Section of Mt. Gay Psychiatric Hospital, Grenada

Carlton House Treatment and Rehabilitation Centre, Grenada - Post Hurricane Ivan

An Evaluation of Grenada's Drug Treatment and Rehabilitation Programs

EUROPEAN UNION AND GOVERNMENT OF GRENADA

An evaluation of Grenada's drug treatment and rehabilitation programs

September 2005

The study, "*An evaluation of Grenada's Drug Treatment and Rehabilitation Programs*" was funded by the European Union and the Government of Grenada, as part of the three-year Drug Demand Reduction Project.

The Drug Demand Reduction Project seeks to achieve the following objectives:

- To strengthen institutional capacities to design, implement and evaluate drug prevention programmes;
- To promote greater community involvement in drug control efforts;
- To provide alternative activities for youth to divert them to more productive and rewarding activities; and
- To promote greater public awareness of matters relating to drug abuse prevention and control.

ACKNOWLEDGEMENTS

This study was conducted by Research Consultant Dianne A. Roberts under the supervision of the Drug Control Secretariat, Ministry of Education Grenada.

The preparation of this report would not have been possible without the tremendous support provided to the consultant by a number of individuals.

Special thanks to Mr. Thorne Roberts, Administrator, Richmond Hill Institution, and Nurse Gittens, Carlton House Treatment Centre for providing initial guidance in selecting key informants.

Mr. Herbert Smith was extremely resourceful and helpful throughout the entire process - acting as a liaison between the Research Consultant and recovering addicts, and clarifying complex issues where necessary.

To all the other professionals at Carlton House Treatment Centre, Rathdune Psychiatric Unit, and Mt. Gay Psychiatric Hospital who participated in this study, thanks for the wealth of information provided. It would be remiss if mention was not made about the recovering addicts who willingly provided information, and shared their stories. It is our hope that you continue to strive for sobriety always.

EXECUTIVE SUMMARY

Skepticism exists among a number of societies regarding the effectiveness of drug treatment and rehabilitation programs in addressing the challenging problem of drug dependence. In fact, treatment programs have not been prioritized by some policy makers and planners due to the negative perceptions of these tertiary interventions. According to the United Nations Office on Drugs and Crime (UNODC) 2002 report "*Investing in drug abuse treatment – A discussion paper for policy makers*," recent surveys show that even a majority of general practice physicians and nurses feel that the currently available medical and health care interventions are not appropriate or effective in treating addiction.

There is broad consensus though among drug abuse treatment implementers and treatment research communities that drug abuse treatment works (McCaffrey, 1996; UNDCP, 2000; UNODC, 2002; DRSATR, 2005). Notwithstanding the difficultly in breaking the cycle of drug addiction, due to its chronic relapsing nature, and the complexity of biological, psychological, and socio-economic challenges that the patient experiences, treatment can produce notable positive outcomes. In fact, control clinical trials and large scale field studies have shown statistically and clinically significant improvements in drug use habits, and in drug related health and social problems of treated individuals (UNODC, 2002; Mc Caffrey, 1996). However, identifying the most effective type of treatment for each patient poses a formidable task. Considering the importance of quality of care, and the urgent need for policy makers and planners to invest more in drug treatment, it is critical to determine which treatment program works, and for which patient. The surest way to make this determination is through rigorous evaluation of treatment modalities, programs and patient outcomes (McCaffrey, 1996).

This study responds to the call for greater priority placed on assessing drug treatment effectiveness. Commissioned by the Drug Control Secretariat, as part of its Drug Demand Reduction project funded by the European Union, the study is designed to measure, inter alia, the extent to which patients in drug treatment remain drug-free after a certain period of time, and the success in matching treatment to patient. It includes a description of the treatment protocols and expected outcomes. Specifically, the study will undertake the following:

1. Determine and describe which drug treatment and rehabilitation modalities exist in Grenada.

2. Identify and describe which drug treatment and rehabilitation services exist in Grenada, and whether they are public or private (private may include NGOs, religious groups, private medical services), how many and their geographic coverage.

3. Evaluate the various early intervention, drug abuse treatment, rehabilitation and after-care/social reintegration programmes and modalities, in order to assess their effectiveness.

4. Recommend areas of improvement, where necessary, in the early intervention drug abuse treatment, rehabilitation and after-care/social reintegration programmes and modalities, in the following areas:

    - Administration
    - Policy
    - Programme content and delivery
    - Follow-up and aftercare

This study used a qualitative approach to assess the effectiveness of drug treatment and rehabilitation services in Grenada. The approach employed paralleled the needs assessment model of evaluation, which focused on identifying the critical elements needed to significantly boost effectiveness of the treatment and rehabilitation landscape. Key informant interviews represented the central research strategy used for this study. Informants were selected from among policy makers, treatment institutions, and outpatient recovering addicts. It is the goal of the executing agency that this study will unearth critical information that will augment the effectiveness of drug treatment and rehabilitation in Grenada.

The study revealed that the drug treatment modalities provide a successful model for achieving the majority (6/7 or 85.7%) of short term outcomes. The critical levels of awareness, knowledge, skills and motivation needed to foster appropriate concrete changes in the journey to sobriety and productive living can be realistically accomplished. Albeit this, the current treatment and rehabilitation modalities do not fully prepare the majority of drug addicts to attain the following long term outcomes:

- Sobriety
- Improved socio-economic status
- Reduced risk behaviour (to a lesser extent)
- Productive citizen.

Six main constraints were identified as hindering national efforts at achieving the above outcomes as described below.

- An unsupportive socio-cultural environment that does not fully support re-integration of recovering addicts. Limited or no family and community support, poor or mediocre socio-economic status of recovering addict, societal stigma and discrimination, inadequate involvement of the public, private and NGO communities in housing and employment provisions, insufficient qualified staffing at the treatment centres, and the unsatisfactory investment by government in treatment and rehabilitation.

- Misinformation or inadequate awareness among family members and communities about the nature of addiction.

- Unsatisfactory preparation of recovering addicts to secure gainful employment.

- Lack of an after care program.
- Lack of a policy on treatment and rehabilitation.
- Lack of a treatment and rehabilitation program at Her Majesty's Prison.

Addressing the above constraints would be instrumental in augmenting the effectiveness of drug treatment and rehabilitation in Grenada. Three primary objectives were provided to remedy the above deficiencies:

- Encourage the development of a supportive socio-cultural environment to adequately meet the physical, social and psychological needs of recovering addicts.
- Promote broad base support among families and communities for treatment and rehabilitation.
- Augment the institutional framework in place for supporting treatment and rehabilitation.

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LIST OF ABBREVIATIONS

AA	Alcoholics Anonymous
ARD	Agency for Reconstruction and Development
CICAD	Inter-American Drug Abuse Control Commission
DMO	District Medical Officer
DRSATR	Drug Rehabilitation and substance treatment referral
EGTR	Enhance Guidelines for Treatment
EC	Eastern Caribbean
GDP	Gross Domestic Product
HIV/AIDS	Human Immunodeficiency Syndrome/Acquired Immune Deficiency Syndrome
Mg	Milligrams
NA	Narcotic Anonymous
NCODC	National Council On Drug Control
NGOs	Non-Governmental Organizations
OAS	Organization of American States
OECS	Organization of Eastern Caribbean States
PAHO	United Nations Drugs Control Programme
UNDCP	United Nations Children Fund
UNICEF	United Nations Office on Drugs and Crime
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

1.0 OVERVIEW AND NATIONAL CONTEXT

1.1 INTRODUCTION

Skepticism exists among a number of societies regarding the effectiveness of drug treatment and rehabilitation programs in addressing the challenging problem of drug dependence. In fact, treatment programs have not been prioritized by some policy makers and planners due to the negative perceptions of these tertiary interventions. According to the United Nations Office on Drugs and Crime (UNODC) 2002 report "*Investing in drug abuse treatment – A discussion paper for policy makers*," recent surveys show that even a majority of general practice physicians and nurses feel that the currently available medical and health care interventions are not appropriate or effective in treating addiction. The report continued that a pervasive view exists that treatment programs convey an implicit message that the addiction and the addiction related problems are not the fault or responsibility of the addicted person. As such, this school of thought purports the view that treatment programs are designed exclusively to help the drug user and not the society (UNODC, 2005, 1).

The surest way to determine which drug treatment program works is through rigorous evaluation of treatment modalities, programs and patient outcomes.

There is broad consensus though among drug abuse treatment implementers an treatment research communities that drug abuse treatment works (McCaffre 1996; UNDCP, 2000; UNODC, 2002; DRSATR, 2005). Notwithstanding th difficultly in breaking the cycle of drug addiction, due to its chronic relapsin nature, and the complexity of biological, psychological, and socio-economi challenges that the patient experiences, treatment can produce notable positiv outcomes. In fact, control clinical trials and large scale field studies have show statistically and clinically significant improvements in drug use habits, and i drug related health and social problems of treated individuals (UNODC, 200 Mc Caffrey, 1996). However, identifying the most effective type of treatme for each patient poses a formidable task. Considering the importance of qualit of care, and the urgent need for policy makers and planners to invest more i drug treatment, it is critical to determine which treatment program works, an for which patient. The surest way to make this determination is throug rigorous evaluation of treatment modalities, programs and patient outcome (McCaffrey, 1996).

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- Determine and describe which drug treatment and rehabilitation modalities exist in Grenada.

- Identify and describe which drug treatment and rehabilitation services exist in Grenada, and whether they are public or private (private may include NGOs, religious groups, private medical services), how many and their geographic coverage.

- Evaluate the various early intervention, drug abuse treatment, rehabilitation and after-care/social reintegration programmes and modalities, in order to assess their effectiveness.

- Recommend areas of improvement, where necessary, in the early intervention drug abuse treatment, rehabilitation and after-care/social reintegration programmes and modalities, in the following areas:

    - ✓ Administration
    - ✓ Policy
    - ✓ Programme content and delivery
    - ✓ Follow-up and aftercare

It is anticipated that the study will unearth critical information that can be used to develop a more comprehensive and effective drug treatment and rehabilitation program in Grenada.

1.2 NATIONAL CONTEXT

1.2.1 Geographical Position

Grenada, part of a tri-island state (Grenada, Carriacou and Petit Martinique), is the southernmost windward island in the Eastern Caribbean. The island group located at 12˚ N latitude and 61˚ W longitude covers approximately 344 square kilometers, with Grenada amassing an area of 307 square kilometers or 89% of the total island group.

1.2.2 Socio - Economic Conditions

1.2.2.1 Economy

The economic fortunes of Grenada have been linked historically to the performance of the agriculture industry. However, a number of internal problems,[1] exacerbated by the removal of

[1] Internal problems included poor quality, low productivity, Moko disease, drought, inadequate marketing and local funding opportunities.

preferential treatment of Grenada's bananas on the international market, negatively affected the industry during the 1980s – 1990s.
During the post millennium period, the economy, based on a diverse service sector[2], agriculture, light manufacturing industries and construction, recorded decrease growth performance of 3.4% and 0.5% during 2001 and 2002 respectively. It rebounded to record real growth of 3.4% in 2003, resulting in a current account surplus of EC$38.3 million. This creditable performance was due primarily to increased economic activity in most of the productive and service sectors of the economy.

The notable improvement in the economic climate was dramatically nullified after the passage of Hurricane Ivan on September 7th, 2004. Documented as the most powerful natural disaster to hit the Caribbean region, Ivan resulted in a scale of devastation that shocked the global community. Translated into monetary terms, the economy suffered damages in excess of EC$2.4 billion, twice the national's annual Gross Domestic Product (Ministry of Finance, 2005). As a result of the widespread destruction of various socio-economic sectors, economic activity declined by 3.2% in 2004, in contrast to the 4.7% growth projected for the middle of the year. The only sectors which demonstrated some level of buoyancy in the post-Ivan period were Construction (7.6% growth); Mining and Quarrying (10.2% growth) and the Cruise tourism sub-sector, which registered a whopping 54.5 % increase in passenger arrivals (Ministry of Finance, 2005).

Projections of 2005 record a current account deficit of EC$51.6 million, representative of 4.4% of GDP. Similarly, an overall financing gap of EC$74.3 million is projected for 2005. In an effort to curb these fiscal hindrances, government has devised a number of strategic interventions with support from the international community, to stimulate positive growth in the future.

1.2.2.2 Poverty assessment

A national poverty assessment survey conducted by Kairi Consultants in 1998 estimated that 32.1% of all individuals in Grenada were poor, in that their annual expenditure was less than EC$3,362, the cost of meeting their minimal food and other requirements. Additionally, 12.9% of all individuals were found to be extremely poor or indigent. Other key features of national poverty highlighted in the report included the following:

- Poverty is seriously affecting young people, *with over 56% of the poor being less than 25 years old;*

- Poverty was distributed almost evenly throughout the country, with the highest levels being found in St. George's (31.7%), St. Andrew's (26.6%) and St. Patrick's (14.0%) (Refer to Table 1).

[2] The services sector is defined as wholesale and retail trade, hotels and restaurants, transport and communication, financial and business services and other services (MTESP, 2002).

- A higher unemployment rate was found among the poor (20%) compared to the non-poor (13%). Moreover, the poor tended to be concentrated in elementary occupations.
- *Approximately 64% of the population had no form of educational certification.* The country had a limited human capital stock, as represented by the level of education attained by the majority of the population.

Table 1: Poverty Estimates by Parish – Grenada (Kairi, 1999)

Parish	Total population	% of population	As a % of the poor population
St. George's	37,057	36.1	31.7
St. John's	8591	8.4	10.0
St. Mark's	3994	3.9	4.8
St. Patrick's	10,674	10.4	14.0
St. Andrew's	24,749	24.1	26.6
St. David's	11,486	11.1	9.8
Carriacou	6081	6.0	3.1
Totals	**102,632**	**100**	**100**

Following the passage of Hurricane Ivan, significant socio-economic destabilization occurred (Refer to Section 1.1.2.1). The OECS *Macro Socio-economic Assessment of Damages Caused by Hurricane Ivan* (2004) reported that the poor who lived in the most affected parishes by Hurricane Ivan (St. George's, St. Andrew's, St. David's and St. John's), *accounted for approximately 75% of all the persons who were poor across the nation* (Refer to Table 1). In fact, the effect of the disaster on the parishes with the significant proportions of the poor, exacerbated an already difficult situation (OECS, 2004), thus enhancing their vulnerabilities.

1.2.2.3 Employment

Unemployment, which registered 13% in the pre-Ivan period, increased sharply immediately after the disaster as many persons lost their jobs (Ministry of Finance, 2005). The Government of Grenada with tremendous assistance from the international community, for instance, the United States Agency for International Development (USAID), has made significant progress in promoting economic recovery at the national level. A number of initiatives have been implemented in the post-Ivan era to revitalize the main engines of growth - agriculture and tourism. A number of business reactivation and skill training initiatives have also been undertaken with the principal objective of generating new, and sustaining previous employment opportunities. Moreover, as indicated in Section 1.1.2.1, tremendous opportunities for skilled and unskilled employment were also made available through the construction, mining and quarrying industries.

1.2.2.4 Population

Results of the 2001 census reported that the population was 101,000, which represented an increase of approximately 7.4% of the 1991 population. The population was fairly evenly distributed along gender lines, with slightly more females than males. The majority of the population, (80%) was 0 - 49 years (Ministry of Finance, 2002). Age distribution showed that 47% were less than 20 years old, and 16% were 50 years and over.

Persons of African decent dominated the population, with a smaller percentage representative of Indians and Caucasians.

1.2.2.5 Psychological climate

Grenadians suffered major psycho-social trauma after the passage of Hurricane Ivan, and to a lesser extent Hurricane Emily.[3] A number of efforts spearheaded by the Government of Grenada, through its Agency for Reconstruction and Development (ARD),[4] the Legal Aid and Counseling Clinic and UNICEF[5] among other agencies provided counseling and psycho-affective programming support for the most affected, including all public primary school students.

1.2.3 Legal and Policy Framework for Drug Treatment and Rehabilitation

1.2.3.1 Legal framework

Grenada does not have any legislation governing standard of care for drug abuse treatment and rehabilitation. However, the Ministry of Health, Social Security, the Environment and Ecclesiastical Relations[6] through its administrative procedures has implemented minimum standards of care using the CICAD model, which the treatment institutions are expected to adhere to.

The Chief Medical Officer and his team from the Ministry of Health are responsible for supervising the operations at the treatment centres. This represents Grenada's mechanism to oversee adherence to the standards of care for drug treatment, and to evaluate the quality of

[3] Hurricane Emily, a category 1 hurricane affected Grenada on July 14, 2005, ten months after Hurricane Ivan.
[4] The ARD Community Caravan initiative provided counseling and debriefing to approx. 2200 persons.
[5] The Return to Happiness program funded by UNICEF was implemented during the first half of 2005 targeting all public primary school students between the ages of 6 – 12 years. The program was designed to decrease levels of post traumatic stress and anxiety, increase level of happiness and self-esteem.

[6] The Ministry of Health, Social Security, the Environment and Ecclesiastical Relations will be referred to as the Ministry of Health throughout the remainder of this document.

services provided. The Ministry is responsible for convening quarterly meetings with the relevant staff, to evaluate the quality of treatment services.

1.2.3.2 Policy Framework

There is no overarching policy on drug treatment and rehabilitation in Grenada. However, policy guidelines pertaining to this aspect of drug control is made reference to in the third National Anti-drug Master plan for the period 2004 – 2008. The plan, developed by the Government of Grenada with financial and technical assistance provided by the Organization of American States and the Inter-American Drug Abuse Control Commission (AOS/CICAD), articulates national policies, priorities, and apportion responsibilities for drug control efforts. In addition, the comprehensive document signals Government's unwavering commitment to local, regional and international efforts to combat and eradicate drug production, use, abuse, trafficking and related ills (Government of Grenada, 2002).

The Master Plan identified five strategic areas to be prioritized during the implementation period: prevention, treatment/rehabilitation, interdiction, money laundering and chemical diversion.

Three major policy guidelines were articulated for drug treatment and rehabilitation during the five year implementation period (2003 – 2007) as listed below.

- To foster institutional strengthening and the standardization of treatment and rehabilitation, within existing programs for the abuse of addictive substances.
- To strengthen networking and encourage collaboration between all stakeholders including Government ministries, NGOs and rehabilitation centers.
- To empower communities to assume responsibility for developing and maintaining a prevention and rehabilitation programme.

As outlined below, three projects emanated from this comprehensive planning for treatment and rehabilitation.

- **The inter-sectoral collaboration programme**: This programme scheduled to begin in March 2004 will be ongoing for five years. It seeks to encourage participation of all sectors on drug treatment and rehabilitation so that a joint approach to, and operating framework for these issues could be established.
  Budgetary allocation: US$3,018.00/EC$8000.00)
- **Enhancement guidelines for Grenada:** This project seeks to establish and enhance guidelines for treatment and rehabilitation (EGTR) or (EGG) so as to standardize programs in Grenada. This allows for a unified approach to issues as well as easy monitoring and evaluation of effectiveness. This project was projected to be

implemented during the period September 2004 – February 2006.
Budgetary allocation: US$1,886.00/EC$5000.00)

- **Community awareness mobilization project:** This program seeks to identify and educate persons in the community to assist in the rehabilitation of drug users and abusers, so that they can be gainfully employed in the community. Program would run for eighteen months with twelve weeks spent in each parish. Proposed commencement date was June 2004.
  Budgetary allocations: US$ 1,132.00 (EC$3000.00)

It is interesting to note that the budgetary allocation for treatment and rehabilitation represented 0.8% for programming efforts as outlined in the master plan. Refer to Table 2 for a summary of the master plan budgetary allocations.

Table 2: Summary of budgetary allocations for the strategic priorities as outlined in the Anti-drug Master Plan

Action	National (EC$)	External (EC$)	Total (EC$)	% of total budget
NCODC – Administration	(US$200,000.00) **EC$530,000.00)**	-	(US$200,000.00) **EC$530,000.00)**	25.3
Prevention	(US$11,640.39) **(EC$30,847.05)**	(US$65,962.24) **(EC$174,799.95)**	(US$77,602.00) **(EC$205,647.00)**	10
Treatment and rehabilitation	(US$905.00) **(EC$2400.00)**	(US$5,132.00) **(EC$13,600.00)**	(US$6,037.73) **(EC$16,000.00)**	0.8
Interdiction	(US$51,905.66) **(EC$137,550.00)**	(US$294,132.07) **(EC$779,450.00)**	(US$346,037.73) **(EC$917,000.00)**	43.8
Anti-money laundering	(US$5,677.35) **(EC$15,045.00)**	(US$32,171.60) **(EC$85,255.00)**	(US$37,849.05) **(EC$100,300.00)**	4.8
Chemical diversion	(US$18,471.00) **(EC$48,948.45)**	(US$104,669.64) **(EC$277,374.55)**	(US$126,914.35) **(EC$336,323.00)**	16.1
TOTALS	(US$288,600.18) **(EC$764,790.00)**	(US$502,067.73) **(EC$1,330,479.50)**	(US$790,667.00) **(EC$2,195,270.00)**	**100**

Discussions emanating from the master plan development alluded to the need to focus more resources on prevention as opposed to treatment, due to the increase potential for greater sustainable impacts. High cost of primary prevention initiatives was identified as a limiting factor in achieving the above (Government of Grenada, 2002).

The Ministry of Health initiated another landmark decision in 2004 with the commencement of the Mental Health Policy and legislature development process. The initiative carded to be completed in December 2006, is anticipated to be funded by PAHO, WHO and the Canadian Government, through the Dalhousie University. Treatment and rehabilitation would represent a

major component of the policy, and is expected to address a range of issues, including but not limited to standard of care, inter-sectoral collaboration, admission, aftercare etc.

1.3 HISTORICAL OVERVIEW OF TREATMENT AND REHABILITATION IN GRENADA

1.3.1 Carlton House Treatment and Rehabilitation Centre

In January 1985, Carlton House Treatment and Rehabilitation Centre[7] was established with the aim of providing treatment to both males and females for alcoholism and related problems. This decision was fuel by the destruction of the Richmond Hill Mental Hospital in October 1983, resulting in limited capacity for in-house patients. It therefore became necessary to conduct a reassessment of patients at the institution.

The late Dr. Michael Beaubrun, Psychiatrist and Professor of Psychiatry at the University of the West Indies, was assigned to conduct the reassessment of patients intake. One of the findings of the reassessment was the large number of patients with alcohol-related problems. Professor Beaubrun recommended the establishment of a facility for the treatment of alcohol addiction; the recommendation was accepted by the Government of Grenada. Dr. Beaubrun along with the late Dr. George Clarke, Psychologist, Dr. Roger Radix, Mrs. Shirley Mathlin, who was the Administrative Officer in the Ministry of Health, Dr. George Mahy, and Dr. Prabakher worked assiduously to establish Carlton House.

Funding for the establishment of the institution was secured from various sources such as the Smithers Foundation, USAID, National Commercial Bank, and Jonas Browne and Hubbard's. At the time of commissioning, Carlton House was designed for accommodating sixteen (16) patients, including four (4) females (adapted from Drug Control Secretariat, 2005).

The passage of Hurricane Ivan in 2004 destroyed the building housing the treatment centre, rendering it unsuitable for use.

1.3.2 Mt. Gay Mental Hospital

Mt. Gay Mental Hospital was established in 1987. It is a ninety-six (96) bed facility which provides long-term stay for patients who experience prolonged psychiatric disorders including drug-related problems.

[7] Carlton House Treatment and Rehabilitation Centre would be referred to as Carlton House throughout this document.

1.3.3 Rathdune Psychiatric Unit[8]

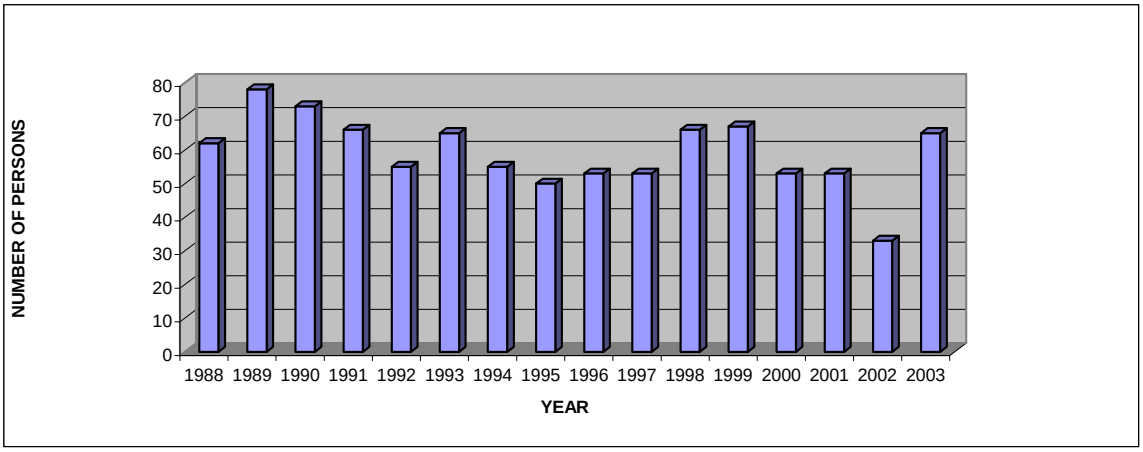
Rathdune Psychiatric Unit was established at the General Hospital in 1986, for patients with psychiatric disorders including acute drug-use problems. It is a twenty (20) bed facility which provides short-term stay for patients. It also serves as a detoxification unit. The Unit is currently housed at the Mt. Gay Hospital.

1.4 STATISTICAL REVIEW OF DRUG TREATMENT AND REHABILITATION, DRUG RELATED OFFENSES AND IMPRISONMENTS

1.4.1 Admissions to Carlton House Treatment and Rehabilitation Centre (1988 – 2003)

During the fifteen year period spanning 1988 – 2003, nine hundred and forty seven (947) persons were admitted to Carlton House, the principal drug treatment and rehabilitation centre in Grenada (Drug Control Secretariat, 2005). As illustrated in Figure 1, the highest and lowest intake occurred during 1989 and 2002 respectively. The dramatic reduction in 2002 occurred as a result of renovations to the treatment facility.

