Annual Report of the

BERMUDA DRUG INFORMATION NETWORK

(BerDIN)

2019

GOVERNMENT OF BERMUDA

Department for National Drug Control

Authors:
Kyla Raynor, DrPH CHES, Senior Research Officer/Policy Analyst, Department for National Drug Control
Stephanie Tankard, Research Officer, Department for National Drug Control

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P. O. Box 480, HM CX, Bermuda

Telephone: (441) 292-3049
Fax: (441) 295-2066

E-mail: dndc@gov.bm
Website: www.gov.bm

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BERDIN'S MISSION

The BerDIN is committed to providing the evidence that allows for discussions and decisions to be informed by sound, centrally available, local data, on a wide range of issues that increase understanding of the complex, dynamic; and evolving nature of the Island's drug problem.

FOREWORD

"If everyone is moving forward together, then success takes care of itself."
~ Henry Ford

The publication of the report of the Bermuda Drug Information Network (BerDIN) for 2019 marks the ninth anniversary of its existence. Without the cooperation of its Members, the Department for National Drug Control (DNDC) would not be able to fulfil its mandate of ensuring that there is current, culturally relevant data available. The 2019 Annual Report of the BerDIN demonstrates that the Island's drug problem is persistent. The cultural shift toward the acceptance of cannabis in some communities may account for the increase in consumption, which makes prevention and intervention that more challenging. Cannabis use, as with use of other traditional drugs, such as heroin and cocaine, show little signs of diminishing. Later this year, the National School Survey 2019 will launch, giving us more information on the consumption patterns of cannabis use amongst our youth. This information will help us determine the nature and direction of programmes for this age cohort.

Internationally, a major challenge is access to and availability of opioid-based pain medication, which has contributed to a public health crisis and increasing overdose deaths. Although Bermuda has not experienced this challenge; an increase in benzodiazepines, fentanyl and synthetic cannabis require that our collective network must remain on alert. The legalisation of the use of cannabis for non-medical purposes in some countries has challenged the universal implementation of the United Nations treaties and a challenge to public health, particularly among young people. The conventions continue to limit the use of controlled substances, including cannabis, to medical and scientific purposes. In many countries, the poorly regulated medical cannabis programmes and the lower perception of risk has contributed to the uptake of cannabis by new users. According to the International Narcotics Control Board, when medical cannabis programmes are not regulated in accordance with the conventions the result is often a diversion to non-medical use.

"The cultural shift toward acceptance of cannabis in some communities may account for the increase in consumption, which makes prevention and intervention that more challenging."

While the drug control efforts seem daunting and the impact wide-reaching, the same spirit and commitment over the past 10 years are needed today. With the establishment of the National Drug Strategy for 2019-2024, there is an effort to better align policy that meets the needs of the community. In order for this to happen, capacity building and technical assistance in the areas of supply and demand reduction are required. As we work together to address the challenges faced and to promote public health and well-being through effective drug control, I wish to highlight that through joint efforts such challenges can be met. I hope this year's annual report will further inspire cooperation, forward thinking, and action by our strategic partners and the community at large. There is much work ahead and only through your engagement and support can we reduce the harms associated with alcohol and drug use.

Joanne Dean
Director
Department for National Drug Control
September 2019

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DATA NOTES

ACAD	Associate Alcohol and Drug Counsellor
ADS	Alcohol Dependence Scale
APP	Associate Prevention Professional
ATOD	Alcohol, Tobacco, and Other Drugs
BAC	Blood Alcohol Concentration
BACB	Bermuda Addiction Certification Board
BARC	Bermuda Assessment and Referral Centre
BPCS	Bermuda Professional Counselling Services
BPS	Bermuda Police Service
BSADA	Bermuda Sport Anti-Doping Authority
BYCS	Bermuda Youth Counselling Services
CAF	Confiscation Assets Fund
CAPS	Customs Automated Processing System
CARIDIN	Caribbean Drug Information Network
CBD	Cannabidiol
CBP	Customs and Border Protection (U.S.)
CCS	Certified Clinical Supervisor
CCES	Canadian Center for Ethics in Sport
CICAD	Inter-American Drug Abuse Control Commission
CLSS	Counselling and Life Skills Services
CPS	Certified Prevention Specialist
Co-Ed	Coeducational
DAST	Drug Abuse Screening Test
Detox	Detoxification
dl	Decilitres
DNDC	Department for National Drug Control
DPP	Department of Public Prosecutions
DSM	Diagnostic and Statistical Manual of Mental Disorders
DTC	Drug Treatment Court
DUI	Driving Under the Influence
EAP	Employee Assistance Programme
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ER	Emergency Room
FCU	Financial Crime Unit
FIA	Financial Intelligence Agency
FY	Financial/Fiscal Year
FOB	Free on Board
g	Grams
GBH	Grievous Bodily Harm
HM	Her Majesty
ICADC	International Certified Alcohol and Drug Counselor
IC&RC	International Certification and Reciprocity Consortium
ICD	International Statistical Classification of Diseases and Related Health Problems
IDU	Injecting/Intravenous Drug User
IOP	Intensive Outpatient Programme
JIU	Joint Inspection Unit of the United Nations
KEMH	King Edward VII Memorial Hospital
kg	Kilograms
L	Litre
LA	Litre of Alcohol
LLA	Liquor Licence Authority
LST	LifeSkills Training Programme
MDMA	Methylenedioxy-Methamphetamine
mg	milligrams
MT	Men's Treatment
MWI	Mid-Atlantic Wellness Institute
n	Number
NADO	National Anti-Doping Organisation
NPT/S	Non-Prescription Tranquilisers/Stimulants
OAS	Organisation of American States
OECD	Organised and Economic Crime Department
OID	Inter-American Observatory on Drugs
PATHS	Promoting Alternative THinking Strategies
POCA	Proceeds of Crime Act
PWC	Professional Worldwide Controls
Q	Quarter
r	Revised
RLH	Right Living House
SAR	Suspicious Activity Report
SI	Specialist Investigations
SSATS	Survey of Substance Abuse Treatment Services
TAAD	Triage Assessment for Addictive Disorders
TC	Therapeutic Community
THC	Tetrahydrocannabinol
TIPS	Training for Intervention Procedures by Servers of Alcohol
u	Units
UKAD	United Kingdom Anti-Doping
UNDCP	United Nations Drug Control Programme
UNODC	United Nations Office on Drugs and Crime
USADA	United States Anti-Doping
WTC	Women's Treatment Centre
%	Percentage
000	Thousands
-	Zero or unit less than 0.1
$	Bermuda Dollar
..	Not Applicable
…	Not Available

Percentage totals may not add to 100% because of rounding. The data and estimates presented in this report are the best approximations available and are subject to revision with the availability of more accurate and revised numbers with improvements in information systems related to drug control. In some instances, data was revised from previous publications.

INTRODUCTION

This publication, now in its ninth year, continues to be the only source of local and culturally relevant information concerning the current drug situation in Bermuda. The publication continues its top-level overview of the drug situation in Bermuda from drug supply, use, public health perspectives, and policy-level solutions. The data provided, compares the years 2017 and 2018 over 11 chapters and is provided by key industry stakeholders. This introductory section features a short analytical comment on some of the key themes emerging from this year's data. As the drug problems facing Bermuda are increasingly influenced by, and interact with, developments occurring internationally, two important topics, cannabis use and synthetic drugs, remain nationally relevant today.

"As the drug problems facing Bermuda are increasingly influenced by, and interact with, developments occurring internationally, two important topics, cannabis use and synthetic drugs, remain nationally relevant today."

As the country approaches the beginning of a new strategic direction concerning drug control, with the renewal of the Master Plan, demand reduction activities will remain focused on stabilising substance abuse prevention and treatment services. Supply reduction agencies continue to meet the challenge of interdiction, while working with significant staff and equipment challenges. The drug control system continues to be burdened by a lack of information with respect to key areas of the drug market, a lack of sufficient and accessible treatment beds, drug intelligence on concealment methods, adulteration steps, the distribution from wholesale all the way down to the retail level and, finally, consumption. Overall, there is still much to learn about synthetic drugs, such as Fentanyl and cannabis products, especially synthetic cannabis.

The data in this report has been collated to aid the reader's understanding of the interrelated elements that comprise drug control. After nine years, the BerDIN remains the chief source of collective statistical information on the use of illegal drugs, alcohol, tobacco, demand and supply reduction activities. The BerDIN Report continues to evolve as new information becomes available. Caveats and qualifications relating to the data are found in each chapter of this report. Also included in each chapter, are detailed information on methodology, qualifications on analysis, and comments on the limitations in the available information. Some of the information contained within this report is derived from self-reported data provided in surveys, while other information is based on record review, psychometric testing, and biological screening results. No one piece of information stands alone. As such, in its totality, the data presented in this report seeks to inform the reader on the current drug situation in Bermuda.

The Drug Situation in Bermuda

"…cannabis and alcohol have remained the most widely used drugs on the Island."

Between 2017 and 2018, cannabis and alcohol accounted for majority of substances used on the Island. They were the drugs of choice for most persons seeking a treatment assessment, at BARC, over the past year and for which people received a clinical diagnosis. This was followed by persons receiving a clinical diagnosis for cocaine or opiates. Often times, narcotic drug use is linked to drug-related or drug-induced crimes, which is discussed in relevant chapters of this publication. However, the Department of Corrections reported that reception inmates continue to test positive for mostly THC, cocaine, and opiates, and a significant increase in poly drug use amongst reception inmates was also reported. Random drug screens revealed the use of THC and opiates, while inmates who were incarcerated dramatically decreased in 2018.

"Synthetic drugs used singly or in combination with other drugs was a serious concern in 2018."

Poly drug use remains constant among users of narcotic drugs. Often observed amongst reception inmates, the use of opiates, namely heroin and cocaine, has been stable among persons committing crimes over the past two years. Synthetic drugs, used singly or in combination with other drugs, was a serious concern in 2018. Anecdotal evidence suggests young people are accessing these man-made drugs more often than in previous years. Such drugs include shatter, molly, and synthetic marijuana.

During 2018, drug-related Hepatitis C cases remained stable, while the number of pregnant women testing positive for THC decreased during the same period. All too common is the use of alcohol and/or drugs in road traffic accidents. This past year saw an increase in toxicology screens, which showed an increase in the proportion of cases that exceeded the legal limit for alcohol and drugs. When it came to suspicious deaths, there were eight cases where the external cause of death were transport accidents along with four cases in 2018 of death by assault and eight road traffic fatalities for which alcohol and drugs were present. This suggests a continued public health crisis related to the presence of substance use in deaths and accidents.

Substance Abuse Treatment and Level of Severity

The year 2018 saw an increase in the number of persons seeking substance abuse treatment, both as an outpatient

and for residential care. Amongst new people seeking treatment services in 2018 for any substance, a large proportion had a clinical diagnosis of moderate to severe substance abuse or dependence. Reports indicate that more people, new to drug treatment, were likely to not be poly drug users, but more likely to meet the criteria for abuse of alcohol, cannabis, and opiates, while persons who have been in treatment before were likely to be poly drug users and more likely to be dependent on cocaine, alcohol, and opiates. The majority of persons referred for substance abuse treatment between 2017 and 2018 were repeat cases.

Alcohol, Drugs, Morbidity and Mortality

There has been little progress in the way of alcohol reduction in the population for the two years covered in this publication. From a public health perspective, alcohol misuse continues to be relevant in several areas. The number of persons stopped and administered the breath test increased significantly between 2018 and 2019 (increase by 80 persons), especially when it came to those who were in excess of the legal limit. Although there were 38 road traffic accidents with breath tests above the legal limit, only 15 people attended the DUI class in 2018. Additionally, when it came to toxicology screens, there were some deaths that were mainly a result of traffic accidents, while a number of deaths in 2018 were due to drugs and a combination of alcohol and drugs.

Ever-Present Drug Market

The Treatment Demand Survey at local treatment centres indicated that the drug market is alive and flourishing in Bermuda as the primary drugs of choice, alcohol and marijuana, were available and affordable in 2018. While resources continue to be dedicated to restricting the supply of drugs into Bermuda as part of an integrated and balanced approach, it also recognises the parallel importance of reducing the demand for drugs. Criminal trials and convictions for drug possession have significantly decreased over the past year, especially trials for possession of cannabis. Universal changes in how cannabis is viewed has led to relaxed policies with respect to simple possession, especially in Bermuda, with the decriminalisation of less than seven grams of marijuana. Synthetic drugs, such as molly, spice, fentanyl, and cannabis were reported to be used in the community. There is also a growing market for marijuana oils, concentrates, and edibles. Youth report that marijuana edibles are readily available and often for sale within their school grounds by fellow students.

Legislation

The legislative framework underpinning drug control appeared, in full swing, in 2018. Coming off of the Cannabis Decriminalization Act of 2017, 2018 saw the announcement of pending legislation for medical cannabis. In essence, the government proposes to pass legislation allowing patients suffering from certain health conditions (such as terminal cancer, epilepsy, and neurological illness) to use cannabindoids and cannabis to treat the symptoms of their illness. In some jurisdictions, medical cannabis programmes have had an adverse impact on public health because they have not been effectively regulated in line with the international drug control treaties, resulting in the diversion of cannabis to non-medical use.

A significant gap in the drug control system continues to exist with the unaddressed enforcement of current legislation such as, restricting alcohol sales to persons 18 years and older.

"A significant gap in the drug control system continues to exist with the unaddressed enforcement of current legislation."

Disparities in Treatment

During 2018, the demand for drugs remain unchanged all while significant challenges persist in adequately addressing the needs of substance users, their families, and the community. In a resource challenged environment, supply and demand reduction agencies have been struggling to meet their mandate. Areas of continued shortages include: sufficient funds to execute operations, equipment purchase, available training, technical assistance, and qualified staff.

While substance abuse treatment remains the largest component of drug control expenditure, there continues to be waiting lists for services, especially for grant-funded agencies that saw level funding during the fiscal year. The treatment gap persisted for persons seeking a substance abuse assessment in that, while a person may go through the assessment phase, he/she may not follow through with the recommended level of care, leaving a "treatment gap" between the persons needing and receiving treatment.

Dual-diagnosed persons, those with mental health conditions and substance dependence/abuse, continue to lack the needed facility to provide treatment services. While the Mental Health Treatment Court, a programme of the Department of Court Services, continues to be operational, there are no in-patient medically-monitored drug treatment facilities on Island which makes placing dual-diagnosed clients in treatment even more difficult.

Demand and Supply Reduction Activities and Initiatives During 2018

During 2018, there were a number of supply and demand reduction activities implemented. In many cases, these initiatives are supported by the data compiled in this report. Other activities, especially those of supply reduction, may be captured elsewhere as a part of the respective agencies' annual report.

Management and Coordination

- The DNDC was consulted on special licenses for terminally ill patients requiring medical marijuana; the processes to make medical marijuana available to the community; CBD oil accessibility and a request to import Kratom. Advice was provided in collaboration with the Department of Health.
- Amendment of the Misuse of Drugs Act and Pharmacy Act schedules to include synthetic drugs and update the formulary.
- DNDC secured approval to recruit for multiple vacant post throughout the Department and successfully recruited for them. Secured a new site for Transitional Housing for the Women's programme in a Government-owned facility and arranged for required renovations in collaboration with the Department of Public Works.
- Government successfully distributed and monitored the utilisation of grant funding to CADA, PRIDE, BACB, FOCUS, and the Salvation Army Harbour Light and The Community LifeSkills Programme.

Substance Abuse Treatment

- CARF re-accreditation supported by developing Quality Improvement Plans for Turning Point (MWI) and Women's Treatment Centre (WTC), while Men's Treatment (MT) maintained compliance with CARF standards.
- DNDC implemented Recovery Month. This was a success, with 12 events including: radio interviews, newspaper supplements, tree planting by Minister Weeks, Turning Point football match, Salvation Army Recovery walk, WTC tea party, RLH Open house, and FOCUS annual recovery cruise.
- Bermuda Addiction Certification Board presented two evidence-based workshops to local treatment and prevention professionals.
- WTC census – admissions ran on average at 33% and successfully achieved three-year CARF accreditation.
- MT census – admissions ran at 63%.
- Salvation Army's Harbour Light programme continued with up to nine clients in the year, while the community life skills programme reached over 20 people.
- FOCUS continued with transitional housing offering 12 beds and over 100 counseling sessions.
- Right Living House selection committee met regularly and saw two clients graduate from the aftercare program, while the Alumni Group met regularly. RLH maintained an annual census of 83% of a 12 bed capacity.

Substance Abuse Prevention

- DNDC's Prevention Unit conducted two training sessions in collaboration with the Bermuda Addiction Certification Board. One training session was specific to substance abuse treatment and prevention ethics. The second training was on the role of prevention practitioners in engaging the broader community. There were a total 36 participants.
- Drug prevention education has been implemented in all government preschools through the Al's Pals programme. Ten government schools use the programme at the lower primary school level. Two schools in the private sector utilised the Al's Pals programme.
- Public education was provided on fentanyl, alcohol and marijuana. Print, audio, and social media outlets included the Royal Gazette, Inter Island Communications, Bermuda Broadcasting, Harper Digital, Crimson Multi-media, and Bernews.
- Two cohorts from the Right Living House received parenting skills for persons in recovery. The evidence-based Parent's Toolshop programme was delivered to a total of 22 inmates.
- The Teen Peace Programme has been implemented at all five middle schools. There were a total of 65 students represented in the programme.
- Substance abuse resource information and education for community stakeholders included the Ministry of Health Celebrating Wellness, where the focus was educating parents on the services, programmes, and resources available for substance abuse.
- Participated in the KAPPA Soccer Classic in collaboration with the Bermuda Anti-doping Authority. There were over 1000 participants at the KAPPA Soccer Classic.
- CADA conducted Lifeskills Training with on average 66 students per quarter at Somersfield Academy and implemented over 100 community awareness and education sessions.
- PRIDE provided the Youth Club to up to nine primary schools during the year reaching over 150 students; lifeskills was implemented with 400 students in the school year.

Research

- DNDC Commissioned the Omnibus Survey on public amenity.
- Institutionalised Training for Intervention Procedures (TIPS) for all servers and waiters of alcohol in licensed establishments continues to be tracked and monitored.
- Completed development of the National Drug Information Network, BerDIN, to identify prevention

indicators in the data management system.

- DNDC liased with HM Customs and BPS, which received funding for interdiction training.
- DNDC held BerDIN annual meeting, October 2018.
- NOVA Ltd. continued to develop database for BerDIN Phase 3 (public access).
- Hired consultant to evaluate National Drug Control Master Plan, 2013-2017.

Coordination Mechanism

The Annual Report of the BerDIN is produced by the DNDC's Research Unit. This report is comprised of national focal points from agencies offering drug-related interventions and services. Under the responsibility of their respective organisations, the focal points are the indicators collected by each agency and provided to the DNDC on either a monthly, quarterly, or annual basis. Data provided to the DNDC for publication is screened for consistency to ensure the provision of valid and reliable information is reported on an annual basis.

This publication of the BerDIN aims to broadly disseminate and inform the public of the magnitude of the drug problem and, in turn, identify ways to improve the general infrastructure and support for applied research in this sector; thereby increasing both the quantity and quality of outputs. To become a Network member, agencies must be working with drug-related information in Bermuda. As is expected, a variety of coordination approaches has been adopted, depending on the priority given to the drug problem within each member agency.

Stability of the BerDIN relies strongly on the participation and cooperation of respective agencies. This 2019 Annual Report marks the ninth year in which over 18 sources of drug-related information were provided to inform the drug situation in Bermuda (see Appendix I). The information continues to be presented in table format and represents the most up-to-date data on the Island in this field. Reporting agencies submitted data by May 15th of the current year to allow sufficient time for data cleaning, verification, and follow-up in preparation for pre-press layout and design.

The establishment of the BerDIN resulted from the 1998 United Nations General Assembly Special Session (UNGASS) meeting where the United Nations Drug Control Programme (UNDCP), now the United Nations Office on Drugs and Crime (UNODC), was mandated to provide assistance for data comparability. This meeting resulted in the Lisbon Consensus where the UNDCP and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) established a Global Programme on Drug Abuse.

However, as a regional response, the Inter-American Observatory on Drugs (OID) was created in 2000 as part of the Inter-American Drug Abuse Control Commission (CICAD) within the Organisation of American States (OAS). It operates at the hemispheric level and assists countries within the Americas and Caribbean to build and promote its respective national drug information network or observatory and to utilise standardised data and methodology.These national networks should offer objective, reliable, up-to-date and comparative information so that the organisation's member states can better understand, design, and implement policies and programmes to confront the drug phenomenon in all its dimensions. Subsequently, as part of this mechanism, a regional surveillance network – the Caribbean Drug Information Network (CARIDIN) – was formulated for countries within the Caribbean region. It held its first meeting in 2001.

Although Bermuda is not a member of the OAS, it has been involved in numerous meetings held regionally, and benefits from the expertise shared at these meetings in developing and expanding its national network.

Definition of the BerDIN

The Bermuda Drug Information Network is a group of people, who represent either themselves or an agency, whose aim is to provide Bermuda with factual, objective, and comparable information concerning drugs and drug addiction, and their consequences; for the purpose of monitoring trends, developing policy, and implementing appropriate programmes and responses. (Adopted from the EMCDDA-CICAD-OAS's Joint Handbook)

Mission of the BerDIN

The BerDIN is committed to providing the evidence that allows for discussions and decisions to be informed by sound, centrally available, local data, on a wide range of issues that increase understanding of the complex, dynamic, and evolving nature of the Island's drug problem.

Importance of the BerDIN

Historically, drug use is a difficult and complex phenomenon to monitor. For a comprehensive understanding of the current drug situation in Bermuda, a multi-source or multi-indicator system was established – the BerDIN – to provide insight into the different aspects of the drug problem. It brings together institutions and individuals working in the areas of drug prevention, education, treatment, rehabilitation, counselling, control, health, and law enforcement to exchange drug-related information. This multi-stakeholder initiative, where all parties seek to collaborate and support each other's efforts at national drug control, provides a mechanism to monitor and evaluate the implementation of the National Drug Control Master Plan over the life of the Master and Action Plans.

Reliable, accurate, and up-to-date data on drug prevalence are needed to guide the development of demand reduction strategies and implementation of their activities. At the community level, data may be able to identify trends within communities, which may lead to identification of shortcomings at an early stage and control measures can be put in place. Regular assessment of the status of the drug use and abuse problem can also serve as an early warning system for new and emerging trends in drug abuse.

Purpose of the BerDIN

The BerDIN serves a critical role in the assessment and evaluation of the Island's drug situation. Its main objective is to provide information essential for policy making, allocation of resources, organisation of drug-related services and programmes, and on drug-related issues of interest. It was setup to:

- Identify existing drug abuse patterns (different time periods and population groups);
- Identify changes in drug abuse patterns (types of drugs, characteristics of drug users);
- Monitor changes to determine if they represent emerging drug problems;
- Provide a detailed analysis of the drug situation in Bermuda through report and dissemination of information;
- Raise awareness of drug-related problems;
- Guide the development of primary prevention, public education, and treatment programmes and policies;
- Stimulate further discussions on drug demand

reduction or drug supply restriction policies and challenges; and

- Serve as a useful methodology for integrating agencies involved in drug reduction or control.

Core Functions of the BerDIN

To meet the main objective, the BerDIN performs the following three core functions:

1. Data collection and monitoring at the national level;
2. Analysis and interpretation of information collected; and
3. Report and dissemination of information.

Contribution to Programme Development

The information collected provides a background for:

- Local prevention, treatment, and control strategies.
- At the national level, strategies are increasingly focused on demand reduction, which must be based on reliable and valid epidemiological data.
- Countries where national data are regularly collected are able to participate better in international discussions on drug issues.
- The regular assessment of the status of drug use and abuse can also serve as an early warning system that will alert other countries, as new trends in drug abuse have the tendency to cross national borders and spread to neighbouring countries.

Network Members

The BerDIN was formed in 2008. Its creation was sanctioned by Cabinet in 2006 as a Throne Speech initiative. To date, it has representation from the following agencies, whether directly or indirectly involved in the area of drug control, and some of which are outside the sphere of government:

1. Bermuda Hospitals Board
   - i King Edward VII Memorial Hospital
   - ii Turning Point Substance Abuse Programme
2. Bermuda Police Service
3. Bermuda Sport Anti-Doping Authority
4. Counselling and Life Skills Services
5. CADA
6. Department of Corrections
   - i Westgate Correctional Facility
   - ii Right Living House
7. Department of Court Services
   - i Bermuda Assessment and Referral Centre
   - ii Drug Treatment Court
8. Department of Health
   - i Central Government Laboratory
   - ii Epidemiology and Surveillance
9. Department for National Drug Control
   - i Men's Treatment
   - ii Research and Policy Unit
   - iii Women's Treatment Centre
10. Financial Intelligence Agency
11. HM Customs
12. Liquor License Authority
13. Supreme Court

Common Sources of Data

Data is usually obtained from a variety of quantitative and qualitative sources:

Quantitative

- Government records/secondary sources
- Primary surveys/studies
- Psychometric tests
- Biological screens
- Indirect estimation or derivation

Qualitative

- Focus groups
- One-on-one meetings
- Treatment and prevention forums
- Expert opinion

(See Summary of Sources and Data in Appendix I)

Data Gaps

While the drug control data monitoring system has operated for some ten years now, it is not without flaws. Information collected from agencies may change periodically as indicators are expanded or if an agency changes its programme focus. Despite the continued challenges facing Network member agencies, the provision of information, even though delayed at times, continued.

There remain gaps in our understanding of the drug phenomena related to the environment in which substance use occurs, alcohol and drug use, prevention, treatment and support activities, criminal justice, and drug-related harms. Information gaps also include, but are not limited to: the drug market in terms of the availability of synthetic drugs; trafficking activities and routes; concealment methods; the adulteration steps; the distribution from wholesale all the way down to the retail level; consumption in terms of problem drug use in the general population; the contribution of drugs to the social and economic environment; and the social outcomes related to treatment programmes.

DNDC's Role

In addition to conducting primary drug-related research and providing technical assistance, the DNDC facilitates and coordinates the BerDIN by collecting, collating, producing, and disseminating updated reports on drug facts and related anti-social behaviours as part of its on-going effort to standardise the drug literature dissemination mechanisms and processes on the Island (technical reports, posters, brochures, and other educational materials). All information provided to the DNDC is treated with confidentiality and are usually reported in an aggregated form.

Organisational Challenges

The BerDIN relies heavily on the ability of Member agencies to provide topic specific information in a timely and organised manner. Organisations that dedicate time, resources, and human capital for the long-term utilisation and maintenance of that information often provide accurate and reliable data. During 2018, the organizational challenges were due, primarily, to reduced funding leading to staff shortages and an inability to offer the full complement of services. At times, this meant the provision of information was delayed. Another main challenge for the BerDIN was the provision of information from the BPS, specifically statistics related to drug seizures and crime statistics. Furthermmore, not all of the agencies inputted their data by the May 15th deadline, the majority were able to provide their information within a reasonable time beyond the deadline.

Despite these issues, this Annual BerDIN Report includes an overall total of about 35 drug control areas being monitored with over 150 indicators. The DNDC continues to work with organisations to build capacity that will allow them to organise, maintain, and effectively utilise data gathered to inform polices and programme direction.

Joining the BerDIN

Any agency that produces drug-related data can join the BerDIN by contacting the Research and Policy Unit of the Department for National Drug Control at 292-3049.

Meeting 2018

The 2018 Annual Meeting of the Bermuda Drug Information Network (BerDIN) was held on the 18th and 19th of October, 2018 in the Princess Victoria Room of the Hamilton Princess (Hotel) and Beach Club.

Anthony Santucci, a BerDIN Member who represented CADA, called the meeting to order and extended a welcome to the meeting's participants and invited guests. The Hon. Michael Weeks, JP, MP, Minister of the Ministry of Social Development and Sports, brought Opening Remarks to the meeting. He noted the vital role of the BerDIN within the health and social service systems to help better understand the trends associated with addiction, prevention, treatment, rehabilitation, and drug interdiction. Mr. Weeks highlighted some of the challenges ahead and called for continued dialogue that can lead to a better understanding of the issues that continue to affect the community. He also shared, that policy makers have to look for effective and humane ways to manage drugs in Bermuda. In closing, Minister Weeks emphasised that the renewal of the National Drug Control Master Plan 2019-2024 is Government's first step at addressing the needs of the community by putting health first. Following the Opening Remarks, the meeting was officially declared open by Minister Weeks.

Participants were reminded of the meeting's objectives by Mrs. Deborah Hunter, Chief Executive Officer, Bermuda Sport Anti-Doping Authority. The meeting's objectives were: to update the BerDIN members on the current drug situation; to provide a forum for dialogue on drug-related special interest topics; and to enhance the well-being of the BerDIN members through team building activities and wellness presentations. The objectives of the second day were outlined as: to develop good working relationships among all Members by providing the experience of working together as a team; and to obtain knowledge regarding the connection between physical, emotional, and spiritual health.

The keynote address was brought by the Clinical

Psychologist of the Mid-Atlantic Wellness Institute, Dr. Shawnee Basden. This was the fourth year, in succession, that the meeting has had a keynote speaker. Dr. Basden was introduced by BerDIN Member, Ms. Isis Wellman, who represented Turning Point Substance Abuse Programme. Dr. Basden was honoured to be invited to the BerDIN Annual Meeting as the keynote speaker. Her presentation focused on substance use and the developing mind. The scientific approach to this topic allowed participants to learn about: substance use in critical developmental stages and the significant impact on future functioning, how substance use changes the functioning brain, and the implications it has for the treatment and prevention processes.

Dr. Basden also shared her insight on the mediating factors that affect substance users, particularly genetics and the age of onset followed by an informative discussion around genetic vulnerabilities with regards to marijuana use on adult psychosis, drug addiction and the effects on the brain, the process of addiction, and accommodations.

The Community Development Coordinator of the DNDC, Mrs. Kimwana Eve, informed the participants about the six prevention programmes currently running in the community. The Government funded and grant-operated programmes discussed were: AL's PALS (DNDC), LifeSkills (PRIDE and CADA), Teen Peace (DNDC), Gang Resistance Education and Training (Bermuda Police Service), and Promoting Alternative Thinking Strategies (PRIDE). Mrs. Eve thanked the agencies that undertake drug prevention work throughout the community and pledged the DNDC's support for these prevention efforts going forward. Lastly, prevention adverts were shown as well as a current AD campaign in the form of a video.

With the assistance of an external vendor, a video was shown capturing the views of a few persons who represented a variety of demographics. These persons were asked six questions that were centered around marijuana and alcohol use on the Island. The six questions that were asked were as follows:

1. Do you think marijuana is a drug?
2. Do you think marijuana it's addictive?
3. Do you support legislation being changed to make marijuana legal?
4. Do you think doing one drug (for example, cigarettes, marijuana) can lead to use of other drugs?
5. Does social media influence your decisions when it comes to drinking and/or using illegal substances (that is, Marijuana) or legal substances (that is, Alcohol)? If yes, why?
6. What do you think 'we' as a country can do better to discourage substance use and/or excessive drinking?

The video caused some discussion amongst participants. The aim of the video was shared with the group, which was to be able to find out the pulse of the community on this subject matter. Participants were encouraged to use this video as a tool to improve and/or create new initiatives that will better educate the public on substance use in Bermuda.

The meeting invited Magistrate Juan Wolffe to give a presentation on the "Glorification of Substance Use". This presentation discussed, in-depth, the many social media apps that parents should know about and the negative influence that marijuana and alcohol have had on the music persons listen. Magistrate Wolffe continued by sharing a variety of flyers used in Bermuda to advertise events (adult and family based) all of which had images of alcohol. He noted that images are powerful as they quickly transmit information to the brain and trigger emotions. They also impact a persons' ability to make decisions that could influence their actions. The remainder of the presentation showed the participants the music lyrics that they, as well as their children listen, which all sing/rap about the use of drugs and/or alcohol use. Magistrate Wolffe showed this concept from a Bermuda context as well as from an international perspective. He concluded by suggesting three solutions, which were as follows:

1. A robust and perpetual educational/media awareness programme in the schools and on social media to counteract the glorification of substance abuse by hammering home the negative consequences of drug and alcohol consumption.
2. Encouraging parents (and maybe showing them how) to limit their child's access to media, social media, and television.
3. Providing parents with resources and information to promote media awareness programmes in their communities and schools.

The meeting received a presentation from Dr. Kyla Raynor, BerDIN Coordinator and Senior Research Officer/Policy Analyst of the DNDC, on the current drug situation in Bermuda: a brief background; new developments including changes, work-in-progress, and new initiatives; updated reports, monitoring mechanisms including coverage, challenges, data gaps, and unresolved areas; the BerDIN data management system; network and institutional strengthening proposals; and keys to sustainability over the next five years, given that this year marked the seventh meeting since the group reengaged. Further, the BerDIN Coordinator provided a snapshot of Bermuda's drug situation as presented within

the 2018 Annual Report of the BerDIN, using some available data on; access and availability of alcohol and other drugs; youth, inmates, and prenatal drug use; treatment referrals; clients in treatment; and the cost of drug control efforts, to highlight the current state. The members of the planning team were acknowledged for their contribution to the meeting preparation.

Chief Inspector Robert Cardwell of the Bermuda Police Service gave an interesting presentation on how the roadside sobriety testing device is used. He also discussed the legal framework for which roadside sobriety check points and breath testing are allowed. He shared data on the number of arrests that have been made thus far, explaining that it is proving to be a deterrent for drink driving. The aim of this initiative is to change the mindset of the public when it comes to drinking and driving, with safety being the priority of all persons.

The DNDC representative, Mrs. Stephanie Tankard, Research Officer, provided the meeting with an update on the Department's newest survey initiatives since the last meeting. The data that was presented came from the 2017-2018 Drug Abuse Monitoring Survey (Prison Survey) and the 2018 Public Perception of Substance Abuse/Misuse Survey. In relation to the 2018 Public Perception of Substance Abuse/Misuse Survey, the presentation gave an overview of the data collected in the areas such as: concern and awareness, social and retail availability, law enforcement, consequences of drug use, and substance use- treatment/prevention. The Prison Survey data that was shared covered topics such as: drug abuse and drug screening, mental health, drug overdose and substance abuse treatment, criminal record, HIV/AIDS and hepatitis B status and abuse history, drug prices, the drug abuse screening test (DAST), and gang involvement.

Mrs. Joanne Dean, Director of the DNDC, gave the meeting an update with regards to the evaluation conducted on the National Drug Control Master Plan 2013-2017 and Action Plan. She highlighted the findings on what has been accomplished and a way forward with the outstanding items contained in the Master Plan. It was noted that the Master Plan is structurally sound with three goals supported by 18 objectives and 59 action plans. The Director stated that, according to the budget for supply and demand reduction, it always comes up short but demand does better then supply with regards to realizing anticipated need.

As of January 2018:

- 27 of the 59 (46 percent) action plan were incomplete,
- 19 action plan points are considered complete,
- eight action points are classified as "ongoing", and
- five action points are catalogued as "partially complete".

There was considerable progress made in reducing adult drug use over the period of the Master Plan, but it was found that youth are using more drugs in Bermuda. Between 2010 and 2016, the number of individuals admitted to drug treatment increased, whilst there was also a noted improvement in crimes, drug possession, and importation of drugs. Moving forward, Mrs. Dean shared the six recommendations which were given and shared that the DNDC intends to spend time researching these recommendations and building the 2019-2023 National Drug Control Master Plan.

