CARIBBEAN SUBSTANCE USE PREVENTION, TREATMENT, AND REHABILITATION-FOCUSED INSTITUTIONS

Results of an Institutional and Human Resource Training Needs Assessment of the OAS English-, French-, and Dutch-Speaking Caribbean Member States

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Acknowledgments

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Executive Summary

Drug use is a complex social, multi–causal, dynamic, and heterogeneous issue that requires an interdisciplinary and intersectoral evidence–based public health approach to influence change. Demand reduction is a priority component that is necessary for a comprehensive and balanced approach to addressing the world drug problem.

The Executive Secretariat of the Inter–American Drug Abuse Control Commission (ES/CICAD) of the Organization of American States (OAS) is committed to assisting its member states in addressing the regional challenges caused by the drug problem that is adversely affecting the public health, security, human rights, environment, and well–being of all humanity. ES/CICAD's work is guided by the core principles and critical elements established by member states in the Hemispheric Drug Strategy and its accompanying Plan of Action. Within its established demand reduction measures, ES/CICAD is committed to support its member states in collecting and analyzing evidence to better identify needs and inform action.

In 2011, ES/CICAD conducted a regional mapping exercise to identify key drug demand reduction stakeholder agencies working in drug use prevention, treatment, and rehabilitation in the OAS English–speaking Caribbean member states and performed a regional Institutional and Human Resource Training Needs Assessment to identify specific priority needs across the Region.

In 2020, this same exercise was conducted in 14 OAS English–, Dutch–, and French–speaking Caribbean member states. This report shares the results of this updated Institutional and Human Resource Training Needs Assessment.

This document is intended to provide a better understanding of the actual and perceived training and support needs of the drug treatment, prevention, and rehabilitation sector in the Caribbean region. It focuses on the current view of the situation from the perspective of professionals in the industry as captured by the needs assessment.

Summary Findings

This section summarizes the findings regarding the characteristics of the agencies that participated in the survey in relation to training development and barriers to training, drug treatment services and activities, training certification, drug court services, new drugs, COVID-19, and prevention–related services and needs.

Characteristics of the agencies

This assessment is based on 117 verified responses from agencies across the Caribbean region.

- An approximately equal number of agencies were characterized as prevention–only (29) or treatment–only (30), while 58 agencies indicated that they offered both prevention and treatment services.
- Most agencies described themselves as governmental (54, or 46.2%). There were 44 private/non–governmental agencies (37.6%), 11 statutory/quasi–governmental agencies (9.4%), and six agencies described as "other" (5.1%).
- 4 agencies stated that they operated at the hemispheric level, 27 at the regional level, 92 at the national level, 28 at the island level, 21 at the district/parish level, and 32 at the community/village level.
- Only 39 agencies, or 34.2%, said staff are required to be licensed by a relevant authority to operate. In addition, about a fifth of the agencies (24, or 21.6%) indicated that clients had to pay for the treatment/prevention services they receive.

Training development and barriers to training

- About 36% of agencies (42) indicated that they had a staff training and development plan. Another 40 agencies (34.2%) had a training and development budget, 48 (41%) had an officer responsible for staff training and development, and 72 (61.5%) had a regular and formal appraisal system covering all permanent staff.
- Of the categories indicated, the most prevalent barrier to training identified by agencies was "no monetary incentive to further training" (71 agencies, or 60.7%). Other barriers identified in rank order of agreement are: cost of training too high (61, or 52.1%), lack of availability of relevant courses (52, or 44.4%), geographical barriers / no local opportunities for training (52, or 44.4%), and lack of career guidance or counseling (42, or 35.9%). The barrier identified the least was lack of interest by staff (6, or 6.8%).
- With regard to participation in a local Drug Information Network (DIN) and capacity to use the internet, 70 agencies indicated that they actively participate in a local DIN, while 98 said they had the capacity to use the internet in relation to drug–related activities such as treatment, prevention, research, sharing of information, etc.

- Seven countries had at least five or more agencies that indicated active participation in the local DIN, and eight countries had at least five or more agencies that indicated they had the capacity to use the internet in drug–related activities.

Funding

- 65% of agencies indicated the government as their primary source of funding, while 18% were self–funded. About 7% received funding from local NGOs or private donors, 3.4% from international donors, and 5% from other sources.

Drug treatment services and activities

- 44 agencies stated that they provided policy or advisory inputs at the national level, 43 agencies provided input related to drug treatment protocols, 38 provided input related to strategic plans for treatment services, 16 provided input related to drug court operations, and 39 provided drug treatment advocacy at the national level.
- 61 agencies stated that they provided assessment, 59 provided treatment, 49 provided rehabilitation, and 32 provided reinsertion services. From the column "percent of cases," 60% or more (63–79%) provided either assessment, treatment, or rehabilitation. Reinsertion services were provided by only four in ten agencies (41.6%).
- 37 agencies were categorized as outpatient treatment, 8 as intensive outpatient treatment, 20 as residential treatment, 15 as residential treatment in a hospital setting, and 31 as community care services.
- Of the five therapeutic strategies listed, 54 agencies indicated that they offered psychotherapy, 30 offered the 12–step program, 30 offered directed therapy, 25 offered religious focused strategies, and 15 offered alternative therapy.
- The five most prevalent activities indicated by agencies were counseling (67 agencies), referral to social services or primary health care services (65 agencies), clinical evaluation of the individuals who use substances (46 agencies), relapse prevention (45 agencies), and treatment of physical and/or psychological illnesses not associated with drug use (36 agencies).

Training certification

- Only 16 agencies (18.2%) indicated that their staff had received certification training in a treatment–related field in the past 12 months. No one had received certification training in Dominica, St. Kitts and Nevis, or Trinidad and Tobago.
- The total number of staff trained ranged from a low of 30 in 17 agencies in the area of "institutional administration: management of treatment centers" to a high of 172 in 19 agencies related to "information for the family and community." Of note is the fact that 148 staff members in 21 agencies were trained in "basic concepts of drug dependency," and 156 staff members in 27 agencies received training related to "counseling techniques."

- 25% or more of the agencies expressed an urgent need for training in all the areas listed except for administration of medicines/drugs. This means that 22 to 38 agencies expressed an urgent need for training in each of the indicated areas. The only other training need noted was clinical supervision, identified by one agency.
- The subject areas with the most urgent training needs (about 30% or more of the agencies indicating an urgent need) were:
  - Conflict resolution;
  - Ethical and professional responsibilities of human resources in drug treatment;
  - Post–treatment plans: reinsertion to society and the workplace;
  - Information for the family and community;
  - Relapse prevention;
  - Management of resistance to treatment and changing behavior;
  - Family systems in the context of drug use and abuse;
  - Design of treatment plans for drug abuse/dependency;
  - Counseling and coordinating services/case referral;
  - Clinical evaluation;
  - Case management;
  - Assessments (brief, in–depth, ongoing);
  - Counseling techniques: individual, group, family;
  - Treatment for patients with dual diagnosis;
  - Treatment models: outpatient and residential.

Drug court services

- 21 agencies indicated that they currently offer services for drug treatment court clients.

New drugs of use, misuse, or abuse

- 25 agencies (28.4%) in 9 countries reported new drugs being consumed. It should be noted that the misuse of cough medicine shows a worrying trend in terms of new drug consumption in the countries.

New drugs, COVID–19

- Agencies were asked to report on the COVID–19 protocols implemented during the pandemic period. Most agencies (75) implemented the government–stipulated protocols. Fewer than a quarter (28 agencies) implemented their own written protocols, while 19 agencies implemented informal unwritten protocols of their own.

Prevention services

- Most agencies (54) indicated targeting "secondary school age (junior or senior high)" students. This was followed by "adult population (18–65 years)," targeted by 48 agencies, and "primary school age" students (39 agencies).

- Most agencies operated within community organizations such as churches, youth groups, or sports clubs (56 agencies). The next most prevalent response was secondary schools (48 agencies), followed by workplace (34 agencies), primary schools (33 agencies), and health care settings (31 agencies).

However, all agencies in countries were operating in the secondary school environment as well as in community organizations, workplaces, prisons (except for Jamaica), and primary schools (except for St. Vincent and the Grenadines). The most prevalent subject areas for which training was conducted related to:

- Peer risk and protective factors;
- Communication and stakeholder involvement;
- Staff development;
- Self–risk and protective factors;
- Community prevention or community risk and protective factors;
- Family prevention or family risk and protective factors;
- Basic prevention principles;
- The theory of change in prevention programs;
- School–based prevention or school risk and protective factors.

The subject areas with the most urgent needs (about 30% or more of the agencies indicating an urgent need for training) were:

- Monitoring and evaluation;
- Sustainability and funding / writing proposals;
- Primary prevention (prevention);
- Community prevention / community risk and protective factors;
- Evidence–based program design;
- Staff development;
- School–based prevention or school risk and protective factors;
- Family prevention or family risk and protective factors;
- Drug prevention program quality standards.

CHAPTER 1

Introduction and Background

In 2012, the Executive Secretariat of the Inter–American Drug Abuse Control Commission (ES/CICAD) completed and reported on the results of an institutional and human resource training needs assessment of the Caribbean English–speaking OAS member states for the CICAD/OAS Training and Certification Program for Drug and Violence Prevention, Treatment, and Rehabilitation (known by the Spanish language acronym, PROCCER). The objectives of that training needs assessment were to identify specific priority needs across the Caribbean region and provide an important baseline of information on service providers.

In 2020, ES/CICAD initiated a survey to remap institutions and assess the training needs across the Caribbean region. The rationale for this survey was borne out of the need for up–to–date information for the development and institutionalization of training and certification for drug prevention and treatment service providers. It is foundational that meeting training and or certification needs will improve the quality of services in drug prevention and treatment efforts.

Goals of the assessment

The information collected from this Institutional and Human Resource Training Needs Assessment is expected to provide an updated census of prevention and treatment programs and baseline information to identify gaps and needs of treatment and prevention institutions in the Caribbean region. In addition, it will provide input to help governmental and non–governmental front–line organizations to optimize the quality of care in drug–abuse prevention, treatment, and rehabilitation in the Caribbean region.

Specific objectives

The survey was designed to gather information on the competencies, skills, training, and professional needs of the human resources of participating organizations, to optimize the level of drug prevention and treatment services offered by these service providers in the Caribbean. More specifically, the objectives of the Institutional and Human Resource Training Needs Assessment are to:

- Provide a characterization of prevention and treatment programs in the region;
- Determine the numbers and types of workers currently in the demand reduction sector and related services;
- Identify training deficiencies and training needs based on the perception of managers in key stakeholder agencies;
- Give sector professionals an opportunity to communicate their perspectives about their organizations;
- Assess the impact of COVID–19 on treatment programs.

Expected outputs from the assessment

The expected outputs are two–fold:

1. An updated directory of prevention, treatment, and rehabilitation institutions in 14 OAS Caribbean member states, and
2. An updated assessment of institutional and human resources training needs within participating agencies and institutions.

Methodology

Study design

The Institutional and Human Resource Training Needs Assessment is a cross–sectional study for which a survey was used to give a snapshot of the current situation with respect to both the primary indicators of interest and associated factors. It provides training–related baseline data as well as a regional situational analysis regarding services to address drug treatment and drug prevention. First, a mapping exercise based on established guidelines and a template (see Appendix 1) was carried out at the national level to identify potential treatment and prevention agencies. The identified agencies were later targeted to self–report on the thematic areas of the assessment.

Study population

All organizations identified through the mapping exercise were targeted for completing the survey. Additionally, while data collection may have commenced with those organizations identified in the mapping exercise, it was not limited to these organizations; all related organizations that were subsequently identified were also targeted for inclusion.

Data collection instrument

The instrument used in the 2011 assessment formed the basis for revising, updating, and adding new components for use in the 2020 assessment. To achieve a comprehensive review and update of the instrument, the following activities were undertaken:

1. To ensure the smooth implementation of this activity, CICAD engaged a consultant to coordinate and provide technical support to a small group of technical persons who were tasked with identifying gaps in terms of important indicators that should be included based on the assessment's overall objective, proposing the changes, and reformatting a workable assessment instrument.
2. A suitable electronic data capture platform was developed; Survey Monkey was later chosen as the platform to administer the assessment.
3. The instrument was pretested on the Survey Monkey platform to identify any administration–related challenges.
4. After pretesting and editing, the instrument was finalized and uploaded to the platform for access by service providers.

Data collection

After finalization of the instrument, a meeting was held with all points of contact to provide detailed instructions about the process of data capture. The points of contact in each member state were tasked with apprising the proposed agencies of the start of the assessment, as well as encouraging those agencies to participate by completing the questionnaire in its entirety.

The instrument was emailed to all proposed participating agencies over a period of four months (December 2020 to March 2021). Consultants provided by CICAD furnished technical support to the agencies for completing the assessment. All but four assessments were completed at the agency level and uploaded to the database for analysis. In the case of the four exceptions, the agencies filled out hard copies of the questionnaire and emailed them to the consultant, who manually entered the data into the database.

The consultants sent periodic country–specific updates to each point person, providing information on the number of organizations that had started and completed the survey. This allowed the point persons to selectively target the non–responders or those who had yet to complete the survey and provide encouragement for completing it.

At the end of the data collection period, the database was cleaned to eliminate multiple responses. The final questionnaire in Appendix 2, covered the following thematic areas:

1. Profile of participating agencies;
2. Human resources;
3. Other resources;
4. Drug treatment services;
5. Effective demand and performance of the organization;
6. Training and training needs in treatment;
7. Other services offered;
8. Perception of the problem and new drugs;
9. Impact of COVID–19 on treatment operations;
10. Training and training needs in drug prevention services.

The format for most of the questions was categorical and simply required the respondents to select one or more answers from the response categories. For the specific training needs questions, the topics were incorporated into Likert–type survey items. The exceptions were the questions that sought information on the numbers and types of staff and the number of patients seen for those organizations involved in the treatment of persons with drug abuse problems; these were all ordinal.

Data handling

Initially, 139 agencies responded to the survey by submitting a questionnaire through the Survey Monkey platform. During data cleaning, unsuitable records were removed from the dataset for lack of insufficient responses (data points) to merit inclusion in the analysis. This resulted in a total of 21 records being removed from the dataset. The data analysis was performed on the remaining 117 quality–assured questionnaires.

Analyzing Multiple Responses

Multiple–response sets use multiple variables to record responses to questions where the respondent can give more than one answer. There are 14 multiple–response sets in this report as indicated in the table below.

Results are presented in frequency tables with column headings labeled "responses" and "percent of cases." The "responses" column presents the number of times respondents agreed with a given statement and the percentage when compared with the total number of times that respondents agreed with any of the statements. The "percent of cases" column displays the percentage of respondents that chose that option with respect to the total number of valid cases (responding agencies).

Question 11	At what geographic level(s) does your organization operate?
Question 25	Which of the following resources are available at your organization?
Question 31	Does your organization provide any national–level input for any of the following?
Question 32	Which of the following treatment services does your organization currently provide?
Question 33	With respect to treatment services, how would you categorize your organization?
Question 46	Please indicate to which of the following populations substance use/misuse treatment is offered by your organization.
Question 37	In which of the following activities is your organization involved?
Question 51	What are the three substances that most frequently impacted clients presenting for treatment?
Question 56	Please indicate whether positive cases of COVID–19 were identified among clients, family members, or staff with respect to your organization's operation.
Question 57	During the pandemic period, which protocols were implemented on COVID 19?
Question 59	What strategies were developed to guarantee the continuity of residential treatments?
Question 60	What strategies were developed to guarantee the continuity of ambulatory treatments?
Question 62	Please indicate which of the following populations are targeted by your organization for its drug prevention programs.
Question 63	What is the environment(s) in which your organization carries out its drug prevention interventions?

Report Outline

Responses in sections 1–4 of this report are from all organizations responding to the survey. Responses in sections 5–10 are from organizations that offer treatment/prevention services as distinct from organizations that offer only prevention services. Responses for those organizations offering primarily prevention services are captured in section 11 of the questionnaire. The dataset includes 88 agencies that offer eith treatment only or both treatment and prevention services, and 29 that offer only prevention services.

Chapter 1 presents the background, introduction, and methodology of the survey. Chapter 2 presents the results, following the same pattern of categorization as outlined in the questionnaire. Chapter 3 presents the conclusions and recommendations.

CHAPTER 2

SECTION 1

COUNTRY AND ORGANIZATION PROFILES

Agencies from 14 English–, French–, and Dutch–speaking countries participated in this initiative. A total of 142 agencies were mapped, but only 117 of those agencies were analyzed after data cleaning. The distribution of agencies was as follows: St. Kitts and Nevis (17), Guyana (14), Suriname (14), Trinidad and Tobago (13), Barbados (10), The Bahamas (10), Haiti (10), Belize (9), St. Lucia (5), Grenada (4), St. Vincent and the Grenadines (4), Jamaica (3), Antigua and Barbuda (2), and Dominica (2).

Table 1: Distribution of Agencies by Country

	Number	Percent
Antigua and Barbuda	2	1.7
The Bahamas	10	8.5
Barbados	10	8.5
Belize	9	7.7
Dominica	2	1.7
Grenada	4	3.4
Guyana	14	12.0
Haiti	10	8.5
Jamaica	3	2.6
St. Kitts and Nevis	17	14.5
St. Lucia	5	4.3
St. Vincent and the Grenadines	4	3.4
Suriname	14	12.0
Trinidad and Tobago	13	11.1
Total	**117**	**100**

Characteristics of the agencies

An approximately equal number of agencies were characterized as prevention–only (29) or treatment–only (30), while 58 agencies indicated that they offered both prevention and treatment services (Figure 1).

Figure 1: Characteristics of the Agencies

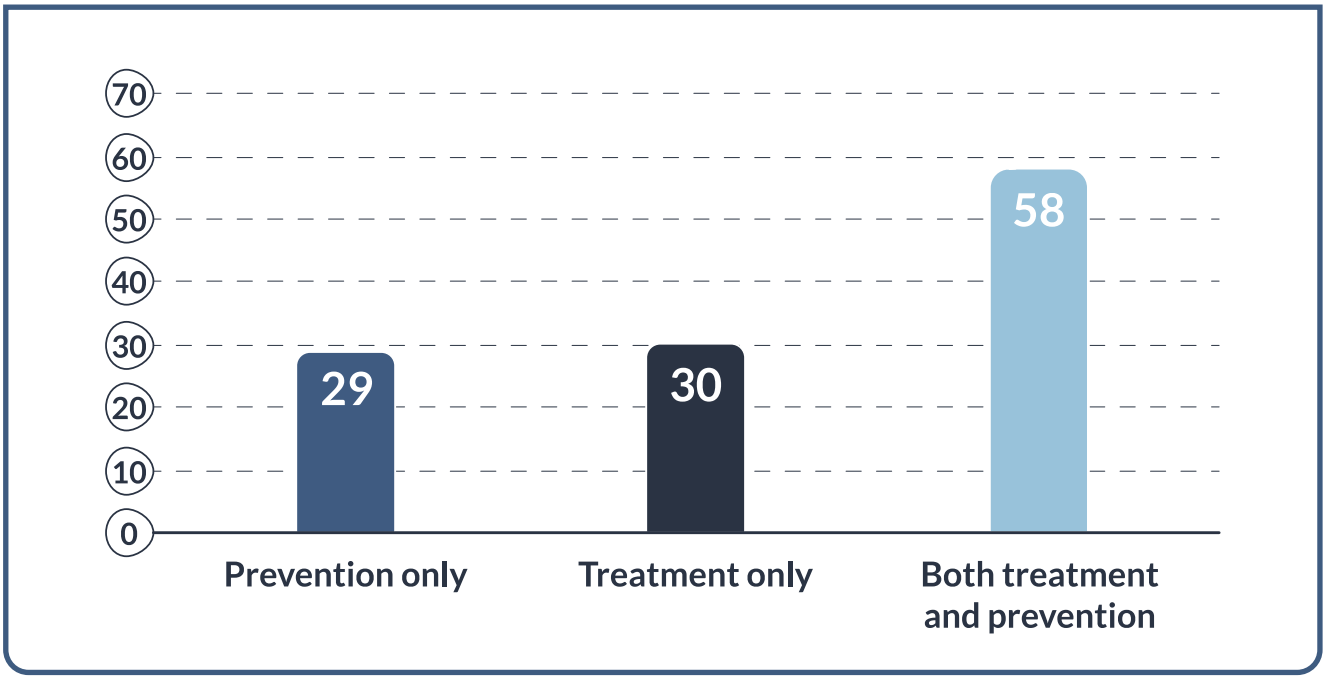


Table 2 below shows the distribution of services offered by the various agencies in each country. At least one agency in each country offered both prevention and treatment services. Agencies in all but four countries offered prevention–only services, while agencies in all but two countries offered treatment–only services.

Table 2: Types of Services Offered by Agencies in each Country

	Types of services offered by agencies			
	Prevention only	Treatment only	Both prevention and treatment	Total Agencies
Antigua and Barbuda	0	0	2	2
The Bahamas	2	3	5	10
Barbados	2	5	3	10
Belize	4	1	4	9
Dominica	1	0	1	2
Grenada	2	1	1	4
Guyana	5	3	6	14
Haiti	0	4	6	10
Jamaica	0	1	2	3
St. Kitts and Nevis	2	3	12	17
St. Lucia	1	1	3	5
St. Vincent and the Grenadines	0	2	2	4
Suriname	5	3	6	14
Trinidad and Tobago	5	3	5	13
Total	**29**	**30**	**58**	**117**

SECTION 2

ORGANIZATION PROFILE

The questions in this section were geared towards helping to better understand the type of organization, the services provided, and their operational methods. Most agencies described themselves as governmental (54, or 46.2%). There were 44 private/non–governmental agencies (37.6%), 11 statutory/quasi–governmental agencies (9.4%), and six agencies (5.1%) described as "other" (4 non–profits, 1 Church of the Mazarine, 1 Alcoholics Helping Alcoholics). Two agencies did not provide a description.

