2016

Annual Report of the

BERMUDA DRUG INFORMATION NETWORK

(BerDIN)

GOVERNMENT OF BERMUDA
Ministry of National Security

Department for National Drug Control

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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

"The individual great spirit and great efforts create a great team." Lailah Gifty Akita

The 2016 Annual Report of the Drug Information Network (BerDIN) comes at a challenging time in drug control in Bermuda as the available funding for demand reduction services continues to decrease, testing the system's ability to respond to the needs of its residents. The Department for National Drug Control (DNDC) however, reaffirms its commitment to take action on shared challenges in order to address the Island's drug problem.

This report, the fifth of its kind, produced annually by the Bermuda Drug Information Network, provides a comprehensive overview of the drug problem, drug market, and the health impact of drug use; and supports a comprehensive, balanced approach to drug control. This year's report offers insight into the wide-ranging impact of drugs, not only on the health and the well-being of individuals, but also on the people around them, families, and communities. The report also reminds us that some of the problems of the past remain with us, even if the challenges that are now being presented for both policy and practice are changing.

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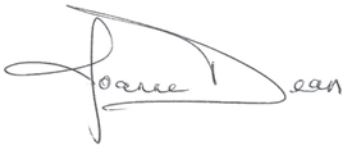
Illicit drugs are one of the most profitable areas for criminal entities, while alcohol sales and profits continue to climb, netting millions of dollars for establishments. If the sums of money spent on legal and illegal drugs are considerable, then the costs for our communities and citizens are even bigger. The analysis presented here explores these costs at a basic level. A wider impact review is important in assessing the contribution of the drug and alcohol trade on the Island's economy; and I am pleased that, this year, the Department joined with treatment agencies around Bermuda to collect information that will lead to an analysis of the drug market and its impact.

We live in an increasingly cohesive and fast-moving world in which Bermuda faces social and economic challenges on several fronts. Technological changes are impacting all aspects of modern life. With the implementation of the BerDIN Data Management System, the Department has increased Government's ability to provide reliable, accurate, and timely information, which is collected from several agencies in a central repository. The Department is working toward developing this web-based data management system to also facilitate public access to archive and current drug-related information. The system has endless possibilities.

Lastly, this report shows clearly that any measures to reduce drug supply will be ineffective unless equal vigour is devoted to addressing the demand for illicit drugs and factors that foster involvement in the drug trade. The 2016 Annual Report of the BerDIN demonstrates the importance and growing complexity of the problems we face in this area. I am convinced, now more than ever, that the points for action contained in the National Drug Control Master Plan 2013-2017 to disrupt the drug market and reduce the harm it causes are key to controlling the drug market in Bermuda.

The work of the BerDIN remains a collective effort of the Department for National Drug Control and our partners. It is the contribution and investment made by Member agencies that not only makes this report possible, but also drives the Network to do and be better. I am proud to present this body of work, which demonstrates the Department's commitment to provide relevant, reliable, and accurate national statistics that informs the drug situation in Bermuda.



Joanne Dean
Director
Department for National Drug Control
October 2016

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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
CARIDIN	Caribbean Drug Information Network
CCS	Certified Clinical Supervisor
CCES	Canadian Center for Ethics in Sport
CICAD	Inter-American Drug Abuse Control Commission
CLSS	Counselling and Life Skills Services
CMIT	Cross-Ministry Team
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
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
KEMH	King Edward VII Memorial Hospital
kg	Kilograms
L	Litre
LA	Litre of Alcohol
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
NAMLC	National Anti-Money Laundering Committee
OAS	Organisation of American States
OID	Inter-American Observatory on Drugs
PATHS	Promoting Alternative THinking Strategies
POCA	Proceeds of Crime Act
Q	Quarter
r	Revised
RLH	Right Living House
SAR	Suspicious Activity Report
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

As in previous years, estimates of the extent of drug use and problem drug use reflect the best available information in 2015, and changes compared with previous years largely reflect information updated by demand and supply reduction agencies for which new data on the extent of drug use or problem drug use were made available. In this, the 2016 report, the cross-cutting themes are presented that help with the understanding of the illicit drug market in Bermuda. Reflecting upon the conclusions drawn from last year's report, it can be said that many of the previous year's findings are still relevant today. For example, dual-diagnosed clients with substance abuse and mental health issues remain a key challenge for treatment centers; often hampered by the refocusing of national priorities or the need to work with diminishing resources. There have been improvements in a few indicators observed in the report, such as new information available on substance abuse treatment capacity and utilisation, and the report has been influential in informing the National Drug Strategy. In some areas, there has been very little change and, as a result, work on these areas needs to continue; however, new challenges are also emerging. The analysis shows how drug markets are related to other criminal activities, and that they create a strain on government institutions in addition to having a serious impact on legal business and the wider economy, not to mention negative effects on communities, families, and individuals.