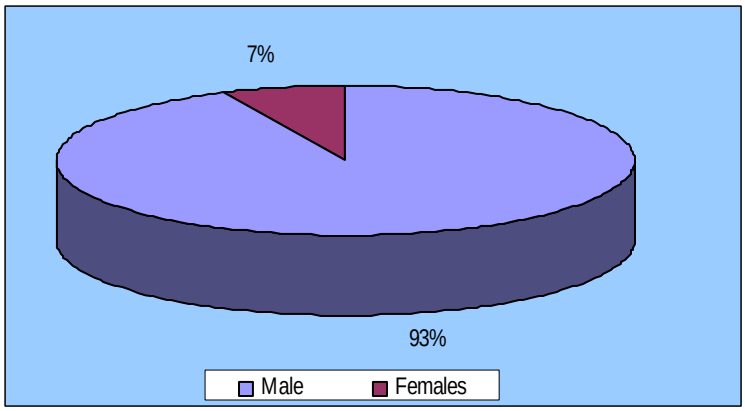
Figure 1: Number of Persons Admitted to Carlton House 1988 – 2003



As illuminated by Figure 2, males represented the greater part of patients admitted to the treatment centre, accounting for approximately 93% of all admissions.

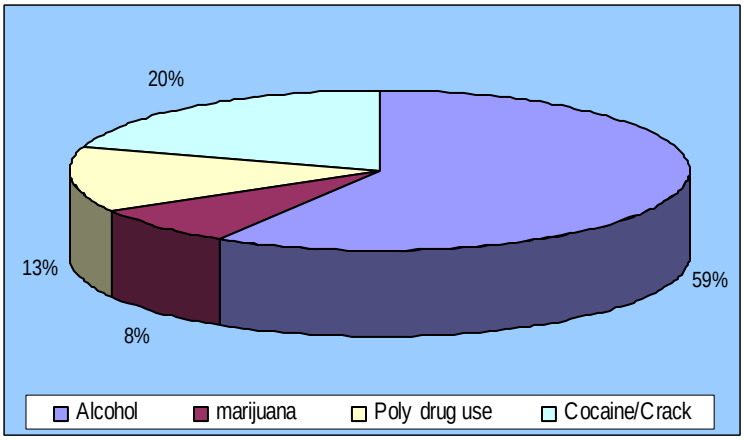
[8] Rathdune Psychiatric Unit would be referred to as Rathdune throughout this document.

Figure 2: Pie chart showing the variation of males and females attending Carlton House during the period 1988 – 2003



Further analysis of the statistics revealed that patients were admitted to Carlton House for the following dependencies: alcohol, marijuana, cocaine and poly drug use. Alcohol dependence represented the most common reason for patient admittance (58%), followed by persons with crack/cocaine addictions (20.2%). Interestingly, 12.8% of all entries to the treatment centre were due to poly drug use, while only 8% entered because of marijuana abuse (Refer to Figure 3).

Figure 3: Pie chart illustrating the percent of patients admitted to Carlton House based on type of substance abused



1.4.2 Readmissions to Carlton House Treatment and Rehabilitation Centre (1996 – 2003)

During the period 1996 to 2003, one hundred and seventy seven (177) recovering addicts were readmitted to Carlton House as shown by Table 3. The mean number of patients readmitted annually as illuminated by the data is twenty two (22).

Table 3: Readmissions to Carlton House, 1996 - 2003

Year	Number of patients readmitted
1996	25
1997	12
1998	23
1999	25
2000	18
2001	22
2002	32
2003	20
2004	0[9]

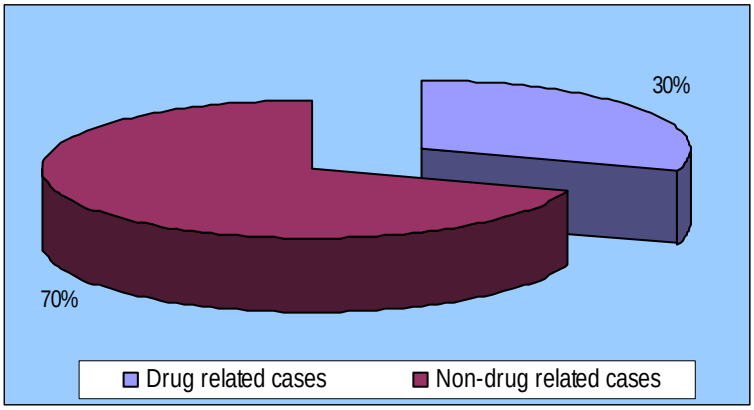
During the eight year period under study (1996 – 2003), 40% of recovering patients were readmitted to the Centre. No data is available to determine the outcome of the remaining 60%.

1.4.3 Admissions to Rathdune Psychiatric Unit during 2002 - 2004

1.4.3.1 Statistics for the period 1st January – December 2002

Of the four hundred and sixty cases admitted to Rathdune during 2002, thirty percent (30%) or one hundred and forty (140) of these patients showed signs of drug induced psychosis (Refer to Figure 4).

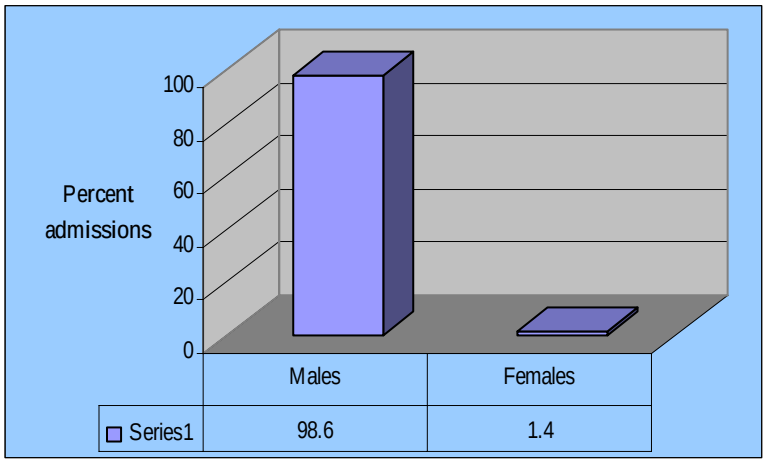
Figure 4: Percentage of drug related cases admitted to Rathdune in 2002



An overwhelming percentage of these drug related admissions as shown by Figure 5 were males (98.6%) – a total of one hundred and thirty eight (138) cases.

[9] Number of patients for the 2004 is representative of January 1 to June 30, 2004. Data for the remaining months of 2004 is unavailable due to the destruction of Carlton House by Hurricane Ivan.

Figure 5: Bar Chart illustrating the gender representations admitted to Rathdune in 2002



The data also revealed that the largest intake to the acute unit in 2002, amounting to 17 and 15 cases occurred during the months of August and December respectively, while the lowest number of admissions occurred in the month of March – seven (7) cases. Further analysis showed that almost three quarter (3/4) of admitted cases during that same year were forty five years and under (101 cases). Approximately one fifth (1/5) of all cases were under fifty nine years, while only 8.6% were sixty nine years and under (Refer to Table 4).

Table 4: Table showing age range of persons attending Rathdune in 2002

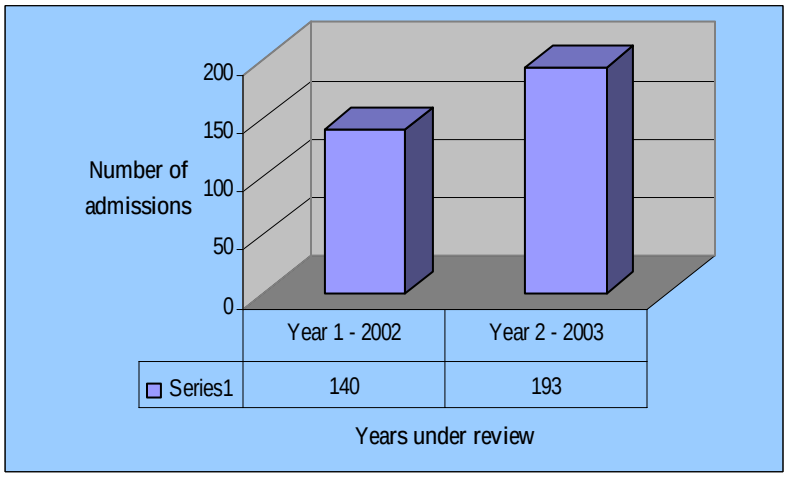
Age range	Number of persons	% of admitted cases
49 years and under	101	72
59 years and under	27	19.4
69 years and under	12	8.6

In summary, persons who attended the acute unit in 2002 were between the ages of 14 – 69, spanning four distinct age groups.

1.4.3.2 Statistics for the period 1st January – December 2003

Drug related admissions to Rathdune increased by 38% in 2003 when compared to the previous year (Admissions in 2002 - 140; Admissions in 2003 - 193) as shown in Figure 7. A dramatic increase in the number of both sexes was noted in the new term, though more significant for females. Specifically, eleven more females (550%) were admitted to the unit in 2003, while forty two more males were admitted (30%).

Figure 6: Bar chart showing the number of persons admitted to Rathdune during 2002 and 2003



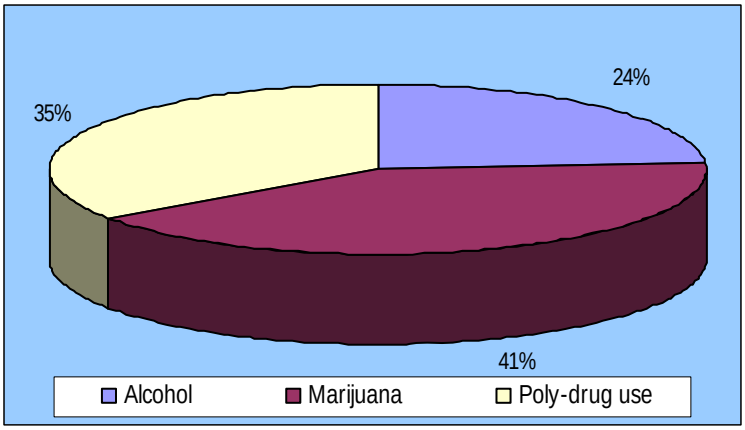
Additionally, a shift in the age range of persons admitted to Rathdune in 2003 was also recorded. As shown in Table 5, the majority of patients were seventy three years (73 years) and under (61%), followed by persons fifty eight years and under (21.3%).

Table 5: Table showing age range of persons attending Rathdune in 2003

Age range	Number of persons	% of admitted cases
73 years and under	118	61.1
58 years and under	41	21.3
46 years and under	34	17.6

Statistical information also revealed that cases admitted to Rathdune during the year under review were due to three types of drug dependencies: alcohol, marijuana and poly drug use. In contrast to the previous year, marijuana addiction was the principal reason for admission (41.5%). This was followed by poly drug use (34.7%) and alcohol abuse (23.8%).

Figure 7: Pie chart illustrating the percent of patients admitted to Rathdune in 2003 based on type of substance/s abuse

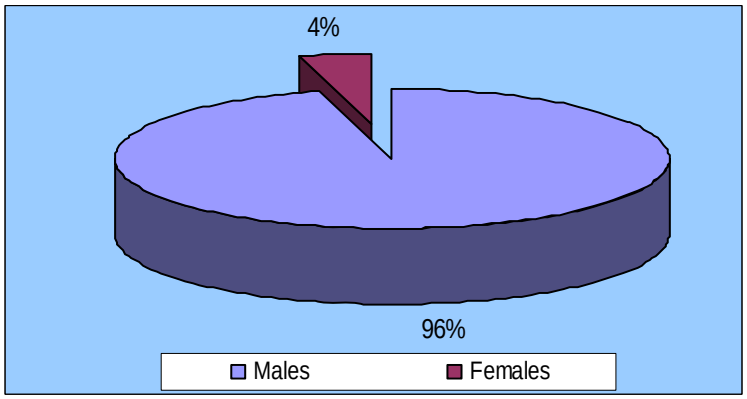


Admissions in 2003 peaked in February and December (22 cases), and were lowest in September and January (12 cases).

1.4.3.3 Statistics for the period 1st January – September 2004

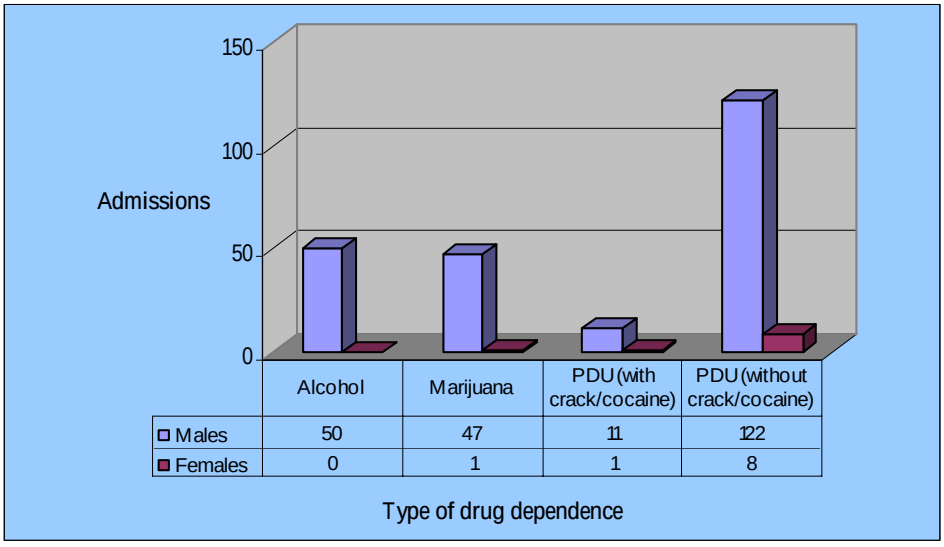
Figure 8: Pie chart illustrating the gender differences in admissions to Rathdune- January 1st to September 2004

During the period 1st January to September 2004, the Drug Control Secretariat reported that two hundred and forty (240) drug related patients entered Rathdune, with the majority of cases being male (96%) (Refer to Figure 8).



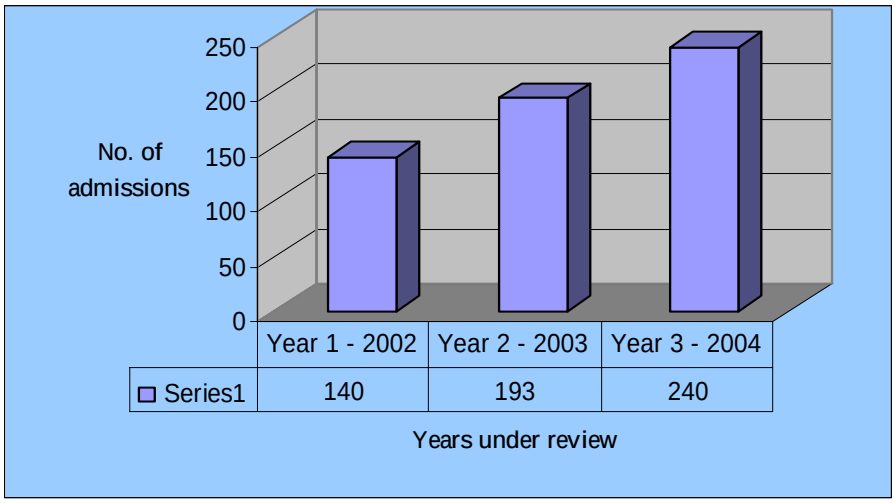
Similar drug dependencies were reported. However, poly drug use without crack/cocaine was recorded as the principal reason for admission (54.2%) as compared to marijuana in the previous year as depicted in Figure 9.

Figure 9: Number of cases admitted to Rathdune during 1st January to September 2004 based on drug type



During the period under study, males outnumbered female admissions considerably.

Figure 10: Summary of admissions to Rathdune during the period 1st January 2002 to September 2004

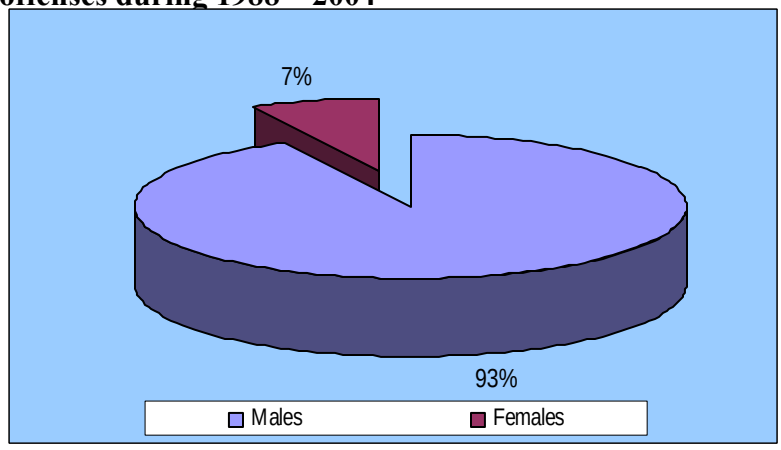


In summary, as illustrated by Figure 10, the incidence of drug related admissions to Rathdune during the period 1st January 2002 to September 2004 increased steadily.

1.4.4 Drug Related Offenses and imprisonments at Her Majesty's Prisons 1988 – 2004

During the period understudy (1988 – 2004), five thousand, three hundred and sixty three (5363) persons were arrested and charged with drug related offenses. On average, nine in every ten persons from this pool were males (93%) as illustrated in Figure 11.

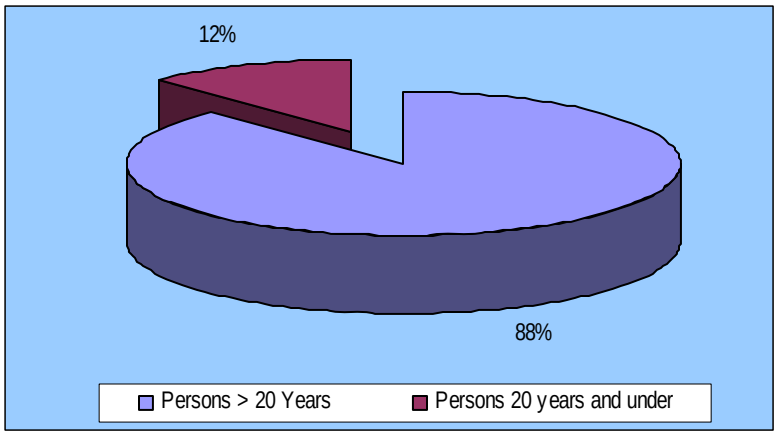
Figure 11: Gender variations among persons charged with drug related offenses during 1988 – 2004



During the period 1988 – 2004, approximately nine in every 10 persons arrested and charged with drug related offences were males.

Approximately 12.3% of persons charged and arrested during the understudy period represented individuals twenty years and under as shown by Figure 12. Similarly, males in this age category outnumbered females by 75.5% (Males: 581 and Females: 81).

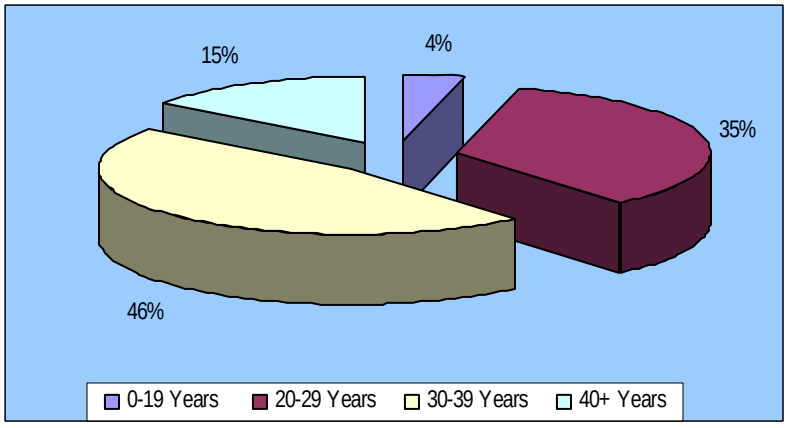
Figure 12: Persons twenty years and under arrested and charged for drug related offences 1988 – 2004



The data further showed that 25.2% of persons (1,349) arrested and charged for drug related offences were convicted to Her Majesty's prison during the sixteen year period.

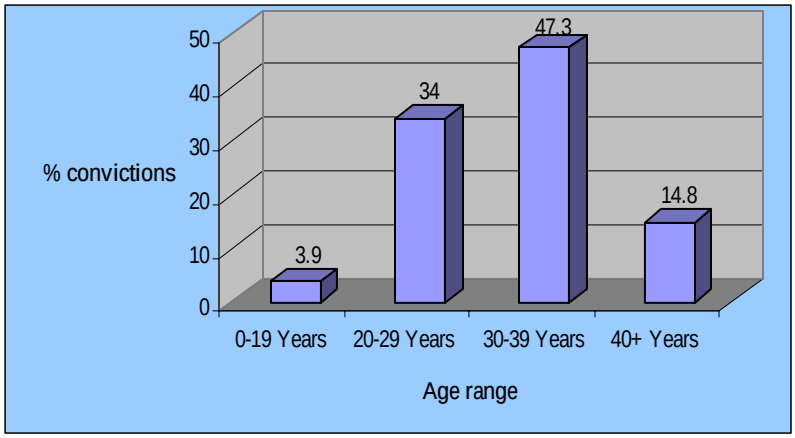
Investigation of the age range of persons convicted for drug related offences revealed that the majority of individuals were between the ages of 30-39 (46.4%) and 20 – 29 (34.8%) as shown in Figure 13.

Figure 13: Age range of males and females convicted for drug related offences 1988 – 2004



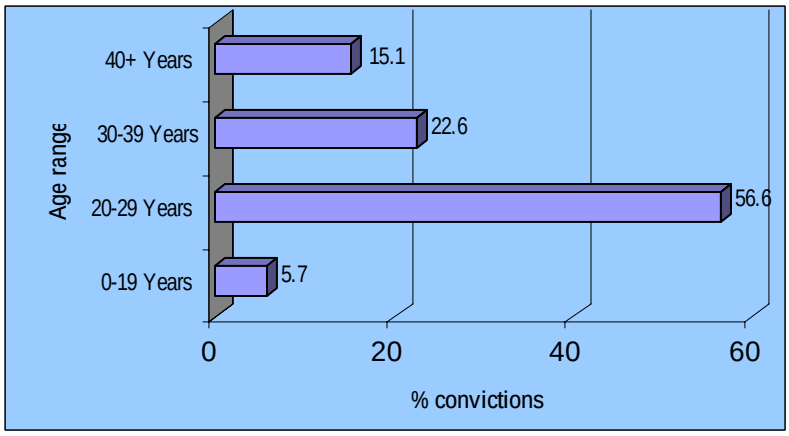
Further analysis pointed out that the majority of males convicted were between the ages of 30 – 39 (47.3%), followed by those 20 – 29 years (34%). Males 0 – 19 years were least convicted (3.9%) during the understudy period as illuminated in Figure 14.

Figure 14: Age range of males convicted to prisons 1988 – 2004



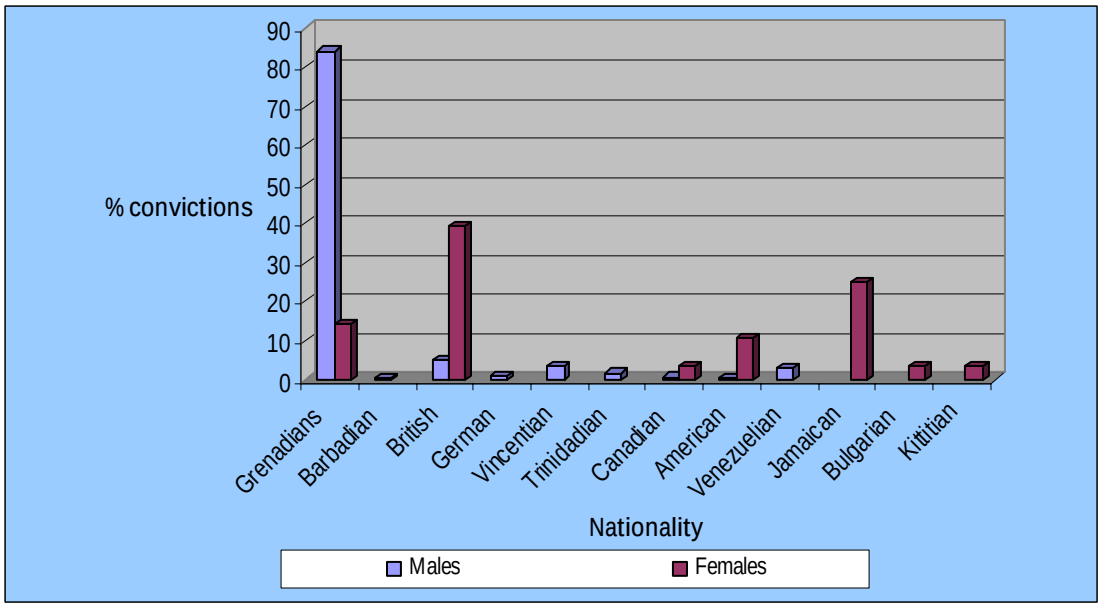
Female convictions revealed a slightly different picture. Almost six in every ten females convicted were between the ages of 20 – 29, with approximately two in every ten between the ages of 30 – 39 as shown in Figure 15.

Figure 15: Age range of females convicted to prisons 1988 – 2004



During the period 1999 – 2004, the vast majority of males convicted to Her Majesty's Prisons were Grenadians (84.2%) as shown in Figure 16. On the other hand, the majority of female convictions were of persons with British/English (39.2%) and Jamaican (25%) nationalities. Grenadians represented only 14.3% of all females convicted during the seven year period.

