VIOLENCE AND MENTAL HEALTH

OPPORTUNITIES FOR EARLY DETECTION AND TREATMENT

Denise Simpson
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Citizen Security and Justice Programme III
Ministry of National Security

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MINISTRY OF NATIONAL SECURITY

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FOREWORD

Projects come and projects go; knowledge sustains. It was while contemplating the many facets of the imminent closing out of the Citizen Security and Justice Programme III (CSJP III) that this, what I would like to term, aphorism, came to mind. While we, the CSJP III staff members, prepared our clients, our communities and our implementing partners for the end of the CSJP III; while we took on the challenges of transitioning services to the relevant Ministries, Departments and Agencies (MDAs) in order to ensure sustainability of CSJP III; it was recognized that the deepest form of sustainability was not the motivational interviewing, job preparedness, training and referrals we were providing to our young men and women. It was also not opportunities for grant support to which we were referring our community organizations; not the Memoranda of Understanding we were arranging with our partners such as the National Parenting Support Commission, National Council on Drug Abuse and HEART/NTA. The deepest form of sustainability to be derived from CSJP III resides in the evidence-based knowledge that the programme generated over the years. This sustainability is assured when the knowledge is shared with all stakeholders in order to enhance and deepen the impact of their respective policies, programmes and practices. The Citizen Security and Justice Programme commenced in 2001 and over the almost 20 years of its implementation in a majority of the most volatile and vulnerable communities in Jamaica, it garnered a wealth of knowledge about violence prevention. Under the final phase, the CSJP III, a robust Monitoring and Evaluation system was put in place. This, coupled with the programme's Case Management system, collected evidence on the effectiveness of some of its most critical interventions. Independent impact evaluations were conducted for the Parenting Education and Vocational Skills Training components of the CSJP III, while a rigorous qualitative evaluation of the Violence Interruption Programme (VIP) was conducted by an independent consultancy. It is critical that the knowledge and insights derived from these and other assessments are shared with stakeholders through the provision of published documents.

Along with a symposium, the knowledge sharing initiative of published documentation seeks to strengthen the capacities of policymakers and practitioners to design, implement and evaluate policies and programmes for crime prevention. The knowledge products

focus on Parenting Education, Violence Interruption and Case Management, which are three of the main pathways to violence prevention and for which evidence is provided as to their efficacy. The knowledge products also treat with the mental health issues of depression and substance abuse as well as pervasive social norms supportive of violence. Over the three phases of the Programme, the CSJP constantly pursued new and innovative ways to improve the impact of its services. The results of this pursuit can be seen in the pioneering Parenting Education programme which included home-based training delivered over a six-month period by trainers mostly drawn from the same communities as the parents. The CSJP III pioneered the use of a case management approach to violence prevention in which locally developed risk assessment instruments were normed and used. The Violence Interruption programme saw the adoption and adaptation of a model from outside the country—a model which brought structure and coherence to efforts which had previously spanned years of implementation. Another major action under the CSJP III was the establishment of a Psychological Services Unit in the Programme Execution Unit (PEU) staffed with psychologists and social workers. This action arose from a lesson learnt over the previous phases of the programme, namely, that the psychosocial challenges of our clients must be addressed in order to achieve sustained behaviour change. The papers on Depression and Substance Abuse came out of that process. The writers are mostly programme staff who, over the years, have worked closely in their respective fields. Early in the second phase of the Programme it was recognized that the CSJP experience was fertile ground for research and documentation. The PEU therefore facilitated research students to gather information on the programme as a whole or on specific services which it delivered. The programme is heartened by the contribution of its own staff to the knowledge documentation and sharing process as reflected in these products. We also recognize and appreciate the contribution of non-staff writers.

Four central observations that the knowledge products highlight are: (i) the high level of social dysfunction pervading vulnerable and volatile communities; (ii) the necessity for a crime prevention programme to utilize community human resources; (iii) the urgent need for a robust and sustained social norms campaign; and (iv), the urgent need for an effective multi-agency collaboration arrangement. Feelings of hopelessness and entrapment are pervasive among community residents, especially among young people, who, as the relevant papers note, become victims of depression and substance abuse. Limited

access to opportunities for self-advancement, exacerbated by the psycho-emotional challenges, becomes the biggest barrier to what Dr. Herbert Gayle in his assessment of the Violence Interruption Programme termed ontological security. The evidence is there that the de-concentration of poverty and the reduction in social and economic inequity must be central planks of the crime prevention agenda. At the core of both the Parenting Education and the Violence Interruption programmes is the recruitment, training and deployment of community persons to deliver the services. The Parenting Education programme recruited and trained community residents as Community Parent Trainers while the Violence Interruption programme recruited and trained community residents as Violence Interrupters. Using this strategy, not only do the services become more accessible and effective but, in addition, the capacities of communities are built in a sustainable manner. Central to addressing crime and violence is the changing of cultural and social norms that are supportive of violent behaviour. However, as noted by the Social Norms Survey and accepted in the theory and practice of the socio-ecological approach to behaviour change, a norm such as the acceptance of reprisal can be mitigated by having a justice system wherein victims feel confident that their victimization will be swiftly and fairly addressed. Notwithstanding, the role of the individual in changing social norms is also recognized. Therefore, a sustained public education campaign is urgently needed in which those individuals at risk of perpetrating pro-violence behaviours, those community human resources, are mobilized to play a central role in its design, implementation and evaluation. Furthermore, the multi-agency collaboration of such a campaign cannot be overemphasized.

Crime prevention must be addressed through a tight partnership between various MDAs. The resources spent on teaching a parent positive parenting practices could achieve greater outcomes if that parent did not have to be "stressed" by trying to figure out from where the next meal was coming. The future of a young man whom a Violence Interrupter motivated to leave a gang would be more secure if that young man had access to employment or training. To date, no strong institutional arrangement exists for MDA collaboration but the proposed National Commission on Violence Prevention (NCVP) signals recognition of the need to establish a mechanism that will help to address governance arrangements for the multi-sector collaboration. However, the impact of crime and violence on the country, the necessity for it be treated through effective multi-agency

partnerships and the failure of mechanisms that have so far been attempted, point to the need for a new approach. It is therefore being posited that, in addition to the proposed NCVP, it is essential to have a public sector reform thrust which is conceptually grounded in a systems approach. With this approach, crime prevention would be embedded in all related MDAs in a comprehensive, integrated and sustainable manner.

I wish to commend the PEU staff, community representatives and other implementing partners for the commitment they have demonstrated to improving the lives of residents of the participating communities. Special mention is made of Mr. Simeon Robinson, former Programme Manager of the CSJP, for his unwavering commitment to the success of the Programme. The International Development Partners involved with the CSJP have been a pillar of support—the Inter-American Development Bank; the Department for International Development, UK; and Global Affairs Canada have been true partners throughout the journey. No CSJP would have existed without the support of the Ministry of National Security, parent ministry of the CSJP, Ministry of Finance and the Public Service and the Planning Institute of Jamaica.

The knowledge products produced by the CSJP III, if used by the relevant decision makers and practitioners, will make a lasting contribution to the prevention of crime and violence in Jamaica. As I have often said to our young, risk-disposed clients, the CSJP III as a programme may be ending but it will continue to live through the positive attitudes and behaviours learnt with its assistance. Further, the transition of selected CSJP III services to the relevant MDAs signals the Government's recognition of Jamaica's crime problem and its commitment to crime prevention. I am confident that the Government of Jamaica (through the various MDAs), policy makers, practitioners and academia recognize the contribution of the CSJP and will contribute to its sustainability by making good use of these knowledge products.

Orville Simmonds
Programme Manager
Citizen Security and Justice Programme III

PREFACE

The Citizen Security and Justice Programme (CSJP) is a multi-faceted crime prevention and violence reduction initiative of the Ministry of National Security, which focuses on building community safety and security. The general objective of the CSJP was to enhance citizen security and justice in Jamaica in 50 targeted communities. The specific objectives were to improve behaviours for non-violent conflict resolution; increase labour market attachment among youths; and increase access to effective community and alternate justice services.

Some interventions under Component 1 of this Programme—Culture Change for Peaceful Co-existence and Community Governance—include the provision of knowledge, skills, and opportunities that allow the residents of the target communities to challenge and change attitudes and behaviours that promote or tolerate violence.

The programme was funded by the Inter-American Development Bank (IDB), the UK's Department for International Development (DFID) and Global Affairs Canada (GAC). It was delivered through the Programme Execution Unit (PEU) attached to the Ministry of National Security (MNS).

The Programme in its third phase introduced a Case Management approach to the interventions that were implemented. Of significance to this process was the Psychological Services Unit (PSU), which assisted beneficiaries to change attitudes and behaviours relating to interpersonal relations. Much has changed in the 18 years of CSJP interventions. Whereas consultations with communities were the chief focus of the services delivered in the early years, the new thrust as of 2014 influenced the introduction of the Case Management approach. Activities that were developed and implemented in this social services programme include, data collection, holistic interventions, and monitoring and evaluation of interventions that informed best practices in the field of behavioural sciences.