Building on previous research, the DNDC continues to collect information on the retail market size, in terms of quantity and value, for the main drugs in use. These have been constructed as far as possible from the data routinely submitted by treatment agencies. In making these estimates, the DNDC has made some very bold assumptions, and these figures that have been derived must be seen as indicative only. While the Department has yet to publish this information until there are sufficient data points, the collection and, later, reporting of this information will be important to drug control efforts. It is a shared belief that this is the right time to start undertaking this work, and that the estimation process itself will highlight knowledge important gaps which, if filled, will lead to improvements in future estimates as the methodology is refined.

…drug-related crimes have increased, demand for drugs remained unchanged; all while significant challenges persist in adequately addressing the needs of substance users, their families, and the community.

In the past year, the focus of demand reduction activities remained on reducing the harms associated with alcohol and drug misuse and the provision of residential and outpatient treatment services for persons with addiction issues. During 2015, drug-related crimes have increased, demand for drugs remained unchanged; all while significant challenges persist in adequately addressing the needs of substance users, their families, and the community. With the enforcement of current legislation still remaining unaddressed and the demand for treatment remaining high, there is a significant gap in the drug control system. A shrinking public purse has resulted in waiting lists for residential treatment services, a significant reduction in services for some agencies, and removal of services for other agencies. Significant effort and resources continue to be dedicated to restricting the supply of drugs into Bermuda as part of an integrated and evidence-based balanced approach that also recognises the parallel importance of reducing the demand for drugs. The justification for these investments is that activities in this area benefit both public health and community safety as well as contributing more generally to economic and social well-being. But sound policy and actions in an area such as drug control are possible only if they are grounded in an understanding of the complex nature of the problems they are addressing.

The extent and nature of the drug market and all its ramifications is an important topic for further discussion. Gaps in the BerDIN exist that prevent a better understanding of the process involved in the drug market, which includes, but is not limited to, the farming of drug crops; the procurement of precursor chemicals and specialist equipment; trafficking activities and routes; concealment methods; the adulteration steps; the distribution from wholesale all the way down to the retail level and, finally, consumption. This report aims to improve our understanding of the drug situation in Bermuda and to provide a platform for debate in the coming years. After all, drug markets are essentially driven by two simple motives: profit and power. The ability to undermine these motives is critical if there is to be any impact on drug-related crime and reduction of the wider impacts on society.

This annual report continues as a set of interlinked elements that allows for access to available data and analysis of the drug situation in Bermuda. The BerDIN remains the primary source of statistical information on the use of illegal drugs, alcohol, tobacco, and drug-related services provided to the civilian population in Bermuda. It provides analysis of the most recent two-year period (2015 data with comparisons to 2014) based on the available data provided by reporting agencies to describe changes over this specified period; contained within the 11 chapters of this report. No reporting system is perfect. Caveats and qualifications relating to the data are found in each chapter of this report. Also included in each chapter is 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

Extent of Drug Use

Since the last report of the BerDIN (2015), cannabis and alcohol remain the most widely used drugs on the Island, supported in part by the fact that there was more litres of alcohol in circulation in 2015. Evidence is presented showing the changing perception of cannabis use amongst youth, leading to more young people experimenting with marijuana than four years ago; and that gender disparities, which use to exist in patterns of drug use, are not as apparent. Poly drug use remains ever present especially amongst persons involved in the criminal justice system who report using some combination of crack cocaine, opiates, and marijuana.

Substance Dependence/Abuse and Treatment

The National Drug Strategy has as one of its tenets, the provision of diversified approaches to prevention and treatment. Assessments done by the Bermuda Assessment and Referral Centre (BARC) continue to show that cocaine and heroin, often accompanying THC and alcohol, and are the primary substances of choice amongst persons seeking treatment services in 2015. Further, many of these persons have met the clinical criteria for dependence or abuse (problems related to their use) of such substances. However, on average, the rates of alcohol or drug dependence/abuse have declined over the years. Reports indicate that more people meet the criteria for abuse of alcohol, cannabis, and cocaine, while an increasing number of heroin abusers have been classified as dependent. The majority of persons referred for substance abuse treatment between 2014 and 2015 were repeat cases.

