ALCOHOL SELF-HELP GROUPS IN SAINT VINCENT AND THE GRENADINES: A CULTURAL APPROACH

APPROVED BY SUPERVISORY COMMITTEE

Lilian Niwagaba, PhD

Adam Brenner MD

Nora Gimpel MD

Craig Katz MD

ALCOHOL SELF-HELP GROUPS IN SAINT VINCENT AND THE GRENADINES: A CULTURAL APPROACH

by

DIVYA CHHABRA

DISSERTATION

Presented to the Faculty of the Medical School
The University of Texas Southwestern Medical Center
In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF MEDICINE WITH DISTINCTION IN GLOBAL HEALTH

The University of Texas Southwestern Medical Center
Dallas, TX

ABSTRACT

ALCOHOL SELF-HELP GROUPS IN SAINT VINCENT AND THE GRENADINES: A CULTURAL APPROACH

Divya Chhabra

The University of Texas Southwestern Medical Center, 2016

Supervising Professor:

Lilian Niwagaba, PhD

Introduction:

In 2004, there were 4.1 deaths from alcohol use disorders per 100,000 people in Saint Vincent and the Grenadines (SVG)- one of the highest rates in the world. There are no medical resources currently for patients with alcoholism in this country. Thus, work was done to pilot self-help groups modeled on Alcoholic Anonymous (AA), in SVG in summer 2012. A follow-up team returned to SVG in summer 2013 to assess the success of those groups and to pilot more groups in various regions. The team worked to tailor a unique self-help program specific to the cultural foundation of the local community. This study looks at what specific factors were associated with the groups that attained success, explores local perceptions regarding alcoholism, and delved into what techniques may aid in preventing alcoholism in this country from the ground up.

Methods:

The goal of the second phase of the project was multi-faceted and was accomplished via three medical students traveling to the country for approximately 9 weeks. The first goal involved ascertaining the reason as to what qualities made the Barrouallie group, the only remaining self-help group from the first phase, sustainable and what qualities caused the other groups to cease meeting. Secondly, due to the needs for programming in other communities, a large goal was to expand the program using the knowledge obtained in qualitative analysis to start other groups.

Lastly, the group aimed to analyze the local adult populations general attitude and understanding of alcoholism as a disease process. Due to the limitations of the project in 2012, this second phase foremost sought to deeply understand the community needs and cultural factors that influence alcoholism and the use of AA in this country. By working towards an understanding rather than immediate progress in terms of number of self-help groups, the team aimed to create sustainable self-help groups.

Ultimately, five new self-help groups were piloted by the end of the 2013 summer. These groups were located in Bequia (two meetings over summer 2013), Kingstown (two meetings), SVG Mental Health Center in Glen (four meetings), and Troumaca (one meeting) and consisted of 2-10 members. The team, after surveying the area to assess alcohol-related education in local schools, also piloted education sessions for local children and adolescents in Troumaca, Kingstown, and Arnos Vale.

Results:

The only remaining self-help group after the 2012 pilot program was Barrouallie. This group had 9 participants attending since August 2013. Eight of them have stopped drinking completely, and the 9th member has been sober since July 2013. Eight members agreed that the group was "very helpful," and five of them joined the group through word of mouth. One participant noticed the "seriousness" of the group he saw at the park, so he decided to join. This openness was not apparent in the failed groups from 2012. When asked what could make their group more successful, approximately 66% of the subjects stated "encouraging more people to join the group." Of the former participants, 100% of them answered "yes" to whether the group helped them overcome their drinking problem. The former subjects stopped coming due to pregnancy or schedule conflicts.

The current participants felt that forgoing anonymity would help to disseminate the group elsewhere in SVG. The group was then aired on local television to spread their message, and they also expressed interest in being aired on the radio and recruiting locals they knew in other villages to start groups in their own communities. The Barrouallie group chose to display shirts conveying their dedication to abstaining from alcohol and place their meetings in open areas where anyone could be welcome. Other pertinent suggestions from former participants to recruit new participants included finding the alcoholics at the rum shops themselves. Lastly, in the convenience sample from Kingstown, 75% of subjects claimed alcoholism is "not a disease," and the majority weren't aware of its specific

organ effects and were not educated in school regarding alcohol and drug abuse and their repercussions.

Recommendations:

Unlike the AA model, which is based on the premise of privacy and unrevealed identities outside of those at the meetings, the only group that was sustained in SVG from the summer 2012 phase of the project explicitly and voluntarily shed its anonymity. This philosophy of community engagement and self-identification was used for establishing five new self-help groups whose viability is currently being assessed. The open culture of SVG allowed a unique group design to attain success. In a country so close-knit and small, obtaining the western ideal of privacy and confidentiality is not only extremely difficult, but simply may not lead SVG towards a decrease in alcoholism. For this culture, openness may be the form of therapy that can make this feat possible.