Figure 16: Nationality of males and females convicted to Her Majesty's Prison 1999- 2004



1.5 REPORT ORGANIZATION

This report is organized into six sections.

Section 1 provided an overview of the study and its context. This included Grenada's geographical position, its socio-economic status and a synopsis of the legislative and policy framework informing drug treatment and rehabilitation. Emphasis was also placed on providing a historic summary and statistical review of drug treatment and rehabilitation admissions, and drug related offences and imprisonments at the national level.

Section 2 presents the study's evaluation protocol.

Section 3 summarizes the findings of the study. Specifically, it describes the treatment modalities and services provided by each drug treatment institution. Logic models, which depict the logical linkages among program resources, activities, and expected outputs for the three drug treatment providers are also highlighted.

Section 4 features the main findings of the study.

Section 5 summarizes the study's findings.

Section 6 proposes recommendations to improve the effectiveness of drug treatment and rehabilitation, with explicit focus on policy directions, administration, program content and delivery and follow up and aftercare.

2.0 EVALUATION METHODOLOGY

2.1 RESEARCH APPROACH

This study used a qualitative approach to assess the effectiveness of drug treatment and rehabilitation services in Grenada. The approach employed paralleled the needs assessment model of evaluation, which focused on identifying the critical elements needed to significantly boost effectiveness of the treatment and rehabilitation landscape. Process and/or outcome evaluation was not a viable option at the time of the research, largely because the prime treatment centre, Carlton House, was not in operation.

2.2 GENERAL RESEARCH STRATEGIES

Key informant interviews represented the central research strategy used for this study. Informants were selected from among policy makers, treatment institutions, and outpatient recovering addicts (Refer to Appendix 1 and 2 for the research instrument used, and the names of persons interviewed).

2.2.1 Selecting Key Informants

Selecting policy makers and institution staff

Key informants were selected using purposeful sampling. The researcher, with guidance provided by the administrator of the Richmond Hill Institution,[10] and the staff of the Carlton House decided upon a number of key informants. Informants were subsequently interviewed at their various workplaces.

Selecting outpatient recovering addicts

Although a very difficult process, recovering addicts were selected using purposeful sampling. Firstly, telephone contacts of previous patients of the Carlton House Treatment Centre were provided to the researcher by a Nursing Assistant attached to the Centre. To supplement this list of names, the Nursing Assistant selected in an adhoc manner names of clients whose files were still available at the Centre. It should be noted that the Assistant made every effort to inform potential interviewees, where possible of the study, and sought their willingness to participate. The researcher followed up with contacts provided, and was successful in securing interviews from eight persons.

[10] The Richmond Hill Institution is a tri-organizational unit comprised of the Mt. Gay Psychiatric Hospital, Carlton House Treatment and Rehabilitation Centre and the Richmond Home. The Institution is managed by an administrator who reports to the Director of Hospital Services under the auspices of the Ministry of Health.

2.3 ANALYSIS

Content analysis was the principal method used to analyze all qualitative data colleted. Analysis sought to determine the frequency of topics being discussed, and also the relative importance of the repeated theme in the informant interviews.

Demographic data obtained from the recovering addicts were analyzed to obtained simple guided frequencies.

2.4 LIMITATIONS OF STUDY

This study was limited by three main factors as discussed below:

- The main treatment centre, Carlton House was not functioning at the time of the study. To this end, the evaluation approach used was limited, since it was not possible to conduct a process and/or outcome type evaluation. This also prevented interaction with key players, and participant observation of the program in action.

- Securing appointments to conduct interviews with recovering addicts proved very challenging. Most of these patients were very difficult to locate since a significant percentage of the telephone numbers provided were out of service or were no longer the residence of the recovering addict. Added to this, a number of the subjects contacted were very hesitant in participating in the interview. For instance, they would agree in principle via telephone conversation to participate in the study; however on follow up conversation would indicate that they would contact me since they were very busy. This never happened.

- Similarly, it proved very difficult to secure appointments with a few critical key informants. In fact, certain policy makers identified were never interviewed due to their extremely hectic schedule.

PRESENTATION OF FINDINGS

3.0 DRUG TREATMENT AND REHABILITATION MODALITIES AND SERVICES

3.1 DRUG TREATMENT AND REHABILITATION MODALITIES

Two principal types of drug treatment and rehabilitation modalities exist in Grenada as listed below:

- One residential inpatient program operated by Carlton House;
- One ambulatory outpatient program managed by the Mt. Gay Psychiatric Hospital delivered primarily through established medical clinics.

The section below describes each modality in detail, with specific emphasis placed on its operating framework, services provided, target audiences and governance structures.

3.1.1 In Patient Residential program

Carlton House is the exclusive provider of in-patient residential drug treatment on the island. The entity, part of the Richmond Hill Institution is managed and regulated by the Ministry of Health. The Centre provides a free three months treatment program for patients in a closed facility irrespective of gender, age and socio-cultural characteristics. Patients are treated for a number of substance abuse problems, inclusive of alcohol, marijuana, crack/cocaine and poly drug use. The treatment modality is based primarily on the Alcoholics Anonymous (AA) 12 steps program, and infused heavily by life skills and cognitive-behavioural therapy.

3.1.2 Ambulatory Outpatient Program

Mt. Gay Psychiatric Hospital is the lone institution that provides long term treatment and care for chronic mental health patients, including those with drug related psychosis. An ambulatory outpatient program is operated by the Hospital, and provides medical services to mental health patients, *including those exhibiting co-morbidity with a known substance abuse problem.*[11] Patient displaying the above co-morbidity are clinically assessed to determine mental stability, and provided with appropriate treatment. Additionally, to address related drug problems, these patients are provided with some limited counseling via a collaborative team of psychiatric doctors, social worker and community mental health officers as deemed necessary.

The outpatient program is delivered to patients across the nation through five AM medical clinics as outlined in Table 5. On average, this community based treatment service is provided to each parish or district at least once per month; with St. George's receiving at least four visits.

[11] A typical patient exhibiting this co-morbidity condition can be diagnosed with schizophrenia and marijuana dependence.

Table 6: Schedule for Mt. Gay Psychiatric Hospital Ambulatory Outpatient Clinics

Name of medical clinic	Principal parish or districts served	Frequency of outpatient service	Expected implementation
St. David's Health Centre	St. David's	Once (1) per month	1st Wednesday in each month from 8: 00 am
Grand Bras Health Centre	St. Andrew's	Once (1) per month	2nd Wednesday in each month from 8:00 am
St. Patrick's Health Centre	St. Patrick's	Once (1) per month	3rd Wednesday in each month from 8:00 am
Gouyave Health Centre	St. John's and St. Mark's	Once (1) per month	4th Wednesday in each month from 8:00 am
Mt. Gay Psychiatric Hospital	St. George's	At least 4 times per month	Every Thursday in each month from 8:00 am
Hillsborough Health Centre	Carriacou and Petite Martinique	Once (1) per month	1st Friday in each month from 8:00 am

It is important to note that the outpatient services can be accessed by persons of any sex and/or age. Table 7 summarizes the drug treatment modalities in Grenada.

Table 7: Summary of drug treatment modalities in Grenada

Type of drug treatment modality	Provider	Status of provider	Target audience
In-patient residential	▪ Carlton House Treatment Centre	Public	▪ All sexes ▪ All ages
Ambulatory outpatient[12] (six sites)	▪ Mt. Gay Psychiatric Hospital	Public	▪ All sexes ▪ All ages

3.2 DRUG TREATMENT AND REHABILITATION SERVICES

This section identifies and describes the drug treatment and rehabilitation services provided in Grenada. Emphasis is placed on describing the governance structures, geographic coverage and treatment protocols of the various services.

As outlined in Table 8, five main types of drug treatment and rehabilitation services exist in Grenada facilitated through three publicly funded providers. All services rendered offer national coverage.

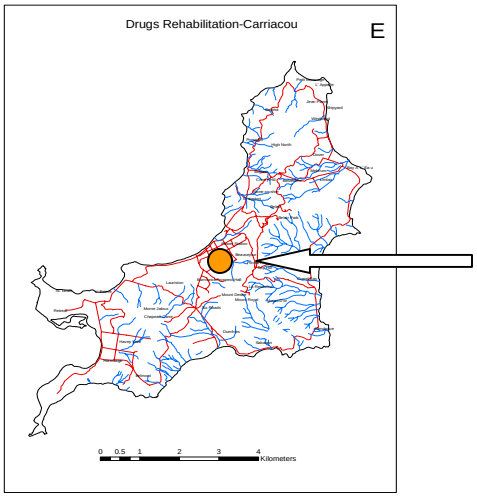
[12] This program is operated through five established public medical clinics.

Table 8: Summary of drug treatment services in Grenada

Services provided	Number of services	Provider/s	Status of provider	Geographic coverage
Referral of cases	3	▪ Carlton House Treatment and Rehabilitation Centre ▪ Rathdune Psychiatric Unit ▪ Mt. Gay Psychiatric Hospital	Public	National
Detoxification	2	▪ Carlton House Treatment and Rehabilitation Centre ▪ Rathdune Psychiatric Unit	Public	National
Treatment and rehabilitation[13]	1	▪ Carlton House Treatment and Rehabilitation Centre	Public	National
Social integration and aftercare	1	▪ Carlton House Treatment and Rehabilitation Centre	Public	National
Self help groups	1	▪ Carlton House Treatment and Rehabilitation Centre	Public	National

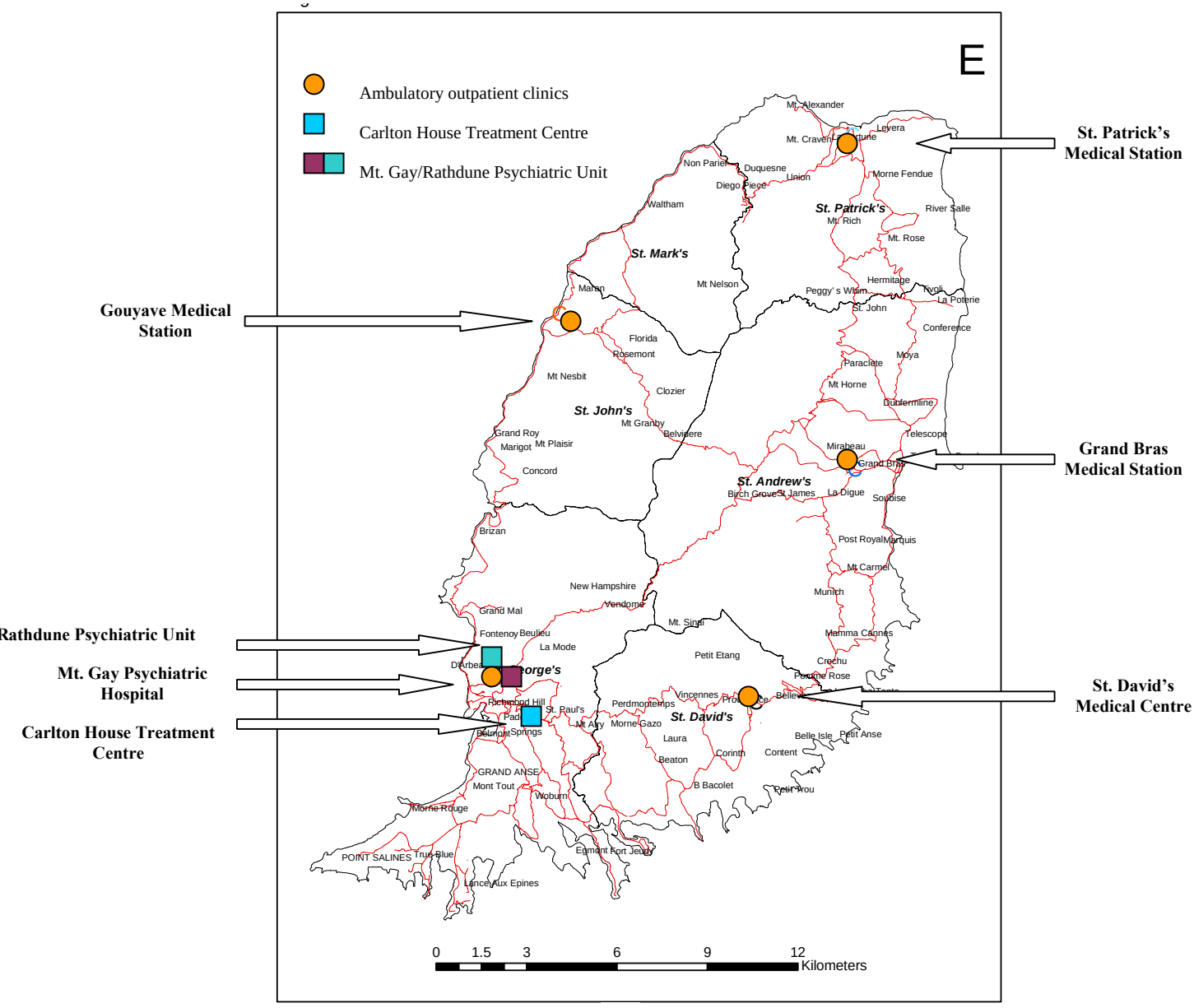
All three drug treatment providers are located in the nation's capital, St. George's. However, as shown in Table 6 above, Mt. Gay Psychiatric Hospital operates five additional ambulatory outpatient clinics located outside of the capital. Figure 17 (a and b) shows graphically the geographical location of the treatment centres and service deliveries in Grenada.

Figure 17a: Map showing the geographical location of the ambulatory outpatient clinic in Carriacou



[13] Some very limited psychotherapy services are provided by Rathdune Psychiatric Unit.

Figure 17b: Geographical location of treatment and rehabilitation centres, and ambulatory outpatient clinics



The subsequent sections elaborate the operating protocol for each service as presented by treatment providers.

3.2.1 Referral of Cases

As reported by key informants, a well established collaborative mechanism exists for the referral of cases to and from the drug treatment centres. Principal players associated with the referral network include Carlton House, Mt. Gay Psychiatric Hospital, Rathdune, the local hospitals,[14] families, employers, medical doctors, Non-Governmental Organizations, the Judicial and Enforcement systems. The subsequent sections describe the referral code of practice used at each of the main treatment centres.

3.2.1.1 Mechanism for referral of cases to and from Carlton House

General Referrals to Carlton House

Patients are referred to Carlton House by a number of individuals and organizations (both public and private) as illustrated in Figure 18. Each referred case must first be authorized by a certified medical doctor prior to admittance. Successful referral to Carlton House nonetheless is dependant on voluntary admission by the patient.

Referrals prior to treatment at Carlton House

All patients admitted to the Carlton House treatment program undergo a routine medical assessment conducted by the Psychiatric Team doctors attached to the Mt. Gay Psychiatric Hospital. The chief objective of the assessment is to evaluate the physical and mental state of the patient, and to make a clinical determination regarding the individual's capacity to successfully participate in the treatment program.

> "The priority is to make sure that the patient is physically well and competent to take the rehabilitation [Key Informant, Mt. Gay Psychiatric Hospital]."

Based on the outcome of the assessment, a joint decision is taken between the Psychiatric Team doctor/s and the staff of Carlton House regarding the most suitable mode of treatment for the patient. If the assessment is deemed positive, which means that the patient is medically robust to participate in the treatment program, that individual is formally accepted at Carlton House. However, the assessment can diagnose underlying mental illnesses and/or physiological problems which could severely hamper any efforts at effective drug treatment outcomes. These

[14] The three hospitals in Grenada namely, the General Hospital, Princess Alice and Princess Royal all refer patients to drug treatment related programs.

patients would therefore be referred to the General Hospital, Rathdune or the Mt. Gay Psychiatric Hospital depending on the nature and/or severity of the diagnosis.

> "If they are not prepared for the treatment program, they are referred to who is best to deal with their needs. Example, if they are still withdrawing, a decision should be taken whether to treat them at Carlton House or at the General Hospital [Key Informant, Mt. Gay Psychiatric Hospital]."

For instance, if the patient is clinically assessed to be psychotic, that individual is referred to the Rathdune for further analysis and treatment. Moreover, the patient could be suffering from non-mentally related chronic diseases that resulted from, or were aggravated by substance abuse, for example, Liver Cirrhosis or Peptic Stomach. In this case, the patient would be referred to the General Hospital. In addition, if the patient is diagnosed to be experiencing major withdrawal symptoms, relocation to the General Hospital or Rathdune becomes a more pragmatic choice.

> "If we believe that they are going through withdrawal and the resulting delirium tremens would be too serious, we can't treat them at Carlton House. They are referred to Causality Department at the General Hospital or Rathdune. This is done at the initial assessment. [Key Informant, Carlton House]."

Staff at Carlton House revealed that some effort is made to convince referred patients, particularly ones sent to Rathdune and the General Hospital of the correlation between their drug consumption habit and current medical problems experienced. Furthermore, treatment at Carlton House is promoted to these patients as the next step after their intermediary treatment to resolve substance dependencies. If the promotion was successful, patients would return for treatment at Carlton House.

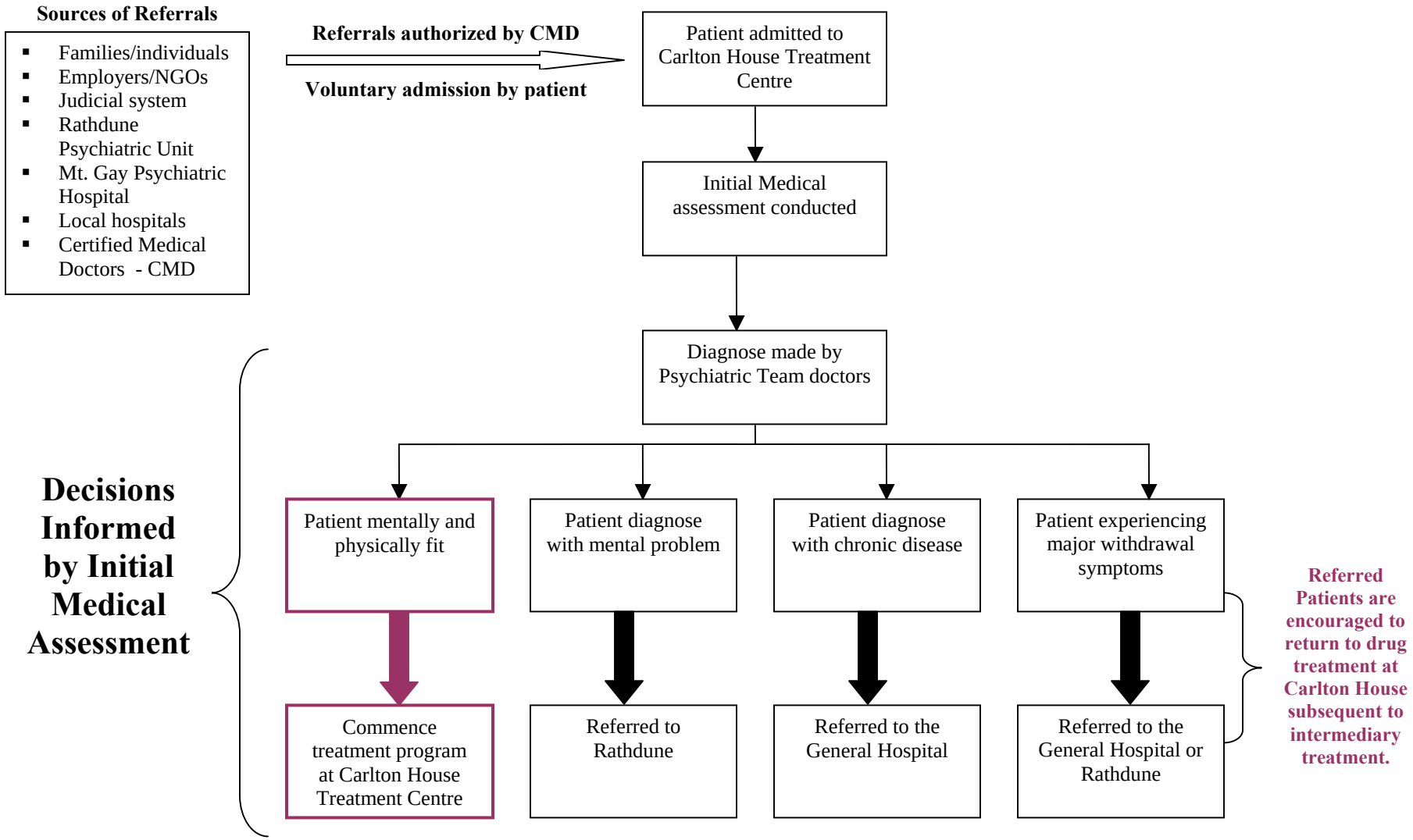
> "Hopefully, by the time they leave we, would have convinced them that the reason for their problem is as a result of drugs or alcohol. If you convince them of the importance of Carlton House, once they buy in they would come back [Key Informant, Carlton House]."

Referrals during treatment

Key informants also reported that during the treatment process, some patients are referred for short term medical treatment at the General Hospital or other more convenient primary health care facility.

> "Remember they were not taking care of themselves they were using drugs maybe for the same pain. So now they are off it, they are experiencing problems. We might have to take them to the dentist or to get blood tests to see how well their liver is functioning. Some may have come in with injuries. All this needs attention [Key Informant, Carlton House]."

Figure 18: Schematic illustrating referral mechanism to and from Carlton House



3.2.1.2 Mechanism for referral of drug related cases: Rathdune

Similar to Carlton House, referrals to Rathdune occur from a multitude of sources, inclusive of families, individuals, local hospitals, District Medical Officers, the enforcement system and Carlton House. One key distinguishing feature of Rathdune's referral system is that patients' consent does not constitute a criterion for admission. The foremost criterion therefore, used as a justification for referral would be symptoms of a psychotic illness.

As discussed in Section 1.3.2, a significant percentage of cases admitted to Rathdune are diagnosed with drug induced psychosis. Subsequent to the pharmacotherapy and limited psychotherapy administered to these patients during their term at the acute unit, the benefits of entering the treatment program at Carlton House would be explained. However, patients must then make an informed voluntary decision to be further treated, if they perceive this path as a worthwhile option.

3.2.1.3 Mechanism for referral of cases: Mt. Gay Psychiatric Hospital

All patients admitted to Mt. Gay Hospital must first be screened at Rathdune Psychiatric Unit. If the individual is clinically diagnosed with drug induced psychosis, detoxification would be the first logical line of treatment. After undergoing treatment at Rathdune, if the patient's is diagnosed with a chronic mental illness, he/she would be referred to Mt. Gay for additional treatment.

Subsequent to treatment at Mt. Gay, if a determination is made that the person has a substance abuse problem, and is mentally and physically stable to undergo psychotherapy, that person would be referred to Carlton House. As indicated above, the final decision to proceed to this route would be dependent on the patient.

3.2.2 Detoxification

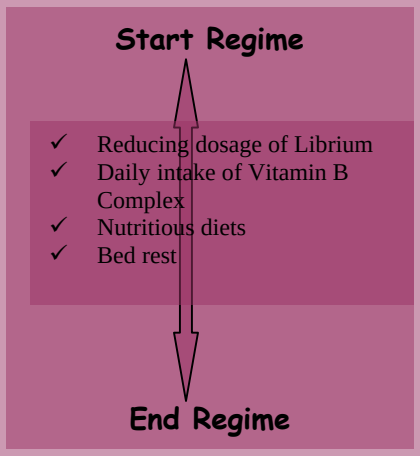
3.2.2.1 Detoxification protocol at Carlton House

Immediately following the medical assessment, formally admitted patients to Carlton House undergo the process of detoxification. The goal of detoxification is to ensure that the patient is drug free, and stable enough to undergo psychotherapy. This process is also extremely critical in helping to manage the impending withdrawal symptoms experienced by patients, due to the drastic change in drug consumption habits.

Two weeks are allotted for this process; although on average, patients are detoxified for approximately seven (7) days. During detoxification, patients are administered the tranquilizer Librium at a reducing dose for seven (7) days (Refer to Box 1 for a summary of the detoxification regimen). Vitamin B complex is also administered for the same duration. The target group is placed on an enriched diet due to the prevalence of dietary deficiencies, and the urgent need for stabilization. Bed rest is also encouraged during this phase. It is important to

note that patients are not kept on this regime for long periods, due to the addictive properties of Librium.

Box 1
Treatment regime during detoxification – Carlton House



Medication and dosage	Number of times daily	Duration
20 mg Librium	3 times daily	Days 1 – 3 (3 Days)
20 mg Librium	Twice daily	Days 4 – 5 (2 days)
20 mg Librium	At nights only	Days 6 – 7 (2 days)

Key informants reported that monitoring of patients during that phase is imperative due to the potential for developing serious withdrawal symptoms, with resultant fatal delirium tremens. In light of this, patients are stationed in a specially designed room, which contains beds that are packed closely together, with rails to prevent patient falling and injuries. Routine medical checks are made every, with special emphasis placed monitoring standard physical indicators such as blood pressure, pulse rate etc.

3.2.2.2 Detoxification protocol at Rathdune Psychiatric Unit

Alcoholic patients diagnosed with drug induced psychosis at Rathdune are detoxified using the protocol in described in Box 2. Tegretol and Thiamine are removed from the regime if the person is marijuana and/or cocaine dependent, while the former is removed if the patient problems are linked to only cocaine.

Box 2
Treatment regime during detoxification for alcohol abuse patients – Rathdune

Medication and dosage	Number of times daily	Duration
Librium (tapering doses) o 20 mg o 20 mg o 20 mg	 Three (3) times daily Twice (2) daily Once (1) daily	 One day (1/7) Two days (2/7) Two days (2/7)
Tegretol o 400 mg	 Twice (2) daily	 Five (5) days (5/7)
Thiamine o 100 mg (intramuscular) o 100 mg (orally)	 Once (1) daily Once (1) daily	 One day (1/7) Regularly
Vitamin B Complex	One tablet twice (2) daily	
Folic Acid	As needed	
Valium o 10 mg	 Twice (2) daily	 Three days (3/7)
Haloperidol (Haldol) o 1.5 mg	 At nights	 Five days (5/7)

3.2.3 Treatment and Rehabilitation

The most comprehensive drug treatment and rehabilitation services are provided by Carlton House. In fact, treatment and rehabilitation represents the most extensive component of the transformation process offered by the treatment institution. Care is provided by a multidisciplinary team of specialists to address the medical consequences of drug dependence, and associated problematic psychosocial behaviors.