Table 3: Description of the Agencies by Country

	Governmental	Statutory body	Private/ NGO	Other	Total
Overall	**54 (46.2%)**	**11 (9.4%)**	**44 (37.6%)**	**6 (5.1%)**	
Antigua and Barbuda	1	0	1	0	2
The Bahamas	7	0	2	1	10
Barbados	2	1	6	0	9
Belize	4	0	3	2	9
Dominica	1	0	1	0	2
Grenada	2	1	1	0	4
Guyana	7	2	4	1	14
Haiti	2	0	5	2	9
Jamaica	1	1	1	0	3
St. Kitts and Nevis	13	2	2	0	17
St. Lucia	2	3	0	0	5
St. Vincent and the Grenadines	2	1	1	0	4
Suriname	6	0	8	0	14
Trinidad and Tobago	4	0	9	0	13
Total	**54**	**11**	**44**	**6**	**115**

Geographic level of operation (multiple–response category)

Four agencies stated that they operated at the hemispheric level, 27 at the regional level, 92 at the national level, 28 at the island level, 21 at the district/parish level, and 32 at the community/village level. A total of 112 agencies responded to this question. From the "percent of cases" column, 82% operated at the national level, while fewer than 30% operated at the other levels.

Table 4: Geographic Level of Agency Operation

	Responses		Percent of cases (n = 112)
	#	%	
Hemispheric	4	2.0	3.6
Regional	27	13.2	24.1
National	92	45.1	82.1
Island	28	13.7	25.0
District/Parish	21	10.3	18.8
Community/Village	32	15.7	28.6
Total	**204**	**100**	

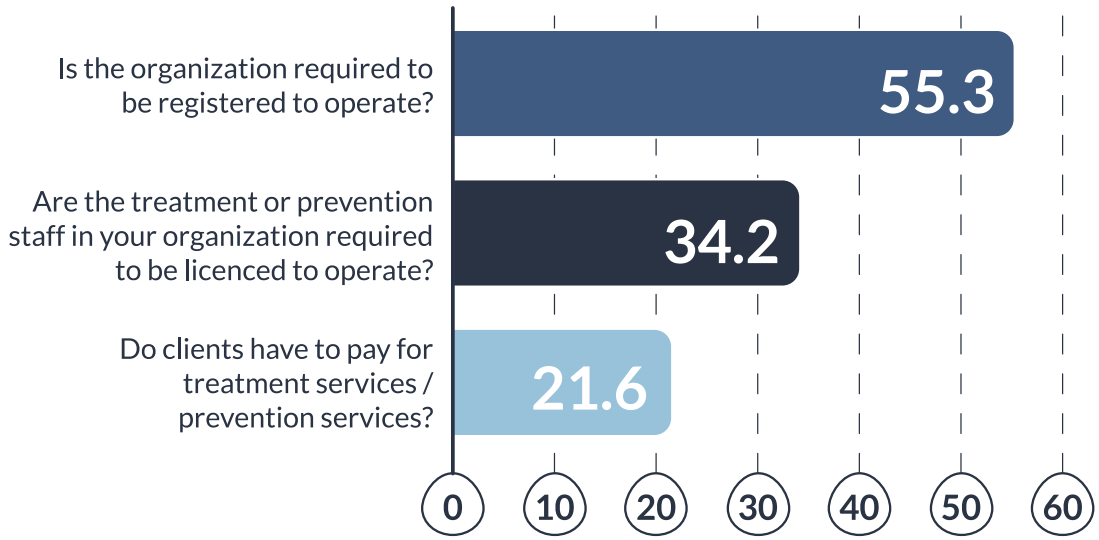
Other organization profiles

When asked to indicate whether they had to register with an authority within their country to operate, more than half of the agencies (63, or 55.3%) said yes. Only 39 agencies (34.2%) said staff are required to be licensed by a relevant authority to operate. In addition, about a fifth of the agencies (24, or 21.6%) indicated that clients had to pay for the treatment/prevention services they receive.

Table 5: Other Organization Profiles

	Yes		No	
	#	%	#	%
Is the organization required to be registered with a relevant authority in your country to operate?	63	55.3	51	44.7
Are the treatment or prevention staff in your organization required to be licensed by a relevant authority to operate?	39	34.2	75	65.8
Do clients have to pay for treatment services received from the organization?	24	21.6	87	78.4

Figure 2: Other Organization Profiles (% that responded "Yes")



SECTION 3
HUMAN RESOURCES

Agencies were required to indicate the total number of staff that worked in their organization. They were asked to include all staff, whether administrative, clinical, technical, security, or support staff. Because of the great diversity amongst the responding agencies, the total number of staff ranged from 2 to 687. Examination of the responses showed that organizations reporting 90 or more staff were organizations such as government offices, hospitals, prisons, police force, and customs and excise departments. These agencies, listed in Table 6 below, were removed from the analysis of this variable to eliminate the exceptionally large variance in the descriptive statistics.

Table 6: Organizations with Total Staff of 90 or More

Organization	Country	Total staff
Western Regional Health Authority (Hospital)	Jamaica	90
St. Kitts Nevis Customs and Excise Department	St. Kitts and Nevis	130
Public Hospital Suddie	Guyana	233
Kolbe Foundation	Belize	250
St. Kitts Nevis Defence Force	St. Kitts and Nevis	150
Department of Education	The Bahamas	350
Medical Mission (Medische Zending Primary Health Care Suriname)	Suriname	231
Prison Services	Barbados	379
HMP Dodds	Barbados	361
Police Services	St. Kitts and Nevis	500
Milton Cato Memorial Hospital	St. Vincent and the Grenadines	687

The remaining 95 agencies had a total of 1,582 staff. The minimum number was zero and the maximum for any agency was 88. The mean number of staff was 16 and the median was 12. Eight agencies (8.4%) had 2–4 people on staff, 25 (26.3%) had 5–9, 23 (24.2%) had 10–14, 13 (13.7%) had 15–19, and 26 (27.3%) had 20 or more staff members.

Table 7: Total Number of Staff

Grouping – Staff size	Responses	
	#	%
0–4	8	8.4
5–9	25	26.3
10–14	23	24.2
15–19	13	13.7
20 or more	26	27.3

Figure 3: Total Number of Staff

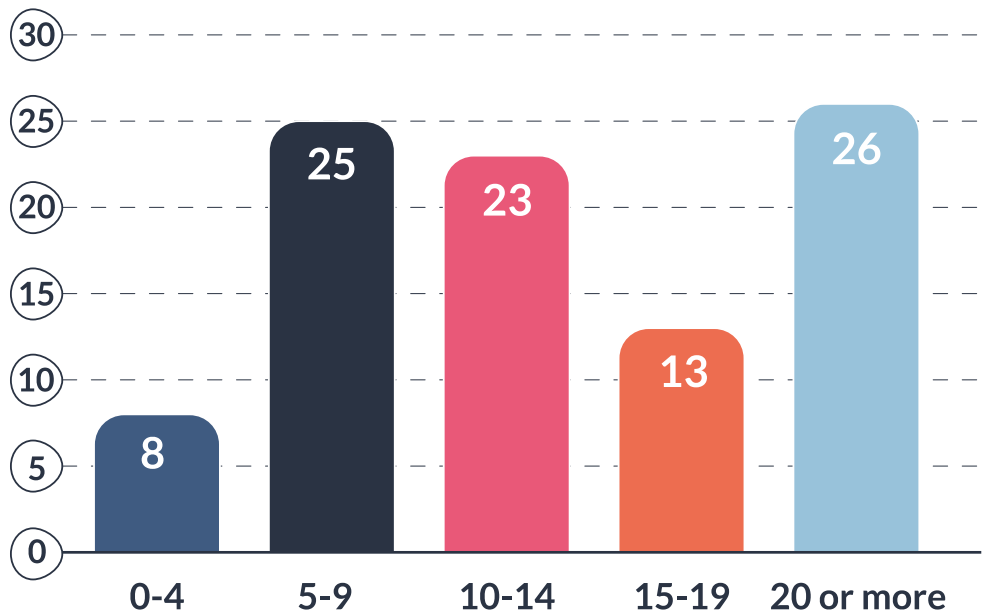


Table 8 below shows the descriptive statistics for the total number of staff as well as for the various categories of staffing. For example, as outlined above for the overall total number of staff, there was a total of 1,079 full–time staff. The minimum number was zero and the maximum for any agency was 88. The mean number of full–time staff was 13 and the median was 8. A total of 83 agencies reported on full–time staffing: 18 agencies had 0–4 people on staff, 28 had 5–9, 14 had 10–14, 6 had 15–19, and 17 had 20 or more staff members.

This is the same pattern of reporting for all other categories of staffing.

Table 8: Total Number of Staff and the Number for the Various Categories

	Total staff and descriptive statistics					Number of agencies by staff–size range					
	Total staff	Min.	Max.	Mean	Median	0–4	5–9	10–14	15–19	20+	Total # of agencies
Total number of staff	1,582	0	88	16.6	12	8	25	23	13	26	95
Full–time staff	1,079	0	88	13	8	18	28	14	6	17	83
Part–time staff	190	0	18	3.2	2	42	11	2	3	–	58
Volunteers	615	0	200	9.9	4	34	11	6	1	10	62
Male	497	0	27	5.6	4	53	20	11	3	3	90
Female	1,030	0	67	11.1	7	19	37	13	10	13	92
Less than high school education	151	0	25	3.2	1	37	8	–	–	2	47
High school diploma	363	0	30	5.4	3	43	15	2	4	3	67
Technical degree	114	0	14	2.4	2	40	4	2	–	–	46
College/University degree	453	0	33	5.9	4	47	15	5	3	6	76
Graduate degree	203	0	12	3.1	2	51	9	4	–	–	64
Post–graduate degree	703	0	600	15.9	1	38	2	2	1	1	44
Other	24	1	3	101	1	14	3	1	–	–	18
Medical doctor	44	0	6	0.8	–	51	2	–	–	–	53
Nurses	164	0	44	2.7	1	50	4	3	1	1	59
Psychiatrist	31	0	8	0.6	–	48	1	–	–	–	49
Psychologist (registered)	76	0	14	1.2	1	60	1	1	–	–	62
Social worker	160	0	16	2.3	1	59	5	2	2	–	68
Administrative staff	229	0	13	2.7	2	70	10	4	–	–	84
Occupational therapist	10	0	2	–	–	45	–	–	–	–	45
Treatment specialist (certified)	83	0	10	1.4	1	50	5	1	–	–	56
Nutritionist	2	0	1	–	–	43	–	–	–	–	42
Religious leader	50	0	8	0.8	–	55	2	–	–	–	57
Prevention specialist (certified)	59	0	10	1.1	–	50	1	1	–	–	52
Security personnel	119	0	22	2.1	–	49	3	1	1	2	56
Researcher	31	0	4	0.6	–	51	–	–	–	–	51
Kitchen (staff/cook)	49	0	4	0.9	–	52	–	–	–	–	52
Recovering addict	39	0	4	0.7	–	54	–	–	–	–	54
Cleaning and maintenance	87	0	11	1.4	1	59	2	1	–	–	62
Other	409	0	200	10.2	3	26	7	1	3	3	40

Training and development resources

Organizations were asked to indicate whether they had any of the resources listed in Figure 4. About 36%, or 42 agencies, indicated that they had a training and development plan for staff; 40 agencies (34.2%) had a training and development budget, 48 (41%) had an officer responsible for training and development of staff, and 72 (61.5%) had a regular and formal appraisal system covering all permanent staff.

Figure 4: Training and Development Resources (%)

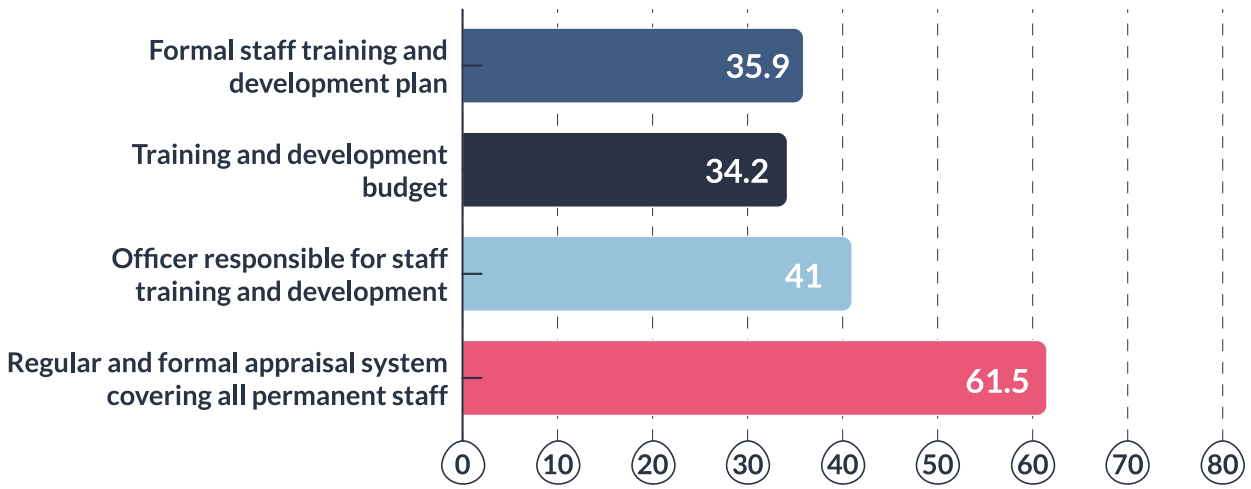


Table 9: Training and Development Resources by Country (# and %)

	(a) Training and development plan		(b)Training and development budget		(c) Officer for training and development		(d) Formal appraisal system	
	Yes	No	Yes	No	Yes	No	Yes	No
Overall	**42 (35.9%)**	**69 (59.0%)**	**40 (34.2%)**	**72 (61.5%)**	**48 (41.0%)**	**63 (53.8%)**	**72 (61.5%)**	**38 (32.5%)**
Antigua and Barbuda	1 (2.4)	1 (1.4)	1 (2.5)	1 (1.4)	1 (2.1)	1 (1.6)	2 (2.8)	–
The Bahamas	7 (16.7)	3 (4.3)	7 (17.5)	3 (4.2)	6 (12.5)	4 (6.3)	9 (12.5)	1 (2.6)
Barbados	6 (14.3)	2 (2.9)	3 (7.5)	5 (6.9)	5 (10.4)	3 (4.8)	6 (8.3)	2 (5.3)
Belize	4 (9.5)	5 (7.2)	4 (10.0)	5 (6.9)	3 (6.2)	6 (9.5)	6 (8.3)	3 (7.9)
Dominica	–	2 (2.9)	–	2 (2.8)	–	2 (3.2)	1 (1.4)	1 (2.6)
Grenada	–	4 (5.8)	1 (2.5)	3 (4.2)	1 (2.1)	3 (4.8)	3 (4.2)	1 (2.6)
Guyana	3 (7.1)	11 (15.9)	4 (10.0)	10 (13.9)	4 (8.3)	10 (15.9)	8 (11.1)	5 (13.2)
Haiti	3 (7.1)	5 (7.2)	2 (5.0)	7 (9.7)	5 (10.4)	4 (6.3)	2 (2.8)	7 (18.4)
Jamaica	2 (4.8)	1 (1.4)	2 (5.0)	1 (1.4)	2 (4.2)	1 (1.6)	3(4.2)	–
St. Kitts and Nevis	6 (14.3)	11 (15.9)	9 (22.5)	8 (11.1)	8 (16.7)	9 (14.3)	13 (18.1)	4 (0.5)
St. Lucia	1 (2.4)	4 (5.8)	1 (2.5)	4 (5.6)	–	5 (7.9)	5 (6.9)	–
St. Vincent and the Grenadines	1 (2.4)	2 (2.9)	–	3 (4.2)	2 (4.2)	1 (1.6)	2 (2.8)	1 (2.6)
Suriname	5 (11.9)	9 (13.0)	4 (10.0)	10 (13.9)	6 (12.5)	7 (11.1)	7 (9.7)	6 (15.8)
Trinidad and Tobago	3 (7.1)	9 (13.0)	2 (5.0)	10 (13.9)	5 (10.4)	7 (11.1)	5 (6.9)	(18.4)

In four countries—Suriname, St. Kitts and Nevis, Barbados, and The Bahamas—at least five or more agencies have a formal training and development plan for staff. Only two countries—St. Kitts and Nevis and The Bahamas—had at least five or more agencies with a training and development budget. In six countries—The Bahamas, Barbados, Haiti, St. Kitts and Nevis, Suriname, and Trinidad and Tobago—at least five or more agencies had an officer responsible for training and development of staff. In eight countries—The Bahamas, Barbados, Belize, Guyana, St. Kitts and Nevis, Suriname, and Trinidad and Tobago—at least five or more agencies had a regular and formal appraisal system covering all permanent staff.

Potential barriers to training

Of the categories indicated, the most prevalent barrier to training identified by agencies (71 agencies, or 60.7%) was "no monetary incentive to further training." Other barriers identified in rank order of agreement are: cost of training too high (61, or 52.1%), lack of availability of relevant courses (52, or 44.4%), geographical barriers / no local opportunities for training (52, or 44.4%), and lack of career guidance or counseling (42, or 35.9%). The barrier identified the least was lack of interest by staff (6, or 6.8%).

Table 10: Potential Barriers to Training (# and %)

	Yes	No	Not sure	Don't know
Cost of training too high	61 (52.1%)	18 (15.4%)	9 (7.7%)	8 (6.8%)
Lack of interest by staff	8 (6.8%)	74 (63.2%)	8 (6.8%)	2 (1.7%)
Lack of availability of relevant courses	52 (44.4%)	31 (26.5%)	5 (4.3%)	4 (3.4%)
Geographical barriers / no opportunities	52 (44.4%)	28 (23.9%)	10 (8.5%)	3 (2.6%)
Lack of career guidance or counseling	42 (35.9%)	36 (30.8%)	9 (7.7%)	3 (2.6%)
No monetary incentive to further training	71 (60.7%)	14 (12.0%)	5 (4.3%)	3 (2.6%)
Other (please specify)	41 (35.0%)	33 (28.2%)	9 (7.7%)	3 (2.6%)

Figure 5: Number of Agencies – Potential Barriers to Training

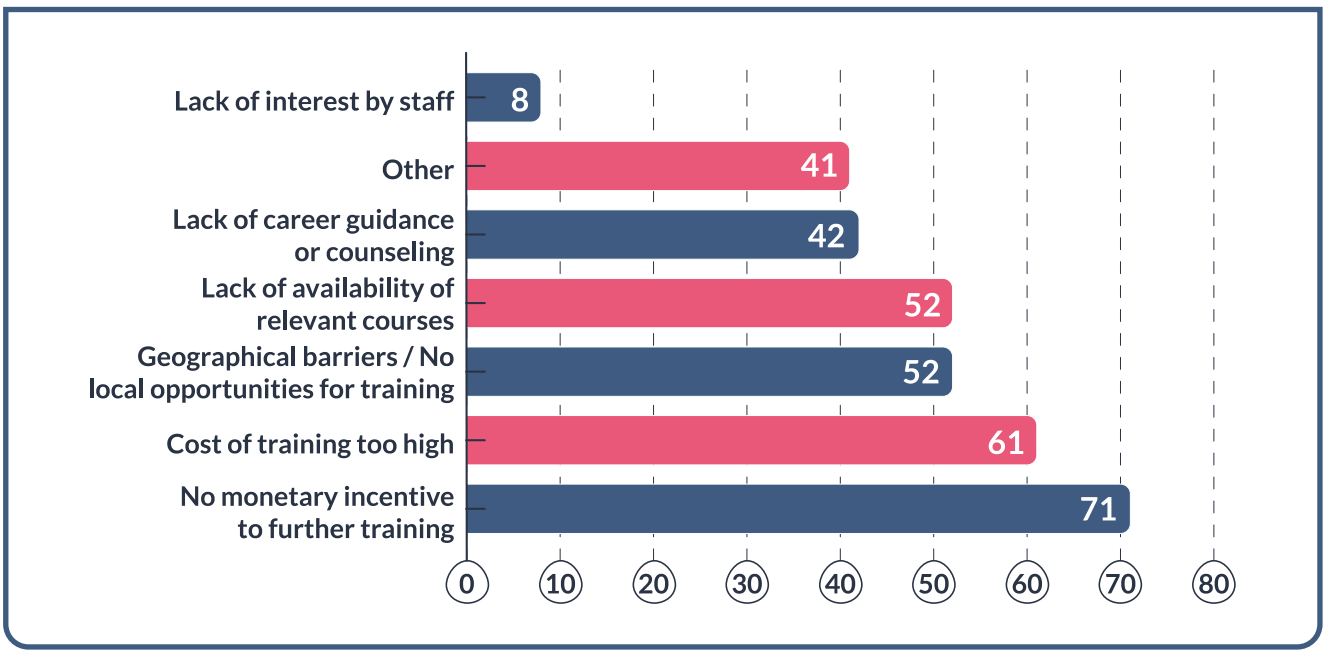


Table 11 below shows the distribution of indicated barriers by country. In Antigua and Barbuda, for example, one agency reported that the cost for training was too high, one identified geographical barriers, and one agency identified no monetary incentive as a potential barrier to training.

Table 11: Distribution of Indicated Barriers, by Country

	Cost too high	Lack of interest	Lack of availability	Geographical barriers	Lack of career guidance	No monetary incentive
Overall	**61**	**8**	**52**	**52**	**42**	**71**
Antigua and Barbuda	1	0	0	1	0	1
The Bahamas	3	0	4	3	3	4
Barbados	5	1	2	3	1	4
Belize	5	1	3	4	4	5
Dominica	2	0	2	2	2	2
Grenada	1	0	2	1	1	2
Guyana	9	2	10	8	3	7
Haiti	4	0	3	6	0	6
Jamaica	3	0	2	1	0	3
St. Kitts and Nevis	9	1	11	9	11	13
St. Lucia	4	1	1	2	3	4
St. Vincent and the Grenadines	3	0	3	2	3	3
Suriname	6	2	5	4	6	9
Trinidad and Tobago	6	0	4	6	5	8

Other potential barriers to training indicated by agencies

- A training component in the Ministry does not exist;
- Cannot afford to hire a special person for trainings;
- Extremely limited budget for training and development;
- Have adequate budget but inappropriate funding given for training;
- Insufficient staff to allow for release for long periods;
- Lack of funds / financial resources to operate normally;
- Lack of human resources – no placement if persons go for training;
- Lack of scholarships or financial assistance for person wanting to continue education;
- Limited staffing to provide ongoing services;
- Most certificate courses have no incentive;
- Not always awareness of or selected for same;
- Organization is developing (new);
- Poor management competencies and lack of data–driven decision making;
- Time constraints;
- Training and development function has not yet been implemented.