Ever-Present Drug Market

The vulnerability of Bermuda to drugs and crime remains a grave concern, with increasing crime rates against the person and property as well as an increase in seizures of cocaine, crack cocaine, and cannabis resin; indicating the continued demand for these illegal drugs. The drug market is still very much active in Bermuda as persons who sought drug treatment, or have been offenders of the law, have reported that their primary drug of choice remains available and accessible.

Simultaneously, there has been an increase in trials for offences such as cannabis possession and cannabis and cocaine possession with intent to supply; as well as increases in possession of drug equipment and cultivating cannabis. There were more seizures of cash in 2015, with a significantly higher value.

Synthetic Drug Use

Synthetic drug use has yet to formally be indicated in traditional reporting methods in Bermuda. The Bermuda Police Service has, however, indicated there was a seizure of fentanyl and synthetic cannabis during 2015. This has led to discussions of gaps in the current legislation, the Misuse of Drugs Act, pertaining to these non-traditional drugs, which are being widely used in other countries.

While there is no evidence of the presence and or use of these substances in Bermuda, there is no place for complacency. Previously, an alert system has been mentioned and, it is hoped, that the BerDIN data management system may have the capability to serve as an early warning system to the Network if there is suspected use of these substances.

Legislation

Law enforcement and the criminal justice system are still, in many ways, not in a position to deal effectively with controlling the drug market. Outdated legislation and a lack of enforcement of current laws have made supply reduction more challenging. For example, the Misuse of Drugs Act is not inclusive of synthetic drugs, making prosecuting such cases even more difficult. Issues around information sharing has meant that agencies often work in silos.

Cost of Treating Drug Problems

Concerning demand reduction activities, substance use treatment remains the largest component of drug control expenditure. The DNDC's treatment programmes saw a slight drop while grant-funded agencies saw level funding in 2015. Other treatment agencies or programmes saw slight increases in funding with the exception of the Turning Point Substance Abuse Programme, whose budget was cut slightly over the last fiscal year. Decreased funding continues to affect the number of clients enrolled in treatment services and, by extension, a number of persons seeking care were unable to get into treatment, while others waited for longer periods than usual. Substance use prevention expenditure for the Prevention Unit of the DNDC saw a decrease in funding while prevention grant-recipient agencies saw level funding in 2015. As a result, prevention programmes remained at 2014 levels of service.

Supply reduction agencies saw a reduction in funding by 9.4% during 2015. The balance between demand and supply reduction cannot occur unless interdiction agencies have sufficient funds to execute operations, secure necessary equipment, and have available the training and technical assistance for their officers.

Existence of a "Treatment Gap"

The year 2015 saw the persistence of the treatment gap for persons seeking substance abuse assessment. While a person may go through assessment he/she may not follow through with the recommended level of care, leaving a "treatment gap" between the persons needing and receiving treatment. An understanding and knowledge of substance users and abusers who are not in care is limited. More information is required on how to access this specific population to determine its needs.

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 and 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 2015 Annual Report marks the fifth year in which over 20 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 current year to allow sufficient time for data cleaning, verification, and follow-up in preparation for pre-press layout and design.

New Data Sources and Report Items

Since the 2015 Annual Report, the data presented for the Bermuda Sport Anti-Doping Authority (BSADA) has been expanded and one new survey was also added during this period benchmarking substance abuse treatment services in Bermuda. Additionally, one periodic survey on drug prevalence among school aged children was updated with another round administered in 2015.

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

The Network will continue to develop with additional drug-related information and statistics on drug availability and environment, use, prevention, treatment and support activities, criminal justice, and drug-related harms. These will include, but not limited to: the drug market in terms of the farming of drug crops; the procurement of precursor

chemicals and specialist equipment; 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 GDP; and outcomes related to prevention and 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 which dedicate time, resources, and human capital for the long-term utilisation and maintenance of that information often provide accurate and reliable data. During 2015 there were fewer organisational challenges than in previous years. The majority of the agencies were able to log into the BerDIN data management system; allowing for a more seamless transfer of data. Although not all of the agencies inputted their data by the May 15th deadline, the majority was able to provide their information within a reasonable time beyond the deadline.