The development of gender-responsive psychotherapeutic and psychosocial support for the risk-assessed beneficiaries of the programme was among the tasks of the PSU. The objective of this initiative was to reduce the distress of these beneficiaries in the case management system. The interventions and strategies were designed to improve their mental and emotional health, and therefore assisted them in making positive changes in

their lives, as they sought to improve their educational and technical skills.

The Unit ensured that systems were in place and were working effectively for the clinical and professional support of all beneficiaries as needed, to address emotional, psychological, and behavioural issues, such as depression and substance abuse. The unit was staffed with psychologists, social workers, and a criminologist, who delivered psychotherapeutic and psychosocial services. These services included Parenting Education, Substance Abuse Treatment, Individual and Group Counselling, and referrals to medical doctors, psychologists and psychiatrists.

It was noted that the psychosocial dysfunctions of beneficiaries were a major factor contributing to their anti-social, violent and criminal behaviours. Therefore, by using a holistic approach, psychosocial interventions were designed to assist clients with managing their psychological, cognitive and behavioural health challenges, and to support them in making positive choices that would lead to affirmative changes to their lives.

As referenced in this paper, data collected by one institution showed that depression was common among adolescents and youths in Jamaica. The CSJP impact evaluation of 2015 also confirmed this phenomenon among the youths who are engaged in the programme. The data collected by the Central Region PSU using the Beck Depression Inventory (BDI - II) also showed that a high percentage (71.0 per cent) of the youths were experiencing moderate to severe depression.

The copious discussions about the medicinal use and benefits of marijuana that are taking place in Jamaica today, and the recent decriminalization of marijuana, have generated many different opinions regarding drug misuse and its treatment. It is evident that there is a great need for increasing awareness, and educating the general public on the meaning and implications of the use or misuse of marijuana. Hopefully, by sharing of this knowledge document, policy makers and implementers of social interventions will have an enhanced understanding of the influences of mental illnesses such as depression, and the abuse of substances such as marijuana, alcohol, and nicotine on the rehabilitation of at risk youths.

Melva Spence PhD
Psychological Services Coordinator

ACKNOWLEDGEMENTS

Special acknowledgment is deserving to Mr. Simeon Robinson who served as Programme Manager for the CSJP Programme for approximately 17 years is deserving of special acknowledgement. His successor Mr. Orville Simmonds is also deserving of much recognition, for without his vision these knowledge based documents would not be available. The writers of the articles would also like to express thanks for the support of the CSJP staff, especially the members of the Psychological Services Unit (PSU) and the practicum students who were assigned to the Unit. The invaluable work of the NCDA staff in data collection and the treatment modality cannot be overstated as this document on substance abuse would not have been possible without their instrumental contributions.

Additionally, we wish to express our gratitude to persons such as Mrs. Kerry-Ann McPherson who helped with Statistical Analysis for the Depression article, persons who vetted and made suggestions, and the beneficiaries who were a part of the interventions. In particular, Dr. Melva Spence, Coordinator for the CSJP's Psychological Service Unit is deserving of acknowledgement, as, in addition to being a co-author, she guided the entire process for both journal articles. Her creative and indefatigable persistence and deep appreciation for the value of mental health intervention have led us to this milestone.

Finally, we are giving thanks to the almighty God for knowledge, strength, sustenance, grace, the ability to complete the project and the opportunity to contribute to knowledge creation and sharing in the mental health field.

ABOUT THE AUTHORS

Denise Antoinette Simpson holds a Master's degree in Human Resource Development (Distinction) from the University of the West Indies (UWI), Mona, as well as a Master's degree in Counselling Psychology (Honours) from the Caribbean Graduate School of Theology (Jamaica). In 2014 Ms. Simpson received the *Excellence in Teaching* award for outstanding teaching in the Faculty of Social Sciences, UWI, Mona. She is a published author. Her first anthology, *The Light & Black I Am is a collection of poetic reflections; her second publication, The Journey Inward: Techniques for Self-Understanding & Interpersonal Relations,* was used as a text for a course she facilitated for over ten years at the University of the West Indies. This text helps the reader to ask critical questions on self-awareness and communication patterns. Currently, Ms. Simpson is completing her PhD at the Northern Caribbean University and is employed as a Psychologist for the Central Region in the Citizens Security and Justice Programme within the Ministry of National Security.

Kenneth Barnes is a graduate of the University of the West Indies with a Master's degree in Social Work Administration. He currently serves as a Social Worker in the Citizen Security and Justice Programme of the Ministry of National Security. Mr. Barnes served as co-chair of the inner-city leadership training programme with the Jamaica Chamber of Commerce, facilitating programmes for inner-city project development. He is married to Peaches Gayle Barnes and is a father to four children.

Melva Spence PhD has worked with the CSJP since 2007—first as a Social Worker, and later as the Psychological Services Unit (PSU) Coordinator—where under her influence as a Counselling Psychologist she sought an expansion of the services delivered and the Psychological Services Unit was established. She began her career as a Trained Teacher from Church Teachers College in Mandeville. She went on to further studies at the Nova Southeastern University in Florida, where she completed her Bachelor of Science Degree in Elementary Education, and later a Master's degree and PhD, in Counselling Psychology at Northern Caribbean University. During her 12 years on staff in the CSJP she gained extensive experience partnering with various agencies at all levels in community social interventions in Jamaica. In her capacity as the PSU Coordinator she provides leadership

for a multi-disciplinary team, and oversees the implementation, monitoring and evaluation of methods used with an aim to improving the impact of subsequent social interventions for beneficiaries of the Unit. She has shared some of the best practices learned by CSJP locally and in the Caribbean.

Desmond Stewart worked in the CSJP with at-risk youth and their families first as a Community Action Officer for four years, and was then promoted to the position of Social Worker/Counsellor for an additional five years. He has assessed and referred many beneficiaries with Substance Misuse addiction in CSJP's Western Region for treatment to the NCDA. He has gained great insight and knowledge about the problem of Substance Misuse, assessing these cases, learning of the varied factors that led many youth and young adults to the point of addiction. He studied at Northern Caribbean University where he gained a BSc. in Social Work. Mr. Stewart decided to contribute to the article after seeing the addictive power of the various substances used by the CSJP's beneficiaries and the amazing dependence developed on these, to the point where the grave health implications are rationalized and trivialized by the misusers.

Patrina Thomas Morrison is the NCDAs Project Manager for the Citizen Security and Justice, and Drug Treatment Court Programmes at the National Council on Drug Abuse. Ms Morrison has extensive administrative experience and has served the Ministry of Education as a Dean of Discipline and as an instructor at various private educational institutions, including Northern Caribbean University. Ms Morrison, who is trained in the social sciences, combines her understanding of human behaviour with writing and editing. She is completing the Master of Arts degree in English Language at the University of the West Indies and holds two Bachelor's degrees, one in Psychology and the other in Social Work, from the Northern Caribbean University.

Acronyms and Terms

BDI-II	The Beck Depression Inventory – 2
CCMO	Community Case Management Officer
CSJP III	The Citizen Security and Justice Programme III
DFID	Department for International Development
GAC	Global Affairs Canada
IDB	Inter-American Development Bank
HEART/NTA	Human Employment and Resource Training Trust/National Training Agency
KMA	Kingston Metropolitan Area
MDAs	Ministries, Departments and Agencies
MNS	Ministry of National Security
NCDA	National Council on Drug Abuse
NCVP	National Commission on Violence Prevention
NPSC	National Parenting Support Commission
PEU	Programme Execution Unit
PSU	Psychological Services Unit
SPSS	Statistical Package for the Social Sciences
VST	Vocational Skills Training

Using The Beck Depression Inventory to Identify Depressive Symptoms in Jamaican Youths

DENISE SIMPSON MSc. MA

KENNETH BARNES MSc.

MELVA SPENCE PhD

ABSTRACT

OBJECTIVES

This study examined the prevalence of depressive symptoms in youths and sought to find the symptoms that tend to occur most frequently within this sample. The assessments were done at a treatment site within the Central Region of the Citizen, Security and Justice Programme (CSJP) under the Ministry of National Security (MNS).

METHODS

Participants aged 18 to 30 years completed the Beck Depression Inventory II (BDI-II) (Beck, Steer, and Brown, 1996), over the period January 2017 to December 2018. Other measures of socio-demographic background were also collected. Data gathered from the 21 categories of the BDI-II instrument were then entered into SPSS (Statistical Package for Social Sciences) for analysis.

RESULTS

A wide cross-section of at-risk youths from four parishes in rural Jamaica was sampled: (n=154; 61.0 per cent male, 39.0 per cent females; mean age =22.7. An analysis of the data showed that approximately seven in every ten participants (71.4 per cent) reported some symptoms of depression, with 16.9 per cent reporting mild symptoms; 22.7 per cent reporting moderate symptoms and 31.8 per cent reporting severe symptoms of depression. Symptoms that were most prevalent in this sample included sadness (73.9 per cent); punishment feelings (70.7 per cent); and guilty feelings (67.5 per cent).