Section 4

Other Resources (Multiple–Response Category)

This section highlights the other material and/or financial resources that are available to agencies. From Table 12 below, a total of 111 (94.9%) of the 117 agencies responded to this question (column labeled Total A). Most responses came from agencies in St. Kitts and Nevis, Guyana, Suriname, Trinidad and Tobago, Barbados, and The Bahamas. A total of 105 agencies (out of a total 266 responses) affirmed that internet was available in their organization (row labeled Total B), while 75 agencies agreed that laptop computers were available, and 86 agencies agreed that they had desktop computers.

Table 12: Material Resources Available to Agencies

	Internet	Laptop computer	Desktop computer	Total A
Overall	**105 (39.5%)**	**75 (28.2%)**	**86 (32.3%)**	
Antigua and Barbuda	2	2	2	**2**
The Bahamas	8	8	9	**10**
Barbados	10	8	9	**10**
Belize	7	3	6	**8**
Dominica	1	1	1	**1**
Grenada	3	3	3	**3**
Guyana	11	7	9	**14**
Haiti	9	7	3	**9**
Jamaica	3	1	3	**3**
St. Kitts and Nevis	17	11	14	**17**
St. Lucia	5	4	5	**5**
St. Vincent and the Grenadines	4	2	3	**4**
Suriname	14	12	10	**14**
Trinidad and Tobago	11	6	9	**11**
Total B	**105**	**75**	**86**	**111**

With regard to participation in a local Drug Information Network (DIN) and capacity to use the internet, 70 agencies indicated that they actively participate in a local DIN, while 98 said they had the capacity to use the internet in relation to drug–related activities such as treatment, prevention, research, sharing of information, etc.

Figure 6: Number of Agencies – Participation in a Local Drug Information Network

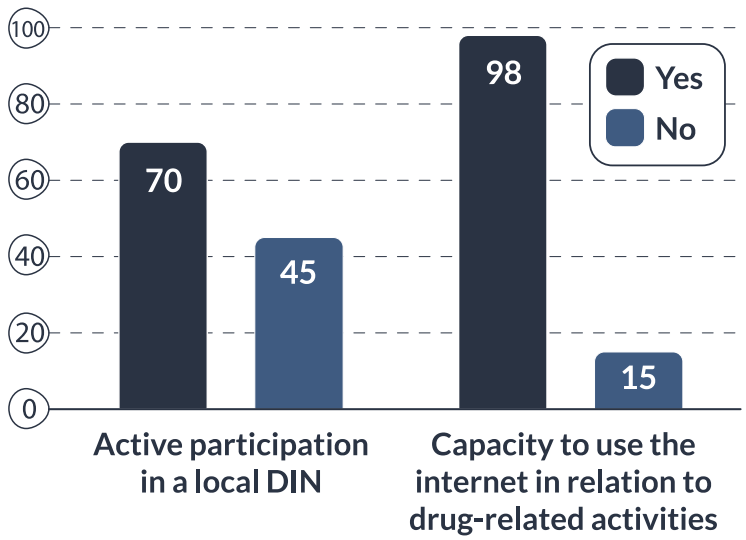


Table 13 below shows the distribution of responses regarding participation in a local DIN and capacity to use the internet by country. Seven countries had at least five or more agencies indicating active participation in the local DIN, while eight countries had at least five or more agencies that indicated they had the capacity to use the internet in drug–related activities.

Table 13: Participation in Local DIN and Capacity to Use Internet, by Country

	Active participation in DIN	Capacity to use internet
Overall	**70 (59.8%)**	**98 (83.3%)**
Antigua and Barbuda	2	2
The Bahamas	6	9
Barbados	5	8
Belize	2	7
Dominica	2	2
Grenada	3	3
Guyana	5	11
Haiti	8	8
Jamaica	2	3
St. Kitts and Nevis	7	16
St. Lucia	4	4
St. Vincent and the Grenadines	3	4
Suriname	11	10
Trinidad and Tobago	10	11

Funding sources

Agencies were asked to state their primary source of funding over the past 12 months; 65% indicated the government as their primary source while 18% were self–funded. About 7% got funding from local NGO or private donors, 3.4% from international donors, and 5% from other sources. The other sources indicated were: donations from National Drug Council (1), other donations (2), funds from live–in clients (1), private donors (1), and self and regional donors (1).

Figure 7: Primary Source of Funding

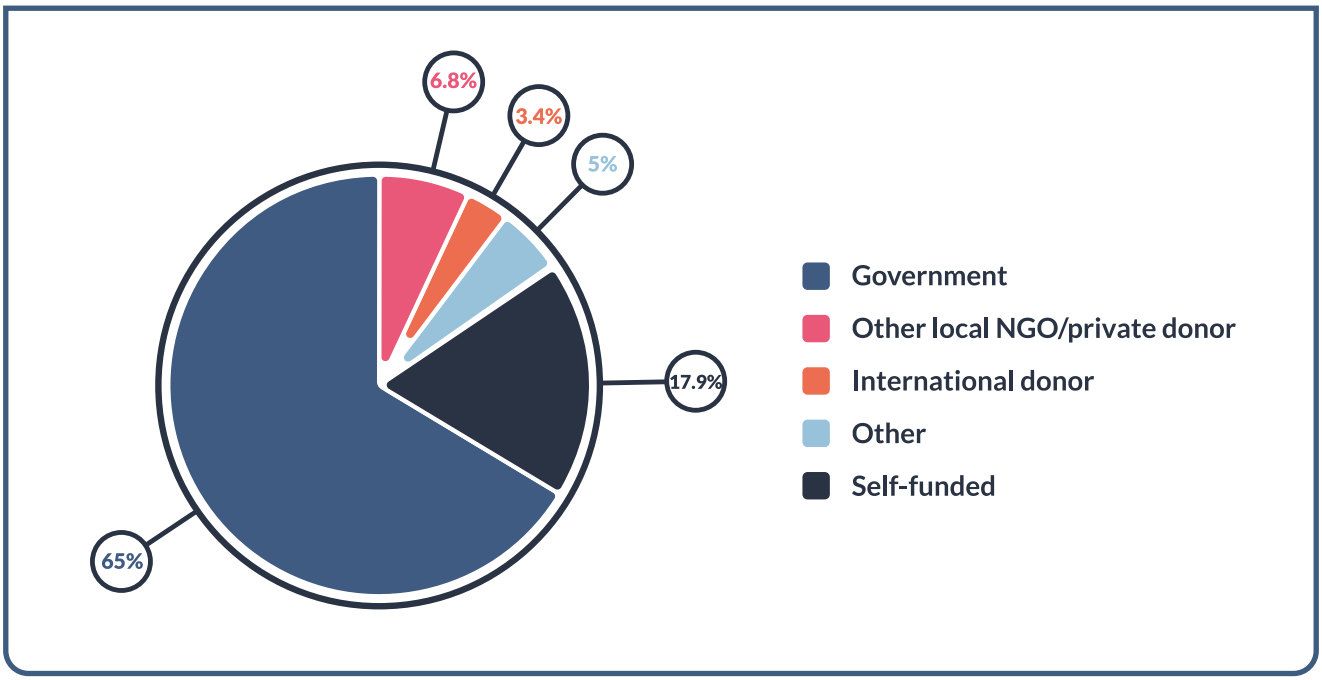


Table 14: Primary Source of Funding

Grouping – Staff size	Responses	
	#	%
Self–funded	21	17.9
Government	76	65.0
Other local NGO/private donor	8	6.8
International donor	4	3.4
Other	6	5.0

Additional sources of funding

The most prevalent source of additional funding indicated by agencies was government (56 agencies), as shown in Table 15 below. The next most indicated source was self–generated (53), followed by other local NGO/private donors (39), international donor (31), and other (13).

Table 15: Additional Sources of Funding

	Number of agencies responding "Yes"
Self–generated (n=102)	53
Government (n=87)	56
Other local NGO/private donor (n=96)	39
International donor (n=95)	31
Other (n=57)	13

SECTION 5
DRUG TREATMENT SERVICES

This section contains information on the characteristics of the care offered by organizations, the population served, modalities, and activities.

National–level input of agencies (multiple–response category)

A total of 69 agencies responded to this question. Of these, 44 agencies stated that they provided policy or advisory input at the national level, 43 agencies provided input related to drug treatment protocols, 38 provided input related to strategic plans for treatment services, 16 provided input related to drug court operations, and 39 provided drug treatment advocacy at the national level. In Table 16, from the column "percent of cases," less than a quarter (23.2%) provided input related to drug court operations. More than half (55–64%) provided input in all the other areas indicated.

Table 16: National Level Input of Agencies

Grouping – Staff size	Responses		Percent of cases (n = 69)
	#	%	
Policy/Advisory	44	24.4	63.8
Drug treatment protocols	43	23.9	62.3
Strategic plan for treatment services	38	21.1	55.1
Drug court operations	16	8.9	23.2
Drug treatment advocacy	39	21.7	56.5
Total	**180**	**100**	

Figure 8: National Level Input of Agencies – Number of Agencies

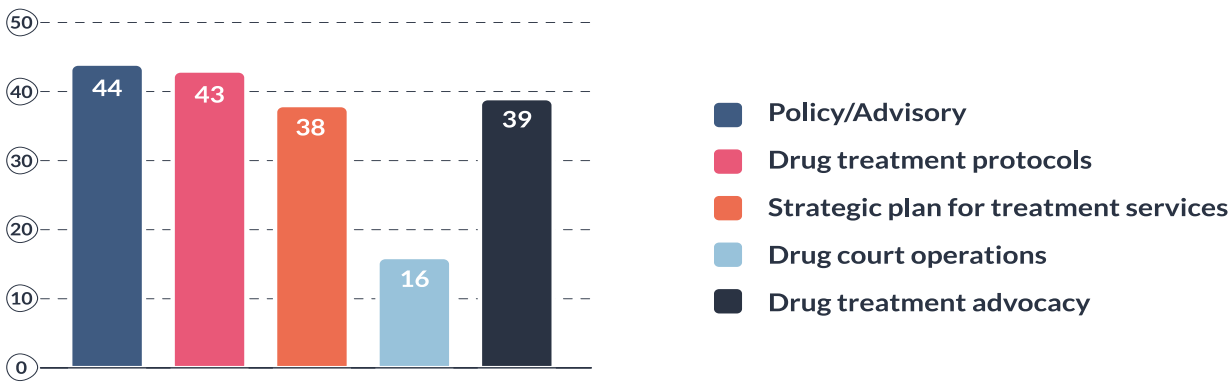


Table 17: National Level Input of Agencies by Country

	Policy	Protocol	Strategic plan	Drug Court	Advocacy	Total A
Overall	**44 (24.4%)**	**43 (23.9%)**	**38 (21.1%)**	**16 (8.9%)**	**39 (21.7%)**	
Antigua and Barbuda	1	1	1	1	0	**2**
The Bahamas	4	3	4	1	3	**6**
Barbados	1	2	2	0	0	**3**
Belize	4	4	4	3	5	**5**
Dominica	–	–	–	–	–	**–**
Grenada	2	2	0	0	2	**3**
Guyana	4	5	2	2	3	**6**
Haiti	5	6	4	0	7	**9**
Jamaica	2	3	2	3	2	**3**
St. Kitts and Nevis	6	5	8	1	5	**10**
St. Lucia	4	2	0	0	3	**4**
St. Vincent and the Grenadines	3	3	3	1	3	**4**
Suriname	5	3	4	2	3	**7**
Trinidad and Tobago	3	4	4	2	3	**7**
Total B	**44**	**43**	**38**	**16**	**39**	**69**

From Table 17 above, a total of 69 of the 117 agencies (59%) responded to this question (column labeled Total A). Most responses came from agencies in St. Kitts and Nevis, Haiti, Suriname, Trinidad and Tobago, Guyana, and The Bahamas. A total of 44 agencies affirmed that their organization provided policy direction at the national level (row labeled total B), while 43 agencies were involved in drug treatment protocols, 38 in strategic planning for treatment services, 16 in drug court operations, and 39 in drug treatment advocacy.

St. Kitts and Nevis, Haiti, and Suriname had five or more agencies involved in policy advice; Haiti, St. Kitts and Nevis, and Guyana had five or more involved in drug treatment protocols; while only in St. Kitts and Nevis were there five or more agencies involved in strategic planning for treatment services. For drug court operations, Jamaica and Belize had at least three agencies involved in this activity. Haiti, St. Kitts and Nevis, and Belize had five or more agencies in involved in drug treatment advocacy.

Treatment services provided by agencies (multiple–response category)

Treatment services were categorized as assessment, treatment, rehabilitation, and reinsertion. A total of 77 agencies responded to this question. Of these, 61 agencies stated that they provided assessment, 59 provided treatment, 49 provided rehabilitation, and 32 provided reinsertion services. As shown in Table 18, 60% or more (63–79%) provided either assessment, treatment, or rehabilitation. Reinsertion services were provided by only four in ten agencies (41.6%).

Table 18: Treatment Services Provided by Agencies

	Responses		Percent of cases (n = 77)
	#	%	
Assessment	61	30.3	79.2
Treatment	59	29.4	76.8
Rehabilitation	49	24.4	63.6
Reinsertion	32	15.9	41.6
Total	**201**	**100**	

Figure 9: Treatment Services Provided by Agencies – Number of Agencies

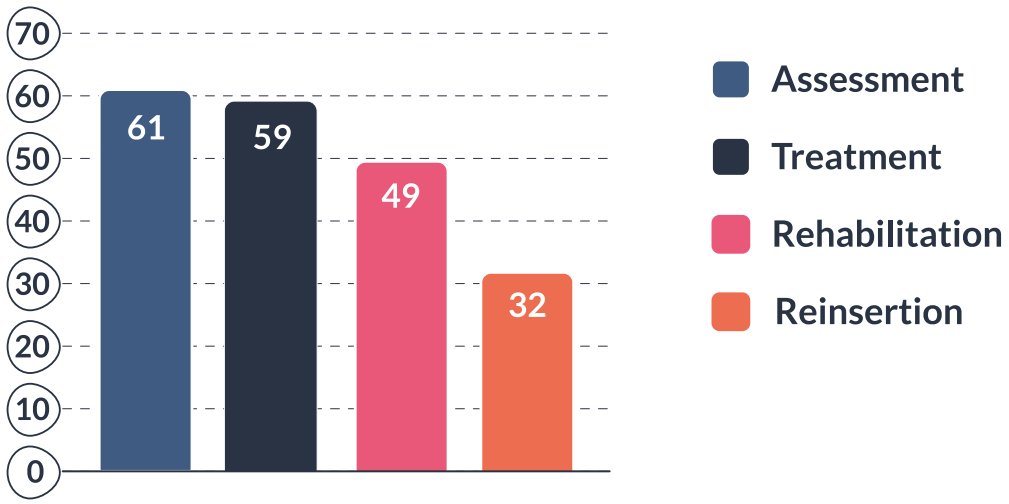


Table 19: Number of Agencies Providing Treatment Services, by Country

	Assessment	Treatment	Rehabilitation	Reinsertion	Total A
Overall	**61 (30.3%)**	**59 (29.4%)**	**49 (24.4%)**	**32 (15.9%)**	
Antigua and Barbuda	2	1	1	1	**2**
The Bahamas	6	5	5	4	**6**
Barbados	7	8	4	4	**8**
Belize	5	3	3	2	**6**
Dominica	1	1	1	1	**1**
Grenada	3	1	2	1	**3**
Guyana	6	5	3	1	**7**
Haiti	5	9	5	4	**9**
Jamaica	3	3	3	1	**3**
St. Kitts and Nevis	10	8	3	1	**11**
St. Lucia	3	3	4	1	**4**
St. Vincent and the Grenadines	2	3	2	0	**3**
Suriname	2	4	5	6	**6**
Trinidad and Tobago	6	5	8	5	**8**
Total B	**61**	**59**	**49**	**32**	**77**

From Table 19, a total of 77 of the 117 agencies (65.8%) responded to this question (column labeled total A). Most responses came from agencies in St. Kitts and Nevis, Haiti, Barbados, Guyana, and Trinidad and Tobago. A total of 61 agencies affirmed that their organization currently provided assessment services, while 59 agencies were involved in drug treatment, 49 in rehabilitation, and 32 in reinsertion services (row labeled total B).

St. Kitts and Nevis, Trinidad and Tobago, Haiti, Guyana, Belize, Barbados, and The Bahamas had five or more agencies involved in assessment services. Barbados, The Bahamas, Guyana, Haiti, St. Kitts and Nevis, and Trinidad and Tobago had five or more agencies involved in direct treatment services; while The Bahamas, Haiti, Suriname, and Trinidad and Tobago had five or more agencies involved in rehabilitation. Suriname and Trinidad and Tobago had five or more agencies involved in reinsertion services. All countries except St. Vincent and the Grenadines had at least one agency offering assessment, treatment, rehabilitation, and reinsertion services.

SPECIFIC CHARACTERISTICS OF THE CARE OFFERED– TREATMENT MODALITIES

Categorization of agencies based on treatment services (multiple–response category)

A total of 63 agencies responded to this question. Of these 63, 37 agencies were categorized as outpatient treatment, 8 as intensive outpatient treatment, 20 as residential treatment, 15 as residential treatment in a hospital setting, and 31 as community care services. From the column "percent of cases" in Table 20, more agencies (about 59% of those that responded) were categorized as outpatient treatment. Fewer than 50% of the responding agencies fell into any of the other categories.

Table 20: Categorization of Treatment Services

	Responses		Percent of cases (n = 63)
	#	%	
Outpatient treatment: treatment in a non–residential setting, limited stay (hours), e.g., outpatient consultation	37	33.3	58.7
Intensive outpatient treatment: treatment in a non–residential setting, stay of several hours during the day (day hospital service)	8	7.2	12.7
Residential treatment: inpatient treatment, stay of 24 hours in a residential facility, structured emphasis, e.g., medium–term treatment community	20	18.0	31.7
Residential treatment in a hospital framework: inpatient treatment, stay of 24 hours, emphasis on general/specialized care, e.g., short or medium–term medically managed residential setting	15	13.5	23.8
Community care services / self help groups: psychosocial support structures that reinforce the interventions at the various phases of the treatment, e.g., AA or NA	31	27.9	49.2
Total	**111**	**100**	

Figure 10: Number of Agencies Offering Indicated Category of Service

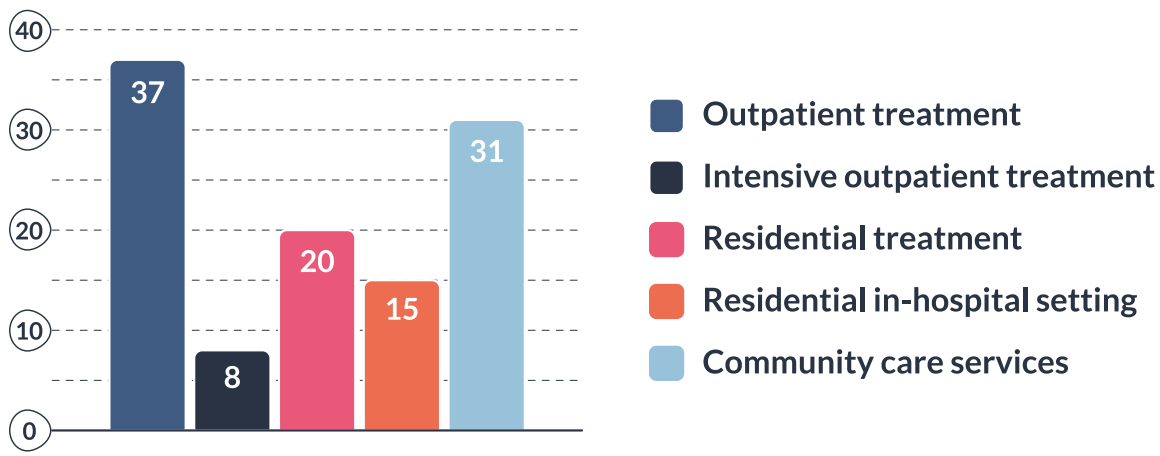


Table 21: Categorization of Treatment Services, by Country

	Outpatient treatment	Intensive outpatient	Residential treatment	Residential treatment in hospital	Community care services	Total A
Antigua and Barbuda	2	1	1	0	1	**2**
The Bahamas	3	0	1	1	4	**6**
Barbados	6	1	1	3	2	**8**
Belize	2	1	1	1	1	**3**
Dominica	0	0	0	0	1	**1**
Grenada	1	0	0	0	2	**2**
Guyana	5	0	2	2	5	**7**
Haiti	5	1	3	2	3	**6**
Jamaica	2	0	1	0	1	**3**
St. Kitts and Nevis	5	1	0	1	7	**9**
St. Lucia	0	0	1	1	0	**2**
St. Vincent and the Grenadines	2	1	1	2	1	**3**
Suriname	3	1	3	1	2	**5**
Trinidad and Tobago	1	1	5	1	1	**5**
Total B	**37**	**8**	**20**	**15**	**31**	**63**

From Table 21 above, St. Kitts and Nevis, Guyana, and Barbados had five or more agencies involved in outpatient treatment services. Agencies in eight countries—Antigua and Barbuda, Barbados, Belize, Haiti, St. Kitts and Nevis, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago—were involved in intensive outpatient services.

Haiti, Suriname, and Trinidad and Tobago reported three or more agencies involved in residential treatment. With respect to residential treatment in a hospital setting, a total of 15 agencies across 10 countries offered this category of service. Community services were offered by agencies in all but one country, St. Lucia.

