education and public awareness, many of the challenges and barriers identified in 2001 are still of concern in 2008. This was a key point coming out of high level discussions during the development of the National Antidrug Plan. Several other issues surrounding health, formal and informal education, and awareness campaigns were identified and comprehensive solutions proposed in the draft Barbados National Antidrug Plan.

The failure of successive administrations to enact legislation, which would address issues identified by various research studies, and the perceived inadequacy of the resources provided, by the same administrations to implement and or sustain important programmes leads to frustration. This frustration has been expressed by several, including Mr. Maurice Foster, a longstanding nationally recognized anti-alcohol activist, and former Board member, who has sought tangible support to fight the glamorization of alcohol for at least twenty years. Ms. Paulavette Atkinson, Programme Officer, of the NCSA also noted that the challenges are essentially the

same and this is why she preferred the tried and tested IDER approach by involving the community in its own demand reduction programmes using activities that interest people.

Marijuana, identified as the drug of first choice, legal or illegal, by Mr. Raphael Cave is still prevalent among the young people being trained at his institution. Mr. Cave noted that he did not receive any significant reports of alcohol use among the young people but that it was more prevalent among staff. Mr. Mathew Farley, Principal of the Garrison Secondary School, cited the accessibility to drugs in and surrounding the school, a lack of awareness of the manifestations of drug use such as absenteeism, persistent unpunctuality, sleepiness, tiredness, red eyes, gambling and aggression and spoke of the challenges in detection. He pointed to several technical issues surrounding searching, securing the substance if found, drug testing, and parental support. A referral system with clear procedures and front line agencies, whose roles are clear and rationalized, was thought by Mr. Farley to be an absolute necessity. He also felt that parents should be held accountable.

It is clear that there has not been much change since 2001 in terms of the incidence of alcohol and marijuana use, the main concerns surrounding their use and abuse, and the proposed solutions. All participants agreed that an integrated approach was needed and this was reflected in the diversity of stakeholders at the two-day national consultation held to disseminate the findings of this report. Magistrate Faith Marshall-Harris spoke of the need to create the special legislation needed to implement a Drug Treatment Court. She outlined the non-punitive and rehabilitative benefits of a well functioning Drug Treatment Court with supporting programmes but noted that in the absence of special legislation, Court Officers apply the concept at their discretion. Mr. Erwin Leacock, Principal of the Government Industrial School, a detention centre for young offenders, agrees that alternatives to custody and early intervention are critical. An education that enables young people to make decisions according to consequences is important. He also sees the need for collaboration, emphasizing parental responsibility and a comprehensive overhaul of the legislation dealing with reform.

HARM REDUCTION: The major new approach discussed was the concept of harm reduction. This concept was able to provide participants with a mental framework that coalesced several, seemingly divergent or fragmented activities under a single rubric. Community programmes such as the "Poverty Alleviation Intervention", by the Pinelands Creative Workshop in Nelson Street, and other such community-based programmes as previously supported by the NCSA under its IDER initiative, could now be viewed as having the same goal as the Drug Treatment Court, the HIV/AIDS awareness drive – viewed as harm reduction by Mr. Shawn Springer – and the bio-psycho-social approach as pointed out by Dr. Ermine Belle.

Importantly, Dr. Belle noted that even though harm reduction has been practiced informally in these various ways, it is now time to formalize the approach and allow it to become second nature. This message resonated with the proposal of the Research Officer of the NCSA, Mr. Jonathan Yearwood, to develop a comprehensive harm reduction model. Both the RBPF and Mr. Farley, however, cautioned that the concept of harm reduction should not send mixed messages. Further, Inspector John Boyce of the RBPF pointed out that harm reduction and zero tolerance were at variance.

Current Challenges and Barriers to Issues Identified by Schools and Institutions

Schools

The following results are based on the responses of only 9 of the 31 (29%) secondary schools within the island. Given the low response rate it is suggested that caution be exercised when interpreting the upcoming statistics.

Barbados' secondary schools generally provide basic education on drugs and drug use (88.9%) and life skills education (77.8%). Counseling on substance abuse is provided by 66.7 percent of those responding. The identical percentage (66.7%) of respondents also had programmes which provide education on the harms associated with substance abuse. The fact that the percentages are the same (66.7%) for responses, suggest that the same person(s) are delivering the same programme(s).This suggest a very heavy reliance on the drug education officers of the NCSA to deliver the programmes that are specifically focused on drug education. Unfortunately,

only1 percent of the respondents linked drug use and HIV/AIDS awareness, an important, even if indirect, harm associated with the high prevalence of sexual activity while drunk or under the influence of other drugs.

It would appear that most of the education on drugs forms part of the general curriculum of the Guidance Counselor who delivers the majority of schools' drugs programme (88.9%). This figure of 88.9 percent is also the number of schools reporting basic education on drugs. Teachers are used less often (44.4%) but are used the same amount as Peer Supporters. Religious educators deliver this information even less (22.2%). Recovering addicts, Clinic Nurses, Mentors, and visits to the Psychiatric Hospital are used marginally (11.1%).

Males and females are generally treated the same as reported by 77.8% of the schools, while age group targeting was done by just under half (44.4%) the schools. This approach seems appropriate since the drugs profile did not show any significant difference between male and female students, while pre-teens for the most part have still not been initiated into frequent drug use. On the other hand, consideration must be given to the unique socio-cultural circumstances of males and females of all ages and perhaps closer attention needs to be paid to the reasons given by male and female youth for using drugs.

Too few schools (55.6%) implement programmes that are supported by needs assessment or local research. Of these, only 44.4 percent update their programmes based on the latest research. Furthermore, only 44.4 percent of the respondents evaluate their drug education programme. Of these, only 11.1 percent do this twice a year and 22.2 percent once a year. Only 22.2 percent of these evaluations involve students. It would appear however, that those schools (44.4%) that are able to conduct evaluations do incorporate the results into their programmes.

Schools for the most part (22.2%) do not involve students in the development and design of drug education programmes. Of those who do, half use focus groups and half use questionnaires.