Results also showed that there were significant differences by gender in the prevalence of depressive symptoms. Females were more likely to report depressive symptoms than males (p=.004). Additionally, the analysis revealed significant differences in educational levels for depressive symptoms. Participants who reported having primary/all age as the highest level of education were more likely to report depressive symptoms than those who reported having secondary/high school education (p=.024).

CONCLUSION

The use of the Beck Depression Inventory II (BDI-II) to assess depressive symptoms in youths in Jamaica is an effective way to identify prevalent symptoms that impact mental health for that population. Gender differences in depression scores are consistent with studies in other countries (Lowe 2005). In comparison to previous studies (Beck 1967), this sample had a higher percentage of youths scoring in the "none to minimal" depressive and severely depressed ranges.

These findings warrant closer examination of the factors contributing to depression among Jamaican youths. This information should be useful for practitioners working with similar populations.

BACKGROUND

Research led by the University of the West Indies in 2013 found that 71.9% of high school students were suffering from mild to severe symptoms of depression. Persons experiencing depression have often related having feelings of decreased interests in activities they used to enjoy, feelings of sadness, and other emotional challenges that are sometimes so severe that they interfere with personal and professional relationships. One research describes depression as emotional pain accompanying a sense of sadness that seems to be far greater than the context or circumstance in which it occurs. According to the article, the pain disrupts and profoundly affects the sufferer's view of the value of life, and traumatizes those who are closely involved with them. (Caribbean Health Research Council, 2010.) The staff of the CSJP Psychological Services Unit have seen clients struggle with the symptoms as real challenges, but with the correct diagnosis and help, they were able to overcome and move on with their daily activities. It is against this background that the staff of Psychological Services Unit sought to look at the data gathered in using the Beck Depression Inventory to treat the beneficiaries of the CSJP programme.

In 2015 data for an Impact Evaluation of the CSJP Vocational Skills Training (VST) beneficiaries were collected. The survey instrument was administered to 306 beneficiaries and the list was randomized after the beneficiaries were risked assessed for violence. Those selected for the CSJP menu of interventions were identified as moderately or highly at-risk for violence, and living in one of the communities served by the CSJP. The survey additionally revealed that 59.0 per cent of the respondents felt so sad or hopeless almost every day for two weeks that they stopped doing some usual activities. According to the researcher, if the beneficiaries are sad and depressed it will be difficult for them to study, work and make changes in their lives. The characteristics of this 2015 group of beneficiaries are similar to those in this study, and may even be some of the same risk assessed beneficiaries who were seen by the Psychological Services Unit.

THE PSYCHOLOGICAL SERVICES UNIT (PSU) IN THE CSJP-III

The PSU of the CSJP-III (PEU) was tasked to develop gender-responsive psychotherapeutic and psychosocial support aimed at reducing the distresses of risk assessed case managed beneficiaries. The interventions and strategies were aimed at improving their mental and

emotional wellbeing, and assisted them in making positive changes to their lives. The psychosocial dysfunctions of programme beneficiaries were a major factor contributing to anti-social, violent and criminal behaviours. By using a holistic approach, psychosocial interventions were designed to assist clients with managing their psychological health and behavioural challenges, and making positive changes to their lives. The Unit ensured that systems were in place, and were working effectively to provide the clinical and professional support of all beneficiaries as needed. Services delivered were carried out by the psychologists and social workers and included (i) Parenting Education, (ii) Substance Abuse Treatment, (iii) Individual and Group Counselling, and (iv), Referrals to medical doctors, psychologists and psychiatrists. The Beck Depression inventory was one instrument that was used in the initial assessment of all beneficiaries.

Beck Depression Inventory (BDI-II)

The Beck Depression Inventory (BDI) is a 21-item, self-report rating inventory that measures cognitive, affective and somatic symptoms of depression (Beck, et al. 1961). The individual must have experienced these symptoms within the past two weeks. BDI-II is designed for individuals aged 13 and over, and is composed of items relating to symptoms of depression such as hopelessness and irritability; cognitions such as guilt; or feelings of being punished; and physical symptoms such as fatigue and lack of interest in sex.

The BDI-II items are rated on a 4-point scale ranging from 0 to 3 based on severity of each item. The maximum score is 63. Raw scores and depression severity for the BDI-II are as follows: 0–13 indicates minimal (low) depression; 14–19 indicates mild depression; 20–22 indicates **moderate** depression; and 29–63 indicates severe depression.

Symptoms of Depression

Some common symptoms of depression are a depressed mood, accompanied by feelings of sadness, hopelessness and emptiness for most of the day, and nearly every day. In addition, some persons may frequently become tearful and their interest or pleasure in all or almost all activities is markedly diminished. Symptoms are also marked by significant weight loss or gain: for example, a change of more than 5.0 per cent of body weight within a month; significant increase or decrease in appetite nearly every day, and

insomnia or hypersomnia nearly every day. Other symptoms may be evidence of fatigue or loss of energy nearly every day; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate, or indecisiveness nearly every day; as well as recurrent thoughts of death. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning. (Diagnostic and Statistical Manual of Mental Disorders 2013).

Childhood emotional and physical abuse are major public health problems that have been linked to depression in adulthood (Widom et al. 2019). Smith and Moore (2013) have argued that increases in authoritarian parenting were significantly related to increases in depression. The American Psychiatric Association in its DSM-5 (2013) shows that depression is a common and serious medical illness that negatively affects how one feels, and the way one thinks and acts. Depression, which is considered the common cold of mental illness, causes feelings of sadness and/or a loss of interest in activities once enjoyed, can lead to a variety of emotional and physical problems and can decrease a person's ability to function at work and at home. Depression can vary from mild to moderate to severe.

Description of Intervention

Atkinson et al. (1996), characterized depression as a disorder of mood that is distinguished by four sets of symptoms: emotional, cognitive, motivational, and physical. Symptoms of depression are considered a normal response to stress, but become abnormal when the individual has difficulty recouping from the hopeless and unhappy state, as others would, from the challenges that would have plunged him/her into depression.

Research led by the University of the West Indies in 2013 found that 71.9 per cent of high school students were suffering from mild to severe symptoms of depression. This is described by the Caribbean Health Research Council (2010), as emotional pain, accompanied by a sense of sadness that seems to be far greater than the context or circumstance in which it occurs. This pain, it is said, disrupts and profoundly affects the sufferer's view of the value of life, and traumatizes those who are closely involved with them.

One of the main interventions offered through the PSU was individual counselling. These sessions gave the clients the opportunities to work one-on-one with the psychologist/social

worker to explore feelings, beliefs and behaviours. The beneficiaries then worked through challenging memories, and past experiences; and identified practical goals to resolve the issues that were raised so that growth could be enhanced. Interventions carried out included individual sessions, group sessions, psycho-educational workshops and life skills sessions. Psychometric tests were applied to assist in ascertaining the level or severity of difficulty that the client had with the particular emotional/behavioural challenge that was highlighted from the assessments and interview. Such tests included the Beck Depression Inventory (BDI), the Personality Assessment Screener (PAS), an Adult Sentence Completion Test, and Projective Tests, to name a few.

METHODOLOGY AND RESULTS

PARTICIPANTS

Data were collected from 154 participants from four parishes in rural Jamaica. The majority of the participants were male (94 or 61.0 per cent male, 60 or 39.0 per cent female). On average, participants were 22.7 years of age with a range from 18 to 30 years of age. In terms of demographic features (see table 1), 87.7 per cent of the participants had secondary/high as the highest level of education; while 7.1 per cent and 4.5 per cent indicated having vocational and primary/all age, respectively, as the highest level of education. With respect to employment status 84.4 per cent were unemployed whilst 14.2 per cent indicated having full-time, part-time or self-employed status.

Table 1: Demographics of Participants by age, gender, highest level of education and employment status

Demographics	n	%
n = 154		
Gender		
Male	94	61
Female	60	39
Age (mean = 22.7)		
Highest Level of Education		
Primary/All Age	7	4.5
Secondary /High	135	87.7
Vocational	11	7.1
Tertiary	1	0.6
Employment Status		
Full-time	7	4.5
Part-time	9	5.8
Self-employed	6	3.9
Unemployed	130	84.4
Student	2	1.3

MEASURES

As part of a larger battery of self-completed measures, participants completed the Depression Inventory II (BDI-II; Beck, Steer, and Brown 1996), over the period January 2017 to December 2018. Other measures of socio-demographic background were also collected.

In addition to the BDI-II, information was also collected on the participants' demographic characteristics, such as age, gender, educational level, employment status, and parish of residence. Such information was gleaned from the CSJP Intake Form that each participant was asked to complete.

Data Analysis

Computations were calculated with SPSS version 20. Frequency analysis was used to clean the data. BDI-II items related to change in appetite and change in sleep were recoded into different variables to reflect the same response pattern as the other symptoms.

With respect to employment, five levels of employment, as reflected on the CSJP Intake Form, were entered into SPSS: full-time, part-time, self-employed, unemployed and student. Employment status was then recoded into two categories. First category (employed) contained full-time, part-time and self-employed persons. The second was the unemployed category, while students were counted as missing.