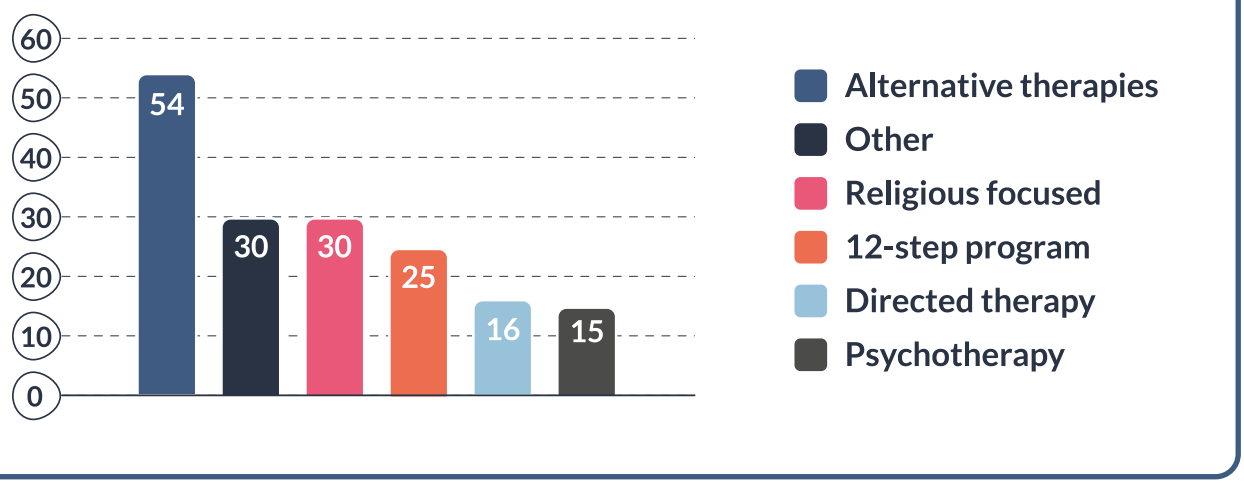
Therapeutic strategies offered at agencies

Choosing from the five therapeutic strategies listed below, 54 agencies indicated that they offered psychotherapy, 30 agencies offered the 12–step program, 30 offered directed therapy, 25 offered religious focused strategies, and 15 offered alternative therapy (Table 22).

Table 22: Therapeutic Strategies Offered at Agencies

	Number of agencies responding "Yes"
12–step program	30 (34.1%)
Psychotherapy	54 (61.4%)
Directed therapy	30 (34.1%)
Alternative therapies	15 (17.0%)
Religious focused	25 (28.4%)
Other	16 (18.2%)

Figure 11: Therapeutic Strategies Offered – Number of Agencies



Other therapeutic strategies offered by agencies included:

- Assessment and monitoring;
- Care to drug patient for mental health disorder;
- Counseling;
- Ergotherapy (therapy by work and activities);
- Harm reduction / getting the homeless back on their feet;
- Have a patient focused/centered approach, collaborative, and integrated multidisciplinary team care model;
- Moral Reconation Therapy / cognitive behavioral therapy;
- Pharmacotherapy;
- Religious focus / "Living Free" Program / clinical counseling;
- Substance use disorders with comorbid psychotic/mood disorders;
- William Glazer's philosophy & Marlatt's theory.

Services or activities offered by agencies

From Table 23, the five most prevalent activities indicated by agencies were counseling (67 agencies), referral to social services or primary health care services (65 agencies), clinical evaluation of the addict (46 agencies), relapse prevention (45 agencies), and treatment of physical and/or psychological illnesses not associated with drug use (36 agencies).

The "other" activities indicated by agencies were support for the work of the drug demand unit on a policy level, drug treatment and prevention, educational work, and skills training for youth and women.

Table 23: Services or Activities Offered by Agencies

	Number of agencies responding "Yes"
Clinical evaluation of the addict	46 (52.3%)
Pharmacological treatment	24 (27.3%)
Substitution therapies with methadone or buprenorphine	1 (1.1%)
Treatment of physical and/or psychological illnesses NOT associated with drug use	36 (40.9%)
Prevention and early detection of illnesses (HIV, TB, hepatitis, etc.)	24 (27.3%)
Physical rehabilitation	20 (20.7%)
Counseling	67 (76.1%)
Social and occupational reinsertion	37 (42.0%)
Relapse prevention	45 (51.1%)
Harm reduction (needle exchange, condom distribution, safe sex practices)	13 (14.8%)
Referral to social services or primary health care services	65 (73.9%)
Services specific to the LGBTQ community/person	10 (11.4%)
Other	5 (5.7%)

Number of beds for inpatient treatment

Of the possible 88 organizations, 33 (37.5%) responded to the question. Because the number of beds stated ranged from zero (36 agencies) to 213, with a standard deviation of 46, no descriptive statistics are presented. It is important to note that the agencies indicating 60 or more beds are agencies such as prison services, hospitals, or those offering social services on a large scale, which do not necessarily provide direct clinical or pharmacological drug treatment.

Table 24 shows the agencies that indicated beds for inpatient treatment, while Table 25 shows those agencies that indicated no beds for inpatient treatment. Table 24 shows, for example, that in Guyana, outside of the Public Hospital Suddie, there are three other agencies that offer beds for impatient treatment: Linden Hospital Complex with 4 beds, Georgetown Public Hospital Psychiatric Clinic with 7 beds, and Phoenix Recovery Project Inc. with 40 beds.

Table 24: List of Agencies and Number of Beds for Inpatient Treatment, by Country

Country	Institution	Number of beds
The Bahamas	Great Commission Ministries	20
	Sandilands Rehabilitation Center	34
Belize	Ministry of the Church of the Nazarene	12
	Jacob's Rehabilitation Farm Center	20
	Hedges Rehabilitation Ministry	35
Guyana	Linden Hospital Complex	4
	Georgetown Public Hospital Psychiatric Clinic	7
	Phoenix Recovery Project Inc.	40
Haiti	Fondation Myrtil Contre la Dependance a la Drogue	10
	Foyer de Renaissance Reeducation pour Toxicomanes	19
	Pension pour Handicapés Mentaux	30
Jamaica	Richmond Fellowship Jamaica	16
St. Kitts and Nevis	Joseph N. France Psychiatric Team	17
St. Lucia	Turning Point Drug & Alcohol Detoxification & Rehabilitation Centre	18
Suriname	Foundation Victory Outreach Suriname	15
	Foundation Faith and New Life	16
Trinidad and Tobago	Serenity Place Empowerment Centre for Women	10
	Teen Challenge Trinidad and Tobago	10
	HEAL	15
	New Life Ministries Treatment and Rehabilitation Centre for Women	30
	Court Shamrock Center for Socially Displaced Persons	40
	Piparo Empowerment Centre	50
Haiti	Centre Hospitalier Universitaire de Psychiatrie et de Neurologie Mars and Kline	60
Suriname	Foundation De Stem (The Voice)	60
Barbados	HMP Dodds	70
	Prison Services Barbados	70
Antigua and Barbuda	Substance Abuse Foundation	72
Guyana	Public Hospital Suddie	165
St. Vincent and the Grenadines	Mental Health Rehabilitation Centre	180
	Milton Cato Memorial Hospital	213
Trinidad and Tobago	Centre for Socially Displaced Persons.	200

Table 25: Agencies with No Beds, by Country

Country	Institution
Antigua and Barbuda	Substance Prevention Assessment and Rehabilitation Centre (SPARC)
The Bahamas	Department of Education
	The Community Counselling and Assessment Centre
	Diversion Behavioural Healthcare Resources and Services
	Youth Empowerment Program
Barbados	Network Services Centre Inc.
	Drug Education and Counselling Services
	The Centre for Counselling Addiction Support Alternatives (CASA)
	The National Council on Substance Abuse
Dominica	Wisdom to Know
Grenada	Adult and Teen Challenge Grenada Inc.
Guyana	Guyana Police Force
	Ministry of Health
	Family Awareness Consciousness Togetherness (FACT)
Haiti	National Commission for the Fight Against Drugs
	APAAC
Jamaica	National Council on Drug Abuse
	Western Regional Health Authority
St. Kitts and Nevis	Nevis CARE Centre – Counselling Unit
	Mental Health Unit
	Probation and Child Protection Services
	Royal St. Kitts and Nevis Police Force
	Ministry of Social Development
	Mental Health Day Treatment Centre
	St. Kitts Mental Health Association
	St. Kitts and Nevis National Council on Drug Abuse Prevention
	Drug Prevention and Treatment Services Inc. (DPATS)
	Department of Youth Empowerment
St. Lucia	Upton Gardens Girls Centre
	Boys Training Centre
St. Vincent and the Grenadines	The University of the West Indies Open Campus
Suriname	Forensisch Maatschappelijke Zorg
	Afdeling Voorlichting Jeugdzaken KPS
	Stichting Buurtwerk Latour (Stibula)

POPULATION GROUPS COVERED

Population groups treated for substance use/misuse (multiple–response category)

A total of 70 agencies responded to this question. At least 40 or more of those agencies provided services to "young male adults from 18 to 29 years" (59), "male adults 30 years or older" (57), "young female adults from 18 to 29 years" (49), "female adults 30 years or older" (47), and "male adolescents from 12 to 17 years" (42). More than ten agencies across the region offered services to multiple population groups listed below. Table 26 shows the multiple–response analysis and Table 27 shows the distribution of responses by country.

Table 26: Populations Groups Treated for Substance Use/Misuse

Category	Responses		Percent of cases (n = 70)
	#	%	
Male children from 0 to 11 years	17	2.9	24.3
Male adolescents from 12 to 17 years	42	7.3	60.0
Young male adults from 18 to 29 years	59	10.2	84.3
Male adults 30 years or older	57	9.9	81.4
Female children from 0 to 11 years	17	2.9	24.3
Female adolescents from 12 to 17 years	36	6.2	51.4
Young female adults from 18 to 29 years	49	8.5	70.0
Female adults 30 years or older	47	8.1	67.1
Dual diagnosed patients	22	3.8	31.4
Pregnant women	36	6.2	51.4
Women with children	27	4.7	38.6
People with physical disabilities	22	3.8	31.4
Homeless children	13	2.2	18.6
People with mental disabilities	29	5.0	41.4
Homeless adults	28	4.8	40.0
People with medical illnesses that require special care	16	2.8	22.9
Patients referred by judge for criminal or civil cases	38	6.6	53.4
LGBTQ community	23	4.0	32.9
Total	**578**	**100**	

Table 27: Populations Group Treated for Substance Use/Misuse, by Country

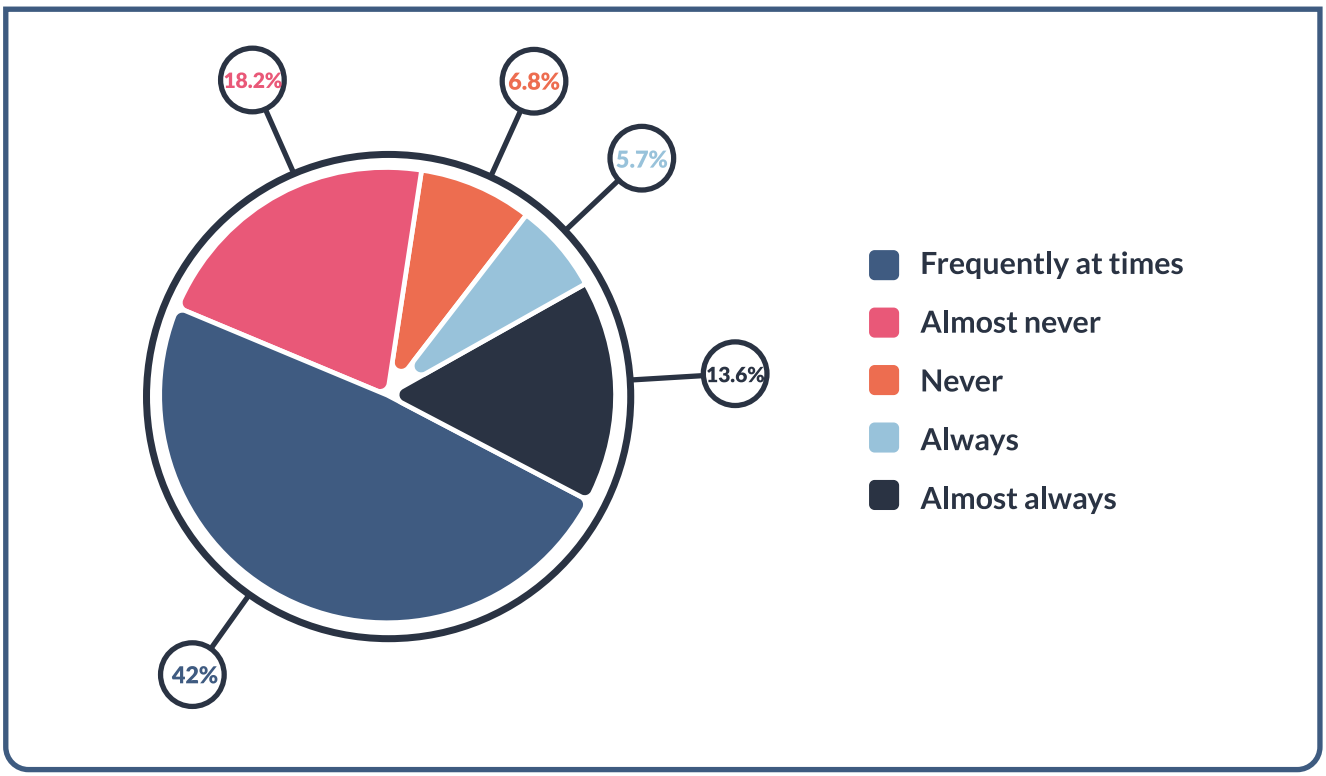
	Antigua and Barbuda	The Bahamas	Barbados	Belize	Dominica	Grenada	Guyana	Haiti	Jamaica	St. Kitts and Nevis	St. Lucia	St. Vincent and the Grenadines	Suriname	Trinidad and Tobago	Total
Male children from 0 to 11 years	0	1	3	3	0	0	1	0	2	4	0	1	1	1	17
Male adolescents from 12 to 17 years	2	5	5	3	0	2	5	5	2	6	3	1	2	1	42
Young male adults from 18 to 29 years	1	5	7	5	1	1	7	9	3	6	2	3	3	6	59
Male adults 30 years or older	1	3	6	5	1	1	7	9	3	5	2	3	5	6	57
Female children from 0 to 11 years	0	1	2	3	0	0	1	0	2	4	0	1	1	2	17
Female adolescents from 12 to 17 years	1	4	5	3	0	2	3	3	2	6	3	1	1	2	36
Young female adults from 18 to 29 years	1	4	7	3	0	1	5	9	3	6	2	3	1	4	49
Female adults 30 years or older	1	2	6	3	1	1	5	9	3	5	2	2	3	4	47
Dual diagnosed patients	1	2	2	3	0	0	1	2	2	3	2	1	0	3	22
Pregnant women	1	2	2	3	0	0	1	7	3	6	2	2	2	4	35
Women with children	1	2	5	3	0	0	4	3	2	3	0	1	1	2	27
People with physical disabilities	0	3	3	3	0	0	1	3	2	3	0	1	1	2	22
Homeless children	0	1	1	3	0	0	2	1	1	2	0	1	1	0	13
People with mental disabilities	1	3	2	2	0	0	2	4	2	4	0	2	1	5	28
Homeless adults	1	3	2	3	1	0	1	3	3	1	0	1	3	6	28
People with medical illnesses / special care	1	1	2	2	0	0	2	3	1	1	0	1	0	2	16
Patients referred by order of the judge for criminal or civil cases	1	4	5	3	0	0	3	5	3	5	2	3	1	2	37
LGBTQ community	1	3	2	3	0	0	4	2	2	2	0	1	1	2	23

SECTION 6
EFFECTIVE DEMAND AND PERFORMANCE OF THE ORGANIZATION

Family member participation in the treatment process

Agencies were asked to indicate if family members participate in the treatment process and the frequency of that participation. Most agencies said family members participated "frequently at times" (37, or 42%). Only five agencies (5.7%) indicated they participated "always," 12 agencies (13.6%) said "almost always," 16 agencies (18.2%) "almost never," and 6.8% said family members never participated.

Figure 12: Frequency of Family Member Participation in the Treatment Process



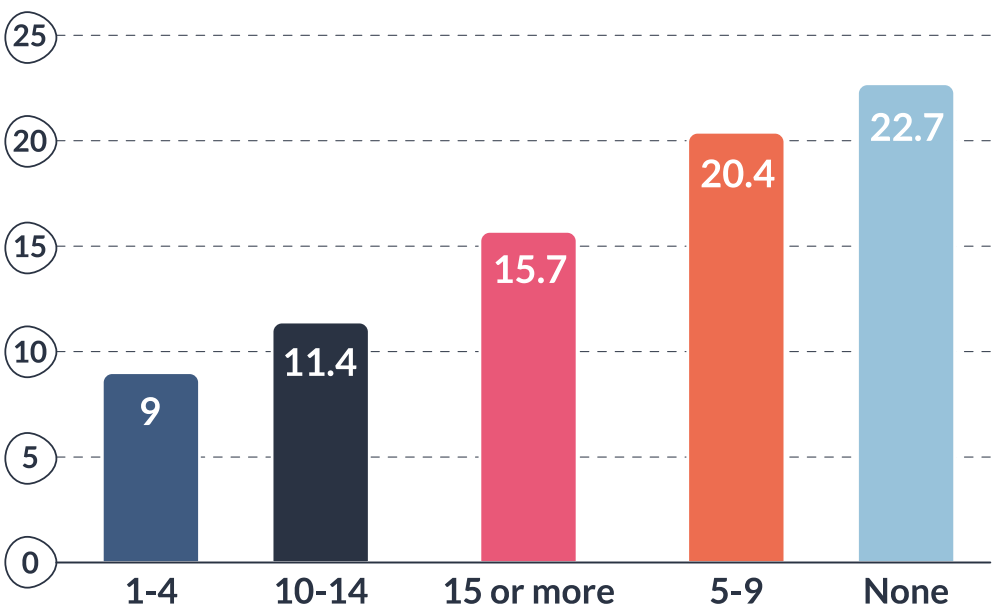
Number of patients receiving treatment for substance use or misuse in the last 30 days

Agencies were asked to indicate the number of patients they had treated for substance use or misuse in the last 30 days. From Table 28 below, 70 of the 88 agencies (79.5%) responded to this question. A small percentage of agencies (14, or 15.7%) indicated that they had treated 15 or more clients in the last 30 days. Ten agencies (11.4%) had treated between 10 to 14 clients, 18 (20.4%) had treated 5 to 9 clients, 8 (9%) had treated 1 to 4 clients, and 20 (22.7%) had not treated anyone during the past 30 days.

Table 28: Distribution of Total Number of Patients (Q39 and Q40)

Number of patients	Treated in last 30 days (Question 39)	Number previously treated (Question 40)
None	20 (22.7%)	28 (31.8%)
1–4	8 (9.0%)	9 (21.6%)
5–9	18 (20.4%)	11 (12.5%)
10–14	10 (11.4%)	3 (3.4%)
15 or more	14 (15.7%)	5 (5.6%)

Figure 13: Patients Treated in Last 30 Days (% of Agencies)



The descriptive statistics on this question indicated that 914 patients were treated in the last 30 days for substance use or misuse problems by the reporting agencies. Note, however, that at least six agencies indicated treating over 30 patients in the last month; for these six agencies, the range was 30 to 171 patients (see Table 29).

Table 29: Agencies Treating over 30 Patients in the Last Month

Country and agency	Number of patients treated
Belize – Hedges Rehabilitation Ministry	31
Antigua and Barbuda – Substance Abuse Foundation	39
Barbados – Drug Education and Counselling Services	45
Belize – Jacob's Rehabilitation Farm Center	60
The Bahamas – Department of Education	138
Jamaica – National Council on Drug Abuse	171

Number of patients previously treated

Agencies were asked to state how many of the patients seen for treatment during the past 30 days had been previously treated for substance use/misuse problems either at their agency or elsewhere. The number of patients previously treated was 252. About a third of the agencies (28, or 31.8%) had not treated any previously treated clients, nine agencies (21.6%) had treated 1 to 4, eleven agencies (12.5%) had treated 5 to 9, three agencies (3.4%) had treated 10 to 14, and five agencies (5.6%) had treated 15 or more previously treated clients (see Table 28 above). The agencies treating over 20 previously treated patients were: Belize – Hedges Rehabilitation Ministry, Guyana – Georgetown Public Hospital Psychiatric Clinic, and Jamaica – National Council on Drug Abuse.

Age–appropriate treatment measures/services tailored to the specific needs of children, youth, or women

Agencies were asked to indicate at least three age–appropriate treatment measures/services that were currently being implemented and were tailored to the specific needs of children, youth, or women. Tables 30 and 31 below show the agencies' responses.