The staff at schools was most often trained in general drug use information (55.6%) and HIV/AIDS and its prevention (66.7%). There has been very little training in harm reduction, approaches to prevention, or communication and motivation. Even where staff is trained, it does not appear as though this training was part of any ongoing systematic programme.

All of the schools queried have implemented referral systems with referrals going to CASA (55.6%), the Guidance Counselor (44.4%), a medical practitioner (22.2%), the Psychiatric Hospital (11.1%), the Edna Nicholls Centre (11.1%), the Juvenile Liaison Scheme (22.2%), the NCSA (11.1%), Drug Education and Counseling Services (22.2%), the Probation Department (11.1%), and the Adolescent Clinic – Psychiatric Hospital (11.1%). An overwhelming number of schools (89.9%) noted, however, that there is need for improvement of the referral system. The schools did not generally state what improvements were needed, but the following suggestions were received:

- A named practitioner who is versed with managing persons who abuse drugs.
- Better post-referral communications and strategies.
- Documentation and clarification of roles.
- More direct involvement by agencies.
- Once students have been tested and proven to be drug users, attendance should be mandatory – too often students attend one or two sessions and do not return because it is voluntary.
- Strategies to expedite the process.
- Students' attendance should be compulsory.
- There needs to be more feedback on the outcome of counseling from CASA to the school.
- Need to involve families.

- Reduce cost.
- Urgent need for a boarding facility for the rehabilitation of school students.

It seems as though all of the schools with drug education programmes (66.7%) also felt the need for improvements to the programmes; hence the following recommendations were made:

- A structured system that exposes each student to a fixed number of hours of drug education.
- Drug awareness programme currently targets mainly fourth formers, There should be a wider spread throughout the school,
- Make them more student-friendly and more interactive.
- More training for staff; more drug education materials; more support for social service organizations responsible for drug education and counseling.
- The way the programme is presented, for example, refrain from lecturing. Need for highly interactive presentations.
- There is a need for more Health and Family Life Education (HFLE) teachers who are trained in the delivery of drug education.
- Greater emphasis on recovering addicts to dispel myths students have about drug use. Students are not always convinced of the dangers when presented in class.

Institutions

Twenty five (25) government and non-governmental organizations were surveyed. In several cases, where there were Yes or No answers required, no answers were given. These omissions are interpreted as "No" for the purposes of this analysis.

Of the 13 government agencies surveyed, 12 have guiding legislation, while 11 have mandates as well. Slightly more than half of them (54%) believe this legislation to be

effective. Almost all (89%) felt that there was a need for improvements to their legislation. All organizations to whom it was applicable believed that their drug-related programmes were effective; even though 95 percent acknowledged the need for improvements in the following areas:

- Training for staff, employers and counselors.
- Public education and awareness messages.
- Targeting of preteens and teenagers.
- Use of the arts and culture to target children.
- Quality assurance monitoring.
- Increased number of support groups.

In terms of improving legislation, the following considerations, facilities and programmes were suggested:

- Mandatory introduction of after-care facilities.
- Establishment of halfway house for recovering addicts.
- Establishment of a hostel for drug vagrants.
- Prosecution of persons driving under the influence.
- Synchronization of efforts across the Civil Service.
- Mandatory attendance of parents at counseling.
- A day programme for adolescents on suspension from school.
- Establishment of a short term (10 day) detox centre for adolescents.
- Mandatory drug education from primary to tertiary.

- Court sanctions to drug offenders should include rehabilitation and follow-up support after discharge from treatment centres.

The non-governmental organizations generally do not have guiding legislation.

Of those with either guiding legislation or mandates only 36 percent have programmes which specifically address efforts to reduce drug use. An even smaller percentage, 32 percent, currently have programmes which seek to reduce harm. Just under a third, some thirty two percent (32%) have written strategic plans that focus on drug use reduction, and less than one fifth (16%) have strategic plans that outline an approach to reducing harm.

Thirty six percent of the institutions have mandates that target youth 12 to 29 years. A similar number of organizations target persons over 29 years but fewer organizations attempt to reach youth under 12 years old (24%). 40 percent of these organizations address substance abuse while 44 percent, the most targeted group, seek to assist persons below the poverty line, one of the root causes of substance abuse.

Twenty percent provide vocational training and 12 percent assist with job placement. In view of the fact that the youth identified unemployment as a factor in becoming involved in drug abuse, there is a likely a need for more employment programmes.

Nearly half of the organizations are mandated to provide counseling, while only 24 percent deliver drug education. This low figure could be caused by respondents conflating counseling and drug education, but in any case, it suggests a lack of the provision of this specialized training.

In terms of those organizations without guiding legislation or mandates the population groups were targeted evenly so that one third of the agencies dealt with youth ages 12 - 29, those under 12 and those over 29. As with those with legislation or mandates, a similarly high number dealt with poverty alleviation (40%). Only 24 percent, however, dealt with substance abuse. Twenty-four percent also addressed persons living with HIV and AIDS. Nearly one third of these agencies include harm reduction in their broad mission but only 16 percent actually have strategic plans.

Efforts to reduce drug use are pursued by fewer organizations with hardly any having a strategic plan (4%).

Nearly all of the organizations (84%) engage in efforts to reduce drug use whether or not it is part of their legislation, mandate or broad aims by providing mainly counseling services (64%) and workshops (64%) targeting young drug users (56%), youth in general (60%), men (44%), women (40%), persons living with HIV and AIDS (40%), drug using minorities (32%), drug users from the subculture (24%), and migrants who use drugs and sex workers (16% each). None of the institutions targeted methamphetamine users. This may be because there are no reports of such users in Barbados.

Importantly, a large number of agencies attempt to reduce the harms associated with drug use (72%) mainly through counseling (64%), information on sexual and reproductive rights and health (52%), outreach and peer services (44%), and tests for HIV prevention. 28 percent did tests for HIV, 16 percent gave vaccination against hepatitis A and B and 12 percent provided information on chaotic drug use.

Less than a quarter (24%) of the respondents offered different programmes for males and females, while about 40 percent catered differently to age groups.