The lack of alcohol education was apparent when the majority of locals surveyed didn't realize that it is a disease or how it affects the organs. The team initiated an educational campaign at camps and churches to promote prevention of alcoholism at an early age.

The team recommends that in the future, a two-tiered approach must be utilized to decrease the incidence of alcoholism in SVG: one aimed at prevention in schools via education, and the second aimed at non-anonymous self-help groups led by local community leaders such as nurses or community-known peace corps members rather than necessarily an alcoholic as the AA would advocate. Cultural

competency must be taken into consideration when implementing programs to address alcohol use disorders, as alcoholism is an overlooked global issue.

TABLE OF CONTENTS

PRIOR PUBLICATIONS AND PRESENTATIONS

Chhabra, DK., Sachdeva, RK., Salwan, JK., Providence K., Katz, CL. (2014). *Culturally Adapting Alcohol Self-Help Groups in Saint Vincent and the Grenadines* Poster presented at: American Psychiatric Association Annual Meeting 2014; New York, NY.

CHAPTER ONE: INTRODUCTION

Mental Health in Saint Vincent and the Grenadines

Saint Vincent and the Grenadines (SVG) is a multi-island country in the Eastern Caribbean that consists of 7 inhabited islands and a population of approximately 110,000 inhabitants. The health system is organized into 39 small health centers located in 9 different districts. There is one psychiatric hospital, the Mental Health Center, that serves the entire country, and it is located a couple of miles outside of the nations capital, Kingstown.

Throughout the span of this project, there was only one psychiatrist who served the entire population, and there is a shortage of mental health workers in the country as well as within the Mental Health Center. The Mental Health Center consists of 160 beds and typically serves greater than 160 inpatients at a time – meaning that patients do not always have a bed or are placed in overflow mobile beds. There are mobile vans that deploy when possible to serve patients who cannot access the Mental Health Center. The mental health resources available in Saint Vincent and the Grenadines are extremely limited for patients with a myriad of psychiatric diagnoses.

One study in SVG consisting of 53 surveys and interviews representing all nine districts demonstrated that the provider population in the country often had inadequate knowledge of mental illness diagnosis and treatment. The results also revealed a group of providers who felt that mental health should be a health priority and wanted further training in various facets of mental health, including on addictions. Due to this scarcity of resources in SVG, community-based self-help

groups for alcohol use disorders represented a mechanism to enhance the existing mental health system.

Alcohol Use in Saint Vincent and the Grenadines

In 2004, there were 4.1 deaths from alcohol use disorders per 100,000 people in Saint Vincent and the Grenadines (SVG), which is almost double the rate in the U.S. and among the highest rates worldwide. In 2010, the prevalence of alcohol use disorders and alcohol dependence in SVG was 8.2% in males, 3.1% in females and 3.8% in males and 1.8% in females respectively. These values, specifically in the male population, are also among the highest rates worldwide (put a comparison here). Meanwhile, a 2009 World Health Organization report found that substance use problems were second only to schizophrenia as reasons for inpatient and outpatient psychiatric care in SVG (WHO and SVG Ministry of Health, 2009). Clinical observations made by healthcare colleagues in SVG as well as psychiatrists from the Mt. Sinai Icahn School of Medicine who have travelled there thus far likewise suggest a need to address alcohol use problems in SVG as a major facet of the mental health challenges in SVG.

In terms of intervention for alcohol use disorders, there are no formal rehabilitation facilities on the island, and Alcoholics Anonymous is not a widely available program in the country. In addition, in terms of policies and interventions, the country has no written national policy or national action plan for alcohol, no national maximum blood alcohol concentration when driving a vehicle, no required health labels on alcohol advertisements, and no national monitoring systems. (WHO

Global Alcohol Report 2010), The recorded alcohol consumption level per capita has increased from 2.5 liters per capita in 1961 to 6 liters in 2010. In terms of drinking patterns, 14.6% of drinkers in 2010 reported "heavy episodic drinking" which was measured by the consumption of at least 60 grams or more of pure alcohol on one or more occasions.

Lastly, little research has been done on mental health, let alone alcoholism in Saint Vincent and the Grenadines. This project serves as the first formal research project implemented on SVG on Alcoholics Anonymous.

Alcoholics Anonymous

Alcoholics Anonymous (AA) is an international organization aimed at facilitating a process of recovery for those suffering from alcohol-use disorders (AUDs) through self-help groups. It currently boasts of having more than 100,000 groups with over 2 million members in 150 countries. The main components are the "AA Twelve Steps" and the "AA Twelve Traditions." In one study, it is shown that AA's rate of abstinence is approximately double for those who attend AA meetings and follow the protocol as compared to those who do not. AA is not well established in Saint Vincent and the Grenadines. There has only been one AA location established in 2003 in Mustique that was largely used for foreigners and no longer meets regularly. The closest country in which AA is a well-established and utilized program is Trinidad and Tobago.