RESULTS

Levels of depression among participants

An analysis of the data showed that approximately seven in every ten participants (71.4 per cent) reported some symptoms of depression (Table 2). Slightly more than a quarter (28.6 per cent) had BDI scores within the normal or minimally depressed range; 16.9 per cent of participants had scores that fall in the mild depression range; 22.7 per cent had scores in the moderate range; and the remaining 31.8 per cent of participants had scores in the severe depression range.

Table 2: Level of Depression among Participants Prevalence of depressive symptom	N	%
Low	44	28.6
Mild	26	16.9
Moderate	35	22.7
Severe	49	31.8

Gender differences in depression scores

The Mann-Whitney U Test revealed a significant difference in the prevalence of depressive symptoms by gender (p=0.023). Females (mean rank = 87.75) were more depressed than males (70.96). This concludes that gender plays a role in youth's experience of depressive symptoms.

Table 3: Prevalence of Depressive Symptoms by Gender

BDI Total Scores	Mean Rank
Males	70.96
Females	87.75
U=2205.000, p=.023	

The impact of educational level on participant's symptoms of depression

When Primary/All age and secondary education levels were analysed, the Mann Whitney U test revealed significant differences (p=.024) where persons with Primary/All Age education were more depressed (mean rank = 105.64) than those with Secondary/High school education (mean rank = 69.73).

Table 4: Prevalence of Depressive Symptoms by Educational Level

BDI Total Scores	Mean Rank
Primary/All Age	105.64
Secondary	69.73
U=233.500, p=.024	

Employment status and the prevalence of depressive symptoms

Five levels of employment were entered into SPSS: full-time; part-time; self-employed; unemployed; student. When all five categories were analysed, there was no significant difference in prevalence of depressive symptoms (p=.399). Employment status was recoded to analyse only employed and unemployed respondents. Although the Mann-Whitney U test revealed no significant difference (p=.081), it is still worthy to note that unemployed respondents were slightly more depressed than employed respondents.

Table 5: Prevalence of Depressive Symptoms by Employment Status

BDI Total Scores	Mean Rank
Employed	61.39
Unemployed	70.06
U=1097.500, p=.081	

Prevalent depressive symptoms in the sample

A frequency analysis was done on all the variables in the BDI assessment. The sum of respondents who chose options from 1 to 3 was computed to identify the most prevalent depressive symptom (table 6). Symptoms that were most prevalent in this sample included changes in sleep pattern (77.3 per cent); sadness (73.9 per cent); punishment feelings (70.7 per cent); guilty feelings (67.5 per cent); and self-dislike (67.5 per cent).

Table 6: Rank order of the BDI Depressive Symptoms Based on Participants' Response

Category	No experience of depressive symptom (%)	Experience of depressive symptom (%)
Changes in Sleep Pattern	22.7	77.3
Sadness	26.1	73.9
Punishment Feelings	29.2	70.7
Guilty Feelings	32.5	67.5
Self Dislike	46.1	67.5
Loss of Pleasure	33.1	66.9
Loss of interest	33.1	66.9
Loss of Energy	42.2	65.9
Changes in Appetite	35.7	64.3
Self Criticalness	37.7	62.3
Tiredness or Fatigue	38.3	61.7
Concentration Difficulty	41.6	58.4
Past Failure	42.2	57.8
Crying	44.2	55.8
Agitation	44.2	55.8
Indecisiveness	44.8	55.2
Loss of Interest in Sex	46.1	53.9
Irritability	51.3	48.7
Pessimism	51.3	48.7
Suicidal Thoughts or Wishes	59.7	40.3
Worthlessness	64.9	35.1

Further analysis was done to ascertain the most frequent depressive symptoms by gender. Gender and Sadness.

Chi-square analyses revealed that there was a significant relationship between gender and sadness (X2=12.052, p=.007, c=.269).

Females (68.3 per cent) were more likely to feel sad much of the time compared to males (43.6 per cent).

However, when the most intense range of the emotion was explored, "I am so sad or unhappy that I can't stand it," males (11.7 per cent) identified with this slightly more than females (10.0 per cent).

Table 7: Mean BDI Scores of Participants by Gender and Sadness

Sadness	Gender		
	Males	Females	Total
I do not feel sad	33 (35.1%)	7 (11.7%)	40
I feel sad much of the time	41 (43.6%)	41 (68.3%)	82
I am sad all the time	9 (9.6%)	6 (10.0%)	15
I am so sad or unhappy that I can't stand it	11 (11.7%)	6 (10.0%)	17
Total	94 (100%)	60 (100%)	154
	X^2=12.052, df=3, p=.007, c=.269		

Chi-square analyses showed that there was a significant relationship between gender and crying (X2=20.67, p=.000). The contingency coefficient (c=.344) showed that this was a moderate relationship. Females were more likely to identify with crying more than usual or crying over every little thing than males. However, when the most intense range of

emotion was explored, "I feel like crying but I can't," males (35.1 per cent) identified with this more than females (23.3 per cent).

Table 8: Mean BDI Scores of Participants by Gender and Crying

Crying	Gender		
	Males	Females	Total
I don't cry any more than I used to	49 (52.1%)	19 (31.7%)	68
I cry more than I used to	6 (6.4%)	10 (16.7%)	16
I cry over every little thing	6 (6.4%)	17 (28.3%)	23
I feel like crying, but I can't	33 (35.1%)	14 (23.3%)	47
Total	94 (100%)	60 (100%)	154
	X^2=20.678, df=3, p=.000, c=.344		

Gender and Past Failures

Chi-square analyses revealed that there was a significant but weak relationship between gender and past failure (n=154, X2=8.339, p=.039, c=.227). Males (28.7 per cent) were more likely to feel like they failed more than they should have compared to females (18.3 per cent).

Similarly, males (26.6 per cent) were more likely to see a lot of failures from past experiences compared to females (23.3 per cent).

Table 9: Mean BDI Scores of Participants by Gender and Past Failure

Past Failure	Gender		
	Males	Females	Total
I do not feel like a failure	39 (41.5%)	26 (43.3%)	65
I have failed more than I should have	27 (28.7%)	11 (18.3%)	38
As I look back I see a lot of failures	25 (26.6%)	14 (23.3%)	39
I feel I am a total failure as a person	3 (3.2%)	9 (15.0%)	12
Total	94 (100%)	60 (100%)	154
	X^2=8.339, df=3, p=.039, c=.227		

Gender and Suicidal Thoughts

Chi-square analyses revealed that there was a significant but weak relationship between gender and suicidal thoughts (X2=13.150, p=.004, c=.280). Females (45.0 per cent) were more likely to have suicidal thoughts but not carry them out, compared to males (24.5 per cent). It should be noted that the majority of the sample (60.0 per cent did not have thoughts of killing themselves.

Table 10: Mean BDI Scores of Participants by Gender and Suicidal Thoughts

Suicidal Thoughts	Gender		
	Males	Females	Total
I don't have any thoughts of killing myself	65 (69.1%)	27 (45.0%)	92
I have thoughts of killing myself but I would not carry them out	23 (24.5%)	27 (45.0%)	50
I would like to kill myself	3 (3.2%)	0 (0.0%)	3
I would kill myself if I had the chance	3 (3.2%)	6 (10.0%)	9
Total	94 (100%)	60 (100%)	154
	X^2=13.150, df=3, p=.004, c=.280		

Gender & Loss of Interest in sex

Chi-square analyses showed that there was a significant but moderate relationship between gender and loss of interest in sex (X2=40.092, p=.000, c=.454). Females were more likely to be less interested in sex than they used to be (43.3 per cent) or have lost interest in sex completely (31.7 per cent) compared to males (20.2 per cent and 5.3 per cent, respectively).

It is interesting to note that a majority of the males (63.8 per cent) did not notice any recent change in interest for sex.

Table 11: Mean BDI Scores of Participants by Gender and Loss of Interest in Sex

Loss of interest in Sex	Gender		
	Males	Females	Total
I have not noticed any recent change in my interest in sex	60 (63.8%)	11 (18.3%)	71
I am less interested in sex than I used to be	19 (20.2%)	26 (43.3%)	45
I am much less interested in sex now	10 (10.6%)	4 (6.7%)	14
I have lost interest in sex completely	5 (5.3%)	19 (31.7%)	24
Total	94 (100%)	60 (100%)	154
	X^2=20.678, df=3, p=.000, c=.344		

Comparison of Jamaican youths to international samples

The findings of this sample were compared with adult samples and other samples of adolescents (table 1). BDI scores were categorized into levels of depressive symptoms according to the standards previously used by Beck in studies with youths (Beck and Beck 1972; Beck, Rial and Rickels 1974) and by other researchers working with adolescents (Terri 1982; Lowe, Lipps, and Able 2005). In comparison to youth in other nations (Beck 1967) this sample had a higher percentage of youths scoring in the "none to minimal" depressive range, as well as in the severely depressed range.