Fewer than half of the organizations base their drugs-related programmes on needs assessment or local research while 40 percent conduct evaluations. Of those that do conduct evaluations, only 16 percent perform them once a year while 30 percent seek to involve the service users. A further 32 percent indicated that they evaluated at irregular or long intervals. 40 percent incorporated the results of the evaluations into the services.

Very few organizations (16%) involve users in the development and design process of services and programmes. Those that did used individual interviews to get input.

Just over half (52%) of the agencies monitor the changes that occur with respect to drug use in Barbados with 40 percent of these updating their programmes based on the latest findings.

A large number of organizations have staff trained in HIV and AIDS and their prevention, communication and motivational interviewing skills as well as on drug use (all over 60%). Many have staff trained in human rights principles, stigma and discrimination and harm reduction (all between 40-60%). Few organizations have staff trained in drug overdose, hepatitis prevention and treatment, and on the use of paraphernalia used in drug-taking behaviour. Training was irregular in most organizations (40%), but a few provided training once a year (32%) with even less just giving training on initial entry into the organization (16%).

A large number of agencies (72%) use volunteers. Volunteers are mostly trained in HIV/AIDS awareness and HIV prevention (36%). Fewer provided training in communication and motivational interviewing skills (20%), human rights principles (24%), stigma and discrimination (24%), harm reduction (16%), and drug use (20%). Only 4 percent trained in overdose response techniques and none were trained in hepatitis prevention and treatment. The training was, however, most irregular.

Just fewer than half (44%) of the responding organizations operate from the perspective that the reduction of drug-related harms is a more feasible option than eliminating drug use entirely, while the majority (68%) will help those who seek to moderate or reduce their drug use.

Most institutions engage in referrals (60%), counseling and in providing information on harms associated with drug use (48% each). Many also provide information on HIV prevention, treatment and life with HIV (44%).

All of the institutions are aware of the existence of the other service providers and the majority (64%) periodically updates their contacts. 68 percent of these organizations are also part of a broader network.

Between 40 - 68 percent of the organizations reported that information was generally available to refer clients to access medical help, drug treatment clinics, social workers at other services, services where people who use drugs can undergo testing for HIV, hepatitis B and hepatitis C, HIV/AIDS clinics and re-socialization/rehabilitation

programmes for people who use drugs. Not many were of the opinion that there was enough information available on shelters for people who use drugs (32%), substitution treatment programmes (16%), and child care centres that are available for parents using drugs (8%).

Recommendations

Based on the foregoing, the following critical gaps in the delivery of drug demand reduction, treatment and harm reduction services were identified and need to be addressed.

Schools

- Explicit harm reduction objectives are lacking.
- Harm reduction education in schools weak or absent.
- Schools may not have the necessary on-staff specialists who can study and integrate new research findings into existing programmes.
- There is a weak referral system in schools.
- The schools' drugs education programmes need to be strengthened.

Institutions

- Very few engage in drug education.
- Employment assistance programmes (EAPs) are weak.
- HIV testing activities are not prevalent.
- Very few agencies have strategic plans.
- There is no national strategic plan.
- The programmes are often not demand driven.
- There are too few harm reduction mandates.
- Programmes are not research driven and evaluations are infrequent and irregular.
- A comprehensive review and updating of legislation is needed.

- There is no synchronization of efforts across government.

Conclusion

There was general agreement on the need for a complete review of the legislation, especially those Acts relevant to drug demand reduction and relevant legislative reform. It is also important to acknowledge the critical role of a comprehensive referral system.. In addition, it was thought that the concept and approach of harm reduction, was a useful way of re-organizing work and refocusing resources.

However, given the Government of Barbados's zero tolerance policy to illegal drug use, it should be made clear that incorporating a harm reduction approach to existing demand reduction programmes should not be mistaken for permission to use illegal drugs. The reality that it is important to first attempt to prevent harm from illegal drug use, and then in those cases where this is impossible, provide a harm reduction alternative. In this vein, there was a call by the Deputy Prime Minister, Attorney General and Minister of Home Affairs, the Hon. Freundel J. Stuart, Q.C., M.P., to concentrate on the reasons for drug abuse by young people. It was proposed that the development of a harm reduction model to formalize the approach in Barbados be pursued by a properly financed NCSA.

Appendix I

Directory of Key Stakeholders and Service Providers

Organization	Business Address	Tel. No.	Fax No.	Contact	Legislation/Mandate
Probation Department	Roebuck Street, Bridgetown, Barbados probation@sunbeach.net	426 3877		Chief Probation Officer – Ms. Dorita Lovell	Probation of Offenders Act, Cap 146 Juvenile Offenders Act, Cap 138
Government Industrial School	Dodds, St. Philip, Barbados	423 6213	423 0905	Principal – Mr. Erwin Leacock	The Reformatory and Industrial Schools Act, Cap169 Juvenile Offenders Act, Cap 138 Mandate was created by the institution to cater to the needs of the residents
The Magistrates Court	Roebuck Street, Bridgetown, Barbados	429 4292	426 3854	Magistrate Faith Marshall-Harris	
Royal Barbados Police Force Juvenile Liaison Scheme	Central Police Station, Bridgetown, Barbados pubrelation@rbpf.gov.bb	430 7681 430 7632	435 3135	Inspector John Boyce	Created by permission of Cabinet Operates under guidelines of RBPF legislation (The Police Act, Cap 167)
Her Majesty's Prisons	Dodds, St. Philip, Barbados bps@caribsurf.com	416 6900	416 6934	Superintendent of Prisons – Lt Col John Nurse	The Prison Act, Cap168
National Task Force on Crime Prevention	2nd Ave. Belleville, St. Michael, Barbados cwilloughby@crimeprevention.gov.bb	436 4742		Director – Cheryl Willoughby	Public Service Act
Ministry of Health	Jemmotts Lane, St. Michael, Barbados cmo@health.gov.bb cmoSecretary@health.gov.bb	467 9306 426 5080		Chief Public Health Nurse – Ms. Joyce Holder	Health Services Act, Cap 44
Psychiatric Hospital	Black Rock, St. Michael, Barbados	425 8680	425 7347	Consultant Psychiatrist -	Mental Health Act, Cap 45