Psychotherapy represents the principal technique of the treatment and rehabilitation component of the program. It is comprised of three focal areas, namely (Refer to Figure 21):

- Group therapy
- Family therapy
- Individual therapy

Some limited psychotherapy is also provided by Rathdune as expounded on in subsequent sections.

Exercise, relaxation and meditation are also integrated as part of the treatment and rehabilitation model for recovery.

3.2.3.1 Group therapy

Group therapy at Carlton House

Group therapy, which occurs twice daily, is designed to provide opportunities for the dissemination of critical didactic information to patients, and a favourable environment for forthright and candid discussions. The ultimate goal of this therapeutic model as expressed by key informants is to increase patients' self awareness, and stimulate cognitive and behavioural changes consistent with the attainment of sobriety and productive living.

The 12 steps of the Alcoholics Anonymous (AA) program embody the guiding philosophies of the treatment process, and are featured prominently during group therapy. Key informants described the program as extremely spiritual, due to the overt focus on seeking divine intervention in the transformation process.

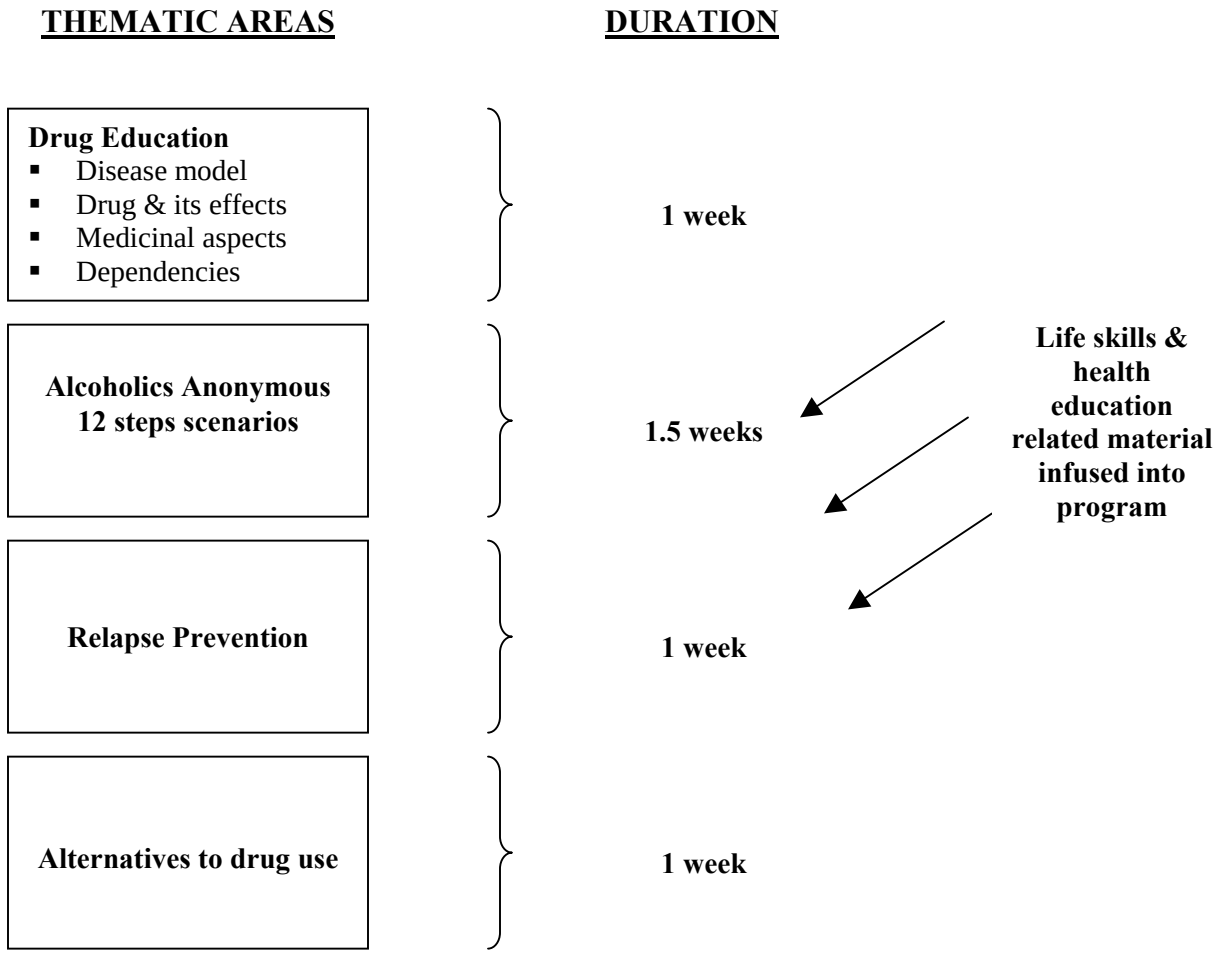
Box 3
Twelve steps of Alcoholics Anonymous

1. We admitted that we are powerless over drugs. That our lives have become unmanageable.
2. We came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives to the care of God as we understood him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being that exact nature of our wrong.
6. We humbly ask God to remove all these defects of character.
7. Humbly ask him to remove our shortcomings.
8. Make a list of all persons we have harmed, and became willing to make amends to them all.
9. Make direct amends to such peoples wherever possible, except when to do so would injure them or others.
10. Continue to take personal inventory, and when we were wrong promptly admit it.
11. Sought through prayer and meditation to improve our conscious contract with God as we understood him, praying only for knowledge of his will for us, and the power to carry it out.
12. Having a spiritual awakening as the result of these steps, we tried to carry his message to addicts and to practice these principles in all our affairs.

> "The 12 steps from the AA program is a spiritual program. It represents a big part of our program. The first AA step is to admit and believe in a supreme being - believe that there is a God… the program is supposed to be a spiritual awakening so that the addicts can go out and share with other addicts ways to change their lifestyle [Key informant, Carlton House]."

Drug education, relapse prevention and alternatives to drug use are the other three main thematic areas addressed during the group therapy sessions. Figure 13 outlines the typical syllabus used for the delivery of the group therapy program.

Figure 19: Typical syllabus used to guide the group therapy sessions at Carlton House



The first part of the group therapy sessions, which spans approximately four and a half weeks (Refer to Figure 13), is focused largely on information dissemination in the four thematic areas. Patients are simply educated on the core issues that matter.

> "During the first part of the group sessions, patients are simply taught key information that they need to wake up and change their behaviour and attitudes [Key Informant, Carlton House]."

The second component of the group sessions which continues to the end of the patient's residential term is more dynamic and introspective. Encounter group, a psychotherapy strategy designed to increase self awareness through honest assessment and communication of one's emotions, past and present, is used as the principal delivery method. During this phase of the program, each thematic area outlined in Figure 13 is re-examined. Patients are motivated to thoughtfully and truthfully assess their past emotional state, and openly communicate the underlying factors fueling past irresponsible and undesirable behaviours. One key informant described encounter groups as follows:

> "These are dynamic teaching groups where you tell the client as it is. It's all about getting in touch with the feelings of the patient. No body escapes. It is really trying to openly discuss the underlying reasons for one's feelings, attitudes and behaviours – truthfully telling the group for instance why you beat your wife or why you drink consistently even though you are aware that it causes you pain [Key informant, Carlton House]."

One key informant noted that encounter groups could be a very painful process for patients since they are trying to come to terms with issues that they probably never seriously analyzed, accepted and/or disclosed. Patients could become very emotional. Crying therefore becomes an inevitable response for many.

> "One time I was conducting an encounter group and a number of student nurses were witnessing the session. At the end of the sessions, all the nurses were crying. They had to be sent to a room away from the proceedings. After discussing with them the reasons for their outburst, most of them indicated that the session invoked memories of abuses they underwent; incest, abuse etc. This just showed how effective these sessions could be [Key Informant, Carlton House]."

In fact, it was reported that due to the emotional impact of these sessions, a few patients sometimes abort the program.

> "Sometimes, the session could be so painful or so difficult for some patients to really accept and openly discuss their prior life; you might find some of them making a decision to leave the program [Key Informant, Carlton House]."

In an effort to develop the critical thinking and decision making skills of the patients, a life skills and health education component are also incorporated into the group sessions or if possible at a more convenient time in the daily programming. Topics such as anger, self assertiveness, self esteem and the correlation between drug use and HIV/AIDS to name a few, are integrated into this aspect of the program.

> "Our program includes life skills such as problem solving, critical thinking, self awareness, self esteem and assertiveness. We also deal with anger. We help them to express their anger in positive ways; to take responsibility of their feelings, to know how they feeling everyday [Key informant, Carlton House Treatment Centre]."

National professionals with relevant expertise are invited to facilitate these sessions.

> "We try to get professional from different areas to come in and give different talks – Ministry of Health Infectious Disease section coming and talk to them about AIDS, and the correlation between AIDS and drugs. We also stress the importance of healthy diet. Sometimes they think they need a drink when in fact they need good food/calcium, so we might have someone from Grenada Food and Nutrition Council to come in to promote good nutrition [Key informant, Carlton House]."

Moreover, largely due to the highly spiritual nature of the program, pastoral counseling is also conducted during the 12 steps component of the group sessions. Religious ministers sharing the same or similar religious beliefs with patients are invited as resource/counseling personnel.

When asked about the types of delivery strategies used during group therapy, key informants identified the following: discussion, role play, experiential learning, use of audiovisual aids, such as educational tapes and literary material.

Group therapy at Rathdune Psychiatric Unit

Some limited group therapy is provided at the Rathdune Unit, which focuses largely on addressing the psychosis exhibited.

> "No intense Psychotherapy occurs at Rathdune [Key Informant, Rathdune]."

The prime objectives of these sessions are to sensitize patients of the determinants and nature of their medical conditions, and the significance of the medication administered. Some other general life style related issues are sometimes discussed dependant on the constitution of the group. Ideally these group sessions should be conducted once per week, however, this target is rarely achieved.

3.2.3.2 Individual therapy

Individual therapy at Carlton House

Individual therapy provides the mechanism for one and one interaction between the patient and the treatment and rehabilitation staff, with the primary player being the social worker.[15] The chief objective of this form of therapy is to provide an additional, more confidential environment for patients to address, and hopefully resolve challenging socio-economic, psychological and/or other personal problems that are impinging their ability to be successfully treated, rehabilitated and reintegrated into society. Therefore, this avenue provides an excellent medium for attending to patients' psychologically related problems such as anger and domestic abuse and/or socio-economic challenges such as unemployment and no housing.

[15] The Social Worker is part of the Psychiatric Team attached to the Mt. Gay Psychiatric Hospital.

> "I use the individual sessions to address more personal issues. For instance, work on their anger problem - perhaps even things like domestic problems and try out figure out a plan for how they will handle the problem now and in the future [Key Informant, Mt. Gay Psychiatric Hospital]."

One informant stated that these sessions are also used as a means of evaluating the patients' progress, and securing their perspectives regarding the effectiveness of the program in meeting needs.

The individual session/s are informed largely by three main sources:

- Background information collected from the patients at admissions by the Carlton House Treatment staff;
- Staff observation of patients during treatment, and issues arising from group therapy sessions;

Historical information collected from each patient by the Social Worker at the initial interview, and the resultant treatment plan developed by that specialist (Refer to Appendix).

Box 4
Development of treatment plan by Social Worker

The treatment plan is developed based on the problems discovered during the initial interview. Once problems have been identified and listed, goals and objectives are developed to address them.

Example of goals:

- The patient will develop the ability to handle anger appropriately.
- The client will learn to share positive feelings with others.

In developing the treatment plan, it is necessary that the client agrees that the issues identified are indeed problems. The client also needs to know what specifically he/she is going to change.

Source: Social Worker, Carlton House

A multitude of strategies are employed for the delivery of these sessions, namely, counseling, discussion, use of educational resource materials, audio visuals and administering of assignments to patients. Specific to career development, techniques for developing and/or enhancing job seeking skills are strengthened.

Regarding the schedule for conducting individual sessions, key informants noted that the primary staff of Carlton House facilitates these sessions on a needs basis. However, the social worker visits the Centre twice a week and meets with different patients on a rotating basis.

Individual therapy at Rathdune Psychiatric Unit

Similar to group therapy, individual therapy at Rathdune occurs in an ad-hoc fashion depending on the needs of the patient. The primary goal is to address any misconceptions and/or beliefs that patients revealed during the group sessions that could prevent attainment of a healthy emotional state.

3.2.3.3 Family therapy

Family therapy is an instituted practice designed to educate the family on the nature of substance addiction, and to solicit their support during and after the treatment process.

> "Alcoholism is a family disease; we are willing to treat family members – interview family members to understand how they can help to treat the client. We try to get the wife for instance to understand that the behaviour is not related to the husband but to the substance [Key Informant, Carlton House]."

During the operation of the treatment centre, key informants reported that family therapy commenced at the point of patient admission.

> "We try to work with them from the start - we might try to see them when they drop the patient off - we will explain the program to them [Key informant, Carlton House]."

At this initial phase in the treatment process, the staff at Carlton House endeavours to make their first attempt to gain the families' perspective of the patients' problems, and to commence the treatment process. Follow up appointments to meet with the therapeutic team at the Centre and/or to interact with the patient are requested as needed. No pre-determined scheduling for family follow up visits is in place. The Centre decides when, and how often families should visit. This is based largely on the extent of the patients' problems.

> "We will try to bring both parties together to address and settle differences. Often this would depend on the severity of the situation, example if there is a threat of divorce or previous extreme physical abuse – we will try to meet more often in this case, once or twice per week and ongoing [Key Informant, Carlton House]."

Fundamental to these sessions would be interventions by the social worker seeking assistance from family members to facilitate the re-integration process. In fact, family members would be contacted by the Social Worker and other members of staff to assist in providing jobs and/or housing for the recovering addict where feasible.

No family therapy program is offered at Rathdune.

3.2.4 Exercise, Relaxation and Meditation

To facilitate physical and mental conditioning, exercise, relaxation and meditation are heavily featured during the program. Using a small in-house gym, patients are expected to exercise at least once daily or more often as they perceive necessary.

Various relaxation techniques are also introduced to patients.

> "It is difficult for addicts to relax; we teach them normal good techniques to relax using water, music etc [Key Informant, Carlton House]."

Largely due to the heavy spiritual overtone of the program, meditation - communication with a higher power represents a major part of the program's protocol.

3.2.5 Social Reintegration and Aftercare

Social reintegration and aftercare generally includes all elements of rehabilitation and relapse prevention, and may also include preparing the neighborhood, local community, the family and/or the workplace to deal with the former drug user. This is a combined effort of the social worker and in house staff at Carlton house. Efforts at social re-integration are achieved largely through the individual and family therapy sessions. Overt attempts are made to assist recovering addicts to obtain jobs, by assisting them with the job application process, following up with family members to determine if they can assist in securing a job or a home, inquiring if former employers are willing to re-employ the individual, alerting them of job enlisting etc.

Some limited occupational therapy is provided to clients. They are engaged in subsistence related agriculture and skill based programs such as animal rearing, gardening and broom making. In fact, the excess products are sold which can provide supplemental monies for patients at discharge or when they are going to visit families and friends.

> "We nee and occupational therapist - help patient to develop an occupation. In the past we had animal rearing, gardening remained up until Ivan. We sell agricultural products such as brooms. A patient wants to go home/discharge and don't have money we help them from the money from the sales of these problems [Key informant, Carlton House]."

No structured aftercare service is available at Carlton House. Routine AA meetings conducted at the Centre represent the only established avenue for follow up.

3.2.6 Self-Help Groups

A standard service provided at the Carlton House is the operation of daily AA meetings. Each in-house patient is expected to attend these sessions on a daily basis. Sessions are led by members with occasional support from the staff at Carlton house. They provide a forum for patients to express their problems, seek support, share lessons learnt for dealing with common issues, and become rejuvenated in their mission to remain drug free. The meetings are also open

for outpatient recovering addicts. These individuals are encouraged to attend these sessions as regular as they think it necessary.

3.3 DRUG TREATMENT AT HER MAJESTY'S PRISONS

Her Majesty's Prisons, located at Richmond Hill St. George's was built by the French in 1860 as a military hospital. In 1888, it was converted as the island's official and sole incarceration institution. The Prison was initially designed to accommodate 76 male inmates. In 1903, the female prison located at the site of the National Museum was relocated to the Richmond Hill compound, providing accommodation for both males and females.

Various governments have undertaken a number of projects geared to enhance the physical structure of the Prison. The current facility was designed to accommodate a maximum capacity of 200 inmates; however, at present, the Prison has exceeded its capacity by 39.5% (279 persons).

The Prison operates a number of skilled based[16] and academic programs (basic literacy to external university degrees) designed to foster rehabilitation of inmates.

Drug prevention programming represents a major part of the rehabilitation drive at the Prison. The Drug Control Secretariat has been a key player in this process through implementation of a number of life skills and drug education related activities. The most consistent contribution in this regard though is provided by the Friends Forever organization, a unit of the Seventh Day Adventist Mission. This organization provides bi-weekly drug education and counseling services to inmates. This program has been going on for the past five years. Negotiations are currently in progress between the religious entity and the Prison's officials to provide pre-discharge and follow up services for inmates.

Some limited drug treatment and rehabilitation services were implemented at the Prison during the late 1990's. The initiative, executed by the Drug Control Secretariat in collaboration with Carlton House Treatment Centre targeted inmates experiencing drug dependent problems. The principal strategies used for these sessions included use of multimedia, lecture and discussion. In 2001, an Alcoholic Anonymous (AA) chapter was added to the program which was short lived due to the discharge of the driving force behind the meetings – a non-national inmate. Overall, the drug treatment and rehabilitation services offered at the Prison proved quite successful due to the number of drug dependent patients who requested referral to Carlton House subsequent to completion of their prison term. Unfortunately, the program was prematurely terminated due to the limited human resource at Carlton House to meet the demanding requirements of outpatient treatment and rehabilitation services.

[16] Skill based programs include baking, cooking, carpentry, masonry, mechanics, joinery, farming, broom and mat making.

3.4 LOGIC MODELS: PERFORMANCE FRAMEWORK FOR TREATMENT AND REHABILITATION

This component of the report presents the logic models for the drug treatment programs offered at Carlton House, and Rathdune. These models depict graphically the logical linkages among program resources, activities, outputs, audiences and short, intermediate and long term outcomes related to the institution goals and objectives. More importantly, they provide a framework for identifying and evaluating critical measures of program performance.

3.4.1 Logic Model: Rathdune Psychiatric Unit

Figure 20: Logic model Rathdune Psychiatric Unit

SITUATION: A statistically significant percentage of all mental cases admitted to Rathdune Psychiatric Unit are drug related. During the period 2002 – 2004, the number of drug induced psychotic cases admitted to the acute unit increased by 71.4%. Prompt diagnosis and interventions are needed to curb potentially dangerous public health, socio-economic and judicial challenges. Public and private entities are key stakeholders in the process.

INPUTS	OUTPUTS		OUTCOMES		
	Activities		Short	Medium	Long Term
22 workers ▪ 1 Ward sister ▪ 1 Depart sister ▪ 2 staff nurses ▪ 18 nursing assistants ▪ Mt. Gay Psychiatric Team ▪ Domestic help **Time invested:** 24 hours **Materials and equipment** ▪ Medication ▪ In-door games ▪ Television **Partners** ▪ Ministry of Health ▪ Mt. Gay Hospital ▪ Carlton House ▪ Local Hospital ▪ Enforcement system ▪ Local doctors	▪ Client assessment ▪ Referrals ▪ Detoxification ▪ Limited psychotherapy ✓ Group therapy ✓ Individual therapy	▪ Patients with mental illness	**Participants** ▪ Understand the determinants and nature of their medical condition ▪ Knowledge of the significance of the medication administered ▪ Recognize that a problem exists	▪ Participants voluntarily decide to enter drug treatment and rehabilitation centre	**Participants** ▪ **Are drug free** ▪ **Mentally stable** ▪ **Functions normally in society**

ASSUMPTIONS

1. Patient willingness to enter unit is not a required criterion for admission.
2. Patient successfully detoxified has an excellent opportunity at achieving sobriety by been admitted to Carlton House.

ENVIRONMENT

1. A free service for treating drug dependent patients exists.
2. The high costs of treatment and rehabilitation programs, and the limited amount of public sector resources allocated for this purpose.
3. Society's stigmatization and discrimination of recovering addicts.
4. The limited skills possessed by recovering addicts, and unavailability of aftercare services.

3.4.2 Logic Model: Carlton House Treatment and Rehabilitation Centre

Figure 21: Logic model of the Carlton House Treatment and Rehabilitation Centre

SITUATION: A statistically significant representative of the Grenadian population is drug dependent. Large scale socio-economic, public health & judicial problems are ultimate results of inadequate drug treatment and rehabilitation services. Carlton House provides the most comprehensive drug treatment & rehabilitation services nationally. The Ministry of Health, local hospitals, mental institutions, families and communities are key stakeholders in this process.

INPUTS

13 workers
- 1 Ward sister
- 1 psychiatric nurse
- 3 domestics

Time invested: 24 hours

Money
Annually

Materials and equipment
- AA resources
- Gym set
- Indoor games
- Audiovisuals

Partners
- Ministry of Health
- Mt. Gay Hospital
- Drug Control Secretariat

OUTPUTS

Activities

- Client assessment
- Referrals
- Detoxification
- Psychotherapy
  - ✓ Group therapy
  - ✓ Individual therapy
  - ✓ Family therapy
- Self help groups
- Exercise
- Relaxation and meditation
- Pastoral counseling
- Drug education
- HIV/health education
- Occupational therapy (limited)

Participation

- Drug addicts
- Families
- Recovery addicts
- Communities

OUTCOMES

Short

Participants

- Understand the effects of drugs on the human body;
- Knowledge of HIV/AIDS and other health related issues increases;
- Recognizes that they have a problem;
- Possess the skills needed to change; drug taking habit
- Have the desire to effect change;
- Take action to overcome their problem;
- Families understanding of drug addiction increase.

Medium

- Participants stop using psychoactive drugs;
- Families support recovery addict;
- Recovering addicts become gainfully employed;
- Private and public sectors become more willing to employ recovering addict;
- Employers provide jobs for recovering addict;
- Social worker secure home for homeless addicts;
- Recovering addicts consistently attend AA meetings.

Long Term

Participants

- **Achieve sobriety**
- **Improves socio-economic status**
- **Reduces risk behaviours**
- **Become a productive citizen**

ASSUMPTIONS

3. Patients enter program voluntarily.
4. Patients that successfully participated in treatment, and received good family support can become sober.
5. Recovering addicts must attend AA meetings.

ENVIRONMENT

5. Families' unwillingness to support client through treatment and rehabilitation.
6. The high costs of treatment and rehabilitation programs, and the limited amount of public sector resources allocated for this purpose.
7. Society's stigmatization and discrimination of recovering addicts.
8. The limited skills possessed by recovering addicts.

4.0 EFFECTIVENESS OF DRUG TREATMENT AND REHABILITATION

4.1 KEY INFORMANTS' PERCEPTION OF CARLTON HOUSE EFFECTIVENESS

This section provides a detailed presentation of key informant's perceptions regarding the effectiveness of Carlton House as a drug treatment and rehabilitation unit. Each of the principal services outlined in Section 3.2 are assessed to determine the following:

- Strengths
- Challenges and/or areas for development
- Qualitative capacity to achieve outputs as listed in logic model - Figure 15.

4.1.1 Referral of Cases

Key informants revealed that a functioning framework for the referral of cases to and from Carlton House exists. Yet, a number of factors impede the effective operation of the referral system, minimizing the potential for successfully matching patient to treatment programs.

4.1.1.1 Strengths of the referral system

- ***Strength 1: Formalized network***
  The referral system under review is formalized, and fully supported by a multi-stakeholder group. Interestingly, a significant percentage of stakeholders, particularly the public entities maximize the use of the referral system, heightening the frequency of successfully matching patient to treatment.

  > "Even now as Carlton House is not up and running, District Medical Officers would call here (Rathdune) to find out specifically what services we offer, and if persons with certain kind of drug dependencies can be treated at our unit. This gives an indication of the kind of referral system that is in place re drug treatment [Key Informant, Rathdune]."

The referral system under review is formalized, and fully supported by a multi-stakeholder group.

- **Strength #2: Heighten probability for effective drug treatment**
  This was viewed as a powerful argument in support of case referral, due to the excellent opportunities for addressing underlying psychotic and/or physiological health problems that could retard the outcome of drug treatment. Once these health problems are treated, the individual's capacity to respond to treatment notably improves. This has positive implications for resource utilization and readmissions.

Notwithstanding the positive acclaims made in favour of the referral system, a number of challenges exist which affect the referral process as discussed below.

4.1.1.2 Challenges experienced with the referral system

- **Challenge #1: Manipulation of system to avoid difficult situations**
  A number of patients use the referral option as an excuse to be dismissed from a supposedly difficult situation. For instance some patients admitted to Rathdune perceive Carlton House as a much freer, saner place to be. Similarly, criminals and persons charged with a crime, rather than face the grueling prison term would select treatment if provided with that option, due to the possibility of a shorter, more acceptable form of confinement. The underlying motivation in most of these cases is not the urgent need to be treated; rather it is part of a scheme to elude justifiable consequences. Under these circumstances, an appreciable percentage of these patients fail to complete the program, largely because they cannot be forcefully kept at the treatment centre.

  > "We have cases where people use Carlton House as a means to get a lesser sentence; they come to Carlton House just to get away if they have a sentence – wrong purpose. Maybe they should go to court and face the consequences [Key Informant, Carlton House]."