Ms. Chalsey Symonds, Government Analyst, addressed the meeting by giving a fascinating update on cannabis and its evolution in Bermuda, over the past two years. There was a noted increase in the number of cases that have been submitted. As of 2017, there has been an increase in "products" that contain cannabinoid sent to the lab. She discussed the legislative changes that have affected these increases as well as the concentrates, which are popularly known to contain THC and CBD. In closing, images were shown of cannabis edibles that were being used in the community and have come into the lab for testing.

Dr. Raynor made brief closing remarks and thanked the participants for contributing to, what she deemed as, another successful meeting, and was grateful for their invaluable contribution. She also acknowledged the contribution over the past seven years of the Graphics and Design team of the Department of Communication and Information, who have designed and laid out the BerDIN Annual Report and meeting items. She encouraged participants to continue the collaboration beyond the meeting.

The second day of the meeting began with a half day morning session on the "4 Essential Roles of Leadership". It allowed the membership to participate in a transformational leadership journey that gave them the framework, skills, and tools to be a great leader. The session was taught by Mr. Richard James and showed participants how to consistently portray the four essential leadership roles whereby they: inspire trust, create a compelling vision and strategy, align core systems to execute strategy, and help team members reach their potential through regular coaching and feedback.

For the afternoon session, there was a live presentation by Ms. Doreen Williams, owner of Wild Herbs and Plants Bermuda. The aim of her business is to empower people with the information they need to live healthy, non-chemical based lives through the use of local plants. During her presentation, she highlighted a number of locally grown plants that can be used for cooking and many other uses. The health benefits of each plant represented was given to the group, whilst also indulging in samples of plant-based

food items that were prepared. The membership completed the day with an informative walk through Admiralty Park. The guided tour, by Ms. Williams, highlighted the different plants that grow at this location and for what purposes they can be used.

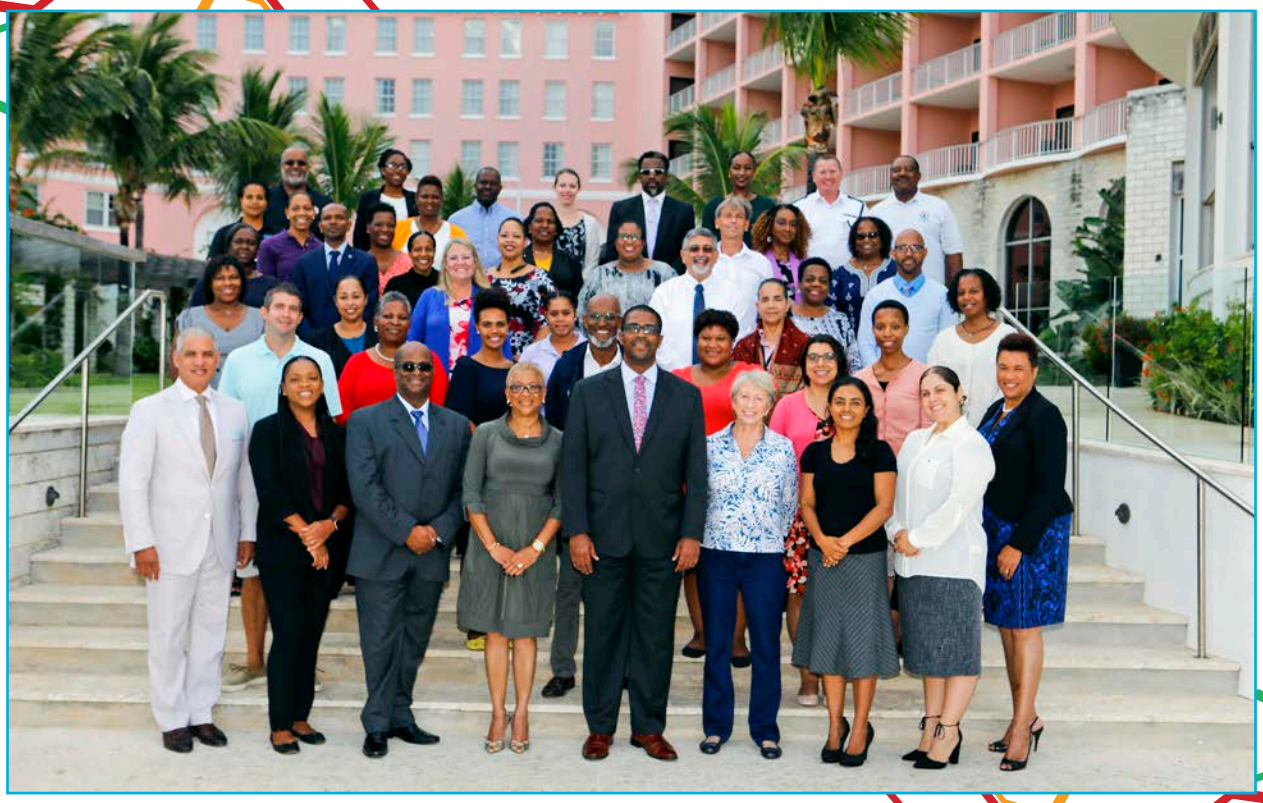


Photo courtesy of DC

Chapter 1
Criminal and Suspicious Activity

- Drug Seizures
- Prosecutions
- Financial Intelligence
- Financial Crime

1.1 DRUG SEIZURES

The BPS made 1,080 drug seizures in 2018, resulting in separate drugs being recovered with a combined weight of 142,011.14 grams (Table 1.1.1), almost double the weight seen in 2017. During 2018, cannabis drugs continued to be the most common drug type seized, with a total of 111.5 thousand grams (Table 1.1.1). This was a significant increase (113.3%) from the amount of cannabis seized in 2017. When it came to narcotic drug seizures, crack cocaine continued to be seized most often than any other drug. There was a notable amount of MDMA type drugs seized in 2018, while no MDMA type drugs were seized in 2017.

Table 1.1.1
Drug Seizures by Type of Drug, Total Count and Total Weight, 2017 and 2018

DRUG	2017		2018	
	Total Count (n)	Total Weight (g)	Total Count (n)	Total Weight (g)
Cannabis	342	52,298.94	467	111,545.20
Cannabis (Resin)	69	7,012.23	68	11,114.27
Cannabis (Seeds)	20	49.76	12	14.6
Cannabis (Plant)	163	-	272	-
Cannabis (Edibles)*	-	778.8	29	502.98
Crack Cocaine	50	704	47	735.05
Cocaine+	31	6,341.27	41	11,479.94
Heroin/Diamorphine drugs	29	3,843.95	26	2,272.56
Not a controlled substance	78		103	2,869.81
Designer Drugs				
Fentanyl drugs	-	-	1	-
MDMA drugs	-	-	12	1,475.81
Synthetic cathinone derivative	2	131.3	2	0.93
TOTAL	**784**	**71,160.25**	**1,080**	**142,011.14**

Notes:
*Edibles are food products similar to candy or gummies.
+ Cocaine Hydrochloride

1.2 PROSECUTIONS

Information on criminal prosecutions is reported by the Registrar of the Supreme Court through its Information Systems Administrator. The composition and constitution of the Supreme Court is defined by the Bermuda Constitution; and its jurisdiction governed by the Supreme Court Act 1905 and various other laws. The Supreme Court hears more serious criminal cases, which are tried by judge and jury.

Criminal trials were for such offences as possessing drugs, possessing drugs with intent to supply, handling drugs with intent to supply, supplying drugs, importing or trafficking, conspiring to import other drugs, possessing drug equipment, cultivating cannabis, and several trials for alcohol-related offences (see Tables 1.2.1 and 1.2.2). Criminal trials for drug-related offences increased from 155 in 2017 to 187 in 2018 (Table 1.2.1). In both years, the majority of drug-related trails were for possession of cannabis, which decreased from 56 in 2017 to 38 in 2018, along with criminal trials for the possession of cannabis with intent to supply (see Table 1.2.1).

There was a significant change (41.9% increase) in the number of criminal trials for alcohol-related offences in 2018, although the breakdown differs by sex of the offender (see Table 1.2.2). In the second consecutive year, a large number of criminal trials were the result of impaired driving of a motor vehicle, excessive alcohol in operating a motor vehicle, and refusing the breathalyser test.

"…of all alcohol-related offences, a significant number of these trails were the result of impaired driving of a motor vehicle, excessive alcohol in operating a motor vehicle and refusing the breathalyser test."

For drug-related offences, most of the acquittals in 2018 were for possession of cannabis (see Table 1.2.3), while for alcohol-related offences, the majority of acquittals were for impaired driving of a motor vehicle (see Table 1.2.4). There were also more convictions in 2018 for both criminal drug- and alcohol-related offences when compared with 2017 (see Tables 1.2.5 and 1.2.6). An increase in criminal convictions for drug-related offences was observed in 2018 for the second year in a row. In both years under review, these convictions were mainly for the possession of cannabis and importation of cannabis; the latter increased by 10 cases. In comparison,

criminal convictions for alcohol-related offences, on the whole, increased considerably in 2018 to 209, up from 151 cases in 2017. Impaired driving of a motor vehicle, excess alcohol motor vehicle, and refusing the breath test represented the highest proportions of alcohol-related criminal convictions.

Lastly, there were some drug- and alcohol-related cases in which the result of the case was classified as 'unknown', meaning that the result of the case (conviction or acquittal) was not recorded. The number of drug-related unknown cases decreased from 25 cases in 2017 to 22 in 2018 (see Table 1.2.7). However, when it came to alcohol-related cases, more cases were classified as 'unknown' in 2018 (187 cases) compared to 2017 (131 cases).

Table 1.2.1
Criminal Trials for Drug-Related Offences by Sex of Offender, 2017 and 2018

JEMS Code	Description	2017				2018			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	46	6	4	56	35	2	1	38
2301	Possession of Cannabis Resin	-	-	-	-	5	-	1	6
2304	Possession of Cocaine	11	-	1	12	7	1	-	8
2308	Possession of Diamorphine	-	-	-	-	2	-	-	2
2312	Possession of Other Drugs	2	-	2	4	7	-	-	7
2313	Possession of Other Drugs With Intent to Supply	-	-	-	-	1	1	-	2
2316	Possession of Cannabis With Intent to Supply	13	3	2	18	11	2	1	14
2320	Possession of Cocaine With Intent to Supply	2	1	-	3	7	-	1	8
2324	Possession of Diamorphine With Intent to Supply	-	-	-	-	2	-	-	2
2332	Handle Cannabis With Intent to Supply	1	-	-	1	-	-	-	-
2364	Import Cannabis	9	3	5	17	5	6	16	27
2368	Import Cocaine	-	1	2	3	2	-	2	4
2372	Import Diamorphine	-	-	-	-	1	-	-	1
2373	Import Other Drugs	1	-	-	1	5	3	4	12
2380	Conspiracy to Import Other Drugs	1	-	-	1	2	-	-	2
2388	Possession of Drug Equipment	12	2	2	16	18	4	2	24
2392	Possession of Drug Equipment Prepare	13	3	1	17	18	2	1	21
2396	Cultivate Cannabis	4	-	-	4	4	-	-	4
2400	Permit on Premises Drug Use	1	1	-	2	1	-	-	1
2404	Obstruction	-	-	-	-	1	-	-	1
TOTAL TRIALS: DRUG-RELATED OFFENCES		**116**	**20**	**19**	**155**	**135**	**22**	**30**	**187**

Source: Supreme Court

Table 1.2.2
Criminal Trials for Alcohol-Related Offences by Sex of Offender, 2017 and 2018

JEMS Code	Description	2017				2018			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	104	12	12	128	162	23	9	194
3059	Impaired Driving (>100 mgs Alcohol)	13	3	10	26	2	-	1	3
3060	Impaired Driving Not Motor Vehicle	1	-	-	1	-	-	-	-
3061	Care and Control of Motor Vehicle Whilst Impaired	11	5	1	17	13	1	-	14
3062	Refuse Breath Test	34	5	2	41	61	10	4	75
3063	Impaired Driving Drug In Body	1	-	-	1	-	-	-	-
3064	Excess Alcohol Motor Vehicle	64	7	1	72	101	13	3	117
3842	Excess Alcohol – Power Craft	1	-	-	1	1	-	-	1
3843	Impaired Driving – Power Craft	1	-	-	1	1	-	-	1

Table 1.2.2 cont'd
Criminal Trials for Alcohol-Related Offences by Sex of Offender, 2017 and 2018

JEMS Code	Description	2017				2018			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
4020	Drunk and Incapable	-	-	-	-	2	-	-	2
4022	Drunk in Public Street	-	-	1	1	-	-	-	-
8403	Drunkenness in Aircraft Contrary to Air Navigation	-	-	-	-	2	-	1	3
TOTAL TRIALS: ALCOHOL-RELATED OFFENCES		**230**	**32**	**27**	**289**	**345**	**47**	**18**	**410**

Source: Supreme Court

Table 1.2.3
Criminal Acquittals for Drug-Related Offences by Sex of Offender, 2017 and 2018

JEMS Code	Description	2017				2018			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	1	1	-	2	5	-	-	5
2312	Possession of Other Drugs	1	-	2	3	-	-	-	-
2316	Possession of Cannabis With Intent to Supply	3	-	1	4	1	1	1	3
2320	Possession of Cocaine With Intent to Supply	-	-	-	-	1	-	-	1
2332	Handle Cannabis With Intent to Supply	1	-	-	1	-	-	-	-
2364	Import Cannabis	9	2	3	14	-	1	-	1
2368	Import Cocaine	-	1	2	3	-	-	-	-
2373	Import Other Drugs	1	-	-	1	-	-	-	-
2380	Conspiracy to Import Other Drugs	1	-	-	1	1	-	-	1
2388	Possession of Drug Equipment	9	1	2	12	1	-	1	2
2392	Possession of Drug Equipment Prepare	10	2	1	13	3	-	-	3
2396	Cultivate Cannabis	2	-	-	2	1	-	-	1
2400	Permit on Premises Drug Use	-	-	-	-	1	-	-	1
TOTAL ACQUITTALS: DRUG-RELATED OFFENCES		**56**	**38**	**7**	**56**	**14**	**2**	**2**	**18**

Source: Supreme Court

Table 1.2.4
Criminal Acquittals for Alcohol-Related Offences by Sex of Offender, 2017 and 2018

JEMS Code	Description	2017				2018			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	41	4	4	49	7	1	-	8
3059	Impaired Driving (>100 mgs Alcohol)	6	2	6	14	1	-	-	1
3060	Impaired Driving Not Motor Vehicle	1	-	-	1	-	-	-	-
3061	Care and Control of Motor Vehicle Whilst Impaired	4	4	1	9	1	-	-	1
3062	Refuse Breath Test	27	5	2	34	3	-	-	3
3063	Impaired Driving Drug In Body	1	-	-	1	-	-	-	-
3064	Excess Alcohol Motor Vehicle	35	4	1	40	1	-	-	1
3841	Ref Breath Test Powercraft S 114 F Mba62	1	-	-	1	-	-	-	-
3843	Impaired Driving – Power Craft	1	-	-	1	-	-	-	-
4022	Drunk in Public Street	-	-	1	1	-	-	-	-
4599	Breach of Liquor Licence	41	4	4	49	-	-	-	-
TOTAL ACQUITTALS: ALCOHOL-RELATED OFFENCES		**158**	**23**	**19**	**200**	**13**	**1**	**-**	**14**

Source: Supreme Court

Table 1.2.5
Criminal Convictions for Drug-Related Offences by Sex of Offender, 2017 and 2018

JEMS Code	Description	2017				2018			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	40	3	4	47	21	2	-	23
2301	Possession of Cannabis Resin	-	-	-	-	4	-	-	4
2304	Possession of Cocaine	10	-	1	11	7	1	-	8
2308	Possession of Diamorphine	-	-	-	-	2	-	-	2
2312	Possession of Other Drugs	1	-	2	3	7	-	-	7
2313	Possession of Other Drugs With Intent to Supply	-	-	-	-	1	-	-	1
2316	Possession of Cannabis With Intent to Supply	7	2	1	10	9	-	-	9
2320	Possession of Cocaine With Intent to Supply	2	-	-	2	1	-	-	1
2324	Possession of Diamorphine With Intent to Supply	-	-	-	-	6	-	1	7
2332	Handle Cannabis With Intent to Supply	1	-	-	1	-	-	-	-
2364	Import Cannabis	9	2	3	14	4	4	16	24
2365	Import Cannabis Resin					-	1	1	2
2368	Import Cocaine	-	1	2	3	2	-	2	4
2372	Import Diamorphine	-	-	-	-	1	-	-	1
2373	Import Other Drugs	-	-	-	-	5	3	4	12
2380	Conspiracy to Import Other Drugs	1	-	-	1	1	-	-	1
2388	Possession of Drug Equipment	9	1	2	12	17	4	1	22
2392	Possession of Drug Equipment Prepare	10	2	1	13	12	2	1	15
2396	Cultivate Cannabis	2	-	-	2	3	-	-	3
2404	Obstruction	-	-	-	-	1	-	-	1
TOTAL CONVICTIONS: DRUG-RELATED OFFENCES		**92**	**11**	**16**	**119**	**104**	**17**	**26**	**147**

Source: Supreme Court

Table 1.2.6
Criminal Convictions for Alcohol-Related Offences by Sex of Offender, 2017 and 2018

JEMS Code	Description	2017				2018			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	41	4	4	49	56	5	5	66
3059	Impaired Driving (>100 mgs Alcohol)	6	2	6	14	-	-	-	-
3060	Impaired Driving Not Motor Vehicle	1	-	-	1	-	-	-	-
3061	Care and Control of Motor Vehicle Whilst Impaired	4	4	1	9	4	1	-	5
3062	Refuse Breath Test	27	5	2	34	48	9	3	60
3063	Impaired Driving Drug In Body	1	-	-	1	-	-	-	-
3064	Excess Alcohol Motor Vehicle	35	4	1	40	63	9	-	72
3842	Excess Alcohol-Power Craft					1	-	-	1
3843	Impaired Driving – Power Craft	1	-	-	1	-	-	-	-
4020	Drunk and Incapable	1	-	-	1	2	-	-	2
8403	Drunkenness in Aircraft Contrary to Air Navigation	-	-	1	1	2	-	1	3
TOTAL CONVICTIONS: ALCOHOL-RELATED OFFENCES		**117**	**19**	**15**	**151**	**176**	**24**	**9**	**209**

Source: Supreme Court

Table 1.2.7
Unknown Results for Drug-Related Offences by Sex of Offender, 2017 and 2018

JEMS Code	Description	2017				2018			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	5	2	-	7	9	-	1	10
2301	Possession of cannabis resin	-	-	-	-	1	-	1	2
2304	Possession of Cocaine	1	-	-	1	-	-	-	-
2312	Possession of Other Drugs	1	-	-	1	-	-	-	-
2316	Possession of Cannabis With Intent to Supply	3	1	-	4	-	-	-	-
2320	Possession of Cocaine With Intent to Supply	-	1	-	1	2	-	-	2
2364	Import Cannabis	-	1	1	2	1	1	-	2
2388	Possession of Drug Equipment	3	1	-	4	3	1	-	4
2392	Possession of Drug Equipment Prepare	2	1	-	3	3	-	-	3
2396	Cultivate Cannabis	1	-	-	1	-	-	-	-
2400	Permit on Premises Drug Use	1	-	-	1	-	-	-	-
TOTAL UNKNOWN RESULTS: DRUG-RELATED OFFENCES		**17**	**7**	**1**	**25**	**17**	**3**	**2**	**22**

Source: Supreme Court

Table 1.2.8
Unknown Results for Alcohol-Related Offences by Sex of Offender, 2017 and 2018

JEMS Code	Description	2017				2018			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	60	7	8	75	99	17	4	120
3059	Impaired Driving (>100 mgs Alcohol)	7	1	4	12	1	-	1	2
3061	Care and Control of Motor Vehicle Whilst Impaired	7	1	-	8	8	-	-	8
3062	Refuse Breath Test	6	-	-	6	10	1	1	12
3064	Excess Alcohol Motor Vehicle	28	2	-	30	37	4	3	44
3843	Impaired Driving – Power Craft	-	-	-	-	1	-	-	1
TOTAL UNKNOWN RESULTS: ALCOHOL-RELATED OFFENCES		**108**	**11**	**12**	**131**	**156**	**22**	**9**	**187**

Source: Supreme Court

1.3 FINANCIAL INTELLIGENCE

The FIA was established by the Financial Intelligence Agency (FIA) Act 2007 to be an independent agency authorised to receive, gather, store, analyse, and disseminate information relating to suspected proceeds of crime and potential financing of terrorism received in the form of Suspicious Activity Reports (SARs). (The Act became operable in November 2008). The FIA may also disseminate such information to the Bermuda Police Service and foreign financial intelligence authority.[1] In addition to the FIA Act, it is guided by other legislations such as: Proceeds of Crime Act 1997, Proceeds of Crime Regulations (Anti-Money Laundering and Anti-Terrorist Financing Supervision and Enforcement) Act 2008, Anti-Terrorism (Financial and Other Measures; Business in Regulated Sector) Order 2008; Proceeds of Crime (Designated Countries and Territories) Order 1998, Anti-Terrorism (Financial and Other Measures) Act 2004, and Proceeds of Crime Appeal Tribunal Regulations 2009.

Data on financial intelligence showed a significant decrease (29.2%) in the SARs received; down from the 942 in 2017 to 667 in 2018 (see Table 1.3.1). With the exception of the first quarter, the other quarters saw a decrease from the corresponding quarters in 2017. Activities within banks, money service businesses and long term

"Data on financial intelligence showed a significant decrease, by SARs received in 2018."

[1] FIA website: http://www.fia.bm/index-2.html

insurers account for the bulk of the SARs in both 2017 (554, 143, and 184, respectively) and 2018 (352, 92, and 68, respectively). The number of SARs received from the Fund Administrators increased considerably in 2018 by 200.0%. Although relatively few, it is worthy to note that, in 2018, there was one SAR in from "high value dealers".

The FIA recorded the filing of 143 SARs in 2017 compared to 92 SARs in 2018 (a 35.7% decrease) that were related to suspicious wire transfers of money out of Bermuda, using money service business as the transmitter. This activity continues to be the most prevalent trend seen by the FIA through its analysis over the past few years. The FIA continues to believe that the transactional activity concerning foreign currency exchange is intimately connected with Bermuda's drug trade and firearm activity.

Also in 2018, 100 local and overseas disclosures contained information from 348 SARs compared to 72 disclosures from 144 SARs in 2017, representing a 38.9% increase in total SARs disclosed.

Table 1.3.1
Suspicious Activity Reports (SARs) by Sector, 2017 and 2018

SECTOR	2017					2018					Annual Percentage Change
	Q1	Q2	Q3	Q4	TOTAL	Q1	Q2	Q3	Q4	TOTAL	
SARs Received											
Banks (includes a Credit Union)	72	120	91	271	554	131	82	81	58	352	-36.5
Investment Providers	3	4	7	4	18	5	6	11	5	27	50.0
Money Service Businesses	42	40	44	17	143	29	21	26	16	92	-35.7
Corporate Service Providers	1	2	1	5	9	12	6	6	21	45	400.0
Law Firm	-	-	3	-	3	3	2	7	2	14	366.7
Trust Company	1	3	-	-	4	1	5	3	4	13	225.0
Local Regulators	2	-	-	5	7	1	3	2	3	9	28.6
Long-Term Insurers	3	91	38	52	184	11	21	14	22	68	-63.0
Other (Metal Dealers)	-	-	1	-	1	-	-	-	-	-	-100.0
Accounting Firm	-	1	-	1	2	1	-	-	-	1	-50.0
Fund Administrators	1	3	-	-	4	3	1	1	7	12	200.0
Insurance Company/Manager	7	-	1	-	8	-	12	12	6	30	275.0
Real Estate*	...	1	...	...	1	-	-	1	-	1	-
Jeweler*	...	...	...	1	1	-	-	1	-	1	-
Registered Charity*	...	...	...	1	1	-	-	-	1	1	-
Asset Recovery/Insolvency*	...	...	...	2	2	-	-	-	-	-	-100.0
High Value Dealers*	..	..	..	..	...	1	-	-	-	1	100.0
TOTAL SARs RECEIVED	132	265	186	359	942	198	159	165	145	667	85.8
ANNUAL PERCENTAGE CHANGE	13.8	138.8	39.8	204.2	97.1	50.0	-40.0	-11.3	-59.6	-29.2	
Total Local and Overseas Disclosures	17	10	31	14	72	30	21	17	32	100	38.9
Local Entities	17	5	27	8	57	28	16	6	18	68	19.3
Overseas Entities	0	5	4	6	15	2	5	11	14	32	113.3
Total SARs Disclosed	50	14	188	6	144	302	9	4	33	348	141.7

Source: Financial Intelligence Agency

Note: * Businesses that sell high value goods such as cars, bikes, boats.

1.4 FINANCIAL CRIME

In 2019, the Bermuda Police Service reorganised the structure of departments and, as a result, the Organised and Economic Crime Department (OECD) was amalgamated into the newly named Specialist Investigations (SI). The SI encompasses: drug crime, financial crime, organised crime, corruption, and cyber-crime.

As part of its role, SI deals with all cash and/or property seized under the provisions of Section 50 of the Proceeds of Crime Act (PoCA) 1997. These are civil powers and are additional to the criminal powers provided by the Misuse of Drugs Act 1972 and the Proceeds of Crime Act 1997. The key difference is that the burden of proof under the civil legislation is based on 'the balance of probabilities', whilst the criminal burden of proof is 'beyond a reasonable doubt'.

Under Section 50 of the PoCA, an officer can seize any cash and/or property (that is, high value watches, jewelry, gold bars, diamonds, etc.) that directly or indirectly represents any person's proceeds of criminal conduct or is intended by any person for use in any criminal conduct. The majority of these cases originate following searches either by Customs Officers at the airport or by Police Officers involved in street or house searches, which are often drug-related.

The legislation requires that within 48 hours of the seizure, an application must be made to a Magistrate for a Detention Order which, if granted, authorises its further detention for up to three months, after which time SI must either re-apply for another Detention Order or return the property. Upon completion of the investigation, and if there is sufficient evidence, a civil forfeiture hearing is held. If the case is proven, the Magistrate signs a Forfeiture Order, ordering the property to be sold or the cash to be paid into the Confiscation Assets Fund (CAF).

In order to be effective in its operations, SI conducts Section 50 PoCA training for BPS personnel; the Customs and Police Joint Intelligence Unit, the Customs Cruise Ship Enforcement Team, and the United States Customs Border Patrol. This is with the aim of promoting awareness and enhancing knowledge of the legislation to assist with the prevention of criminal assets being laundered.

Confiscation proceedings take place after criminal conviction in cases primarily involving drug-trafficking and/or money laundering. The Judge can make a Confiscation Order in monetary terms after a hearing in relation to all known assets (for example, houses, cars, jet skis, etc.) held by the person, if those assets represent the proceeds of crime. The onus is then on the person to satisfy that Order or face a term of imprisonment in default, with interest added, until the Confiscation Order is satisfied. If the person fails to comply, the Judge can order all assets to be seized and sold with the funds to be paid into the CAF.

SI has working relations with the Practitioners Sub-Committee of the National Anti-Money Laundering Committee (NAMLC) and continues to provide assistance to law enforcement partners, including the Financial Action Task Force, the International Criminal Police Organisation, the United States Department of Justice, and the United Kingdom National Crime Agency.

SI has reported a total of 20 seizures in 2018 amounting to $327,050.74 compared to a significantly lower number (13) of seizures in 2017 amounting to $225,330.00 (see Table 1.4.1). In 2018, cash seizures accounted for the largest proportion ($240,295.66) and were significantly higher than in the previous year ($72,115.00). No confiscations, civil recovery cases, or civil recovery orders were recorded in 2017 and 2018.

Table 1.4.1
Cash Seizures, 2017 and 2018

Year/Quarter	Number of Seizures	Section 50 Cash Seizures ($)	Forfeiture ($)	Total ($)
2017				
Q1	5	21,246.00	9,038.00	30,284.00
Q2	2	5,150.00	105,545.00	110,695.00
Q3	3	21,097.00	34,494.00	55,591.00
Q4	3	24,622.00	4,138.00	28,760.00
Total	**13**	**72,115.00**	**153,215.00**	**225,330.00**
2018				
Q1	1	1,532.00	9,097.00	10,629.00
Q2	10	151,282.00	18,136.98	169,418.98
Q3	4	43,081.00	14,334.00	57,415.00
Q4	5	44,400.66	45,187.10	89,587.76
Total	**20**	**240,295.66**	**86,755.08**	**327,050.74**

Source: OECD, Bermuda Police Service

Chapter 2
Imports, Exports, and Licensing

- Quantity and Value of Alcohol for Domestic Consumption
- Quantity and Value of Tobacco for Domestic Consumption
- Duty Collected on Alcohol and Tobacco
- Liquor Licences

2.1 IMPORTS AND EXPORTS

Quantity and Value of Alcohol and Tobacco Available for Domestic Consumption and Duty Collected for the Domestic Economy

The importation of alcohol and tobacco provides an indication of the availability of these products and the environment in which residents are surrounded. During 2018, taxes related to the importation of alcohol and tobacco increased. An increased duty was levied on imported cigarettes from $0.37 to $0.40 per stick, while $31.35 was the duty charged on two litres of hard liquor.[2] However, there were varying rates of duty applied to different alcoholic beverages and tobacco products (see Appendix III). These rates have been revised and became effective as of April 1, 2018 and were in use up until March 31, 2019; after which they have again been revised.

There are over 250 establishments licenced to serve or sell alcohol in Bermuda. There is no available data on the number of establishments that sell cigarettes and other tobacco products; although many supermarkets and gas stations carry these products.

Alcohol and tobacco use continue to be a trend evidenced in Bermuda's society and the Island continues its trade, more so, the importation of alcohol and alcoholic beverages and tobacco and its products. It may be argued that most of these imported products are for tourists' consumption. However, this does not mean that Bermuda residents do not consume a portion of the imported alcohol and tobacco. However, Bermuda laws prohibit the sale or supply of these products to minors (under 18 years). According to the Tobacco Products (Public Health) Act 1987, a photo identification is required if a person appears to be under 25 years. [3]

Of importance is the quantity and value of alcohol and alcoholic beverages available for domestic consumption (that is, used by persons on the Island whether they are residents or tourists). This usually is comprised of quantities imported in the given year in addition to the amount removed from bonded warehouses valued at the 'free on board' (FOB) basis (not inclusive of handling and freight costs, taxes and duties, and mark-up for profit).

In 2017, there was 7.01 million litres of alcohol and alcoholic beverages were available for local consumption, valued at $31.0 million, and contributed $20.0 million in customs duty (see Table 2.1.1). Whereas, in 2018, there was a decline in the amount of alcohol and alcoholic beverages available for local consumption. There were 6.4 million litres valued at $29.2 million and contributed $19.5 million to customs duty. Beer and wine in containers holding two litres or less accounted for a significant portion of the beverages available for consumption. An additional 2.9 million litres valued at $19.7 million in 2017 and a lesser quantity, 2.3 millions, valued at $16.4 million in 2018, were placed in bonded warehouses upon importation for future consumption (see Table 2.1.2). Rum and other spirits, gin and geneva, and wine in containers holding more than 2 litres but not more than 10 litres accounted for the bulk of alcohol and alcoholic beverages placed in bonded warehouses in both years under review.

The year 2017 saw 1.4 million litres of alcohol and alcoholic beverages exported from bonded warehouses, valued at $5.3 million, with $20,638 received in customs duty (see Table 2.1.3). On the other hands, in 2018, there were fewer litres of alcohol and alcoholic beverages, 931 thousand, exported from bonded warehouses, valued at $3.8 million, with just over $20, 592 received in customs duty.

The value of tobacco and tobacco products available for domestic consumption was approximately $3.3 million in and 2017 and $2.1 million in 2018 (see Table 2.1.4). This resulted in a decrease in the duty recwived from $10.1 million in 2017 to $6.0 million in 2018. The major component of tobacco imports is that of cigarettes, with 41.8 thousand kilograms and 29.8 million units, valued at $2.1 million, being brought to the Island in 2017 or removed from bonded warehouses, contributing $9.7 million towards customs duty. In comparison, the year 2018 saw significantly less at just over 24 thousand kilograms and 17.6 million units, valued at $1.4 million, brought to the Island or removed from bonded warehouses, contributing $5.8 million towards customs duty.

[2] Customs Department. 2017. Bermuda Customs Tariff 2017. Government of Bermuda.

[3] Laws of Bermuda. Tobacco Products (Public Health) Act 1987. p. 5

Table 2.1.1
Quantity, Value, and Duty of Alcohol and Alcoholic Beverages for Home Consumption (Imports and Removals from Bonded Warehouses), 2017 and 2018

Tariff Code	Description	2017			2018		
		Litreage	Value ($)	Duty ($)	Litreage	Value ($)	Duty ($)
2203.000	Beer	4,352,192.25	7,169,854.63	5,483,762.16	3,861,355.41	6,771,590.80	4,865,307.75
2204.100	Sparkling Wine	164,150.73	2,826,031.13	709,544.05	132,766.78	2,125,469.03	644,339.71
2204.210	Wine in containers holding 2 litres or less	1,345,170.52	12,668,907.28	5,790,028.44	1,190,845.23	11,281,631.58	5,826,261.59
2204.220	Wine in containers holding more than 2L but not more than 10L*	3802.75	66626.86	17872.93	3,079.25	24,467.57	14,847.85
2204.290	Wine in containers greater than 2 litres	63,537.53	1,020,209.08	275,905.65	56,696.94	1,452,498.53	279,138.66
2204.300	Other Grape Must	2,824.15	53,163.63	13,259.83	1,024.00	24,035.72	5,119.70
2205.100	Vermouth in containers holding 2 litres or less	8,941.00	49,567.22	40,969.06	6,595.05	39,793.38	32,814.60
2205.900	Vermouth in containers holding greater than 2 litres	-	-	-	739.5	18,604.27	3,697.50
2206.000	Other Fermented Beverages	176,752.27	387,313.78	241,578.45	245,367.35	530,604.40	309,163.07
2207.100	Undenatured Ethyl Alcohol	476.48	1,321.57	12,297.21	822.29	2,335.46	14,663.64
2207.200	Denatured Ethyl Alcohol	420.84	1,089.19	260.98	611.73	2,661.46	313.99
2208.200	Brandy and Cognac	38,459.09	807,858.18	462,014.67	38,930.35	866,789.03	473,670.13
2208.300	Whiskies	111,044.38	1,659,199.02	1,265,380.99	107,266.83	1,626,781.62	1,277,918.51
2208.400	Rum and Other Spirits Distilled from Sugar Cane	247,805.12	1,438,239.86	2,535,339.20	251,438.87	1,438,603.99	2,681,344.90
2208.500	Gin and Geneva	27,100.50	258,985.58	330,003.89	32,176.49	373,232.01	400,924.81
2208.600	Vodka	163,108.09	1,312,552.78	1,864,119.38	163,598.99	1,326,382.81	1,750,798.19
2208.700	Liqueur & Cordials	58,863.57	647,273.34	466,251.65	55,079.00	582,609.91	456,785.26
2208.900	Other Spirituous Beverages	245,484.80	597,236.87	514,558.06	244,317.97	670,619.07	505,023.54
	TOTAL	**7,010,134.07**	**30,965,430.00**	**20,023,146.60**	**6,392,712.03**	**29,158,710.64**	**19,542,133.40**

Source: HM Customs

Table 2.1.2
Quantity and Value of Bonded Alcohol and Alcoholic Beverages Placed in Bonded Warehouses Upon Arrival, 2017 and 2018*

Tariff Code	Description	2017		2018	
		Litreage	Value ($)	Litreage	Value ($)
2203.000	Beer	-	-	-	-
2204.100	Sparkling Wine	115,017.43	2,111,956.80	102,544.96	1,512,408.10
2204.210	Wine in containers holding 2 litres or less	858,193.37	9,020,024.62	777,634.51	7,498,268.59
2204.220	Wine in containers holding more than 2 litres but not more than 10 litres	102.00	7,431.43	57	1,219.32
2204.290	Wine in containers greater than 2 litres	12,903.00	33,114.99	12,093.00	27,109.11
2204.300	Other Grape Must	-	-	-	-
2205.100	Vermouth in containers holding 2 litres or less	1,842.00	5,767.24	2,970.00	14,133.81
2205.900	Vermouth in containers holding greater than 2 litres	-	-	-	-
2206.000	Other Fermented Beverages	1,415.88	15,401.20	2,707.74	22,771.25
2207.100	Undenatured Ethyl Alcohol	5,824.00	6,328.00	-	-
2207.200	Denatured Ethyl Alcohol	-	-	-	-
2208.200	Brandy and Cognac	48,078.90	1,148,227.84	45,389.24	1,078,604.60
2208.300	Whiskies	92,865.00	1,525,863.48	74,067.15	1,310,619.39
2208.400	Rum and Other Spirits Distilled from Sugar Cane	1,568,246.70	3,760,085.15	1,075,382.55	2,863,610.73
2208.500	Gin and Geneva	24,655.50	244,919.17	27,027.60	316,205.97
2208.600	Vodka	125,169.60	1,109,118.34	110,910.00	1,069,290.08
2208.700	Liqueur & Cordials	42,028.95	439,690.80	39,297.15	386,726.58

Table 2.1.2 cont'd

Quantity and Value of Bonded[*] Alcohol and Alcoholic Beverages Placed in Bonded Warehouses Upon Arrival, 2017 and 2018

Tariff Code	Description	2017		2018	
		Litreage	Value ($)	Litreage	Value ($)
2208.900	Other Spirituous Beverages	20,940.75	276,463.60	17,450.40	278,683.24
	TOTAL	**2,917,283.08**	**19,704,392.66**	**2,287,530.30**	**16,379,650.77**

Source: HM Customs

Notes: [*] Goods placed into a bonded warehouse are in duty suspension and no duty is collected until such time that the goods are removed from the bonded warehouse.
[**] There is no correlation between the figures for the goods placed into Bond and the figures for goods being removed from Bond. Goods being removed from Bond may have arrived in Bermuda at any time in the past.