Organization	Business Address	Tel. No.	Fax No.	Contact	Legislation/Mandate
	erminebelle@hotmail.com			Dr. Ermine Belle	
Centre for Addiction Support Alternatives	Suite #1, President Kennedy Medical Centre, Corner St. Leonard's Ave & Westbury Road, St. Michael, Barbados casa@sunbeach.net	427 5953	228 3797	Drug Counselor – Ms. Vanya Mayers	CASA is committed to providing a crisis intervention, community based prevention, treatment and rehabilitation service to persons experiencing substance abuse and related problems regardless of culture, ethnic origin, religion, age, sexual preference, disability and social status.
Verdun House	St. John, Barbados jlewis_verdun@caribsurf.com	433 3488	433 5499	Clinical Director – Ms. Jacqui Lewis	To provide a drug free supportive environment where clients can build a foundation for their recovery efforts and integrate the necessary behavioural changes to maintain a commitment to sobriety.
Barbados Family Planning Association	Bay Street, Bridgetown, Barbados bfpa@sunbeach.net	426 2027		Executive Director – Mr. George Griffith	The BFPA dedicates itself to the achievement of a better quality of life for Barbadians through the promotion and provision of Sexual and Reproductive Health services, Family Planning, Family Life Education and other related services.
The Elroy Phillips Centre	Chief Medical Officer, Ministry of Health Jemmotts Lane, St. Michael cmo@health.gov.bb	467 9439		Senior Medical Officer of Health - Dr. Anton Best	
CARE Barbados	Lady Meade Gardens, Jemmotts Lane, St. Michael, Barbados carebarbados@hotmail.com	436 7770 237 6073		Ms. Ingrid Hope	
HIV/AIDS Commission	2nd Floor, Government Building,	310 1000		Deputy Director - Ms.	**MANDATE:** To coordinate

Organization	Business Address	Tel. No.	Fax No.	Contact	Legislation/Mandate
	Warrens, St. Michael, Barbados larmstrong@HIV-AIDS.GOV.BB			Lyn Armstrong	effectively the national expanded response to reduce the incidence and spread of the epidemic in Barbados. **VISION:** The National HIV/AIDS Commission will strive to ensure that all Barbadians are empowered to effectively respond to the threat posed by the HIV/AIDS to the sustainable development of our nation. **MISSION:** Our Mission is to advise the government on plans and policies and to build strategic partnerships to effectively manage, control and reduce the spread of HIV in Barbados. We will also endeavor to mobilize widespread community participation and support their involvement in programmes of this nature.
Barbados Vocational Training Board	Culloden Road, St. Michael, Barbados rcave@bvtb.gov.bb	436 7970	437 8759	Director – Mr. Raphael Cave	The Occupational Training Act, Cap 42
Youth Entrepreneurship Scheme	Ministry of Youth, Family and Sports Hincks Street, Bridgetown, Barbados	430 2803	228 8514	Director – Mrs. Selma Green	Created by a decision of Cabinet. The Youth Enterprise Scheme's objective is to become the government agency on youth entrepreneurship, dealing with

Organization	Business Address	Tel. No.	Fax No.	Contact	Legislation/Mandate
	shusbands@mes.gov.bb				issues and needs affecting young people in business, including those in existing programs in the private sector.
Barbados Youth Business Trust	Building #6, Harbour Industrial Park, Bridgetown, Barbados bybt@youthbusiness.bb	228 2772	228 2773	Executive Director – Ms. Marcia Brandon	The BYBT is a registered Charity No. 271 and duly registered as a benevolent organization under the Income Tax Act. **Mission Statement:** Assisting young people to develop their self-confidence, achieve economic independence, fulfill ambitions, and contribute to the community through the medium of self-employment and job creation.
Pinelands Creative Workshop	The Pine, St. Michael, Barbados pwc_office@caribsurf.com	429 5359	429 5358	Director – Mr. Rodney Grant	**Mission:** To use economic, social and cultural strategy to bring resources and solutions to vulnerable individuals and communities in Barbados and the region.
Young Men's' Christian Association	Pinfold Street, Bridgetown, Barbados	426 3910	435 2230	General Secretary – Mr. Vasco Phillips	The YMCA seeks to share the Christian ideal of building a human community of peace with justice for all, irrespective of race, class, religion, or gender.
The Young Women's Christian Association	Deacons Road, St, Michael ywca@sunbeach.net	425 7308	425 6290	President – Mrs. Marilyn Rice-Bowen	The YWCA of Barbados, primarily a women's organization with a Christian Basis and Purpose, strives to build a fellowship through which members may recognize the value of human beings irrespective of age, religion, nationality or race.
The Youth Development Programme	Ministry of Youth, Family and Sports	430 2700 430 2855	425 1296	Director of Youth – Mr. Hally Haynes	

Organization	Business Address	Tel. No.	Fax No.	Contact	Legislation/Mandate
	Elsie Payne Complex, Constitution Road, Bridgetown, Barbados				
Barbados Youth Service	Ministry of Youth, Family and Sports Warrens, St. Michael	310 4010		Director – Ms. Therese James	Created by a decision of Cabinet
Teen Challenge	Mapp's College, St. Philip, Barbados tcadmin@caribsurf.com	423 8273	423 8248	Director – Mr. Stephen Gilkes	**Mission:** Teen Challenge Barbados is a residential drug and alcohol rehabilitation center providing Spiritual, Academic and vocational training based on Christian principles, equipping the individual to return to society as a responsible and well rounded citizen.
Welfare Department	Cole's Building, Bay Street, Bridgetown, Barbados	426 5417	228 7647	Chief Welfare Officer – Mrs. Angela Mendez	The National Assistance Act, Cap 48 The Family Law Act 1981 The Maintenance Act 1981, The Domestic Violence Act
The National Council on Substance Abuse	James Street, Bridgetown, Barbados info@ncsa.org.bb	429 6272	427 8966	Manager – Mrs. Tessa Chaderton-Shaw	NCSA Act 1995-13 *Mission:* ***To promote sustained action for positive change in the fight against substance abuse and in the facilitation of drug education, prevention, and drug-free lifestyles.***
The Edna Nicholls Centre	Boscobelle, St. Peter, Barbados encentre@hotmail.com	439 1212		Principal – Ms. Deborah Hewitt	The Education Act
Girl Guides Association of Barbados	"Pax Hill" Belmont Road, St. Michael, Barbados	426 2202		Admin Assistant – Ms. Lilian Lubin	**Mission:** To help our girls and young women develop to their fullest extent as effective and responsible citizens of Barbados and the world.