  A consensus was not reached among key informants regarding how criminals and/or persons charged with a crime should be handled. A section of the respondents were convinced that they should be treated prior to been incarcerated, while the other endorsed the need for drug treatment at Her Majesty's Prison.

A number of patients use the referral option as an excuse to be dismissed from a supposedly difficult situation.

Box 5
Views from Her Majesty Prison

There is no existing drug treatment services offered at Her Majesty's Prison. However, effective primary prevention programs are delivered by the Drug Control Secretariat and the Friends Forever Mission of the Seventh Day Adventist Ministries.

Key Informants at the Prison were very concern of the following issues:

- The inadequate data collection process for drug related statistics at the Prison. The view was expressed that the statistics department of the Drug Control Secretariat exclusively collects data on inmates that were involved in one or more of the following: Drug trafficking, possession of a controlled substance with intention to sell. The process though, omits all criminal cases that were drug induced, for instance murder or robbery. The data therefore does not provide a complete picture of the extent of the drug problem at the prison.

- Lack of a drug treatment program at the Prison encourages readmission.

- ***Challenge #2: Potential for drug dependent cases to evade treatment***

  The referral landscape provides a favourable environment for drug dependent cases to avoid drug treatment. This phenomenon is highly probable, subsequent to a patient been transferred to another health care facility for prerequisite mental or physiological attention. Regaining the patient back into Carlton House is largely dependent on the individual's conviction of the treatment benefits. Failing this, the patient can easily evade treatment, and return to society untreated.

Challenge #3: Reduced motivation to undergo further treatment

It was reported that a number of patients transferred from Rathdune after detoxification, are sometimes not genuinely interested in further drug treatment, since they believe that they have been cured. This intrinsic unwillingness can retard the effectiveness of the treatment process, and ultimately program outcomes.

The referral landscape provides a favourable environment for drug dependant cases to avoid drug treatment.

Challenge #4: Lack of early detection and outreach services

A major challenge facing Carlton House is the lack of early detection and outreach services. Inadequate staff was identified as the main restrictive factor in provision of this critical service.

> "Yes we know that providing community outreach officers would be a great thing to do – that's the ideal, but we don't even have enough staff to take care of our in-house needs at Carlton House. Do you think that we can consider working in the community? It is not possible [Key Informant, Carlton House]."

This deficiency has far reaching negative consequences. It drastically limits the Centre's capacity to undertake secondary prevention. Any outreach or detection currently conducted is very minimal, and performed in a reactive manner.

Learned Pointer

Overall, Carlton House has a well established referral system which is implemented in collaboration with a number of public and private entities. The system has the capacity to successfully match patient to treatment program largely due to its formalized structure and its potential for promoting effective drug treatment. Yet, irresponsible manipulation of the system, potential for drug dependent cases to avoid treatment, reduced motivation for referred patient to undergo complete treatment, and lack of an early detection and outreach service can seriously hamper the effectiveness of the referral system in the long term.

4.1.2 Detoxification

Key informants unanimously reported that detoxification is successfully undertaken at the treatment centre, and consistently ensures a drug free and stabilized patient. In addition, the technique is augmented by an excellent monitoring system, easy access to emergency medical services or more specialized care if required, and the availability of medication needed for this process. In fact it was described as a:

> "tested method with good clinical track record [Key Informant, Carlton House]."

When asked about the shortcomings or challenges, one main issue was raised. Detoxification does not guarantee sobriety, since it was not designed to achieve this output.

Learned Pointer

Carlton House has a reputable detoxification program in place which is supported by a competent team of professionals, an effective monitoring system for prevention of major withdrawal symptoms, availability of required medication and other dietary needs, and easy access to emergency medical services or more specialized care if needed. However, the treatment outcome could be threatened by relapse, since the procedure does not guarantee sobriety.

4.1.3 Treatment and Rehabilitation

4.1.3.1 Group Therapy

Based on the study's reports, group therapy was highly rated as one of the most effective and successful components of psychotherapy. Three main reasons were identified for this claim as discussed below.

Strength 1: Conducive psycho-social environment for therapy

The single greatest reason articulated in favour of group therapy was the ability of this medium to provide a comfortable, empathetic environment for patients to share and work through their problems. This supportive, psycho-social environment according to key informants is critical in the metamorphosis to sobriety and productive living. Group therapy therefore, plays a significant role in breaking the historical problems of denial and unacceptable modes of communication among addicts. Moreover, it was reported that the homogenous nature of groups motivates addicts to genuinely analyze their problems in a cooperative environment, with the goal of achieving positive change.

The single greatest reason articulated in favour of group therapy was the ability of this medium to provide a comfortable, empathetic medium for patients to share and work through their problems.

Strength 2: Excellent forum for education

Secondly, group therapy plays a paramount role in educating patients - stimulating altitudinal and behaviour changes consistent with wise decision making and productive living. As illustrated by Figure 13 (Refer to Section 3.2.3.1), patients are exposed to a range of topics which deepen their understanding of the medical and social ramifications of drug use. Moreover, didactic information is also provided for enhancing lifestyle, and adapting to challenging future situations.

Strength 3: Well established collaborative mechanism

The centre enjoys very good collaborative arrangements with other public, private and Non-Governmental Organizations. These institutions complement the treatment process through provision of resource persons to facilitate required group sessions. This augments the treatment process in two ways. Firstly, it sends a powerful message to patients that members of the wider population are interested in their welfare and overall development. Secondly, the inclusion of varied experts brings a unique and diverse perspective on the multiplicity of issues tackled.

In spite of the apparent effectiveness of group therapy, its overall impact is negated by a number of physical and technical factors. Informants identified three main factors hindering the overall impact of group therapy: Lack of trained specialists, unsuitability of the physical facility and unavoidable interruptions.

Challenge #1: Limited technical capacity among in-house staff

Unavailability of trained specialists attached to Carlton House was unanimously voted as one of the chief factors hindering effectiveness of the treatment program. Medication is not given as a means to overcome one's addiction; rather breaking the dependency necessitated a revolution of the patient's thought processes, belief systems and attitudes which are chiefly facilitated through counseling. Despite the immense focus on counseling, key informants lamented that the Centre lacks a qualified counselor. Furthermore, there has been no forthcoming assistance from government in fulfilling this gap. This deficiency greatly affects the staff's capacity to address deep-seated emotional needs of patients, limiting the attainment of program outcomes.

> "We lack quality staff. The job we do here is a counselor's job; we all have some training in counseling some more than others but not enough to be qualified counselors, and we struggle a lot. I know for a fact I struggle a lot. We have never been afforded the training to be counselors, no matter how often we apply, no body really assisted us in obtaining full time training. We had a number of workshops, but we are not counselors. Yet, the majority of the job we do there is counseling work – we have to talk to people [Key Informant, Carlton House]."

The insufficiency noted above is further aggravated by the lack of a resident psychologist at the Centre. Staff unequivocally identified a critical need for at least one psychologist to be actively involved in the treatment process. This they believe would boost the

Centre's capacity to stimulate recommended changes in patients' cognition, emotions and behavior. One informant mentioned that staff lack certain specialize techniques to truly "open" patients, which could potentially affect the quality of therapy.

> "For instance you might think that this person needs a psychologist, somebody who can go back a little further than you and carry out some exercise to reveal something that might be bothering that person. Whether we believe it or not, any person that takes a mind altering substance is escaping from reality. What is it in reality that they cannot face? Sometimes they themselves can't remember. They don't know. We (Carlton House staff) lack that technique; we can't go that far [Key Informant, Carlton House]."

Although a psychologist is attached to the Centre through the Mt. Gay Psychiatric Hospital's, two problems are endeavoured. The language and culture of the psychologist are vastly different to that of the patients, which presents a major barrier to effective communication between patient and specialist.

Unavailability of trained specialists attached to Carlton House was unanimously voted as one of the chief factors hindering effectiveness of the treatment program.

> "The Psychologist attached to the institution does not work, due to the language barrier. This is not good for treatment since the specialist needs to have good language. Cultural difference is also a problem; patients would not open up to the psychologist [Key Informant, Carlton House]."

Moreover, the time allotted for the psychologist to interact with patients is extremely limited, neutralizing the therapeutic effect in both the short and long term.

Limitations in the general competencies of selected staff members also compromise the integrity of the program.

> "Sometimes we don't have the quality of staff to have the programs that we would love to carry out. This makes it difficult to deliver a complete program. Sometimes a patient is ready to go home but they did not receive the amount of didactic teachings that you would prefer them to get, and this is due to a lack of quality staff [Key Informant, Carlton House]."

A case in point occurs when inadequately trained persons who have very limited or no knowledge in addiction studies are transferred to the Centre. This poses a problem since these individuals are not fully equipped to meet the patients' needs. Moreover, their flawed perceptions of the treatment process and its occupants are conveyed to patients, which ultimately affect patients' morale, and willingness to be treated.

> "They send people here (nurses) who don't have the knowledge, and I don't think it is helpful to the clients if they have no experience or skills. They should be trained in rehabilitation or treatment. Nurses are transferred from the General Hospital and Mt Gay if someone is sick or on maternity leave. Some of them come here with their own notions which are erroneous. Clients are not foolish, they pick that up and would tell me that this nurse don't know what she is talking about [Key Informant, Mt. Gay Psychiatric Hospital]."

Another problem reported was that a few staff members are intimidated by patients who are strong willed and/or formally educated. This trend hinders the competencies and willingness of these staff members in conducting group and/or individual sessions with related patients. This can dilute the impact of the therapy session, and could also place other staff members under undue stress.

Refer to Box 6 for key informants' summary of the basic skills required by the typical staff employed at Carlton House.

Box 6
Basic skills needed by Carlton House staff

Each staff member at Carlton House should meet the following criteria:

- ✓ Trained counselor
- ✓ Trained in addiction studies
- ✓ Be committed and, maintain patient confidentiality
- ✓ Competent in information delivery

The limited human resource base and inadequate usage of available staff also have implications for the execution of the program. For instance, a religious person is normally invited to facilitate the sessions associated with the fifth step of the AA program. Occasionally, this part of the program would not be implemented as planned, simply because the responsible staff member was engaged with other important issues, and was unavailable to attend to this need.

> "Sometimes pastoral sessions are not held as planned since the person to contact him is unavailable. We have one ward sister; she is responsible for that part of the program. If she is absent, that part of the program would not be done. This also indicates the inadequate usage of staff potential at the Carlton House [Key Informant, Carlton House]."

The proposal of ensuring that each member of staff at the Centre shadows the responsibilities of another member, which began initial implementation prior to Hurricane Ivan, could offer some solution to this challenge.

Challenge 2: Unsuitability of physical facility

Lack of privacy, inadequate space, and insulation to distractions were the main problems associated with the facility. Key informants revealed that two spaces are available for therapeutic sessions – the verandah and main welcoming area (living room). Both spaces are in close proximity to the other sections of the Centre's operation, for instance the domestic department and the visitors' station. Fear of unauthorized persons privy to personal information infringes on patients' right to confidentiality and freedom of expression. A number of patients might therefore be hesitant to genuinely participate in discussions.

Lack of privacy, inadequate space, and insulation to distractions were the main problems associated with the facility.

> "The verandah and living room are very close to where other people (domestic help, visitors etc) are located. Clients become paranoid and suspicious, and think that somebody is listening to their conversation. This leads to hindrance in clients' freedom in expressing themselves [Key Informant, Carlton House Treatment Centre]."

Photo 1: Front view of Carlton House.

Photo 1: Welcome area is situated directly behind main entrance. Visitor and domestic sections are located directly adjacent, and to the back of this area respectively.

Furthermore, key informants noted that the above situation could impinge on the realization of treatment outcomes, since it prevents full disclosure of the emotional self.

> "This (lack of privacy) can affect successful rehabilitation and overall treatment. If you don't empty properly you won't be filled properly [Key Informant, Carlton House Treatment Centre]."

Added to this, the problem of inadequate space to conduct multiple sessions simultaneously compounds the problem. In particular, it was noted that it was very difficult, and sometimes impossible to conduct a group therapy session concurrently with an individual session, which might be needed in some cases.

> "Our facility would not allow us to do all we want to do. For instance, if we have group counseling and individual counseling going on at the same time it would be very difficult, and we might have to abort one - most likely the individual session [Key Informant, Carlton House]."

Challenge 3: Unavoidable interruptions

Unavoidable interruptions were also identified as a major problem threatening the integrity of group sessions. Two issues were raised. First, due to the location of the Centre (adjacent to a major road network), and the main entrance (in front of or opposite the patients working areas), patients are easily distracted by passing vehicles and the arrival of visitors.

Photo 2: Verandah where group sessions are conducted – notice the road to the eastern part of verandah.

Unavoidable interruptions identified as a major problem threatening the integrity of group sessions.

This seriously affects their focus, and thus the success of the session undertaken, hindering its merit.

> "We have most of the sessions in the verandah. If they have to watch a video or a movie they do it in the sitting room. Again there is distraction because the kitchen is right there. Vehicles distract them; the visitors come up, and once they see visitors they loose focus. [Key Informant, Carlton House]."

Another unavoidable interruption noted related to referred patients that needed to attend to court or seek primary or secondary health care treatment.

> "During the day there will be some interruptions – they are tailored differently. Some persons might want to go to the dentist, remember they were not taking care of themselves; they were using drugs maybe for the same pain. So now they off it (drug), they are experiencing problems. We might have to take them to test their blood to see how their liver is functioning. Whatever needs to be done during that day; the program will have to be interrupted for these things [Key Informant, Carlton House]."

These interruptions although almost impossible to avoid, interrupt the planned schedule for group sessions. Facilitators would therefore have to make a decision; sacrifice the continuity of the program with the larger group and insert a nonessential lesson or proceed with planned program. These occurrences affect patients' motivation, and the ability of the facilitators to cover all aspects of the curriculum.

> "Another area of concern is dealing with the legal/criminal related patients. When they attend court it makes it difficult for general administration. I (facilitator) would say I am not repeating this session, but when you miss Monday you can't understand Tuesday. In such a situation for accommodation, you as the teacher will have to cancel and get something else to do while you wait on them. This could affect outcome [Key Informant, Carlton House]."

Challenge 4: Insufficiently coordinated program curriculum, and inadequacies in delivery methods

Although a framework for the basic curriculum for group therapy exists (Refer to Figure 13, Section 3.2.3.1), there appears to be an ad-hoc and individualistic approach to the development and delivery of the final content material. Moreover, this approach is compounded by the limited guidance and skill among some staff members in determining the most appropriate pedagogical style for program delivery.

There appears to be an ad-hoc and individualistic approach to the development and delivery of the final content material that informs group therapy sessions.

> "We use the resources that we have and we put something together to deliver our sessions. What happens now each of us pull out from out of our own experience and shoot. We see this is working and we do it, and we come up with our own program - it's a real challenge. We try and they don't do as well as they should, but we do get the projected 10% recovery expected from this relaspable disease, but I still feel we can do better. We are too individualistic - too my way [Key Informant, Carlton House]."

Key informants believed that staff training in teaching methods would be paramount in improving their overall performance, particularly due to the diversity of patients catered to at the treatment centre.

> "We need to get the teachers to teach us how to teach. I tried to get into Teachers College but it did not happen. What we do at Carlton House is imparting knowledge, people learn in different ways. Adult learning has its own ways, and it's a real challenge sometimes. We get through to them, sometimes we don't. We need to be tutored into teaching basically - we have to teach them and convince them that drugs are not good for them [Key Informant, Carlton House]."

4.1.3.2 Individual therapy

The most notable strength of the individual therapy sessions is the fact that it provides opportunities for addressing issues and weaknesses that could be missed during the group sessions. This therefore guarantees a more comprehensive approach to treatment.

The most notable strength of the individual therapy sessions is the fact that it provides opportunities for addressing issues and weaknesses that could be missed during the group sessions.

> "When they give me (Social Worker) their personal history, I see personal problems that may not come up in their group therapy [Key Informant, Mt. Gay Psychiatric Hospital]."

The social worker noted that literacy related problems exacerbate staff ability to successfully deliver the program to patients. It limits the diversity of assignments that can be given, and thus hinders growth among some patients.

> "The majority of clients are weak at reading and a lot of sessions I like to give homework, but it is difficult for them to do homework. The better ones I ask them to read a chapter fro the AA/NA book and they weak ones it's difficult to give homework when they weak in reading because they are not home they do not have the support of children or wife to help [Key Informant, Medical Team Mt. Gay Psychiatric Hospital].

In addition, limited staff reduces opportunities for frequent individual sessions.

4.1.3.3 Family therapy

Family therapy, though extremely important as part of the treatment process, was reported to be the most poorly delivered component of the psychotherapy program. Strengths of this part of the program included the following:

Family therapy was reported to be the most poorly delivered component of the psycho-therapy program.

- Availability of a plan for family therapy
- A team of persons convinced of the importance of this aspect of the treatment process
- The support provided by a miniscule of the related families.

Most of the above are neutralized by the relentless problems of no family involvement and support, socio-economic status of families, and emotional stress associated with limited availability of social services.

Strength 1: Availability of a family therapy plan and a committed team

Probably the greatest strong point presented in favour of family therapy, is the team of passionate and committed staff members, who clearly understand the implications of family involvement in the treatment process. This is enhanced by the availability of a plan for the delivery of this service, as described in Section *3.2.3.3*.

Strength 2: Support provided by a small percentage of families

Reports indicated that an extremely small percentage of families offer support for the recovering addict. One key informant summarized the extent of support to be approximately 3%.

> "The supportive ones we try to explain what they should expect when the patient comes out. We also ask them to sit in on the group sessions sometimes. About 3% of the families are supportive. We have sixteen beds - about 13 – 14 patients on average. Only about one patient in each group has a supportive family [Key Informant, Carlton House]."

Familial support has been shown to be a major criterion in determining success of the patient. In fact a number of informants revealed quite adamantly that consistent family support throughout the treatment process, and during the post-discharge period, enhances the possibility of a favourable outcome.

> "If you have families on your side, half of your problem would be solved [Key Informant, Mt. Gay Psychiatric Hospital]."

Principal challenges associated with implementation of family therapy are discussed below.

Challenge 1: Unsupportive, frustrated and alienated family members

The vast majority of family members are extremely unsupportive towards addicts. One key informant reported that "75% of families *loose all confidence* in the patient, resulting in most of these clients falling through the treatment process." This apathetic attitude exhibited by the vast majority of families, was cultivated in an environment rife with recurrent undesirable behaviours displayed by the addicts. These intolerable actions fueled bitterness, anger and mistrust among family members, making it almost impossible to engender family support.

> "And the families don't want anything to do with them because they don't trust them anymore. So when these people really want to work the program, they are alone they have no support. They let down everybody so it takes a lot to convince the family, employer or significant other to lend support to the client because the client is really trying now [Key Informant, Carlton House]."

This disdain towards the addict could be so severe that the addict is admitted to the treatment centre without any family presence.

> "Sometimes things could be so bad with the family that the client comes for himself [Key Informant, Carlton House]."

Challenge 2: Most families do not understand the nature of addiction

Lack of understanding among most families regarding the nature of addiction presents a formidable challenge in securing support for addicts throughout the treatment process. Families perceive themselves to be victims of an abusive and deplorable relationship, and fail to envision any positive connection to the addict.

> "We try to work with them; we might try to see them when they drop the patient. We will explain the program to them. They will say, why you telling me this, I don't drink, I am the victim. The aggression over the years has affected them severely – the wife is normally very frustrated at this time [Key Informant, Carlton House Treatment Centre]."

Informants posited that families undoubtedly do not understand the need for their involvement in the reformation process. Specifically, they mistakenly view addiction exclusively as a patient's disease, and fail to grasp the concept that the family unit is an essential ingredient in the recovery process.

"75% of families loose all confidence in the patient, resulting in most of these clients falling through the treatment process."

> "To start, the family believing that the addiction is a patient disease and not a family disease is an error. The family is critical, addiction is a family disease. If families had education and understood that addiction is a family disease, and that the family is needed to help the patient live a new life, it would be better [Key Informant, Carlton House Treatment Centre]."

Moreover, this lack of education of the nature of addiction proliferate unrealistic expectations for which the addict is unable to accomplish. Families fail to realize that the problem is not merely a bad habit; rather a disease for which emotional and technical support are needed in sustaining recovery.

> "They don't understand that it is impossible to just stop drinking. It is a nasty habit. They just can't help themselves, they need help. They just cant say I am going to stop, I am not going to do this. For the most part they need a lot of support form family and groups [Key Informant, Carlton House Treatment Centre]."

Challenge 3: Financial status of families

The financial status of family members also impacts the program negatively. Some families lack the financial resources to prioritize follow up visits to the treatment centre. Considering the culture of families traumatized by addiction, prioritizing meager resources to visit

an individual perceived to be willfully making irresponsible choices, would not be high on the agenda. Moreover, the small number of family members who are interested in supporting the recovering addict, are sometimes deterred by transportation cost (Refer to Table 9, Section 4.1.6), and distance to travel to get to Carlton House.

> "Family need transport to visit. They talk about distance to come [Key Informant, Carlton House]."

Challenge 4: Cancelled family appointments

Though a rare occurrence, a few family appointments have been canceled in the past, primarily due to limited and inadequate utilization of human resource at Carlton House. The case presented occurred because the responsible staff member to meet with the family members, needed to attend to other conflicting businesses, which necessitated canceling. In fact the situation is sometimes aggravated when that information was not communicated in advance to families. Considering the sacrifice that some families make in showing interest in the treatment process, these mishaps seriously erode the limited source of interest on the part of the family member. One key informant described this phenomenon as an inadequate utilization of staff capital (Refer to Section.

> "Nurse responsible for talking with them went out, so we have to cancel. This is inadequate utilization of staff. I am the only one responsible is not the right approach. We are not indispensable, so we have to utilize all aspect of our human resources [Key Informant, Carlton House]."

Learned Pointer

Treatment and rehabilitation, with specific emphasis on group and individual therapy provide a successful model for achieving the majority (6/7 or 85.7%) of short term outcomes as illustrated by the program's logic model in Figure 15, Section 3.3.2. The critical levels of awareness, knowledge, skills and motivation needed to foster appropriate concrete changes in the journey to sobriety and productive living can be realistically accomplished. Albeit this, the model fails miserably in changing families attitude towards the recovering addict, seriously limiting much needed psycho-social and socio-economic support.

4.1.4 Social Integration

This component of the program could be described as one of the weakest links in the treatment and rehabilitation process. The presence of a committed social worker attached to the program offers a major boost. However, problems of societal stigmatization and discrimination, lack of an after care program, limited occupational skills for recovering addicts, inadequate social services, and family support seriously restrict effective social re-integration.

Strength 1: Social Worker attached to Carlton House

A very commendable observation was that a social worker is attached to Carlton House, and consistently provides a weekly service to residents. The focus of the social worker in addressing psycho-social problems and socio-economic challenges, such as unemployment and housing is paramount to the re-integration process. Some limited success is achieved by the Social Worker in securing housing for recovering addicts.

> "One young man who was living with his mother…his mother threw him out when she found out of his condition. Due to the addiction, she did not want to her about him. In addition, he did not think that speaking to her would be productive. I spoke to her and helped her understand addiction. She did take him back when he completed the program [Key Informant, Medical Team, Mt. Gay Psychiatric Hospital]."

Similarly, a few part time and full time jobs were secured by patients after been discharged from the Centre due to the career enhancement skills transferred, and negotiations with potential employers.

Strength 2: Empowering approach used in career development

Very profound, is the empowering approach utilized in preparing patients to obtain employment. The Social Worker deviated from the traditional strategy used to secure jobs, and presently actively engages patients throughout all stages in the process.

> "When they told me how they found the job for them I found a problem with that need to make an impact in getting the job. They will be more motivated. You are making them dependent and you want to empower them rather than being dependent. My approach - I would say here is an opening, why don't you apply. I will help them with the application process. I never thought it beneficial to the client to say here is the job [Key Informant, Mt. Gay Psychiatric Hospital]. "

The limited occupational therapy provided by the Centre also heightens patients' usefulness, and encourages the development of a positive attitude to work and thrift.

Challenge 1: Difficulty in securing housing for recovering addicts

A major dilemma facing the social recovery program is securing housing for the discharged patients. Two reasons are largely responsible for this quandary. Firstly, the frustrations and alienation of the family seriously erodes any interest in accommodating the patient at the end of the residential term.

> "There are some situations where patients have no home to go to at the end of the program. The Social Worker is supposed to solve this. The importance of housing and recovery always represents a challenge; families will always say we struggle with this drinking for years - he always going back. Because of all of this we have to give up on

> him. Invariably families are reluctant to take him back – if it's a young druggie they might consider [Key Informant, Mt. Gay Psychiatric Hospital]."

Secondly, amassing the required financial resources to purchase a home is an even more dismal preposition for the patient. For instance, it was reported that the sub-population of recovering addicts represents a marginalized group which is definitely unable to provide the normal securities needed by financial institutions to acquire a home.

> "These persons are a special group. You can't tell these people that they need to get a job letter and land title if they want resources to buy a house, it is not possible. They won't have it [Key Informant, Richmond Hill Institution]."

Lack of formalized partnerships to assist in the housing acquisition process seriously complicates the process. These hurdles have a profound negative impact on the emotional state of the patient, affecting his/her ability to be successfully treated. According to one Key informant:

> "Once you get a client you need to start thinking about discharge. The client would be thinking, I don't have no way to go, and this can affect the effectiveness of the program [Key Informant, Carlton House]."

Furthermore, the social recovery process could be additionally exacerbated when the social environment is not conducive for reintegration.

Challenge 2: Problems of obtaining employment for recovering addicts

Obtaining employment for recovering addicts is yet another major impediment in the system. The research reported that very few persons obtain jobs, particularly full time ones. Two major problems were identified: Literacy level and skill base possessed by addicts. This creates a major problem in attracting jobs in a competitive market place.