Table 12: Comparison of Beck Depression Inventory Classifications for Youths in this Study to Adolescents and Youths in Previous Studies

	Percentage of younger children [1]	**Percentage of Youths (Adults) [2]**	Percentage of adolescents in Teri's study [3]	Percentage of adolescents in Lowe's study[4]	**Percentage of youths within this sample**
None or minimal depression	30	**23**	51	62	**29**
Mild depression	33	**30**	17	10	**17**
Moderate Depression	33	**37**	27	19	**23**
Severe depression	6	**10**	5	9	**32**

[1] Albert and Beck, (1975)

[2] Beck, (1967)

[3] Teri. (1982)

[4] Lowe, (2005)

DISCUSSION, RECOMMENDATIONS AND CONCLUSION

Within the sample of this study, the prevalence of depression between genders showed that females were more depressed than males. This result reflects international findings, which show that the prevalence of major depression is higher in women than in men (Cyranowski et al. 2000; Ford et al; 2004). Rai, Zitko and Jones (2013) further state that the findings of similar female:male prevalence ratios globally suggest that this difference may primarily stem from biological sex differences and depend less on race, culture, diet and other social and economic factors.

With respect to the prevalence of depressive symptoms and educational levels, numerous studies have purported that the more educated experience fewer depressive symptoms than the less educated (Bauldry 2015; Bjelland et al. 2008; Lorant et al. 2003). Additionally, a majority of longitudinal studies indicate that more education leads to less depressive symptoms (Johnson et al. 1999). Education provides opportunities for an individual to develop cognitive skills—those skills that persons use to think, reason, remember, and problem solve. The better a person understands the role of cognition; the better is he/she able to modify emotional and behavioural responses. (Stangor, Tarry and Jhangiani 2014). The depressive symptoms in the Beck Depression Inventory (BDI-II) are categorized into two subscales: a cognitive-affective subscale and a somatic-performance subscale (Storch et al. 2004). Thirteen of the 21 symptoms reflect somatic symptoms, which include sadness, loss of pleasure, crying, agitation, loss of interest, indecisiveness, loss of energy, changes in sleep pattern, irritability, changes in appetite, concentration difficulties, tiredness or fatigue, and loss of interest in sex. The symptoms that reflect a cognitive-affective subscale include pessimism, past failure, guilty feelings, punishment feelings, self-dislike, self-criticalness, suicidal thoughts, and worthlessness (Kapfhammer 2006).

Two of the top five most prevalent symptoms of depression within this sample are "changes in sleep pattern" and "sadness" which fall in the somatic-performance subscale, whilst the remaining three of the top five most prevalent symptoms fall in the cognitive-affective subscale. These include punishment feelings; guilty feelings; and self-dislike (67.5 per

cent). These results show that culture plays a large role in the experience and expression of symptoms of depression (Sue, Sue and Sue 2003). Sue et al. argue that in some cultures depression may be experienced largely in somatic or bodily complaints. For example, in Latino and Mediterranean cultures persons suffering from depression share complaints on "nerves" and headaches, whilst in the Chinese and Asian cultures, complaints of weakness, tiredness, or "imbalance" are expressed.

Three of the BDI-II items—self criticism, self-dislike and worthlessness—can be associated with self-esteem. In this study a majority of the sample experienced symptoms of self-dislike (67.5 per cent), self-criticism (62.4 per cent); and a little over a third of the sample (35.0 per cent) experienced symptoms of worthlessness. Statements include "I have lost confidence in myself," "I am disappointed in myself." and "I blame myself for everything bad that happens." According to Beck's (1967) cognitive theory of depression, negative beliefs about self, which are central to low self-esteem, would contribute to the development of depressive disorders. Subsequent theories of depression have confirmed this view, proposing that a defining feature of depression (Brown and Harris 1978), indeed, low self-worth, is one of the diagnostic criteria for depression in the DSM-5 (APA, 2013).

RECOMMENDATIONS AND CONCLUSION

The use of the Beck Depression Inventory II (BDI-II) to assess depressive symptoms in youths in Jamaica is an effective way to identify prevalent symptoms that impact mental health for that population. Further research should be done with the focus on having a closer examination of the factors that contribute to depression among Jamaican youths. Such information should be useful for practitioners who are working with similar populations, and would aid in developing therapeutic approaches that specifically target areas (symptoms) that are prevalent with such populations. Additionally, this information should be shared with primary caregivers, parents, and teachers to help them understand the nature of depression and the consequences if it is not treated, and to identify resources or institutions that can aid in treating this mental illness.

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The Role of Substance Misuse Treatment in Case Managed Youths

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ABSTRACT

Objectives

This article examined the prevalence of substance misuse among the beneficiaries in the Ministry of National Security's Citizen Security and Justice Programme 111 (CSJP 111). The article also scrutinized some factors serving as motivation for the behaviour and explored the potential of substance misuse treatment to aid in the success of the Case Management interventions with at-risk youths.

Methods

The intervention was carried out through a Memorandum of Understanding (MOU) with the National Council on Drug Abuse to which the CSJP beneficiaries across the three counties of Jamaica were referred and treated for substance misuse. There were 168 beneficiaries ranging in age from 14 to 39. The process included, intake, drug screening, continuous assessment, drug education sessions, individual and group counselling sessions, monitoring, and, where needed, referrals for psychiatric and medical evaluations and care. There were 36 group sessions and 1,052 individual sessions conducted during this intervention.

Results

The results revealed that of the 168 clients seen the predominant drug of impact was ganja for the majority (156 or 93.0 per cent). Of this number, a majority (54 or 32.0 per cent) had been using substances since they were between seven and nine years of age. There were seven clients whose drug of impact was alcohol, and five clients used tobacco. The largest number of clients (36) had a voluntary abstinence period of five or fewer days. The second highest number of clients (33) had a four-week abstinence period. Only 18 clients had a voluntary abstinence period of five months and more, and ten clients never had a period of abstinence.

Conclusion

The misuse of substances among at-risk youth is very prevalent and it has the potential to negate the impact of intervention among the population.

INTRODUCTION

Substance misuse is a crippling health disease, which has many adverse effects on the individual, family and community. As a relapsing disorder, it is among the most challenging illnesses in the health sciences to combat. Numerous interventions have been used, both independently and in combination, to treat substance misuse. Within the behavioural health discipline, the value of case management as an effective intervention tool for substance misuse and its attendant challenges cannot be overstated. Numerous studies have shown that, as a multi-disciplinary approach to treatment, it affords clients the best options for cessation and sustained recovery (Talisman et al. 2015; Substance Abuse and Mental Health Services Administration 2012; Schaefer et al. 2008).

Case Management is a collaborative process of assessing, planning, and facilitating care for clients. It involves careful evaluation of and advocacy for services to meet a comprehensive range of health needs for individuals and families (Case Management Society of America 2017). While various studies about substance misuse have been conducted in Jamaica, none was executed prior to the Citizen Security and Justice Programme (CSJP) and the National Council on Drug Abuse (NCDA) collaboration. This undertaking examined a multi-disciplinary, multi-agency case management approach to treating moderate and high risk clients who present with pervasive substance misuse and correlated psychological challenges. The case management approach utilized by the Citizen Security and Justice Programme consisted of a rigorous assessment and reassessment, which unveiled five critical domains: violence history, anger management, thinking skills, substance abuse, and criminal association. While all five domains are critical for in-depth examination, this article focuses primarily on the substance abuse domain. The findings of this intervention highlighted the need for a deeper focus on targeted treatment interventions for at-risk youths and their families; as well as for greater local, regional and international collaborations that will support more persistent service delivery and enhanced sustainability of established interventions.

BACKGROUND

The dangerous use of alcohol, tobacco, and illegal drugs is considered to be the source of significant public health issues throughout the world. According to a survey conducted in Jamaica, 70.0 per cent of 12–65-year-old Jamaicans reported having easy access to cannabis. The study also revealed that tobacco, alcohol and cannabis are the substances most commonly used by Jamaicans, and that the burden of use of all of these substances is disproportionately higher, with earlier onset of use among males (Younger-Coleman et al. 2017). The research postulated that suitably targeted interventions are needed to stem the lop-sided burden of current use found in males; decrease underage substance use; and curtail access to the substances.

The study highlighted existing perceptions of no risk or low risk associated with infrequent or frequent use of substances. These are also issues to be addressed, and they too must be addressed through appropriate strategies, and educational programmes.

Media reports have highlighted various challenges that governments in some Caribbean countries are having with the illicit drug trade and its impact on the physical, social and economic wellbeing of members of the various countries. A Rapid Situation Assessment (RSA) was conducted as a follow up to the 2016 National Drug Prevalence Household Survey by the National Council on Drug Abuse (Whitehorne-Smith, and Reid 2017). This follow-up was to gather perspectives from decision makers, experts and academia on Jamaica's drug situation in relation to drug policies, research, prevention and treatment. The RSA highlighted the multi-faceted challenges experienced by Jamaica and the recommendations that were made to alleviate these challenges. The assessment has confirmed the popular belief expressed by many of the CSJP beneficiaries: they generally considered decriminalization of marijuana to be equivalent to legalization. Whitehorne-Smith and Reid (ibid) stated:

> There was an overarching recognition of the need for public education around drug use. Several participants shared that the cultural acceptance and 'glamorization' of illicit drugs through the media and advertising campaigns have left the public misinformed and vulnerable, especially in the absence of adequate counter messaging from the government and other stakeholders. (p.7)

THE CITIZEN SECURITY AND JUSTICE PROGRAMME

The CSJP III Case Managers anecdotal risk assessment reports in 2015 stated that they administered approximately 600 risk assessment instruments to participants interested in the programme activities. It was noted that roughly 80.0 per cent of those assessed were evaluated within the medium to high range risk level for violence. Among this group, substance misuse (alcohol and marijuana) was one of the more frequent co-occurring negative behaviours. Given the established association between drugs and crime it is reasonable to conclude that substance misuse among the participants tested could be a contributing factor to their involvement in crime and violence. Youths reported using substances for recreational purposes (especially to fit in with peers); as stress relief; and to boost their confidence. It is a scientific fact, however, that these psychoactive substances alter the individual's thoughts, mood, or behaviour and can negatively impact brain development, particularly if introduced during adolescence.