Organization	Business Address	Tel. No.	Fax No.	Contact	Legislation/Mandate
The Boy Scouts Association	"Hazelwood" Collymore Rock, St. Michael, Barbados	429 4051 437 0162		Deputy Scout Commissioner - Col Owen Springer	**Mission:** To promote the development of young people in achieving their full physical, intellectual, social and spiritual potential as responsible citizens.
Sankofa Productions	222 Maycocks, St. Lucy, Barbados	250 2788		Director - Danny Hinds	**Mission:** To promote an awareness and appreciation of the arts as a means of educational and cultural development.
Israel Lovell Foundation	The Ivy, St. Michael, Barbados israellovellfoundation@gmail.com	437 3113		Director – Cheryl Hunte	**Mission:** To be a humane and effective provider of demand driven, collaborative and sustainable development, in addition to providing the social and economic framework for the empowerment and reintegration of the marginalized into mainstream society.
Parent Education for Development in Barbados (PAREDOS)	4th Ave, Welch's Terrace, St. Michael paredosbarbados@yahoo.com	427 0212		Director – Mrs. Marva Springer	**Mission:** To promote sound harmonious family life in Barbados through education in effective parenting.
Khemit Konnections	Tweedside Road, St. Michael, Barbados	431 4450		Director – Heru Holligan	**Mission:** Khemit Konnections is a not-for-profit organization of like-minded people committed to creating better societies by reawakening the African consciousness. We aim to groom a holistic collective of people dedicated to the maintenance of sacred community &social values, through community

Organization	Business Address	Tel. No.	Fax No.	Contact	Legislation/Mandate
					outreach programmes, lectures, exhibitions and entertainment activities.
Barbados Cadet Corps	Barbados Defence Force, The Garrison, St. Michael, Barbados	436 6185	420 7360	Cadet Executive Officer – Major Patrick Skeete	**Laws of Barbados** Cap 159 part X1 under the Ministry of Defence and Security **Mission:** The Barbados Cadet Corps shall be a formal, well- regulated and highly disciplined organisation operating within all sectors of the school and youth communities, colleges and polytechnics in the island. · It shall attract to its ranks significant numbers of young people between the ages of ten (10) and twenty one (21) and shall seek by all means to instill in them spiritual, moral, national and human values of honesty, justice, discipline and social responsibility. · It shall establish the highest possible standards in all areas of operation, and shall seek to maximize levels of self-respect, self-confidence and self-discipline into a critical mass of Barbadian young persons.
Barbados Community College	"Eyrie" Howells' X Road, St. Michael, Barbados principal@bcc.edu.bb	426 3186	429 5935	Principal – Dr. Gladstone Best Director Counseling & Placement – Dr. Vanessa Alleyne	Barbados Community College Act, 1968-23
Samuel Jackman Prescod	Wildey, St. Michael, Barbados	426 1920	426 0843	Principal (Acting) – Mr.	The mission of the Samuel Jackman

Organization	Business Address	Tel. No.	Fax No.	Contact	Legislation/Mandate
Polytechnic	wcozier@sjpp.edu.bb	426 6302		Merton Forde	Prescod Polytechnic is to be a leader in the preparation of a highly trained workforce by providing qualified persons with quality competency-based technical and vocational training that responds to the future employment and lifelong needs of its students.
University of the West Indies	Cave Hill Campus, St. Michael, Barbados hilary.beckles@cavehill.uwi.edu studentservices@cavehill.uwi.edu	417 4030 417 4165	 425 5348	Pro Vice Chancellor and Principal – Sir Hilary Beckles Head of Student Services – Ms. Sandra Yearwood	
Barbados Assoc. of Principals of Public Secondary Schools	C/o Combermere School, Waterford, St. Michael, Barbados combermereschool@hotmail.com	429 2822	435 0037	Secretary – Mr. Vere Parris, Principal, Combermere School President – Mr. Jeffrey Broomes, Principal, Alexandra School	
Lady Meade Reference Unit	Chief Medical Officer, Ministry of Health Jemmotts Lane, St. Michael, Barbados cmo@health.gov.bb	467 9439		Senior Medical Officer of Health - Dr. Anton Best	
Office of the Advisor on Poverty Eradication and Millennium Development Goals	Letchworth Complex, The Garrison, St. Michael, Barbados	228 6759 228 6768	228 6777	Advisor – Ms. Undine Whitaker	

Organization	Business Address	Tel. No.	Fax No.	Contact	Legislation/Mandate
Ministry of Social Care, Constituency Empowerment, Urban and Rural Development	4th Floor Warrens Office Complex, Warrens, St. Michael, Barbados	310 1600	424 2908	Minister – Honourable Christopher Sinckler, MP Permanent Secretary – Ms. Sonja Welch	
Ministry Home Affairs	GPO Building, Cheapside, Bridgetown, Barbados	228 8950	437 3794	Minister – Honourable Freundel Stuart, MP Permanent Secretary – Mrs. Lucene Wharton-Isaac	
Ministry of Education and Human Resource Development	Elsie Payne Complex, Constitution Road, Bridgetown, Barbados	430 2700	436 2411	Minister - Honourable Ronald Jones, MP Permanent Secretary – Mrs. Atheline Haynes	The mission of the Ministry is: To ensure equitable access to quality education for all our citizens so that their potential is fully realized; To assist in the development of responsible citizens who are disciplined, industrious, creative and confident and who can function effectively in a modern society.
Optimists Club of Bridgetown	P.O. Box 451, Bridgetown, Barbados oibridgetown@yahoo.com	228 9075 820 1382		President – Alicia Roachford	**Mission:** Bringing out the best in kids.
Lions Club of Bridgetown	St. Paul's Avenue, Beckles Road, St. Michael, P.O. Box 476, Bridgetown, Barbados rawle@usa.net ken@caribsurf.com	438 1307 420 5638		President – Shonda S. Forde Secretary – Rawle Gibson	**Mission:** To create and foster a spirit of understanding among all people for humanitarian needs by providing voluntary services through community involvement and international cooperation.