Table 2.1.3

Quantity, Value, and Duty of Alcohol and Alcoholic Beverages Exported from Bonded Warehouses[*], 2017 and 2018

Tariff Code	Description	2017			2018		
		Litreage	Value ($)	Duty ($)	Litreage	Value ($)	Duty ($)
2203.000	Beer	2,662.00	716.90	-	1,570.80	1,126.50	-
2204.100	Sparkling Wine	1,310.25	48,487.02	222.59	801.5	37,312.46	164.66
2204.210	Wine in containers holding 2 litres or less	2,193.00	12,513.74	8.30	793.25	5,598.97	8.84
2204.290	Wine in containers greater than 2 litres	-	-	-	1,477.09	1,477.09	-
2204.300	Other Grape Must	-	-	-	-	-	-
2205.100	Vermouth in containers holding 2 litres or less	5.00	51.29	-	36	281.28	-
2205.900	Vermouth in containers holding greater than 2 litres	-	-	-	-	-	-
2206.000	Other Fermented Beverages	-	-	-	-	-	-
2207.100	Undenatured Ethyl Alcohol	-	-	-	-	-	-
2207.200	Denatured Ethyl Alcohol	-	-	-	-	-	-
2208.200	Brandy and Cognac	7,348.97	255,319.82	1,836.19	6,582.55	239,752.81	1,645.89
2208.300	Whiskies	2,964.00	91,943.84	730.32	3,220.33	110,190.57	802.38
2208.400	Rum and Other Spirits Distilled from Sugar Cane	1,375,732.65	4,771,593.83	13,725.53	898,852.00	3,207,055.38	13,509.19
2208.500	Gin and Geneva	1,825.62	19,098.56	375.59	1,608.80	21,448.95	364.23
2208.600	Vodka	2,740.74	37,442.10	649.88	2,487.75	36,233.93	621.97
2208.700	Liqueur & Cordials	4,254.05	36,408.06	1,061.06	4,890.05	39,752.53	1,222.61
2208.900	Other Spirituous Beverages	8,113.50	51,144.87	2,028.46	9,010.75	56,722.72	2,252.76
	TOTAL	**1,409,149.78**	**5,324,720.03**	**20,637.92**	**931,330.87**	**3,756,953.19**	**20,592.53**

Source: HM Customs

Notes: [*] There is no correlation between the figures for the goods placed into Bond and the figures for goods being removed from Bond. Goods being removed from Bond for the purposes of export may have arrived in Bermuda at any time in the past.

The duty figures provided reflect the amount of duty collected by HM Customs. These figures are composed of varying rates of duty depending on the Customs Procedure Code ("CPC") that was applied when the goods were declared. In certain instances, the applicable rate of duty imposed by a CPC may be either 0.0% or $0.00 per litre, even though the "full" import duty in the Bermuda Customs Tariff is different. In cases were the value of duty is 0, the product is duty free.

Table 2.1.4
Quantity, Value, and Duty of Tobacco and Tobacco Products for Home Consumption (Imports and Removals from Bonded Warehouses), 2017 and 2018

Tariff Code	Description	2017			2018		
		Quantity	Value ($)	Duty ($)	Quantity	Value ($)	Duty ($)
2401.200	Tobacco, Partly or Wholly Stemmed/ Stripped	9,391.40 kg	153,216.60	18,325.15	3.4 kg	426	1,020.00
2401.300	Tobacco Refuse*	4.00 kg	220.82	77.29	-	-	-
2402.100	Cigars, Cheroots, etc. Containing Tobacco	4,518.68 kg	400,120.91	125,493.46	5,877.60 kg	331,901.01	93,716.13
2402.200	Cigarettes Containing Tobacco	41,812.63 kg 29,786,000.00 u	2,117,894.05	9,740,650.00	24,248.16 kg 17,560,000 u	1,448,320.97	5,841,042.00
2402.900	Other Tobacco Products; or Products of Tobacco Substitutes	10.00 kg	5,303.50	1,856.23	2.0 kg	59.9	20.97
2403.110	Water Pipe Smoking Tobacco	3,814.19 kg	130,558.46	44,449.10	2.25 kg	40	675
2403.190	Other Smoking Tobacco	13,047.84 kg	165,224.97	57,828.75	49,426.08 kg	224,293.02	79,022.40
2403.990	Tobacco Extracts and Essences; Other Manufactured Products of Tobacco	20,435.00 kg	344,116.27	120,440.39	4,847.00 kg	70,026.00	27,970.50
9803.163	Smoking Tobacco; Cigars, Cheroots and Cigarillos, Containing Tobacco (Imported by Post or Courier)	- 8,940.00 u	16,023.47	5,552.07	609.00 kg	10,765.10	3,767.83
2401.100	Tobacco, Not Stemmed/Stripped*	29.00 kg	1,398.00	8.41	8.02 kg	135.67	47.49
9803.171	Cigarettes Containing Tobacco	9.75 kg 7,800.00 u	1,825.63	2,846.00	5,002.00 kg 27 u	1,610.41	1,998.00
	TOTAL	**93,072.49 kg 29,802,740.00 u**	**3,335,902.68**	**10,117,526.85**	**90,025.51 kg 17,560,027 u**	**2,087,578.08**	**6,049,280.32**

Source: HM Customs

Table 2.1.5
Quantity and Value of Bonded Tobacco and Tobacco Products Placed in Bonded Warehouses Upon Arrival**, 2017 and 2018*

Tariff Code	Description	2017		2018	
		Quantity	Value ($)	Quantity	Value ($)
2402.100	Cigars, Cheroots, etc. Containing Tobacco	325.44 kg	129,457.56	572.24 kg	171,017.24
2402.200	Cigarettes Containing Tobacco	6,695.23 kg	298,520.20	138,956.45 kg 3,252,000 u	256,071.30
	TOTAL	**7,020.67 kg**	**427,977.76**	**139,281.89 kg 4,050,000 u**	**427,088.54**

Source: HM Customs

Notes: * Goods placed into a bonded warehouse are in duty suspension and no duty is collected until such time that the goods are removed from the bonded warehouse.
** There is no correlation between the figures for the goods placed into Bond and the figures for goods being removed from Bond. Goods being removed from Bond may have arrived in Bermuda at any time in the past.

Table 2.1.6
Quantity, Value, and Duty of Tobacco and Tobacco Products Exported from Bonded Warehouses, 2017 and 2018*

Tariff Code	Description	2017		2018	
		Quantity	Value ($)	Quantity	Value ($)
2402.100	Cigars, Cheroots, etc. Containing Tobacco	-	-	-	-
2402.200	Cigarettes Containing Tobacco	2,121.87 kg	146,472.00	1,990.82 kg 1,531,000 u	171,882.66
	TOTAL	**2,607.99 kg**	**167,559.65**	**1990.82 kg 1,531,000 u**	**171,882.66**

Source: HM Customs

Note:
* There is no correlation between the figures for the goods placed into Bond and the figures for goods being removed from Bond. Goods being removed from Bond for the purposes of export may have arrived in Bermuda at any time in the past.

2.2 LIQUOR LICENCES

Licensing of Establishments for Sale of Intoxicating Liquor

According to the Liquor Licence Act of 1974, persons or businesses engaged in the sale of intoxicating liquor, whether retail or wholesale, must first be licensed. Otherwise, there may be legal actions in the form of imprisonment or fines instituted by the Liquor Licence Authority.[4] In addition, the sale of liquor by establishments is in respect of the type of licence granted (Class A, Class B, Tour Boat, Nightclub, Restaurant, Hotel, Member's Club, Permit for Association or Organisation).[5] Data is not currently collected on the number of new licences issued. However, the trend over the years has mainly been the renewal of licences by existing establishments rather than new or existing establishments applying for first-time licence. Data on liquor licences granted by the Liquor Licence Authority (LLA) to the various establishments located across the Island provides a representation of the ease of availability of, and access to, alcohol by residents.

In both 2017 and 2018, most licences were issued to establishments in the Central district, followed by the Western and Eastern districts. There has been a decrease of 3.9% in the number of licences issued to establishments between 2017 and 2018, from 310 to 298; the vast majority consisted of renewed liquor licences. Applications for licences primarily consisted of persons or companies that already had licences for other businesses. Therefore, in most instances, the LLA was satisfied that applicants were fit to manage a licensed premise.

"Overall, there has been a decrease, by 3.9%, in the total number of liquor licences issued…"

The Liquor Licence Authority has also issued occasional liquor licences, which increased by 78.5%, from 312 in 2017 to 557 in 2018. There were three more licences issued over the past year, for al fresco (outdoors) events. Overall, there has been a sharp increase, by 37.5%, in the total number of licences issued, that is, from 622 granted in 2017 to 855 in 2018.

[4] Laws of Bermuda. Liquor Licence Act 1974. p. 5.

[5] Ibid. p. 9.

Table 2.2.1
Liquor Licenses Issued by District and Type of Licence, 2017 and 2018

Districts and Type of Licence	2017	2018
CENTRAL	**187**	**182**
Class 'A'	49	46
Class 'B'	4	5
Tour Boat	31	33
Nightclub	12	12
Restaurant	57	53
Hotel	9	7
Member's Club	21	19
Alfresco	3	5
Proprietary club license	-	-
Permit for Association or Organisation*	1	2
WESTERN	**69**	**67**
Class 'A'	26	26
Class 'B'	2	2
Tour Boat	-	-
Nightclub	2	2
Restaurant	22	20
Hotel	4	4
Member's Club	8	7
Alfresco	4	6
Proprietary club license	1	-
Permit for Association or Organisation*	-	-

Table 2.2.1 cont'd

Liquor Licenses Issued by District and Type of Licence, 2017 and 2018

Districts and Type of Licence	2017	2018
EASTERN	**54**	**49**
Class 'A'	15	16
Class 'B'	1	-
Tour Boat	-	-
Nightclub	-	-
Restaurant	20	18
Hotel	6	4
Member's Club	8	7
Alfresco	3	4
Proprietary club license	-	-
Permit for Association or Organisation	1	-
Total Licences Issues to Establishments	**310**	**298**
Annual Percentage Change in Total Licences Issued to Establishments (%)	**7.6**	**-3.9**
Total Occasional Liquor Licences Island-Wide	**312**	**557**
Annual Percentage Change in Total Occasional Liquor Licences Island-Wide (%)	**16.9**	**78.5**
Total Licences Issued	**.5**	**622**
Annual Percentage Change in Total Licences Issued (%)	**622**	**855**
Annual Percentage Change in Total Licences Issued (%)	**12.1**	**37.5**

Source: Liquor Licence Authority, Magistrate's Court

Notes:

1. Eastern District consists of the parishes of St. George's, Hamilton Parish, and Smith's and including the Town of St. George
2. Central District consists of the parishes of Pembroke, Devonshire, and Paget and including the City of Hamilton. The licensing authority for the Central District issues Tour Boat Licences.
3. Western District consists of the parishes of Warwick, Southampton, and Sandy's.
4. Class A Licence is for the sale on the premises in respect of which the licence is granted of intoxicating liquor not to be consumed on such premises.
5. Class B Licence is for the sale on the premises in respect of which the licence is granted of intoxicating liquor to be consumed on such premises.
6. Hotel Licence is for the sale on the premises in respect of which the licence is granted of intoxicating liquor to be consumed on such premises.
7. Restaurant Licence is for the sale on the premises in respect of which the licence is granted of intoxicating liquor to be consumed on such premises.
8. Night Club Licence is for the sale on the premises in respect of which the licence is granted of intoxicating liquor to be consumed on such premises.
9. Proprietary Club Licence is for the sale on the premises in respect of which the licence is granted to bona fide members of the proprietary club of intoxicating liquor to be consumed on such premises.
10. Members' Club Licence is for the sale on the premises in respect of which the licence is granted to bona fide members of a members' club, and guests introduced by them, of intoxicating liquor to be consumed on or off such premises.
11. Tour Boat Licence for the sale on the boat (being a boat equipped to carry not fewer than ten passengers) in respect of which the licence is granted, of intoxicating liquor to be consumed on the boat.
12. A Class A or Restaurant Licence may be limited to the sale of beer and wine only and any such limitation shall be endorsed on the licence.
13. A holder of one class of licence is not precluded from obtaining concurrently a different class of licence in respect of the same premises.

Chapter 3
Training Intervention ProcedureS (TIPS)

- Sessions
- Participants
- Outcomes

3.1 ALCOHOL SALES, SERVICE TRAINING, AND CERTIFICATION

CADA is responsible for the Training for Intervention ProcedureS (TIPS) programme. The TIPS programme is funded through a grant received from the Government of Bermuda, which is disbursed by the DNDC.

TIPS is the premier responsible alcohol sales and service training and certification programme. The programme trains and equips participants to be able to spot underage drinkers and prevent alcohol sales to minors; intervene quickly and assuredly in potential problem situations; understand the difference between people enjoying themselves and those getting into trouble with alcohol; handle alcohol-related situations with greater confidence; and use proven strategies to prevent alcohol related problems.

As of June 2011, TIPS certification became mandatory for managers, supervisors, and persons in-charge of bars at on-premise licensed facilities. This mandate was given in Section 39B of the Bermuda Liquor Licence Amendment Act 2010. All TIPS trainings take place at the Leopards Club on Cedar Avenue, a community partnership for which CADA is grateful.

In 2018, there was a slight increase, by 3.7%, in the number of TIPS training sessions from the previous year (up from 27 to 28), with an increase in the number of participants from 427 in 2017 to 443. A noted decrease was also seen in the number of participating establishments in 2018 with a decline of 45.3% from 2017 (see Table 3.1.1). During 2018, participants (managers, owners, and supervisors) were from 133 licenced establishments (an establishment could have been represented by different participants over the year and, hence, the number of establishments is not unique) compared to 75 licenced establishments in the previous year; averaging 16 participants per session in 2017 and 2018. It is important to note, that the TIPS programme can train anywhere from 10 to 22 persons per session. In terms of training outcome, fewer persons (405) passed the TIPS training in 2018 than in 2017 (407) and there were also more failures (38) in the most recent year when compared to the previous year (20).

Table 3.1.1
Training for Intervention ProcedureS (TIPS) Programme Statistics, 2017 and 2018

Year/Quarter	Number of TIPS Sessions	Number of Participants	Average Number of Participants Per Session	Outcome		Number of Participated Establishments
				Passed	Failed	
2017	**27**	**427**	**16**	**407**	**20**	**75**
Q1	8	162	20	148	14	20
Q2	8	135	17	135	-	22
Q3	5	58	12	57	1	18
Q4	6	72	12	67	5	15
2018	**28**	**443**	**16**	**405**	**38**	**133**
Q1	6	86	26	77	9	14
Q2	7	130	19	118	12	36
Q3	7	116	17	104	12	40
Q4	8	111	14	106	5	43

Source: CADA

Chapter 4
Substance Abuse Treatment and Counselling

- BARC Statistics
- CLSS Statistics
- Drug Treatment Court Statistics
- Drug Abuse Among Men and Women in Treatment
- Drug Abuse Among Turning Point Clients
- Right Living House Statistics
- Salvation Army Harbour Light and Community Life Skills Programme Statistics
- Focus Counselling Services Programme Statistics
- Clients in Treatment

4.1 BARC STATISTICS

Treatment Assessment and Referral

Individuals referred to the Bermuda Assessment and Referral Centre (BARC) are assessed to determine if there is an issue with substance misuse, abuse, or dependence. The assessment is done to identify and decide on the level of care clinically indicated for the client and, where specified, the Case Manager will facilitate entry into treatment. The assessment is a one- to two-hour process. At times, collateral contacts with others are necessary. The questions asked address the "whole" person in areas such as employment, education, family history, legal history, spirituality, previous treatment, mental health, medical, financial, and drug and alcohol history. In addition to the battery of questions, two screening tests are conducted, urinalysis performed, and ongoing support and monitoring are offered. During 2017 BARC switched from using DSM-IV to DSM-V for clinical diagnosis.

The number of persons who accessed services at BARC has increased over the last two years. In 2018, BARC saw 315 clients compared to 310 in the previous year (see Tables 4.1.1 and 4.1.2). Over the past year, the number of new clients accessing services at BARC (assessments and referrals of persons seeking treatment for the first time) decreased by 13.9%, from 101 cases in 2017 to 87 cases in 2018 (see Table 4.1.1). At the same time, the number of existing or repeat cases (assessments and referrals of clients who previously accessed services at BARC) increased by 9.1%, from 209 in 2017 to 228 in 2018 (see Table 4.1.2). In other words, in both years, repeat clients accounted for the greater proportion of all referrals. For instance, 228 (72.4%) of the 315 referrals in 2018 were cases of existing clients compared to 87 (27.6%) new clients.

"…repeat clients accounted for the greater proportion of all referrals."

In both years under review, males represented the majority of the total referrals, by a significant margin, compared to females (see Tables 4.1.1 and 4.1.2). Males were also more likely to re-enter the system seeking assessment for treatment services than their female counterparts. Neither of the two years saw any client being assessed more than once within that year.

Most of the persons being referred considered themselves Black (72.7% or 229 in 2018) (see Tables 4.1.1 and 4.1.2). Similar to 2017, the largest proportion (38.7%) of all referred persons were between the ages of 46-60 years. On the other hand, new clients tended to be in a younger age group, that is, 31-45 years for the current year under review (see Tables 4.1.1 and 4.1.2).

Both the new and existing referrals tended to consume a minimum of two drugs. There were also instances where persons reported the use of three or more drugs; where reports of more than two drugs in use were likely to be seen among repeat clients (see Tables 4.1.1 and 4.1.2). When it came to clinical diagnosis of abuse or dependence, most of the clients assessed in 2018 had a clinical diagnosis of "severe" followed by the category "moderate" (see Table 4.1.4).

A greater number of referrals to BARC was made through the Magistrate's Court, directly by the persons who sought treatment (self-referral), Turning Point, or via the Department of Court Services. Most of the new and existing client referrals came from Magistrate's Court.

The Drug Abuse Screening Test (DAST) scores showed that of all clients to whom the assessment was administered in both 2017 and 2018, 69 39.2% and 84 or 22.6%, respectively, were classified as having substantial to severe substance abuse dependence (see Tables 4.1.5 and 4.1.7). Similarly, the Alcohol Dependence Scale (ADS) scores indicated that of all clients to whom this test was administered, in 2017 and 2018 there were 30 people or 18.9% and 14 people or 8.2% respectively that were classified as having substantial alcohol dependence or severe alcohol dependence (see Tables 4.1.6 and 4.1.8).

Table 4.1.1
Bermuda Assessment and Referral Centre Programme Statistics for New Referrals, 2017 and 2018

	2017*	2018
Total New Referrals:	**101**	**87**
Annual Percentage Change	**20.2**	**-13.9**
Sex:		
Males	81	69
Females	19	18
Not available	1	-
Age (Years):		
16 & Under	1	-
17-30	27	26
31-45	39	31
46-60	19	21
61-75	7	7
76+	-	-
Not Stated	-	-
Not available	8	2
Race:		
Black	50	51
White	17	8
Portuguese	2	-
Mixed	3	1
Other	-	1
Not Stated	29	-
Not available	-	26
Drug of Choice (Dependence Or Abuse): Combination		
One Drug	33	9
Two Drugs	26	28
Three Drugs	8	13
More than three drugs	2	3
Not Stated	-	-
Not Available	32	31
Level of care:		
Level I –- Outpatient	10	21
Level II – IOP	28	19
Level III & IV – Residential (Medically Monitored/Managed Intensive Inpatient Treatment)	8	2
None	6	23
Not Stated/ No Show	49	15
Not Available	-	-
No Treatment/Level of Care Recommended	**-**	**7**

Source: Bermuda Assessment and Referral Centre

**Revised*

Table 4.1.1
Bermuda Assessment and Referral Centre Programme Statistics for New Referrals, 2017 and 2018

	2017*	2018
Referred from:	**101**	**87**
Magistrate's Court	26	23
Self-Referral	31	22
Court Services (including DTC, Probation Team, Parole Officer)	2	7
Turning Point	16	11
Family Services	7	3
EAP	6	13
Parole Board	3	-
Other/Other Community	4	4
Private Practice	-	2
Supreme Court	1	-
Corrections	4	2
MWI	5	2
Financial Assistance	6	3
Focus	1	-
Family Court	1	-
Not Stated	1	-
Referred to:		
Turning Point	29	28
Court Services	-	3
EAP	1	3
Men's Treatment	4	2
Other	3	1
Harbour Light	6	1
WTC	-	-
None	-	**36**
Refused Care Level	13	7
Private Practice	-	1
Not Stated/No Show	3	28

Source: Bermuda Assessment and Referral Centre

**Revised*

Table 4.1.2
Bermuda Assessment and Referral Centre Programme Statistics for Existing Referrals, 2017 and 2018

	2017*	2018
Total Existing Referrals:	**209**	**228**
Annual Percentage Change	**53.7**	**9.1**
Sex:		
Males	174	192
Females	35	36
Age (Years):		
16 & Under	-	-
17-30	23	19
31-45	68	75
46-60	93	103
61-75	18	30
76+	2	-
Not Stated	5	-
Not Available	-	1
Race:		
Black	123	178
White	9	18
Portuguese	1	2
Mixed	1	2
Not Stated	-	-
Not Available	75	27
Other	-	1
Drug of Choice (Dependence Or Abuse): Combination		
One Drug	56	21
Two Drugs	51	70
Three Drugs	45	40
More than three drugs*	17	36
Not Available	40	61
Level of Care:		
Level I – Outpatient	15	16
Level II – IOP	45	65
Level III & IV – Residential	17	45
(Medically Monitored/Managed Intensive Inpatient Treatment)	79	76
None	34	26
Not Stated/ No Show	31	37
Not Available*	-	-
Other*	5	-
No Treatment/Level of Care Recommended	-	8

Source: Bermuda Assessment and Referral Centre

**Revised*

Table 4.1.2 cont'd

Bermuda Assessment and Referral Centre Programme Statistics for Existing Referrals, 2017 and 2018

	2017*	2018
Referred from:	**209**	**228**
Corrections	14	9
Court Services (including DTC, Probation Team, Parole Officer)	20	15
EAP	5	5
Family Court	2	1
Family Services	4	7
Financial Assistance	4	15
Focus	2	1
Harbour Light	1	1
Magistrate's Court	41	39
Mental Health Treatment Court	-	18
MWI	1	-
Not Stated/No Show	5	-
Other/Other Community	2	1
Parole Board*	5	1
Self-Referral	66	89
Supreme Court	7	-
Turning Point	35	53
Not Available	40	61
Referred to:		
Court Services	-	1
Harbour Light	14	7
Men's Treatment	18	10
None	94	45
Not Available*	-	-
Not Stated/ No Show	10	32
Other	2	-
Residential (including RLH)	32	22
Turning Point	79	117
WTC	5	7

Source: Bermuda Assessment and Referral Centre

**Revised*

Table 4.1.3
*Clinical Diagnosis (Abuse or Dependence) of New and Existing Clients' Drug Use by Drug(s) of Choice, 2017**

Drug of Choice	Abuse		Moderate		Severe	
	New Clients	Existing Clients	New Clients	Existing Clients	New Clients	Existing Clients
Alcohol	3	11	12	14	16	39
Cannabis	13	21	6	14	4	22
Cocaine	-	10	1	22	5	39
Heroin	-	1	1	2	8	61*
Other	1	1	-	2	-	2
TOTAL	**17**	**44**	**20**	**54**	**33**	**163**

Source: Bermuda Assessment and Referral Centre

Note: In 2017, BARC moved to DSM-V; therefore, clinical diagnosis is categorized as mild, moderate, and severe.
**Revised*

Table 4.1.4
Clinical Diagnosis (Abuse or Dependence) of New and Existing Clients' Drug Use by Drug(s) of Choice, 2018

Drug of Choice	Abuse		Moderate		Severe	
	New Clients	Existing Clients	New Clients	Existing Clients	New Clients	Existing Clients
Alcohol	8	13	10	24	5	18
Cannabis	8	25	4	19	2	2
Cocaine	2	21	8	32	4	22
Heroin	1	2	1	16	5	71
Other	-	1	-	4	1	-
TOTAL	**19**	**62**	**23**	**95**	**17**	**113**

Source: Bermuda Assessment and Referral Centre

Note: In 2017, BARC moved to DSM-V, therefore, clinical diagnosis is categorized as mild, moderate, and severe.

Table 4.1.5
DAST Results (Number of Clients by Level of Severity of Drug Abuse) of New Clients from the Bermuda Assessment and Referral Centre Programme, 2017 and 2018

		Number of Clients	
	Level of Severity (DAST Score)	2017*	2018
Substance Abuse or Dependence	None (0)	4	5
	Low (1-5)	22	17
	Intermediate (6-10)	14	17
	Substantial (11-15)	3	6
	Severe (16-20)	-	-

Source: Bermuda Assessment and Referral Centre

**Revised*

Table 4.1.6
ADS Results (Number of Clients by Level of Severity of Alcohol Dependence) of New Clients from the Bermuda Assessment and Referral Centre Programme, 2017 and 2018

		Number of Clients	
	Level of Severity (ADS Score)	2017*	2018
Substance Abuse or Dependence	None (0)	7	13
	Low (1-13)	29	27
	Intermediate (14-21)	4	9
	Substantial (22-30)	6	-
	Severe (31-47)	2	-

Source: Bermuda Assessment and Referral Centre

**Revised*

Table 4.1.7
DAST Results (Number of Clients by Level of Severity of Drug Abuse) of Existing Clients from the Bermuda Assessment and Referral Centre Programme, 2017 and 2018

		Number of Clients	
	Level of Severity (DAST Score)	2017*	2018
	None (0)	1	2
	Low (1-5)	30	21
Substance Abuse or Dependence	Intermediate (6-10)	36	50
	Substantial (11-15)	40	48
	Severe (16-20)	26	30

Source: Bermuda Assessment and Referral Centre

**Revised*

Table 4.1.8
ADS Results (Number of Clients by Level of Severity of Alcohol Dependence) of Existing Clients from the Bermuda and Assessment Referral Centre Programme, 2017 and 2018

		Number of Clients	
	Level of Severity (ADS Score)	2017*	2018
	None (0)	21	37
	Low (1-13)	51	57
Substance Abuse or Dependence	Intermediate (14-21)	17	13
	Substantial (22-30)	14	9
	Severe (31-47)	8	5

Source: Bermuda Assessment and Referral Centre

**Revised*

4.2 COUNSELLING AND LIFE SKILLS SERVICES STATISTICS

Youth Counselling

The Counselling and Life Skills Services (CLSS) remains a unit within the Department of Child and Family Services. It is the only addiction counselling agency developed to address the drug counselling, drug educational, and drug rehabilitative needs for Bermuda's youths and their families. Eligibility to the programme is consistent with the Department's mandate under the Children Act 1988, which caters to persons zero to 18 years of age. Referrals to CLSS are received from schools, parent(s)/guardian(s), the courts, other agencies within the community, as well as concerned individuals. The CLSS offers a range of services from assessments and treatment planning to referral, community programmes, and aftercare. It also offers the Al-a-teen programme (a 12-step recovery programme for adolescents affected by an adult alcoholic) as part of its services.

CLSS facilitates two groups based on clients' needs and referral trends. There is also a four-session Active Parenting of Teens group, which provides the guidance and support parents need to turn the challenges of raising a teenager into opportunities for growth. The curriculum also covers pressures, such as social media, bullying, and substances, geared at increasing parents' awareness. The other, which was a six-session Cooperating Parenting and Divorce group, provides divorced or separated parents education about dealing with conflict and shifting their focus onto their child while building a positive co-parenting alliance.

In comparing 2017 to 2018, there has been a decrease in the number of referrals, from 94 to 74, and also a decline in the number of assessments conducted, from 98 to 80, respectively (see Table 4.2.1). CLSS has seen 100 clients in 2018 compared to 60 clients in 2017, which represents a 66.7% increase over the previous year. Clients are usually referred for either behavioural or substance use reasons. Of the 74 referrals in 2018, substance screenings or assessments were completed for 27 people. CLSS also offers substance education groups that are short-termed, ranging from eight to 10 sessions, which uses evidence-based curriculums tailored to the needs of its clients. There were nine group participants in 2018 compared to 16 in 2017.

Table 4.2.1
Counselling and Life Skills Services Statistics, 2017 and 2018

Year	2017	2018
Number of Referrals	94	74
Number of Substance Referrals	…	36
Number of Clients Seen	60	100
Number of Readmissions	11	13
Number of Assessments	98	80
Other Assessments	…	53
Substance Assessment	49	27
Number of Discharges	88	55
Number of Group Participants	16	9

Source: Department of Child and Family Services - Counselling and Life Skills Services (CLSS)

4.3 DRUG TREATMENT COURT STATISTICS

Drug Treatment Court

The Drug Treatment Court (DTC) programme is an intense, comprehensive, case management programme for offenders with substance abuse issues, and not strictly a substance abuse treatment programme. Referrals are considered to be the number of persons that were sent to the programme for consideration. These are usually made by the courts. Admissions, on the other hand, are the number of persons who were accepted into the programme. Some persons may have been referred by another magistrate but may be found ineligible or unsuitable for the programme, so they are not admitted.

The last year saw an increase in the number of new referrals to the programme, with 47 cases being referred in 2018, up from 44 in 2017 (see Table 4.3.1). 1. Referrals are the number of persons that were sent to the programme for consideration, whereas, admissions are the number of persons accepted into the programme. Some persons are referred by another Magistrate or a Justice, but may be found ineligible or unsuitable for the programme, so they are not admitted.

It should be noted that as of 2014, the DTC programme was revised to make the completion of Phase V (a year-long programme consisting of monitoring and support) mandatory for all participants (prior to 2014, finishing Phase IV was deemed as a programme completion and remaining in Phase V was voluntary). As such, since the DTC programme's inception in 2001, there have now been 38 programme completions with one person completing (Phase V) in 2018.

The DTC programme has not been able to retain all of its clients and see them through completion. In 2018, eight persons were terminated from the programme, eight were referred to the Mental Health Treatment Court; two were incarcerated; one received a fine for a DUI offence; four were remanded in custody and committed to Plea Court to be sentenced. Persons may apply to the programme multiple times. In 2018, six previous participants were allowed to re-enter the programme; two were terminated for non-compliance and the other four remain in treatment.

Table 4.3.1
Drug Treatment Court (DTC) Statistics, 2017 and 2018

	2017	2018
New referrals	**44**	**47**
Programme Admissions	6	12
Terminations from Programme	-	8
Successful Completion Phase IV	4	-
Successful Completion Phase V	2	1

Source: Drug Treatment Court

4.4 MEN'S TREATMENT STATISTICS

Drug Abuse among Men in Treatment

Men who were screened included all men who were admitted for services in addition to those who were still receiving treatment in the years under review. A total of five and 15 men were screened for drugs in 2017 and 2018, respectively. Drug screening is done randomly, on suspicion of drug use, for clients going on outings or requiring day passes, for work detail, and for Drug and Mental Health Treatment Court programmes.

Men's Treatment (MT) collected a total of 539 urine samples from its clients to test for drug use during 2018; increasing significantly from the 114 recorded in the previous year (see Table 4.4.1). This corresponded to 1,806 drug screens in 2018, significantly up from 1,368 drug screens in 2017 (each test consists of 12 substances). Nonetheless, 0.1% in 2017 and 2.0% in 2018 yielded positive results. The positive results observed in 2018 were for methadone and THC. In 2018, heroin and crack cocaine were the primary drugs used by men prior to treatment (see Table 4.4.2). None of the clients identified marijuana, in either year, to be their primary drug of choice prior to entering treatment.

As seen in both 2017 and 2018, poly drug use was prevalent with drugs in highest combination being heroin with crack and THC in 2018. Other two- and three-drug combinations included alcohol, crack and THC and heroin and alcohol among others (see Table 4.4.3).

Table 4.4.1
Drug Screening Results among Men in Treatment, 2017 and 2018

	2017	2018
Total Samples	114	539
Total Screens	1,368	1,806
Number of Positive Screens		
Benzodiazepine	2	-
Methadone	1	14
Opiates (Heroin)	1	-
THC	5	3
Diluted or Substituted Specimen	-	18
Total	**9**	**36**
% POSITIVE SCREENS	**0.1**	**2.0**

Source: Men's Treatment

Table 4.4.2
Primary Drug Used by Men Prior to Treatment, 2017 and 2018

Drug	Number of Men	
	2017	2018
Alcohol	2	5
Crack	1	18
Heroin	4	14
Marijuana	-	-
Cocaine	7	-
Methadone	1	2
TOTAL CLIENTS	**15**	**39**

Source: Men's Treatment

Note: Primary drug is drug of choice is self-identified by the client upon admission to treatment.