Table 30: Age–appropriate Treatment Measures Indicated by Agencies

Measure 1	Measure 2
Adolescent MET/CBT cannabis youth treatment	Abstinence skills
Adolescent treatment groups, virtual	Adolescent psychoeducation lectures upon request to schools
Brief intervention	Alcoholics Anonymous
Cognitive Behavioral Therapy (CBT)	Assessment
Counseling	Behavioral and Cognitive–Behavioral Therapies (BCBT)
Direct reception for women	Drug counseling and empowerment session for children referred from Drug Treatment Court and Child Diversion
Drug abuse screening test - adolescents	Drug treatment protocol
Dual diagnosis	Family intervention / family therapy
Early treatment intervention	General bio–psycho–social counseling tailored to age of individual
Family therapy	Group therapy
Group therapy	Individual psychotherapy
Harm reduction	Make parents aware of strange behavior about young people as well as their new associates
Individual therapy	Medical issues at hospitals
Medical detoxification	Motivational interviewing
MRT for juveniles	

Table 31: Additional Age–appropriate Treatment Measures Indicated by Agencies

Indicated Measures continued	Indicated Measures continued
Acute management of substance use disorders	Pharmacological therapy
Anger management	Prevention of fetal risks
Available support meetings (NA, AA, CA)	Prevention through seminars
Gender specific treatment	Post COVID-19 readjustment therapy for primary school children
Generalized anger and anxiety	Psychiatric intervention when presenting with a mental illness
Insertion	Reading clinics for children with reading problems
Lighthouse Family Program	Reconciliation with kids/spouse
Maintenance of patients / reintegration back into community (institution of drug relapse prevention program; reintegration and after-care program))	Referral for drug treatment
National screening for one grade	Referral psychiatric care
Prevention programs	Rehabilitation
Preventive measures of individual and group therapy for children, youth and women	Skills training
Psycho-educational training	Solution-focused therapy
Psychotherapy / Psychodynamic psychotherapy	Speakers on relevant topics
Referral psychotherapy	Stabilization of inpatients who complete detoxification (promotion of drug abstinence; dynamic group psychotherapy)
Relationship therapy	Talk therapy
Substance abuse education	Tapering down
Step Up program for adolescents	Trauma informed care for women
Use of play therapy	Trauma therapy

Appropriate treatment measures/services tailored to the specific needs of the LGBTQ community

Treatment measures for LGBTQ Community:

- Abstinence/coping skills;
- Acute management of acute substance withdrawal symptoms (medical detoxification);
- Adjustment support for children in state homes;
- Anger management;
- Available support meetings (NA, AA, CA);
- Brief interventions;
- Cognitive behavioral therapy;
- Confidentiality on the sexual orientation of all inpatients to avoid any form of discrimination;
- Counseling;
- Discreetly perform tests for infectious diseases;
- Drug counseling – individual and group;
- Drug treatment advocacy/protocol;
- Dual diagnosis assessment;
- General bio–psycho–social counseling targeted to the individual;
- Generalized anger and anxiety;
- Greater family/community support;
- HIV prevention, health fairs, and medical referrals;
- Individual psychotherapy;
- Maintenance therapy / reintegration back into communities;
- Marlatt's theory;
- Parent counseling for parents with LGBTQ children;
- Psychotherapy / Psychodynamic psychotherapy;
- Psychoeducation;
- Referral for drug treatment, psychiatric care, medical issues, and QPCC;
- Self–coaching technique for antisocial conflict in sexual orientations;
- Social public reintegration;
- Stabilization of inpatients with SUDs who complete detoxification (promote drug abstinence and commence dynamic group psychotherapy);
- Strengthening of the primary system;
- Teach employable skills;
- Training to the staff for adopting tolerance towards this group;
- William Glazer's philosophy;

SECTION 7

TRAINING AND TRAINING NEEDS IN TREATMENT

Certification training in a treatment–related field in the past 12 months

Only 16 agencies (18.2%) indicated that their staff had received certification training in a treatment–related field in the past 12 months. No one had received certification training in Dominica, St. Kitts and Nevis, or Trinidad and Tobago. The numbers were cross–tabulated with the type of treatment services provided in each country in Table 32, which shows the number of agencies in each country for which staff had certification training specific to the four types of treatment services offered in each country.

At 14 agencies, staff were given certification training in the last 12 months related to assessment services, staff at 14 agencies were trained related to treatment services, 12 agencies had staff get training related to rehabilitation services, and for nine agencies, training was related to reinsertion services.

Table 32: Certification Training in a Treatment–related Field in the Past 12 Months, by Country

Country	Yes	Types of treatment services			
Overall	**16 (18.2%)**	**Assessment**	**Treatment**	**Rehabilitation**	**Reinsertion**
Antigua and Barbuda	1	1	1	1	1
The Bahamas	2	2	2	2	1
Barbados	2	2	2	2	2
Belize	1	1	0	0	0
Dominica	0	0	0	0	0
Grenada	1	1	1	1	0
Guyana	1	1	1	0	0
Haiti	1	1	1	1	1
Jamaica	2	2	2	2	1
St. Kitts and Nevis	0	0	0	0	0
St. Lucia	1	1	1	1	1
St. Vincent and the Grenadines	2	1	1	0	0
Suriname	2	1	2	2	2
Trinidad and Tobago	0	0	0	0	0
Total	**16**	**14**	**14**	**12**	**9**

From Table 33 below, the total number of staff trained ranged from a low of 30 in 17 agencies in the area of "Institutional administration: management of treatment centers" to a high of 172 in 19 agencies related to "information for the family and community." Of note is the fact that 148 staff members in 21 agencies were trained in "basic concepts of drug dependency," and 156 staff members in 27 agencies received training related to "counseling techniques."

Table 33 also includes a column showing the percentage of agencies with less than 5% of their staff trained in each of the subject areas. For example, of the 20 agencies that indicated their staff were trained in "treatment for patients with dual diagnosis," 85% had five or fewer staff trained in that field.

With respect to "Institutional administration: management of treatment centers," all 17 agencies had five or fewer trained staff in this field. The subject areas with the highest number of agencies exposed to training were counseling techniques (27), case management (26), conflict resolution (24), and counseling and coordinating services/case referral (23 agencies).

Table 33: Number of Agencies Receiving Training and Number of Staff Trained in Various Topics

	Number of agencies	Minimum	Maximum	Total number trained	Mean number trained	% with 5 or fewer trained
Basic concepts of drug dependency	21	0	45	148	7.0	67
Treatment models: outpatient and residential	20	0	10	72	3.6	75
Pharmacological treatment of drug abuse and dependency	17	0	12	50	2.9	88
Treatment for patients with dual diagnosis	20	0	45	131	6.5	85
Administration of medicines/drugs	15	0	45	78	5.2	80
Counseling techniques: individual, group, family	27	0	25	156	5.7	63
Assessments (brief, in depth, ongoing)	21	0	25	109	5.1	71
Case management	26	0	25	127	4.8	69
Clinical evaluation	19	0	15	83	4.3	74
Counseling and coordinating services / case referral	23	0	11	101	4.3	65
Design of treatment plans for drug abuse/dependency	16	0	25	66	4.1	81
Family systems in the context of drug use and abuse	18	0	9	64	3.5	78
Management of resistance to treatment and changing behavior	16	0	11	63	3.9	69
Relapse prevention	19	0	9	63	3.3	84
Information for the family and community	19	0	45	172	9.0	58
Post–treatment plans: reinsertion to society and the workplace	19	0	10	61	3.2	79
Institutional administration: management of treatment centers	17	0	5	30	1.7	100
Data collection and electronic data entry/filing	20	0	45	87	4.3	90
Ethical and professional responsibilities of human resources in treatment	17	0	30	82	4.8	77
Conflict resolution	24	0	22	119	4.9	71

Training needs assessment

Agencies were asked to indicate their perception of training needs in each of the areas outlined (see Table 34). Response options were "not needed," "needed but not urgently," and "needed urgently"). Twenty–five percent or more of the agencies expressed an urgent need for training in all the areas listed except for administration of medicines/drugs (22–38 agencies in each area). The only other training need identified was clinical supervision, identified by one agency.

Table 34: Perception of Training Needs in Various Areas of Drug Treatment

	Responses		
	Not needed (# and %)	Needed but not urgently (# and %)	Needed urgently (# and %)
Basic concepts of drug dependency	5 (5.7)	29 (33.0)	24 (27.3)
Treatment models: outpatient and residential	7 (8.0)	22 (25.0)	28 (31.8)
Pharmacological treatment of drug abuse and dependency	8 (9.1)	25 (28.4)	22 (25.0)
Treatment for patients with dual diagnosis	3 (3.4)	25 (28.4)	29 (33.0)
Administration of medicines/drugs	16 (18.2)	22 (25.0)	13 (14.8)
Counseling techniques: individual, group, family	6 (6.8)	19 (21.6)	32 (36.4)
Assessments (brief, in depth, ongoing)	7 (8.0)	19 (21.6)	28 (31.8)
Case management	8 (9.1)	20 (22.7)	29 (33.0)
Clinical evaluation	6 (6.8)	21 (23.9)	26 (29.5)
Counseling and coordinating services / case referral	5 (5.7)	22 (25.0)	30 (34.1)
Design of treatment plans for drug abuse/dependency	3 (3.4)	16 (18.2)	36 (40.9)
Family systems in the context of drug use and abuse	3 (3.4)	23 (26.1)	32 (36.4)
Management of resistance to treatment and changing behavior	4 (4.5)	20 (22.7)	32 (36.4)
Relapse prevention	6 (6.8)	16 (18.2)	34 (38.6)
Information for the family and community	11 (12.5)	19 (21.6)	27 (30.7)
Post–treatment plans: reinsertion to society and the workplace	6 (6.8)	12 (13.6)	38 (43.2)
Institutional administration: management of treatment centers	6 (6.8)	26 (29.5)	24 (27.3)
Data collection and electronic data entry/filing	10 (11.4)	21 (23.9)	25 (28.4)
Ethical and professional responsibilities of human resources in drug treatment	8 (9.1)	19 (21.6)	29 (33.0)
Conflict resolution	7 (8.0)	18 (20.5)	31 (35.2)

Priority treatment needs

The subject areas identified with the most urgent needs (about 30% or more of the agencies indicating an urgent need for training) were:

- Conflict resolution
- Ethical and professional responsibilities of human resources in drug treatment
- Post–treatment plans: reinsertion to society and the workplace
- Information for the family and community
- Relapse prevention
- Management of resistance to treatment and changing behavior
- Family systems in the context of drug use and abuse
- Design of treatment plans for drug abuse/dependency
- Counseling and coordinating services/case referral
- Clinical evaluation
- Case management
- Assessments (brief, in depth, ongoing)
- Counseling techniques: individual, group, family
- Treatment for patients with dual diagnosis
- Treatment models: outpatient and residential

SECTION 8
OTHER SERVICES OFFERED

Other activities in which agencies are involved (multiple–response category)

A total of 76 agencies responded to this question (see Table 35). The most common additional services/activities mentioned by agencies were education/training (45 agencies), outreach (44 agencies), coordination of activities (38), policy development (36), drug–related treatment or prevention activities with the probation services (35), and preventative health care (35 agencies).

Figure 14: Other Activities in Which Agencies are Involved (%)

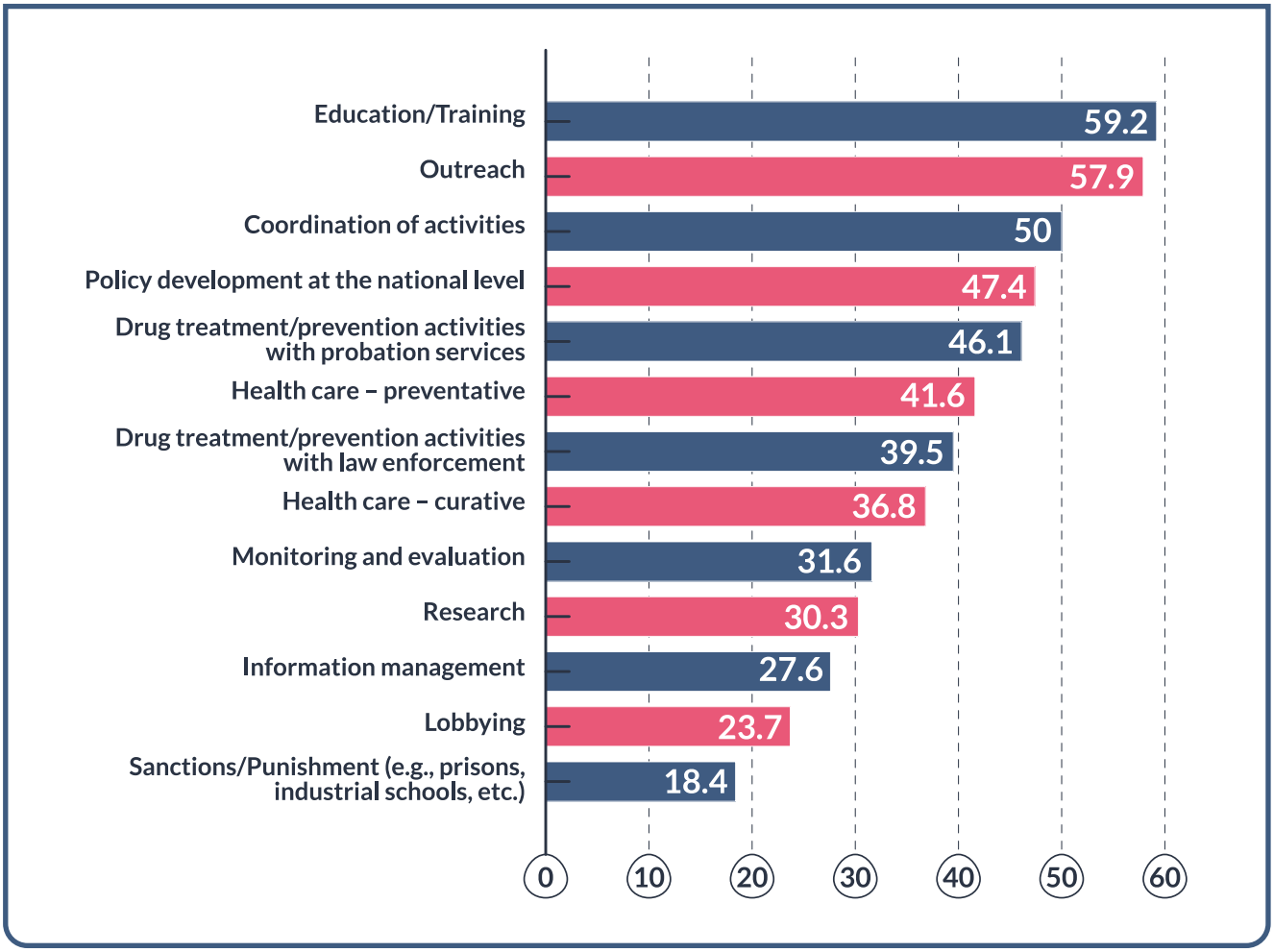


Table 35: Other Activities in Which Agencies are Involved

Category	Responses		Percent of cases (n = 76)
	#	%	
Coordination of activities	38	9.7	50.0
Policy development at the national level	36	9.2	47.4
Drug related treatment or prevention with law enforcement	30	7.7	39.5
Drug related treatment or prevention activities with probation	35	9.0	46.1
Sanctions/Punishment (e.g., prisons, industrial schools, etc.)	14	3.6	18.4
Health care – curative	28	7.2	36.8
Health care – preventative	35	9.0	41.6
Information management	21	5.4	27.6
Monitoring and evaluation	24	6.1	31.6
Research	23	5.9	30.3
Education/Training	45	11.5	59.2
Outreach	44	13.3	57.9
Lobbying	18	4.6	23.7
Total	**391**	**100**	

Table 36: Distribution of Other Activities in Which Agencies are Involved, by Country

	Antigua and Barbuda	The Bahamas	Barbados	Belize	Dominica	Grenada	Guyana	Haiti	Jamaica	St. Kitts and Nevis	St. Lucia	St. Vincent and the Grenadines	Suriname	Trinidad and Tobago	Total
Coordination of activities	0	5	4	3	0	1	6	5	1	4	0	0	4	5	**38**
Policy development at the national level	0	4	2	3	0	0	5	1	2	7	1	3	3	5	**36**
Drug related treatment or prevention activities with law enforcement	1	3	5	3	0	0	4	2	1	4	1	1	1	4	**30**
Drug related treatment or prevention activities with probation services	2	4	6	3	0	1	3	5	2	4	1	0	1	3	**35**
Sanctions/Punishment	0	2	2	1	0	1	0	0	1	4	1	0	1	1	**14**
Health care – curative	1	0	3	1	0	0	4	4	2	4	1	2	2	3	**27**
Health care – preventative	1	2	3	3	0	0	4	5	2	7	0	1	2	4	**34**
Information management	1	1	2	2	0	0	1	2	2	6	0	0	1	3	**21**
Monitoring and evaluation	1	3	3	1	0	0	3	2	2	4	0	0	1	4	**24**
Research	1	3	4	2	0	0	0	4	2	3	0	0	1	3	**23**
Education/Training	1	4	6	2	0	1	4	5	2	8	1	2	3	5	**44**
Outreach	1	4	5	2	1	0	5	4	1	7	1	2	4	6	**43**
Lobbying	0	3	2	1	0	0	2	1	2	3	0	1	1	2	**18**

Table 36 shows the distribution of agencies involved in other activities by country. For example, of the 35 agencies that were involved in drug–related treatment or prevention activities with the probation services, both Barbados and Haiti had five or more each. With respect to outreach activities, of the 43 agencies involved with this activity, 7 of 14 countries that participated in the need assessment had four or more agencies each.

Services for drug treatment court

Twenty–one agencies indicated that they currently offer services for drug treatment court clients. Table 37 below shows the distribution of agencies by country.

Table 37: Agencies Offering Services for Drug Court

Antigua and Barbuda	1 (4.8%)
The Bahamas	5 (23.8%)
Barbados	2 (9.5%)
Belize	1 (4.8%)
Dominica	0
Grenada	0
Guyana	3 (14.3%)
Haiti	1 (4.8%)
Jamaica	3 (14.3%)
St. Kitts and Nevis	2 (9.5%)
St. Lucia	0
St. Vincent and the Grenadines	1 (4.8%)
Suriname	0
Trinidad and Tobago	2 (9.5%)
Total	**21 (23.9%)**

Services for drug court:

- After-care program (duration of 18–24 months after community reintegration);
- Anger management;
- Assessment of clients to determine eligibility for program;
- Case management for drug case student suspensions;
- Clinical assessment;
- Clinical management of clients with underlying medical or psychiatric disorders;
- Community service;
- Counseling / Drug counseling;
- Court preparation;
- Court referral drug court program;
- Diversion;
- Drug testing;
- Evaluations;
- Follow up;
- Inpatient medical detoxification for referred persons with SUDs (medical detoxification for 4–6 weeks);
- Inpatient residential drug rehabilitation, short to medium program (4–6 months dynamic group psychotherapy);Housing while attending court and after.Life skills program;
- Medication;
- Outpatient substance use treatment;
- Patient referred by the court;

- Pre-trial assistance;
- Provision of clinical expertise as part of the drug court treatment team;
- Psychoeducation and counseling;
- Psychotherapy;
- Psychological and psychiatric assessment;
- Referral to mental health treatment;
- Rehabilitation/Counseling;
- Remedial education for children with family drug problems;
- Social integration;
- Strengthening the primary system;
- Student placements for children suspected of drug use;
- Substance abuse counseling;
- Therapy;
- Treatment /Treatment planning;

Risk factors affecting women and girls

Agencies were asked to state any new risk factors or conditions that they felt made women and girls vulnerable to participation in drug–related activities. Twenty–six agencies responded. Table 38 below illustrates the distribution of agencies by country. The risk factors indicated are listed below.

Table 38: Country Response: Risk Factors Affecting Women and Girls

Country	Agencies responding
Antigua and Barbuda	1 (3.8%)
The Bahamas	2 (7.7%)
Barbados	3 (11.5%)
Belize	2 (7.7%)
Dominica	–
Grenada	–
Guyana	8 (30.8%)
Haiti	3 (11.5%)
Jamaica	1 (3.8%)
St. Kitts and Nevis	3 (11.5%)
St. Lucia	–
St. Vincent and the Grenadines	1 (3.8%)
Suriname	1 (3.8%)
Trinidad and Tobago	1 (3.8%)
Total	**26 (29.5%)**

New risk factors for women and girls

- Abuse – sexual and physical
- Availability of substances
- Broken relationships and losses
- Changes in culture
- COVID–19 pressures, anxiety/lockdown, confinement, etc.
- Domestic abuse/domestic violence
- Early initiation of antisocial behavior
- Fear no return to their families/death
- Financial difficulties/issues
- Desensitization of children as it relates to the harmful effects of drugs
- Accessibility of ecstasy in rural communities and night clubs
- Human trafficking
- Increased supply of e–cigarettes on the market
- Intimidation
- Lack of community social support groups
- Lack of education
- Lack of family support
- Lack of information on drugs
- Lean has become popular among youths
- Low socio–economic conditions
- Musical choices
- Neglect
- No face–to–face school
- Not being in school and an increase in sexual activity
- Peer pressure
- Poor education achievements
- Poor housing environments
- Poverty
- Proliferation of drug use
- Recreational
- Relationship choices
- Single–headed household
- Social/political instability
- Social media bullying
- Social media influences
- Socio–economic
- Suicide intent
- Unemployment
- Unhealthy family environment

Section 9
Perception of the Problem and New Drugs (Multiple–Response Category)

This section reports information on drugs that are driving the demand for treatment and new substances reported by agencies to be impacting drug use. A total of 76 agencies responded to this question. The important substances reported by agencies as impacting clients presenting for treatment were primarily: alcohol, marijuana, and crack cocaine. Outside of the traditional substances of misuse, agencies identified other substances that were impacting the demand for treatment, such as: mixture of marijuana and cough medicine (St. Kitts and Nevis), shisha[1] with chemical additives (Haiti), and heroin (Haiti).

1 A shisha is an instrument used for heating or vaporizing drugs such as tobacco, marijuana, or hashish, which can then be smoked with chemical additives as desired.