Alcoholics Anonymous has been studied internationally as a widely-used tool for those suffering from alcohol-use disorders. In some countries and within

different populations, it has been shown to be more effective than in others due to a myriad of factors, some of which include cultural differences. For example, a study done in Los Angeles culturally adapted the AA Model to align with the cultural tendencies of young male immigrants from Central America. Alcoholism in this subpopulation is often associated with domestic violence and is also influenced culturally by 'machismo.' The model used with young Hispanic men assesses these concepts. The method called "terapia dura," or rough therapy, adapts the expressions of the machismo value complex to produce social alternatives in the context of alcohol, which culturally are two integrated phenomenon. This is one of several examples where internationally and within communities, AA meetings and strategies have been altered to adapt to an ethnicity, economic status, or culture.

The Disease Burden of Alcoholism

AUDs are responsible for a significant portion of global burden of disease. Seventy-five percent of people affected by AUDs reside in developing countries, and these same countries commonly possess the least amount of necessary resources for treatment. Furthermore, these countries are often the least. Aside from alcohol consumption itself being a major direct cause of death, it also contributes to the progression of several diseases that can result in death. According to the International Journal of Cancer in conjunction with estimates made by the World Health Organization, over the time period between 2002 and 2012, the total number of alcohol-attributable cancer cases increased to 770,000 world wide (5.5% of the total number of cancer cases reported, from 3.6% in 2002), and cancer deaths

increased to 480,000. These proportions were particularly high in developing regions. This in and of itself calls for public health measures worldwide in order to limit excessive alcohol consumption. Alcohol is associated with a myriad of health problems in addition to cancer, such as cirrhosis and malnutrition. Studies have also shown that those with AUDs are less likely to take medications for currently existing health problems and to monitor health overall.

First Phase of the Project

In Summer 2012, a team from Mount Sinai travelled to SVG to establish self-help groups and ascertain whether these groups could indeed be established and sustained. The project stemmed from a history of clinical observations made by leaders in global mental health at Mount Sinai School of Medicine. These colleagues found a scarcity of mental health resources available in the country and also found that local health leaders in the community strongly felt the need for resources for those with alcohol use disorders. The researchers that implemented the groups in summer 2012 concluded that self-help programming in the community could provide a valuable and cost-effective complement to the existing mental health system.

The group chose to pilot self-help groups in Barrouallie, Calliaqua, and Stubbs that utilized a group leader as well as followed the AA Twelve Steps and AA Twelve Traditions. The groups findings were that, overall, the self-help groups were seen positively – with 27 of 35 participants describing the group as "very helpful." By summer 2012, the Calliaqua and Stubbs groups were no longer being sustained.

In fact, the group in Stubbs did not end up having a single successful self-help meeting as it was difficult to attain participants this area. In Calliaqua, one self-help group meeting was held, but it was not sustained, for unclear reasons, after the Mount Sinai researchers left the country at the end of summer 2012. However, the Barrouallie group continued to meet through the year, and into summer 2013 onwards. Among a majority of group members from all the regions, most reported a decrease in their individual drinking, but most members did not feel that the self-help group initiative had improved awareness of the dangers of alcohol abuse throughout the community.

Second Phase of the Project

The goal of the second phase of the project was multi-faceted and was accomplished via three medical students traveling to the country for approximately 9 weeks. The first goal involved ascertaining the reason as to what qualities made the Barrouallie group sustainable and what qualities caused the other groups to cease meeting. Secondly, due to the needs for programming in other communities, a large goal was to expand the program using the knowledge obtained in qualitative analysis to start other groups. Lastly, the group aimed to analyze the local adult populations general attitude and understanding of alcoholism as a disease process. Due to the limitations of the project in 2012, this second phase foremost sought to deeply understand the community needs and cultural factors that influence alcoholism and the use of AA in this country. By working towards an understanding

rather than immediate progress in terms of number of self-help groups, the team aimed to create sustainable self-help groups.

This intervention was approved by the institutional review boards of the Icahn School of Medicine at Mount Sinai in New York City and the Saint Vincent and the Grenadines Ministry of Health.

CHAPTER 2: METHODS

Research entailed holding several focus groups in the communities including Kingstown, Georgetown, Troumaca, Bequia, and Glen regarding community issues with alcoholism and local views about starting self-help groups. This is further described below. A convenience sample of local Kingstown inhabitants was also collected to gain information about the community's experience with alcohol and their knowledge of its effects. Finally, current and former self-help group members in Barrouallie, the only surviving group from 2012, were surveyed on their experiences with the group. Ultimately, four new self-help groups were piloted by the end of the 2013 summer.