Table 4.4.3
Number of Cases of Poly Drug Use among Clients at Men's Treatment, 2017 and 2018

Combinations	Number of Clients	
	2017	2018
Three-Drug Combination:		
Heroin, Crack, THC	2	5
Alcohol, Heroin, THC	1	-
Alcohol, Crack, THC	1	4
Alcohol, Heroine, Crack	3	3
Two-Drug Combination:		
Alcohol, THC	1	-
Alcohol, Cocaine	2	-
Alcohol, Crack	-	5
Crack, THC	-	5
Heroin, Crack	-	6
Heroin, Cocaine	1	-
Heroin, Alcohol	3	-
Heroin, THC	1	-
TOTAL	**15**	**28**

Source: Men's Treatment

4.5 WOMEN'S TREATMENT CENTRE STATISTICS

Drug Abuse among Women in Treatment

Women who were randomly screened encompass: women referred for services but not admitted, women who entered WTC for treatment, women in transitional care, and those in after-care. The total number of random urine screens conducted by the WTC, which test for alcohol and illicit drug use, increased from 528 in 2017 to 986 in 2018 (see Table 4.5.1). The number of positive screens accounted for 1.9% (19) in 2018, slightly less than the previous year (2.5% or 13). Of all the substances screened, THC and opiates were found an equal number of times (eight) during urinalysis in 2018 compared to cocaine in 2017.

At the same time, heroin was the primary drug used by most of the women prior to treatment in 2018 versus cocaine in the prior year (see Table 4.5.2). Poly drug use was evident in both years with drugs in highest combination being heroin, crack and THC followed by alcohol and THC (see Table 4.5.3). Other two- and three-drug combinations included alcohol and cocaine, and heroin, crack, THC among others (see Table 4.4.3).

Table 4.5.1
Drug Screening Results among Women in Treatment, 2017 and 2018

	2017	2018
Total Samples	88	58
Total Screens	528	986
Number of Positive Screens		
Cocaine	6	3
Opiates	3	8
THC	4	8
Total	**13**	**19**
% POSITIVE SCREENS	**2.5**	**1.9**

Source: Women's Treatment Centre

Note: Primary drug is drug of choice is self-identified by the client upon admission to treatment.

Table 4.5.3
Number of Cases of Poly Drug Use among Clients at Women's Treatment Centre, 2017 and 2018

Combinations	Number of Clients	
	2017	2018
Three-Drug Combination:		
Heroin, Crack, THC	1	3
Crack, THC, Ecstacy	1	-
Two-Drug Combination:		
Alcohol, THC	3	3
Alcohol, Cocaine	1	1
Heroin, Crack	2	-
Heroin, THC	-	1
Crack, THC	-	2
TOTAL	**8**	**10**

Source: Women's Treatment

4.6 TURNING POINT SUBSTANCE ABUSE PROGRAMME STATISTICS

Drug Abuse among Turning Point Clients

Turning Point Substance Abuse Treatment Programme received a total of 5,787 specimens in 2018, a decrease from the 6,169 specimens in 2017 (see Table 4.6.1). Of the total specimens provided in 2018, 42.9% (2,377) tested positive for illicit drugs compared to 47.3% (2,756) in 2017. The number of positive specimens excludes those specimens that were tested positive for prescribed medications such as opiates, benzodiazepines, and methadone. In both years, male clients provided the larger number of tested specimens (5,014 in 2017 and 5,535 in 2018) compared to females (816 in 2017 and 661 in 2018,). The majority of positive specimens tested positive for only one drug (55.4% in 2017 and 53.2% in 2018) while the remainder tested positive for poly drug use of two or more drugs, inclusive of prescription medication.

In both years, the drug most often found in positive screens was opiates (heroin) (71.5% in 2017 and 69.0% in 2018), cocaine (47.1% in 2017 and 48.4% in 2018), and THC (marijuana) (26.7% in 2017 and 27.6% in 2018) (see Table 4.6.3). Noticeably in 2018, positive screens for all drugs increased with the exception of opiates, which saw a slight decline over the previous year.

Over the two-year period under review, the total number of methadone clients decreased from an average of 94 in 2017 to 87 in 2018 (see Table 4.6.4). Similarly, inpatient detoxes also decreased from 88 in 2017 to 71 in 2018; while, at the same time, outpatient detoxes were zero in 2017 and increased to 4 in 2018.

Table 4.6.1
Proportion of Positive Drug Screens and Poly Drug Use by Turning Point Clients, 2017 and 2018

	2017	2018
Total Specimens Requested	**6,169**	**5,787**
from Females	849	707
from Males	5,320	5,080
Total Specimens Provided	**5,830**	**5,535**
by Females	816	661
by Males	5,014	4,874
Total Positive Specimens for Illicit Drugs*	**2,756**	**2,377**
% Positive Specimens Of Total Specimens Provided	**47.3**	**42.9**

Table 4.6.1 cont'd

Proportion of Positive Drug Screens and Poly Drug Use by Turning Point Clients, 2017 and 2018

		2017	2018
Positive Specimens for Drugs*			
	for One Drug	1,528	1,265
Poly Drug Use	for Two Drugs	966	791
	for Three Drugs	292	268
	for More than Three Drugs	53	53

Source: Turning Point Substance Abuse Programme

Notes: * Exclude positive urine results with substances such as opiates, benzodiazepines, methadone, creatinine, suboxone, due to prescribed medication.
+ Includes alcohol and medically prescribed drugs.
Only specimens for active patients are counted (pre-admission tests and tests that are unable to be obtained are ignored).

Table 4.6.2

Positive Screens as a Proportion of Total Specimens Provided by Year and Type of Drug Detected at Turning Point, 2017 and 2018

Drug	2017	2018
Methadone	5,764 (98.9%)	118 (3.0)
Opiates	1,971 (33.8%)	1,639 (41.4%)
Cocaine	1,299 (22.3%)	1,151 (29.1%)
Marijuana	735 (23.6%)	656 (16.6%)
Benzodiazepines	135 (2.3%)	128 (3.2%)
Alcohol	76 (1.3%)	70 (1.8%)
OxyContin	22 (0.4%)	22 (0.6%)
Other	158 (2.7%)	171 (4.3%)

Source: Turning Point Substance Abuse Programme

Table 4.6.3

Positive Screens as a Proportion of Total Positive Specimens by Year and Type of Drug Detected at Turning Point, 2017 and 2018

Drug	2017	2018
Opiates	1,971 (71.5%)	1,639 (69.0%)
Cocaine	1,299 (47.1%)	1,151 (48.4%)
Marijuana	735 (26.7%)	656 (27.6%)
Benzodiazepines	135 (4.9%)	128 (5.4%)
Alcohol	76 (2.8%)	70 (2.9%)
OxyContin	22 (0.8%)	22 (0.93)
Other	158 (5.7%)	171 (7.2%)

Source: Turning Point Substance Abuse Programme

Table 4.6.4

Number of Methadone Clients, Inpatient, and Outpatient Detoxifications at Turning Point, 2017 and 2018

Year	Methadone Clients*	Inpatient Detoxes	Outpatient Detoxes
2017	94	88	-
2018	87	71	4

Source: Turning Point Substance Abuse Programme

Note: *Average

4.7 RIGHT LIVING HOUSE STATISTICS

Mandatory Drug Treatment

The Right Living House (RLH) originated as part of a Throne Speech commitment by the then Governor of Bermuda, in 2007. It received its first residents on January 7, 2010. Offenders are referred through the Department of Corrections, Court Services, and the Parole Board. The Right Living House treatment cottage formerly housed the Commissioner of Corrections and is a self-contained property located on the Prison Farm and housed separately from general population.

The Right Living House is a nine- to 12-month residential therapeutic community (TC), followed by six months of aftercare subsequent to the resident reentering society. The overall goal is to reduce recidivism. All offenders directed toward the full TC continuum must be within 12-18 months of Earliest Release Date (ERD) or parole eligibility date at the time of admission to the programme. In addition, they should have sufficient time (six to nine months) remaining on post-release conditions of parole in order to benefit from the community-based, outpatient (aftercare) component of the treatment continuum.

During 2017 and 2018, the RLH had a maximum of 12 and 10 residents in care, respectively; however, in 2018, the average number of residents over the 12 months decreased to nine when compared to 11 in 2017 (see Tables 4.7.1 and 4.7.2). There was, on average, one person who was placed on the waiting list for admissions in 2018 versus two persons in 2017. Persons from the wait list did not get into the residential programme immediately, although it was not full to capacity. This is mainly because some of these waitlisted persons would have had to first complete any outstanding requirement at the Westgate Correctional Facility, for example, a class such as anger management or the GED programme, before acceptance in the RLH residential treatment programme. Aftercare, a programme component, saw on average one client in 2017 and three in 2018. Drug screens were conducted over the two years at various intervals including: at random, after outings and day passes, after work detail, and on suspicion. In total, 264 screens were conducted in 2017 in comparison to 141 in 2018, with one positive substance abuse test result recorded in 2017 and none in 2018.

Table 4.7.1
Right Living House Programme Statistics, 2017

Programme Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Number of Residents	10	10	10	10	9	12	12	12	12	12	11	11	11*
Total Programme Admissions	-	1	1	1	-	3	1	-	-	-	-	-	7
Number of Discharges	-	1	1	-	2	-	1	-	-	1	-	-	6
Number of Substance Abuse Tests													
Random Tests	18	8	8	7	5	8	18	17	19	10	4	9	131
Tests for Outings & Day Passes	6	4	5	6	8	8	7	12	16	13	10	8	103
Work Detail	6	4	3	-	-	-	-	5	-	-	4	-	22
Suspicious Tests	7	-	1	-	-	-	-	-	-	-	-	-	8
Total	**37**	**16**	**17**	**13**	**13**	**16**	**25**	**34**	**35**	**23**	**18**	**17**	**264**
Number of Positive Substance Abuse Test	-	-	1	-	-	-	-	-	-	-	-	-	1
Wait Listed for Admission	3	2	2	2	2	1	1	1	1	1	1	1	2*
Residents in Aftercare	2	1	1	-	-	-	1	1	-	-	-	-	1*

Source: Right Living House

Note: *Average

Table 4.7.2
Right Living House Programme Statistics, 2018

Programme Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Number of Residents	10	9	9	6	8	8	10	8	8	8	9	9	9*
Total Programme Admissions	-	-	-	3	-	-	2	-	-	-	1	-	6
Number of Discharges	1	-	2	1	-	-	2	-	-	-	-	-	6
Number of Substance Abuse Tests													
Random Tests	11	6	7	4	6	4	16	4	9	4	9	7	87

Table 4.7.2 cont'd
Right Living House Programme Statistics, 2018

Programme Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Tests for Outings & Day Passes	5	5	11	7	2	1	2	1	3	4	1	3	**5**
Work Detail	-	3	3	-	-	1	-	-	-	-	-	-	**7**
Suspicious Tests	-	1	-	-	-	1	-	-	-	-	-	-	**2**
Total	**16**	**15**	**21**	**11**	**8**	**7**	**18**	**5**	**12**	**8**	**10**	**10**	**141**
Number of Positive Substance Abuse Test	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Wait Listed for Admission	-	-	-	-	-	-	-	-	-	-	1	1	**1***
Residents in Aftercare	1	1	3	4	4	3	4	4	2	2	1	1	**3***

Source: Right Living House

Note: *Average

4.8 SALVATION ARMY TREATMENT PROGRAMMES

The Salvation Army Harbour Light programme is a six to 12-month residential substance abuse treatment and rehabilitation programme for adult males based on individual need. This programme is motivated by the Christian philosophy of love for God and our fellow man and exists to offer support, understanding, guidance, and healing to its clients. It recognises the need to minister to the 'whole person'. On completion of the programme, it is expected that clients will be ready to be reintegrated into society, continue to develop healthy lifestyles, acquire the moral and spiritual principles of conduct, and have responsible work habits.

Over the last two financial years (April to March), the Harbour Light programme was operating at capacity, during all of the quarters, ranging from seven to 13 (see Table 4.8.1). During 2018, up to two clients on average, were admitted in each quarter while, at the same time, at least one client completed the programme. The programme randomly conducts drug tests with its clients and none of the tests administered to its clients were found to be positive for an illicit substance.

The Community Life Skills Recovery programme, also offered by Salvation Army, supports and provides services to persons in the community, who are referred from either inpatient or outpatient treatment services or both. It accepts clients who might be in any of the various stages of recovery but who are in need of life skills training or relapse prevention counselling. This programme understands that life skills training is an important treatment modality in helping both adult males and females become productive citizens and provides services for its clients with a holistic approach.

Table 4.8.2 shows the performance of this programme over the last two fiscal years. During this time, the number of clients who participated in the programme ranged from 20 clients in the first quarter of FY 2018/2019 to 16 clients in the fourth quarter of that same year. During the past year, seven life skills group session were conducted. There were less clients who received crisis intervention in 2018/2019 and there were fewer families who received relapse prevention education in 2018/2019. The programme's success can be judged by the fact that a number of clients successfully reintegrated with their families and into the community. For instance, in any given quarter during 2018, one to seven clients successfully reintegrated. At the same time, less clients were in stable committed relationships for the two years under review. Another success measure of the programme is that of financial stability. A number of clients have either opened or reactivated bank accounts, have secured savings in a bank, and made regular payments towards outstanding bills. Most importantly of all, is the number of clients who abstained from substance abuse. The data shows that a significant number of clients did, in fact, abstain from drug use, with a range of 17 to 31 clients in any given quarter, over the last two years under review.

Table 4.8.1
Salvation Army Harbour Light Residential Treatment Programme Performance, 2017/2018 and 2018/2019

Programme Indicators	FY 2017/2018				FY 2018/2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Intakes/Screenings/Assessments	5	5	3	7	4	4	2	3
Enrollment	2	3	1	2	2	2	1	-
Completions	1	2	2	1	1	1	1	2
Total Clients	11	13	7	8	9	8	9	9
Random Drug Tests	2	2	1	1	-	1	2	1
Positive Drug Tests	-	-	-	-	-	-	-	-
Departures	36	36	36	36	39	39	39	39
NA/AA Meetings (Mandatory)	4	8	9	4	4	9	17	12
Community Outreach: Volunteer Days	11	13	7	8	9	8	9	9
Community Outreach: Number of Client's Volunteering	1	1	2	1	3	2	3	4
Community Outreach: Other Activities	3	4	5	5	1	1	2	1

Source: Salvation Army

Table 4.8.2
Salvation Army Community Life Skills Recovery Programme Performance, 2017/2018 and 2018/2019

Programme Indicators	FY 2017/2018				FY 2018/2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total number of clients who participated in the programme	35	27	27	20	20	20	18	16
Number of new clients referred	4	3	-	2	2	3	1	4
New Care Plans	3	3	2	1	2	1	1	3
Care Plans reviewed	3	3	2	2	7	8	5	3
Number of intakes/screenings/ assessments	4	3	-	1	2	3	1	1
Number of evening groups	13	12	11	11	11	11	10	10
Life Skills training groups	2	2	1	-	3	2	1	7
Referrals for outside services	5	5	5	6	5	6	-	1
Case management sessions	12	12	10	12	13	13	11	13
Clients who received crisis intervention	15	17	15	10	10	12	10	3
Families who received relapse prevention	9	9	7	2	10	2	3	1
Clients who reintegrated with families, employment, education, community	9	10	9	3	7	4	1	2
Clients who were in stable committed relationships	8	6	6	4	2	1	3	1
Clients who obtained financial stability (financial planning and banking)	13	14	14	10	10	11	7	7
Clients who opened and reactivated bank accounts	-	4	4	2	2	1	1	-
Clients with secured savings in bank accounts	13	11	11	8	11	11	7	7
Clients who made regular payments towards outstanding bills	2	3	3	3	4	4	4	4
Clients who abstained from substance abuse	31	22	22	19	19	20	18	17

Source: Salvation Army

4.9 FOCUS COUNSELLING SERVICES SUPPORTIVE RESIDENCY PROGRAMME

Focus' Supportive Residency programme, otherwise known as Transitional Housing or Accommodation, houses men who have completed a residential substance abuse treatment programme and who want to rebuild their lives. Residents are expected to work and pay a portion of their earnings towards the rent. They are also expected to attend weekly meetings and submit to random drug testing.

Table 4.9.1 shows the performance of the programme over the last two fiscal years. During 2018, the programme operated two houses with a 14-bed capacity. There was an average of 12 clients who were accommodated by this programme. There were between eight and 20 after-care sessions (with one exception) in 2018/2019. Each of these aftercare sessions provided services to between 11 and 13 clients. Random drug tests of clients show a few positive results, especially for cocaine, THC, and alcohol.

Table 4.9.1
Focus Counselling Services Supportive Residence Programme Performance, 2017/2018 and 2018/2019

Programme Indicators	FY 2017/2018				FY 2018/2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Houses	2	2	2	2	2	2	2	2
Number of Beds	14	14	14	14	14	14	14	14
Average Number of Clients/ Occupancy	14	12	13	11	12	14	11	12
Number of Drug Tests	25	31	28	30	40	28	40	32
THC	3	2	2	1	1	2	1	2
Opiates	2	1	1	2	1	-	1	1
Cocaine	2	1	-	2	2	3	1	6
Alcohol	1	1	2	1	1	2	1	-
Number of After-Care Sessions	13	14	13	13	13	13	8	20
Average Number of Participants in Aftercare	13	11	12	13	12	13	11	12
House meetings	13	13	12	13	13	13	12	20
Number of residents employed	2	2	2	2	2	3	4	3
Number of Drug Court clients	3	3	3	3	2	2	1	2
Number of Probation/Parole clients	2	3	3	3	1	1	-	-

Source: Focus Counselling Services

4.10 CLIENTS IN TREATMENT

Tables 4.10.1 and 4.10.2 show the number of 'unique' individuals admitted to treatment during 2017 and 2018 and the numbers of different persons who received treatment during that year, respectively. This is the fourth year these indicators are being monitored and there is now a four-year series of available data on treatment admissions and persons receiving substance abuse treatment services. They provide an indication of access to and availability of treatment services in Bermuda for persons with substance abuse and dependence problems. Further, they can serve as an indication as to whether or not persons assessed and referred by BARC are actually engaged in the recommended level of care. These numbers do not include any person who sought treatment or were in treatment more than once in the given year. It should be noted, however, that there were in fact a few repeat clients who received treatment services.

Clients received publicly- or grant-funded services from any one of the seven programmes listed on the tables below. This list of facilities/programmes has remained unchanged for the past several years with no new service provider added. These programmes offered three major types of care: outpatient, including the opioid treatment programme, inpatient, or residential (including in-prison) non-hospital services to residents of Bermuda. Persons usually receive treatment for three broad categories of substance abuse problems: both alcohol and drug abuse, drug abuse only, or alcohol abuse only. However, there are clients known to have co-occurring disorders; but data using this level of disaggregation is currently not collated, though available.

The year 2018, saw a decline in the total of new treatment admissions, while persons who had a previous episode of treatment (repeaters) saw an increase from the previous year (see Tables 4.10.1 and 4.10.2). Specifically, the number of new clients admitted to treatment in 2018 was 62 (38 men and 24 women) and the number of persons who were in treatment, which includes any person(s) still in treatment from a previous year, together with the newly admitted persons, totaled to 363 (244 men and 43 women). As is quite noticeable, the number of males in treatment far outweighed their female counterparts. This does not mean that there were no females who needed treatment; it may simply mean that fewer women are accessing the treatment services provided for any number of reasons. It is, however, known that women face certain distinctive barriers to treatment than do men. At the same time, treatment facilities also conduct intake and assessment of other persons seeking services but who may not meet the criteria for admission into a programme and those who do meet the criteria, but cannot be accommodated because of the facility's capacity, are placed on a waiting list. These numbers are not accounted for on the tables below. In terms of capacity and utilisation of the treatment services, the majority was seen by the Turning Point Substance Abuse Programme for mainly inpatient detoxification or methadone maintenance. Almost one out of every four persons who were in treatment received residential care in 2018.

> "…fewer women are accessing the treatment services provided… women face certain distinctive barriers to treatment than do men."

Table 4.10.1
Number of New Treatment Admissions, 2017 and 2018

Treatment Agency	2017			2018		
	Male	Female	Total	Male	Female	Total
WTC	-	3	3	-	7	7
MT	10	-	10	13	-	13
Turning Point (Methadone, Inpatient, Outpatient/Detox)	17	6	23	6	17	23
Salvation Army Harbour Light	10	-	10	-	-	-
Salvation Army Life Skills	7	5	12	-	-	-
Focus	17	-	17	13	-	13
RLH	7	-	7	6	-	6
TOTAL	68	14	82	38	24	62

Source: Treatment Agencies

Table 4.10.2
Number of Persons in Treatment, 2017 and 2018

Treatment Agency	2017			2018		
	Male	Female	Total	Male	Female	Total
WTC	-	8	8	-	9	9
MT	15	-	15	19	-	19
Turning Point (Methadone, Inpatient, Outpatient/Detox)	155	33	188	244	43	287
Salvation Army Harbour Light*	21	-	21	9	-	9
Salvation Army Life Skills	29	5	34	16	-	16
Focus	17	-	17	13	-	13
RLH	26	-	26	10	-	10
TOTAL	263	46	309	311	52	363

Source: Treatment Agencies

Notes: * Number includes those in aftercare outpatient treatment.

Chapter 5
Drug Screening Surveillance

- Illicit and Anti-Doping Tests
- Drug Screening Among Criminal Offenders

5.1 BERMUDA SPORT ANTI-DOPING AUTHORITY STATISTICS

Anti-Doping and Illicit Drug Use in Sports

The Bermuda Sport Anti-Doping Authority (BSADA) has the responsibility of ensuring sports bodies in Bermuda are compliant with the World Anti-Doping Code and the Illicit Policy through the implementation and management of the Bermuda Government Policy Paper on Anti-Doping. This is accomplished by meeting the needs of all stakeholders in achieving a doping free and drug-free sporting environment by providing education and information programmes; athlete testing; intelligence management and exclusive results management for anti-doping rule violations.

It is important to note that BSADA offers two programmes – World Anti-Doping Agency (WADA) Programme and the Illicit Drug Programme. The first is anti-doping or performance enhancing testing, which is carried in accordance with the World Anti-Doping Code and is a global initiative. The other is the illicit drug programme carried out in accordance with the Illicit Drug Policy and is solely a Bermuda based initiative put in place by the various stakeholders.

The year 2018 saw a decrease to 490 (571 in 2017) in the number of illicit drug tests administered by BSADA (see Table 5.1.1). Four positive test results for THC (marijuana) were observed in 2017 and 2018. The number of anti-doping tests (of both urine and blood) also increased from 82 in 2017 to 83 in 2018.

The figures in Table 5.1.2 show the breakdown of illicit drug tests conducted in each sport for the years 2017 and 2018. Most of these tests were done for the sports of football and rugby and to a lesser extent basketball and the other sports. On the other hand, most of the anti-doping tests were administered for competition purposes by BSADA (see Tables 5.1.3 and 5.1.4). In 2017 and 2018, two tests screened positive for performance enhancing drugs (see Table 5.1.1). There was one more performance enhancing test done in 2018 than in 2017. These tests were for a number of sports, but mainly for athletics, aquatics, bodybuilding, cycling, and triathlon in both years under review (see Tables 5.1.5 and 5.1.6).

In addition to testing for illicit drugs and anti-doping in sports, the BSADA also provides drug prevention information to its athletes attending sport and anti-doping education sessions. Athletes, ranging from less than 13 years to 50 years and their parents or guardians attended these sessions.

Table 5.1.1
Drug Testing Results at BSADA, 2017 and 2018

Year	Illicit Tests			Anti-Doping Tests	
	Number of Tests	Number of Positive		Number of Tests	Positive
		THC	Cocaine		
2017	571	4	-	82	2
2018	490	4	-	83	2

Source: BSADA

Table 5.1.2
Illicit Drug Tests by Sport, 2017 and 2018

Sport	2017	2018
Archery	3	3
Athletics	30	14
Badminton	7	-
Basketball	46	25
Bicycling	20	3
Boccia (Para Sport)	-	-
Bowling	6	14
Cricket	24	24
Equestrian	1	-
Football	150	156
Golf	10	5
Gymnastics	5	-
Hockey	12	-

Table 5.1.2 cont'd
Illicit Drug Tests by Sport, 2017 and 2018

Sport	2017	2018
Lawn Tennis	12	-
Martial Arts	11	6
Netball	14	14
Rugby	122	57
Sailing	11	18
Squash	9	3
Swimming	23	27
Table Tennis	-	6
Triathlon	10	20
Volleyball	45	73
Total	**571**	**490**

Source: BSADA

Table 5.1.3
Performance Enhancement Testing by National Anti-Doping Organisations (Testing Missions Issued by BSADA), 2017

National Anti-Doping Organisations/ Service Provider	Urine In Competition	Urine Out of Competition	Blood In Competition	Blood Out of Competition
Bermuda Sport Anti-Doping Authority (BSADA)	52	3	-	-
United States Anti-Doping (USADA)	-	10	-	8
Professional Worldwide Controls (PWC)	-	1	-	1
United Kingdom Anti-Doping (UKAD)	-	2	-	1
Canadian Center for Ethics in Sport (CCES)	-	1	-	1
Total	**52**	**17**	**-**	**11**

Source: BSADA

Table 5.1.4
Performance Enhancement Testing by National Anti-Doping Organisations (Testing Missions Issued by BSADA), 2018

National Anti-Doping Organisations/ Service Provider	Urine In Competition	Urine Out of Competition	Blood In Competition	Blood Out of Competition
Bermuda Sport Anti-Doping Authority (BSADA)	52	6	-	2
United States Anti-Doping (USADA)	-	9	-	3
Professional Worldwide Controls (PWC)	-	1	-	1
United Kingdom Anti-Doping (UKAD)	-	2	-	1
Canadian Center for Ethics in Sport (CCES)	-	1	-	1
Australian Sports Anti-Doping Authority	-	1	-	1
South African Institute for Drug Free Sports	**-**	**1**	**-**	**1**
Total	**52**	**21**	**-**	**10**

Source: BSADA

Table 5.1.5
Performance Enhancing Tests by Sport (Testing Missions Issued by BSADA), 2017

National Anti-Doping Organisations/ Service Provider	Urine In Competition	Urine Out of Competition	Blood In Competition	Blood Out of Competition
Aquatics	16	2	-	1
Athletics	16	6	-	4
Body Building	8	-	-	-
Cycling	5	1	-	-
Equestrian	-	1	-	1

Source: BSADA

Table 5.1.5 cont'd
Performance Enhancing Tests by Sport (Testing Missions Issued by BSADA), 2017

National Anti-Doping Organisations/ Service Provider	Urine In Competition	Urine Out of Competition	Blood In Competition	Blood Out of Competition
Triathlon	7	7	-	5
Para Sport	-	1	-	1
Total	**52**	**18**	**-**	**12**

Source: BSADA

Table 5.1.6
Performance Enhancing Tests by Sport (Testing Missions Issued by BSADA), 2018

National Anti-Doping Organisations/ Service Provider	Urine In Competition	Urine Out of Competition	Blood In Competition	Blood Out of Competition
Aquatics	16	2	-	1
Athletics	16	6	-	4
Body Building	8	-	-	-
Cycling	5	1	-	-
Equestrian	-	1	-	1
Triathlon	7	7	-	5
Para Sport	-	1	-	1
Total	**52**	**18**	**-**	**12**

Source: BSADA

5.2 DEPARTMENT OF CORRECTIONS STATISTICS: WESTGATE CORRECTIONAL FACILITY

Drug Use among Criminal Offenders

Monthly provision of urinalysis screening results from the Westgate Correctional Facility[6] has yielded data that allows for comparison of patterns of use amongst offenders. The data is analysed according to type of drug used and whether or not persons were first-time or repeat offenders.

In 2018, 86.6% of reception inmates were screened for illicit drugs (see Table 5.2.1), 8.3% refused to participate in screening (8.5% refused in 2017), and 5.1% were released prior to specimen collection (4.5% in 2017). However, drug screening of offenders on reception decreased slightly in 2018 by 3.6% from the previous year, which saw 87.0% of specimens screened. The overall proportion of positive screens for illicit drugs decreased in 2018 to 137 compared to 158 in 2017 (see Table 5.2.2). Screening results indicated that marijuana, cocaine, and opiates, in sequential order, remained the most prevalent drugs amongst this population (see Tables 5.2.3 and 5.2.5). In 2017 and 2018, there was an increase, by 50%, in poly drug use, at the time of reception over the previous year (see Table 5.2.5). Random urine results provided evidence of mostly THC (marijuana) and, to a lesser extent, opiate use among offenders serving a sentence at Westgate Correctional Facility (see Table 5.2.4).

"Screening results indicated that marijuana, cocaine, and opiates remained the most prevalent drugs amongst this population."

Of the reception inmates, the number of first-time offenders increased from 40 (17.9%) in 2017 to 44 (20.3%) in 2018 (see Table 5.2.6). The proportion of repeat offenders received into Westgate decreased by 6.0% from the last year, moving from 183 (82.1%) in 2017 to 172 (79.6%) in 2018 (see Table 5.2.6). The urinalysis screens revealed that most first-time and repeat offenders used THC, cocaine, or opiates (see Table 5.2.7). The highest prevalence-of-use was recorded for marijuana, followed by cocaine and opiates (heroin). In both 2018 and 2017, when it came to poly drug use, there were significantly more repeat offenders (almost 1 in 5) that were multiple substance users, at least at the time of reception (see Table 5.2.8).

[6] The Westgate Correctional Facility is a maximum and medium security prison that houses adult males with a capacity for 228 inmates.

Table 5.2.1
Screening Results at Reception by Number and Proportion of Inmates, 2017 and 2018

Year	Reception Inmates	Screened	Refused	Released
2017	223	194 (87.0)	19 (8.5)	10 (4.5)
2018	216	187 (86.6)	18 (8.3)	11 (5.1)

Source: Westgate Correctional Facility

Table 5.2.2
Percentage of Positive Illicit Drug Screens among Prison Reception Inmates, 2017 and 2018

Year	Number of Positive Illicit Drug Screens	Percentage of Total Screens
2017	158	81.4
2018	137	73.3

Source: Westgate Correctional Facility

Table 5.2.3
Drug Prevalence (Urinalysis) at Reception by Number and Proportion of Screened Offenders, 2017 and 2018

Year	Marijuana	Cocaine	Opiates	METH	MET*	BUP*	BEN*	PROP*	PHEN*	Poly Drug Use
2017	133 (68.6)	46 (23.7)	45 (23.2)	10 (5.2)	9 (4.6)	1 (0.5)	16 (8.2)	1 (0.5)	1 (0.5)	54 (27.8)
2018	88 (47.1)	41 (21.9)	40 (21.4)	1 (0.5)	1 (0.5)	-	7 (3.4)	1 (0.5)	-	62 (33.2)

Source: Westgate Correctional Facility

Note: * Category not available in 2016; METH-Methadone; ECS-Ecstasy; MET-Methamphetamines; BUP-Buprenorphine; BEN-Benzoiazepines; PROP- Propoxyphene; PHEN- Phencyclidine.
Drug prevalence is derived from the number of positive results in each category compared to the overall number of offenders who were screened.

Table 5.2.4
Random Positive Urine Screens by Substance and Number and Proportion of Inmates, 2017 and 2018

	2017	2018
Overall Positive	**26 (11.7)**	**6 (2.8)**
Marijuana	15 (6.7)	4 (1.9)
Opiates	11 (4.9)	2 (0.9)

Source: Westgate Correctional Facility

Table 5.2.5
Drug Prevalence at Reception by Number and Proportion of Positive Illicit Drug Screens, 2017 and 2018

Year	Marijuana	Cocaine	Opiates	METH	MET*	BUP*	BEN*	PROP*	PHEN*	Poly Drug Use
2017	133 (84.2)	46 (29.1)	45 (28.5)	10 (6.3)	9 (5.7)	1 (0.6)	16 (10.1)	1 (0.6)	1 (0.6)	54 (34.2)
2018	88 (64.2)	41 (29.9)	40 (29.2)	1 (0.7)	1 (0.7)	-	7 (5.1)	1 (0.7)	-	62 (45.3)

Source: Westgate Correctional Facility

Note: * METH-Methadone; MET-Methamphetamines; BUP-Buprenorphine; BEN-Benzoiazepines; PROP-Propoxyphene; PHEN- Phencyclidine.
Drug prevalence is derived from the number of positive results in each category compared to the overall number of offenders who were screened.

Table 5.2.6
Number and Proportion of First-Time and Repeat Offenders by Year, 2017 and 2018

Year	Category of Offenders		
	Reception inmates	First time offenders	Repeat offenders
2017	223	40 (17.9)	183 (82.1)
2018	216	44 (20.3)	172 (79.6)

Source: Westgate Correctional Facility

Table 5.2.7
Any Illicit Drug Prevalence (Urinalysis) by Number and Proportion of First-Time and Repeat Offenders, 2017 and 2018

Year	Offender	Marijuana	Cocaine	Opiates
2017	Repeat offender	110 (49.3)	42 (18.8)	40(17.9)
	First-time offender	23 (10.3)	4 (1.8)	5 (2.2)
2018	Repeat offender	80 (37.0)	54 (25.0)	39 (18.1)
	First-time offender	26 (12.0)	6 (2.8)	10 (4.6)

Source: Westgate Correctional Facility

Table 5.2.8
Number of First-Time and Repeater Offenders with Poly Drug Use, 2017 and 2018

Year	First-Time Offender	Repeat Offender
2017	4	44
2018	10	52

Source: Westgate Correctional Facility

5.3 DEPARTMENT OF CORRECTIONS STATISTICS: PRISON FARM

Drug Use among Criminal Offenders

The Prison Farm is a correctional facility in Bermuda that houses adult males in a minimum-security setting, with capacity for 111 inmates. During 2018, the Prison Farm requested and collected 365 urine specimens, which was more than the number (289) requested in 2017 (see Tables 5.3.1 and 5.3.2). These specimens were collected at intervals for various types of drug tests, including randomly conducted drug tests, tests done for day or work release, and those done if drugs are suspected to be in use, among other reasons. Of those specimens provided, 2.7% (eight) tested positive for an illicit substance in 2018 and 1.4% (four) in 2017. Specifically, two of the four positive specimens and four of the eight specimens, in 2017 and 2018, respectively, tested positive for THC. There were positive tests for opiates in both years (two in 2017 and four in 2018). There were no positive tests for cocaine in either year of reference.

Table 5.3.1
Drug Screening Results for Persons at the Prison Farm, 2017

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens		
			Total	THC	Opiates
Random	228	228	4	2	2
Day Pass	9	9	-	-	-
Suspicion	3	3	-	-	-
Work Detail	49	49	-	-	-
Total	**289**	**289**	**4**	**2**	**2**

Source: Department of Corrections

Table 5.3.2
Drug Screening Results for Persons at the Prison Farm, 2018

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens		
			Total	THC	Opiates
Random	295	295	3	-	3
Day Pass	-	-	-	-	-
Suspicion	18	18	4	3	1
Work Detail	44	44	-	-	-
Other	8	8	1	1	-
Total	**365**	**365**	**8**	**4**	**4**

Source: Department of Corrections

5.4 DEPARTMENT OF CORRECTIONS STATISTICS: CO-ED FACILITY

Drug Use among Criminal Offenders

The Co-Ed is a correctional facility in Bermuda that houses females and juvenile offenders in a minimum-security setting. During 2018, the Co-Ed facility requested and collected 45 urine specimens compared to 61 specimens in 2017 (see Tables 5.4.1 and 5.4.2). These specimens were collected at intervals for various types of drug tests, such as randomly conducted drug tests, tests done for day or work release, and those done if drugs are suspected to be in use. Of those specimens provided in 2018, 4.4% (two) were found to be positive for an illicit substance and 3.3% or two in 2017. Both of the positive specimens tested positive for THC in 2017 and 2018 (see Table 5.4.2).