Organization	Business Address	Tel. No.	Fax No.	Contact	Legislation/Mandate
Leo Club of Bridgetown	Fisher Pond, St. Thomas, Barbados leo.paul.byer@gmail.com saymes@gmail.com	233 0249		Secretary - Paul Byer Director - Saymes	Sponsored by Lions Club of Bridgetown.
Haynesville Youth Club	Block 3F, Central Close, Haynesville, St. James, Barbados lascellessophia@hotmail.com	829 4891 421 9040 424 0972		President - Peter Skeete Vice President – Sophia Lascelles	**Mission:** committed to the holistic development of the community's youth through sport, cultural and educational activities.
Kiwanis Club of Barbados South	P.O. Box 1384, Bridgetown, Barbados a_sealy@caribsurf.com	231 8822 437 4060		President – Veronica Squires Director – Andrew Sealy	Community based projects and activities continue to be the focus of the club. The club has worked closely with Children's Day nurseries and educational institutions throughout the years.
Goodwill Cavaliers Cricket Club	Lanmings Park, St. Joseph, Barbados	433 8965		Secretary – Rosemary Downes	Community based cricket club
Pioneers for Christ	c/o Ambrose Headley, Rock Dundo, St. James, Barbados prospern222@yahoo.com	419 0627		Director - Ambrose Headley	Youth organization within the Sion Hill New Testament Church of God - a boys' club mentored by adult males.
North Stars Sports & Social Club	Crab Hill, St. Lucy asobers@hotmail.com	422 1392 439 8142		Secretary - Ashley Toppin Project Coordinator – Anthony Sobers	

Appendix II – Interview Schedule for Focus Groups

General Substance Use Information

1. What does the term “drugs” mean to you? (note: If alcohol is not mentioned ask about alcohol use)
2. Why do you think that persons use drugs? (note: Ensure that participants discuss legal and illegal drugs)
3. Have you ever used drugs (note: Ask about alcohol use; Ask about legal and illegal drugs)
4. **If yes, -** Why do you use drugs?
5. How often do you use drugs?
6. How old are you? (obtain information on ages of individual group members)

Problems with Drug Use

7. Do you think that using drugs would cause a person to behave differently (note: Ask participants to explain their answer)
8. Which drugs do you think can cause the most problems?
9. Have you ever had a problem caused by using drugs?
10. **If yes, -** What kind of problems did you have?
11. Which drugs cause/caused you the most problems?

Harm Reduction Promotion

12. Do you think that using drugs can be harmful? (note: Ask participants to explain their answer)
13. Has anyone ever spoken to you about the harm that drugs can cause you?
14. **If yes, -** From where/whom did you receive this information? (Note: Ask if they received information from the current institution or somewhere/someone else)
15. What kind of information did you receive?
16. Were you told of ways in which you could avoid the harm which substance use can cause?
17. Has this information helped you in any way?
18. **If yes, –** How has it helped you?

Appendix III – School Questionnaire

Developing Comprehensive Responses to Drug Demand and Harm Reduction in Barbados

Research Department
National Council on Substance Abuse

Dear

Your school has been selected to participate in a study being undertaken by the National Council on Substance Abuse in collaboration with the United Nations Education, Scientific and Cultural Organization (UNESCO), which seeks to investigate the current programmes within Barbados that attempt to reduce drug use and its associated harms among the youth.

To this end we are requesting that you complete the attached questionnaire which requests information regarding your school's drug education programmes. Please respond as honestly as possible as all information provided will be kept confidential and your institution will not be identified in any way.

The NCSA would like to take this opportunity to thank you for your assistance in propelling its research initiative, as your participation is needed to ensure the current study's success.

INSTRUCTIONS:
Please answer all of the questions in each section unless otherwise directed. Indicate your answers by placing a check (√) in the box next to the relevant response option, or by writing it in the space provided.

SECTION I - DRUG EDUCATION PROGRAMMES/SERVICES/ACTIVITIES

1. Which of the following are included in your school's drug education programmes/activities?
   - □ General/basic education on drugs and drug use
   - □ Education on the health harms associated with drug use
   - □ Life skills education
   - □ Counselling on substance abuse
   - □ Other (Please specify)_____

2. Which of the following persons are involved in the delivery of your school's drug education programmes/activities?
   - □ Guidance Counsellor
   - □ Religious Educator
   - □ Peer Supporters
   - □ Drug Education Officer
   - □ Recovering Addicts
   - □ Teachers
   - □ Other (please specify) _____

3. Does your school offer different drug education programmes/activities to males and females?
   - □ Yes
   - □ No
   - □ Don't know

4. Does your school offer drug education programmes/activities to different age groups?
   - □ Yes
   - □ No
   - □ Don't know

5. (a) Are your school's drug education programmes/activities based on the findings of a needs assessment or local research?
   - □ Yes
   - □ No
   - □ Don't know

If yes,

(b) Does your school update its drug education programmes/activities based on the latest research findings?
   - □ Yes
   - □ No

6. (a) Is there an evaluation of your drug education programmes/activities?
   - □ Yes
   - □ No

If yes,

(b) How often?