The Citizen Security and Justice Programme (CSJP) also in 2015 conducted a survey of 306 beneficiaries between 17 and 25 years old who were randomly chosen for the survey, but had been previously risk assessed for violence, and programme intervention. These beneficiaries were evaluated for the Vocational Skills Training Programme (VST). They were selected because they were identified as being moderately or highly at risk for violence, and they were living in one of the communities served by the CSJP. The survey revealed that 67.0 per cent of respondents had used marijuana during the past 30 days, and that 20.0 per cent of them smoked marijuana at least 20 times during that period. The results of the survey also showed that the respondents from the sample seemed to think that alcohol consumption was riskier than marijuana, as only 7.0 per cent indicated that alcohol consumption was not risky, and 19.0 per cent indicated that marijuana consumption was not risky. Additionally, 45.0 per cent believed that marijuana consumption implied very little, or no risk at all (CSJP Impact Evaluation Survey for VST beneficiaries 2015).

It was also consistently revealed in counselling sessions conducted by the Psychological Services Unit (PSU) of the CSJP among participants, that some individuals turned to substance misuse as a way to self-medicate themselves to relieve stress in their lives. It is based on these realities that the conception and implementation of the CSJP's substance treatment collaboration with National Council on Drug Abuse was initiated.

THE NATIONAL COUNCIL ON DRUG ABUSE (NCDA)

The National Council on Drug Abuse (NCDA) is a statutory body that was established over 30 years ago to coordinate the national response to drug abuse. According to the NCDA, its mandate is to provide quality and reliable information to policy makers, international partners and the general public regarding substance use and abuse in Jamaica. Additionally, the agency monitors the nature and extent of substance use among the population and leads the development of evidence based prevention and treatment initiatives that assist in addressing the problems associated with this social issue. With knowledge of the Agency's vital responsibilities, an MOU was established between the CSJP and the NCDA and referrals were made. The main target group for this treatment intervention were CSJP participants who were assessed as using and abusing substances, and were in need of counselling , having acknowledged their need for help. The participants were from the 50 vulnerable communities served by CSJP.

DESCRIPTION OF THE BENEFICIARIES

The services of the CSJP span 50 communities, in eight parishes. These parishes are divided into three regions: they are Kingston and St. Andrew (KMA Region) with 23 communities; the Central Region with 13 communities from four parishes (St. Catherine, Clarendon, St. Ann and St. Mary); and the Western Region comprising St. James and Westmoreland with 14 communities. A total of 168 clients were seen from the three regions for the period April to November 2019. The Central region saw the highest number of clients at 83 in total, while the Western region had 58 clients and KMA, 27. The participants ranged from age 14 to 39, were risk assessed for violence by CSJP Case Managers as described above, turning out scores within the medium to high ranges. Re-assessment was planned at nine months for adults and six months for adolescents. Figure 1 shows the age range of clients by region.

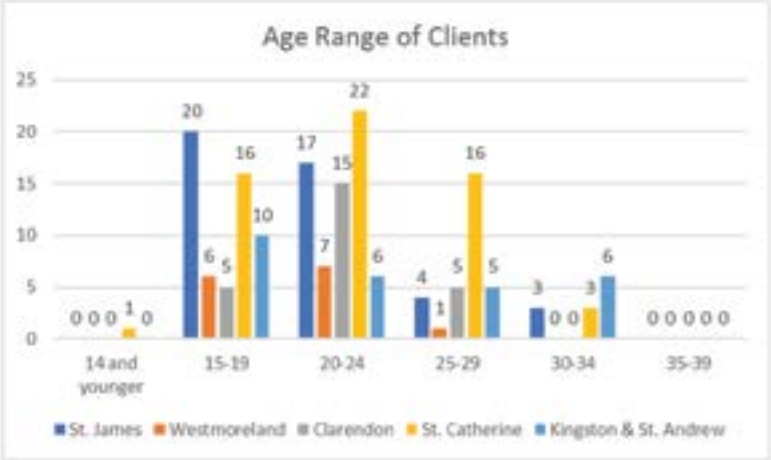

Figure 1: Age range of clients, by region.

NCDA TREATMENT METHODOLOGY

As shown in Figure 2, the process of the NCDA counselling intervention involves:

- Intake and continuous assessment
- Drug education sessions
- Individual and group counselling (building self-efficacy through motivational enhancement strategies and cognitive behavioural therapy)
- Family counselling to aid assessment and treatment and to provide support for the beneficiaries
- Drug screening and monitoring
- Referrals for psychiatric and medical evaluations

Figure 2: Process of Counselling Intervention

A total of 36 group sessions, and 1,052 individual and family counselling sessions were conducted across all parishes, and 229 substance tests were conducted.

THE FINDINGS

1. REASONS FOR SUBSTANCE USE

The reason for substance use varied from stress relief to relaxation to pass time. A total of 68 clients (40.0 per cent) indicated that they used substances for stress relief, while 45 (39. 0 per cent) used it to relax. A small number of clients (2.0 per cent) used the substances of their choice for falling asleep. Figure 3 provides a percentage breakdown of clients' feedback.

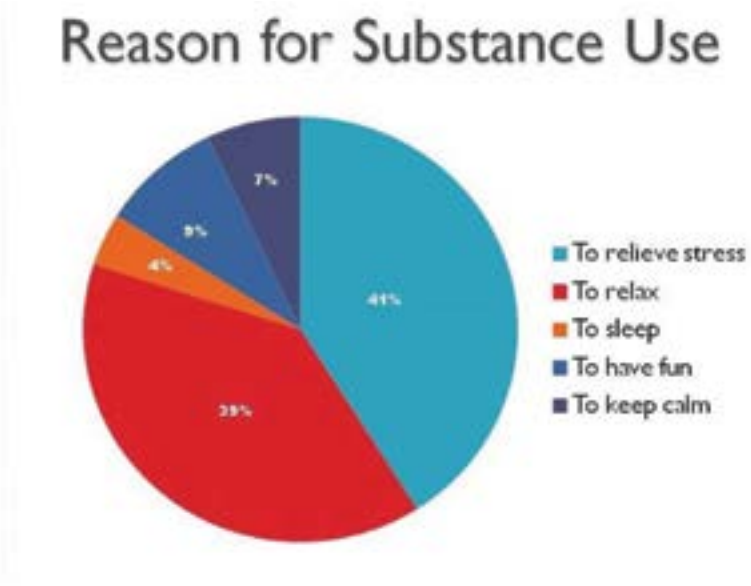

Figure 3: Reasons for substance use

The most frequent setting for use, as cited by clients, is home (87 clients or 52.0 per cent). While a few stated that they smoked in bars and shops, a total of 27 clients (16.0 per cent) smoked with friends, followed by 12.0 per cent (20) who smoked anywhere. Figure 4 shows the distribution of settings for substance use.

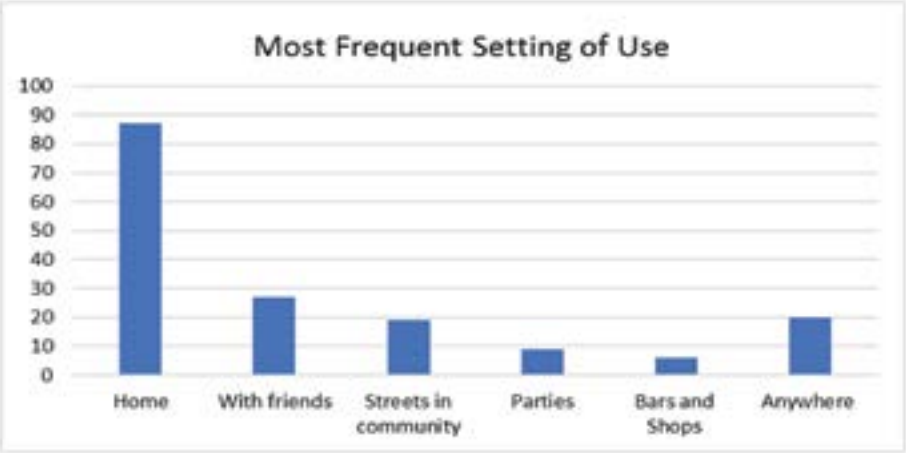

Figure 4: Most frequent setting of substance use

3. AGE AT FIRST USE

Forty-nine clients (29.0 per cent) began substance use in the 15–16 age group, followed by the 13–14 age group, which had 48 clients (29.0 per cent). St. Catherine, with 22 clients, accounted for the highest number who started smoking in the 15–16 age group. Westmoreland and Clarendon were the only parishes without clients in the eight and younger age group. Of the 168 clients seen, 16 (10.0 per cent) began smoking between ages nine and ten. Figure 5 shows the age of first use for the clients by parish.