During 2015, there were a few challenges with the provision of requested information by the established submission date. Issues ranged from: 1) not having personnel to research and provide recent information; 2) changes in contact staff resulted in a need for relationship building to obtain buy-in; 3) completeness of the data being captured and reported; and 4) inability of one Member agency to log into the BerDIN data management system to input data.

Despite these issues, this Annual BerDIN Report includes an overall total of about 38 drug control areas being monitored with over 150 indicators. The DNDC continues to work with organisations to build capacity 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 2015

The 2015 Annual Meeting of the Bermuda Drug Information Network (BerDIN) was held on the 5th and 6th November, 2015 in the Poinciana Ballroom 3 of the Fairmont Southampton (Hotel) Bermuda. Mrs. Deborah Hunter, a BerDIN Member who represented BSADA, extended welcome to the meeting's participants and invited guests. She also introduced the Cabinet Secretary and Head of the Civil Service, Dr. Derrick Binns, JP, who brought Opening Remarks to the meeting. He commended the participants on the progress made since 2008 in developing a vibrant drug information network in contrast to his personal experience and lamentations of the then National Drug Commission and the limitations posed on their efforts by the lack of reliable data. Dr. Binns, while recognising that the BerDIN has, in fact, come a long way in its efforts to generate and analyse drug-related data, he stated that there are still a few challenges ahead. He called for academic research into drug topics to become a higher priority at the tertiary level and that students need to be encouraged to pursue studies in statistics and research and, of course, to consider applying their skills in the public service. He claimed that this is a sustainable approach to ensure the longevity of the work that has begun. Dr. Binns also praised the work of the BerDIN member agencies and the DNDC for their dedication and commitment. Further, he noted that the BerDIN is an example of a successful collaboration that can be replicated throughout Government, and throughout the community.

Following the Opening Remarks, the meeting was officially declared open by Dr. Binns. Mrs. Deborah Hunter extended gratitude to the Cabinet Secretary, on behalf of the BerDIN, with a presentation of a small token of appreciation. Participants were reminded of the meeting's objectives by Ms. Tashema Bholanath, Research Officer of the DNDC; who also informed the participants of the meeting's objectives.

The keynote address was then brought by the Senior Magistrate of the Magistrates' Court, Mr. Juan Wolffe. Senior Magistrate Wolffe was introduced by BerDIN Member, Mrs. Angria Bassett, who represented the Women's Treatment Centre. Senior Magistrate Wolffe stated the alarming statistics of drug use by the younger population and what is most important is how our decisions affect future generations; and, the extent or impact of our decisions on our families and our community. In this regard, he spoke

of the decriminalisation and legalisation of marijuana versus treatment of offenders and addiction as a public health issue as opposed to a criminal issue.

The meeting received a presentation from Dr. Kyla Raynor, BerDIN Coordinator and Senior Research Officer/Policy Analyst, DNDC, on an update of the BerDIN and the current drug situation in Bermuda. Next, the meeting was introduced to the newly developed data management platform for data collection by the developer, Nova Ltd. Ms. Sandra DeSilva and Mr. Chris Shallcross demonstrated to the participants the various features of the application as well as introduced them to some of the screens that are part of the process of data entry and submission.

As a follow-up from last year's meeting and the call to have more information on the (counselling and life skills) services provided by the Department of Child and Family Services (DCFS), last year's meeting received a presentation from the Director of the DCFS, Mr. Alfred Maybury, supported by Ms. Sherrie Walker, Supervisor of Counsellors. The presenters outlined the various services provided by the DCFS, all of which are aligned to its mission. The Executive Director of CADA, Mr. Anthony Santucci, made a presentation on Sobriety Checkpoints. He made the case for non-selective sobriety checkpoints in helping to change behaviours and by extension saving lives by providing statistics on road traffic accidents and fatalities and examples of where this process works. The DNDC's representative, Ms. Tashema Bholanath, provided the meeting with an update on the primary data collection efforts, in the form of surveys, undertaken by the DNDC since the last meeting. These included the Survey of Substance Use among the Homeless Population and Pregnant Women and the Drug Abuse Monitoring Survey among the Prison Population.

At the conclusion of the meeting there were recommendations for bilateral meetings, additional data from BSADA, the courts, Prevention Unit of the DNDC, and on drug prices. Closing remarks were made and an evaluation of the session concluded the day. More information on the BerDIN can be found on the government's portal at www.gov.bm.