> "I would say 80% of the clients cannot read. What kind of job you will get when you cannot read, you can only be the gardeners something like that. Some cannot even full out a form - now they are in trouble, can't read form to answer questions [Key Informant, Mt. Gay Psychiatric Hospital]."

Added to this, clients who were successful in attaining employment fail to meet the requirements demanded by the institution. Relapse occurs, which creates a range of problems, ultimately ending in dismissal.

> They (employers) use to have a lot of problem with that. In most cases persons would relapse, therefore employer was having problems with relapsing. Addict would be cursing supervisors on the job, tardy, poor performance, and reluctant to take people on etc. [Key Informant, Mt. Gay Psychiatric Hospital]."

It was suggested that a basic literacy program should be incorporated into the program. Yet in light of the short duration of the program, and the need to focus on sobriety, this might not be feasible or pragmatic.

> "I think there should be a basic literacy program to engage them while they are there. Help them to become more employable, maybe 3 months is too short to accommodate this maybe it can be a follow up program [Key Informant, Carlton House]."

Societal stigma and discrimination towards recovery addicts and the treatment centre compound the issue. It was reported that the public appears to direct its attention exclusively on the unsuccessful segment of the recovering addict population. There appears to be very little overt public knowledge about the successfully treated patients.

> "Recovery rate at Carlton House is about 20 – 25%. The public only sees the 75-80 % that does not make it; they fail to see the small, yet significant group that was successful [Key Informant, Carlton House]."

Stigma and discrimination is so rife, that it destroys an employer's image of a recovering addict instantaneously, hindering fair treatment.

> "With our society, there is a lot of stigma attached to drug addiction. We had a patient that did well and got a job, and someone saw him and told his boss. The boss fired him [Key Informant, Carlton House]."

Key informants purported the view that an inter-sectoral approach led by the Ministry of Health, should be utilized in seeking employment for patients.

> "The Ministry has to realistic. As an institution Carlton House cannot do it alone we need to take an inter-sectoral approach on this. We need the Ministries of Labour, Social Services, Health and Education working with an employment agency. There should be a direct link with Ministry of Health of Health and Labor where we could identify jobs for these people [Key Informant, Richmond Hill Institution]."

Challenge 3: Insufficient integration of social services into work programme

From an administrative standpoint, a stumbling block limiting effort at re-integration is the fact that no specific guidelines or Terms of Reference were provided to the Social Worker on commencement of duties at Carlton House. To this end, the individual's workplan was developed based solely on academic training, observation and prior experience.

> "When I joined the service, no one really said these are the things we want you to accomplish - no procedure no guide. I had to carve out my own rules. Nobody said these are the needs, expectations etc. I saw this as a weakness in the system. No guidance was given to a new social worker in this new situation. I assessed how the program functioned, and I said maybe I can do the individual sessions [Key Informant, Mt. Gay Psychiatric Hospital]."

Consequently, the work programme of the social worker was not formally integrated into the comprehensive treatment plan of the Centre. This was perceived as a distinct

weakness in the system, due to the potential for reactive planning, duplication of efforts and/or omission of crucial areas.

> "I think the program needs to be more holistic, I think it needs to be looked at so that the Social Worker work fits into what other staff is doing. Social Worker is just using her initiative and doing what she thinks should be done. Things could be overlooked or duplicated [Key Informant, Mt. Gay Psychiatric Hospital]."

Challenge 4: Conflict of interest of the social worker

The social worker attached to Carlton House, although very consistent in the delivery of social services, is principally attached to the Mt. Gay Psychiatric Hospital. This professional arrangement detracts full attention to Carlton house, due to the hectic environment at the Hospital. In light of this, informants believed that this could affect the capacity of the Social Worker to deliver required services.

> "Mt. Gay is always in crisis. It is not like the social worker is going to come to Carlton House in a relax mood to look for recovering patients. Something will always be happening at Mt Gay that would be critical, more of a priority than Carlton House, so a lot of her attention is focused there [Key Informant, Carlton House]."

Moreover, the ratio of social worker to patients is on average 1:14 which makes it extremely difficult for the specialist to allocate sufficient time for each patient to seriously resolve their problems.

> "We have a social worker but time is the problem. She visits once or twice per week. We have an average of 10 clients, and this social worker coming once a week to deal with one person. What happens to the other nine? And lets say the time she is coming she can deal with two patients in one week, you cannot finish with the two persons in one week. One social worker for 1 – 2 hours a week is not enough [Key Informant, Carlton House]."

Learned Pointer

Social reintegration represents one of the most ineffective components of the treatment model. Although there is evidence of limited family involvement and successful attainment of employment, the strategic interventions implemented by Carlton House do not satisfactorily prepare the individual to be employed or the family and/or wider society to accept and support the recovering addict. Lack of formalized inter-sectoral partnerships, alienated and frustrated families, inadequate socio-economic status of recovering addicts, societal stigma and discrimination, insufficient integration of social services into the comprehensive treatment program all seriously encumber effective social reintegration. *The potential therefore, to attain anticipated medium and long term outcomes are drastically reduced.*

4.1.5 Aftercare

As reported in Section 3.2.5, the drug treatment and rehabilitation program at Carlton House does not include a structured aftercare program. Despite the impromptu efforts made by staff members in following the progress of a few recovering addicts, and the daily AA meetings, lack of a comprehensive after care program greatly invalidates the benefits of the residency program.

Aftercare represents the most poorly developed and delivered service offered by Carlton House.

> "The time will come for them to go home, and then there is nobody here to go to them, no one to check up on them. Sometime you can't see them; you want to know what they are doing, what's happening to them, we don't have anybody to do that kind of community care. What we do is call the last number or ask one of the recovering addicts to go and check up on them [Key Informant, Carlton House]."

This situation places undue emotional stress on staff members who are already functioning under strained conditions.

> "You see somebody miss two meetings and you start getting worried and you try to get in touch with them, but we have to do this on top of whatever else we have to do inside, we still have to do the limited follow up ourselves, and this should not be so [Key Informant, Carlton House]."

The situation is so severe that one informant noted that after discharging one patient, no evidence of his whereabouts was known.

> "After he went home, I did not see him again. I don't know if he is dead or alive or even if he is in Grenada [Key Informant, Medical Team, Mt Gay Psychiatric Hospital]."

This seclusion, especially in a socio-cultural environment that does not fully support reintegration of recovering addicts, could lead to crippling results.

The above discussion sums up the scale of the problem, and the extent of patient isolation that occurs following discharge. This seclusion, especially in a socio-cultural environment that does not fully support re-integration of the recovering addict could lead to crippling results, particularly during the vulnerable first three months. The inevitable problems of relapse and readmission to the treatment program have been proven to be logical outcomes of no aftercare services.

> "You need to have someone out there to keep an eye on them to support them and don't let them go too far. Because sometimes you slip but the problem with slipping is not falling but is what you do when you fall down. Because we don't have adequate follow up we have a large percentage of readmission – sometimes they don't come back in 3 months but once they start feeling sick they come back, because addiction is a relapsable illness [Key Informant, Carlton House Treatment Centre]."

Key informants also noted that many recommendations have been made to the Ministry of Health with detailed suggestions itemizing how the problems can be resolved; yet the results to date have been negative. Appendix 4 presents the Terms of Reference for a Rehabilitation Officer presented to the Ministry of Health in 2003 by the Board of the Richmond Hill Institution on behalf of Carlton House.

Key informants noted that government and policy makers pay "lip service" to drug treatment and rehabilitation. There appears to be no serious investment in remedying historical problems experience at the Carlton House.

Learned Pointer

Aftercare represents the most poorly developed and delivered service offered by Carlton House. Lack of an aftercare program fails to support the attainment of the long term outcomes of the program. Consequently, the situation propagates relapse, readmissions, continued poor or mediocre socio-economic status, and unproductive living. Inadequate priority by government was identified as the principal fueling factor.

4.1.6 Self Help Groups

The research findings revealed that the Alcoholics Anonymous (AA) meetings offer a powerful mechanism for maintaining sobriety. However, the majority of discharged recovering addicts do not maximize this free available service in the life long process of drug abuse prevention. The section below elaborates on the strengths and challenges experienced with AA meetings.

Strength 1: Excellent maintenance system and support group

These AA meetings are a proven tool in maintaining lifelong sobriety.

As indicated in Section 3.26, the meetings are consistently hosted each day for all recovering addicts. These meetings are a proven tool in maintaining lifelong sobriety.

> "We don't give medication to maintain their sobriety. A major part of maintaining contented sobriety is attendance at AA meetings. It's like a medium for these recovering addicts to keep them from taking their first drink [Key Informant, Carlton House]."

These forums are psychologically rejuvenating for recovering addicts. They augment the individual's decision making skills, boost patient's self esteem, and provide a team environment for soliciting support in the sojourn to consistent abstinence.

> "It's where they come and talk about what is helping them, and about their problems. You can get some recovering addicts who remain sober for ten, fifteen, even forty years and that's how they do it – they attend AA meetings [Key Informant, Carlton House]."

Albeit the benefits of this medium in sustaining the recovery process, the majority of discharged patients do not capitalize on the benefits offered by this group due to reasons discussed below.

Challenge 1: Poor attendance

The reports revealed a major problem in attendance to AA meetings among discharged recovering addicts. It was reported that approximately 10% of that populace consistently attend these meetings.

> "They might come the first, second and even third time and then they stop coming. If you have a group of about 100 recovering addicts outside, we have about 10 attending consistently [Key Informant, Carlton House]."

A number of reasons were expressed for this trend. One possibility alluded to was that patients relapsed, and are therefore embarrassed to reveal this among peer groups.

> "They don't come because they start using it again, and with addiction recovery is until you take the first drink and once you take the first drink you drinking and smoking for all the time you did not drink and smoke. So eventually you back to square one, and that happens to 90% of addicts, and this is why we encourage them to work the program for life and attend AA meetings, if not you will go back and start using drugs again. [Key Informant, Carlton House]."

Transportation costs, lack of understanding of the program, and the importance of AA meetings were also identified as possible reasons for the low turn out.

> "Transportation costs is a problem; but also a lot of them do not really understand the program and its necessity – they did not reach the stage to give up the habit and to go to all lengths to stop it [Key Informant, Carlton House]."

Challenge 2: AA meetings are limited to one location – St. George's

Although recovering addicts are dispersed throughout all parishes on the island, including Carriacou, only one establish venue exists for convening AA meetings – St. George's. Considering the socio-economic status of the target group, it seems unlikely that this location offers an incentive for superior attendance. Although accessible by public transportation, the costs to attend at least two meetings per week could be considerable as illustrated in Table 9. The majority of discharge patient opt to use the limited resources available to satisfy their cravings, especially if they are plague by the additional problems discussed previously.

> "He would prefer to take the $5.00 or $10.00 and drink instead of pay transport [Key Informant, Mt. Gay Psychiatric Hospital]."

Table 9: Approximate cost for attending AA meetings twice weekly from all parishes

Parish	Return daily fair daily to attend AA meeting (EC$)	Total costs for 2 visits per week to AA meetings (EC$)[17]
St. George's	6.00	12.00
St. David's	9.00	18.00
St. Andrew's	13.00	26.00
St. Patrick's	15.00	30.00
St. Mark's	12.00	24.00
St. John's	8.00	16.00
Carriacou	93.00	186.00

Learned Pointer

Self help groups offer a powerful medium for maintaining sobriety. In spite of this, over 90% of outpatient clients do not maximize this resource. Poor attendance stemming from lack of incentives to attend meetings, relapse, high transportation cost and inadequate understanding of the role of this forum in attaining desired outcomes were proposed as reasons for partial effectiveness of this service.

4.1.7 Cross Cutting Issues

Throughout the research, a number of issues were identified by Key informants that hindered or augmented the treatment process. These issues affected various programs, and therefore it was not prudent to discuss them continuously throughout the document. This section summarizes these cross cutting issues due to their obvious importance in obtaining a holistic understanding of the treatment process.

4.1.7.1 Additional program strengths

Commitment and competence of staff

The most profound positive feature of the treatment program was identified as the commitment, diligence and competence of some staff members at Carlton House. It was very clear that despite the numerous challenges faced in delivering the program, a few staff members stood out as exceptional. In fact, it was reported that these members used their own capital to purchase resource materials for the program that they perceived to be beneficial to the process.

[17] These costs can inflate significantly depending on which part of the parish the patient is located.

4.1.7.2 Additional program challenges

Availability of the Psychiatric Team

Most key informants interviewed from Carlton House stressed the problems faced in securing routine visits by the Psychiatric Team doctors attached to Mt. Gay Hospital. These informants believed that the team does not sufficiently prioritize the work at Carlton House. In fact, a number of conflicting views were provided on this issue. One viewpoint suggested that Carlton House is part of the team's responsibility. Another perspective indicated that although this is true, insufficient human resource, aggravated by a hectic schedule limits the Team's investment in Carlton House. This issue requires further discussion by the Board of the Richmond Hill Institution, to determine an amicable solution for all concerned.

> "Even when we need the medical team, we not seeing them since they show slight interest in Carlton House. They say our people at Carlton House are more stable ad could wait. They put much more emphasis in Mt. Gay psychiatry instead of coming to see the addicts. It should be compulsory that they visit once a week. In a group of clients over a three months period, we have only two successful visits from team members. This is a great hindrance [Key Informant, Carlton House]."

Limited incentive provided to nursing assistants

A few informants noted that nursing assistants attached to Carlton House must be commended for their hard work, in particular one individual. Informants believed that these workers are not encouraged to continue their outstanding performance, and should therefore be provided with incentives. Possible incentives proposed included the following:

- Change the name from Nursing Assistant to something more descriptive of their responsibilities;
- Upgrade outstanding members from among this group.

Adherence to rules

Some mention was made of the need for more stringent adherence to the rules of the institution. Discrepancies in the implementation of rules were observed, which created additional problems for effective functioning of the treatment program.

> "The question of rules at Carlton House is creating an issue. I don't know who should look into this issue, but apparently people use to do their own thing. Sometimes people would be allowed to go other times they would not – rules are not strictly enforced by staff. Failure to follow rules consistently leads to confusion, division among staff and client problems [Key Informant, Mt. Gay Psychiatric Hospital]."

Table 10: Summary of Carlton House strengths and challenges in delivering drug treatment and rehabilitation services

Services provided by Carlton House	Strengths	Challenges
Case referral	▪ Potential to successfully match patient to treatment ▪ Formalized structure ▪ Heighten probability for effective drug treatment	▪ Irresponsible manipulation of the system ▪ Potential for drug dependent cases to avoid treatment ▪ Reduced motivation for referred patient to undergo complete drug treatment ▪ Lack of an early detection and outreach service
Detoxification	▪ Ability to stabilize and render patient drug free ▪ Competent professionals ▪ Effective monitoring system for prevention and control of withdrawal symptoms ▪ Availability of required medication (Carlton House) ▪ Easy access to emergency medical services	▪ Threatened by relapse ▪ Patient non-compliance ▪ Lack of available medication (Mt. Gay) ▪ Aggressive patients ▪ Lack of required staff onsite to manage risky situations (Mt. Gay)
Treatment and rehabilitation ▪ **Group therapy**	▪ With the exception of family therapy, the treatment and rehabilitation model provides a successful model for achieving the majority short term program outcomes. ▪ Conducive psycho-social environment for therapy ▪ Excellent forum for education ▪ Well established collaborative mechanism	▪ The model fails miserably in changing families' attitude towards the recovering addict ▪ Limited competence among staff members ▪ Unsuitability of physical facility ▪ Insufficiently coordinated program curriculum and delivery methods ▪ Large size of group ▪ Inadequately developed program at Rathdune

Services provided by Carlton House	Strengths	Challenges
Treatment and rehabilitation continued ▪ **Individual therapy**	▪ Addresses issues that could be missed by group therapy ▪ Opportunities for more introspective counseling	▪ High level of illiteracy among patients ▪ Low frequency of individual sessions
Treatment and rehabilitation continued ▪ **Family therapy**	▪ Committed team of professionals ▪ Availability of a plan for family therapy ▪ Support provided by a few families ▪ Emotional support provided by Carlton House staff	▪ Unsupportive and alienated family members ▪ Lack of understanding of the nature of addiction among family members ▪ Financial status of families ▪ Cancelled family appointments
Social integration	▪ Social Worker attached to Carlton House ▪ Empowering approach used in career development ▪ Commitment of selected staff members	▪ Difficulty in identifying housing and employment for recovering addicts ▪ Insufficient integration of social services into work program ▪ Social Worker attachment to Mt. Gay Psychiatric
Aftercare	▪ Ad-hoc follow up services provided by some staff members ▪ Availability of daily AA meetings at Carlton House	▪ Lack of a comprehensive aftercare program ▪ High potential for propagating relapse, readmissions, continued poor or mediocre socio-economic status ▪ Societal stigma and discrimination
Self help groups	▪ Excellent maintenance and support system	▪ Poor attendance by outpatient recovering addicts ▪ AA meetings are limited to one location ▪ Lack of a venue to host meetings post Hurricane Ivan

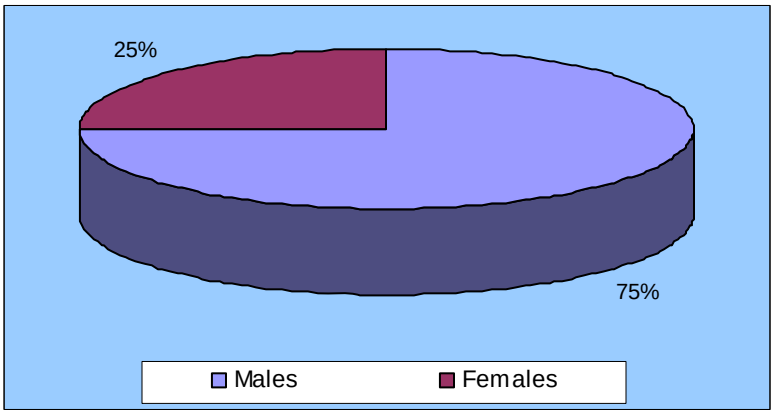
4.2 RECOVERING ADDICTS PERCEPTION OF CARLTON HOUSE EFFECTIVENESS

This section provides an overview of recovering addicts' perceptions of Carlton House effectiveness. Although effort was made to secure clients views on all services provided by the treatment centre, the majority of respondents spoke to the following: treatment and rehabilitation, re-integration, aftercare, and self help groups. Due to the nature of the recovering addict population (hard-to-reach), only a small number of persons were actually interviewed. In light of this, the results should not be generalized to all recovering addicts, but could serve as indicators that can inform and reinforce future improvement of the treatment program.

4.2.1 Demography and Indicators of Drug Treatment Success

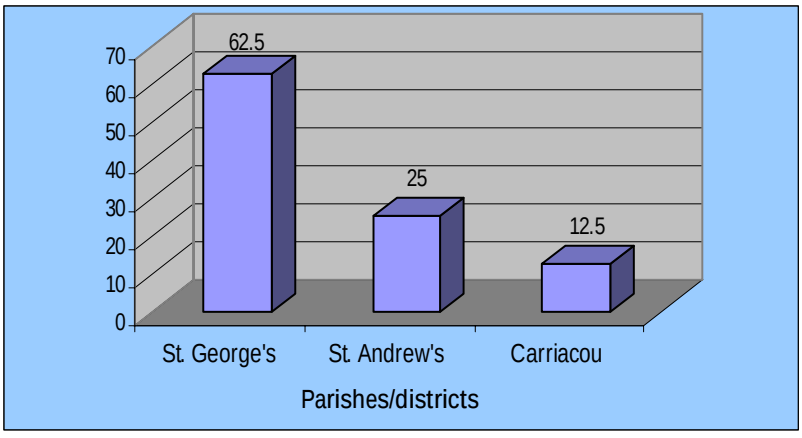
Eight recovering addicts were interviewed for this study. As displayed in Figure 16, 3/4 of the research subjects were males (75%) while only 1/4 were females (25%).

Figure 22: Pie chart showing gender distribution of respondents



Research subjects represented three main parishes/districts in Grenada, with St. George's amassing the majority of responders (62.5%), followed by St. Andrew's and Carriacou respectively (25% and 12.5%).

Figure 23: Bar chart illustrating respondents' place of residence



The majority of respondents as illustrated in Figure 18 were between the age range of 31 – 50 years (75%). Approximately 12.5% of respondents were between the age range of 21-30 and 51-60.

Figure 24: Age range of respondents

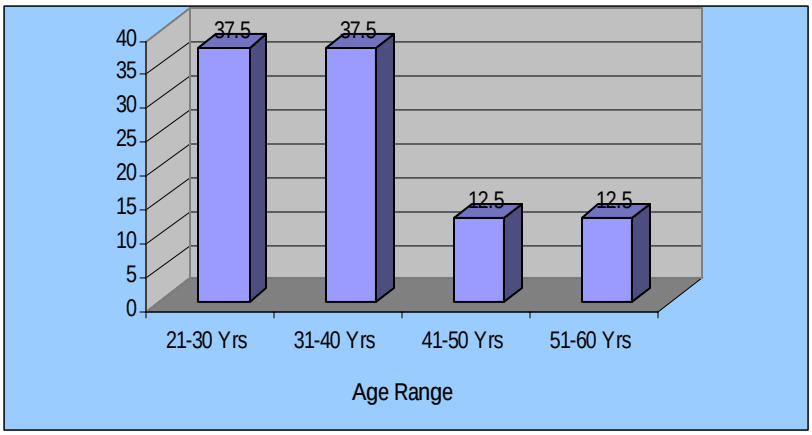
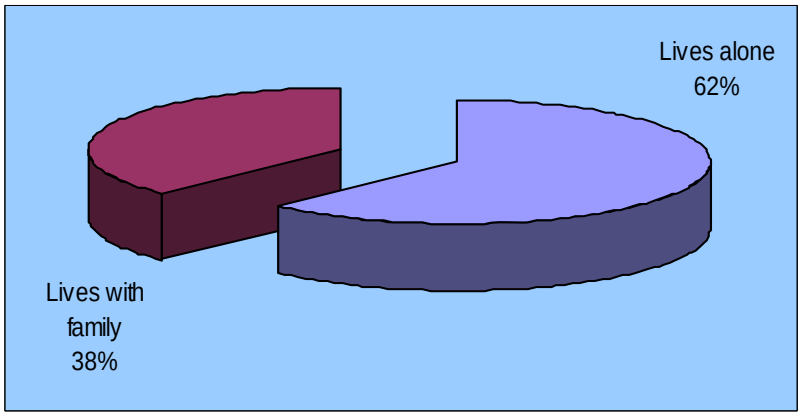


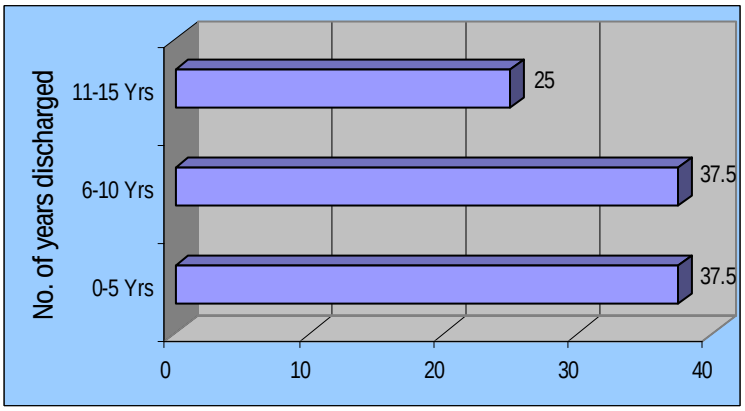
Figure 19 illustrates the cohabitation arrangements of research subjects. Approximately two thirds lived alone (62.5%), while about a third lived in a family setting (37.5%). Interestingly, 67% of individuals living with family were females.

Figure 25: Living arrangements of respondents



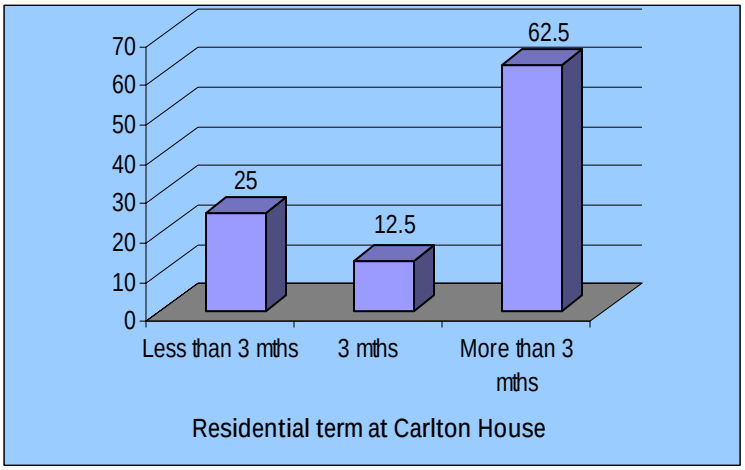
As shown by Figure 20, ¾ of patients were discharged 0-10 years prior to 2005 (75%), while 25% were discharged 11-15 years ago.

Figure 26: Number of years discharged from Carlton House



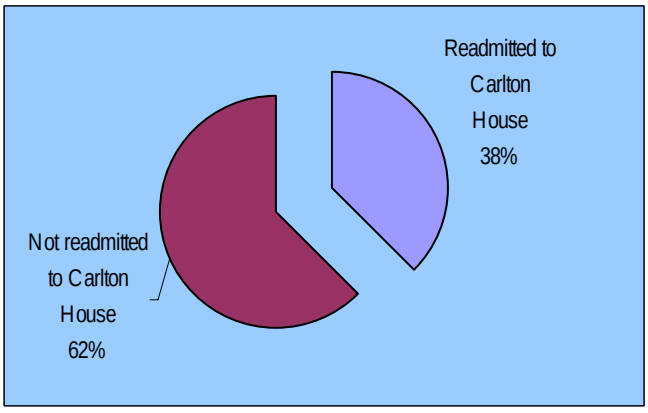
Regarding length of residency at Carlton House, only 12.5% of respondents remained for the designated three months period. The majority of person (62.5%) remained an extended period of time at the treatment centre.