Table 5.4.1
Drug Screening Results for Persons at the Co-Ed Facility, 2017

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens	
			Total	THC
Random	48	48	2	2
Day Release	-	-	-	-
Suspicion	9	9	-	-
Work Detail	4	4	-	-
Work Release	-	-	-	-
Total	**61**	**61**	**2**	**2**

Source: Department of Corrections

Table 5.4.2
Drug Screening Results for Persons at the Co-Ed Facility, 2018

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens	
			Total	THC
Random	43	43	2	2
Day Release	-	-	-	-
Suspicion	-	-	-	-
Work Detail	-	-	-	-
Work Release	2	2	-	-
Total	**45**	**45**	**2**	**2**

Source: Department of Corrections

Chapter 6
Impaired Driving

- Breathalyser Results
- Failed BAC Readings
- Limits of BAC Readings
- DUI Education Programme Statistics

6.1 BLOOD ALCOHOL CONCENTRATION

Blood Alcohol Levels of Motorists

The proportion of alcohol to blood in the body is expressed as the blood alcohol concentration (BAC). In the field of traffic safety, BAC is expressed as the percentage of alcohol in deciliters of blood, for example, 0.08 percent (that is, 0.08 grams per deciliter or 80 mg/100 dl). Research has documented that the risk of a motor vehicle crash increases as BAC increases and that the more demanding the driving task, the greater the impairment caused by low doses of alcohol. Compared with drivers who have not consumed alcohol, the risk of a single-vehicle fatal crash for drivers with BAC between 0.02 and 0.04 percent is estimated to be 1.4 times higher; for those with BAC between 0.05 and 0.09 percent, 11.1 times higher; for drivers with BAC between 0.10 and 0.14 percent, 48 times higher; and for those with BAC at or above 0.15 percent, the risk is estimated to be 380 times higher.[7]

Alcohol, a very simple molecule, is probably the most widely used drug in the world. It is distributed to all the organs and fluids of the body, but it is in the brain that alcohol exerts most of its effects. Like other general anesthetics, alcohol is a central nervous system depressant. In general, its effects are proportional to its concentration in the blood. Alcohol is rapidly absorbed from the gastrointestinal tract into the bloodstream and from there it is distributed throughout the other bodily fluids and tissues. It is principally metabolised by the liver into acetaldehyde, with the remainder being excreted in the urine.

On average, it takes the liver about an hour to break down one unit of alcohol – the amount typically found in 12 ounces of beer, four ounces of wine, or one ounce of 50-proof hard liquor. Blood alcohol levels decline at a fixed rate irrespective of the amount consumed. The more consumed, the longer it takes to be metabolised. Additionally, blood levels are greatly, and inversely, influenced by body weight. The thinner one is, the greater the alcohol blood level for any given amount of alcohol consumed. Because of these factors, blood levels may remain elevated for many hours after the last drink.

In 2018, there has been a large increase (41%) in the number of persons who were stopped to undertake a breathalyser test, when compared to 2017. This increase can be attributed to the roadside sobriety testing which was initiated on September 23rd, 2018. Specifically, in 2018, 274 persons were stopped to undertake a breathalyser test compared to 194 in the previous year (see Table 6.1.1). However, not all of the persons who were stopped have agreed to undertake a breathalyser test; 79 persons refused to do so in 2018. Breathalyser testing is not mandatory, not even when there has been an accident.

A larger number of males (233 in 2018 and 173 in 2017) provided a sample for testing compared to females (31 in 2018 and 21 in 2017); however, overall, more males were stopped than females. In general, most persons failed the breathalyser test, irrespective of whether they were male or female. For instance, of those who provided a breathalyser sample, 158 out of 264 and 134 out of 194 failed in 2018 and 2017, respectively (with 32 in 2017 and 37 in 2018 passing the breathalyser test).

Overall, the mean BAC reading for all samples provided increased from 154 mg/dl in 2017 to 157 mg/dl in 2018 (see Table 6.1.2). At the same time, the mean BAC reading for individuals who failed the breathalyser test decreased slightly from 187 mg/dl in 2017 to 178 mg/dl in 2018. In instances where there were accidents, the average BAC was significantly above the legal limit. In 2017, the mean failed BAC, in cases where there were accidents, was recorded at 170 mg/dl and somewhat higher at 183 mg/dl in 2018. There were also instances where accidents occurred and the average BAC was under the legal limit – 23 mg/dl in 2017 and 29 mg/dl in 2018. As a reminder, the alcohol limit in Bermuda is less than 80 mg/dl. Breathalyser readings, nonetheless, ranged from 86 to 333 mg/dl in 2017 and 86 to 341 mg/dl in 2018; where the upper end of the range in 2018 is equivalent to as much as over four times the legal limit. On average, the majority of persons who failed the breathalyser test were two to three times above the legal limit in both 2017 and 2018 (see Table 6.1.3). Of those who were tested in 2018, only 27 were within the legal limit, when compared to 33 in 2017. In both 2017 and 2018, there were a number of instances (15) where accidents occurred and the corresponding breathalyser readings were as much as three to four times or more above the legal limit.

> "…there were 15 instances where accidents occurred and the corresponding breathalyser readings were as much as three to four times or more above the legal limit."

[7] The Westgate Correctional Facility is a maximum and medium security prison that houses adult males with a capacity for 228 inmates.

Table 6.1.1
Impaired Driving Incidences by Sex and Breathalyser Results, 2017 and 2018

Year	Number of Persons Stopped	Gave Sample						Male			Female		
		Total	Male	Female	Failed	Passed	Refusals	Failed	Passed	Refusals	Failed	Passed	Refusals
2017	**194**	**194**	**173**	**21**	**134**	**32**	**28**	**117**	**29**	**27**	**17**	**3**	**1**
Q1	41	44	42	2	31	2	11	30	2	10	1	-	1
Q2	41	39	34	5	25	10	4	21	9	4	4	1	-
Q3	42	42	38	4	31	9	2	28	8	2	3	1	-
Q4	70	69	59	10	47	11	11	38	10	11	9	1	-
2018	**274**	**264**	**233**	**31**	**158**	**37**	**79**	**139**	**29**	**65**	**19**	**8**	**14**
Q1	54	54	45	9	31	7	16	28	2	15	3	5	1
Q2	47	47	40	7	25	6	16	23	5	12	2	1	4
Q3	63	63	57	6	30	11	22	28	11	18	2	-	4
Q4	110	99	91	8	72	13	25	60	11	20	12	2	5

Source: Bermuda Police Service

Table 6.1.2
Breathalyser Readings for Impaired Driving Incidences, 2017 and 2018

	2017					2018				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Mean Reading: All Breathalyser Samples	148	148	155	164	**154**	141	179	156	150	**157**
Mean Reading: Failed Breathalyser Samples	174	192	185	195	**187**	169	191	186	164	**178**
Mean Reading: Failed Breathalyser Samples of Males	173	149	156	198	**169**	168	189	189	163	**177**
Mean Reading: Failed Breathalyser Samples of Females	178	132	170	181	**166**	175	212	146	172	**176**
Mean Reading: Accident with Failed Breathalyser Samples	192	136	166	186	**170**	169	213	193	158	**183**
Mean Reading: Accident with Passed Breathalyser Samples	57	-	17	18	**23**	26	-	79	12	**29**
Range of Reading: Failed Breathalyser Samples	86-333	87-307	90-285	90-280	**86-333**	100-334	90-308	86-341	87-294	**86-341**
Range of Reading: Passed Breathalyser Samples	35-80	0-78	0-79	0-76	**0-80**	0-30	0-54	0-79	0-76	**0-79**

Source: Bermuda Police Service

Notes: Readings in mg/dl.
* This figure is over the 80 mg/dl which is considered a passed breathalyser test, due to the fact that it is required by law that every person stopped take 2 breathalyser tests and the lowest reading is the one that is used. For example, the first reading can be 79 and the second can be 83, in this case the 79 would be taken but the 83 will still be submitted for records purposes.

Table 6.1.3
Number of Breathalyser Sample Readings by Limit, 2017 and 2018

Year	Within Limit	1-2 Times Above Limit	2-3 Times Above Limit	3-4 Times Above Limit	4+ Times Above Limit
2017	**33**	**46**	**48**	**14**	**1**
Q1	4	12	6	2	1
Q2	11	10	10	4	-
Q3	8	11	16	4	-
Q4	10	13	16	4	-
Male	**31**	**41**	**43**	**12**	**1**
Female	**2**	**5**	**5**	**2**	**-**
Accident	**21**	**19**	**11**	**4**	**1**
2018	**27**	**67**	**68**	**15**	**-**
Q1	7	15	14	1	-
Q2	2	6	15	3	2
Q3	8	10	15	4	-
Q4	10	36	24	7	2

Table 6.1.3 cont'd
Number of Breathalyser Sample Readings by Limit, 2017 and 2018

Year	Within Limit	1-2 Times Above Limit	2-3 Times Above Limit	3-4 Times Above Limit	4+ Times Above Limit
Male	20	59	60	13	2
Female	7	8	8	2	-
Accident	5	17	15	5	1

Source: Bermuda Police Service

6.2 DUI EDUCATIONAL PROGRAMME STATISTICS

Counselling and Treatment for DUI Offenders

The Bermuda Professional Counselling Services (BPCS) offers the driving under the influence (DUI) educational programme is offered by. International Certified Alcohol and Drug Counsellors (ICADC) provide counselling and treatment services focusing on treating chemical dependency and addictive behaviours. Apart from the DUI educational programme, which is part of the traffic safety services offered by the BPCS, it also offers services such as individual counselling of adolescents and adults, codependency counselling, family counselling, and relapse prevention as well as group counselling, which includes art therapy, children's groups, women's issues, and also relapse prevention. The BPCS also offers outpatient treatment for alcoholism and drug addiction as well as another traffic safety programme.

The BPCS instituted the DUI educational programme in 2001 as it was approved by the then National Drug Commission and was supported by the Bermuda Traffic Act 1947 (amended 2012; Section 35K). This programme seeks to decrease the numerous accidents, injuries, and deaths resulting from drinking and driving on Bermuda's road through education. It is a 12-hour education programme for impaired driving offenders, geared toward increasing their awareness of the consequences and effects of substance abuse to themselves and society, which includes their families, friends, and the broader social network to which they belong. By attending and successfully completing this 12-hour programme, a person who is temporarily disqualified from driving on the roads, can reduce his/her time off the road by three months.

Over the last two years, an increased number of inquiries has been made into this programme, 15 in 2017 and 22 in 2018 (see Table 6.2.1). However, of these inquiries, the majority of the persons participated in the programme, 12 in 2017 and 15 in 2018, respectively. Most of the participants in either year were males (see Table 6.2.2). In 2017, most of the participants were 31 to 35 years compared to 31 to 40 years in 2018 (see Table 6.2.2).

The programme uses the Triage Assessment for Addictive Disorders (TAAD) to assess participants for chemical dependency and addictive behaviours. The results of the TAAD showed that 33.3% of the programme participants in 2018 were diagnosed as 'mild' when compared to just over four in ten (41.7%) in the previous year. No person in 2018 was assessed to be in mid to late dependence stage of alcohol abuse or misuse, the most severe diagnosis; a similar trend was observed in 2017 (see Table 6.2.3). Specifically, in 2017, 33.3% (four) of the participants were diagnosed as mild, another 41.7% (five) as moderate, and 4.2% (one) were judged to be in the early dependence stage. In comparison, 33.3% (five) of the participants in 2018 were diagnosed as mild, another 13.3% (two) as moderate, and 26.7% (four) were judged to be in the early dependence stage. Each person received a certificate for programme attendance and completion, indicating that he/she has completed all aspects of the Level 1 DUI Programme.

Table 6.2.1
DUI Education Classes' Inquiries and Participants, 2017 and 2018

	2017	2018
Number of Inquiries	15	22
Number of Participants	12	15

Source: Bermuda Professional Counselling Services

Table 6.2.2
DUI Programme Participants' Statistics, 2017 and 2018

Year	Sex		Age							
	Male	Female	17 – 21	22 – 25	26 – 30	31 – 35	36 – 40	41 – 45	46 – 50	50+
2017	9	3	1	1	2	4	1	-	-	3
2018	13	2	-	-	3	4	4	-	1	1

Source: Bermuda Professional Counselling Services

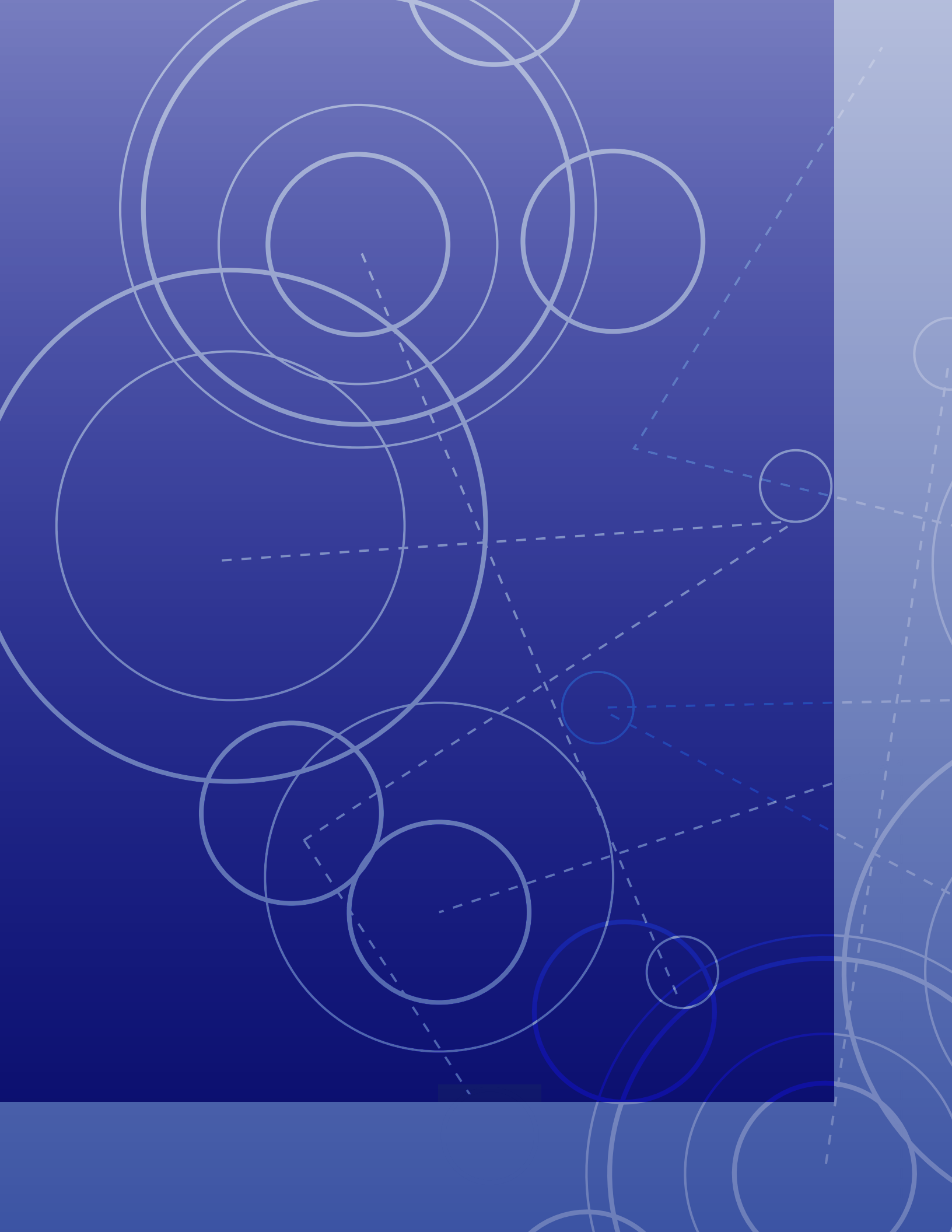
Table 6.2.3
Triage Assessment for Addictive Disorders Results (TAAD) by Number of Participants, 2017 and 2018

TAAD Scores		2017	2018
No Diagnosis		2	4
Mild		4	5
Moderate		5	2
Severe	Early Dependence	1	4
	Mid to Late Dependence	-	-
TOTAL		**12**	**15**

Source: Bermuda Professional Counselling Services

Chapter 7
Health

- Drug-Related Infectious Diseases
- Cases Related to Drugs, Poisoning, and Toxic Effects of Substances
  - »Inpatient Cases
  - »Emergency Room (ER)
  - »MWI Drug-Related Cases
- Mortality
  - »Toxicology Screens
  - »Substances Detected
  - »Causes of Death
- Prenatal Drug Use



7.1 DRUG-RELATED INFECTIOUS DISEASES

One of the more serious health consequences of the use of illicit drugs, and in particular of drug injection, is the transmission of HIV and other infectious diseases, notably hepatitis B and C. They may have the largest economic impact on health care systems of all consequences of drug use, even in countries where HIV prevalence in intravenous drug users (IDUs) is low. The relationship between intravenous drug use and the transmission of infection is well established. Reducing intravenous drug use and the sharing of injecting equipment has therefore become a primary goal of public health interventions in this area. Studies also point to a relationship between drug use and high-risk sexual activity; this suggests a growing importance in linking drug use interventions with public health strategies aimed at sexual health.[8]

This key epidemiological indicator collects data on the extent of infectious diseases – primarily HIV/AIDS, hepatitis B, and hepatitis C infection – among people who inject drugs for non-medical purposes (intravenous drug users or IDUs). The Epidemiology and Surveillance Unit of the Department of Health collects data for this indicator and tracks it on an on-going basis through the monitoring of routine diagnostic testing for HIV, hepatitis B, and hepatitis C infection.

Prevalence of drug-related infectious diseases were existent in both 2017 and 2018. In particular, the Epidemiology and Surveillance Unit reported six drug-related cases of hepatitis C in 2017 and decreased to three in 2018. Reports on these cases indicate a history or current use of injection drugs. No case of HIV or AIDS, related to drug use, was recorded in either of the years under review (see Table 7.1.1).

Monitoring of this indicator needs to be strengthened to make it more reliable and further improve the comparability of prevalence data in IDUs; especially in the areas where data is not available, that is, to know whether other infectious diseases such as chlamydia, Gonorrhoea, herpes, and syphilis, were as a result of injected drug use. In addition, there may also be under-reporting of some of these infections.

"Monitoring of this indicator needs to be strengthened to make this indicator more reliable and further improve the comparability of prevalence data in IDUs…"

[8] EMCDDA. (2006). *Annual Report 2006: The State of the Drug Problem in Europe. Luxembourg: Office for Official Publications of the European Communities.* p. 75.

Table 7.1.1
Drug-Related Infectious Diseases, 2017 and 2018

Infection	2017		2018	
	Number of Cases	Number of ATOD-Related Cases	Number of Cases	Number of ATOD-Related Cases
HIV	-	-	5	-
AIDS	-	-	-	-
Hepatitis B[a]	7	-	6	-
Hepatitis C[b]	8	6	8	3
Chlamydia	333	…	384	…
Gonorrhoea	48	…	61	…
Herpes[c]	78	…	46	…
Syphilis	3	…	3	…
Total	477	6	513	3

Source: Epidemiology & Surveillance

Notes: [a] Hepatitis B is a vaccine-preventable disease in Bermuda and is in Bermuda's immunization schedule; therefore, the vast majority of hepatitis B cases is imported from countries where hepatitis B is endemic and is not related to local drug-use.
[b] Almost all (>90%) of Hepatitis C cases are local and related to injection drug use.
[c] Data on genital herpes should not be used for trends as there were differences in reporting practices from prior years.

7.2 INPATIENT CASES RELATED TO DRUGS, POISONING, AND TOXIC EFFECTS OF SUBSTANCES

Information received from the King Edward Memorial VII Hospital (KEMH) is reported by treatment status, such as inpatient or emergency room case. Further, the classifications are reported by primary and secondary diagnosis using the International Statistical Classification of Diseases and Related Health Problems, Ninth Revision (ICD-9), codes. For purposes of the BerDIN, codes related to the following are reported: 1) inpatient and emergency drug cases and 2) inpatient and emergency cases related to poisoning, and toxic effects of substances.

Primary diagnosis is the major diagnosis used to identify the reason for the patient's stay and services required that the hospital uses for coding purposes. The principal diagnosis is defined as that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care or for outpatient treatment. It may not necessarily be the diagnosis which represents the greatest length of stay, the greatest consumption of hospital resources, or the most life-threatening condition. This principal diagnosis is selected by physicians based on their interpretation of what was treated or evaluated. Since the principal/primary diagnosis reflects clinical findings discovered during the patient's stay, it may differ from the admitting diagnosis. In the case of admission to the hospital-based ambulatory surgery service or freestanding ambulatory surgery center, the principal/primary diagnosis is that diagnosis established to be chiefly responsible for occasioning the admission to the service or center for the specific procedure. In the case of emergency room visits, the principal/primary diagnosis code is that diagnosis established to be chiefly responsible for occasioning the visit to the emergency room. Physicians "sequence" all of the diagnoses, complications and comorbidities in the following order: 1) principal diagnosis; 2) complication; and 3) comorbidity.

The principal diagnosis may not always be the most important or significant condition of a patient. For example, if a patient is admitted for dehydration, but three days into the admission has a myocardial infarction (MI), the principal diagnosis will be dehydration. Consistent, complete documentation in the medical record is vital to the accurate assignment of the principal diagnosis. Additional diagnoses are used to identify conditions that are present in addition to the major diagnosis.

The general guideline to determine a secondary diagnosis is if a clinical evaluation is provided, diagnostic procedures may be performed, and the patient may require an extended length of hospital stay or increased nursing care or monitoring. The definition of a secondary diagnosis is "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay." Diagnoses that relate to an earlier episode, which have no bearing on the current hospital stay, are excluded.

Inpatient cases for which drugs were the primary diagnosis was very low as reported by King Edward Memorial VII Hospital. There were only three cases reported in 2017 and one in 2018 (see Tables 7.2.1 and 7.2.2). In 2018, there were 21 inpatient cases in which poisoning and toxic effects were the primary diagnosis, which was an increase from the 19 cases recorded in the previous year. Regarding secondary diagnosis cases, 1,214 cases were reported for inpatient drug-related cases in 2017 compared to 1,174 cases in 2018 (see Tables 7.2.5 and 7.2.6). Secondary diagnoses of greatest occurrence were for conditions such as tobacco use disorder, chronic alcohol dependence, cannabis, and alcohol abuse. A similar trend was observed as in previous years. Secondary diagnoses for inpatient drug-related cases over the combined years of 2017 and 2018 were more prevalent in males (1,689) than females (699). In 2017, there were 11 cases of secondary diagnosis of inpatient cases of poisoning and toxic effects of substances; whereas, in 2018, there were 10 cases (see Tables 7.2.7 and 7.2.8).

"Secondary diagnoses of greatest occurrence were for conditions such as tobacco use disorder, chronic alcohol dependence, cannabis, and alcohol…"

Table 7.2.1
Primary Diagnoses of Inpatient Drug-Related Cases, 2017*

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other+
Opioid Abuse – Continuous	1	-	-	-	-	-	1	-	-	1	-	-	-
Alcohol Abuse – Continuous Drinking Behavior	2	-	-	-	-	-	1	1	1	1	-	-	-
TOTAL	**3**	**-**	**-**	**-**	**-**	**-**	**2**	**1**	**1**	**2**	**-**	**-**	**-**

Source: King Edward VII Memorial Hospital

Note: * Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.
+ Includes Portuguese, and persons of 'Other' races.

Table 7.2.2
Primary Diagnoses of Inpatient Drug-Related Cases, 2018*

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other+
Acute Alcoholic Intoxication In Alcoholism, Unspecified Drinking Behavior	1	-	-	-	-	-	1	-	-	1	-	-	-
TOTAL	**1**	**-**	**-**	**-**	**-**	**-**	**1**	**-**	**-**	**1**	**-**	**-**	**-**

Source: King Edward VII Memorial Hospital

Note: * Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.
+ Includes Portuguese, and persons of 'Other' races.

Table 7.2.3
Primary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2017

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other+
Poisoning - Antihypertensive agents	-	1	-	-	-	-	1	-	-	1	-	-	-
Poisoning – Insulin & Antidiabetic Agents	-	1	-	-	-	-	-	1	-	1	-	-	-
Poisoning – Salicylates	1	2	1	-	-	2	-	-	3	-	-	-	-
Poisoning- Anticoagulants	-	1	-	-	-	-	-	1	1	-	-	-	-
Poisoning- Other Opiates and Related Narcotics	-	1	-	-	-	-	-	1	1	-	-	-	-
Poisoning-Opium (Alkaloids) Unspecified	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning- Antiasthmatics	-	1	-	-	-	-	1	-	1	-	-	-	-
Poisoning- Unspecified Drug or Medicinal Substance	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning – Aromatic Analgesics	1	2	1	1	1	-	-	-	3	-	-	-	-
Poisoning - Antipsychotic, neuroleptic, and major tranquilisers	-	1	1	-	-	-	-	-	1	-	-	-	-
Poisoning By Other Diuretics	2	-	-	-	-	-	1	1	2	-	-	-	-
Poisoning By Other Antidepressants	1	-	-	-	-	1	-	-	-	-	-	-	1
Poisoning – Heroin	1	-	-	-	1	-	-	-	1	-	-	-	-
Toxic Effect Of Unspecified Substances, Chiefly Nonmedicinal As To Source	1	-	-	-	-	-	1	-	1	-	-	-	-
TOTAL	**9**	**10**	**3**	**1**	**2**	**3**	**6**	**4**	**16**	**2**	**-**	**-**	**1**

Source: King Edward VII Memorial Hospital

Notes: + Includes Portuguese, and persons of 'Other' races.

Table 7.2.4
Primary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2018

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning- Anticoagulants	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning-Opium (Alkaloids) Unspecified	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning – Aromatic Analgesics	-	2	2	-	-	-	-	-	2	-	-	-	-
Poisoning – Central Nervous System stimulant – crack	4	-	-	-	-	2	2	-	4	-	-	-	-
Poisoning - Antipsychotic, neuroleptic, and major tranquilisers	1	1	-	1	-	-	-	1	1	1	-	-	-
Poisoning - other specified drugs or medicinal substances	-	1	-	-	1	-	-	-	-	1	-	-	-
Poisoning – By Antimalarial and Drugs Acting on the Other Blood Protozoa	-	1	1	-	-	-	-	-	-	1	-	-	-
Poisoning- By Other Specified Psychotropic Agents	-	1	-	-	-	1	-	-	-	1	-	-	-
Poisoning – By Hydantion Derivatives	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning – By Psychodysleptics (Hallucinogens)	1	-	1	-	-	-	-	-	1	-	-	-	-
Poisoning – By Other and Unspecified Agents Primarily Affecting the Cardiovascular System	-	1	1	-	-	-	-	-	1	-	-	-	-
Poisoning – By Local Anti-infective and Anti- inflammatory Drugs	1	-	-	-	-	1	-	-	-	-	-	-	1
Toxic Effect – Chlorine Gas	1	-	-	-	-	1	-	-	-	-	-	-	1
Toxic Effect – Petroleum Products	1	-	-	-	-	1	-	-	-	1	-	-	-
Toxic Effect – Of Fish and Shellfish Eaten as Food	-	2	-	-	-	-	2	-	1	-	-	-	1
TOTAL	**12**	**9**	**5**	**1**	**1**	**6**	**7**	**1**	**12**	**6**	**-**	**-**	**3**

Source: King Edward VII Memorial Hospital

Notes: * Includes Portuguese, and persons of 'Other' races.

Table 7.2.5
Secondary Diagnoses of Inpatient Drug-Related Cases, 2017*

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Acute Alcohol Intoxication-Unspecified	2	-	-	-	-	-	-	2	2	-	-	-	-
Acute alcoholic intoxication - continuous	4	-	-	-	1	-	1	2	3	1	-	-	-
Alcohol Dependence NEC/Nos-Unspecified	29	13	-	1	2	4	14	21	30	11	-	-	1
Cannabis Dependence, Episodic Use	1	-	-	-	-	1	-	-	1	-	-	-	-
Amphetamine And Other Psychostimulant Dependence, In Remission	1	-	-	-	-	1	-	-	1	-	-	-	-
Cannabis Dependence, In Remission	1	-	-	-	-	1	-	-	1	-	-	-	-
Other And Unspecified Alcohol Dependence, Episodic Drinking Behavior	3	-	-	-	2	-	1	-	3	-	-	-	-
Alcohol abuse - continuous	55	15	-	2	5	5	25	33	38	31	-	-	1
Alcohol abuse - episodic	3	1	-	1	-	1	2	-	3	1	-	-	-
Alcohol abuse - in remission	17	3	-	-	-	-	6	14	11	9	-	-	-
Alcohol abuse - unspecified	49	9	-	7	15	4	13	19	45	11	-	-	2
Amphetamine Or Related Acting Sympathomimetic Abuse, Unspecified Use	-	1	-	-	-	-	1	-	1	-	-	-	-
Cannabis abuse - continuous	86	32	-	15	24	22	36	21	107	11	-	-	-

Source: King Edward VII Memorial Hospital

Table 7.2.5 cont'd
Secondary Diagnoses of Inpatient Drug-Related Cases, 2017*

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other+
Cannabis abuse - episodic	19	7	-	3	5	5	9	4	23	3	-	-	-
Cannabis abuse - in remission	12	2	-	-	2	-	9	3	13	1	-	-	-
Cannabis abuse - unspecified	81	26	1	9	24	19	38	16	93	14	-	-	-
Chronic alcohol dependence - continuous	36	13	-	-	2	1	24	22	29	16	-	-	4
Chronic alcohol dependence - in remission	7	3	-	-	-	-	5	5	5	5	-	-	-
Cocaine abuse - continuous	7	-	-	-	1	-	6	-	7	-	-	-	-
Cocaine abuse - episodic	-	1	-	-	-	-	1	-	1	-	-	-	-
Cocaine abuse - in remission	23	5	-	-	-	-	17	11	26	2	-	-	-
Cocaine Abuse-Unspecified	28	7	-	-	-	-	23	12	33	2	-	-	-
Cocaine Depend-Remiss	4	-	-	-	-	2	1	1	4	-	-	-	-
Cocaine dependence - continuous	2	1	-	-	-	-	2	1	2	1	-	-	-
Cocaine dependence - unspecified	2	-	-	-	-	-	-	2	2	-	-	-	-
Opioid abuse - continuous	6	-	-	-	1	1	3	1	5	1	-	-	-
Opioid abuse - in remission	8	2	-	-	-	-	7	3	9	1	-	-	-
Opioid abuse - unspecified	13	2	-	-	-	1	7	7	14	1	-	-	-
Opioid dependence - continuous	6	2	-	-	-	2	4	2	7	1	-	-	-
Opioid type dependence - in remission	2	-	-	-	-	2	-	-	2	-	-	-	-
Opioid type dependence - unspecified	6	6	-	-	-	2	9	1	8	4	-	-	-
Other, mixed, or unspecified drug abuse - continuous	1	-	-	-	-	-	1	-	-	1	-	-	-
Other, mixed, or unspecified drug abuse - in remission	1	-	-	-	-	-	-	1	1	-	-	-	-
Other, mixed, or unspecified drug abuse - unspecified	1	1	-	-	-	-	2	-	2	-	-	-	-
Tobacco use disorder	353	193	-	10	59	70	186	221	381	152	-	2	11
TOTAL	**869**	**345**	**1**	**48**	**143**	**144**	**453**	**425**	**913**	**280**	**-**	**2**	**19**

Notes:

* Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.
+ Includes Portuguese, and persons of 'Other' races.

Table 7.2.6
Secondary Diagnoses of Inpatient Drug-Related Cases, 2018*

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other+
Acute Alcoholic Intoxication - Continuous	5	-	-	-	2	-	2	1	3	2	-	-	-
Other And Unspecified Alcohol Dependence, Unspecified Drinking Behavior	17	4	-	-	1	2	9	9	13	8	-	-	-
Sedative, Hypnotic Or Anxiolytic Dependence, Continuous	1	-	-	-	-	-	1	-	1	-	-	-	-
Chronic Alcohol Dependence - Continuous	30	-	-	-	1	2	13	14	19	11	-	-	-
Chronic Alcohol Dependence - In Remission	4	4	-	-	-	-	4	4	6	2	-	-	-
Opioid Type Dependence - Unspecified	11	2	-	-	-	-	9	4	12	1	-	-	-
Opioid Dependence - Continuous	4	3	-	-	-	2	4	1	7	-	-	-	-
Opioid Type Dependence - In Remission	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Dependence - Continuous	3	1	-	-	-	3	1	-	4	-	-	-	-
Cannabis Dependence - Continuous	1	-	-	-	-	-	1	-	1	-	-	-	-
Cannabis Dependence - Unspecified	2	2	-	-	-	-	3	1	4	-	-	-	-

Table 7.2.6 cont'd
Secondary Diagnoses of Inpatient Drug-Related[*] Cases, 2018

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other[+]
Opioid/Other Dependence - Continuous	1	2	-	-	-	1	2	-	3	-	-	-	-
Unspecified Drug Dependence, Unspecified Use	2	-	-	-	-	-	1	1	2	-	-	-	-
Alcohol Abuse - Unspecified	70	12	-	10	8	10	20	34	65	15	1	-	1
Alcohol Abuse - Continuous	57	14	-	-	4	10	26	31	45	25	-	-	1
Alcohol Abuse - Episodic	3	2	-	1	-	-	2	2	4	1	-	-	-
Alcohol Abuse - In Remission	6	6	-	-	-	1	4	7	7	5	-	-	-
Other & Unspecified Alcohol Dependence, Episodic Drinking Behavior	1	-	-	-	-	1	-	-	-	1	-	-	-
Tobacco Use Disorder	337	201	-	22	43	84	163	226	379	145	-	3	11
Cannabis Abuse - Unspecified	80	41	1	11	27	21	35	26	103	18	-	-	-
Cannabis Abuse - Continuous	91	24	-	15	23	28	31	18	103	12	-	-	-
Cannabis Abuse - Episodic	10	6	1	1	2	5	6	1	11	4	-	1	-
Cannabis Abuse - In Remission	12	1	-	1	1	1	4	6	11	2	-	-	-
Opioid Abuse - Unspecified	10	3	-	-	-	4	7	2	13	-	-	-	-
Opioid Abuse - Continuous	3	1	-	-	-	1	2	1	4	-	-	-	-
Opioid Abuse - In Remission	5	2	-	-	-	1	2	4	3	4	-	-	-
Cocaine Abuse, Unspecified Use	29	12	-	1	1	3	22	14	41	-	-	-	-
Cocaine Abuse - Continuous	8	2	-	-	-	3	5	2	10	-	-	-	-
Cocaine Abuse - Episodic	1	2	-	-	-	-	3	-	3	-	-	-	-
Cocaine Abuse - In Remission	13	1	-	-	-	-	4	10	11	3	-	-	-
Amphetamine Or Related Acting Sympathomimetic Abuse, Unspecified Use	1	1	-	-	-	1	1	-	2	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse - Unspecified	2	5	-	-	2	4	-	1	6	1	-	-	-
TOTAL	**820**	**353**	**2**	**62**	**115**	**188**	**387**	**420**	**896**	**260**	**1**	**4**	**13**

Source: King Edward VII Memorial Hospital

Notes: [+] Includes Portuguese, and persons of 'Other' races.