Recruitment for Self-Help Groups and Focus Groups

Recruitment varied by community, but entailed utilizing leaders in each community. The local psychiatrist, Dr. Morris-Patterson and nurse, Sister Smart , who aided in the organization of this project on-site, helped use their resources to recruit members in each community for focus groups. They reside in Kingstown and work at the main hospital, but were able to contact nurses in various districts to recruit members for the focus groups. The team from Mount Sinai postered in areas such as the district health centers, the local churches, the town halls prior to town hall meetings for focus groups and self-help groups. Leaders in each community and at the focus groups were able to spread interest for the self-help groups via word of mouth. In addition, in each community, a local leader was recruited to sustain each

focus group after the Mount Sinai team had left the country. In communities where groups had been started and were not sustained, attempts were made to contact former group members who had dropped out. These members were surveyed to assess what could have been changed about these groups and what caused them to leave. In Barrouallie, local self-help group members aided in recruiting for the existing group via word of mouth. Inclusion criteria for the group were age above 18 (an adult), and for the participant to feel that he or she suffers from an alcohol use disorder. Figure 1 details an example self-help group recruitment flyer.

Worried?
Want to stop but don't know how?

Come to our Meeting

At the Community Center

Figure 1

Preintervention Focus Group Structure

As stated above, before initiating the first 'self-help' group meeting, a focus group was held in each community to obtain details specific to the location, the demographics of the population, the culture, and the infrastructure of the location, in order to see how to tailor the self-help group as well as deem if the area was fit for a sustainable self-help group. The focus group meetings consisted of local leaders in each community, such as principals, teachers, government officials, and nurses, social workers, and Peace Corps members. The group members were also given handouts of the AA Twelve Steps and AA Twelve Traditions, as well as a copy of the self-help group guide compiled by the investigators. As the group in Barrouallie was already running, the focus group in this community consisted of the prior self-help group members themselves and its structure varied from the rest of the communities as they were already familiar with the AA materials.

The focus groups were led with the following list of questions:

Questions for Focus Groups

1. Can everyone please introduce themselves? First names will be sufficient.
2. To what extent is alcohol use a problem in your community?
3. How has alcohol affected anyone personally or those close to you?
4. How familiar are you with using self-help groups, often known in the U.S. and other countries as Alcoholics Anonymous, to help people with drinking problems?
5. These groups rely on open discussion and support of other people with drinking problems to help group members. How helpful could these be in SVG?
6. What are your impressions of the Alcoholics Anonymous 12 Steps and 12 Traditions listed on the handouts?
7. How helpful do you think the self-help group guide will be in encouraging self-help group members to participate in the self-help groups?
8. What ideas do you have for how we can best encourage people in need of these groups to attend and keep attending?

Self-help Group Structure

After information was attained at each focus group, a self-help group was run. The groups were located in Bequia (two meetings over summer 2013), Kingstown (two meetings), SVG Mental Health Center in Glen (four meetings), and Troumaca (one meeting), Barrouallie (four meetings), and consisted of 2-10 members. Self-help groups from the first phase of the project in Calliaqua and Stubbs were not continued due to lack of sustainability in terms of finding a local community leader to run the group as well as transportation difficulties. After attaining information in other communities, new groups were piloted in Kingstown, Bequia, Troumaca, and the SVG Mental Health Center in Glen. The group in Kingstown was led by a local nurse, the group in Bequia was led by an expatriate who was a community leader living on the island, the Troumaca group was led by The map below details the layout of the island (Figure 2):

Figure 2

For research purposes, the focus groups were structured similarly to those conducted in the first phase of the project in summer 2012. Focus group participants took post-intervention surveys after consenting orally. The focus groups were audio-recorded at least once in each area, and notes were scribed from each group.

The basic structure of each meeting was as follows:

1. Reiterate purpose of the self-help group; ask for confidentiality; explain how the day's self-help group meeting will work
2. Individual introductions by the participants (name, age, #days sober)
3. Ask a participant to volunteer their experiences with alcohol
4. Allow other members of the self-help group to volunteer their stories
5. Identify a group leader for the next meeting
6. Close with positive remarks
7. Inform the group that the next meeting will take place in one week
8. Distribute post-participation survey

The content of the meetings followed the "Alcoholics Anonymous 12-Steps" as well as the "Alcoholics Anonymous 12 Traditions," and were led by various community members.

Certain activities varied between meetings in each area when feasible. Examples of these variations included watching a video on the effects of alcohol consumption on the liver and attending a picnic near a local waterfall for the Barrouallie group during Carnival.

At the end of each self-help group meeting, participants completed a post-intervention questionnaire, which is included below:

1. Have you attended this group before?
2. When did you first start attending the group?
3. How many sessions have you attended so far?
4. How helpful do you find the group to be (circle one)?
   Not at all helpful Somewhat helpful Very helpful I am not sure
5. What about the group has/has not been helpful?
6. How often do you feel comfortable speaking and sharing experiences within the group?
   Always Most of the time Sometimes Never
7. Do you think this group is helping you overcome your problem with alcohol?
   Yes No I do not have a problem
8. Do you plan to continue attending the group?
   Yes No Maybe
9. Have you ever recommended this group to other people with similar problems?
   Yes No Maybe
10. Did anyone else suggest you to join this group?
   Yes No
11. Please give us any suggestions you may have to make this group more helpful.
12. What other approaches would you like to see available in Saint Vincent/Grenadines for helping people with alcohol use problem?