Figure 27: Bar chart illustrating respondents' residential term at Carlton House



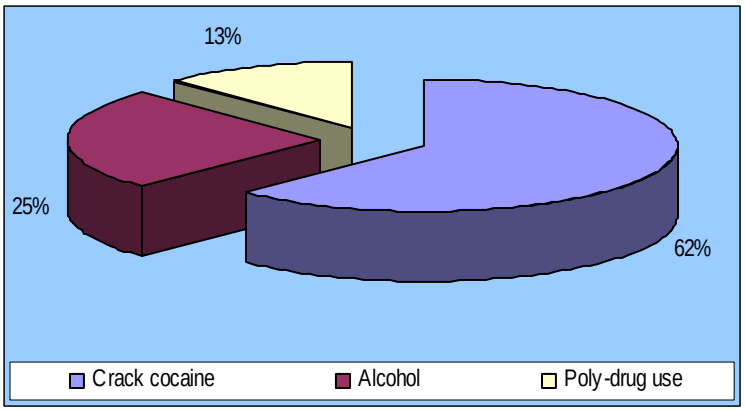
When asked about readmission to Carlton House, 38% of respondents revealed that they were readmitted to the treatment centre at least once, while 62% stated that they were never readmitted (Refer to Figure 22).

Figure 28: Percentage readmissions to Carlton House



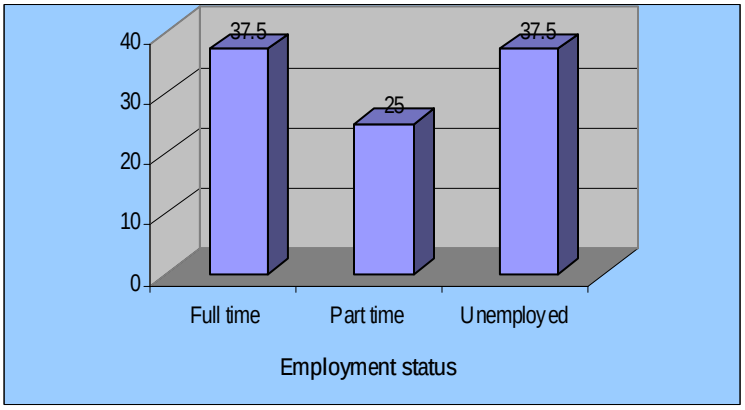
Similar to that reported in Figure 3, the vast majority of respondents were admitted to Carlton House for alcohol addiction (62.5%), followed by admissions for crack cocaine (25%) and poly drug use (12.5%).

Figure 29: Reasons for admission to Carlton House



Almost two thirds of respondents had some form of employment (62.5%), with 37.5% working fulltime and 25% part-time. Over 37.5% of recovering addicts were unemployed as shown in Figure 24.

Figure 30: Employment status of recovering addicts



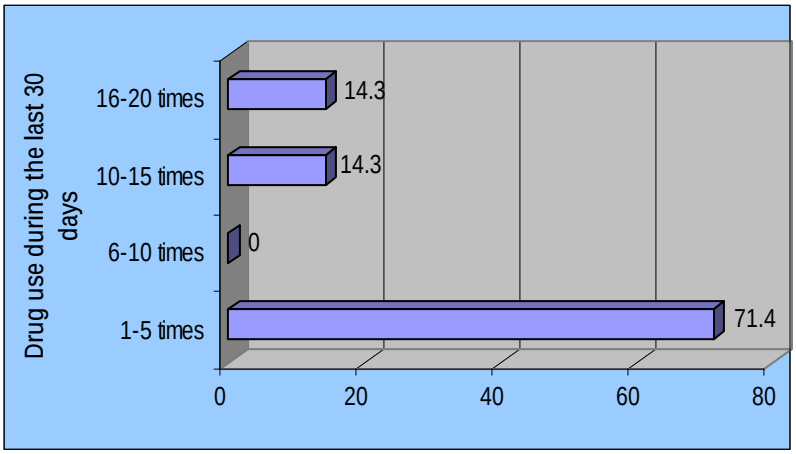
When questioned about sobriety, 87.5% of respondents indicated that they were not completely sober. *Only one respondent, a female indicated adamantly that she enjoys "quality" sobriety (12.5%).* A total of 75% of respondents stated that they consumed drugs within the last twelve months, while one indicated that relapse occurred within the last six months (12.5%) – post Hurricane Emily.

Of the persons consuming drugs, almost ¾ (71.4%) indicated that they used drugs 1 – 5 times during the last 30 day period. On the other hand, 14.3% of persons used drugs 10 - 15 times and 16-20 times within the period under review as shown in Figure 25.

The drug of choice for 85.7% of consumers was alcohol which was in fact the drug fueling their admission to Carlton House. However, in 14.3% of cases, recovery addicts

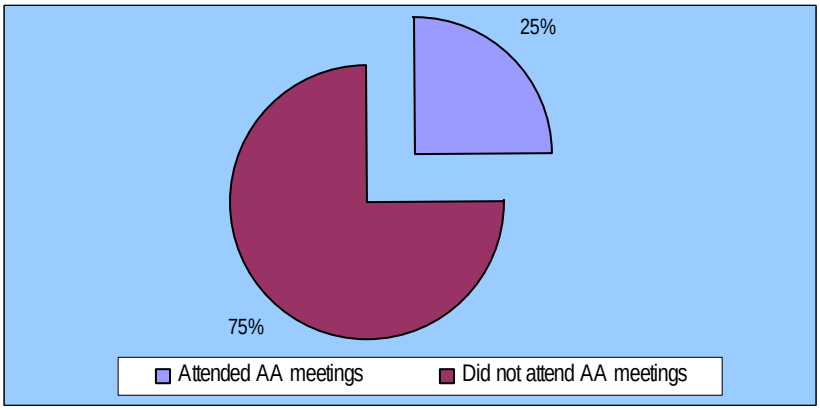
used what was referred to as a "softer drug"- alcohol, as opposed to use of crack cocaine which was the drug of choice prior to been admitted to the treatment centre.

Figure 31: Respondents consumption of drugs during the last 30 day period



An overwhelming 75% of respondent stated that they do not attend Alcoholics Anonymous meetings. The 25% consistent attendees noted that they cease participating in meetings after the passage of Hurricane Ivan, due to the problems in securing a meeting venue.

Figure 32: Pie chart showing attendance to AA meetings pre-Hurricane Ivan



When asked about risky behaviours, all respondents (100%) indicated that they have not been involved in any deviant behaviours after been discharged from Carlton House.

CASE STUDIES[18]

RHONDA JONES STORY
"Life is worth living now"

Rhonda is a 40 year old female who lives in an urban community in Grenada with her five children and her partner. Rhonda overcame her addiction. This is her story.

I was a cocaine addict; I tell you all I could think about was cocaine. I was not even interested in sex. If someone really wanted to make me happy, all they had to do was fill the house with cocaine and leave me there. I spent all my money on cocaine. Sometimes when the urge for a fix take me, I use to run from Vendome to town in a flash...it is amazing what you will do to get a fit.

For some time people were telling me Rhonda why don't you go to Carlton House, but for whatever reason I was not interested. One Friday night I was smoking and just started to cough up blood, I got real scared. I immediately call Dr. John, and I said Dr. John I have a serious problem and you need to refer me to Carlton House. Well I did not even wait for the referral from the doctor. I went straight up to Carlton house and I told them I en moving, until you decide to take me in. They did, and that was my best decision yet. For 12 years now, I am clean. My sobriety is quality now, and I don't mess with nobody when it comes to that.

I lost everything, my self esteem, respect, family, name it, I had nothing. I was in the dungeon, I hit rock bottom. Every body gave up one me. Carlton House picked me up in my most vulnerable time and gave me back my life. I will always be grateful for Carlton house. Worse yet, I went in there [Carlton House] pregnant - a cocaine addict and pregnant. They use to call me queen drake, Russian tires, because I was always smoking. I remember I had no things for the baby, Nurse Brown sent to the United States to get me baby clothes. I did not have any family, but my family was Nurse Brown, the staff, doctors and Carlton house. My life is to Carlton house. I remember when I was giving birth to my baby, the first thing I ask the doctor when she came out was: she okay doc, she normal, she deformed because by then I understood how my drug habit could have affected the child. Well god bless me, I had a beautiful daughter, she is 13 years now. Every now and then I remind her about my life before she came, and what I did when I was pregnant, she cries sometimes.

I look back and I just thank god for Carlton house. The program works if you work it. If it was not for Carlton house I would not be here sitting with you, I'll probably be a prostitute, in jail or just killing somebody. I know one thing that each day I have to work my program and remind myself that I am a recovering addict and I cannot change that, but with God's help I can make it, one day at a time. I also know that all that is sitting between my sobriety and addiction is one smoke, and all that I worked for would be loss, so I make no joke with that.

[18] All names have been changed to maintain confidentiality of the subject.

JOHN CRONY'S STORY
"I screw up mightily"

John is a 55 old male who lives in a rural village in Grenada. He lives alone, and could be found parading the community apparently aimlessly each day. John has been, and continues to be a poly-drug user. This is his story.

Cocaine is my problem, but I use three drugs: cocaine, alcohol and marijuana. I got hooked on cocaine out of Grenada. I used to work for a cruise line and I got hooked. They sent me to rehad because I was a good worker and the boss believed in me. The health insurance cost US$10,000.00 to keep me in rehad. But I never got over it, and I loss my job. I screw up mightily.

Then I came back to Grenada and I had the same problems, so I went into Carlton House in 1998. I had a little family support, not a lot, but at least they use to come and take my clothes and wash it. I had a very high relapse rate there. I use to spend more time in Carlton House than at home - sometimes 7 months in Carlton House and 5 months home.

Ah get hooked, me whole life mess up. Carlton House could do so much and no more, we have a role to play to. Sometimes I might be dreaming someone give me a piece of cocaine. I want it so much, but before I take it, I wake up in a sweat. Ah want to pee [urinate], ah going to see how ah could get the money, and you doing anything to get the money. I tried to fight it (cocaine), but why the hell they en come up with something to deal with that kind of cravings.

I am underemployed now. I work one day per week for EC$25 – 30. That's how I come. But every other day I spend $EC10.00 on cocaine, $EC5.00 on alcohol and $EC2.00 on marijuana.

Learned Pointer

Although not generalizable, the vast majority of recovering addicts were unable to fully attain all targeted long term outcomes of drug treatment and rehabilitation. Maintaining sobriety proved to be the most difficult objective, as exhibited by approximately 9 out of 10 respondents. Poor attendance at AA meetings, aggravated by an unsupportive socio-economic and psycho-social environment particularly in the post hurricane era were possible fueling factors for this trend. Despite this apparent ineffectiveness, indicators of success were evident. Specifically, 100% of all respondents claimed access to housing (although the study did not determine the type of housing possessed), while almost 2/3 had some form of employment.

4.2.2 Recovering Addicts Perception of Carlton House Effectiveness

4.2.2.1 Comments about specific services

Group therapy

Respondents were very clear in articulating the educational benefits of group therapy. Moreover, some respondents stated that these sessions encouraged discussion and motivated patients to be honest about complex issues (Refer to Section 4.1.3).

> "Everyday Nurse will pick a topic, for example anger or resentment, and we learn a lot about what could make you angry. I find the group meeting very important that is how the patients learn [Employed, male recovering addict]."

Another positive feature identified about group sessions was the focus on augmenting literacy levels among patients. Special emphasis was made of the delivery methods employed, and the supporting activities provided during these sessions.

> "Not everybody who enter Carlton House could read or write, but how they do it [delivery methods], you could follow on the blackboard. They learn to read at Carlton House. They will get to know the steps by heart, and other patients helping them read the AA/NA books or the bible [Unemployed, female recovering addict]."

The most prevalent problem reported though about group therapy was the inadequate training and preparedness of selected nurses. Real practical application of the information disseminated was the primary deficiency identified (Refer to Section 4.1.3.1).

> "There were some nurses who were leading a group session and don't know about the steps and how to apply it. They read the book and they may be able to say all 12 steps, but they don't know how to teach it. They need to be highly trained…some nurses did not know how to put down the program [Employed, male recovering addict]."

According to respondents the problem stemmed from the recruitment of Nursing Assistants who were not trained in addiction studies and/or the haphazard selection of professionals attached to the general hospital.

> "Somebody apply for a job they take them as nursing assistants when they ready they give you a set of pills and before you know it, you out. They need some properly trained people at Carlton House. You can't just say you go take someone from General Hospital and put them in Carlton House, they not trained in addiction studies [Unemployed, male recovering addict]."

Size of the group used during group therapy was also reported as an area of concern. A few recovering addicts noted that groups were too large, which seriously hindered honest discussion about personal problems by some patients. Smaller groups were proposed, with greater focused on individual counseling.

> "Groups are too large, counselors have an idea of what they want to do but the patients suffer from not been honest. You know some people have been touched, been homosexuals it hard to be honest. You need more individual counseling. Each counselor needs to have smaller groups [Employed, male recovering addict]."

Individual therapy

Generally speaking respondents were of the belief that individual therapy was beneficial due to the opportunities for more introspective counseling.

> "It's good (individual therapy) … they would ask you about the problems that were bothering you, how you feeling, what is your intention after you leave Carlton House…, a whole new picture is revealed in these sessions. They will ask you what you want to do, or how is your resentment [Employed, male recovering addict]."

Yet, the frequency of individual therapy was the limiting factor in sustaining the effectiveness of this therapeutic approach.

> "We don't meet very regular, maybe it would be a good thing to meet twice a week [Employed, male recovering addict]."

Family therapy

Seven out of eight (87.5%) respondents adamantly indicated that family support was not forthcoming during the treatment process (Refer to Section 4.1.3.3). The role of Carlton House in assuming the role of family, and providing much needed emotional support for most patients was very clear.

> "I did not have any family, but my family was Nurse Brown, the staff, doctors and Carlton house. My life is to Carlton house. Carlton house was my life, I would not be here today - everybody gave up on me. Carlton House never gave up on me – that's where I got back my new life [Unemployed, female recovering addict]."

> "My family was Carlton House, and that is where everything start back for me. She (nurse at Carlton House) takes care of you like a son, that's the difference. She takes you on personally [Employed, male recovering addict]."

Re-integration

A few respondents (25%) noted the tremendous role played by Carlton House in securing employment during and after their residential term. They accredited this to the level of staff commitment and interest in patients' personal development (Refer to Box 7).

BOX 7
A success story: The power of collaboration between employer, recovering addict and Carlton House

I was out of a job for at least a year. Actually, I had a very good job before I went into Carlton House. Nurse Brown was instrumental in getting me my job back. She and her staff wrote to management and say I am okay. Management accepted and took me on for a second time. I had to work while in Carlton House…they put me on a special program. Ah mean, the day I was suppose to go back to work, they dress me, (I did not have shoes or shirt) and sent me back there. The interest they showed in patients…I got good treatment. Today I am still in my job [Employed, male recovering addict]."

The above documentation highlighted the key ingredients needed to secure meaningful employment for recovering addicts:

- Marketable skill/s possessed by recovering addict
- Partnership with employers
- Evidence of recovery among addict
- Staff commitment to the process
- Sustained productive lifestyle exhibited by recovering addict

After care

Respondents lamented on the detrimental problems that could ensue from no aftercare provided by the Centre, especially during the vulnerable three months after the discharge period (Refer to Section 4.1.5). Respondents recommended the need for half way houses which could provide an intermediate bridge between the society and the treatment centre.

> "There is no follow up. The real test is when you release. That is when you know if someone really take the program. After 3 months, they (discharged patients) need something to hold on to…example, half way houses where they get a job for you and monitor you, so they could evaluate whether you are fit enough to be on you own or not [Employed, male recovering addict]."

The problem of re-integration is also compounded by the lack of support provided by society in the recovering process. Slander and patients' mistake of conforming to prior socialization methods can affect ability to maintain sobriety.

> "They would say drake, you go never make it, you going back on the thing. They really cry me down. But when they cry me down, it gives me strength; I know then that I could be the person I want to be, not what they want me to be. So I would say, Rhonda Jones not going back, no relapse [Unemployed, female recovering addict]."

Self help groups (AA meetings)

The majority of patients acclaimed the educational and rejuvenating nature of AA meetings.

> "AA meeting is like a battery, if you don't recharge you battery you will go down because you have a relapsable disease. You have to keep working on it, complacency will step in when you least expect it, and you back on the thing again – meetings give you an avenue to stay sober [Unemployed, female recovering addict]."

> "It's a form of strength within each other because you have a place to come back. It's an obligation a priority - that's where we get our strength from. Ex patients coming back and share their experiences with inside patients give them strength [Employed, male recovering addict]."

Specific mention was also made of the role of AA meetings in augmenting an individual's coping strategies, and assisting in the prevention of anger tantrums.

> "Helps you to cope and remain positive: when you go to meeting you less angry [Employed, male recovering addict]."

Three crucial challenges were identified regarding AA meetings. Firstly, as indicated in Figure 26, the majority of outpatient individuals do not attend AA meetings. Knowledge of the program, and preoccupation with other important issues such as employment were rated as the primary reasons for low attendance.

> "They come to meeting 1 – 4 times and you don't see them again until something bad happen. They say to themselves, I know the 12 steps, I okay now, I en bound to come to meeting [Employed, male recovering addict]."

> "I never attended AA meetings. After I left (Carlton House), ah did not really make time to do this, I was busy to go, I use to work [Employed, male recovering addict]."

In the aftermath of Hurricane Ivan the small consistent members that attended meetings have not been doing so due to lack of an appropriate venue and resultant frustrations with the situation.

> "Most the outside patients don't have a place to meet, we use to use Carlton house before Ivan, but now we don't have a place and there is no body to establish any kind of meeting. It's a very long time I did not go [Employed, male recovering addict]."

Respondents indicated that this situation could breed higher incidence of relapse and other frustrations.

> "You going to have a lot of relapse. I drink occasionally now, a beer every now and then. I know that this is not good because the softer drug can get me back taking my drug of choice, but I get turned off because we don't have no place to meet, it does bother me [Employed, male recovering addict]."

> "Now and then I does get angry, and I resent people, it's only a matter of time before I go back to the drug. The good thing though is that my uptightness don't get to the extreme [Employed, male recovering addict]."

Respondents proposed that management should encourage inexperienced nurses to attend AA meetings, primarily as observers. This they believed would provide a practical perspective to the underlying reasons for addicts' behaviour and emotional state, thus enhancing capacity to deliver program.

> "The inexperience nurse, they might read a book or they might be in the office trying to get an awareness of what its (addiction) all about. Nurses should be around in AA sessions and understand how cocaine really is and what's affecting you. They might see you in a corner, they new to the work and not properly trained so they don't know how to deal with that [Employed, male recovering addict]."

When asked their views on the establishment of parish based AA meetings, the majority of respondents fully supported the idea. However, one respondent stated that the problem of poor attendance lies mainly in the priority addicts place on such meetings, and not so much in the distance.

> "Parish meeting is good, but I don't really support that because it's all about priority. Before you (addict) use to leave Grenville to go Tivoli and sometimes all in St. George's to get it (drug). Why not take a bus and come out here, why not give the meetings the same urgency [Employed, male recovering addict]?"

Occupational therapy

One thing that was very lucid was the fact that most respondents appreciated the structured incorporated into the program at Carlton House. Specifically, they saw the routine for various activities beneficial to addicts who lacked such rigidity.

> "It was a real experience, its keeps you occupied, you have to make up your bed, say prayers in a group, each person assigned a task for the day. Example you in charge of the bathroom or the toilet, this helps especially for us who were not use to routine [Employed, male recovering addict]."

> "For me I loved the gardening, that was very refreshing and especially since Grenada is a farming place, that was a good idea [Employed, male recovering addict]."

4.2.2.2 General comments about program effectiveness

BOX 8

Positive perspectives

Spiritual awakening

"It's not only for drugs; it's a way of life. Before I went to Carlton House I grew up in a Christian home but I did not really read the bible. Carlton house change all that - it's a spiritual awakening I got that from Carlton house, it's more than the 12 steps [Employed male recovering addict]."

Negative perspectives

Duration of program too short

"Time is too short. What could you really achieve in a couple months, too much relapse going on outside in the space of two weeks? After been discharged they not making it, like they learn nothing, need a longer period to get them real accustom to the program [Employed, male recovering addict]."

Lack of commitment among a number of addicts

"A lot of us addicts we take rehad as a joke. We feeling here is free of cost, so we take it like a joke or they saying I want food to eat and a place to stay, and that's it, they not working the program. Some of them deliberately play the fool [Employed, male recovering addict]."

Societal myths about Carlton House

"People have the impression that you will get injection at Carlton house, and that creates a scary thought, people needs to be taught what the program is about [Employed, male recovering addict]."

"My first impression about the place is that its about crazy people getting injection, so I chose to go to Rathdune. I spent 1 month and 2 weeks in Rathdune, my real problem lied in Carlton House [Employed, male recovering addict]."

Staff competence

"They need a psychologist there, they need people who can get to the core why a person use drugs, get them to reach the emotional psychic side of persons [Employed, male recovering addict]."

"People need to come to work and care about the work, more passionate [Employed, male recovering addict]."

Learned Pointer

Generally, recovering addicts viewed the treatment and rehabilitation program as effective. The principal factors contributing to program effectiveness as reported by recovering addicts included the educational benefits of group therapy, enhance counseling through individual therapy, tremendous emotional support and commitment provided by Carlton House staff, rejuvenating potential of AA meetings, and positive experiences of occupational therapy. The ability of recovering addicts to achieve the desired outcomes of the program are seriously negated by the following issues: large group size used during group therapy sessions, inadequate training and preparedness of selected staff members, unavailability of a resident psychologist, insufficient frequency for convening individual therapy sessions, lack of family and societal support, very poor attendance at AA meetings, lack of venue for hosting AA meetings post Hurricane Ivan, inadequate length of treatment program and lack of commitment among selected recovering addicts.

4.3 KEY INFORMANTS PERSPECTIVE OF RATHDUNE EFFECTIVENESS

This section provides an overview of key informants' perspectives regarding the effectiveness of services provided by Rathdune.

4.3.1 Case referral

Rathdune Psychiatric Unit possesses the technical and collaborative capacity to successfully refer patients to more appropriate treatment centres. However, operationalizing the referral to Carlton House Treatment Centre could be difficult as described below:

- All patients entering Carlton House must be admitted based on voluntary consent. Therefore, if a patient does not perceive the importance of Carlton House in his/her overall wellbeing, then this referral would most probably not come to fruition.

4.3.2 Detoxification

Similar to Carlton House, Rathdune operates an effective detoxification program - patients are stabilized and cleared of all internal drugs. The protocol though is challenged by a number of factors, chief of which are:

- Patients' willingness to comply with procedure: In a number of cases, patients do not cooperate with supporting staff and would hide medication in mouth and discard when no one is noticing. This practice obviously can encourage wastage of limited resources, and if undetected, can reduce the overall integrity of the process.

- The range of medication as presented in Box 3 to support the process is sometimes not always available.

- Inadequate staff on duty during the detoxification process: As reported, only one male is sometimes available during the detoxification of patients. This is a risky situation, due to the potential for the manifestation of aggressive and other psychotic related behaviours by patients.

4.3.3 Psychotherapy

Though very limited, the process has been reported to provide some basic awareness of the nature of the mental health problem, possible determinants and the significance of treatment. This could assist in the behaviour modification process needed for wiser lifestyle choices. The effectiveness of the psychotherapeutic sessions is severely affected by the following factors:

- Inability to maintain expected frequency of sessions.

  "We are supposed to have these sessions once a week, but sometimes a week pass and we don't do it [Key Informant, Rathdune]."

- Inadequate cooperation of patients.

  "This is an acute unit, so challenging behaviour is expected. Once this occurs, its make is difficult to conduct any structure program [Key Informant, Rathdune]."

- Unsuitable facility: Informants reported that group therapy is carried out in the foyer area at the Unit. This area is used for recreational purposes by patients, and is directly opposite the main gate where patients from Mt. Gay frequent. Additionally, this area is in direct visual and auditory pathways to the visitors centre. Consequently interference particularly from Mt. Gay mental patients poses a major distraction. Furthermore, the setting does not encourage privacy and/or confidentiality of information. This deters open communication, and invalidates efforts at counseling.

- Staff availability and competence: Rathdune in severely understaffed. The problem is compounded by the limited number of registered nurses[19] attached to the Unit (4), the high number of nursing assistants not trained in counseling (82%), and the irregular attendance displayed by a number of nurses. These challenges compromise the quality of the counseling sessions conducted, with short and long term implications for attitudinal and behavioural changes. In fact, one key informant started that "*patient's leave Rathdune empty*" as evident by the high readmission rate.

[19] Two registered nurses are currently been trained in Jamaica, and are expected to return in the very near future.

- The psychotherapy program does not target drug addiction specifically as an issue. The focus is on the determinants of mental problems, significance of the treatment protocol and other general lifestyle issues such as hygiene. The informant reported that drugs would only be introduced in a serious way into the group sessions if more than half of the cases were diagnosed with drug induced psychosis, which is a rare occurrence. In light of this, patients exhibiting drug related problems rarely receive counseling to addressing the underlying issues pertaining to drug use.

Rathdune does not offer after care services. However, patients can receive outpatient treatment and care through the Mt. Gay Hospital ambulatory outpatients clinics (Refer to Figure 11(a and b).

Learned Pointer

Rathdune Psychiatric Unit possesses the technical capacity to operate a successful detoxification program. The integrity and ease of delivering this service to patients is negatively affected by these factors: patient non compliance, unavailability of required medication and inadequate onsite staff.

Although some effort is made at providing psychotherapy services, the benefits of these sessions for patients with drug related problems are limited because of low frequency of sessions, uncooperative patients, unsuitable facility, limited and incompetent staff, and almost negligible emphasis placed on addressing drug related issues. The drug treatment model at Rathdune therefore, does not satisfactorily prepare patients to remain drug free for extended periods.