Table 39: Drugs Driving the Demand for Treatment

	Responses		Percent of cases (n = 76)
	#	%	
Cigarettes	31	12.9	40.3
Alcohol	75	31.3	97.4
Marijuana	75	31.3	97.4
Crack cocaine	37	15.4	48.1
Cocaine powder	7	2.9	9.1
Ecstasy	7	2.9	9.1
Pharmaceuticals	7	2.9	9.1
Total	**237**	**100**	

Figure 15: Drugs Driving the Demand for Treatment (%)

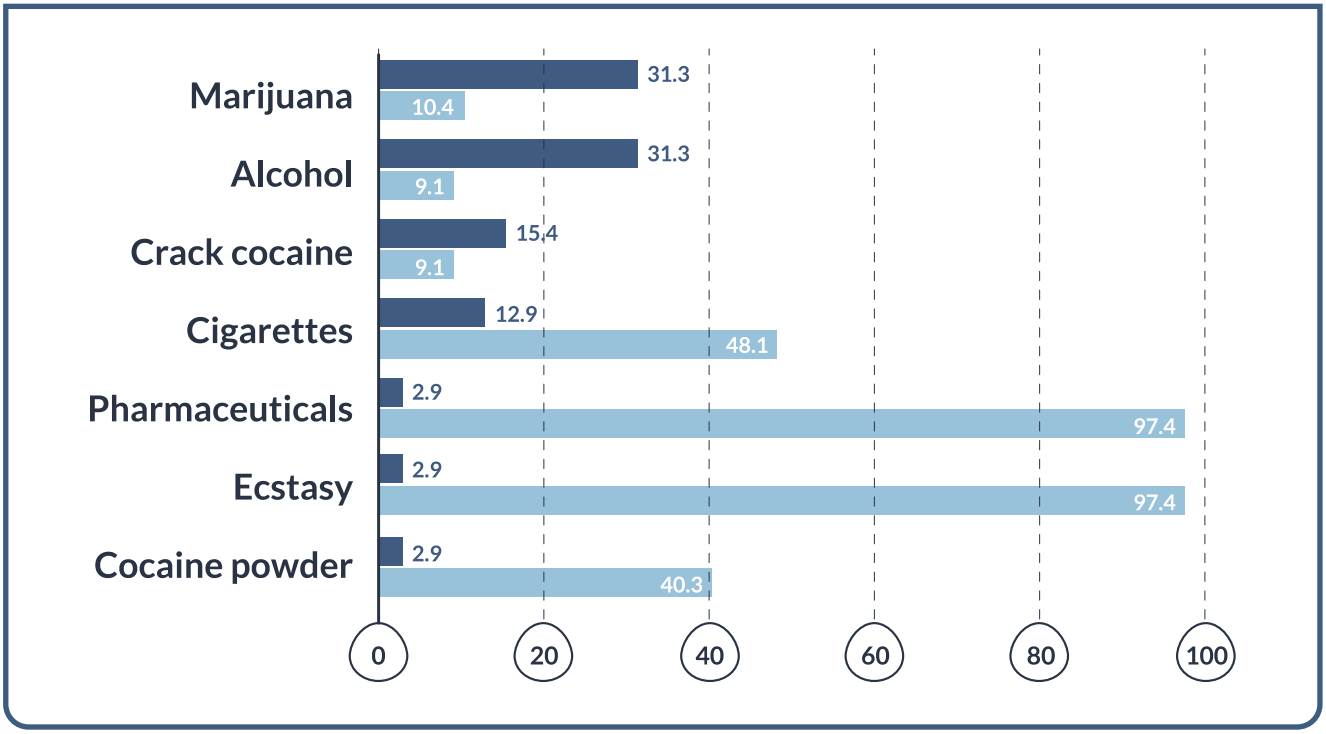


Table 40: Drugs Driving the Demand for Treatment, by Country

Country	Cigarettes	Alcohol	Marijuana	Crack cocaine	Cocaine	Ecstasy	Pharmaceuticals	Total
Antigua and Barbuda	0	2	2	1	0	0	1	**2**
The Bahamas	4	6	6	2	0	1	1	**6**
Barbados	3	8	8	5	0	1	0	**8**
Belize	1	5	5	5	0	0	0	**5**
Dominica	0	1	1	1	0	0	0	**1**
Grenada	1	1	1	0	0	0	0	**1**
Guyana	1	8	8	1	1	3	1	**8**
Haiti	7	10	8	3	2	1	2	**10**
Jamaica	1	3	3	2	0	0	0	**3**
St. Kitts and Nevis	4	11	12	5	4	0	2	**12**
St. Lucia	1	2	2	1	0	0	0	**2**
St. Vincent and the Grenadines	0	3	3	1	0	0	0	**3**
Suriname	3	6	7	4	0	1	0	**7**
Trinidad and Tobago	5	8	8	6	0	0	0	**8**
Total	31	74	74	37	7	7	7	**76**

As seen in Table 40 above, the demand for treatment with respect to alcohol, marijuana, and crack cocaine impacted agencies in all countries, except for Grenada, where agencies did not report an impact with respect to crack cocaine. Treatment for cocaine powder impacted seven agencies across three countries, while treatment demand for ecstasy also impacted seven agencies but across five countries. Treatment demand for pharmaceutical drugs was also reported by seven agencies across five countries.

Consumption of new drugs

Agencies were asked to report if they had detected any new drugs being consumed. Twenty–five agencies (28.4%) in nine countries reported consumption of new drugs. Table 41 shows the distribution of new drugs indicated by agencies. Very few agencies indicated the routes of administration.

It should be noted that the misuse of cough medicine shows a worrying trend in terms of new drug consumption in the countries.

Table 41: New Drugs Identified, by Country

Substance(s) indicated	Country responding
Cold medicine mixed with gummy bears and marijuana	St. Kitts and Nevis
Colo, cocaine, and sukru (designer drugs), laughing gas	Suriname
Ecstasy – oral; Percocet – oral; Xanax – oral; methamphetamine	Barbados
Ecstasy	The Bahamas, St. Kitts and Nevis
Glue, through the nose	Haiti
Ketamine (snorting)	Guyana
Lean (cough medicine, candy, and sodas mixed)	St. Kitts and Nevis
Lean and molly – school age youths	Guyana
LSD, ecstasy	Dominica
Mixture of marijuana and other substances, such as cough medicine and candy	St. Kitts and Nevis
Oral use of cough syrup	Barbados
Pharmaceuticals	Jamaica
Shisha, consumed through smoking (by mouth)	Haiti

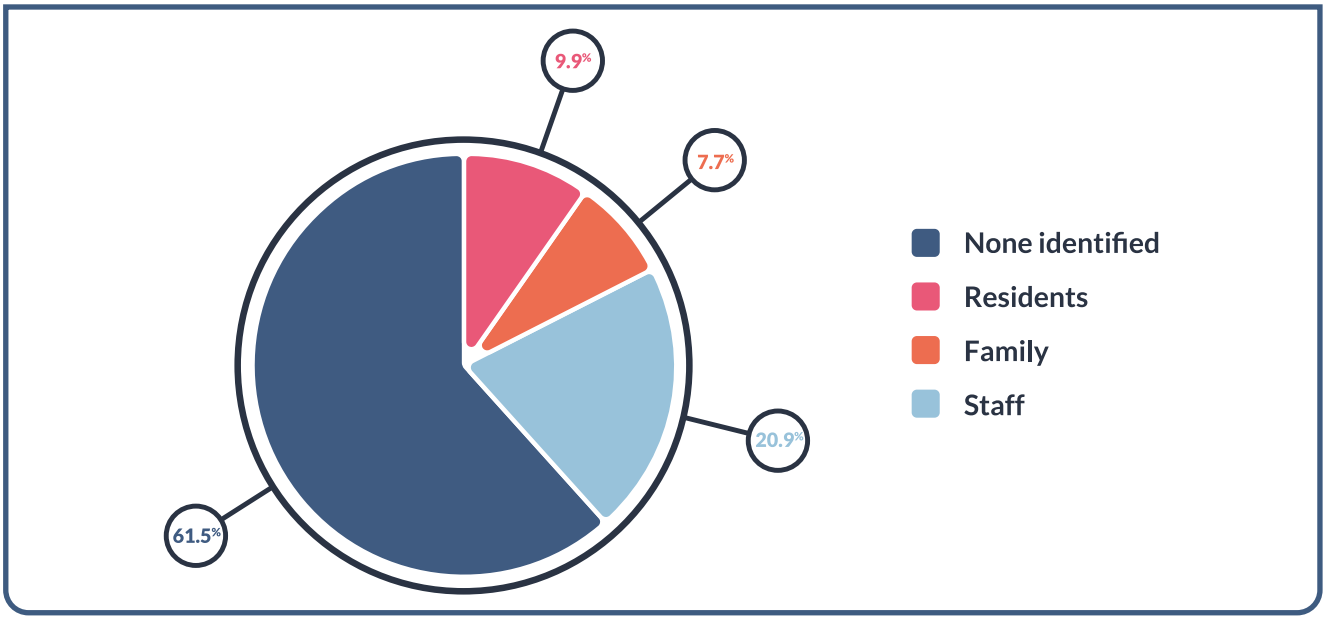
Section 10
Impact of COVID–19 on Drug Treatment Operations (Multiple–Response Category)

This section reports information on the impact of the present COVID–19 pandemic on the agencies' operations. Agencies were asked to report whether positive cases of COVID–19 were identified among clients, family members, or staff. A total of 78 agencies responded to this question. Most agencies (56) reported no cases of COVID–19. However, cases were reported among staff at 19 agencies, among family members at 7 agencies, and among residents at 9 agencies.

Table 42: Impact of COVID–19 on Drug Treatment Operations

	Responses		Percent of cases (n = 78)
	#	%	
Residents	9	9.9	11.5
Family	7	7.7	9.0
Staff	19	20.9	24.4
None identified	56	61.5	71.8
Total	**91**	**100**	

Figure 16: Agency Reported Impact of COVID–19 on Drug Treatment Operations



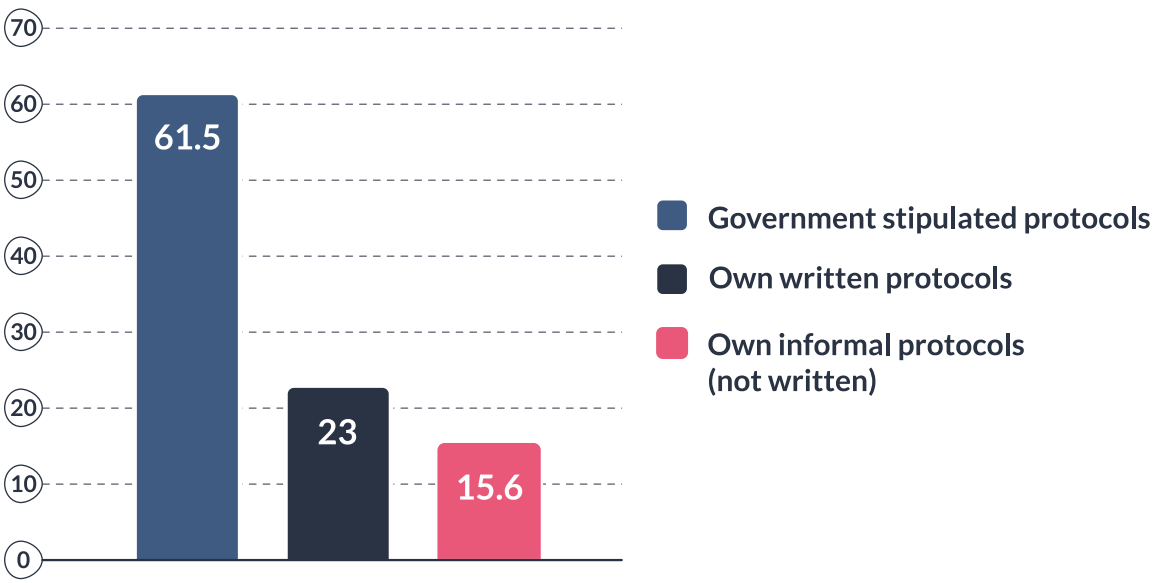
COVID–19 protocols implemented during pandemic period (multiple–response category)

Agencies were asked to report on the COVID–19 protocols implemented during the pandemic period. A total of 77 agencies responded to this question. Most agencies (75) implemented the government–stipulated protocols. Less than a quarter (28 agencies) implemented their own written protocols, while 19 agencies implemented informal unwritten protocols of their own.

Table 43: COVID–19 Protocols Implemented During Pandemic Period

	Responses		Percent of cases (n = 77)
	#	%	
Government stipulated protocols	75	61.5	97.4
Own written protocols	28	23.0	36.4
Informal own protocols (not written)	19	15.6	24.7
No protocol	–	–	–
Total	**122**	**100**	

Figure 17: COVID–19 Protocols Implemented During Pandemic Period (%)



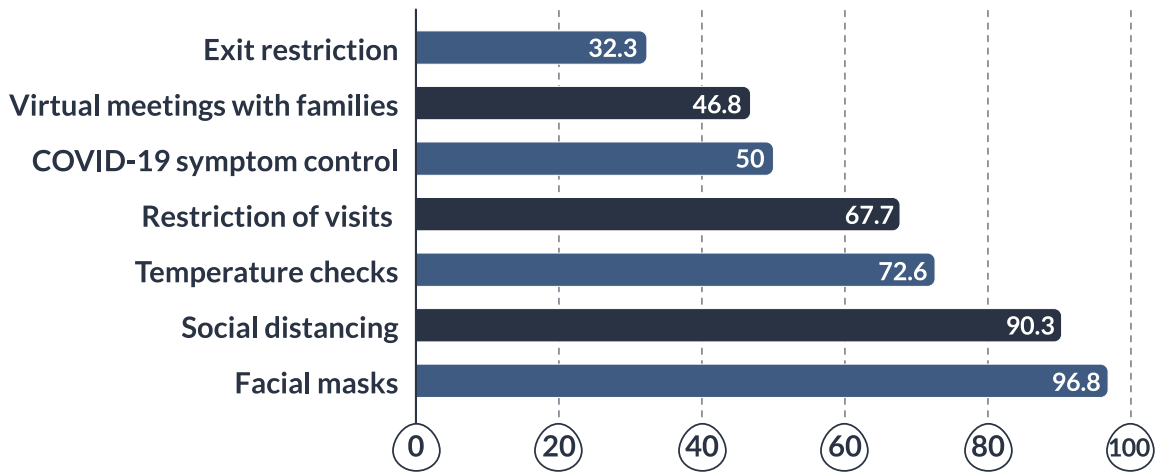
Continuity of care – Residential treatment measures (multiple–response category)

Of the 88 agencies, 67 (76%) reported that they had continued to care for people in treatment during the pandemic. When asked what strategies were developed to guarantee the continuity of residential treatments, 62 agencies responded (see Table 44). Wearing of face masks was the most prevalent measure, reported by 60 agencies. This was followed by social distancing (56 agencies), temperature checks (46 agencies), and restriction of visits (42 agencies).

Table 44: Continuity of Care – Residential Treatment Measures

	Responses		Percent of cases (n = 62)
	#	%	
Restriction of visits	42	14.8	67.7
Exit restriction	20	7.1	32.3
Virtual meetings with families	29	10.2	46.8
COVID–19 symptom control	31	11.0	50.0
Social distancing	56	19.2	90.3
Facial masks	60	21.2	96.8
Temperature checks	46	15.9	72.6
Total	**283**	**100**	

Figure 18: Continuity of Care – Residential Treatment Measures (%)



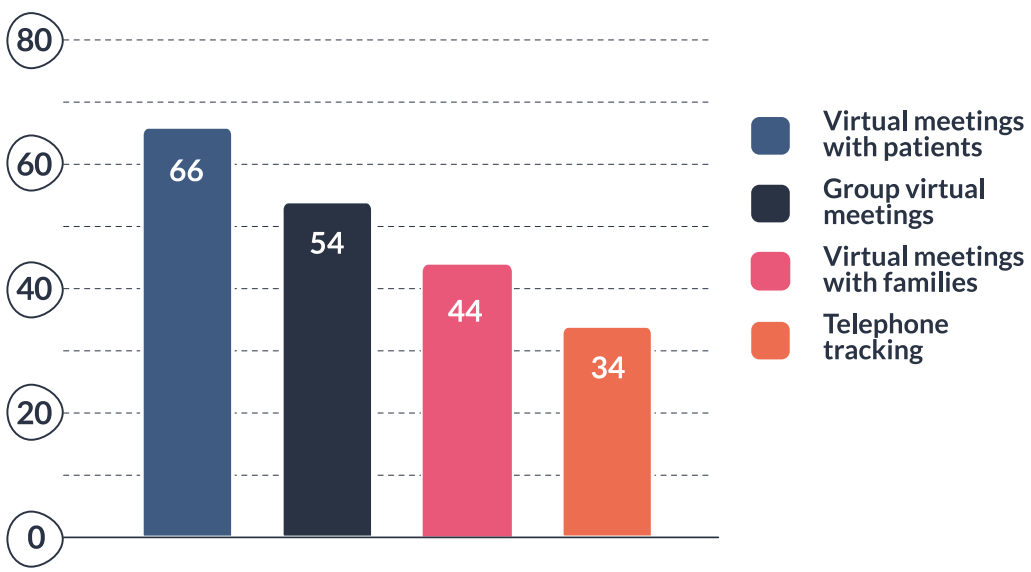
Continuity of care – Ambulatory treatment measures (multiple–response category)

When asked what strategies were developed to guarantee the continuity of ambulatory treatments, 50 agencies responded. Telephone tracking was the most common measure, reported by 33 agencies. This was followed by virtual meetings with patients (27 agencies) and families (22 agencies) and group virtual meetings, reported by 17 agencies.

Table 45: Continuity of Care – Ambulatory Treatment Measures

	Responses		Percent of cases (n = 50)
	#	%	
Virtual meetings with patients	27	27.3	54.0
Virtual meetings with families	22	22.2	44.0
Telephone tracking	33	33.3	66.0
Group virtual meetings	17	17.2	34.0
Total	**99**	**100**	

Figure 19: Continuity of Care – Ambulatory Treatment Measures (%)



The COVID–19 measures were cross–tabulated by country in Table 46 below, which shows the distribution of responses (the number of agencies to which the responses apply, by country).

Table 46: COVID–19 Measures by Country

	Antigua and Barbuda	The Bahamas	Barbados	Belize	Dominica	Grenada	Guyana	Haiti	Jamaica	St. Kitts and Nevis	St. Lucia	St. Vincent and the Grenadines	Suriname	Trinidad and Tobago	Total
Who got COVID–19															
Residents	0	1	3	0	0	0	0	0	1	1	0	1	1	1	**9**
Family	0	2	1	1	0	0	0	0	1	1	0	1	0	0	**7**
Staff	1	3	3	3	0	0	2	0	2	0	1	1	2	1	**19**
None identified	1	3	5	2	1	1	5	9	1	13	1	2	5	6	**55**
Which protocols implemented															
Government–stipulated protocols	2	6	8	4	1	1	8	7	3	14	2	3	8	7	**74**
Own written protocols	2	4	5	4	0	1	1	0	2	2	1	2	1	3	**28**
Informal unwritten protocols	2	0	1	1	0	0	4	0	0	3	0	2	4	2	**19**
Which strategies for residential treatments															
Restriction of visits	1	2	4	3	0	1	3	5	3	5	2	3	4	6	**42**
Exit restriction	1	1	2	3	0	0	1	1	1	0	2	1	2	5	**20**
Virtual meetings with families	1	3	7	1	0	1	2	2	2	5	1	1	0	3	**29**
COVID–19 symptom control	1	4	3	2	0	0	3	1	3	4	2	3	1	4	**31**
Social distancing	2	5	7	3	1	1	5	5	3	7	2	3	5	7	**56**
Facial masks	2	4	7	3	1	1	6	7	3	9	2	3	5	7	**60**
Temperature checks	1	4	7	1	0	1	4	3	3	6	2	2	5	6	**45**
Which strategies for ambulatory treatments															
Virtual meetings with patients	1	3	6	2	–	–	1	3	2	4	1	1	0	3	**27**
Virtual meetings with families	1	3	6	1	–	–	1	3	1	2	1	0	0	3	**22**
Telephone tracking	1	2	3	4	–	–	5	3	2	4	0	1	2	5	**32**
Group virtual meetings	1	4	1	1	–	–	1	2	1	1	1	1	1	2	**17**

SECTION 11

TRAINING AND TRAINING NEEDS IN SUBSTANCE USE PREVENTION SERVICES

This section presents results for training and training needs in substance use prevention services. Agencies that were categorized as dedicated prevention–only services, as well as those that offered both treatment and prevention, responded to this series of questions.

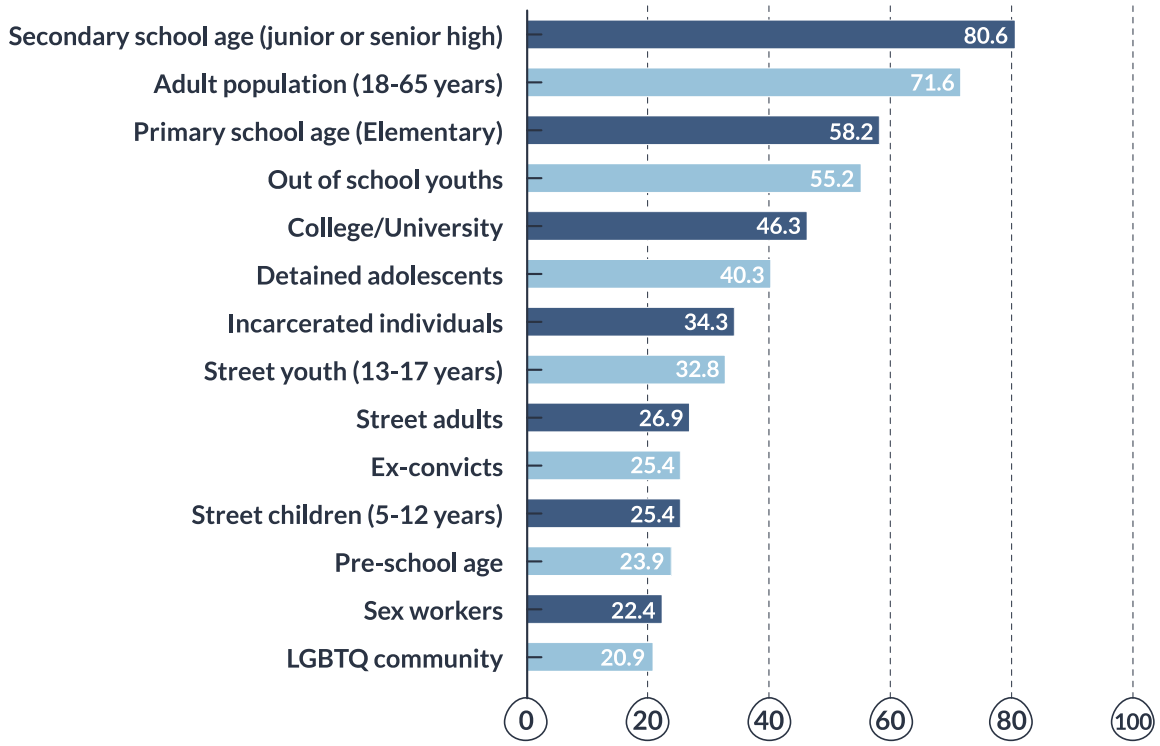
Populations targeted for drug prevention programs (multiple–response category)

Agencies were asked to indicate which population groups are targeted by their agencies for drug prevention programs. A total of 67 agencies responded to this question. Most agencies (54) indicated targeting secondary school age (junior or senior high) students. This was followed by "adult population (18–65 years)," targeted by 48 agencies, and "primary school age" students (39 agencies).