Former Group Members whom the investigators could contact completed surveys explaining why they no longer attended the group. Their survey is as follows:

1. When was the last time you attended an alcohol self-help group?
2. How many groups did you attend?
3. How helpful did you find the group to be (circle one) ?
   Not at all helpful Somewhat helpful Very helpful I am not sure
4. Did you feel comfortable speaking and sharing experiences within the group?
   Yes No
5. Do you currently have a problem with alcohol?
   Yes No I am not sure
6. Do you think this group helped you overcome your problem with alcohol?

Yes No I am not sure

7. Would you ever attend this group again?

Yes No Maybe

8. Has anyone else ever suggested you to return to the group?

Yes No

8. Have you ever recommended this group to other people with similar problems?

Yes No Maybe

9. Do you have any suggestions on how to improve the group?

10. What other approaches would you like to see available in Saint Vincent/Grenadines for helping people with alcohol use problems?

In addition, when the investigators were unable to contact group members from Stubbs and Calliaqua, community members at the health centers explained why these groups were no longer running. A group meeting in an open area park in Barrouallie (Figure 3) and a meeting in Troumaca (Figure 4) are pictured below.

Figure 3

Figure 4

Local Survey and Education Pilot Program

The team, after surveying the area to assess alcohol-related education in local schools, also piloted education sessions for local children and adolescents in Troumaca, Kingstown, and Arnos Vale. The educational sessions were held at school summer programs, summer camps, and at a church.

The survey given to community members was as follows:

1. What quantity of drinks do you consider excessive such that a person should seek treatment?

2. What percentage of people in St. Vincent consume excess alcohol? (to the best of your knowledge)

3. Do you consider alcoholism to be a disease? Why or why not?
4. What was your exposure to alcohol growing up?
5. How do people stop themselves from drinking too much?

6. Why do you feel people choose to consume excess alcohol?
7. What are the health effects of drinking too much alcohol?
8. How many people do you know who are a part of the self help group program?
9. Have the drinking behaviors of these people changed? If so, how?
10. To what extent do you feel the community is aware of the self-help groups?

CHAPTER 3: RESULTS

The data was analyzed using the method used by the investigators in the summer 2013 first phase of the project in SVG. The investigators read transcripts of the qualitative interviews during the focus groups as well as the self-help groups and mined the data to identify themes. The investigators then met to reach a consensus about common themes, created a list of recurrent themes, and recorded salient quotations to exemplify current themes. Quantitative analysis included assessment of frequencies from qualitative survey data, quantitative assessment of frequencies in various questions in surveys, as well as correlational analysis between quantitatively and qualitatively measurable responses to see if conclusions are consistent.

Focus Groups

A total of five focus groups were held in Bequia, Georgetown, Troumaca, Kingstown, Barrouialle, and Glen with a range of 5-24 members including nurses, community leaders, peace corps members, principals, teachers, government officials, and former self-help group members (in Barrouialle) The following themes emerged in the meetings:

- The cultural normalization of excessive drinking beginning in early adolescence
- The relationship between accidents, violence, and drinking
- A need for more interventions in the community, but one that is tailored to the cultural norms of the SVG community

- Illegal alcohol sales and underage drinking are rampant
- No formal teaching in schools on public health initiatives, including alcohol and drug prevention
- Lack of awareness of what "Alcoholics Anonymous" is, but openness to idea
- Feelings that AA could not be anonymous in SVG, but the spiritual dimension could carry far
- AA meetings should be held by local leader

The table below lists direct quotes from the focus group meetings that highlight these themes (Table 1).

QUOTES
"young people are seen carrying beers all the time"
"even the teachers drink on school campuses. It is quite obvious the kids will od as they see"
"There would be no anonymity here. The group could be effective if people gossip about it"
"they are not putting enough regulations. School children can go to any shop and buy any drink"
"for people to give in the festive mood, they feel they have to drink"
"People get stabbed and some even chop off one another. There are a lot of vehicle and pedestrian accidents"
"alcohol is one of the major causes for crimes"
"younger people need to be targeted the most because they do not know and will not ask for help"
"they do not know the effects it has on their body, so they consume it very frequently"
"even though the Bible tells to drink alcohol in moderation, the churches do not emphasize consuming alcohol in limit'
"Almost all of the time there is domestic abuse, alcohol is involved"
"The spiritual dimension is something that would apply here (in reference o AA)"

Table 1

The focus group participants in the all of the regions supported the idea of implementing the AA in these new communities with less "anonymity" and a focus on "spirituality." Many participants felt that groups could be held in public areas, such as churches and parks, and that the groups should be held by a local community member rather than someone who has suffered from alcoholism. This was due to the desire to establish the idea of AA in the country in a slow and organized fashion.