4.3 KEY INFORMANTS PERSPECTIVE OF THE INSTITUTIONAL FRAMEWORK FOR DRUG TREATMENT AT HER MAJESTY'S PRISON

Key informants reported that the institutional framework for promoting and sustaining drug treatment and rehabilitation at Her Majesty's Prisons is severely deficient. Two fundamental problems exist. Firstly, there are no policy and legislation mandating inmates' attendance at drug treatment programs at the Prison. Any attendance at such programs is totally voluntary by law. To this end, even though a drug treatment or related program exist at the Prison, legally inmates can decide not to attend the sessions despite been authorized to do so by Prison officials.

> "Even if you bring the program, there is nothing compelling them to attend. They do not have to attend if they don't want to because there are not laws governing this [Key Informant, Her Majesty's Prisons]."

Consequently, the legal environment encourages the demise of these and similar programs if they are not perceived as important or interesting by inmates.

> "So sessions sometimes don't live if they are not viewed as important by inmates because there is nothing saying that they must attend [Key Informant, Her Majesty's Prisons]."

Secondly, attendance at drug treatment and rehabilitation programs are not included as part of the convict's sentence. The legal and judicial systems do not prioritize this issue despite the numerous repeat offences that are drug related as elucidated in Section. Officials at Her Majesty's Prison posited that it is extremely critical that the court system collaborates with the Department of Social Services to conduct background checks on repeated offenders to determine the underlying factors fueling their delinquent behaviours. If the behaviours are proven to be drug related, drug treatment should therefore be a mandated part of their sentence. Officials noted though that this is remotely considered. Rather hard labour is normally the model proposed for rehabilitation via the sentencing authorization.

> "The sentence never says, six months with drug treatment. It normally states six months with hard labour [Key Informant, Her Majesty's Prison]."

Failure to recognize the role of drugs in criminal behaviours according to key informants, have resulted in significant readmissions and minimal rehabilitation prior to discharge for a large number of inmates.

> "For instance, there is a young woman here in the prison now. She should not be here, since her criminal actions are directly linked to drug abuse. Keeping her here for 6 months or six years would not change anything much about her. She would still remain with a drug problem. Once she is discharged, she will return to her old drug habits and very soon would be getting involved in delinquent behaviours and then back in prison [Key Informant, Her Majesty's Prisons]."

In the final analysis, additional work needs to be conducted to determine the most feasible model for implementing a sustainable drug treatment and rehabilitation program at the Prison. What is clear is that the original model used during the late 1990's serviced by Carlton House staff proved inadequate due to immense shortage of human resource.

5.0 SUMMARY OF FINDINGS

This study commissioned by the Drug Control Secretariat as part of its Drug Demand Reduction project, seeks to measure the extent to which patients in drug treatment remain drug-free after a certain period of time, and the success in matching treatment to patient.

The study employed a qualitative research paradigm due to its exploratory nature. Specifically, the principal data collection strategies included key informant interviews and content analysis of secondary data. It is the goal of the implementing agency that this study would provide the information needed to develop more effective drug treatment and rehabilitation programs, with the long term goal of increasing sobriety among recovering addicts.

This section summarizes the main findings of this study. Results are summarized under the following headings: Drug treatment modalities and services and effectiveness of drug treatment and rehabilitation services.

5.1 DRUG TREATMENT MODALITIES AND SERVICES

5.1.1 Drug Treatment Modalities

- Two principal types of drug treatment modalities exist in Grenada as listed below:

  - ✓ One residential inpatient program operated by Carlton House;
  - ✓ One ambulatory outpatient program managed by the Mt. Gay Psychiatric Hospital, delivered through six established medical clinics.

5.1.1.1 Residential inpatient

- Carlton House provides a comprehensive three months treatment program, and target persons diagnosed with alcohol, marijuana, crack/cocaine, prescription drugs, and poly-drug use dependencies.

- The treatment modality at Carlton House is based on the Alcoholics Anonymous (AA) twelve steps program, infused with life skills and cognitive-behavioural therapy.

- The treatment modality has national coverage, and targets all persons irrespective of socio-economic status, age and sex.

5.1.1.2 Ambulatory outpatient

- The ambulatory outpatient program operated by Mt. Gay Psychiatric Hospital provides medical services to mental health patients, *including those exhibiting co-morbidity with a known substance abuse problem.*

- Patients exhibiting the above described co-morbidity (drug induced psychosis) are clinically assessed and provided with appropriate treatment at the ambulatory clinics. In addition, they are counseled by the Hospital's Psychiatric Team as deemed necessary.

- Ambulatory services are provided at six parish based medical clinics across the island, inclusive of Carriacou. On average, each parish/district receives at least one monthly visit, while St. George's is provided with at least four visits.

- The treatment modality has national coverage, and targets all persons irrespective of socio-economic status, age and sex.

5.1.2 Drug Treatment Services

- Five main drug treatment and rehabilitation services are provided in Grenada through three publicly funded providers: Carlton House Treatment Centre, Rathdune Psychiatric Unit and Mt. Gay Psychiatric Hospital. Chief services provided are as follows:

  - ✓ Referral of cases
  - ✓ Detoxification
  - ✓ Treatment and rehabilitation
  - ✓ Social integration
  - ✓ Self help groups.

- All three institutions are involved in the business of case referral.

- Detoxification is provided by Carlton House Treatment Centre and Rathdune Psychiatric Unit.

- Carlton House Treatment Centre is the exclusive provider of self help groups, treatment and rehabilitation, and social integration services.

- Her Majesty's Prison, the sole detention unit for criminals lacks a drug treatment and rehabilitation program despite the large percentage of drug related convictions. Absence of this critical service propagates readmissions among individuals that have drug abuse problems – true rehabilitation does not occur in the prison for these individuals.

- The institutional framework for promoting and sustaining drug treatment and rehabilitation at Her Majesty's Prisons is severely deficient. Two fundamental problems exist.

  - ✓ Firstly, there are no policy and legislation mandating inmates' attendance at drug treatment programs at the Prison.
  - ✓ Secondly, attendance at drug treatment and rehabilitation programs are not included as part of the convict's sentence.

5.2 EFFECTIVENESS OF DRUG TREATMENT SERVICES

5.2.1 Referral of cases

- Overall, a well established collaborative mechanism exists for the referral of cases to and from the drug treatment centres.

- On average, the drug treatment and rehabilitation sector has the capacity to successfully match patient to treatment program due to the following reasons:

  - ✓ Formalized framework for referral
  - ✓ Potential for promoting effective drug treatment.

- A number of factors as listed below seriously hamper the effectiveness of the referral system in the long term, impinging on the integrity of the matching process.

  - ✓ Irresponsible manipulation of the system
  - ✓ Potential for drug dependent cases to evade treatment
  - ✓ Reduced motivation for referred patients to undergo complete treatment
  - ✓ Lack of an early detection and outreach service.

5.2.2 Detoxification

- Grenada has a reputable detoxification program in place which is supported by the following:

  - ✓ A competent team of professionals
  - ✓ Effective monitoring system for prevention of major withdrawal symptoms
  - ✓ Easy access to emergency medical services or more specialize care
  - ✓ Availability of required medication and other dietary needs (specific to Carlton House).

- Detoxification is a proven successful method in stabilizing patients and rendering them drug free.

- The integrity and ease of delivering this service to patients is negatively affected by these factors:

- ✓ Patient non compliance
- ✓ Unavailability of required medication and inadequate onsite staff (relevant to Rathdune)
- ✓ Patient aggressive behaviour

5.2.3 Treatment and Rehabilitation

5.2.3.1 Group therapy at Carlton House

- Group therapy was highly rated as one of the most effective and successful components of psychotherapy offered at Carlton House.

- A conducive psycho-social environment, excellent forum for education and a well established collaborative mechanism with private, public and Non-governmental sectors were the identified strengths of the group therapeutic sessions.

- Notwithstanding the apparent effectiveness of group therapy, its overall impact is negated by a number of physical and technical factors. Informants identified six main factors hindering the overall impact of group therapy:

  - ✓ Lack of trained specialists
  - ✓ Unsuitability of the physical facility
  - ✓ Unavoidable interruptions
  - ✓ Large size of group
  - ✓ Insufficiently coordinated program curriculum, and
  - ✓ Inadequacies in staff delivery methods.

5.2.3.2 Group therapy at Rathdune

- Rathdune provides a very basic form of group therapy designed to provide awareness of the nature of the mental health problem, possible determinants and the significance of treatment.

- The long term effectiveness of these sessions in sustaining attitudinal changes consistent with sobriety among drug related patients is deterred by the following factors:

  - ✓ No structured approach to address the drug related issues – negligible emphasis placed on addressing drug as an issue
  - ✓ Inconsistently delivered sessions at
  - ✓ Very few sessions conducted
  - ✓ Unsuitable facility
  - ✓ Limited and incompetent stag
  - ✓ Uncooperative patients

- Group therapy at Rathdune does not satisfactorily prepare patients to remain drug free for extended periods.

5.2.3.2 Individual therapy

- Individual therapy guarantees a more comprehensive approach to treatment, since it provides opportunities for addressing issues and weaknesses that could be missed during the group sessions.

- The limited frequency of these sessions and problems of patient illiteracy hampers the benefits inherent in the approach.

- Staff incompetence

- Irregular attendance at work by some workers at Rathdune.

5.2.3.3 Family therapy

- Family therapy, though extremely important as part of the treatment process, was reported to be *the most poorly delivered component* of the psychotherapy program.

- Strengths of this program included the following:

  ✓ Availability of a family therapy plan
  ✓ Emotional support provided by Carlton House staff
  ✓ Staff commitment to family therapy
  ✓ Support provided by the minority of families.

- Most of the above advantages are neutralized by the following relentless problems:

  ✓ No family involvement and support
  ✓ Lack of understanding among families of the nature of addiction
  ✓ Marginalized socio-economic status of families
  ✓ Rare occurrence of cancelled family appointments
  ✓ Emotional stress associated with limited availability of social services provided to recovering addict.

- Family therapy fails miserably in changing families' attitude towards the recovering addict, seriously limiting attainment of long term outcomes of drug treatment.

5.2.4 Social Integration

- Social reintegration represents *the second most ineffective component* of the treatment and rehabilitation model.

- Although there is evidence of limited family involvement and successful attainment of employment, the strategic interventions implemented by Carlton House do not adequately prepare the family and/or wider society to accept and support the recovering addict.

- The following factors were identified as the main stumbling blocks in the implementation of an effective social integration strategy:

  - ✓ Lack of formalized inter-sectoral partnerships
  - ✓ Alienated and frustrated families
  - ✓ Inadequate socio-economic status of recovering addicts
  - ✓ Societal stigma and discrimination
  - ✓ Insufficient integration of social services into the comprehensive treatment program

- The above factors seriously encumber the potential to attain anticipated medium and long term outcomes associated with treatment and rehabilitation.

5.2.5 Aftercare

- Aftercare represents the *most poorly developed* and delivered service offered by Carlton House.

- Lack of an aftercare program fails to support the attainment of the long term outcomes of the program. This situation therefore propagates:

  - ✓ Relapse
  - ✓ Readmissions
  - ✓ Continued poor or mediocre socio-economic status
  - ✓ Unproductive living.

- Inadequate priority by government was identified as the principal fueling factor.

5.2.6 Self help groups

- Self help groups offer a powerful medium for maintaining sobriety.

- Notwithstanding this, over 90% of patients do not maximize this resource.

- Poor attendance stemming from lack of incentives to attend meetings, high transportation cost, and inadequate understanding of the role of this forum in attaining desired outcomes were proposed as reasons for partial effectiveness of this service.

- Hurricane Ivan aggravated the situation due to the destruction of previously used venues for meetings. Some patients have already begun to experience the problems associated with non-attendance.

5.2.7 Cross Cutting Issues

This section summarizes the cross cutting issues identified by key informants that hindered or augmented the treatment process.

- One of the most profound positive features of the treatment program was the commitment, diligence and competence of some staff members at Carlton House.

- Insufficient involvement of the Psychiatric Team in the operation of Carlton House, limited incentives provided to nursing assistants, irregularity in adherence to rules, lack of commitment among some recovering addicts, and inadequate length of treatment program were factors negatively affecting the overall program effectiveness.

5.2.8 SUMMARY OF THE EFFECTIVENESS OF TREATMENT SERVICES

This section qualitatively summarizes the effectiveness of each treatment service in attaining the long term objectives as outlined in Figures 14 and 15.

Table 11: Level of significance in the attainment of long term program outcomes in the residential inpatient program operated by Carlton House

	Level of significance in attainment of long term program outcomes[20]				
Services provided	**Excellent**	**Good**	**Fair**	**Poor**	**Extremely poor/N/A**
Referral of cases			√		
Detoxification[21]		√			
Treatment & rehabilitation[22]					
▪ Group therapy	√				
▪ Individual therapy		√			
▪ Family therapy					√
Reintegration				√	
Aftercare					√
Self help groups		√			

[20] Four long term outcomes are expected from the residential inpatient program at Carlton House: attainment of sobriety, improved socio-economic state, reduced risk behaviours, and a functioning productive citizen.
[21] Detoxification relates to both Carlton House and Rathdune.
[22] Treatment and rehabilitation relates exclusively to program at Carlton House.

Notes:

- Excellent denotes that the service has the potential to significantly impact more than 75% of program outcomes.
- Good indicates that the service has the potential to significantly impact 75% of program outcomes.
- Fair suggests that the service has the potential to significantly impact 50% of program outcomes.
- Poor denotes that the service has the potential to significantly impact 25% of program outcomes.
- Very poor symbolizes that the service provides negligible significant impact on program outcomes.

5.2.9 CAPACITY CONSTRAINTS AT THE NATIONAL LEVEL

The study revealed that the drug treatment modalities provide a successful model for achieving the majority (6/7 or 85.7%) of short term outcomes. The critical levels of awareness, knowledge, skills and motivation needed to foster appropriate concrete changes in the journey to sobriety and productive living can be realistically accomplished. Albeit this, the current treatment and rehabilitation modalities do not fully prepare the majority of drug addicts to attain the following long term outcomes:

- Sobriety
- Improved socio-economic status
- Reduced risk behaviour (to a lesser extent)
- Productive citizen

The following section summarizes the primary constraints hindering the principal drug treatment and rehabilitation providers and related institutions from achieving the above outcomes.

- An unsupportive socio-cultural environment that does not fully support re-integration of recovering addicts. Limited or no family and community support, poor or mediocre socio-economic status of recovering addict, societal stigma and discrimination, inadequate involvement of the public and private sectors in provision of housing and employment opportunities, and the unsatisfactory investment by government in treatment and rehabilitation.

- Misinformation or inadequate awareness among family members and communities about the nature of addiction.

- Inadequate preparation of recovering addicts to secure gainful employment.

- Lack of an after care program.

- Lack of a drug treatment and rehabilitation program at Her Majesty's Prisons.

- Lack of a policy and legislative framework on treatment and rehabilitation.

Addressing the above constraints would be instrumental in augmenting the effectiveness of drug treatment and rehabilitation in Grenada. The subsequent chapter presents a recommended plan for resolving these constraints.

6.0 RECOMMENDATIONS

This section presents the recommended areas of improvement in early intervention, drug abuse treatment, rehabilitation and after-care/social reintegration programmes and modalities, in the following areas:

- Administration
- Policy
- Programme content and delivery
- Follow-up and aftercare

6.1 GENERAL OBJECTIVES

- Encourage the development of a supportive socio-cultural environment to adequately meet the physical, social and psychological needs of recovering addicts.

- Promote broad base support among families and communities for treatment and rehabilitation.

- Augment the institutional framework in place for supporting treatment and rehabilitation.

6.2 STRATEGIC INTERVENTIONS

6.2.1 Administration

Strategies

- Augment the human resource capacity at the treatment and rehabilitation institutions.

- Reassess the data collection process for drug related incarcerated cases at Her Majesty's Prisons.

- Establish a drug treatment and rehabilitation program at Her Majesty's Prisons.

- Update the management of information at the treatment and rehabilitation centres.

- Establish a framework for evaluating the effectiveness of drug treatment and rehabilitation.

Actions

- Working in collaboration with relevant stakeholders, conduct an inventory of human resource capacities at each treatment centres.

- Using a phased in approach, train all permanent staff, and new staff especially at Carlton House in Addiction Studies and Counseling.

- Develop a protocol for successfully orienting new staff members to Carlton House. Protocol should address at a minimum the following areas:

  ✓ Terms of Reference for the position
  ✓ Expectations and existing standard protocols.

- Update the human resource capacity at the treatment centres as recommended below:

  ✓ Carlton House: Resident psychologist, full time social worker, and assigned medical doctor
  ✓ Rathdune: Greater percentage of Registered Nurses, and Nursing Assistants trained in basic counseling and addiction studies
  ✓ Mt. Gay Psychiatric Hospital: Increase number of medical doctors and/or psychiatrists.

- Evaluate the drug related data collection process conducted by the Drug Control Secretariat at her Majesty's Prisons, and identify avenues for improvements where necessary.

- Using a participatory approach, determine the most appropriate framework for implementing a drug treatment and rehabilitation program at Her Majesty's Prison. The model should at a minimum achieve the following:

  ✓ Develop supportive policies and legislature
  ✓ Secure the support of the judicial and other social service related organizations in the planning and implementation of this program.

- Procure the necessary software and hardware to establish a database system for managing patient information at the various treatment and rehabilitation centres.

- Train personnel at the various institutions in information management. Specifically, develop skills in computer literacy, database management and data analysis.

- Establish a multi-sectoral task force to review the feasibility of introducing a fee system at Carlton House.

- Conduct a process and outcome evaluation of drug treatment and rehabilitation programs, with urgent emphasis placed on Carlton House.

- Reassess the expected ongoing monitoring and evaluation system in place for the operation of drug treatment and rehabilitation centres.

- Using a multi-sectoral approach, determine the most feasible model for implementing a drug treatment and rehabilitation program at Her Majesty's Prison.

- Solicit funding from national, regional and international agencies to support and sustain implementation of the treatment and rehabilitation program at the Prison.

- Develop a protocol that addresses issues pertaining to rule adherence at Carlton House. Critical to this process are the following:

  - ✓ Develop a mechanism that familiarizes all staff members with accepted rules of the institution.
  - ✓ Establish a framework of consequences associated with deviation from accepted behaviour
  - ✓ Establish a monitoring and accountability code of practice to inform staff decision making re rules adherence.

6.2.2 Policy

Strategies

- Establish a protocol to ensure the inclusion of these policy issues in the currently developed Mental Health Policy and Legislation documents.

Actions/policy guidelines

- Working in collaboration with the Ministry of Health, the Richmond Hill Institution, treatment and rehabilitation centres, Her Majesty's Prison and other relevant stakeholders, ensure the inclusion of these policy guidelines in the Mental Health Policy.

  - ✓ To develop and augment the collaborative arrangements between the treatment and rehabilitation centres and the public, private, NGO (Non-governmental Organization) and CBO (Community Based Organizations) communities.

  - ✓ To expand the drug treatment services to include inmates at Her Majesty's Prison.

  - ✓ Develop a protocol for handling unique judicial issues experienced by some patients.

  - ✓ To empower families and communities to assume responsibility for supporting the drug treatment and rehabilitation program.

- ✓ To empower recovering addicts to lead productive lives after been discharged from treatment program.

- ✓ To continually augment the human resource capacity of the treatment centres in recognition of new national, regional and international trends, and best practices and service needs.

6.2.3 Program Content and Delivery

Strategies

- Develop a collaborative approach for delivery of program didactic information

- Maintain the implementation of best practices in program content and delivery

Actions

- Prior to the re-opening of the Carlton House Treatment Centre, organize a one or two week training and planning workshop for all staff members. Where necessary, external expert assistance should be used to supplement local resources. The session should accomplish the following objectives:

  - ✓ Reassess, and where necessary redevelop the curriculum to parallel the best practices in the field of drug treatment and rehabilitation.
  - ✓ Identify the key messages that should be disseminated in each thematic area;
  - ✓ Augment staff skills in delivery methods, thus catering to the unique learning styles of target audience.

- Develop a system for ensuring proper maintenance of in-house equipment.

- Procure required audiovisual equipment to enhance the pedagogical process at Carlton House and Rathdune.

- Develop a more structured psychotherapy program at Rathdune Psychiatric Unit. Use lessons learnt and competent staff from Carlton House to inform the process.

6.2.4 Follow up and After care

Strategies

- Establish a comprehensive follow up and after care program targeting all recovering addicts.

Actions

- Secure required funding and establish a post for at least two (2) Community Rehabilitation Officers attached to Carlton House Treatment Centre (Refer to Appendix 4 for summary of principal responsibilities).

- Working in collaboration with recovering addicts, establish AA meetings in each parish, including Carriacou with ongoing support provided by Carlton House.

- Establish partnership with Community Based Organizations, Non-Governmental Organizations, public and private sector agencies to provide assistance to recovering addict where possible.

- Identify and secure funding for the involvement of grassroots involvement in follow up and after care.

- Secure the assistance of community mental health officers to follow up on discharged cases from Rathdune, and promote visits to ambulatory clinics.

- Establish and operate an ambulatory outpatient program targeting recovering addicts, patterning the model used by Mt. Gay Psychiatric Hospital. The ambulatory program should be designed to achieve at a minimum the following objectives:

  - ✓ Operate and outreach and early intervention program
  - ✓ Counsel families and referred drug dependent cases
  - ✓ Promote the benefits and operation of Carlton House
  - ✓ Follow up with outpatients recovering addicts over time

- Evaluate the opportunities of establishing a half way house for recovering drug addicts in Grenada.

- Working in collaboration with key partners such as the Drug Control Secretariat, develop and implement a public awareness and education campaign to address the following issues:

  - ✓ Stigma and discrimination of recovering addicts
  - ✓ The nature and effects of drug addiction
  - ✓ The role of the family and community in treatment and rehabilitation
  - ✓ The model of treatment used in Grenada.

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APPENDIX 1

KEY INFORMANT SEMI STRUCTURE RESEARCH GUIDE

1. Share with me your understanding of the drug treatment modality/s in operation at this institution and in Grenada.

2. Describe these modalities paying attention to governance, protocol etc

3. Share with me your understanding of the drug treatment services provided by this institution. Describe these services, with specific emphasis on the protocol, target audiences, geographic coverage and governance.

4. Lets discuss your views on the effectiveness of each service provided. Identify any strengths and/or weaknesses in delivering these services.

5. Share with me your views on how well these services achieve the expected outcomes of this program.

6. Please share with me any additional information that would improve my understanding of the effectiveness of the drug treatment services at this institution.

RECOVERING ADDICT SEMI STRUCTURE RESEARCH GUIDE

1. Kindly provide me with this information:

- ✓ Age, place of residence, date of admission at Carlton House, length of stay at Carlton House, date of discharge, readmissions, living arrangements, employment status, drug consumption, attendance at AA meetings

2. Share with me the main activities undertaken at Carlton House (if they fail to remember, prompts would be provided as reminders)

3. What are your views on the effectiveness of these services in the treatment process?

4. Any other comments are welcome.

APPENDIX 2

LIST OF PERSONS INTERVIEWED

Key informants interviewed:

- Thorne Roberts – Administrator, Richmond Hill Institution
- Dave Duncan, Senior Planner, Ministry of Health, Social Services, the Environment and Ecclesiastical Relations
- Nurse Brenda Gittens – Ward Sister, Carlton House Treatment Centre
- Nurse Brenda Scott – Nurse, Carlton House Treatment Centre
- Herbert Smith – Nursing Assistant, Carlton House Treatment Centre
- Dr. Doris Keens Douglas, Psychiatrist, Mt. Gay Mental Hospital
- Nurse Mendes, Rathdune Psychiatric Unit
- Derick John, Her Majesty's Prison
- Bernard Coard, Inmate, Her Majesty's Prison

Recovering addicts interviewed:

Eight recovering addicts were interviewed. Due to confidentiality reasons, their names would not be listed in this document.

APPENDIX 3

SAMPLE QUESTIONS ASKED DURING INITIAL INTERVIEW WITH SUBSTANCE ABUSERS AT CARLTON HOUSE

1. Name

2. Age

3. Marital status

4. Number of children

5. Address

6. Who else lives with client?

7. Educational level/occupation

8. Chief complaints (what brought the client to treatment)?

9. History of the problem from as far back as the client can recall. (This history should include age of onset, patterns of use, problems or consequences of use, and previous treatment).

10. Clients past life history, to include who he/she grew up with, and what it was like to grow up in his/her home. Also any history of substance abuse by other family members.

APPENDIX 4

NEW POSITION FOR CARLTON HOUSE REHABILITATION CENTER

TITLE OF POST: Rehabilitation officer

GRADE: H and should be a designated traveling officer

POST OBJECTIVE: To coordinate, follow up and manage the delivery of all rehabilitative services at the rehad center and at the community level.

IMMEDIATE SUPERVISORS: Health Services Administrator/Senior Nursing Officer

KEY TASKS:

- To evaluate, plan, manage and coordinate the delivery of all rehabilitative services to substance and alcohol abusers at the institution and community.
- To develop a coherent and coordinated strategy for Alcoholics Anonymous (AA) meetings in every community/district.
- To foster collaboration with and among employers/work places and the rehab center (Carlton House) and have dialogue with employees.
- To provide follow up visits and support to clients when they are discharged back into the community.
- To assist in developing public health policies, plans, and programs to guide the delivery of services.

SPECIAL FEATURES OF THE JOB:

Flexible and long working hours, good communication skills, ability to maintain positive interpersonal relationships, good communication skills, mature and confidential.

QUALIFICATION AND EXPERIENCE FOR APPOINTMENT

At least five (5) years in a supervisory position
Should have attain training in drug addiction studies
Should be a registered nurse/Midwife with psychiatric training

FUTURE TRAINING REQUIRED
Ongoing, seminars, workshops etc
NB: This job description is designed to be revised from time to time to reflect the changes on the global environment, and in support of the health sector reform initiative.