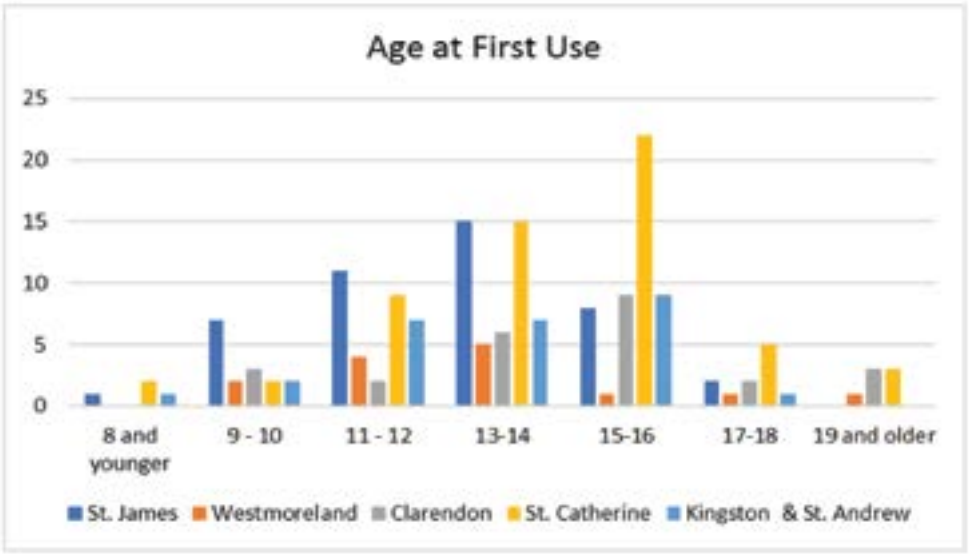

Figure 5: Age at first substance use, by parish.

4. INCIDENCE OR SITUATIONS WHICH TRIGGERED FIRST USE

A majority of the clients (27.0 per cent) identified peer influence as the trigger for their first substance use. Family issues and stress (25.0 per cent) followed, and emotional trauma was 23.0 per cent. Figure 6 shows the distribution of triggers by percentage as reported by clients.

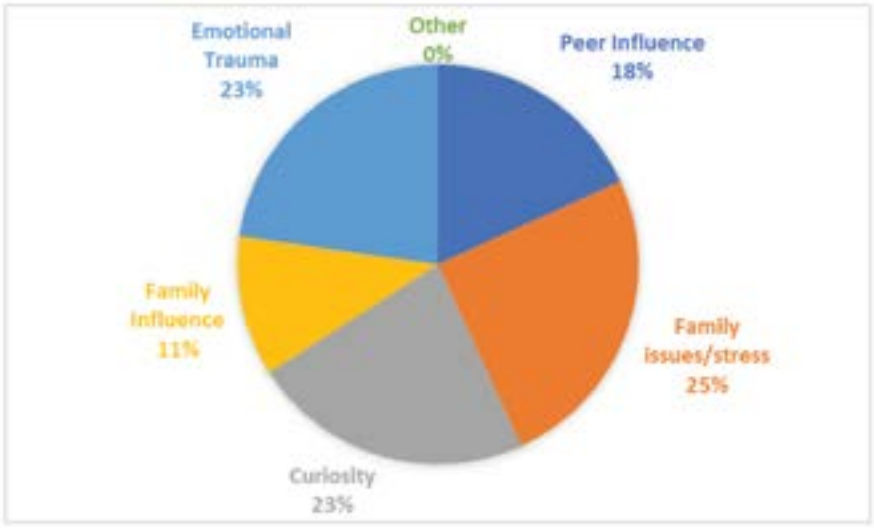

Figure 6: First Use Triggers

5. NUMBER OF YEARS OF USE

Clients' years of use ranged from a low of one year to a high of 16 or more years. The majority of the clients (54 or 32.0 per cent) have been using substances between seven and nine years. Persons in the 16 and more years category accounted for 8.0 per cent (13) of the clients. Figure 7 illustrates the number of years of use among clients for all parishes combined.

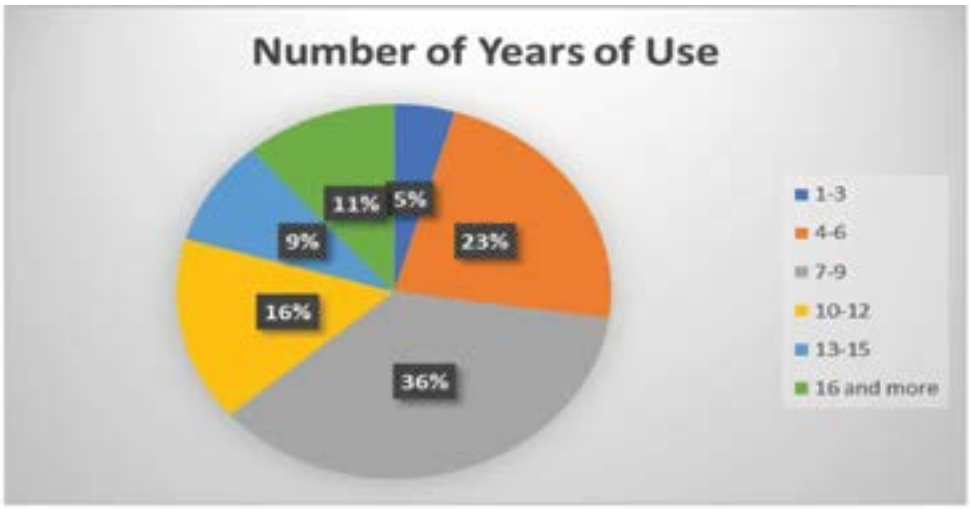

Figure 7: Years of substance use among clients.

6. DRUG OF IMPACT

As shown in figure 8, of the 168 clients seen, the predominant drug of impact was ganja with 156 (93.0 per cent) identifying this as their drug of choice. There were seven clients [two from Clarendon, three from St. Catherine, one from St. James and one from Kingston and St. Andrew) whose drug of impact was alcohol. Only five persons had their drug of impact as tobacco.

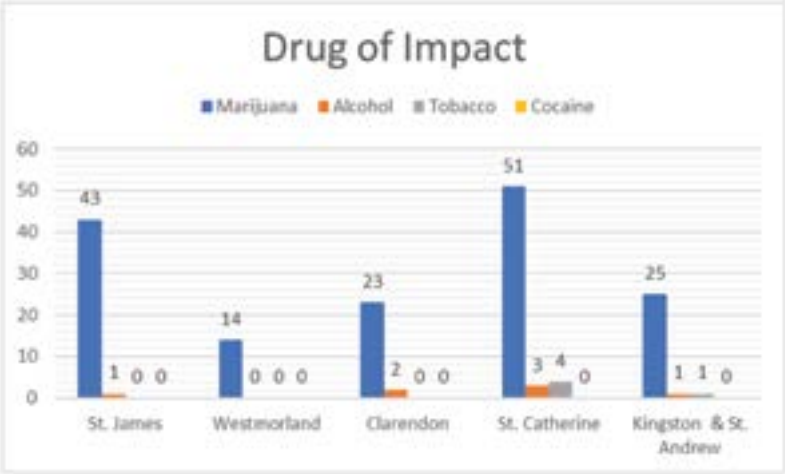

Figure 8: Drug of impact

7. POLYSUBSTANCES

Poly-substance use refers to the simultaneous use of more than one substance by an individual. Clients and use a secondary substance with the primary drug of impact. Figure 9 shows that 53.0 per cent (89) of the total number of clients seen are poly-users with tobacco being the most predominant polysubstance used. The parish with the highest number of poly-users is St. Catherine at 37. The fact that St. Catherine is the only parish with poly-users in all three substance categories is noteworthy.