Table 7.2.7
Secondary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2017

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other[+]
Poisoning By Caffeine	1	1	-	1	-	1	-	-	2	-	-	-	-
Poisoning By Psychodysleptics (Hallucinogens)	1	-	-	-	1	-	-	-	1	-	-	-	-
Poisoning – Anticoagulants	-	1	-	-	-	-	-	1	1	-	-	-	-
Poisoning By Saluretics	-	2	-	-	-	-	-	2	2	-	-	-	-
Poisoning - Benzodiazepine-based tranquilisers	-	1	-	-	-	-	1	-	-	1	-	-	-
Poisoning - Codeine, meperidine, morphine	-	1	-	-	-	1	-	-	1	-	-	-	-
Poisoning-Salicylates	1	-	-	1	-	-	-	-	1	-	-	-	-
Poisoning By Antipruritics	1	-	1	-	-	-	-	-	1	-	-	-	-
Toxic Effect Of Carbon Monoxide	-	1	-	-	-	-	1	-	-	-	-	-	1
TOTAL	**4**	**7**	**1**	**2**	**1**	**2**	**2**	**3**	**9**	**1**	**-**	**-**	**1**

Source: King Edward VII Memorial Hospital

Note: [+] Includes Portuguese, and persons of 'Other' races.

Table 7.2.8
Secondary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2018

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning By Anti-Infectives And Other Drugs And Preparations For Ear, Nose, And Throat	-	1	1	-	-	-	-	-	1	-	-	-	-
Poisoning By Unspecified Drug Or Medicinal Substance	2	1	-	1	-	-	-	2	1	2	-	-	-
Poisoning – Opium	-	1	-	-	-	-	1	-	1	-	-	-	-
Poisoning – Heroin	1	-	-	-	-	1	-	-	1	-	-	-	-
Poisoning - Codeine, Meperidine, Morphine	-	1	-	-	-	-	-	1	1	-	-	-	-
Poisoning By Other Antidepressants	-	1	-	-	-	1	-	-	-	1	-	-	-
Toxic Effect Of Other Specified Gases, Fumes, or Vapors	-	2	-	-	1	1	1	2	2	-	-	-	-
TOTAL	3	7	1	1	1	3	2	5	7	3	-	-	-

Source: King Edward VII Memorial Hospital

Note: * Includes Portuguese, and persons of 'Other' races.

7.3 EMERGENCY ROOM CASES RELATED TO DRUGS, POISONING, AND TOXIC EFFECTS OF SUBSTANCES

The emergency room saw 99 cases in 2017 in which the primary diagnosis was related to drugs and dropped to 91 cases in 2018 (see Tables 7.3.1 and 7.3.2). The main primary diagnosis was for alcohol abuse. Emergency room cases in which poisoning and toxic effects were the primary diagnosis and saw 164 cases in 2017 compared to 209 cases in 2018 (see Tables 7.3.3 and 7.3.4). In 2017, there was an overall total of 666 cases reported to the emergency room for which there was a drug-related secondary diagnosis compared to 377 cases in 2018 (see Tables 7.3.5 and 7.3.6); with significantly more cases of males than females. The secondary diagnoses for the majority of drug-related cases in both years were due to tobacco use disorder, alcohol abuse, acute alcoholic dependence, opioid abuse, cocaine abuse, and opioid dependence. When it came to secondary diagnosis of emergency room cases of poisoning and toxic effects of substances, 22 cases presented in 2017 and 28 cases in 2018 (see Tables 7.3.7 and 7.3.8); with more incidents occurring to females versus males in 2017 and 2018.

Table 7.3.1
Primary Diagnoses of Emergency Room (ER) Drug-Related Cases, 2017*

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other+
Acute Alcoholic Intoxication In Alcoholism, Unspecified Drinking Behavior	10	-	-	-	2	-	2	6	8	2	-	-	-
Acute alcoholic intoxication - continuous	1	1	-	-	-	-	1	1	2	-	-	-	-
Alcohol Abuse, Continuous Drinking Behavior	1	1	-	-	1	-	-	1	2	-	-	-	-
Alcohol Abuse, Unspecified Drinking Behavior	49	23	6	14	14	8	18	12	47	23	-	-	2
Cannabis Abuse, Unspecified Use	2	2	2	1	-	-	1	-	3	1	-	-	-
Hallucinogen Abuse, Unspecified Use	1	-	1	-	-	-	-	-	1	-	-	-	-
Cocaine Abuse, Unspecified Use	2	-	-	-	-	-	1	1	2	-	-	-	-
Opioid Abuse, Unspecified Use	3	-	-	-	-	2	1	-	3	-	-	-	-
Amphetamine Or Related Acting Sympathomimetic Abuse, Unspecified Use	1	-	-	-	1	-	-	-	-	1	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, Unspecified Use	2	-	-	-	-	-	1	1	1	1	-	-	-
TOTAL	**72**	**27**	**9**	**15**	**18**	**10**	**25**	**22**	**69**	**28**	**-**	**-**	**2**

Source: King Edward VII Memorial Hospital

Notes: * Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.
+ Includes Portuguese, and persons of 'Other' races.

Table 7.3.2
Primary Diagnoses of Emergency Room (ER) Drug-Related Cases, 2018*

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other+
Acute Alcoholic Intoxication – Continuous	2	-	-	-	-	-	2	-	1	1	-	-	-
Acute Alcoholic Intoxication In Alcoholism, Unspecified Drinking Behavior	2	-	-	-	-	-	-	2	2	-	-	-	-
Other & Unspecified Alcohol Dependence	1	1	-	-	-	-	1	1	1	1	-	-	-
Opioid Dependence- Continuous use	1	-	-	-	-	-	1	-	1	-	-	-	-
Cocaine Dependence - Unspecified Use	1	-	-	-	-	-	1	-	1	-	-	-	-
Alcohol Abuse – Continuous Drinking Behaviour	2	1	-	1	1	-	-	1	2	1	-	-	-
Alcohol Abuse – Unspecified Drinking Behaviour	42	21	5	17	12	7	6	16	38	23	-	-	2
Tobacco Use Disorder	1	-	-	-	-	-	1	-	-	1	-	-	-
Cannabis Abuse – Unspecified Use	3	2	-	1	1	1	2	-	4	1	-	-	-
Opioid Abuse – Unspecified Use	4	1	-	-	-	-	4	1	5	-	-	-	-
Cocaine Abuse, Unspecified Use	3	1	-	2	1	-	1	-	3	1	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, Unspecified Use	2	-	-	-	1	1	-	-	2	-	-	-	-
TOTAL	**64**	**27**	**5**	**21**	**16**	**9**	**19**	**21**	**60**	**29**	**-**	**-**	**2**

Source: King Edward VII Memorial Hospital

Notes: * Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.
+ Includes Portuguese and persons of 'Other' races.

Table 7.3.3
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2017

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other+
Poisoning By Penicillins	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning - Antiallergic and antiemetic drugs	-	1	-	1	-	-	-	-	1	-	-	-	-
Poisoning By Other Psychostimulants	1	-	-	-	1	-	-	-	1	-	-	-	-
Poisoning By Coronary Vasodilators	-	1	-	-	-	-	-	1	-	1	-	-	-
Poisoning - Antipsychotic, neuroleptic, and major tranquilisers	-	2	1	-	1	-	-	-	1	1	-	-	-
Poisoning - Antitussives	1	-	-	-	1	-	-	-	1	-	-	-	-
Poisoning - Aromatic Analgesics	2	5	3	1	3	-	-	-	3	2	-	-	2
Poisoning - Benzodiazepine-based tranquilisers	-	3	2	-	-	-	1	-	2	1	-	-	-
Poisoning - Codeine, meperidine, morphine	-	1	-	-	-	-	-	1	-	1	-	-	-
Poisoning By Antipruritics	2	-	2	-	-	-	-	-	2	-	-	-	-
Poisoning - Emollients, demulcents and protectants	-	2	2	-	-	-	-	-	-	-	-	-	2
Poisoning - ENT preparation	-	1	-	-	1	-	-	-	-	1	-	-	-
Poisoning - Hallucinogens	1	2	2	1	-	-	-	-	1	2	-	-	-
Poisoning - Hydantoin derivatives	1	-	-	-	1	-	-	-	1	-	-	-	-
Poisoning - Insulin and antidiabetic agents	-	2	-	-	-	-	1	1	2	-	-	-	-
Poisoning - Local anti-infective and antiinflammatory drugs	1	-	1	-	-	-	-	-	1	-	-	-	-
Poisoning By Other And Unspecified Agents Primarily Affecting The Cardiovascular System	1	-	-	-	-	-	-	1	1	-	-	-	-
Poisoning By Other Antidepressants	1	-	-	-	-	1	-	-	-	-	-	-	1

Table 7.3.3 cont'd
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2017

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning By Other Antihypertensive Agents	-	1	-	-	-	-	-	1	1	-	-	-	-
Poisoning By Selective Serotonin Reuptake Inhibitors	-	1	-	-	1	-	-	-	-	1	-	-	-
Toxic Effect - Caustic unspecified	-	3	-	-	1	-	-	2	2	1	-	-	-
Toxic Effect - Ethyl alcohol	-	3	-	1	2	-	-	-	1	1	-	1	-
Toxic Effect - Fish and shellfish	-	1	-	-	-	-	1	-	1	-	-	-	-
Poisoning - Methadone	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning - Opium	4	-	-	-	-	-	4	-	3	1	-	-	-
Poisoning - Other sedative or hypnotics	-	1	-	-	-	-	-	1	-	1	-	-	-
Poisoning - Other specified drugs or medicinal substances	3	5	4	1	-	-	1	2	7	1	-	-	-
Poisoning - Propionic acid derivatives	-	4	1	-	2	-	1	-	4	-	-	-	-
Poisoning - Salicylates	1	-	1	-	-	-	-	-	1	-	-	-	-
Poisoning - Sympatholytics (antiadrenergics)	-	3	-	-	-	-	-	3	3	-	-	-	-
Poisoning - Unspecified drugs or medicinal substances	4	3	-	2	-	2	2	1	7	-	-	-	-
Poisoning By Heroin	3	-	-	-	1	-	1	1	3	-	-	-	-
Toxic Effect - Non-medicinal substances	1	1	1	-	-	-	-	1	1	-	-	1	-
Toxic Effect - Non-petroleum-based solvents	-	1	1	-	-	-	-	-	1	-	-	-	-
Toxic Effect - Other specified gases, fumes, or vapours	1	2	-	-	1	-	2	-	3	-	-	-	-
Toxic Effect - Pesticides	-	1	-	-	1	-	-	-	-	-	-	-	1
Toxic Effect - Soap and detergent	1	-	1	-	-	-	-	-	1	-	-	-	-
Toxic Effect - Unspecified gas, fumes, or vapour	-	1	-	-	-	-	-	1	1	-	-	-	-
Toxic Effect - Venom	40	39	14	8	13	9	24	11	33	38	-	2	6
Toxic Effect Of Other Hydrocarbon Gas	1	-	-	-	-	-	1	-	-	1	-	-	-
Toxic Effect Of Unspecified Substance, Chiefly Non-medicinal As To Source	1	1	1	-	1	-	-	-	2	-	-	-	-
TOTAL	**73**	**91**	**37**	**15**	**31**	**12**	**41**	**28**	**93**	**55**	**-**	**4**	**12**

Source: King Edward VII Memorial Hospital

Notes: * Includes Portuguese.

Table 7.3.4
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2018

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning By Antineoplastic And Immunosuppressive Drugs	-	2	-	-	-	-	1	1	1	1	-	-	-
Poison - Insulin & Antidiabetic Agents	1	1	1	-	-	-	1	-	2	-	-	-	-
Poisoning - Antiallergic & Antiemetic Drugs	1	1	-	-	2	-	-	-	1	-	-	-	1
Poisoning - Vitamins	-	2	2	-	-	-	-	-	2	-	-	-	-
Poisoning - Anticoagulants	2	-	-	-	-	-	-	2	1	1	-	-	-
Poisoning - Opium	2	-	-	-	-	-	2	-	2	-	-	-	-
Poisoning - Heroin	2	-	-	-	-	-	2	-	2	-	-	-	-

Table 7.3.4 cont'd

Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2018

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning - Codeine, Meperidine, Morphine	-	1	-	-	1	-	-	-	1	-	-	-	-
Poisoning - Salicylates	-	1	1	-	-	-	-	-	-	1	-	-	-
Poisoning - Aromatic Analgesics	1	2	2	-	1	-	-	-	2	1	-	-	-
Poisoning - Propionic Acid Derivatives	1	-	1	-	-	-	-	-	-	-	-	-	1
Poisoning - Hydantoin Derivatives	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning - Other Sedative or Hypnotics	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning - Other Antidepressant	1	1	-	1	-	1	-	-	2	-	-	-	-
Poisoning – By Iron and its Compounds	-	1	1	-	-	-	-	-	-	1	1	-	-
Poisoning – By Other and Unspecified Anticonvulsants	1	-	-	-	-	-	-	1	1	-	-	-	-
Poisoning By Other Psychostimulants	2	-	1	-	1	-	-	-	2	-	-	-	-
Poisoning - Antipsychotic, Neuroleptic, & Major Tranquilisers	1	4	2	2	-	-	1	-	4	1	-	-	-
Poisoning - Benzodiazepine-Based Tranquilisers	1	-	-	-	-	-	-	1	-	1	-	-	-
Poisoning - Hallucinogens	1	2	1	-	1	-	1	-	2	-	1	-	-
Poisoning - Antilipemic & Antiarteriosclerotic Drugs	1	-	-	-	-	1	-	-	1	-	-	-	-
Poisoning- Other Agents Affecting Skin and Mucous Membrane	-	1	1	-	-	-	-	-	-	1	-	-	-
Poisoning - Other Antihypertensive Agents	1	-	1	-	-	-	-	-	-	1	-	-	-
Poisoning - Other and Unspecified Agents Primarily Affecting the Cardiovascular System	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning - Local Anti-Infective & Anti-Inflammatory Drugs	-	1	-	-	-	-	1	-	1	-	-	-	-
Poisoning - Other Specified Drugs or Medicinal Substances	3	3	3	-	1	-	1	1	3	2	-	-	1
Poisoning - Unspecified Drugs or Medicinal Substances	3	1	1	1	-	1	1	-	2	2	-	-	-
Poisoning - Uric Acid Metabolism Drugs	-	1	-	-	-	-	1	-	-	1	-	-	-
Poisoning by Antimalarial and Drug Acting on Other Blood Protozoa	-	1	1	-	-	-	-	-	-	1	-	-	-
Poisoning by Adrenal Cortical Steroids	-	1	1	-	-	-	-	-	-	1	-	-	-
Toxic effect - Non-Medicinal Substances	-	3	1	-	1	-	1	-	3	-	-	-	-
Toxic Effect - Unspecified Alcohol	-	1	-	1	-	-	-	-	-	1	-	-	-
Toxic Effect Of Acids	1	-	-	-	-	-	1	-	1	-	-	-	-
Toxic Effect - Caustic Alkalis	-	1	1	-	-	-	-	-	1	-	-	-	-
Toxic Effect - Caustic Unspecified	4	5	3	-	-	1	3	2	8	-	-	-	1
Toxic Effect - Carbon Monoxide	1	-	-	1	-	-	-	-	1	-	-	-	-
Toxic Effect Of Other Specified Metals	-	1	-	-	-	1	-	-	-	1	-	-	-
Toxic Effect - Liquefied Petroleum Gases	-	1	-	-	-	-	1	-	-	-	-	-	1
Toxic effect - Ethyl alcohol	1	-	-	1	-	-	-	-	1	-	-	-	-
Toxic effect - Fish and shellfish	3	5	-	-	-	3	4	1	3	2	-	-	3
Toxic Effect - Other Specified Gases, Fumes, or Vapours	2	-	-	-	-	1	1	-	2	-	-	-	-
Toxic Effect - Unspecified Gas, Fumes, or Vapour	1	2	-	-	-	2	1	-	2	-	-	-	1
Toxic Effect - Venom	56	48	19	13	9	15	29	19	63	38	-	2	1
Toxic Effect - Soap & Detergent	1	2	1	-	-	-	-	2	2	1	-	-	-

Table 7.3.4 cont'd
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2018

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Toxic effect - Petroleum Products	3	1	-	-	-	3	1	-	2	2	-	-	-
Toxic effect - Pesticides	-	1	-	-	-	-	-	1	1	-	-	-	-
Toxic Effect - Unspecified Substances, Chiefly Nonmedical As to Source	5	2	2	-	3	1	1	-	5	1	-	1	-
TOTAL	**108**	**101**	**48**	**20**	**20**	**30**	**58**	**33**	**132**	**64**	**2**	**3**	**10**

Source: King Edward VII Memorial Hospital

Note: * Includes Portuguese.

Table 7.3.5
Secondary Diagnoses of Emergency Room Drug-Related Cases, 2017*

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Acute Alcohol Intoxication-Unspecified	7	-	-	-	1	-	1	5	6	-	-	1	-
Acute alcoholic intoxication - continuous	2	-	-	-	-	-	2	-	1	1	-	-	-
Alcohol Dependence Nec/Nos-Unspecified	47	22	-	1	2	10	36	20	48	20	-	-	1
Cannabis Dependence, Unspecified Use	2	-	-	1	-	-	1	-	2	-	-	-	-
Alcohol Abuse - continuous	4	1	-	-	2	1	1	1	3	2	-	-	-
Alcohol Abuse - unspecified	133	29	2	20	26	26	56	32	103	52	-	2	5
Alcohol Abuse - in remission	-	1	-	-	-	-	-	1	-	1	-	-	-
Hallucinogen Abuse, Unspecified Use	1	1	1	1	-	-	-	-	1	1	-	-	-
Sedative, Hypnotic Or Anxiolytic Abuse, Unspecified	-	1	1	-	-	-	-	-	-	1	-	-	-
Cannabis abuse - continuous	6	-	-	1	1	2	1	1	5	1	-	-	-
Cannabis abuse - unspecified	47	33	3	20	23	13	16	5	63	16	-	-	1
Chronic alcohol dependence - continuous	3	2	-	-	1	-	1	3	2	2	-	1	-
Cocaine abuse - in remission	-	1	-	-	-	-	1	-	-	1	-	-	-
Cocaine Abuse-Unspecified	12	10	-	4	2	4	10	2	19	3	-	-	-
Amphetamine Or Related Acting Sympathomimetic Abuse, Unspecified Use	1	-	-	-	1	-	-	-	1	-	-	-	-
Drug Dependence Nec-Unspecified	15	3	-	1	1	4	8	4	15	3	-	-	-
Drug Dependence Nos-Remission	2	-	-	-	-	-	1	1	2	-	-	-	-
Drug Dependence Nos-Unspecified	1	2	-	-	-	-	3	-	3	-	-	-	-
Opioid abuse - continuous	3	-	-	-	-	2	1	-	3	-	-	-	-
Opioid abuse - unspecified	30	8	-	-	2	14	16	6	33	5	-	-	-
Opioid dependence - continuous	5	-	-	-	-	-	5	-	4	1	-	-	-
Opioid type dependence - unspecified	12	-	-	-	-	2	10	-	10	2	-	-	-
Tobacco use disorder	136	82	-	7	24	41	87	59	141	68	-	1	8
Other, Mixed, Or Unspecified Drug Abuse, In Remission	1	-	-	-	-	1	-	-	-	1	-	-	-
TOTAL	**470**	**196**	**7**	**56**	**86**	**120**	**257**	**140**	**465**	**181**	**-**	**5**	**15**

Source: King Edward VII Memorial Hospital

Note: * Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.
* Includes Portuguese.

Table 7.3.6
Secondary Diagnoses of Emergency Room Drug-Related Cases, 2018*

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other+
Acute Alcoholic Intoxication In Alcoholism, Unspecified Drinking Behavior	4	-	-	-	1	-	3	-	3	1	-	-	-
Acute Alcoholic Intoxication - Continuous	1	1	-	-	1	-	1	-	1	1	-	-	-
Other And Unspecified Alcohol Dependence, Unspecified Drinking Behavior	43	5	-	-	3	10	25	10	36	12	-	-	-
Chronic Alcohol Dependence - Continuous	1	4	-	-	2	3	9	4	6	10	-	1	1
Opioid Type Dependence - Unspecified	12	2	-	-	-	3	11	-	13	1	-	-	-
Opioid Type Dependence- In Remission	-	2	-	-	-	-	2	-	2	-	-	-	-
Opioid Dependence - Continuous	4	-	-	-	-	1	3	-	4	-	-	-	-
Cannabis Dependence, Unspecified Use	1	-	-	-	-	1	-	-	-	1	-	-	-
Other Specified Drug Dependence, Unspecified Use	1	-	-	-	-	1	-	-	1	-	-	-	-
Unspecified Drug Dependence, Unspecified Use	2	-	-	-	-	1	1	-	2	-	-	-	-
Unspecified Drug Dependence - Continuous Use	1	-	-	-	-	-	1	-	1	-	-	-	-
Alcohol Abuse - Unspecified	85	17	-	19	24	19	18	22	70	30	-	-	2
Alcohol Abuse - Continuous	7	1	-	-	1	-	1	6	7	1	-	-	-
Tobacco Use Disorder	41	32	-	1	8	14	24	26	45	27	1	-	-
Cannabis Abuse - Unspecified	25	15	-	3	19	7	9	2	38	2	-	-	-
Cannabis Abuse - Continuous	5	2	-	2	2	1	2	-	6	1	-	-	-
Cannabis Abuse – Episodic Use	1	-	-	1	-	-	-	-	1	-	-	-	-
Opioid Abuse - Unspecified	14	7	-	-	4	7	8	2	15	6	-	-	-
Opioid Abuse - Continuous	1	-	-	-	-	-	1	-	1	-	-	-	-
Cocaine Abuse, Unspecified Use	16	10	-	2	7	8	7	2	22	4	-	-	-
Other, Mixed, or Unspecified Drug Abuse, Unspecified Use	9	3	-	-	4	3	2	3	10	2	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, In Remission	-	1	-	-	-	-	1	-	1	-	-	-	-
TOTAL	**275**	**102**	**-**	**28**	**75**	**79**	**124**	**77**	**285**	**168**	**1**	**1**	**3**

Source: King Edward VII Memorial Hospital

Note: * Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.
+ Includes Portuguese.

Table 7.3.7
Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2017

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other+
Poisoning By Antiallergic And Antiemetic Drugs	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning By Alkalizing Agents	-	1	-	-	-	-	-	1	1	-	-	-	-
Poisoning By Vitamins, Not Elsewhere Classified	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning By Opium (Alkaloids), Unspecified	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning-Antidepressant Nec	-	1	-	1	-	-	-	-	1	-	-	-	-
Poisoning-Insulin/Antidiabetic	-	1	-	-	-	-	-	1	1	-	-	-	-
Poisoning - Aromatic analgesics	-	3	2	1	-	-	-	-	3	-	-	-	-

Table 7.3.7 cont'd

Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2017

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning - Codeine, meperidine, morphine	-	1	1	-	-	-	-	-	1	-	-	-	-
Poisoning By Caffeine	1	-	-	1	-	-	-	-	1	-	-	-	-
Poisoning By Other Antihypertensive Agents	-	3	-	-	-	-	1	2	2	1	-	-	-
Poisoning - Salicylates	-	2	-	-	2	-	-	-	-	-	-	-	2
Poisoning- Gastrointestinal Agents Nec	-	2	1	-	-	-	-	1	2	-	-	-	-
Toxic Effect - Acids	1	-	-	-	-	-	1	-	-	-	-	-	1
Toxic Effect Of Asbestos	1	-	-	-	-	-	-	1	1	-	-	-	-
Toxic Effect - Venom	-	2	-	-	-	1	1	-	1	1	-	-	-
Toxic Effects - Unspecified alcohol	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**6**	**16**	**4**	**3**	**2**	**1**	**6**	**6**	**15**	**4**	**-**	**-**	**3**

Source: King Edward VII Memorial Hospital

Note: * Includes Portuguese, and persons of 'Other' races.

Table 7.3.8

Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2018

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning - Anticoagulants	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning - Aromatic Analgesics	-	1	-	-	1	-	-	-	-	1	-	-	-
Poisoning - Propionic Acid Derivatives	1	1	-	1	1	-	-	-	1	1	-	-	-
Poisoning - Salicylates	1	-	-	-	-	1	-	-	1	-	-	-	-
Poisoning - Codeine, Meperidine, Morphine	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning - Heroin	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning By Opiate Antagonists	-	1	-	-	-	1	-	-	-	-	-	-	1
Poisoning By Skeletal Muscle Relaxants	-	1	-	-	1	-	-	-	1	-	-	-	-
Poisoning - Other and Unspecified Agents Primarily Affecting the Cardiovascular System	1	-	-	-	-	-	-	1	1	-	-	-	-
Poisoning by Penicillin's	1	1	-	-	-	-	1	1	-	2	-	-	-
Poisoning- Anticonvulsants NEC/NOS	-	1	-	-	-	1	-	-	-	1	-	-	-
Poisoning by Anti- Parkinsonism Drugs	-	1	-	-	-	1	-	-	-	1	-	-	-
Poisoning – Cardio tonics	-	1	-	-	-	-	-	1	1	-	-	-	-
Poisoning – Insulin/ Anti-diabetics	1	1	-	-	-	-	-	2	2	-	-	-	-
Poisoning – by Antitussives	-	1	-	-	-	-	1	-	1	-	-	-	-
Poisoning – by Expectorants	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning – Other Specified Drugs or Medicinal Substances	-	2	-	-	-	-	-	2	2	-	-	-	-
Toxic Effects - Unspecified Alcohol	1	-	-	-	-	-	1	-	1	-	-	-	-
Toxic Effect Of Fish And Shellfish Eaten As Food	1	-	-	-	-	-	1	-	1	-	-	-	-
Toxic Effect - Venom	1	2	-	1	1	-	1	-	2	1	-	-	-
Toxic Effect – of Carbon Monoxide	1	-	-	-	-	-	-	1	1	-	-	-	-
Toxic Effect – Caustic Agents	-	1	-	-	-	-	-	1	1	-	-	-	-
TOTAL	**13**	**15**	**-**	**2**	**4**	**4**	**9**	**9**	**18**	**9**	**-**	**-**	**-**

Source: King Edward VII Memorial Hospital

Note: * Includes Portuguese.

7.4 MID-ATLANTIC WELLNESS INSTITUTE CASES RELATED TO DRUGS, POISONING, AND TOXIC EFFECTS OF SUBSTANCES

The Mid-Atlantic Wellness Institute (MWI) is the only inpatient medical facility providing detoxification services for opiate and alcohol dependence. In 2017, there were 96 cases with a primary diagnosis that was drug-related within the MWI compared to 77 in 2018 (see Tables 7.4.1 and 7.4.2). Black males and between the ages of 46 and 60 accounted for the majority of these cases, with the primary diagnosis being opioid dependence, and acute alcohol intoxication.

In terms of the secondary diagnoses, a total of 160 cases were reported in 2017 compared to 163 cases in 2018 (see Tables 7.4.3 and 7.4.4), with significantly more males versus females, diagnosed with cannabis dependence, a tobacco use disorder, cocaine dependence, acute alcohol intoxication, amongst other secondary diagnoses. As with the primary diagnoses, black persons between the ages of 46 and 60 accounted for the bulk of the secondary diagnoses. There were no reported case of poisoning and toxic effects of substances in either 2017 or 2018.

Table 7.4.1
Primary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2017*

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other+
Acute Alcoholic Intoxication In Alcoholism, Continuous Drinking Behavior	20	11	-	1	5	7	15	3	15	16	-	-	-
Other And Unspecified Alcohol Dependence, Unspecified Drinking Behavior	1	-	-	-	1	-	-	-	1	-	-	-	-
Other And Unspecified Alcohol Dependence, Continuous Drinking Behavior	3	-	-	-	2	-	1	-	2	1	-	-	-
Combinations Of Opioid Type Drug With Any Other Drug Dependence, Continuous Use	1	2	-	-	3	-	-	-	3	-	-	-	-
Combinations Of Drug Dependence Excluding Opioid Type Drug, Continuous Use	-	1	-	1	-	-	-	-	1	-	-	-	-
Cannabis dependence - continuous	1	-	-	-	1	-	-	-	1	-	-	-	-
Cocaine dependence - continuous	2	-	-	-	-	1	1	-	1	1	-	-	-
Opioid abuse - continuous	1	-	-	-	-	1	-	-	1	-	-	-	-
Opioid dependence - continuous	44	9	-	-	-	21	26	6	48	5	-	-	-
TOTAL	**73**	**23**	**-**	**2**	**12**	**30**	**43**	**9**	**73**	**23**	**-**	**-**	**-**

Source: King Edward VII Memorial Hospital

Notes: * Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.
+ Includes Portuguese.

Table 7.4.2
Primary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2018*

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other+
Acute Alcoholic Intoxication In Alcoholism, Continuous Drinking Behavior	17	4	-	-	4	9	8	-	12	9	-	-	-
Other And Unspecified Alcohol Dependence, Continuous Drinking Behavior	2	1	-	-	-	1	1	1	1	2	-	-	-
Opioid Dependence – Continuous	29	10	-	-	2	13	22	2	37	2	-	-	-
Cocaine Dependence – Continuous	1	-	-	1	-	-	-	-	1	-	-	-	-
Cannabis Dependence – Continuous	4	-	1	-	1	-	2	-	3	1	-	-	-
Combinations Of Opioid Type Drug With Any Other Drug Dependence, Continuous Use	1	1	-	1	-	-	1	-	2	-	-	-	-

Table 7.4.2 cont'd
Primary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2018*

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other+
Cannabis Abuse, Unspecified Use	-	1	1	-	-	-	-	-	1	-	-	-	-
Opioid Abuse – Continuous	1	-	-	-	-	-	1	-	1	-	-	-	-
Acute Alcoholic Intoxication In Alcoholism, Unspecified Drinking Behavior	-	1	-	-	-	1	-	-	-	1	-	-	-
Combinations Of Opioid Type Drug With Any Other Drug Dependence, Unspecified Use	-	1	-	-	1	-	-	-	1	-	-	-	-
Combinations of Drug Dependence Excluding Opioid Type Drug, Continuous Use	1	-	-	-	-	-	-	1	1	-	-	-	-
Alcohol Abuse- Unspecified Drinking Behaviour	1	-	-	-	-	-	1	-	-	1	-	-	-
Unspecified Drug Dependence, Continuous Use	1	-	-	-	-	1	-	-	1	-	-	-	-
TOTAL	58	19	2	2	8	25	36	4	61	16	-	-	-

Source: King Edward VII Memorial Hospital

Note: * Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.
+ Includes Portuguese, and persons of 'Other' races.

Table 7.4.3
Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2017*

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other+
Acute Alcoholic Intoxication In Alcoholism, Unspecified Drinking Behavior	1	-	-	-	-	-	1	-	1	-	-	-	-
Acute Alcohol Intoxication- continuous	24	5	-	3	6	9	9	2	22	7	-	-	-
Alcohol Dependence Nec/Nos-continuous	2	-	-	-	1	-	1	-	1	1	-	-	-
Cocaine Dependence, Unspecified Use	2	-	-	-	1	-	1	-	2	-	-	-	-
Cannabis Dependence, Unspecified Use	2	-	-	-	2	-	-	-	1	1	-	-	-
Amphetamine And Other Psychostimulant Dependence, Unspecified Use	1	-	-	-	1	-	-	-	1	-	-	-	-
Unspecified Drug Dependence, Continuous Use	1	1	-	-	1	1	-	-	1	1	-	-	-
Alcohol Abuse-Unspecified	-	1	-	-	1	-	-	-	-	1	-	-	-
Cannabis abuse - unspecified	2	-	-	1	1	-	-	-	2	-	-	-	-
Cannabis dependence - continuous	1	-	-	-	-	-	1	-	1	-	-	-	-
Cocaine Abuse - Unspecified Use	24	5	-	3	6	9	9	2	22	7	-	-	-
Cannabis dependence - continuous	37	10	1	9	15	12	8	2	44	2	-	-	1
Cocaine Abuse - Unspecified Use	1	-	-	-	-	-	1	-	1	-	-	-	-
Cocaine dependence - continuous	13	5	-	-	-	8	8	2	18	-	-	-	-
Combination Drug Dependence Nec-Continuous	1	-	-	1	-	-	-	-	1	-	-	-	-
Drug Abuse Nec- continuous	1	-	-	-	-	1	-	-	1	-	-	-	-
Opioid dependence - continuous	1	-	-	-	-	-	-	1	1	-	-	-	-
Opioid Dependence-Unspecified	1	-	-	-	1	-	-	-	-	1	-	-	-
Opioid/Other Dependence-Continuous	17	4	-	2	8	6	5	-	15	6	-	-	-
Tobacco use disorder	20	7	-	-	5	7	12	3	21	6	-	-	-
TOTAL	**127**	**33**	**1**	**16**	**43**	**44**	**46**	**10**	**133**	**26**	**-**	**-**	**1**

Source: Mid-Atlantic Wellness Institute

Notes: * Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.
+ Includes Portuguese.

Table 7.4.4
Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related[*] Cases, 2018

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other[+]
Acute Alcoholic Intoxication In Alcoholism, Continuous Drinking Behavior	19	4	-	1	5	6	9	2	17	6	-	-	-
Acute Alcoholic Intoxication In Alcoholism, Unspecified Drinking Behavior	2	-	1	-	-	1	-	-	1	1	-	-	-
Other And Unspecified Alcohol Dependence, Continuous Drinking Behavior	1	-	-	-	1	-	-	-	1	-	-	-	-
Amphetamine And Other Psychostimulant Dependence, Continuous Use	1	-	-	-	-	-	1	-	1	-	-	-	-
Hallucinogen Dependence, Continuous Use	2	-	-	-	-	-	1	1	-	2	-	-	-
Opioid Abuse – Continuous	1	-	-	-	-	1	-	-	1	-	-	-	-
Opioid Dependence – Continuous	3	-	-	-	-	1	2	-	2	1	-	-	-
Cocaine Dependence – Continuous	12	9	-	-	3	8	9	1	17	4	-	-	-
Cocaine Abuse – Continuous	1	-	-	-	-	-	-	1	1	-	-	-	-
Cannabis Dependence – Continuous	35	7	1	4	13	11	8	5	34	8	-	-	-
Cannabis Dependence – Unspecified Use	5	1	-	1	3	1	1	-	6	-	-	-	-
Cannabis Dependence – Episodic Use	-	1	-	1	-	-	-	-	-	1	-	-	-
Combinations Of Opioid Type Drug With Any Other Drug Dependence, Continuous Use	13	5	-	-	6	5	7	-	13	5	-	-	-
Combinations Of Drug Dependence Excluding Opioid Type Drug, Continuous Use	1	1	-	-	-	1	1	-	2	-	-	-	-
Combinations Of Drug Dependence Excluding Opioid Type Drug, Unspecified Use	1	1	-	-	-	1	1	-	-	2	-	-	-
Unspecified Drug Dependence, Continuous Use	2	-	-	1	1	-	-	-	1	1	-	-	-
Alcohol Abuse, Continuous Drinking Behavior	-	2	-	1	-	1	-	-	1	1	-	-	-
Alcohol Abuse – Unspecified Drinking Behavior	2	-	-	-	1	1	-	-	2	-	-	-	-
Tobacco Use Disorder	10	5	-	1	4	2	5	3	13	2	-	-	-
Cannabis Abuse – Unspecified	3	1	-	-	2	1	-	1	4	-	-	-	-
Cannabis Abuse – Continuous	5	2	1	2	2	2	-	-	7	-	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, Unspecified Use	2	-	-	-	1	1	-	-	1	1	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, Continuous Use	2	1	1	-	-	1	1	-	3	-	-	-	-
TOTAL	**123**	**40**	**4**	**12**	**42**	**45**	**46**	**14**	**128**	**35**	**-**	**-**	**-**

Source: Mid-Atlantic Wellness Institute

Notes: [*] Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.
[+] Includes Portuguese.