Table 47: Populations Targeted for Drug Prevention Programs

	Responses		Percent of cases (n = 67)
	#	%	
Pre–school age	16	4.2	23.9
Primary school age (elementary)	39	10.3	58.2
Secondary school age (junior or senior high)	54	14.3	80.6
College/University	31	8.2	46.3
Street children (5–12 years)	17	4.5	25.4
Street youth (13–17 years)	22	58	32.8
Out of school youths	37	9.8	55.2
Detained adolescents	27	7.1	40.3
Street adults	18	4.8	26.9
Incarcerated individuals	23	6.1	34.3
Ex–convicts	17	4.5	25.4
Sex workers	15	4.0	22.4
Adult population (18–65 years)	48	12.7	71.6
LGBTQ community	14	3.7	20.9
Total	**378**	**100**	

Figure 20: Agencies Serving Indicated Population (%)



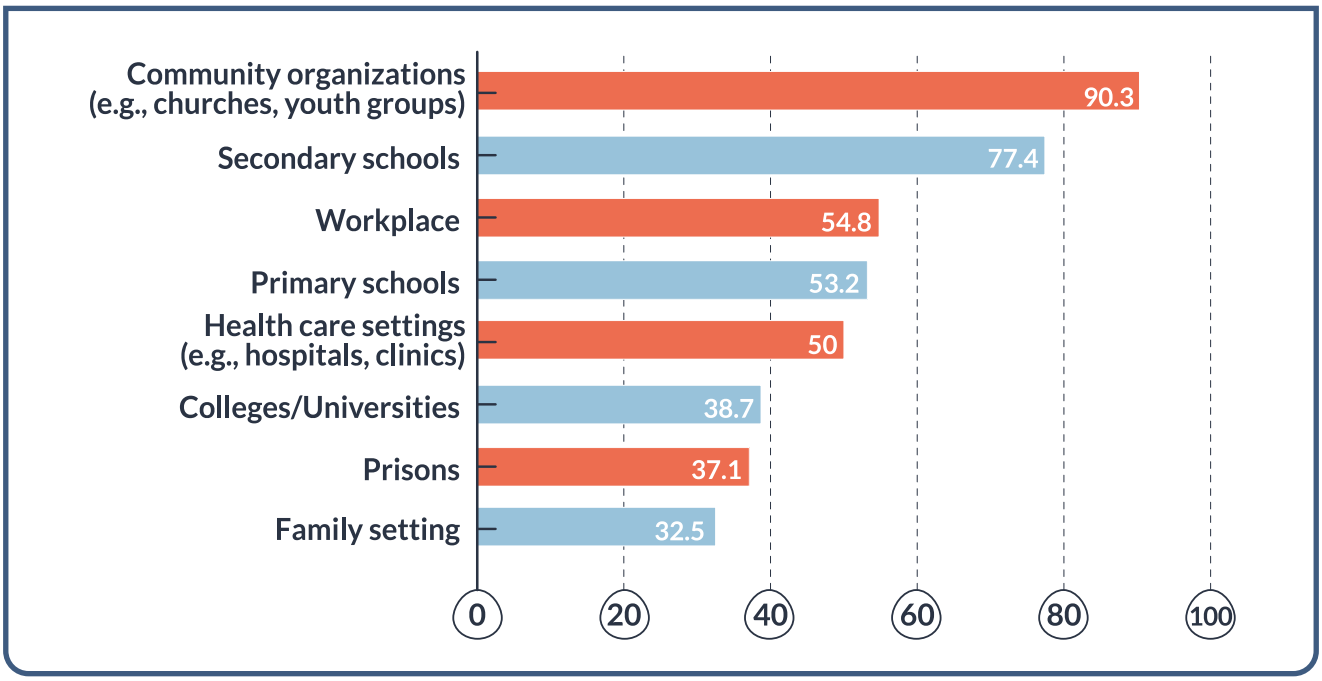
Environment for drug prevention interventions (multiple–response category)

Agencies were asked to indicate the environment in which they carry out drug prevention interventions. A total of 62 agencies responded to this question. Most agencies operated within community organizations such as churches, youth groups, or sports clubs (56 agencies). The next most prevalent response was secondary schools (48 agencies), followed by workplace (34 agencies), primary schools (33 agencies), and health care settings (31 agencies).

Table 48: Environment for Drug Prevention Interventions

	Responses		Percent of cases (n = 62)
	#	%	
Colleges/Universities	24	8.9	38.7
Community organizations (e.g., churches, youth groups)	56	20.8	90.3
Family setting	20	7.4	32.5
Health care settings (e.g., hospitals, clinics)	31	11.5	50.0
Primary schools	33	12.0	53.2
Prisons	23	8.6	37.1
Secondary schools	48	17.8	77.4
Workplace	34	12.6	54.8
Total	**269**	**100**	

Figure 21: Agencies Operating in Indicated Environment (%)



Agency services – Target population and environment

The cross–tabulation below (Table 49) shows that agencies in all countries were involved with primary and secondary school age students as well as the adult population for drug prevention programs. Agencies in 6 of 14 countries were not involved with street adults, ex–convicts, the LGBTQ community, or sex workers (7 of 14 countries).

With respect to the environment within which agencies operated, the analysis showed that agencies in 7 of 14 countries were not operating in a family setting environment. However, all countries had agencies operating in the secondary school environment as well as in community organizations, workplaces, prisons (except for Jamaica), and primary schools (except for St. Vincent and the Grenadines).

Table 49: Population and Environment for Drug Prevention Programs – Number of Agencies

	Antigua and Barbuda	The Bahamas	Barbados	Belize	Dominica	Grenada	Guyana	Haiti	Jamaica	St. Kitts and Nevis	St. Lucia	St. Vincent and the Grenadines	Suriname	Trinidad and Tobago	Total
Adult population (18–65 years)	2	3	3	2	2	1	5	6	2	7	1	1	5	8	**48**
College/University	0	1	4	2	1	1	1	6	2	3	1	1	5	3	**31**
Detained adolescents	0	2	2	2	0	1	1	2	1	6	2	0	6	2	**27**
Ex–convicts	0	1	1	2	1	1	0	3	0	0	0	0	6	2	**17**
Incarcerated individuals	0	1	1	3	1	1	2	2	0	4	1	0	5	2	**23**
LGBTQ community	0	0	1	2	0	0	3	2	1	0	0	1	3	1	**14**
Out of school youths	1	1	5	2	2	1	6	3	0	4	0	1	8	3	**37**
Pre–school age	1	1	1	2	1	1	0	1	0	0	1	0	4	3	**16**
Primary school (elementary)	1	3	4	3	1	1	1	4	2	3	2	0	9	5	**39**
Secondary school (junior/ senior high)	1	4	4	3	2	1	5	6	2	9	2	1	8	6	**54**
Sex workers	0	0	1	2	0	0	4	1	1	0	0	0	5	1	**15**
Street adults Street youth (13–17 years)	0	1	0	2	1	0	1	4	1	0	0	0	4	4	**18**
Street children (5–12 years)	0	2	2	1	1	0	2	2	0	1	1	0	4	1	**17**
Street youth (13–17 years)	0	3	2	1	1	0	3	4	0	1	1	0	5	1	**22**
Colleges/Universities	1	1	3	3	0	1	1	5	1	0	1	0	3	4	**24**
Community organizations (e.g., churches)	2	4	4	3	2	1	6	6	2	7	2	1	10	6	**56**
Family setting	0	0	0	3	0	1	0	5	1	3	0	0	5	2	**20**
Health care settings (e.g., hospitals, clinics)	1	0	1	3	1	1	4	3	1	5	2	0	4	5	**31**
Primary schools	1	2	3	4	1	1	2	4	1	3	1	0	6	4	**33**
Secondary schools	2	2	4	4	1	1	6	6	1	7	1	1	7	5	**48**
Prisons	1	1	1	4	1	1	1	2	0	3	1	1	4	2	**23**
Workplace	2	2	4	4	1	1	2	4	1	3	1	0	4	5	**34**

Certification training in a prevention–related field in the past 12 months

Agencies were asked to indicate how many staff had received certification training over the past 12 months in the subject areas listed. From Table 50 below, 34–40 of the eligible agencies responded for each of the areas included in the question. The subject areas for which training was most commonly conducted related to:

- Basic prevention principles;
- Communication and stakeholder involvement;
- Community prevention or community risk and protective factors;
- Family prevention or family risk and protective factors;
- Peer risk and protective factors;
- School–based prevention or school risk and protective factors.
- Self–risk and protective factors;
- Staff development;
- The theory of change in prevention programs;

In the areas highlighted above, some 29–75 staff members across agencies were trained. In the areas listed below, fewer than 10 staff members across the region had received certification training:

- Comprehensive (environmental) prevention;
- Dissemination and communication;
- Indicated prevention (screening and brief intervention);
- Introduction to prevention science;
- Needs assessment;
- Program formulation;
- Resource assessment;
- Secondary prevention (treatment);
- Selective prevention;
- Sustainability and funding / writing proposals;
- Tertiary prevention (rehabilitation and integration);
- Universal prevention;

The maximum number of persons trained throughout the region in any of the subject areas was 37, in the areas of self–risk and protective factors, and peer risk and protective factors.

Table 50: Number of Agency Staff Receiving Certification Training in Various Areas

	Number of staff trained	Min.	Max.	Number of agencies responding	0–1	2–3	4–5	6–10	>10
Introduction to prevention science	6	0	3	40	39	1	–	–	–
Basic prevention principles	36	0	26	40	35	4	–	–	1
Theory of change in prevention programs	29	0	26	38	36	1	–	–	1
Comprehensive (environmental) prevention	9	0	4	41	38	2	1	–	–
Drug prevention program quality standards	10	0	4	40	37	2	1	–	–
Family prevention or family risk and protective factors	37	0	26	40	36	2	1	–	1
Community prevention or community risk and protective factors	40	0	26	38	35	3	1	–	1
School–based prevention or school risk and protective factors	35	0	26	37	37	2	–	–	1
Workplace prevention or workplace risk and protective factors	22	0	12	39	36	–	2	–	1
Self–risk and protective factors	53	0	37	38	33	1	3	–	1
Peer risk and protective factors	75	0	37	37	32	–	3	–	2
Professional ethics in drug prevention	10	0	3	39	35	4	–	–	–
Primary prevention (prevention)	20	0	11	39	35	3	–	–	1
Secondary prevention (treatment)	6	0	2	37	35	2	–	–	–
Tertiary prevention (rehabilitation and integration)	8	0	2	39	36	3	–	–	–
Universal prevention	8	0	2	40	37	3	–	–	–
Selective prevention	7	0	2	39	36	3	–	–	–
Indicated prevention (screening and brief intervention)	9	0	5	37	35	2	1	–	–
Sustainability and funding / writing proposals	9	0	5	37	34	2	1	–	–
Communication and stakeholder involvement	52	0	26	40	33	4	1	1	1
Staff development	53	0	29	37	34	–	–	1	2
Needs assessment	9	0	3	38	36	2	–	–	–
Resource assessment	5	0	3	34	33	1	–	–	–
Program formulation	6	0	3	36	35	1	–	–	–
Intervention design / intervention for targeted populations	10	0	3	37	33	4	–	–	–
Evidence–based program design	14	0	6	39	36	2	–	1	–
Monitoring and evaluation	10	0	3	38	35	3	–	–	–
Dissemination and communication	7	0	3	38	37	1	–	–	–
Legal and normative regulations regarding drug use	10	0	3	36	33	3	–	–	–
Promotion of comprehensive public policies for the prevention and treatment of addictions	14	0	3	38	34	4	–	–	–
Other	7	0	3	18	16	2	–	–	–

Perception of training needs for prevention–related concepts

Agencies were asked to indicate their perception of training needs in each of the prevention–related concepts outlined (Table 51). Response options were "not needed," "needed but not urgently," and "needed urgently."

Table 51: Perception of Training Needs for Prevention–Related Concepts

	Not needed (# and %)	Needed, but not urgently (# and %)	Needed urgently (# and %)	n
Introduction to prevention science	6 (5.1)	36 (30.8)	22 (18.8)	64
Basic prevention principles	1 (0.9)	34 (29.1)	29 (24.8)	64
Theory of change in prevention programs	3 (2.6)	26 (22.2)	33 (28.2)	62
Comprehensive (environmental) prevention	4 (3.4)	28 (23.9)	29 (24.8)	61
Drug prevention program quality standards	1 (0.9)	28 (23.9)	34 (29.1)	63
Family prevention or family risk and protective factors	3 (2.6)	27 (23.1)	34 (29.1)	64
Community prevention / community risk and protective factors	3 (2.6)	22 (18.8)	38 (32.5)	63
School–based prevention or school risk and protective factors	5 (4.3)	24 (20.5)	34 (29.1)	63
Workplace prevention or workplace risk and protective factors	3(2.6)	30 (25.6)	29 (24.8)	62
Self–risk and protective factors	5 (4.3)	29 (24.8)	30 (25.6)	64
Peer risk and protective factors	4 (3.4)	28 (23.9)	30 (25.6)	62
Professional ethics in drug prevention	4 (3.4)	27 (23.1)	32 (27.4)	63
Primary prevention (prevention)	3 (2.6)	24 (20.5)	36 (30.8)	63
Secondary prevention (treatment)	10 (8.5)	22 (18.8)	30 (25.6)	62
Tertiary prevention (rehabilitation and integration)	8 (6.8)	26 (22.2)	27 (23.1)	61
Universal prevention	5 (4.3)	30 (25.6)	24 (20.5)	59
Selective prevention	8 (6.8)	28 (23.9)	21 (17.9)	57
Indicated prevention (screening and brief intervention)	8 (6.8)	26 (22.2)	26 (22.2)	60
Sustainability and funding / writing proposals	7 (6.0)	20 (17.1)	36 (30.8)	63
Communication and stakeholder involvement	3 (2.6)	27 (23.1)	32 (27.4)	62
Staff development	2 (1.7)	27 (23.1)	35 (29.9)	64
Needs assessment	3 (2.6)	29 (24.8)	32 (27.4)	64
Resource assessment	4 (3.4)	30 (25.6)	28 (23.9)	62
Program formulation	5 (4.3)	23 (19.7)	33 (28.2)	61
Intervention design / intervention for targeted populations	6 (5.1)	22 (18.8)	32 (27.4)	60
Evidence–based program design	6 (5.1)	19 (16.2)	35 (29.9)	60
Monitoring and evaluation	3 (2.6)	23 (19.7)	37 (31.6)	63
Dissemination and communication	3 (2.6)	25 (21.4)	32 (27.4)	60
Legal and normative regulations regarding drug use	4 (3.4)	31 (26.5)	26 (22.2)	61
Promotion of comprehensive public policies for the prevention and treatment of addictions	6 (5.1)	28 (23.9)	28 (23.9)	62

Very few agencies expressed that training in any of the concepts indicated was not necessary (1 to 10 agencies). For example, 10 of the 62 agencies responding to this item said training in "secondary prevention" was not needed, while 1 of 64 agencies said training in "basic prevention principles" was not needed.

Twenty–five percent or more of the agencies expressed an urgent need for training in all the concepts listed except for the following subject areas:

- Community prevention / community risk and protective factors;
- Drug prevention program quality standards;
- Evidence–based program design;
- Family prevention or family risk and protective factors;
- Monitoring and evaluation;
- Primary prevention;
- School–based prevention or school risk and protective factors;
- Staff development;

Priority prevention training needs

The subject areas identified with the most urgent needs (about 30% or more of the agencies indicating an urgent need for training) were:

- Community prevention/community risk and protective factors;
- Drug prevention program quality standards;
- Evidence–based program design;
- Family prevention or family risk and protective factors;
- Monitoring and evaluation;
- Primary prevention;
- School–based prevention or school risk and protective factors;
- Staff development;
- Sustainability and funding/writing proposals.

Supplemental Analysis – Comparison of 2013 and 2021 Training Needs

Comparison of treatment training needs in 2013 versus 2021

Table 52 below shows the treatment–related priority training needs for the two periods of assessment. Of the 16 areas identified in 2013 as priority training needs, 10 (63%) were also identified in 2021. As indicated in the previous assessment, these priority needs are areas where the agencies felt that additional training was required, and which 30% or more of the agencies had identified as being urgently needed.

Table 52: Comparison of Treatment Training Needs 2013 Versus 2021

2021 priority training needs	2013 priority training needs
• Assessments (brief, in depth, ongoing) • Case management • Clinical evaluation • Counseling and coordinating services/ case referral • Conflict resolution • Counseling techniques: individual, group, family • Design of treatment plans for drug abuse/ dependency • Ethical and professional responsibilities of human resources in drug treatment • Family systems in the context of drug use and abuse • Information for the family and community • Management of resistance to treatment and changing behavior • Post–treatment plans: reinsertion to society and the workplace • Relapse prevention • Treatment for patients with dual diagnosis • Treatment models: outpatient and residential	• Assessments (brief, in–depth, ongoing) • Conflict resolution • Counseling techniques: individual, group, family • Design of treatment plans for drug abuse/ dependency • Ethical and professional responsibilities of human resources in drug treatment • Family systems in the context of drug use and abuse • Information for the family and community • Management of resistance to treatment and changing behavior • Post–treatment plans: reinsertion to society and the workplace • Relapse prevention

Comparison of prevention training needs 2013 versus 2021

Table 53 below shows the prevention–related priority training needs for the two periods of assessment. The priority needs are those that 30% or more of the agencies identified as urgently needed. The priorities identified in 2021 were very dissimilar to those identified in the 2013 report.

Table 53: Comparison of Prevention Training Needs 2013 Versus 2021

2021 priority training needs	2013 priority training needs
• Community prevention/community risk and protective factors • Drug prevention program quality standards • Evidence–based program design • Family prevention or family risk and protective factors • Monitoring and evaluation • Primary prevention • School–based prevention or school risk and protective factors • Staff development • Sustainability and funding/writing proposals	• Delivery and monitoring • Dissemination and communication • Ethical drug prevention • Evaluation • Intervention environments and populations • Management and mobilization of resources • Promotion of comprehensive public policies for the prevention and treatment of addictions • Resource assessment • Workplace prevention

CHAPTER 3

Conclusion and Future Opportunities for Action

Prevention and treatment services are offered in each country by at least one agency. Agencies in all but four countries offered prevention–only services, while agencies in all but two countries offered treatment–only services. The data, therefore, show that all countries possess the capacity to offer prevention and treatment services. A notable percent (38%) were private or non–governmental agencies, while about 56% were either governmental or quasi–governmental agencies.

Not many agencies indicated having a training and development plan for staff – about a third – while only 34% had a training and development budget, and about four in ten had an officer responsible for training and development. The most predominant barrier to training was "no monetary incentive to further training" or "other cost–related barriers." Moreover, a notably high proportion of agencies indicated "geographic barriers or no local opportunity for training" as factors that limit training.

More than four in ten agencies provided either assessment, treatment, or rehabilitation services. Reinsertion services were offered by a slightly lower number of agencies. Outpatient services were offered in all but two countries by at least 37 agencies, while community care services were offered in all but one country by at least 31 agencies. The treatment services gaps were in relation to intensive outpatient services, which were offered by only eight agencies across eight countries (one agency per country), and residential treatment services, which were offered in 11 countries but by only 20 agencies total.

The five main therapeutic strategies for client treatment/management were offered by many agencies, with psychotherapy being the predominant strategy, followed by directed therapy and the 12–step program. Religious focused therapy and alternative therapies were used to a lesser extent. Agencies were involved in many activities that were geared toward adequate management of their clients, such as clinical evaluation, treatment of physical or psychological illnesses, counseling, harm reduction, and referral to social services or primary health care services. Drug treatment services offered by the agencies covered a wide cross–section of the population—adults (both male and female), children, dual diagnosed clients, people with mental or physical disabilities, the homeless, the LGBTQ community, and patients referred by order of the courts.

Drug treatment training and certification within the last 12 months prior to the survey was not widespread; only 16 agencies (18%) responded yes. More than a quarter of the agencies expressed an urgent need for training in all the areas outlined in the survey instrument. The 15 subject areas identified for urgent treatment–related training are listed on page 60 and include such areas as conflict resolution, ethical and professional responsibilities of human resources in drug treatment, relapse prevention, family systems in the context of drug use and abuse, and design of treatment plans for drug abuse or dependency.

The subject areas with the most urgent need for prevention–related training included monitoring and evaluation, primary prevention, community prevention, evidence–based program design, and staff development.

The findings of the assessment can be used to address training and development needs in drug treatment and drug use prevention in the member states. The findings also suggest that many opportunities exist for future actions, the development of which can be guided by the following recommendations.

Recommendations

1. Encourage agencies to develop training and development plans and to identify suitable staff for training opportunities.
2. With the new exposure to online training platforms due to the experiences during the COVID–19 pandemic, it should not be difficult to engage agencies in online training. Future training should seek to utilize and maximize these opportunities.
3. Based on the training and prevention needs to be identified as "urgent" or "needed but not urgently," efforts can be directed at developing targeted modular training (introductory or certification level) for online delivery that will seek to increase the exposure of critical staff members to various treatment and prevention concepts.
4. Support efforts being made by numerous agencies in the region to implement prevention programs as well as provide assessment, treatment, and rehabilitation services.

Appendix 1

Mapping Guidelines and Template

A national point–person (point of contact) was identified and tasked with coordinating national teams of prevention and treatment experts for both the mapping and the assessment exercises. The following basics guidelines and template were shared with the points of contact to guide the mapping exercise.

Basic Guidelines for Identifying Treatment Institutions:[2]

Please include all institutions in your country offering pharmacological and/or psychosocial interventions for substance use disorders to stop or reduce drug use; improve health, well–being, and social functioning of the affected individual; and prevent future harms by decreasing the risk of complications and relapse.

Treatment services include community–based outreach; services in settings not specialized for the treatment of people with substance use disorders; inpatient and outpatient treatment; medical and psychosocial treatment (including the treatment of alcohol and other substance use disorders as well as other psychiatric or physical health comorbidities); long–term residential or community–based treatment or rehabilitation; and recovery–support services.

Specific treatment modalities and interventions can be delivered through: Screening, Brief Interventions and Referral to Treatment (SBIRT); psychosocial interventions; pharmacological interventions; overdose identification and management; and/or the treatment of co–occurring psychiatric and physical health conditions.