□ Once a year
□ Two or more times a year
□ Once every two years□ Other _____

(c) Are the students involved in the evaluations?
□ Yes
□ No
□ Don't know

(d) Are the results of evaluations incorporated into the programmes/activities?
□ Yes
□ No
□ Don't know

7. (a) Do you involve students in the development and design process of drug education programmes/activities?
□ Yes
□ No
□ Don't know

If yes,
(b)Which of the following does your organisation use to obtain the input of the students?
□ Focus groups
□ Questionnaires
□ Individual interviews
□ Other

SECTION II – STAFFING

8. On which of the following topics have your school's staff members received training?
□ The ways to reduce the harm associated with drug use
□ General drug use information
□ Approaches to drug use prevention
□ Hepatitis and its prevention
□ Communication and motivational interview skills
□ HIV/AIDS and its prevention
□ None of the above

9. If your staff is trained in any of the subject areas outlined in question 8, how often is the training provided?
□ Upon initial entry into the school only
□ Once a year
□ Twice a year
□ Every two years
□ Other_____

SECTION III - REFERRAL SYSTEM

10. Is there a referral system at your school for students who are possible drug users?
□ Yes
□ No
□ Don't know

If you answered "Yes" to question 10, proceed to questions 11 and 12. If you answered "No" proceed to Section IV

11. To whom/where are these students referred?
    a._____
    b._____
    c._____
    d._____
    e._____

12. (a) Is there a need for improvements to the current referral system?
    □ Yes
    □ No
    □ Don't know

    If yes,
    (b) What types of improvements are necessary?

_____
_____
_____
_____

SECTION IV - NEED FOR IMPROVEMENTS

13. (a) Is there a need for improvements to the current drug education programmes/activities at your school?
    □ Yes
    □ No
    □ Don't know

    If yes,
    (b) What types of improvements are necessary?

_____
_____
_____
_____

THANK YOU FOR YOUR PARTICIPATION!

Appendix IV – Institutional Questionnaire

Developing Comprehensive Responses to Drug Demand and Harm Reduction in Barbados

Research Department
National Council on Substance Abuse

Dear Sir/Madam

Your institution has been selected to participate in a study being undertaken by the National Council on Substance Abuse in collaboration with the United Nations Education, Scientific and Cultural Organization (UNESCO), which seeks to investigate the current programmes within Barbados that attempt to reduce drug use and its associated harms among the youth.

To this end we are requesting that you complete the attached questionnaire which requests information regarding your institution's mandates, guiding legislation and services. Please respond as honestly as possible as all information provided will be kept confidential and your institution will not be identified in any way.

The NCSA would like to take this opportunity to thank you for your assistance in propelling its research initiative, as your participation is needed to ensure the current study's success.

INSTRUCTIONS:
Please answer all of the questions in each section unless otherwise directed. Indicate your answers by placing a check (√) in the box next to the relevant response option, or by writing it in the space provided.

SECTION I – PRESENCE OF LEGISLATION AND EXISTENCE OF MANDATE

1. Is there legislation that guides your organisation?
   □ Yes
   □ No

   If yes, please identify: _____

2. Does your organisation possess a mandate?
   □ Yes
   □ No

If you answered "YES" to either question 1 or 2, proceed to Section II-A. If you answered "NO" to both, proceed to Section II-B.

SECTION II-A – MANDATE AND LEGISLATION INFORMATION

(TO BE COMPLETED BY ORGANISATIONS POSSESSING A MANDATE AND/OR GUIDING LEGISLATION ONLY)

3. To which of the following populations is your organisation mandated to offer services?
□ Youth (12-29 years)
□ Persons over 29
□ Persons under 12
□ Persons living with HIV/AIDS
□ Substance Abusers
□ Persons below the poverty line
□ Other (Please specify)_____

4. Which of the following functions is your organisation mandated to provide?
□ Drug education
□ Vocational training &/or education
□ Counselling
□ HIV/AIDS testing
□ Job placement
□ Other (Please specify)_____

5. (a) Are efforts to reduce drug use included in the mandate and/or guiding legislation of your organisation?
□ Yes
□ No

If yes,
(b) Does your organisation have a strategic plan that outlines its approach to reducing drug use?
□ Yes
□ No

6. (a) Are efforts to reduce the harm associated with substance use included in the mandate and/or guiding legislation of your organisation?
□ Yes
□ No

If yes,
(b) Does your organisation have a strategic plan that outlines its approach to reducing the harm associated with substance use?
□ Yes
□ No

SECTION II-B – ORGANISATIONAL PURPOSE AND FUNCTIONS

(TO BE COMPLETED BY ORGANISATIONS <u>WITHOUT</u> MANDATES AND GUIDING LEGISLATION <u>ONLY</u>)

7. What are the broad aims of your organisation? (If your organisation possesses a mission statement, this can be referenced here)
_____
_____
_____
_____

8. Which of the following populations does your organisation serve?
□ Youth (12-29 years)
□ Persons over 29
□ Persons under 12
□ Persons living with HIV/AIDS
□ Substance Abusers
□ Persons below the poverty line
□ Other (Please specify)_____

9. (a) Are efforts to reduce the harm associated with substance use incorporated into the mission of the organisation?
□ Yes
□ No

If yes,
(b) Does your organisation have a strategic plan that outlines its approach to reducing the harm associated with substance use?
□ Yes
□ No

10. (a) Are efforts to reduce drug use incorporated into the mission of the organisation?
□ Yes
□ No

If yes,
(b) Does your organisation have a strategic plan that outlines its approach to reducing drug use?
□ Yes
□ No

SECTION III – EFFORTS TO REDUCE DRUG USE AND PROMOTE HARM REDUCTION

11. (a) Does your organisation engage in efforts to reduce drug use?
□ Yes
□ No

If yes,
(b) Which of the following are included in your organisation's efforts to reduce drug use?
□ Education
□ Counselling
□ Referrals
□ Advertising Campaigns
□ Workshops
□ Other (Please specify)_____

12. (a) Does your organisation engage in efforts to reduce the harms associated with drug use?
□ Yes
□ No

If yes,
(b) Which of the following are included in your organisation's efforts to reduce the harms associated with drug use?
□ Needle and syringe exchange
□ Outreach and peer services
□ Overdose prevention programme
□ Tests for HIV
□ Safer injecting training to people who use drugs
□ Information on HIV prevention, treatment and life with HIV
□ Information on hepatitis prevention, treatment and life with hepatitis
□ Information on management of chaotic drug use
□ Information on sexual and reproductive rights and health
□ Vaccination against hepatitis A and B
□ Referrals to other services
□ Counselling
□ Other (Please specify)_____

If you answered "YES" to either question in this section, proceed to Section IV. If you answered "NO" to both questions in this section, proceed to Section V.