7.5 MORTALITY: SUSPICIOUS DEATHS

Toxicology Screening Results

The concept of "drug-related" mortality is complex. The collection of data on drug-related mortality is technically demanding but extremely important. The difficulty often arises because of the fact that some deaths are attributed to multiple causes. Summarising the conditions that caused the death can be intricate and patterns or trends of death might be missed. A death can be directly attributable to drugs, for example, overdose, or indirectly by the use of drugs related to external circumstances, for example, traffic accidents. In addition, there are deaths attributable to problem drug use

as well as deaths related to drugs but which are due to circumstantial reasons, for example, violence related to drug trafficking or drug-related crime.[9]

The challenge with drug-related deaths is that the causes of death recorded by physicians certifying the deaths in certain cases are usually linked to causes other than substance or drug use overdose. For instance, a person may be involved in a fatal road traffic accident. In this case, the physician records or codes the death as "transport accident" using the ICD-10[10]. In this instance, it was the transport accident that led directly to the death. This is, therefore, the underlying cause of death, otherwise known as the primary or proximate cause of death. In other words, it is the disease or injury that initiated all other causes or conditions and started the train of morbid events leading directly to death, or the circumstances or violence that produced the fatal injury. However, any antecedent or intermediate causes of death must also be observed and recorded. As such, a death record usually provides an arrangement of the causal or etiological relationship of the medical conditions that finally led to the death; in the end, yielding the underlying cause of death. For example, the transport accident may have been caused by excess alcohol or drug overdose. In instances where there may be an intermediate cause, physicians must determine if these suspicious deaths are related to substance use and then send these cases to the Central Government Laboratory for toxicology screening.

The toxicology screening is performed by the Government Analyst to determine the presence or absence of drugs. In 2018, 55 cases were screened compared to 48 in 2017 (see Table 7.5.1). Most of the cases forwarded for screening were for males, 39 in 2017 and 41 cases in 2018. In addition, the majority of the cases screened were of older persons, in particular persons over the age of 46.

Ethanol in excess of the legal limit and drugs (illegal or psychoactive medicines above therapeutic range), were detected in some of the cases screened in each year under review. For instance, in 2017, 50% of the cases (24 of 48) screened positive for excess ethanol or illegal or non-prescribed drugs compared to 53% (29 of 55) in 2018. Drugs, for example, THC, cocaine, codeine, morphine, and others, as well as drugs in combination with others, were more often detected than excess alcohol. In other instances, ethanol was detected, but the quantity was below the legal limit or no substance at all was detected. The Epidemiology and Surveillance Unit, which is responsible for determining the underlying cause of death, determined that there were two drug-induced deaths (acute episode of poisoning or toxicity to drugs, for example, accidental overdose or intentional self-harm, or drug dependence) and one alcohol-induced death among those deaths with toxicology screens in 2018. Additionally, in 2018, there were three alcohol-induced deaths, for which toxicology screens were not conducted. This results in a total of two drug-induced and four alcohol-induced deaths for 2018. Alcohol- and drug-induced deaths do not include accidents, homicides, and other causes indirectly related to alcohol and drug use. However, toxicology results showed that there were eight road traffic fatalities and four homicides in which alcohol and or drugs were present.

The Epidemiology and Surveillance Unit also calculates smoking-attributable mortality, which is an estimate of the number of deaths that are related to smoking. In 2018, there were 58 tobacco-related deaths. These include an attributable fraction of deaths from various cancers, cardiovascular or heart diseases, and respiratory diseases, such as chronic obstructive pulmonary disease.

"…Of all cases where excess alcohol or drugs were detected in the toxicology screens, the cause of death was recorded as transport accident or assault."

In general, of all cases where excess alcohol or drugs were detected in the toxicology screens, the cause of death was recorded as mainly transport accident or assault (see Table 7.5.1). However, there were also instances of deaths, which were caused as a result of other external causes, such as some disease of the circulatory system and drowning, where excess alcohol or drugs were detected. Epidemiological research has indicated that alcohol use increases the risk for many chronic health consequences (for example, diseases) and acute consequences (for example, traffic crashes).[11] However, conclusions on causality of death due to excess alcohol or drug use cannot be inferred, but the data suggests that there may be some relationship between substance use and cause of death, especially, among those categorised as external causes. As a consequence, considerable care should be exercised when interpreting statistics on drug-induced deaths.

[9] EMCDDA. (2009). Statistical Bulletin 2008. *Drug Related Deaths – Methods and Definitions*. http://www.emcdda.europa.eu/stats08/drd/methods (accessed September 13, 2012)

[10] See http://apps.who.int/classifications/icd10/browse/2010/en

[11] J. Rehm, G. Gerhard, C. T. Sempos, M. Trevisan. (2003). *Alcohol-Related Morbidity and Mortality*. National Institute on Alcohol Abuse and Alcoholism.

Table 7.5.1
Toxicology Screens, Substances Detected, and Causes of Death, 2017 and 2018

	2017	2018
Total Number of Deaths (All Causes)	**494**	**543**
Proportion of Deaths with Toxicology Screens (%)	9.7	10.1
Total Number of Toxicology Screens	48	55
By Sex:		
Males	39	41
Females	9	14
By Age Group:		
< 18 Years	1	1
18 – 25 Years	6	3
26 – 35 Years	7	6
36 – 45 Years	6	4
46 – 60 Years	12	20
60+ Years	16	21
Substances Detected in Toxicology Screens (Number of Cases)		
Ethanol[a] (>80 mg)	7	3
Drugs[b]	10	17
Ethanol and Drugs	7	9
None/<80 mg Ethanol/Drugs in Therapeutic Range	24	26
Causes of Death (ICD-10)[c,d] (Persons with Detected Substances)	**24**	**31**
Diseases of the Circulatory System	2	3
Diseases of the Nervous System	1	1
External Causes of Morbidity and Mortality		
Transport Accident	10	8
Other External Causes of Accidental Injury	2	-
Assault	5	4
Intentional Self-Harm	1	1
Accidental Drowning and Submersion	1	1
Accidental Poisoning by Exposure to Noxious Substance	1	1
Certain Infectious & Parasitic Disease	…	2
Pending	…	9
Defined and Unknown Causes of Death Not Elsewhere Classified	1	1

Source: Central Government Laboratory and Epidemiology and Surveillance

Notes:
[a] Whether in blood, vitreous, or urine.
[b] Drugs whether in blood, vitreous, urine, or liver and include: 6-MAM, amitriptyline, benzoylecgonine, BZE, cocaine, codeine, diphenhydramine, hydrocodone, ibuprofen, midazolam, morphine, paracetamol, THC, THC-OH, THC-COOH, or a combination.
[c] All death certificates for 2017 have not been received. Therefore this data is based on 95% of registered deaths.
[d] Internationally accepted classification of deaths according to the World Health Organisation (WHO) http://apps.who.int/classifications/icd10/browse/2010/en

7.6 PRENATAL DRUG USE

Drug Use among Pregnant Women

Public health and child advocates agree that substance abuse by pregnant mothers raises numerous complexities and poses a threat to the welfare of the mother, but especially the newborn.

Many pregnant women sometimes use medications without prior consideration to the adverse effects of these substances on their unborn children. Pregnant women who use drugs during their pregnancy pass the drugs along to the baby through the placenta. Women who smoke marijuana while they are pregnant are more likely to have low birth-weight, premature babies. These conditions can both lead to developmental delays and respiratory problems. Another obstacle these babies face is withdrawal symptoms for almost a week after birth. The most common long-term effect on these infants is that they may have a shorter attention span than a child not exposed to the drug. These problems are more prevalent in women who smoke more than six times per week.[12] At birth, the baby may experience drug withdrawal, depending on the amount of drug the mother used and when the drug was last consumed. The American Academy of Pediatric explains that if a week or more elapses between the mother's last use of the drug and delivery of the baby, the risk that the baby will develop drug withdrawal is, however, low. Drugs such as heroin, oxycodone, cocaine, alcohol, marijuana and even inhalants such as glue, gasoline, and paint thinner can all cause newborns to experience drug withdrawal.[13]

[12] P.A. Fried & J. E. Makin. (1987). *Neonatal behavioural correlates of prenatal exposure to marijuana, cigarettes and alcohol in a low risk population. Neurotoxicology and Teratology.* p. 5.

[13] B. Zuckerman, D.A. Frank, R. Hingson, H. Amaro, et al. (1989). *Effects of maternal marijuana and cocaine use on fetal growth. New England Journal of Medicine,* 32, 762-768. p. 765.

In Bermuda, no national legislation exists for newborn drug screening laws. The baby may be screened for illicit substances at birth if the mother is suspected to be a substance user or has a history of illicit drug use. Over the years, illicit substances were found in at most three newborns (in 2008). In other years, there were only one or two reported cases of newborns who screened positive for drugs at birth. Drugs present included cocaine or a combination of drugs, for example, cocaine and cannabis.

The data reported by the Maternal Health Clinic in Bermuda (see Table 7.6.1) only represents a proportion of pregnant women receiving pre-natal care, with one or more than one illicit drug present in their system over their gestational cycle. In 2018, one of the three confirmed positive tests was for marijuana and the other two were for cocaine. In 2018, there was one woman who tested positive for marijuana in her second trimester. Whereas, in 2017, 52.4% of the women who have tested positive for using marijuana have done so in their third trimester.

"In 2018, one of the three confirmed positive tests were for marijuana and the other two were for cocaine."

Table 7.6.1
Drug Screening for Marijuana among Pregnant Women Attending the Maternal Health Clinic, 2017 and 2018

	Number of Pregnant Women	
	2017	2018
Total Number of Tests	21	3
Total Number of Positive Tests	21	1
Positive Tests by Gestation		
First Trimester	5	-
Second Trimester	5	1
Third Trimester	11	-

Source: Maternal Health Clinic

Chapter 8
Drug Prevention Programmes

- PRIDE Bermuda's LifeSkills Training
- CADA's LifeSkills Training
- PATHS Programme

8.1 BOTVIN'S LIFESKILLS TRAINING PROGRAMME

Botvin's LifeSkills Training (LST) is a research-validated substance abuse prevention programme proven to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviours.[14] It is recognised as a model or exemplary programme and has been adopted for use in Bermuda in the past few years by drug prevention partners PRIDE Bermuda and CADA. The LST programme runs in selected classrooms at the primary, middle, and high school levels during the school year at either scheduled class times or times dedicated for this curriculum. This comprehensive programme provides adolescents and young teens with the confidence and skills necessary to handle successfully challenging situations. Rather than merely teaching information about the dangers of drug abuse, Botvin's LST consists of three major components – drug resistance skills, personal self-management skills, and general social skills – that cover the critical domains found to promote drug use. These skills help to promote healthy alternatives to risky behaviours through activities designed to: teach students the necessary skills to resist social (peer) pressures to smoke, drink, and use drugs; help students to develop greater self-esteem and self-confidence; enable students to effectively cope with anxiety; increase their knowledge of the immediate consequences of substance abuse; and enhance cognitive and behavioral competency to reduce and prevent a variety of health risk behaviours.

PRIDE and CADA, as part of their programme performance monitoring, compile LST programme data. The data in Table 8.1.1 shows that in both school years, 2017/2018 and 2018/2019, PRIDE has implemented the LST programme in classrooms at only the primary level. Specifically, in the 2017/2018 school year, 20 classrooms across nine primary schools implemented the LST programme. Similarly, the LST programme coverage in the 2018/2019 school year spanned 27 classrooms across nine primary schools. There were a number of students (13) who dropped out of the programme during the 2017/2018 school year, which increased to 18 dropouts in 2018/2019. A total of 296 and 396 students completed the programme at this level during the two academic years in review, respectively.

"…the LST programme coverage in the 2018/2019 school year spanned 27 classrooms across 9 primary schools."

Across all participating classrooms in the primary schools, there were 178 sessions for students in 2017/2018 and 241 in 2018/2019. The notable increase in the number of sessions from the 2017/2018 school year to the 2018/2019 school year can be attributed to the addition of a facilitator who conducted two more sessions per lesson than is required for the school year. This extra facilitation took place due to the many issues that arose and needed to be addressed with the students. Each session, averaging approximately 45 minutes, covered all three levels of the primary curriculum, which is equivalent to each class completing the assigned eight modules in each school year under review. The average pre-test score for the students at the primary level was 58.0% versus 72.0% at the post test in 2017/2018 and 57.0% versus 72.0% in 2018/2019. This is equivalent to an average gain score (difference between post test and pre-test scores) of more than 10.0% in both years under review.

CADA, on the other hand, implemented the LST in only the middle- and high-school levels in both school years in 2017/2018 and only the middle school level in 2018/2019, due to a lack of resources for the choosen high school. During the 2017/2018 school year, two classes in one school received the 14-module Level 1 middle-school programme, with 39 students completing the curriculum over 36 sessions. The 2018/2019 school year had three classes in one school that participated in the 14-module Level 1 middle-school programme, with 59 students completing the curriculum over 65 sessions (see Table 8.1.2). There was a 100.0% completion rate of all the modules in the two classes in both years. In 2017/2018, the average gain score at this level was 3.0% with an average pre-test score of 72.0% versus 78.0% at the post test; and, in 2018/2019, the gain score increased to 10.0% with an average pre-test score of 68.0% compared to 78.0% at the post test.

[14] http://lifeskillstraining.com/overview.php?t=overview

Table 8.1.1
PRIDE Bermuda's LifeSkills Programme Statistics, 2017/2018 and 2018/2019

Programme Indicators	School Year and Level	
	2017/2018	2018/2019
	Primary	Primary
Number of Schools Participated	9	9
Number of Classes Participated	20	27
Number of Students Engaged	309	414
Number of Students Dropped Out	13	18
Number of Students Retained	296	396
Number of Sessions	178	241
Number of Modules Completed	168	210
Total Number of Modules	168	216
Proportion of Curriculum Completed (%)	100	97
Average Pre-Test Score (%)	58	57
Average Post Test Score (%)	72	72

Source: PRIDE Bermuda

Table 8.1.2
CADA's LifeSkills Programme Statistics, 2017/2018 and 2018/2019

Programme Indicators	School Year and Level			
	2017/2018		2018/2019	
	Middle	High	Middle	High
Number of Schools Participated	1	1	1	..
Number of Classes Participated	2	3	3	..
Number of Students Engaged	41	43	52	..
Number of Students Dropped Out	2	3	1	..
Number of Students Retained	39	40	51	..
Number of Sessions	36	30	65	..
Number of Modules Completed	28	21	54	..
Total Number of Modules	28	21	54	..
Proportion of Curriculum Completed (%)	100	100	100	..
Average Pre-Test Score (%)	72	83	68	..
Average Post Test Score (%)	75	86	78	..

Source: PRIDE Bermuda

8.2 PROMOTING ALTERNATIVE THINKING STRATEGIES PROGRAMME

The Promoting Alternative THinking Strategies (PATHS) curriculum is a model social and emotional learning programme that was designed to help children develop self-control, positive self-esteem, emotional awareness, and interpersonal problem-solving skills; and it has been recognised for its effectiveness. An evaluation tool is used to assess the PATHS lessons to see how well students received these lessons. Students are evaluated at two different time points: at the beginning of the school year (pre-curriculum) with a pre-test and then again at the end of the school year (post curriculum) with a post test to monitor the progress that they have made during the school year. Both the pre- and post tests contain questions on three key behavioural areas (aggression/disruptive behaviour, concentration or attention, and social and emotional competence). Students are evaluated using a numerical rating scale of 0 to 5 (never or almost never, rarely, sometime, often, very often, and almost always) on a total of 31 (Primary 1 level) and 30 (Primary 2 level) individual behaviours.

This programme is coordinated by PRIDE Bermuda and, in the last two academic years, the curriculum was delivered to two primary schools. However, the PATHS Developer indicated that, going forward, the number of students assessed should

be reduced to alleviate the burden on teachers to assess every student. There were challenges noted with teachers being able to complete assessments for all of their students. Therefore, the suggestion from the PATHS Developer to randomly select eight students per class began during the 2017/2018 school year. The data on Table 8.2.1 shows that three classes at all six of the primary levels participated in the 2017/2018 school year. The curriculum was delivered two times each week with each session being approximately 30 minutes in length. A total of 261 students at the six primary levels were engaged for the entire programme in 2017/2018 and 223 students at the six primary levels in 2018/2019. The students at the Primary 1 level completed 103 of 135 modules in 2017/2018 (76.3% curriculum completion) and all of the 135 in 2018/2019 (100.0% curriculum completion). The Primary 2 level saw completion rates of 31.7% in 2017/2018 and 41.0% in 2018/2019. At the Primary 3 level, the classes completed 60.7% of the curriculum in 2017/2018 and 70.7% in 2018/2019. For the 2017/2018 school year, Primary 4 completed 53.2% of the curriculum, Primary 5 completed 35.8%, and Primary 6 completed 44.4%. Whilst, in the 2018/2019 school year, Primary 4 completed 78.6% of the curriculum, Primary 5 completed 41.7%, and Primary 6 completed 59.3%.

In terms of behavioural maturity for 2018/2019, the average change results (difference between the post test and pre-test scores) showed that, in most instances, about half or more of the students showed improvement in the three key behavioural areas, with the largest proportion of students showing improvement in social and emotional competence. At the same time there was a fraction of the students who showed no change, on average, in any of the behaviours assessed or whose behaviours actually became worse (negative change). Students at the higher grades were more likely to show a negative average change on aggression/disruptive behaviours. For instance, in 2018/2019, 58% of the Primary 4 students, 56% of the Primary 5 students, and 53% of the Primary 6 students, showed a negative average change on aggression/disruptive behaviours, which include elements such as fights, handling disagreements negatively, and getting angry when provoked, among others. This indicates that, for these students, their behaviours on this component worsened.

"…Primary levels 4 to 6 showed a more negative average change on aggression/ disruptive behaviours…"

Table 8.2.1
PRIDE Bermuda's PATHS Programme Statistics, 2017/2018

Programme Indicators	2017/2018					
	Primary 1	Primary 2	Primary 3	Primary 4	Primary 5	Primary 6
Number of Schools	2	2	2	2	2	2
Number of Classes Participated	3	3	3	3	3	3
Number of Students Engaged	42	37	39	46	44	53
Number of Students Dropped Out	-	1	2	-	1	-
Number of Students Retained	42	36	37	46	43	53
Number of Sessions	103	33	91	67	43	48
Number of Modules Completed	103	33	91	67	43	48
Total Number of Modules	135	104	150	126	120	108
Proportion of Curriculum Completed (%)	76.3	31.7	60.7	53.2	35.8	44.4
Number of Students Evaluated	(n=24)	(n=15)[a]	(n=22)[b]	(n=24)	(n=23)[c]	(n=24)
Evaluation of Behaviours						
Improvement (% of students)						
Aggression/Disruptive Behaviours	63.0	27.0	41.0	17.0	9.0	25.0
Concentration/Attention	54.0	67.0	86.0	42.0	57.0	58.0
Social and Emotional Competence	84.0	20.0	86.0	67.0	65.0	66.0
Negative Change (% of students)						
Aggression/Disruptive Behaviours	29.0	53.0	46.0	63.0	91.0	62.0
Concentration/Attention	29.0	20.0	9.0	38.0	30.0	21.0
Social and Emotional Competence	16.0	53.0	14.0	21.0	30.0	25.0

Table 8.2.1 cont'd
PRIDE Bermuda's PATHS Programme Statistics, 2017/2018

Programme Indicators	2017/2018					
	Primary 1	Primary 2	Primary 3	Primary 4	Primary 5	Primary 6
No Change (% of students)						
Aggression/Disruptive Behaviours	8.0	20.0	13.0	20.0	-	13.0
Concentration/Attention	17.0	13.0	5.0	20.0	13.0	21.0
Social and Emotional Competence	-	27.0	-	12.0	5.0	9.0

Source: PRIDE Bermuda

Table 8.2.2
PRIDE Bermuda's PATHS Programme Statistics, 2018/2019

Programme Indicators	2018/2019					
	Primary 1	Primary 2	Primary 3	Primary 4	Primary 5	Primary 6
Number of Schools	2	2	2	2	2	2
Number of Classes Participated	3	3	3	3	3	3
Number of Students Engaged	35	33	34	38	46	37
Number of Students Dropped Out	-	2	-	1	1	1
Number of Students Retained	35	31	34	37	45	36
Number of Sessions	135	64	106	99	50	64
Number of Modules Completed	135	64	106	99	50	64
Total Number of Modules	135	156	150	126	120	108
Proportion of Curriculum Completed (%)	100.0	41.0	70.7	78.6	41.7	59.3
Number of Students Evaluated	(n=24)	(n=24)[a]	(n=23)[b]	(n=24)	(n=16)[c]	(n=15)
Evaluation of Behaviours						
Improvement (% of students)						
Aggression/Disruptive Behaviours	25.0	46.0	43.0	25.0	31.0	47.0
Concentration/Attention	54.0	58.0	70.0	46.0	50.0	67.0
Social and Emotional Competence	54.0	75.0	96.0	33.0	43.0	93.0
Negative Change (% of students)						
Aggression/Disruptive Behaviours	46.0	41.0	48.0	58.0	56.0	53.0
Concentration/Attention	29.0	34.0	26.0	37.0	50.0	33.0
Social and Emotional Competence	38.0	17.0	4.0	42.0	38.0	-
No Change (% of students)						
Aggression/Disruptive Behaviours	29.0	13.0	9.0	17.0	13.0	-
Concentration/Attention	17.0	8.0	4.0	17.0	-	-
Social and Emotional Competence	8.0	8.0	-	25.0	19.0	7.0

Source: PRIDE Bermuda

Note:
[a] One class of P2 students was not assessed since the teacher was out sick at the start of the programme and did not complete the pre-assessment. One student left.
[b] Two students left.
[c] One student left.

Chapter 9
Certified Professionals

- Occupation
- Type of Certification

9.1 CERTIFIED TREATMENT AND PREVENTION PROFESSIONALS

The Bermuda Addiction and Certification Board (BACB) is responsible for ensuring the availability of a highly skilled and professionally credentialed workforce, governed by uniform professional standards. In other words, men and women who work to prevent and counsel addiction-related problems meet rigorous, quality standards reflecting competency-based knowledge, skills, and attitudes. The BACB has been a member board of the International Certification and Reciprocity Consortium (IC&RC) since 1997 and believes that the IC&RC credentialing process is based on the highest standards set by professionals in the addiction field, which requires specific education, training, and supervised practice as preparation for a written examination and a case presentation oral examination. This certification process enables Bermuda's alcohol and other drug clinicians, clinical supervisors, and prevention specialists to be recognised as able to demonstrate the professional practical competencies necessary to provide quality substance abuse services.

Re-certification of treatment and prevention professionals occurs every two years, ending in May, at which time persons must be recertified. Statistics from the BACB showed that the fields of drug treatment and prevention gained seven professionals since the last report. Specifically, in 2018, there were 57 certified persons in substance abuse treatment and prevention occupations, compared to 61 professionals in 2017; most of whom are alcohol or drug counsellors followed by clinical supervisors (see Table 9.1.1). This means that most persons are holders of the ICADC (International Certified Alcohol and Drug Counselor) certification, a few of whom may also be CCS (Certified Clinical Supervisor) certified (see Table 9.1.2). The number of certified clinical supervisors decreased by four persons in 2018, while prevention specialists remained the same over the last two years. It should be noted that there are also private and other practitioners who have not yet been certified by the BACB.

"…there were 57 certified persons in substance abuse treatment and prevention occupations; most of whom are alcohol or drug counsellors…"

Table 9.1.1
Certified Treatment and Prevention Professionals by Occupation, 2017 and 2018

Occupation	2017	2018
Treatment		
Alcohol/Drug Counsellors	37	40
Associate Counsellors	8	6
Clinical Supervisors	10	11
Prevention		
Prevention Specialists	6	6
Associate Prevention Professional	-	-
Total	**61**	**57**

Source: Bermuda Addiction Certification Board

Table 9.1.2
Certified Treatment and Prevention Professionals by Type of Certification, 2017 and 2018

Field of Certification	2017	2018
Treatment		
ICADC	37	40
CCS	10	11
ACAD	8	6
Prevention		
CPS	6	6
APP	-	-
Total	**61**	**57**

Source: Bermuda Addiction Certification Board

Chapter 10
Survey Data

- Public Perceptions of Crime and Health
- Treatment Demand Indicators

10.1 PUBLIC PERCEPTIONS OF CRIME AND HEALTH

Concerns relating to crime, drug prevalence, and health have been common issues for Bermuda's residents in recent years. The DNDC utilised the second quarter 2019 Omnibus Survey, a sample survey of 400 residents, to evaluate the community's perceptions of issues regarding safety in neighbourhoods, crime committed in nighbourhoods, and the perception of respondents' overall health.

Safety in Neighbourhood

Bermuda residents' perceived that safety remained stable for the fifth consecutive year, with virtually all residents reporting that they feel safe in their neighbourhoods. Twice as many residents continued to indicate that they feel mostly safe as opposed to extremely safe. Compared with the past three years, results remain virtually unchanged. It is positive to note that these results are highly consistent across the Island and have remained unchanged over the past three years. The degree to which residents feel safe is highly consistent across parishes and demographics (see Table 10.1.1).

"Residents' perceived safety remains stable for the fifth consecutive year, with virtually all residents reporting that they feel safe in their neighbourhoods."

Furthermore, residents predominantly feel as safe or safer in their neighbourhood compared to six months ago, consistent with past years. One in 10 indicate that they now feel less safe. Over the past two years, fewer stated that they feel as safe as they did six months ago and more now feel either safer or less safe. Across parishes, those in Warwick/Paget were most likely to indicate that they feel as safe as they did six months ago, while those in Pembroke/Devonshire were most likely to feel either safer or less safe. Lower income earners and black residents were significantly more likely to now feel safer. Meanwhile, non-Bermudian citizens are more likely to feel less safe than they did six months ago.

Crimes Committed in Neighbourhood

When considering residents' knowledge of crimes occurring in their neighbourhood over the past year, findings are highly consistent with one year ago. Specifically, in terms of the top types of crimes committed, one in three residents were aware of a theft (auto or personal property), while a similar proportion of residents were aware of an instance of breaking and entering to steal personal property having occurred over the past twelve months. While these two types of crime remain most common since tracking began in 2012, over time, a noteworthy decline in these crimes is evident (see Table 10.1.2).

A minimal shift is evident in the prevalence of different types of crimes reported by residents, though a few notable changes compared to two years prior warrant mention. Particularly, a notable decrease in awareness of breaking and entering to steal personal property was seen compared with results two years ago, while a greater number or residents knew of people openly selling or using drugs. Across parishes, residents of Sandys/Southampton were more likely to report awareness of an assault. Meanwhile, residents in Hamilton/Smiths/St. George's were least likely to report awareness of crimes committed with guns. Compared to previous results, awareness of breaking and entering and murder were at the lowest levels since tracking began. Meanwhile, awareness of people openly selling or using drugs is now at the highest level. Of note, those with mid-range household incomes and white residents were more likely to report awareness of a theft having occurred. Consistent with past results, just over one-half of residents cited knowledge of at least one type of crime committed in their neighbourhood within the past 12 months, with few residents reporting awareness of three or more different types of crimes.

"A notable decrease in awareness of breaking and entering to steal personal property is seen … while a greater number or residents know of people openly selling or using drugs."

Across the population, those with mid-range household incomes were more likely than their counterparts to report awareness of one or more types of crime. Residents in Hamilton/Smith's/St. George's were less likely to have reported awareness of three or more types of crime than those elsewhere.

Perception of Overall Health

Overall, residents generally perceived themselves to be in good mental and physical health, with approximately one in three residents rating their health as very good. Results in this regard remained in line with previous findings. Residents continue to note highly positive ratings of their own health in terms of physical and mental well-being. Compared with 2016 results, the degree to which residents positively rated their own health appears to be waning. Regionally, residents of Warwick/Paget parishes were more likely than residents in Sandy's/Southampton to report being in very good health. Across the population, results were highly consistent, although non- Bermudian citizens were more likely than their counterparts to report being in very good health (see Table 10.1.3).

"Residents continue to note highly positive ratings of their own health in terms of physical and mental well-being."

Table 10.1.1

How safe do you feel in your neighbourhood? (Do you feel extremely safe, mostly safe, mostly unsafe, or extremely unsafe?)

(n = 400)

	Bermuda Overall %	Parish				Gender		Household Income			Age			Race		Bermudian?	
		Sndy/ Sthp	War/ Paget	Pem/ Devon	Ham/ Sm/Sg	Male	Female	<$75K	$75K-$150K	>150K	18-34	35-54	55+	Black	White	Yes	No
Extremely Safe	33	38	38	26	34	38	29	32	33	39	33	33	33	37	33	35	27
Mostly Safe	63	56	59	69	64	59	66	62	64	59	66	63	59	58	64	61	72
Mostly Unsafe	2	1	2	4	1	2	3	3	2	3	1	3	3	4	1	3	1
Extremely Unsafe	1	3	1	1	-	1	2	3	-	-	-	1	3	1	1	2	-
Don't Know/No Answer	-	1	-	-	-	1	-	1	-	-	-	-	1	1	-	-	-
Weighted Sample Size (#)	**400**	**82**	**88**	**114**	**115**	**190**	**210**	**159**	**124**	**90**	**104**	**165**	**131**	**215**	**127**	**333**	**67**
Unweighted Sample Size (#)	**400**	**81**	**86**	**112**	**118**	**193**	**207**	**154**	**125**	**91**	**84**	**171**	**145**	**194**	**137**	**338**	**62**
% Exremely/Mostly Safe	96	94	97	95	98	97	96	94	97	97	99	96	93	95	98	96	99
% Mostly/Extremely Unsafe	4	5	3	5	2	3	4	5	3	3	1	4	6	5	2	4	1

Source: DNDC's Commissioned Questions in 2nd Quarter 2019 Bermuda Omnibus Survey©

Table 10.1.2

Which of the following types of crimes do you know to have occurred in your neighbourhood in the past 12 months? Do you know of:

People openly selling or using drugs?

(n = 400)

	Bermuda Overall %	Parish				Gender		Household Income			Age			Race		Bermudian?	
		Sndy/ Sthp	War/ Paget	Pem/ Devon	Ham/ Sm/Sg	Male	Female	<$75K	$75K-$150K	>150K	18-34	35-54	55+	Black	White	Yes	No
Yes	25	30	20	30	20	27	23	22	30	23	25	26	23	27	24	26	21
No	73	64	79	68	78	71	74	76	68	74	73	72	74	70	74	72	76
Don't Know	2	6	1	2	2	3	2	2	2	3	2	2	3	3	2	2	3
Weighted Sample Size (#)	**400**	**82**	**88**	**114**	**115**	**190**	**210**	**159**	**124**	**90**	**104**	**165**	**131**	**215**	**127**	**333**	**67**
Unweighted Sample Size (#)	**400**	**81**	**86**	**112**	**118**	**193**	**207**	**154**	**125**	**91**	**84**	**171**	**145**	**194**	**137**	**338**	**62**

Source: DNDC's Commissioned Questions in 2nd Quarter 2019 Bermuda Omnibus Survey©

Which of the following types of crimes do you know to have occurred in your neighbourhood in the past 12 months? Do you know of:

A theft (auto or personal property) having occurred?

(n = 400)

	Bermuda Overall %	Parish				Gender		Household Income			Age			Race		Bermudian?	
		Sndy/ Sthp	War/ Paget	Pem/ Devon	Ham/ Sm/Sg	Male	Female	<$75K	$75K-$150K	>150K	18-34	35-54	55+	Black	White	Yes	No
Yes	33	32	34	34	31	33	33	26	45	34	32	34	33	30	41	33	32
No	63	65	62	62	64	64	62	70	52	62	65	63	62	65	56	63	64
Don't Know	4	3	4	4	5	4	4	5	3	4	3	4	5	5	3	4	4
Weighted Sample Size (#)	**400**	**82**	**88**	**114**	**115**	**190**	**210**	**159**	**124**	**90**	**104**	**165**	**131**	**215**	**127**	**333**	**67**
Unweighted Sample Size (#)	**400**	**81**	**86**	**112**	**118**	**193**	**207**	**154**	**125**	**91**	**84**	**171**	**145**	**194**	**137**	**338**	**62**

Source: DNDC's Commissioned Questions in 2nd Quarter 2019 Bermuda Omnibus Survey©

Breaking and entering to steal personal property?

(n = 400)

	Bermuda Overall %	Parish				Gender		Household Income			Age			Race		Bermudian?	
		Sndy/ Sthp	War/ Paget	Pem/ Devon	Ham/ Sm/Sg	Male	Female	<$75K	$75K-$150K	>150K	18-34	35-54	55+	Black	White	Yes	No
Yes	31	35	35	26	30	32	30	25	39	36	29	34	30	30	33	31	32
No	67	62	65	72	69	67	68	73	59	63	71	64	68	68	65	68	65
Don't Know	1	3	-	2	1	1	2	2	2	1	-	2	2	2	1	1	3
Weighted Sample Size (#)	**400**	**82**	**88**	**114**	**115**	**190**	**210**	**159**	**124**	**90**	**104**	**165**	**131**	**215**	**127**	**333**	**67**
Unweighted Sample Size (#)	**400**	**81**	**86**	**112**	**118**	**193**	**207**	**154**	**125**	**91**	**84**	**171**	**145**	**194**	**137**	**338**	**62**

Source: DNDC's Commissioned Questions in 2nd Quarter 2019 Bermuda Omnibus Survey©

Crimes committed with guns?

(n = 400)

	Bermuda Overall %	Parish				Gender		Household Income			Age			Race		Bermudian?	
		Sndy/ Sthp	War/ Paget	Pem/ Devon	Ham/ Sm/Sg	Male	Female	<$75K	$75K-$150K	>150K	18-34	35-54	55+	Black	White	Yes	No
Yes	14	18	17	16	7	15	13	10	16	16	19	14	10	12	18	13	18
No	84	78	82	82	92	82	86	87	81	83	80	85	86	85	81	85	81
Don't Know	2	4	1	2	1	3	2	3	2	1	1	1	4	3	1	2	1
Weighted Sample Size (#)	**400**	**82**	**88**	**114**	**115**	**190**	**210**	**159**	**124**	**90**	**104**	**165**	**131**	**215**	**124**	**333**	**67**
Unweighted Sample Size (#)	**400**	**81**	**86**	**112**	**118**	**193**	**207**	**154**	**125**	**91**	**84**	**171**	**145**	**194**	**137**	**338**	**62**

Source: DNDC's Commissioned Questions in 2nd Quarter 2019 Bermuda Omnibus Survey©

Table 10.1.1

Overall, how would you rate your own health in terms of physical and mental well-being?

(n = 400)

	Bermuda Overall %	Parish				Gender		Household Income			Age			Race		Bermudian?	
		Sndy/ Sthp	War/ Paget	Pem/ Devon	Ham/ Sm/Sg	Male	Female	<$75K	$75K-$150K	>150K	18-34	35-54	55+	Black	White	Yes	No
Very Good	35	28	45	32	36	39	32	31	36	42	33	37	34	32	41	33	46
Good	60	64	48	64	62	56	64	63	60	56	60	60	61	63	55	62	50
Poor	4	7	6	3	-	4	3	6	3	2	4	2	5	5	3	4	1
Very Poor	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Refused	1	1	-	-	2	-	1	-	-	-	3	-	-	-	2	-	3
Don't Know/No Answer	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Weighted Sample Size (#)	**400**	**82**	**88**	**114**	**115**	**190**	**210**	**159**	**124**	**90**	**104**	**165**	**131**	**215**	**127**	**333**	**67**
Unweighted Sample Size (#)	400	81	86	112	118	193	207	154	125	91	84	171	145	194	137	338	62
% Very Good/Good	96	92	94	97	98	95	96	94	97	98	93	98	95	95	96	96	96
% Poor/Very Poor	4	7	6	3	-	4	3	6	3	2	4	2	5	5	3	4	1

Source: DNDC's Commissioned Questions in 2nd Quarter 2019 Bermuda Omnibus Survey©

10.2 TREATMENT DEMAND INDICATORS

Demand for treatment services and the characteristics of problem drug use is being monitored by an on-going survey developed by the DNDC and administered by each treatment agency on the Island. Although some of the agencies are still unable to demonstrate full coverage, the data in this report mainly reflect the responses of clients seeking treatment at six agencies: Men's Treatment, Women's Treatment Centre, Turning Point Programme, Salvation Army Harbour Light, FOCUS, and Right Living House.