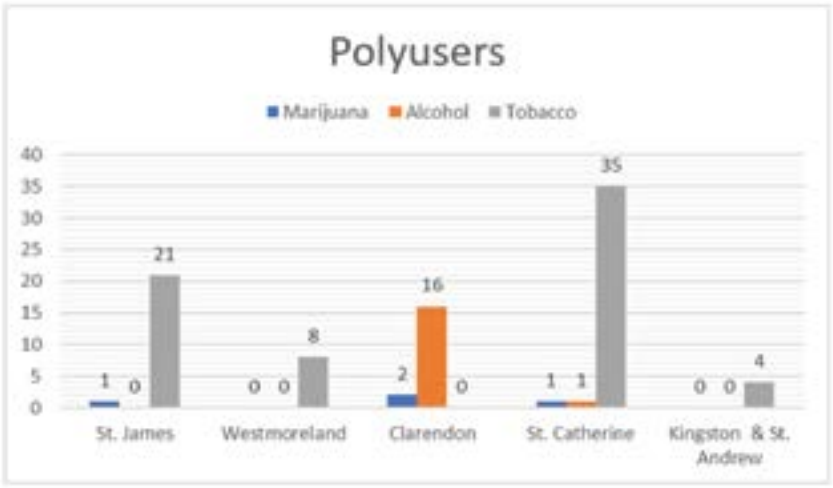

Figure 9: Polysubstances

8. LONGEST PERIOD OF VOLUNTARY ABSTINENCE

The largest number of clients (36) had a voluntary abstinence period of five or fewer days. The four-week abstinence period had the second highest number of clients at 33. Only 18 clients had a voluntary abstinence period of five months and more and 10 clients had never had a period of abstinence. Among the reasons cited for voluntary abstinence were illness with accompanying prescription drug use, and educational and employment opportunities. Figure 10 provides a breakdown of the abstinence periods for clients.

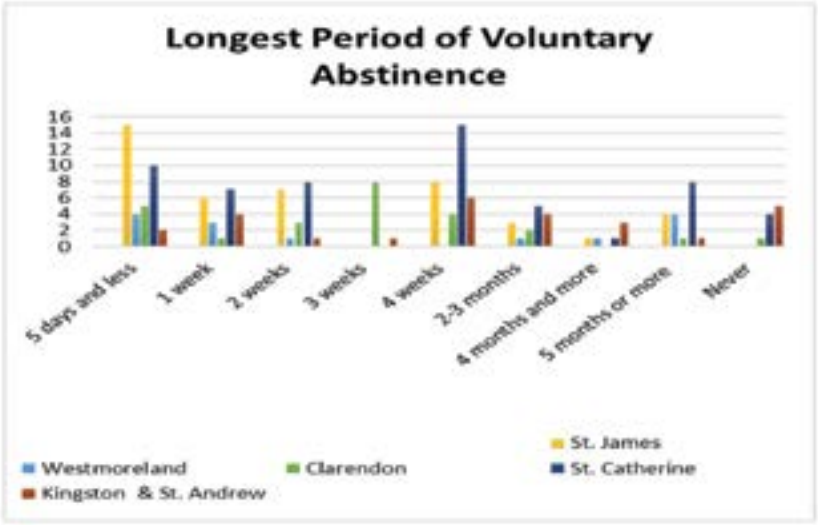

Figure 10: Longest period of voluntary abstinence

CSJP CASE MANAGEMENT RE-ASSESSMENT AND SUBSTANCE ABUSE FINDINGS

The Case Management process includes reassessment of the clients to check for any changes in the domains' risk for the client and to check the effectiveness of the case management interventions. For adults, reassessment was scheduled for every nine months, and for youths every six months. This process allowed the Case Manager and the clients to see the improvements or setbacks, and to make the necessary adjustments to the case plans.

A reassessment exercise was conducted in June 2019 with 1,130 beneficiaries, which included some of the participants under consideration in this document. Among that number 844 were previously assessed for substance misuse. The results indicated that for the reassessed clients, 22.4 per cent (253) remained at medium risk for substance use. A further 27.3 per cent (308) remained at low risk after reassessment. A total of 14.0 per cent (158) moved from high to medium risk and another 11.2 per cent (126) moved from medium to low risk (CSJP Reassessment Summary 2019).

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

Substance Misuse is a seriously downplayed problem in Jamaica, especially among vulnerable at-risk youths like those engaged by the CSJP. The substances can have serious physiological and psychological effects, but, the negligible regard demonstrated by both adults and youths in respect of the substance misuse, is even more deleterious. The use of illicit substances (especially Marijuana) has been widely accepted, and its misconceived benefits so normalized, that children as young as nine years old indulge in its use (NCDA Report 2019). The NCDA's report of the CSJP's clients indicated that almost all (93.0 per cent) of beneficiaries referred from the CSJP programme had a family history of substance abuse. Most clients identified immediate relatives such as fathers, mothers, siblings and extended relatives such as grandparents, who used substances for many years. Other distant relatives included aunts, uncles and cousins who smoked marijuana, drank alcohol, or used both.

It is noteworthy that a majority of the adolescents in the CSJP Programme, who received treatment for substance misuse, were from the Western Region. If these adolescents are not helped or they do not comply with the process of intervention, their educational and health outcomes are likely to be negatively impacted. Additionally, they may become prime recruits for gang membership and criminal activity. This is reinforced by a statement made by the present Minister of National Security Dr. Horace Chang, in an RJR news report on July 4, 2019. He stated: "Seven out of ten teenage boys in Montego Bay, St. James, drop out of school before grade nine." Dr Chang further noted that it was a challenge keeping these boys engaged in productive activities and as such, many of them were getting involved in criminal activities. He believed this was "fuelling the wave of violence in the Western city." Teens are said to be at the stage where the area of their brains responsible for decision-making is still developing. Weinberger et al. (2005) confirm this as they contend that although rapid cognitive development occurs during childhood, brain development continues throughout adolescence up to mid-twenties.

Adolescents differ from adults in the way they think, reason, problem solve or make

decisions. With respect to the discussion on brain development during childhood, adolescence and early adulthood, scientists have asserted that the amygdala, that area of the brain responsible for immediate reactions such as aggressive behaviour and fear, develops early. The frontal cortex however, which controls reasoning and contributes to helping the individual to think before acting, develops later (American Academy of Child and Adolescent Psychiatry 2019). With that said, we can understand the concern about the effects of marijuana when used during adolescence. Weir (2015) argued that the use of marijuana has been shown to curtail certain brain functions such as attention, memory, learning and decision-making. Weir further argued that there is a direct association between heavy marijuana use in adolescence and a dismal set of life outcomes that include poor school performance, higher dropout rates, increased welfare dependence, increased unemployment and lower life satisfaction.

When the premature school leavers were engaged by the CSJP, it became a challenge for them to be compliant and, as a result, behaviour change was difficult. Hence, there was a major concern that though participants agreed to be engaged in substance misuse counselling, they were not compliant with the requirements needed to achieve behaviour change and break the habit. This resulted in the continued misuse and continued dependence on the substance by this age group.

It was further noted that the CSJP beneficiaries who were substance abusers have shown the effects by their maladaptive behaviours, mood swings, and inability to control their anger when faced with provocation or situations that called for critical thinking. Discussions in counselling sessions led some beneficiaries to admit to having breathing problems, diminished capacity to remember important information, difficulty paying attention and concentrating for extended periods of time, and keeping appointments. These behaviours demonstrate the powerful influence of drug dependence.

The collaboration with the National Council on Drug Abuse has shown that providing support to the youths in this vulnerable cohort, which the CSJP was mandated to reach, takes more than just offering them a skill, getting them to go into a class room, or even to attend an interview. Rather, it demonstrated an urgent need to address, either preliminarily or concurrently, the myriad psychological issues, which pervade their existence, particularly

in the context of Jamaica's cultural and social landscape and the necessity to effectively utilize resources. The power and benefits of collaboration were also demonstrated with the memorandum of understanding between the CSJP and the NCDA, whereby they were working with each other through case managers, social workers, psychologists, psychiatrists and substance abuse counsellors to address the matter of substance misuse. The many benefits of the Case Management Methodology in seeking to assist this cohort of individuals were reinforced. Among the lessons learned were that precise assessment, along with a multidisciplinary team addressing the deficiencies among beneficiaries, worked as an effective social intervention to positively transform the lives of our vulnerable youths across Jamaica.

RECOMMENDATIONS

Based on the CSJP experience with the prevalence of substance misuse among the target population, it is recommended that with any similar intervention, a risk assessment and other clinical assessments should be integrated into the selection approach in order to identify any emotional, cognitive or psychological issues that would inhibit intervention. If there is any substance misuse, the relevant assessments would identify such areas so that the necessary intervention could be effected.

A second recommendation is the continuous and rigorous execution of public awareness campaigns on the serious negative effects of substance misuse, and especially its impact on the adolescent population. As discussed earlier, the implication for brain development and effective functioning is one area that should be taken seriously. A third recommendation is that participants who are identified as substance users should be mandated to receive counselling and treatment before they are engaged in other pursuits such as academic learning, vocational skills training or job internship. A fourth recommendation is to increase the availability of funds, material resources and multidisciplinary professionals to address this problem and to provide holistic care for persons who are in need of such services.

A fifth recommendation is that more stringent enforcement of laws or fines should be put in place for those who sell illicit substances in their enterprises (corner shops, stalls, etc.) to small children and adolescents. Additionally, parents and family members who expose children to substance use should be held accountable when they are proven to be engaged in such conduct.

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Violence and Mental Health presents two articles that highlight interventions and strategies designed to improve the mental and emotional health of risked assessed case managed beneficiares of the CSJP III Programme. The two articles are: *Using the Beck Depression Inventory to Identify Depressive Symptoms in Jamaican Youths* and *The Role of Substance Misuse Treatment in Case Managed Youths.*

Hopefully, with the sharing of the information presented in this book, policy makers and implementers of social interventions will have a better understanding of depression and substance abuse

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