Essential treatment services for drug use disorders can be available at different levels of health systems, from primary health care to tertiary health services, with specialized treatment programs for substance use disorders.

2 Information based on the International Standards for the Treatment of Drug Use Disorders. Available at: https://www.unodc.org/documents/drug–prevention–and–treatment/UNODC–WHO_International_Standards_Treatment_Drug_Use_Disorders_April_2020.pdf

Mapping Template

Name of organization	
Acronym of organization	
Full postal address	
Organization telephone number	(000) 000-0000
Organization e–mail address	
Name of host organization	
Name of contact person	
Position of contact person	
Contact person email address	
Contact telephone number	(000) 000-0000
Core or main business of the organization	

Appendix 2

Survey Instrument

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SECTION 1 - CONTACT INFORMATION

1- Organization name, full address, email, and telephone information

Organization Name	
Address	
Address 2	
City/Town	
ZIP/Postal Code	
Country	
Email Address	
Phone Number	

2- Name of Parent Institution (If any)

3- Mission statement of the organization

4- Country (pick list)

5- Organisation Website (If any)

6- Name of Respondent

7- Position of Respondent

8- Respondent's Email Address

9- Respondent's Telephone Number (XXX-XXX-XXXX)

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SECTION 2 - ORGANIZATION PROFILE

The questions in this section will help us to better understand your organization, the servicesprovided and the operational methods.

10- Which of the following best describes your organization? (Please tick one answer only).

- [ ] Governmental
- [ ] Statutory Body/Quasigovernmental
- [ ] Private/Nongovernmental
- [ ] Other (please specify)

11- At what geographic level(s) does your organization operate? (Please tick all that apply).

- [ ] Hemispheric
- [ ] Regional
- [ ] National
- [ ] Island
- [ ] District/Parish
- [ ] Community/Village
- [ ] Other (please specify)

12- Is the organization required to be registered with a relevant authority in your country to operate?

- [ ] Yes
- [ ] No

13- Are the treatment or prevention staff in your organization required to be licenced by a relevant authority to operate?

	Yes
	No

14- Do clients have to pay for treatment services/prevention services received from the organization?

	Yes
	No

15- Other (please specify)How many staff work in your organization? Please include all staff (administrative, clinical, technical, security, and all support staff).

Total number of staff	

16- How many of the following categories of staff does your organisation employ

Full-time Staff	
Part-time Staff	
Volunteers	

17- Of the total number of staff in your organization, how many of are male and how many female?

Males	
Females	

18- Indicate the number of staff in your organization with the following academic qualifications as their highest educational level. (Each staff member should only be counted once).

Less than High School Education	
High School Diploma	
Technical Degree	
College/University Degree	
Graduate Degree	
Post Graduate Degree	
Other	

19- Of the persons who work in this organization, either full-time, part-time or volunteer, please say how many of them are of the following categories?

Medical doctor	
Nurses	
Psychiatrist	
Psychologist (registered)	
Social worker	
Administrative staff	
Occupational therapist	
Treatment specialist (certified)	
Nutritionist	
Religious leader	
Prevention specialist (certified)	
Security personnel	
Researcher	
Kitchen (staff/cook)	
Recovering addict	
Cleaning and maintenance	
Other (specify)	

DOES YOUR ORGANIZATION HAVE ANY OF THE FOLLOWING?

20- A formal training and development plan for staff:

- [ ] Yes
- [ ] No

21- Training and development budget:

- [ ] Yes
- [ ] No

22- An officer responsible for training and development of staff:

- [ ] Yes
- [ ] No

23- A regular and formal appraisal system covering all permanent staff:

	Yes
	No

24- From the following list of potential barriers to training, please select those that are true or reflect the situation in your organization. (Please answer each question).

Cost of training too high	
Lack of interest by staff	
Lack of availability of relevant courses	
Geographical barriers/ No local opportunities for training	
Lack of career guidance or counseling	
No monetary incentive to further training	
Geographical barriers/ No local opportunities for training	
Other (please specify)	

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SECTION 4 – OTHER RESOURCES

In this section, please indicate what other resources are available to your organization (material and/or financial)

25- Which of the following resources are available at your organization? (tick all that apply)

- [ ] Internet
- [ ] Laptop computer
- [ ] Desktop computer

26- Does your organization actively participate in a local Drug Information Network (DIN)?

- [ ] Yes
- [ ] No

27- Does your organization have the capacity to use the internet in relation to drug-related activities such as treatment, prevention, research, sharing of information, etc?

- [ ] Yes
- [ ] No

28- During the past

- [ ] Self-funded
- [ ] Government
- [ ] Other Local NGO/Private Donor
- [ ] International donor
- [ ] Other (please specify)

29- During the past 12 months, in addition to your primary source of income, did your organization receive funds from any of these other sources? (Please answer each question). yes/no

	Yes	No
Self-generated		
Government		
Other local NGO/Private Donor		
International donor		
Other		

30*- Are you a dedicated ***prevention only*** service provider? If your answer is yes, you will be skipped to the prevention needs module (Section 11) of this questionnaire. If answer is no you will be continuing with the questions in Section 5.

	Yes
	No

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SECTION 5 - DRUG TREATMENT SERVICES

This section collects information on the characteristics of the care offered by your organization, the population served, etc.

31- Does your organization provide any national level input for any of the following (tick all that apply)

	Policy/advisory
	Drug treatment protocols
	Strategic plan for treatment services
	Drug Court operations
	Drug treatment advocacy

32- Which of the following treatment services does your organization currently provide? (Tick all that apply)

	Assessment
	Treatment
	Rehabilitation
	Reinsertion

SPECIFIC CHARACTERISTICS OF THE CARE OFFEREDTREATMENT MODALITIES

33- With respect to treatment services, how would you categorize your organization? (Tick all that apply).

	Outpatient Treatment: Treatment in a non-residential setting; limited stay (hours); e.g., Outpatient consultation
	Intensive Outpatient Treatment: Treatment in a non-residential setting; stay of several hours during the day (Day Hospital service)
	Residential Treatment: Inpatient treatment; stay of 24 hours in a residential facility; structured emphasis. E.g. medium-term treatment community
	Residential Treatment in a hospital framework: Inpatient treatment; stay of 24 hours; emphasis on general/specialized care: e.g. short or medium-term medically managed residential setting
	Community Care Services/ Self Help Groups: Psycho-social support structures that reinforce the interventions at the various phases of the treatment, e.g. AA or NA
	Other (please specify)

34- Please indicate which therapeutic strategies are offered at your organization? (Please answer each question).

	Yes	No
12 Step Programme		
Psychotherapy		
Directed Therapy		
Alternative Therapies		
Religious focus		
Other (please specify)		

SERVICES OFFERED

35- Please indicate which of the following services/activities are offered by your organization? (Please answer each question).

	Yes	No
Clinical evaluation of the addiction		
Pharmacological Treatment		
Substitution therapies with methadone or buprenorphine		
Treatment of physical and/or psychological illnesses NOT associated with drug use		
Prevention and early detection of illnesses (HIV, TB, Hepatitis, etc.)		
Physical Rehabilitation		
Counselling		
Social and occupational reinsertion		
Relapse Prevention		
Harm reduction (needle exchange, condom distribution, safe sex practices)		
Referral to social services or primary health care services		
Services specific to the LBGTQ community/person		
Other (please specify)		

36- How many beds does your organization have for inpatient treatment?

Number of beds	

37- Please indicate which of the following populations substance use/misuse treatment is offered by your organization. (Please tick all that apply)

	Male children from 0 to 11 years
	Male adolescents from 12 to 17 years
	Young male adults from 18 to 29 years
	Male adults 30 years or older
	Female children from 0 to 11 years
	Female adolescents from 12 to 17 years
	Young female adults from 18 to 29 years
	Female adults 30 years or older
	Pregnant women
	Dual diagnosed patients
	Women with children
	People with physical disabilities
	Homeless children
	People with mental disabilities
	Homeless Adults
	People with medical illnesses that require special care
	Patients referred by order of the judge for criminal cases Patients referred by order of the judge for civil cases
	LBGTQ community
	Other (please specify)

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SECTION 6 - EFFECTIVE DEMAND AND PERFORMANCE OF THE ORGANIZATION _

38- How often do family members of patients participate in the treatment process? (choose only one answer)

	Always
	Almost Always
	Frequently At times
	Almost never
	Never

39- During the last 30 days, approximately how many patients received treatment for substance use or misuse problems at your organisation?

Total Number of Patients	

40- Of the patients seen for treatment during the past 30 days, how many were previously treated for substance use/misuse problems either at your organization or elsewhere?

Number of Patients Previously Treated	

41- Indicate at least three age-appropriate treatment measures/services currently being implemented by your organization tailored to the specific needs of children, youth or women

Measure 1	
Measure 2	
Measure 3	

42- Indicate the appropriate treatment measures/services currently being implemented by your organization tailored to the specific needs of the LBGTQ community?

Treatment measure re LBGTQ 1	
Treatment measure re LBGTQ 2	
Treatment measure re LBGTQ 3	

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SECTION 7 - TRAINING AND TRAINING NEEDS IN TREATMENT

43- Have any of your staff received certification training in a treatment-related field in the past 12 months? If no, you will go to section 8 and continue.

	Yes
	No

44- If yes, how many of your staff have been trained in the following areas? (Indicate the number trained for each item)

Basic concepts of drug dependency	
Treatment models: outpatient and residential	
Pharmacological treatment of drug abuse and dependency	
Treatment for patients with dual diagnosis	
Administration of medicines/ drugs	
Counseling techniques: individual, group, family	
Assessments (brief, in depth, ongoing)	
Case management	
Clinical evaluation	
Counselling and coordinating services/ case referral	
Design of treatment plans for drug abuse/dependency	
Family systems in the context of drug use and abuse	

Management of resistance to treatment and changing behaviour	
Relapse prevention	
Information for the family and community	
Post-treatment plans: reinsertion to society and the workplace	
Institutional administration: management of treatment centers	
Data collection and electronic data entry/filing	
Ethical and professional responsibilities of human resources in drug treatment	
Conflict resolution	

45- Please indicate how important to your organization is the need for training in each of the following treatment-related concepts. (Tick the appropriate response for each item).

	not needed	needed but not urgently	needed urgently
Basic concepts of drug dependency			
Treatment models: outpatient and residential			
Pharmacological treatment of drug abuse and dependency			
Treatment for patients with dual diagnosis			
Administration of medicines/drugs			
Counselling techniques: individual, group, family			
Assessments (brief, in depth, ongoing)			
Case management			
Clinical evaluation			
Counselling and coordinating services/case referral			

	not needed	needed but not urgently	needed urgently
Design of treatment plans for drug abuse/ dependency			
Family systems in the context of drug use and abuse			
Management of resistance to treatment and changing behaviour			
Relapse prevention			
Information for the family and community			
Post-treatment plans: reinsertion to society and the workplace			
Institutional Administration: management of treatment centres			
Data collection and electronic data entry/ filing			
Ethical and professional responsibilities of human resources in drug treatment			
Conflict resolution			
Other (please specify)			

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SECTION 8 - OTHER SERVICES OFFERED

46- In which of the following activities is your organisation involved? (Please tick all that apply)

	Coordination of activities
	Policy development at the national level
	Drug related treatment or prevention activities with Law Enforcement
	Drug related treatment or prevention activities with Probation Services
	Sanctions/Punishment (e.g. prisons, industrial schools, etc)
	Health care – Curative
	Health care – Preventative
	Information Management
	Monitoring and Evaluation
	Research
	Education/training
	Outreach
	Lobbying
	Other (please specify)

47*- Do you currently offer services for drug treatment court clients?

	Yes
	No

48- If yes, please list the services provided?

Drug Court Services 1	
Drug Court Services 2	
Drug Court Services 3	

49*- In the past year have you identified any new risk factor or conditions that make women and girls vulnerable to participation in drug-related activities?

	Yes
	No

50- If yes, please specify:

Risk Factor 1	
Risk Factor 2	
Risk Factor 3	

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SECTION 9 - PERCEPTION OF THE PROBLEM AND NEW DRUGS

This section collects information on drugs that motivate the demand for treatment and new substances

51- What are the three substances that most frequently impacted clients presenting for treatment? (choose only the most important three)

- [ ] cigarettes
- [ ] alcohol
- [ ] marijuana
- [ ] crack cocaine
- [ ] cocaine powder
- [ ] ecstasy
- [ ] pharmaceuticals
- [ ] other (please specify)

52*- In the last year, have you detected new drugs being consumed?

- [ ] Yes
- [ ] No

53- If yes, please specify the substance(s) and route of administration.

54*- Are you aware of any new drug treatment service providers that are currently offering treatment services to clients?

- [ ] Yes
- [ ] No

55- If yes, can you provide the name(s) and contact details so they too may be contacted to participate in this assessment.

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SECTION 10 - IMPACT OF COVID-19 ON DRUG TREATMENT DEMAND FOR YOUR ORGANIZATION

This section collects information on the impact of the present COVID-19 pandemic on your operations

56- Please indicate whether positive cases of COVID 19 were identified among clients, family members or staff with respect to your organization's operation? (tick all that apply)

- [ ] Residents
- [ ] Family
- [ ] Staff
- [ ] None identified

57- During the pandemic period, which protocols were implemented on COVID 19? (tick all that apply)

- [ ] Protocols of official organizations (Government stipulated)
- [ ] Own written protocols
- [ ] Informal own protocols (not written)
- [ ] No protocol
- [ ] Other (please specify)

58*- Did you continue to care for people in treatment?

- [ ] Yes
- [ ] No

59- If yes, What strategies were developed to guarantee the continuity of residential treatments? (Tick all that apply)

- [ ] Restriction of visits
- [ ] Exit restriction
- [ ] Virtual meetings with families
- [ ] COVID-19 symptom control
- [ ] Social distancing
- [ ] Facial masks
- [ ] Temperature checks
- [ ] Other (please specify)

60- What strategies were developed to guarantee the continuity of ambulatory treatments? (Tick all that apply)

	Virtual meetings with patients
	Virtual meetings with families
	Telephone tracking
	Group virtual meetings
	Other (please specify)

IF YOU ORGANIZATION ONLY OFFERS TREATMENT SERVICES, YOU HAVE COME TO THE END OF THE QUESTIONNAIRE. WE THANK YOU FOR YOUR PARTICIPATION, PLEASE ANSWER THE NEXT QUESTION IN ORDER TO COMPLETE AND SUBMIT THE SURVEY.

61*- Does your organization ***only*** offer treatment services?

	Yes
	No

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SECTION 11 – TRAINING AND TRAINING NEEDS IN SUBSTANCE USE PREVENTION SERVICES

The following questions seek to gather information on the substance use prevention services provided by your organization. Please respond based on actual practices

62- Please indicate which of the following populations are targeted by your organisation for its drug preventionprograms. (Tick all that apply)

	Pre-school Age		Street adults
	Primary School Age (Elementary)		Incarcerated Individuals
	Secondary School Age (Junior or Senior High)		Ex-convicts
	College/University		Sex workers
	Street Children (5-12 years)		Adult population (18-65 years)
	Street Youth (13-17 years)		LBGTQ community
	Out of school youths		Other (please specify)
	Detained adolescents		

63- What are the environment(s) in which your organisation carries out its drug prevention interventions? (Tick all that apply)

	Primary Schools		Colleges/Universities
	Secondary Schools		Prisons
	Health Care Settings (e.g., hospitals, clinics)		Workplace
	Family Setting		Other (please specify)
	Community Organizations (e.g., churches, youth groups, sports clubs)		

64- Over the past 12 months, how many of your staff have received certification training in the following areas?

Introduction to prevention science	
Basic prevention principles	
The theory of change in prevention programs	
Comprehensive (environmental) prevention	
Drug prevention program quality standards	
Family Prevention or Family risk and protective factors	
Community Prevention or Community risk and protective factors	
School-based Prevention or School risk and protective factors	
Workplace Prevention or Workplace risk and protective	
Self-risk and protective factors	
Peer risk and protective factors	
Professional ethics in drug prevention	
Primary prevention (Prevention)	
Secondary prevention (Treatment)	
Tertiary prevention (Rehabilitation and Integration)	
Universal prevention	
Selective Prevention	
Indicated prevention (Screening and brief intervention)	
Sustainability and funding/ writing proposals	

Communication and stakeholder involvement	
Staff development	
Needs assessment	
Resource assessment	
Program formulation	
Intervention design/ Intervention for targeted populations	
Evidence-based program design	
Monitoring and Evaluation	
Dissemination and Communication	
Legal and normative regulations regarding drug use	
Promotion of comprehensive public policies for the prevention and treatment of addictions	
Others (specify)	

65- Please indicate how important is the need for training in each of the following prevention-related concepts for your organization. (Tick the appropriate response for each item).

	not needed	needed but not urgently	needed urgently
Introduction to prevention science			
Basic prevention principles			
The theory of change in prevention programs			
Comprehensive (environmental) prevention			
Drug prevention program quality standards			
Family prevention or family risk and protective factors			
Community prevention or community risk and protective factors			
School-based Prevention or School risk and protective factors			
Workplace prevention or workplace risk and protective factors			
Self-risk and protective factors			
Peer risk and protective factors			
Professional ethics in drug prevention			
Primary prevention (Prevention)			
Secondary prevention (Treatment)			
Tertiary prevention (Rehabilitation and Integration)			
Universal prevention			
Selective prevention			
Indicated prevention (Screening and brief intervention)			
Sustainability and funding/writing proposals			
Communication and stakeholder involvement			
Staff development			
Needs assessment			
Resource assessment			

	not needed	needed but not urgently	needed urgently
Program formulation			
Intervention design/ Intervention for targeted populations			
Evidence-based program design			
Monitoring and evaluation			
Dissemination and communication			
Legal and normative regulations regarding drug use			
Promotion of comprehensive public policies for the prevention and treatment of addictions			
Others			
Other (please specify)			

66- Are you aware of any new prevention service providers that are currently offering prevention services to clients?

	Yes
	No

67- If yes, can you provide the name(s) so they too may be contacted to participate in this assessment.

68- PLEASE RATE YOUR COMFORT LEVEL WITH FILLING IN THIS QUESTIONNAIRE

uncomfortable	somewhat uncomfortable	neither comfortable or uncomfortable	fairly comfortable	very comfortable
★	★	★	★	★

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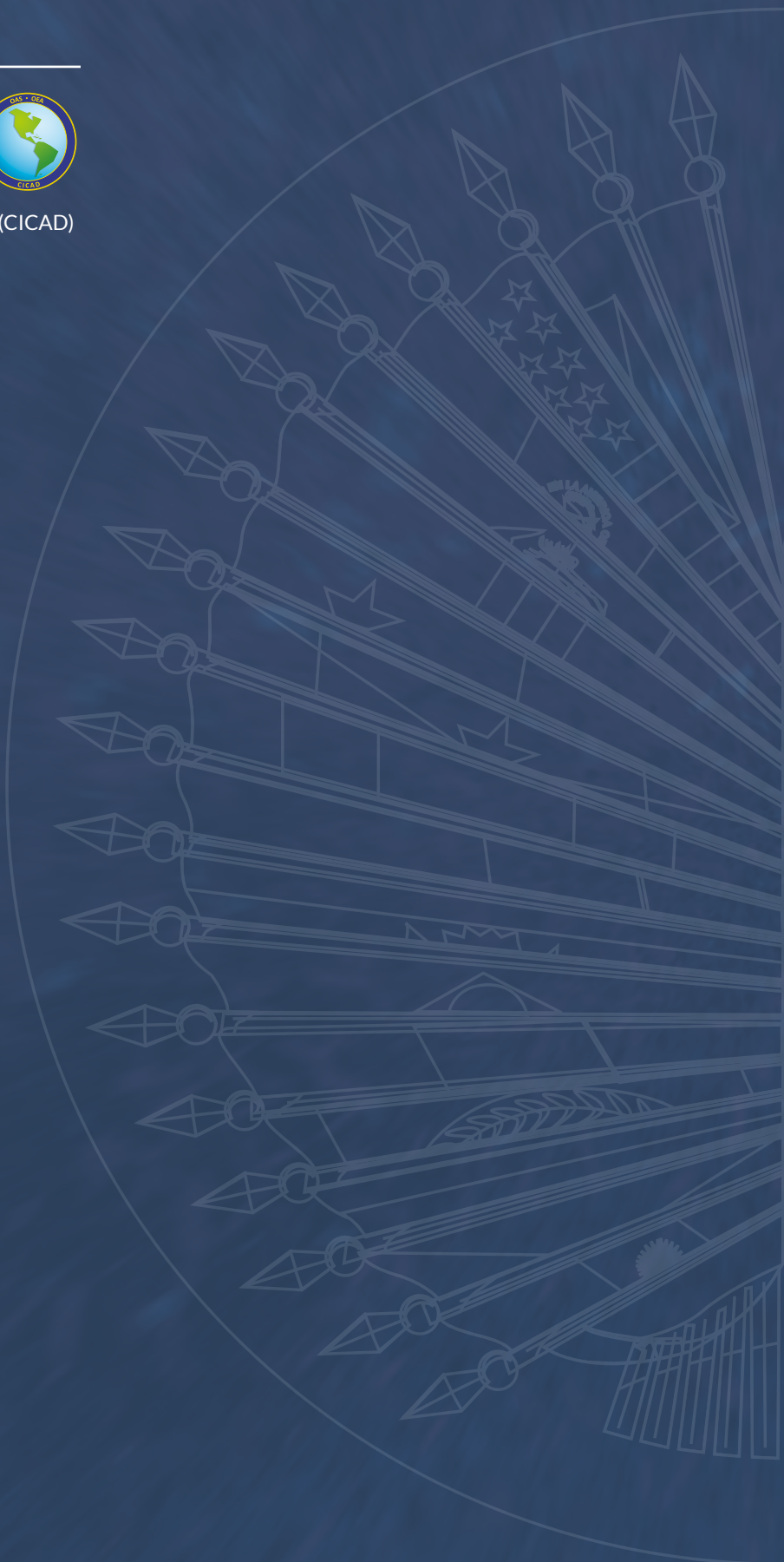

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