Self-Help Groups

Of the 12 self-help meetings organized, 0 included 0-1 participants (aside from the leader), 4 consisted of at least 2-5 participants, and 8 meetings had between 6-10 participants . The total number of participants across all meetings was approximately 30 people.

During the self-help group discussion, one of the three field investigators read the Twelve AA Steps and Traditions aloud. A significant difference from the typical arrangement of AA meetings was that the SVG meetings were led by a local leader as well as the investigator rather than a person who had suffered from alcoholism him or herself. In the new locations, the participants did not volunteer to read the steps, but they had started reading the steps in Barrouallie (which did not happen during the first phase of the project). Patients shared their views on various steps and how these related to their personal experiences with alcohol, and how alcohol has affected their life. At the conclusion of each group meeting, participants

completed a post-participation questionnaire that provided feedback on the usefulness and value of the groups. Many participants required assistance reading and completing the post-participation questionnaire.

The Kingstown group had two meetings with 3-5 participants and continued to meet for several months after the conclusion of the project. However, it stopped meeting in February 2014 as the nurse who led the group was no longer available.

The Bequia group had two meetings that consisted of 2-3 participants each; the largest challenge in this community was recruitment given the widespread layout and older population of this island. However, the group is still meeting as of February 2014 due to the dedication of the local expatriate.

The Mental Health Center had four meetings consisting of 8-10 participants, and continued to meet, but inconsistently.

One meeting was held in Troumaca, which consisted of 3 participants. This group did not continue to meet after the initial meeting as the local leader was no longer available.

The only remaining self-help group after the 2012 pilot program was Barrouallie. This group had 9 consistent participants attending since August 2012. The four meetings in Barrouallie consisted of 8 to 12 participants (returning

members and new members), and is still meeting today. Eight of them had stopped drinking completely, and the 9th member had been sober since July 2013. As other teams have traveled to SVG to implement mental health programming, information has been given indicating that the group is still running today.

Eight of the nine members in Barrouallie who completed a survey agreed that the group was "very helpful," and five of them joined the group through word of mouth. One participant noticed the "seriousness" of the group he saw at the park, so he decided to join. This openness was not apparent in the failed groups from 2012. When asked what could make their group more successful, approximately 2/3 of the subjects stated statements with the theme of encouraging more people to join the group. Of the three former participants who had stopped attending meetings in Barrouallie, 100% of them answered "yes" to whether the group helped them overcome their drinking problem. The former subjects stopped coming due to pregnancy or schedule conflicts, and all three stated that they would attend the meetings again if it was possible. In the open-ended questions, several current participants felt that forgoing anonymity would help to disseminate the group elsewhere in SVG.

The Barrouallie group was then aired on local television to spread their message, and they also expressed interest in being aired on the radio and recruiting locals they knew in other villages to start groups in their own communities. The Barrouallie group chose to display shirts conveying their dedication to abstaining from alcohol and place their meetings in open areas where anyone could be

welcome. Other pertinent suggestions from former participants to recruit new participants included finding the alcoholics at the rum shops themselves.

Convenience Sample Results

In the convenience sample from Kingstown (12 surveys), 75% of subjects claimed alcoholism is "not a disease," and the majority weren't aware of its specific organ effects and were not educated in school regarding alcohol and drug abuse and their repercussions. Seventy-five percent of the subjects had not heard of AA before. One-hundred percent of subjects showed concern that alcoholism is a problem in SVG.

CHAPTER 4: CONCLUSIONS AND RECOMMENDATIONS

This paper highlights the need for organized action to aid those afflicted with AUDs in SVG. AUD's are a significant problem in that they contribute greatly to the global burden of disease. The majority of people affected are in developing countries, and it is in these countries where there are the least amount of resources. Specifically in SVG, very little research has been done on mental health and even less has been studied in terms of alcohol use disorders, resources in this arena, and attitudes on alcoholism in this country.

Unlike the AA model, which is based on the premise of privacy and unrevealed identities outside of those at the meetings, the group that succeeded in SVG from the summer 2012 explicitly shed its anonymity, and chose to do this. This philosophy of community engagement and self-identification was used for establishing four new self-help groups whose viability is currently being assessed. The open culture of SVG allowed a unique group design to attain success. In a country so close-knit and small, obtaining the western ideal of privacy and confidentiality is not only extremely difficult, but simply may not lead SVG towards a decrease in alcoholism. For this culture, openness may be the form of therapy that can make this feat possible.

The qualitative data gathered from the preintervention focus groups served as a guide in implementing self-help groups. Spirituality and discussion was recommended as a key component of self-help groups, so interactive activities that promoted self-expression and spirituality were used. Focus groups also supported the AA model but recommended making the model less structured depending on the

culture of the group as well as the pace in which the group moved. The AA model was used as a guide rather than a rulebook. The Barrouallie group had a picnic meeting near a local waterfall, which allowed for a less structured and more spiritual meeting. The group also began to meet in the park. Through reflection from former Barrouallie members, empowerment to quit drinking was often attained through openness and a desire to spread public awareness. Thus, the group initiated new activities such as speaking for the radio station and being taped on an interview for the local news.