SECTION IV - DRUG EDUCATION PROGRAMMES/SERVICES/ACTIVITIES

13. Which of the following groups does your organisation's drug education, awareness and other related services target?
□ Women who use drugs
□ Men who use drugs
□ Young persons who use drugs
□ Meta/amphetamine users
□ Drug users from minority populations
□ Drug users from subculture populations
□ Foreign persons/migrants who use drugs
□ Sex workers
□ Persons Living with HIV/AIDS
□ Youth in general

14. Does your organisation offer different drug-related programmes/services/activities to males and females?
□ Yes
□ No

15. Does your organisation offer different drug-related programmes/services/activities to different age groups?
□ Yes
□ No

16. Are your organisation's drug-related programmes/services/activities based on the findings of a needs assessment or local research?
□ Yes
□ No

17. (a) Is there an evaluation of your drug-related services/programmes?
□ Yes
□ No

If yes,
(b) How often?
□ Once a year
□ Two or more times a year
□ Once every two years
□ Other _____

(c) Are the service users involved in the evaluations?
□ Yes
□ No

(d) Are the results of evaluations incorporated into the services?
□ Yes
□ No

18. (a) Do you involve service users in the development and design process of services/programmes?
□ Yes
□ No

If yes,
(b) Which of the following does your organisation use to obtain the input of the service users?
□ Focus groups
□ Questionnaires
□ Individual interviews
□ Other

19. (a) Does your organisation monitor changes that occur with respect to drug use in Barbados?
□ Yes
□ No

If yes,
(b) Does your organisation update its services/programmes based on the latest research findings?
□ Yes
□ No

SECTION V – STAFFING

20. On which of the following topics have your organisation's staff members received training?
□ Harm reduction
□ Drug use
□ Overdose
□ Hepatitis prevention and treatment
□ Equipment people who use drugs use/prefer
□ Communication skills, motivational interview
□ Human rights principles
□ Stigma and discrimination
□ HIV/AIDS and its prevention
□ None of the above

21. If your staff is trained in any of the subject areas outlined in question 1, how often is the training provided?
□ Upon initial entry into the organisation only
□ Once a year
□ Twice a year
□ Every two years
□ Other_____

22. (a) Within your organisation do you have volunteers?
□ Yes
□ No

If yes,

(b) On which of the following topics does your organisation provide training for volunteers?
- □ Harm reduction
- □ Drug use
- □ Overdose
- □ Hepatitis prevention and treatment
- □ Equipment people who use drugs use/prefer
- □ Communication skills, motivational interview
- □ Human rights principles
- □ Stigma and discrimination
- □ HIV/AIDS and its prevention
- □ None of the above

(c) How often is this training provided?
- □ Upon initial entry into the organisation only
- □ Once a year
- □ Twice a year
- □ Every two years
- □ Other_____

SECTION VI - HARM REDUCTION PRINCIPLES

23. Does your organisation operate from the perspective that the reduction of drug-related harms is a more feasible option than eliminating drug use entirely?
□ Yes
□ No

24. (a) Does your organisation support those who seek to moderate or reduce their drug use?
□ Yes
□ No

If yes,
(b) In what ways is this support offered?

_____
_____
_____
_____

25. Which of the following services does your organisation provide to drug users?
□ Needle and syringe exchange
□ Outreach and peer services
□ Substitution treatment programme
□ Overdose prevention programme
□ Safer injecting training to people who use drugs
□ Legal help in cases of human rights violation or discrimination of people who use drugs
□ Information on human rights violations and causes of discrimination against people who use drugs
□ Basic medical care
□ Information on HIV prevention, treatment and life with HIV
□ Information on hepatitis prevention, treatment and life with hepatitis
□ Information on management of drug use
□ Information on sexual and reproductive rights and health
□ Vaccination against hepatitis A and B
□ Referrals to other services
□ Information on harms associated with drug use
□ Counselling
□ Voluntary Counselling and Testing (HIV/AIDS)
□ None of the above

SECTION VII - REFERRAL SYSTEM

26. Is the staff of your organisation aware of other organisations that work with vulnerable populations within Barbados?
□ Yes
□ No

27. (a) Is your organisation part of a broader referral system/network?
□ Yes
□ No

If yes,
(b) Are the contacts in your organisation's referral system periodically updated?
□ Yes
□ No

28. Is information available (location and working hours) to refer clients to:
□ Access to Anti-Retroviral Treatment
□ Access to medical help
□ Drug treatment clinics
□ Shelters for people who use drugs
□ Names of social workers at other services
□ Substitution treatment program
□ Services where people who use drugs can undergo testing for HIV, hepatitis B, hepatitis C
□ Self support groups for persons living with HIV/AIDS
□ HIV/AIDS clinics
□ Child care centres that are available for parents using drugs
□ Re-socialization/rehabilitation programs for people who use drugs

SECTION VIII - NEED FOR IMPROVEMENTS

29. In your opinion, is the current legislation associated with your organisation effective in assisting with the reduction of drug demand and the promotion of harm reduction?
□ Yes
□ No
□ Not applicable

30. (a) In your opinion, is there a need for improvements to legislation related to the provision of services in the area of substance abuse?
□ Yes
□ No
□ Not applicable

If yes,
(b) Give examples of the improvements/additions you think are necessary and give justifications for your suggestions.
_____
_____
_____
_____

31. In your opinion, are your organisation's present drug-related programmes/services effective?
□ Yes
□ No
□ Not Applicable

32. (a) Is there a need for improvements to the current drug-related programmes/ additional programmes?
□ Yes
□ No
□ Not Applicable

If yes,
(b) What types of improvements are necessary and why?
_____
_____
_____
_____

THANK YOU FOR YOUR PARTICIPATION!