This section of the report contains data on the clients who sought treatment from January 2018 to December 2018. There were 98 persons who sought substance abuse treatment over this period at these treatment facilities and for whom a questionnaire was completed (see Table 10.4.1). A total of 85 males and 12 females required inpatient (including residential), outpatient, and in-prison (residential) treatment services. Most persons (68) were clients of the Turning Point Programme.

Persons requiring treatment services ranged from 19 years to 67 years with the majority (51.3%) of these clients being 50 years old. These persons who sought treatment were more likely to self-refer (71.4%) or, in other instances, sought treatment because of a court order or to complete probation or parole (10.2%). There were 6.3% of clients who sought treatment during this period that have received treatment sometime in the past, from as early as the year 2004 to as recent as 2018. However, only 5.4% of persons who sought treatment have been receiving substitution treatment, such as methadone.

In terms of the primary drug of impact for which persons sought treatment (see Table 10.4.2), slightly over four in 10 (43.3%) of the persons sought treatment for heroin use, while nearly one in five sought treatment for use of alcohol (17.5%) or crack (14.4%). Persons also sought treatment for cannabis, cocaine, and opiates in general (including methadone).

Most of the persons (71.9%) have reported daily use of drugs, whereas 19.8% indicated that they have used drugs in the two to six days per week or less prior to seeking treatment (see Table 10.4.3). Sniffing (38.3%) was reported as the main method of administering the drugs, followed by smoking or inhaling (36.2 %) (see Table 10.4.4).

"Sniffing was reported as the main method of administering the drugs followed by Smoking or inhaling."

The age of first use of the identified primary drug ranged from eight years to 45 years, with an average age of onset being 20.5 years. However, most (29.6%) of the persons who sought treatment indicated that they first used their primary drug between the ages of 13 to 17 years, while less than one in 10 (9.2%) used drugs before becoming a teenager (see Table 10.4.5). Apart from the main drug of choice, some persons also reported the use of a secondary drug, for which the age of initiation ranged from an average of 15.6 years for alcohol to 46.0 years for methadone (see Table 10.4.6). The average age at which smoking marijuana began was 12.6 years. First use of harder drugs began later at about 46.0 years for methadone and 21.0 to 24.3 years for crack, opiates, MDMA, and other derivatives.

The drug market is still operational in Bermuda as reflected by the demand for and availability or supply of drugs. A significant proportion of the persons who sought treatment reported that their primary drug was "always available" (73.9%) or "mostly available" (18.5%) and over half (56.8%) indicated that they purchased their drugs from a regular supplier (see Table 10.4.7). At the same time, the majority of the persons (60.0%) stated that they did not make money or obtain drugs by selling illegal drugs or being involved in the manufacture or transportation of drugs.

Persons also specified the way(s) in which the various drugs were usually packaged for sale (see Table 10.4.8), utilising paper, plastic, or foil in which drugs are wrapped or twisted, and quantities can be sold for any dollar value in demand; but some common denominations are $10, $20, $50, and $100. Reported prices paid for drugs still seemed volatile and, hence, were not included in this publication until they can be reliably validated, possibly from other sources or treatment agencies.

Table 10.2.1
Demographic Characteristics of Clients Seeking Treatment, 2018

Characteristic	Number of Persons
Total	**98**
Sex	
Males	85
Females	12
Facility	
Men's Treatment	8
Women's Treatment Centre	4
Turning Point	68
Right Living House	10
Salvation Army Harbour Light	8
Type of Treatment Facility	
Inpatient	38
Outpatient	56
Treatment in Prison	1
Not Stated	3
Source of Referral	
Self-Referred	70
Court/Probation/Parole	10
Family/Friends	1
Other Drug-Treatment Centre	5
Other	6
Not Known	6
Living Status (With Whom)	
Alone	30
With Parents	22
Alone with Partner	6
With Partner and Child/Children	12
With Friends	5
Other	19
Not Known	4

Table 10.2.1 cont'd
Demographic Characteristics of Clients Seeking Treatment, 2018

Characteristic	Number of Persons
Living Status (Where)	
Stable Accommodation	68
Unstable Accommodation	22
Institution (Prison/Clinic)	4
Not Known	4
Nationality	
National of Bermuda	96
National of Another Country	1
Not Stated	1
Labour Status	
Regular Employment	31
Economically Inactive	1
Unemployed	53
Other	12
Not Known	1
Highest Education Level Completed	
Never Went to School/Never Completed Primary School	-
Primary Level of Education	18
Secondary level of Education	61
Higher Level of Education	16
Not Known	3

Table 10.2.2
Primary Drug of Impact of Clients Seeking Treatment, 2018

Primary Drug of Impact	Number of Persons
Heroin	42
Crack (only)	14
Alcohol	17
Cannabis	7
Opiates (Methadone, Other Opiates)	7
Cocaine	10
Not Known	1

Source: DNDC's Treatment Demand Indicators Survey

Table 10.2.3
Frequency of Drug Use, 2018

Frequency	Number of Persons
Used daily	69
Not used in past month	8
Used 2-6 days per week or less	15
Used once per week or less	4
Not Known	2

Source: DNDC's Treatment Demand Indicators Survey

Table 10.2.4
Primary Route of Drug Administration, 2018

Primary Route	Number of Persons
Smoke/Inhale	34
Sniff	36
Eat/Drink	16
Inject	7
Others	1
Not Known	4

Source: DNDC's Treatment Demand Indicators Survey

Table 10.2.5
Age of First Use of Primary Drug, 2018

Age	Number of Persons
Less than 13 years	9
13 – 17 Years	29
18 – 20 Years	20
21 – 24 Years	10
25 – 29 Years	14
30 – 34 Years	9
35 – 39 Years	4
40+ Years	1
Not Known	2

Source: DNDC's Treatment Demand Indicators Survey

Table 10.2.6
Average Age of Initiation by Type of (Secondary) Drug, 2018

Drug	Average Age of Initiation
Cannabis	12.6
Alcohol	15.6
Opiates (Total)	21.0
Heroin	30.7
Methadone	46.0
Cocaine (Total)	24.3
Cocaine	24.0
Crack	21.0
MDMA and Other Derivatives	21.3

Source: DNDC's Treatment Demand Indicators Survey

Table 10.2.7
Drug Market (Availability, Supplier, and Proceeds), 2018

Availability of Primary Drug	Number of Persons
Always Available	68
Mostly Available	17
Sometimes Available	7
Not Known	6
Purchased from Regular Supplier	
Yes	50
No	38
Not Known	10

Table 10.2.7 cont'd
Drug Market (Availability, Supplier, and Proceeds), 2018

Made Money or Obtained Drugs by Selling Illegal Drugs or Being Involved in Manufacture or Transportation of Drugs	Number of Persons
Yes	36
No	54
Not Known	8

Source: DNDC's Treatment Demand Indicators Survey

Table 10.2.8
Drug Market (Packaging of Drugs), 2018

Cannabis	Cocaine
Any dollar amount	$20, $30, $40, $50, $100 wraps
Brown paper twist	Brown paper twist
Plastic (sandwich) bags	Clear twist
Crack	**Heroin**
Rocks	¼ and ½ gram
Brown paper twist	$20, $25, $45, $50
Clear plastic twist	Foil wrap/twist
	Plastic bag/twist
Crack	**Heroin**
Bags	Bottle
	Can

Source: DNDC's Treatment Demand Indicators Survey

Chapter 11
Financing Drug Control

- Drug Treatment and Prevention Expenditure
- Enforcement and Interdiction Expenditure

11.1 DRUG CONTROL EXPENDITURE

The DNDC funds and oversees the majority of Bermuda's demand reduction programmes and activities. The Department directly funds a few treatment and prevention programmes, while it supports other initiatives through an annual grant provision to community-based partners and stakeholders. Allocation of funding for drug control has seen an increase in overall demand and supply reduction.

"…demand reduction activities received the larger proportion of the allocated resources in both years under review…"

In total, the government expended just over $16.5 million on drug control in Bermuda in FY 2018/2019, up from the previous FY 2017/2018, where drug control expenditure stood at $15.5 million. Of the overall drug control expenditure, demand reduction activities received the larger proportion of the allocated resources in both years under review when compared to the allotment given to supply reduction; $9.8 million and $9.9 million vs. $5.7 million and $6.5 million in FY 2017/2018 and FY 2018/2019, respectively (see Tables 11.1.1 and 11.1.2).

On the demand reduction side, in particular, disparity in allotment continued to exist between treatment and prevention, with treatment receiving the greater proportion. Funding for treatment services, in general, increased by 2.1% from FY 2017/2018 to FY 2018/2019; funding for prevention services, increased by 1.0% (see Table 11.1.1).

In both fiscal years under review, HM Customs received the majority allocation of the supply reduction budget for its interdiction efforts and the BPS received a smaller proportion for its drugs and intelligence division (see Table 11.1.2). Government expenditure on supply reduction, which entails enforcement, interdiction, and intelligence, saw a considerable increase by 15.1% year over year – moving from a $5.7 million in FY 2017/2018 to $6.5 million in FY 2018/2019.

Sufficient evidence exists that point to the fact that Bermuda continues to witness a constant presence of illicit drug use and drug-related criminal activities, such as violence and illicit trafficking. In response to this growing threat, the Government of Bermuda has initiated and continued to operationalise a complementary battery of measures to combat the problem, on both the demand and supply reduction sides. With the technical support from the DNDC and through the implementation of the National Drug Control Master Plan and Action Plan for 2019-2024, the Government will continue to make a commitment to, and have a strategy for, the adequate funding of substance abuse prevention and drug addiction treatment and rehabilitation.

Table 11.1.1
Government Expenditure on Drug Treatment and Prevention, 2017/2018 and 2018/2019

	2017/2018 ACUTAL ($000)	2018/2019 REVISED ($000)
TREATMENT	**9,023**	**9,210**
% Change	**-1.8**	**2.1**
DNDC (MT, WTC, Treatment Unit)	2,374	2,417
Grantees		
Salvation Army	100	100
FOCUS Counselling Services	-	300
Other (BACB)	**100**	**100**
Other Agencies		
BARC	1,064	1,064
CLSS	1,070	1,133
Drug Treatment Court	430	437
Mandatory Drug Treatment (RLH)	1,352	1,352
Turning Point Substance Abuse Programme+	2,533	2,307
PREVENTION	**770**	**774**
% Change	**11.6**	**1.0**
DNDC (Prevention Unit & Community Education)	487	491

Table 11.1.1 cont'd
Government Expenditure on Drug Treatment and Prevention, 2017/2018 and 2018/2019

	2017/2018 ACUTAL ($000)	2018/2019 REVISED ($000)
PREVENTION		
Grantees		
PRIDE	183	183
CADA	100	100
TOTAL DEMAND REDUCTION	**9,793**	**9,984**
% Change	**-0.8**	**2.0**

Source: Government of Bermuda Budget

Notes: + Sourced directly from Turning Point Substance Abuse Programme.

Table 11.1.2
Government Expenditure on Enforcement and Interdiction, 2017/2018 and 2018/2019

	2017/2018 ACTUAL ($000)	2018/2019 REVISED ($000)
ENFORCEMENT AND INTERDICTION		
Police – Enforcement (Drugs, Financial Crime, & Intelligence Divisions)	1,443	2,751
Customs – Interdiction	4,259	3,787
TOTAL SUPPLY REDUCTION	5,682	**6,538**
% Change	**12.5**	**15.1**

Source: Government of Bermuda Budget

LOOKING AHEAD

This, the 2019 Report of the BerDIN demonstrates the best available information on the current alcohol and drug situation in Bermuda. Evidence continues to demonstrate the pervasive and persisting nature of drug use in Bermuda, especially when it comes to alcohol and cannabis. The landscape has changed in Bermuda with respect to the consumption of these substances and with these changes, there have been challenges with interdicting drugs and enforcement of legislation. Enforcement of legislation, such as with liquor sales to minors and a lack of regulations for the TIPS programme, continue to test the system of drug control.

The main focus of demand reduction in Bermuda has traditionally been to prevent substance use and treat those with the disease of addiction. However, the changing demand and nature of drug use requires a shift to methodology, focusing mostly on harm reduction. Little was accomplished in 2018 to address adolescent substance abuse services or the gaps in services for dual-diagnosed persons. The demand for treatment services also remained high because of the continued flow of persons in treatment for cocaine, including crack cocaine, especially when it came to those diagnosed as being severely dependent. Even so, access and sufficient resources still posed significant challenges to the continuum of care. Supply reduction agencies continue to be resource challenged with funding and staffing. For some time now, a lack of financing for equipment, continuing education and training in behavioural observance, financial crime, and other specialszed areas, have been delinquent. Although the drug control system remains imperfect there has been some successes, such as with the implementation of road side sobriety checkpoints, reinstatement of transitional housing with grant funding to FOCUS, and the Al's Pals and Botvin's Lifeskills programmes, which have now having been in operation for almost 10 years and with proven successes.

The BerDIN is committed to filling in the current data gaps to provide a more comprehensive picture of the current drug situation. This includes: 1) the number of establishments selling cigarettes and other tobacco products, 2) information related to emergency room cases as it relates to drug use and data related to cannabis users driving under the influence, with the exception of toxicology cases related to road traffic fatalities, 3) the actual number of drug addicts that exist in the Bermuda population, and 4) the social impact of cannabis use.

The National Drug Control Master Plan 2019-2024, currently in draft form, has as a main component the need to modify demand reduction interventions to meet the needs of the community affected by alcohol and drug misuse. As international drug policy shifts, so too must we change the mindset of preventing drug use, intervening when appropriate, and treating those who are accepting of beating the cycle of addiction.

It is this publication that has provided a cultural and local snapshot of the Island's drug consumption patterns for the past ten years. The Network has done a tremendous job capturing and expanding over the years, always ensuring the information available provides the best evidence for decision-making in Bermuda. Through the efforts of many, this publication stands, with other local information, as one of the principal bodies of information to advise the drug situation in Bermuda. The DNDC and the Coordinator of BerDIN, are commended for thier efforts in driving this initiative. It is, however, the dedicated work of key stakeholders, which are relied upon for key information that keeps the Network alive and fit for purpose.

"Enforcement of legislation, such as with liquor sales to minors and a lack of regulations for the TIPs programme, continue to test the system of drug control."

APPENDIX I

SUMMARY OF SOURCES AND DATA

SOURCES	DATA
1. Bermuda Addiction Certification Board	Certified Professionals
2. Bermuda Hospitals Board	
– King Edward VII Memorial Hospital	Inpatient Cases Related to Drugs, Poisoning, and Toxic Effects of Substances Emergency Room Cases Related to Drugs, Poisoning, & Toxic Effects of Substances
– Mid-Atlantic Wellness Institute	MWI Cases Related to Drugs, Poisoning, & Toxic Effects of Substances
– Turning Point Substance Abuse Programme	Drug Screening Results Methadone Clients Outpatient Detoxifications Clients in Treatment
3. Bermuda Police Service	Crimes (including Financial Crimes) Drug Enforcement Activity Drug Seizures and Arrests Breathalyser Results and Blood Alcohol Concentration
4. Bermuda Professional Counselling Services	DUI Educational Programme Statistics
5. Bermuda Sport Anti-Doping Authority	Illicit and Anti-Doping Tests
6. CADA	Training for Intervention ProcedureS
7. Department of Child and Family Services	
– Counselling and Life Skills Services	CLSS Programme Statistics
8. Department of Corrections	
– Westgate Correctional Facility	Drug Screening Results (Reception and Random) Drug Prevalence First-Time and Repeat Offenders Poly Drug Use
– Prison Farm	Drug Screening Results
– Co-Ed Facility	Drug Screening Results
– Right Living House	Residents, Admissions, Discharges, Drug Tests & Results
9. Department of Court Services	
– Bermuda Assessment and Referral Centre	New and Existing Referrals to Treatment Drug Abuse and Dependence Level of Severity of Substance Abuse (DAST and ADS Results)
– Drug Treatment Court	Referrals, Admissions, Completions
10. Department of Health	
– Central Government Laboratory	Mortality - Toxicology Results Road Traffic Fatalities
– Epidemiology and Surveillance	Drug-Related Infectious Diseases, Cause of Deaths ATOD-Related Deaths
– Maternal Health Clinic	Pre-natal Drug Use
11. Department for National Drug Control	
– Research and Policy Unit	Public Perceptions* Treatment Demand Government Expenditure on Drug Prevention and Treatment; Enforcement and Interdiction
– Men's Treatment	Drug Screening Results Primary Drug of Impact Poly Drug Use Clients in Treatment
– Women's Treatment Centre	Drug Screening Results Primary Drug of Impact Poly Drug Use Clients in Treatment
12. Focus Counselling Services	Programme Outcomes Clients in Treatment
13. Financial Intelligence Agency	Suspicious Activity Reports
14. HM Customs	Alcohol and Tobacco Imports and Exports Duty Collected on Alcohol and Tobacco Imports
15. Magistrate's Court	
– Liquor Licence Authority	Licensing of Establishments
16. PRIDE Bermuda	Drug Prevention Education: Botvin's LifeSkills Programme Drug Prevention Education: PATHS Programme
17. Salvation Army	Programme Outcomes Clients in Treatment
18. Supreme Court	Prosecutions

* Updated/Expanded indicators.

DUTY RATES FOR ALCOHOL, ALCOHOLIC BEVERAGES, TOBACCO, AND TOBACCO PRODUCTS

TARIFF CODE	DESCRIPTION	2017 (From April 1, 2017)	2018 (From April 1, 2018)
2202.910	Non-alcoholic beer	15% per L	15% per L
2202990	Other	15% per L	15% per L
2203.000	Beer	$0.99 per L	$1.26 per L
2204.100	Sparkling Wine	$4.70 per L	$4.70 per L
2204.210	Wine in Containers Holding 2 Litres or Less	$4.70 per L	$5.00 per L
2204.290	Wine in Containers Greater Than 2 Litres	$4.70 per L	$5.00 per L
2204.220	Wine in containers holding more than 2 l but not more than 10 l	$4.70 per L	$5.00 per L
2204.300	Other Grape Must	$4.70 per L	$5.00 per L
2205.100	Vermouth in Containers Holding 2 Litres or Less	$4.70 per L	$5.00 per L
2205.900	Vermouth in Containers Holding Greater Than 2 Litres	$4.70 per L	$5.00 per L
2206.000	Other fermented beverages (for example, cider, perry, mead, saké); mixtures of fermented beverages and mixtures of fermented beverages	$1.26 per L	$1.26 per L
2207.100	Undenatured Ethyl Alcohol	$31.35 per LA	$31.35 per LA
2207.200	Denatured Ethyl Alcohol	$0.75 per LA	$0.75 per LA
2208.200	Brandy and Cognac	$31.35 per LA	$31.35 per LA
2208.300	Whiskies	$31.35 per LA	**$31.35 per LA**
2208.400	Rum and Other Spirits From Sugar Cane	$31.35 per LA	**$31.35 per LA**
2208.500	Gin and Geneva	$31.35 per LA	**$31.35 per LA**
2208.600	Vodka	$31.35 per LA	$31.35 per LA
2208.700	Liqueur and Cordials	$31.35 per LA	$31.35 per LA
2208.900	Other Spirituous Beverages	$31.35 per LA	$31.35 per LA
9802.001	Accompanied Personal Goods:Wine of Fresh Grapes	$2.89 per L	$2.89 per L
9802.002	Accompanied Personal Goods: Spirituous Beverages	$10.63 per L	$10.63 per L
2401.100	Tobacco, Not Stemmed/Stripped	35.0% per KG	$300.00 per KG
2401.200	Tobacco, Partly or Wholly Stemmed/Stripped	35.0% per KG	$300.00 per KG
2401.300	Tobacco Refuse	35.0% per KG	$300.00 per KG
2402.100	Cigars, Cheroots, etc. Containing Tobacco	35.0% per KG	$300.00 per KG
2402.200	Cigarettes Containing Tobacco	$0.37 per U	**$0.37 per U**
2402.900	Other Tobacco Products; or Products of Tobacco Substitutes	35.0%	35.0%
2403.110	Water Pipe Smoking Tobacco	35.0%	35.0%
2403.190	Other Smoking Tobacco	35.0%	35.0%
2403.910	"Homogenised" or "Reconstituted" Tobacco	35.0%	35.0%
2403.990	Tobacco Extracts and Essences; Other Manufactured Products of Tobacco	35.0%	35.0%
9802.003	Accompanied Personal Goods: Cigarettes Containing Tobacco	$44.00 per 200 U	$44.00 per 200 U
9803.163	Smoking Tobacco; Cigars, Cheroots and Cigarillos, Containing Tobacco (Imported by Post or Courier)	35.0%	35.0%
9803.171	Cigarettes Containing Tobacco	$74 per carton	$74 per carton

Notes:

[1] Goods that are removed from a bonded warehouse for local sale are charged duty at the rate that is in effect at the time when the goods are removed from the bonded warehouse regardless of when the goods were placed into the bonded warehouse, e.g., a case of wine that was bonded in 2010 and then exbonded in 2014 will attract the 2014 duty rate.

[2] The categories of goods that start with the digits "**98**" as the tariff code are for items that either arrive with passengers (**9802.xxx**); or, are shipped through the post or courier (9803.xxx).

[3] Except for 9803.163, the statistical volume/value data for the other "**98**" tariff codes are not shown individually, as the goods they represent and the rates of duty being imposed allow for them to be included with the "proper" tariff code classification, e.g., volume/values for **9802.001** are included within the figures for 2204.210.

[4] Since the **9803.163** category amalgamates different goods that would be classified separately, those figures are provided individually, as the volumes/values could not be separated into the "proper" tariff codes.

DEFINITIONS OF TERMS AND CONCEPTS

ADS: The Alcohol Dependence Scale (ADS) provides a quantitative measure of the severity of alcohol dependence symptoms consistent with the concept of the alcohol dependence syndrome. It is widely used as a research and clinical tool, and studies have found the instrument to be reliable and valid. The ADS is a 25-item pencil and paper questionnaire, or computer self-administered or interview that takes approximately 10 minutes to complete and five minutes to score. The 25 items cover alcohol withdrawal symptoms, impaired control over drinking, awareness of a compulsion to drink, increased tolerance to alcohol, and salience of drink-seeking behaviour among clinical adult samples and adults in the general population and correctional settings. The printed instructions for the ADS refer to the past 12-month period. However, instructions can be altered for use as a outcome measure at selected intervals (e.g., 6, 12, or 24 months) following treatment. ADS scores have proven to be highly diagnostic with respect to a DSM diagnosis of alcohol dependence, and have been found to have excellent predictive value with respect to a DSM diagnosis. A score of nine or more is highly predictive of DSM diagnosis of alcohol dependence. The ADS can be used for treatment planning, particularly with respect to the level of intervention and intensity of treatment as well as in basic research studies where a quantitative index is required regarding the severity of alcohol dependence. For clinical research, the ADS is a useful screening and case-finding tool. It is also of value with respect to matching clients with the appropriate intensity of treatment and for treatment outcome evaluations.

ANNUAL/PAST YEAR PREVALENCE: the proportion of survey respondents who reported using a named drug in the year prior to the survey. For this reason, last year prevalence is often referred to as recent use, and also classified as lifetime prevalence.

ATODs: Alcohol, Tobacco, and Other Drugs. In common usage, the term often refers specifically to psychoactive drugs, and often, even more specifically, to illicit drugs, of which there is non-medical use in addition to medical use. Caffeine, tobacco, alcohol, and other substances in common non-medical use are also drugs in the sense of being taken at least in part for their psychoactive effect.

BINGE DRINKING: A pattern of heavy drinking that occurs in an extended period set aside for the purpose. In most surveys, the period is usually defined as a report of five drinks or more in a row within the past two weeks.

BLOOD ALCOHOL LEVEL: The concentration of alcohol (ethanol) present in blood. It is usually expressed as a mass per unit volume, e.g., mg/100 dl. The blood alcohol concentration is often extrapolated from measurements made on breath or urine or other biological fluids in which the alcohol concentration bears known relationship to that in the blood.

DEMAND REDUCTION: A broad term used to describe a range of policies or programmes directed at reducing the consumer demand for psychoactive drugs. It is applied primarily to illicit drugs, particularly with reference to educational, treatment, and rehabilitation strategies, as opposed to law enforcement strategies that aim to interdict the production and distribution of drugs.

CURRENT/LAST MONTH (PAST 30 DAYS) PREVALENCE: The proportion of survey respondents who reported using a named drug in the 30-day period prior to the survey. Last month prevalence is often referred to as current use; and also classified as lifetime and recent prevalence. A proportion of those reporting current use may be occasional (or first-time) users who happen to have used in the period leading up to the survey – it should therefore be appreciated that current use is not synonymous with regular use.

DAST: The Drug Abuse Screening Test (DAST) is a widely recognised screening tool traditionally used to classify degrees of severity of substance abuse problems among persons. It is a 20-item self-report scale that has exhibited valid psychometric properties and has been found to be a sensitive screening instrument for the abuse of drugs other than alcohol. The DAST-20 item scores can be transformed to yield classification of substance abuse problems in terms of "*none*" (a score of 0), "*low*" (a score between 1 and 5), "*intermediate*" (a score between 6 and 10), "*substantial*" (a score between 11 and 15), and "*severe*" (a score between 16 and 20).

DETOXIFICATION: Detox for short. (1) The process by which a person who is dependent on a psychoactive substance ceases use, in such a way that minimises the symptoms of withdrawal and risk of harm. In other words, the individual is withdrawn from the effects of a psychoactive substance. (2) It is a clinical procedure, the withdrawal process carried out in a safe and effective manner, such that withdrawal symptoms are minimised. The facility in which this takes place may be variously terms a detoxification centre, detox centre, or sobering-up station. Typically, the individual is clinically intoxicated or already in withdrawal at the outset of detoxification. Detoxification may or may not involve the administration of medication. When it does, the medication given is usually a drug that shows cross-tolerance and cross-dependence to the substance(s).

DOPING: Defined by the International Olympic Committee and the International Amateur Athletic Federation as the use or distribution of substances that could artificially improve an athlete's physical or mental condition, and thus his or her athletic performance. The substances that have been used in this way are numerous and include various steroids, stimulants, beta blockers, antihistamines, and opioids.

DRUG: Any chemical substance that produces physical, mental, emotional, or behavioural changes in the user.

DRUG ABUSE: The use of a chemical substance for purposes other than medical or scientific, including use without prescription, in excessive dose levels, or over an

unjustified period of time in such a fashion that it impacts on or impairs an individual in a physical, psychological, behavioural, or social manner.

DRUG MISUSE: Use of any drug (legal or illegal) for a medical or recreational purpose when other alternatives are available, practical or warranted, or when drug use endangers either the user or others with whom he or she may interact.

DRUG TESTING: Toxicology analysis of body fluids (such as blood, urine, or saliva) or hair or other body tissue to determine the presence of various psychoactive substances (legal or illegal). Drug testing is employed to monitor abstinence from psychoactive substances in individuals pursuing drug rehabilitation programmes, to monitor surreptitious drug use among patients on maintenance therapy, and where employment is conditional on abstinence from such substances.

DSM-IV: The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, better known as DSM-IV, is used to categorise psychiatric diagnoses. The manual is published by the American Psychiatric Association and covers all mental health disorders for both children and adults. It also lists known causes of these disorders, statistics in terms of gender, age at onset, and prognosis as well as some research concerning the optimal treatment approaches. The DSM uses a multi-axial or multidimensional approach to diagnosing because rarely do other factors in a person's life not impact their mental health. It assesses five dimensions: Axis I – Clinical Syndromes; Axis II – Developmental Disorders and Personality Disorders; Axis III – Physical Conditions which play a role in the development, continuance, or exacerbation of Axis I and II Disorders; Axis IV – Severity of Psychosocial Stressors; and Axis V – Highest Level of Functioning.

DSM-V: The Diagnostic and Statistical Manual of Mental Disorders (**DSM**) is the handbookused by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders. **DSM** contains descriptions, symptoms, and other criteria for diagnosing mental disorders.

ENFORCEMENT: Detect, monitor, and counter the production, trafficking, and use of illegal drugs.

ICD: The International Classification of Diseases, published by the WHO, is the standard diagnostic tool for epidemiology, health management, and clinical purposes. It promotes international comparability in the collection, classification, processing, and presentation of mortality data. It organises and codes health information that is used for statistics and epidemiology, health care management, allocation of resources, monitoring and evaluation, research, primary care, prevention, and treatment. It helps to provide a picture of the general health situation of countries and populations. It is used to monitor the incidence and prevalence of diseases and other health problems, as well as to classify diseases and other health problems recorded on many types of health and vital records including death certificates and health records. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological and quality purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics by WHO Member States.

ILLICIT (OR ILLEGAL) DRUG: A psychoactive substance, the production, sale, or use of which is prohibited. Strictly speaking, it is not the drug that is illicit, but its production, sale, or use in particular circumstances in a given jurisdiction. "Illicit drug market", a more exact term, refers to the production, distribution, and sale of any drug outside the legally sanctioned channels.

INPATIENT TREATMENT: A type of treatment in which a patient is provided with care at a live-in facility. Both psychiatric and physical health assistance are included in this treatment. In most cases, patients will stay at inpatient treatment facilities for months at a time. Before becoming accepted to this type of high-maintenance treatment, various assessments must be taken. In inpatient treatment, constant medical supervision is placed over each resident.

INTERDICTION: A continuum of events focused on intercepting illegal drugs smuggled by air, sea, or land. Normally consists of several phases – cueing, detection, sorting, monitoring, interception, handover, disruption, endgame, and apprehension – some which may occur simultaneously.

LICIT DRUG: A drug that is legally available by medical prescription in the jurisdiction in question, or sometimes, a drug legally available without medical prescription.

LIFETIME PREVALENCE: The proportion of survey respondents who reported ever having used the named drug at the time they were surveyed; that is, at least once. A person who records lifetime prevalence may – or may not – be currently using the drug. Lifetime prevalence should not be interpreted as meaning that people have necessarily used a drug over a long period of time or that they will use the drug in the future.

OUTPATIENT TREATMENT: a type of care used to treat those in need of drug rehabilitation. These types of programmes can be very useful to those who must continue to work or attend school. Programmes for outpatient treatment vary depending on the patient's needs and the facility but they typically meet a couple of times every week for a few hours at a time.

POLY DRUG USE: The use of more than one psychoactive drugs either simultaneously or at different times. The term is often used to distinguish persons with a more varied pattern of drug use from those who use one kind of drug exclusively. It usually is associated with the use of several illegal drugs. In many cases, one drug is used as a base or primary drug, with additional drugs to leaven or compensate for the side effects of the primary drug and make the experience more enjoyable with drug synergy effects, or to supplement for primary drug when supply is low.

PREVALENCE: The terms prevalence refers to the proportion of a population who has used a drug over a particular time period. Prevalence is measured by asking

respondents to recall their use of drugs. Typically, the three most widely used recall periods are: lifetime (ever used a drug), last year (used a drug in the last twelve months), and last month (used a drug in the last 30 days).

PREVENTION: A proactive process that attempts to prevent the onset of substance use or limit the development of problems associated with using psychoactive substances. Prevention efforts may focus on the individual or their surroundings and seeks to promote positive change. It typically focuses on minors – children and teens.

SCREENING TEST: An evaluative instrument or procedure, either biological or psychological, whose main purpose is to discover, within a given population, as many individuals as possible who currently have a condition or disorder or who are at risk of developing one at some point in the future. Screening tests are often not diagnostic in the strict sense of the term, although a positive screening test will typically be followed by one or more definitive tests to confirm or reject the diagnosis suggested by the screening test.

SUBSTANCE ABUSE: The excessive use of a substance, especially alcohol or a drug. The taking into the body of any chemical substance that causes physical, mental, emotional or social harm to the individual.

SUBSTANCE DEPENDENCE: commonly known as addiction, is characterised by physiological and behavioural symptoms related to substance use. These symptoms include the need for increasing amounts of the substance to maintain desired effects, withdrawal if drug-taking ceases, and a great deal of time spent in activities related to substance use.

SUPPLY REDUCTION: A broad term used to refer to a range of activities, policies, or programmes designed to stop the production and distribution of drugs, particularly law enforcement strategies for reducing the supply of illicit drugs.

SUSPICIOUS ACTIVITY REPORT: is a report made by a financial institution to the Financial Intelligence Agency regarding suspicious or potentially suspicious activity of money laundering or fraud.

SYNTHETIC DRUGS: are man-made drugs created to mimic the effects of controlled substances. Most of the synthetic drugs are manufactured in clandestine laboratories in China. The substances are then smuggled in bulk into the United States and packaged for individual sale. Synthetic Drugs are often sold in convenience stores or on the street in colorful packaging with catchy names to appeal to the younger generation. The drugs are also illegally distributed in shops that sell drug paraphernalia and over the Internet.

TAAD: The Triage Assessment for Addictive Disorders is a brief structured face-to-face interview or triage instrument designed to identify current alcohol and drug problems related to the DSM-IV criteria for substance abuse and dependence. The interview consists of 31 items and takes 10 minutes to administer and 2-3 minutes to score. The TAAD addresses both alcohol and other drug issues to discriminate among those with no clear indications of a diagnosis, those with definite, current indications of abuse or dependence, and those with inconclusive diagnostic indications. The user can document negative findings for those who deny any problems or focus further assessment on positive diagnostic findings.

THERAPEUTIC COMMUNITY: A structured environment in which individuals with psychoactive substance use disorders live in order to achieve rehabilitation. Such communities are often specifically designed for drug-dependent people and operate under strict rules. They are characterised by a combination of "reality testing" (through confrontation of the individual's drug problem) and support for recovery from staff and peers.

TOXICITY: The extent to which a substance has the potential to cause toxic or poisonous effect. Any substance in excessive amounts can act as a poison or toxin. With drugs, the margin between the dosage that produces beneficial effects and the dosage that produces toxic or poisonous effects varies with the drug and the person receiving it.

TREATMENT: The process of that begins when psychoactive substance abusers come into contact with a health provider or any other community service and may continue through a succession of specific interventions until the highest attainable level of health and well-being is reached. More specifically, treatment may be defined as a comprehensive approach to the identification, assistance, and health care with regard to persons presenting problems caused by use of any psychoactive substance. Essentially, by providing persons, who are experiencing problems caused by use of psychoactive substances, with a range of treatment services and opportunities which maximise their psychical, mental, and social abilities, these persons can be assisted to attain the ultimate goal of freedom from drug dependence and to achieve full social integration. Treatment services and opportunities can include detoxification, substitution/maintenance therapy, and/or psychosocial therapies, and counselling. Additionally, treatment aims at reducing the dependence on psychoactive substances, as well as reducing the negative health and social consequences caused by, or associated with the use of such substances.

URINALYSIS: Analysis of urine samples to detect the presence of psychoactive substances a person may have ingested, or for other medical or diagnostic purposes. Different drugs can be detected in the urine for different time periods. Heroin and amphetamines can only be detected in the urine at most within a few days of last ingestion in persons who have been long-term heavy users. In recent years, the analysis of saliva, blood, sweat, and hair strands has also become available for detection of past drug use.

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