Focus groups also suggested that groups would be more sustainable and more effective if the leadership was "non-peer" but rather, led by a local leader who is a non-alcoholic. This differs from the traditional AA model. Typical group leaders were local nurses, peace corps members, or a well-respected community organizer. This model worked well in the Barrouialle group and was another reason as to which this group remained sustained. With AA being a new concept in the country and the general lack of awareness on alcoholism in the country overall, a local leader which greater knowledge created a sense of organization and legitimacy for group members. This model was used for the new groups that were created. When a new group of investigators traveled to SVG in February 2014, the Barrouallie and Bequia group were the only two groups still running. The Kingstown group remained meeting several months after summer 2013, but ceased before February 2014. The findings indicate that groups that continued to run had a local leader who showed extreme dedication and a level of intimacy with the group, as well as the

empowerment obtained from meeting in public areas and becoming involved in public endeavors such as the TV or radio.

The lack of alcohol education was apparent when the majority of locals surveyed didn't realize that alcoholism is a disease or how it affects the organs. In addition, focus groups had a strong theme of concern for lack of education on drugs and alcohol and alcohol-use and binge drinking seen as a cultural norm starting as young as age 10. The team initiated an educational campaign at camps and churches to promote prevention of alcoholism at an early age. Three educational sessions were led via PowerPoint, group discussion, and artwork, on drug and alcohol-use. The local school, church, and summer camp in which these sessions were held, showed enthusiasm for future sustained educational campaigns through future groups. However, the investigators were not able to find sustainable in-country personnel to lead educational sessions once the project was completed in August 2013. Pictured below is a photo of an educational session at a church camp (Figure 5).

Figure 5

Limitations

A significant limitation to this study was low power in the data given the low number of participants overall in the various self-help groups in relation to the number of people with AUDs. The questionnaires given after the self-help groups were only completed after the Barrouallie group given the logistical constraints of the group members in the other areas. Given that the AA Method is new to the country, the investigators sough to balance the desired format and goals of the AA meeting and the desires of the group members with implementing the post-participation interventions, which was a difficult task given schedule constraints. Thus, the small study population that was assessed may not be representative of the projects entire self-help group population itself. Although the information gathered from former self-help group members who were no longer attending was useful, not all former group members were accessible to attain information from.

In addition, given time constraints, the number of surveys that were collected on local attitude and knowledge towards alcohol were limited as well with a low sample size. Also most of the surveys were done near the main area of the country, in Kingstown. Thus, they may not be representative of the entire population.

Another limitation to the study is that there is no specific guide that has been created on how to lead AA groups in SVG. The team has identified changes that should be made, but there is no evidence that these groups are being led in each community in the same fashion or in a controlled manner. The lack of verifiable

uniformity between groups could be addressed by creating a more structured guide or script to lead the groups in a culturally-competent manner. However, the community desire for non-structured meetings that align with the specific groups' goals and pace must also be considered within this context. The fact that the after the second phase of the project, more groups were running for longer than after the first phase of the project gives evidence that the conclusions made based on the self-help group surveys from former and current members as well as the focus groups were helpful to sustaining the groups. However, there is no measurable proof of how much this did decrease level of drinking in each group.

After a second group returned to SVG in February 2014, the only remaining groups were the Barrouallie self-help group as well as the Bequia group. The Kingstown group continued to run for several months but is no longer running. This is an improvement from the first phase of the project in 2012, where only one group continued to run and only one group had more than 2 meetings. This makes it clear that our analysis has improved the sustainability of these groups; however, they are still not at a point that will truly be fruitful in statistically decreasing the burden of disease from alcoholism in this country.

The improved sustainability of these groups is likely due to two factors. Firstly, the lack of anonymity in these groups that led to local empowerment of the group members themselves was a likely contributor. However, almost all of the pilot groups in 2013 were not anonymous. The second factor would be the groups being led by extremely dedicated local leaders. Several of the groups that were no longer running stopped meeting due to the lack of a dedicated leader to the group. This

suggests that in the future, leaders should be chosen who may have a specific relationship to the local community itself (this was true in Barrouallie as well as Bequia), and who have a unique sense of dedication and time to dedicate to the group. This is difficult due to the lack of ability to compensate the group leaders. Methods to combat this would be to raise funding or allot a budget for these local leaders, or to have a selection process for the leaders prior to the leading of self-help groups. Leaders who are active in not only sustaining the group each week but also in continuing to recruit new members are likely to be ideal candidates for this type of role.

Due to time constraints, post-intervention focus groups were not held in summer 2013. Obtaining the perspective of the local leaders in each community after the groups had been initiated would have been useful in solidifying the qualitative data as well as in making changes to current groups.

The team recommends that in the future, a two-tiered approach be utilized to decrease the incidence of alcoholism in SVG: one aimed at prevention in schools via education, and the second aimed at non-anonymous self-help groups led by carefully selected and if possible, compensated, local, dedicated community leaders such as nurses or community-known leaders rather than necessarily an alcoholic as the AA would advocate. Cultural competency must be taken into consideration when implementing programs to address alcohol use disorders, as alcoholism is an overlooked global issue.

Overall, the preliminary findings of this project were humbling. One basic component of Alcoholics Anonymous is that it is "anonymous." This project sheds

light on the idea that cultural variations between countries must be taken into consideration. Paternalistically imposing well-intentioned Western paradigms and values onto other communities may make implementing programs more difficult. However, using already-created and evidence-based paradigms and making changes via the results of qualitative and quantitative research allows us to enhance already existing resources and implement them in a country that is in need of these types of programs.

Acknowledgments

I would like to thank my parents, Ashok and Rekha Chhabra, and my brother, Vineet Chhabra for giving me the patience, work ethic, and education, and moral support to write this thesis and complete medical school. I would also like to thank my wonderful mentors, Dr. Brenner, Dr. Katz, Dr. Gimpel, and Dr. Niwagaba, for guiding me through this process. Thank you to my boyfriend, Cameron Locke, for impeccable grammar skills and for being by my side.

References

American Psychological Association. March 2013. Available at: http://www.apa.org/helpcenter/alcohol- disorders.aspx.

Cayetano C. Upgrading of the mental health community service in St. Vincent and the Grenadines: a way forward. St. Vincent and the Grenadines 2009.

Chen MS, Smart Y, Morris-Patterson A, Katz CL. Piloting Self-Help Groups for Alcohol Use Disorders in Saint Vincent and the Grenadines 2013.

Collins PY, Patel V, Joestl SS. Grand challenges in global mental health. Nature 2011;475:27-30.

Ezzati M,Lopez AD, RodgersA, VanderHoornS, MurrayCJ. Selected major risk factors and global and regional burden of disease. Lancet 2002;360:1347-60.

Hoffman F.Cultural adaptations of Alcoholics Anonymous to serve Hispanic populations. Int J Addict. 1994 Mar;29(4):445-60.

Kaskutas LA. Alcoholics anonymous effectiveness: Faith meets science. J Addict Dis 2009;28:145-57.

Knapp M, Funk M, Curran C, Prince M, Grigg M, McDaid D. Economic barriers to better mental health practice and policy. Health Policy Plan 2006;21:157-70.

Ministry of Health and the Environment. Strategic Plan for Health 2007-2012. St. Vincent & the Grenadines 2007.

Praud D, Rota M, Rehm J, Shield K, Zatoński W, Hashibe M, La Vecchia C, Boffetta P. Cancer incidence and mortality attributable to alcohol consumption. Int J Cancer. 2016 Mar 15;138(6):1380-7. doi: 10.1002/ijc.29890. Epub 2015 Oct 28.

Saxena S, Thornicroft G, Knapp M, Whiteford H. Resources for mental health scarcity, inequity, and inefficiency. Lancet 2007;370: 878-89. American Psychological Association. Understanding alcohol use disorders and their treatment.

Zylstra, R. The Use of Spirituality in Alcohol Recovery. Southern Medical Journal 2006:99:643-649.

World Health Organization (WHO). Assessment Instrument for Mental Health Systems (AIMS): Report on Mental Health System in Saint Vincent and the Grenadines. Geneva: WHO and Ministry of Health, Saint Vincent and the Grenadines. 2009.

World Health Organization (WHO). Global Health Observatory Data Repository.

World Health Organization. 2014. Available at: http://apps.
who.int/gho/data/node.main.A1071?lang1/4en.

World Health Organization (WHO). Mental health. World Health Organization. 2013.
Available at: http://www.who.int/mental_health/mhgap/ en/index.html.

Vitae

Divya Chhabra (September 23, 1989 – present) grew up in Calabasas, California, and Spring, Texas. She spent a year at UT Austin and transferred to Northwestern University, where she completed a degree in Psychology and Global Health. She has done global health work and education work in Saint Vincent and the Grenadines, Mauritius, Haiti, Nicaragua, and Mexico, and spent time at Sciences Po, Paris, to learn about global health systems. After college, she taught 5th grade on the south side of Chicago for Teach for America, and went on attend UT Southwestern for medical school. She will be attending the University of California at San Francisco to complete her residency in Psychiatry, and hopes to complete a fellowship in child psychiatry. She plans on continuing to work in global mental health for the remainder of her career. In her spare time, she enjoys wine, cheese, dancing, Broadway musicals, playing the violin and piano, and traveling.

Permanent Address: 16514 Glorietta Turn, Houston TX 77068