Photo courtesy of DCI

Chapter 1
Criminal and Suspicious Activity

- Crimes
- Drug Enforcement Activity
- Drug Seizures and Arrests
- Prosecutions
- Financial Intelligence
- Financial Crime

1.1 CRIME AND DRUG ENFORCEMENT ACTIVITY

The Bermuda Police Service (BPS) records, collates, and monitors information related to criminal offences on the Island. Analyses include statistics related to patterns or trends in criminal activity as well as incidences of specific categories of offences. This information, reported quarterly and annually, provides the basis from which criminal activities are quantified. Data reported is aggregated and reported by year, gender, and type of offence.

Between 2014 and 2015, Bermuda saw an increase in overall crimes by 10.5%; with crime against the person increasing by 32.1%, against the community increasing by 15.6%, and against property increasing by 4.5% (see Table 1.1.1). In both years, there were mostly crimes against property with characterised predominantly by motor vehicle theft (see Table 1.1.2). With regard to offences against the person, 'other assaults' have significantly decreased over the past year. In term of crimes against the community, the classification 'antisocial behaviour' and 'disorder offences' saw the largest increases in the number of offences with 35 and 40 more cases, respectively. For property offences, the largest increases were observed for residential burglary and criminal damage. In contrast, a decrease in motor vehicle theft was observed. Although a number of major offences were on the rise, others such as motor vehicle theft and other weapon offences recorded a decrease in numbers.

On the other hand, drug importation and local drug offences have increased by 5.8% over the past year under review; with 20 additional drug enforcement activities undertaken by the BPS; mainly for local drug offences (see Tables 1.1.5). While it was evident that drug enforcement activities have increased in 2015 when compared to 2014, the data does not provide information as to why these differences were observed (increased activities were possibly due to improved funding for drug-related enforcement, adequate intelligence, or simply because of greater supply on the market).

…drug importation and local drug offences have increased by 5.8%; with 20 additional drug enforcement activities undertaken.

Table 1.1.1
Number and Proportion of Crimes by Type of Crime and Annual Absolute and Percentage Change, 2014 and 2015

CRIMES	2014		2015		Annual Change	
	n	%	n	%	n	%
Against the Person	536[r]	15.8	708	18.9	172	32.1
Against the Community	507	14.9	586	15.6	79	15.6
Against Property	2,351	69.3	2,456	65.5	105	4.5
Total – All Crimes	**3,394[r]**	**100.0**	**3,750**	**100.0**	**356**	**10.5**

Source: Bermuda Police Service

Table 1.1.2
Number of Crimes against Person, Community, and Property by Type of Crime and Annual Absolute Change, 2014 and 2015

CRIMES	2014	2015	Annual Absolute Change
AGAINST THE PERSON	**535**	**708**	**173**
Indecency	20	25	5
Manslaughter	-	1	1
Murder	5	4	-1
Offences Against Children	10	25	15
Robbery	33	46	13
Serious Assaults	61	58	-3
Sexual Assault	30	35	5
Other Assaults	377	514	137
AGAINST THE COMMUNITY	**507**	**586**	**79**
Animal Offences	1	2	1
Antisocial Behaviour	386	421	35
Disorder Offences	67	107	40
Firearm Offences	17	29	12
Other Weapon Offences	36	27	-9

Table 1.1.2 cont'd
Number of Crimes against Person, Community, and Property by Type of Crime and Annual Absolute Change, 2014 and 2015

CRIMES	2014	2015	Annual Absolute Change
AGAINST PROPERTY	**2,351**	**2,456**	**105**
Burglary (Residential)	78	143	65
Burglary (Non-Residential)	442	449	7
Burglary (Tourist Accommodation)	4	12	8
Criminal Damage	224	289	65
Fraud and Deception	137	154	17
Motor Vehicle Theft	830	771	-59
Theft of Property	636	638	2

Source: Bermuda Police Service

Note: Absolute change is the total numeric change in quantity between two numbers, that is, the numerical difference from one period/year to the next.

Table 1.1.3
Number of Crimes against Person, Property, and Community as a Proportion of Each Crime Category, 2014 and 2015

CRIMES	2014	2015
AGAINST THE PERSON	**100.0**	**100.0**
Indecency	2.4	3.5
Manslaughter	-	0.1
Murder	0.8	0.6
Offences Against Children	1.6	3.5
Robbery	5.4	6.5
Serious Assaults	9.1	8.2
Sexual Assault	5.1	4.9
Other Assaults	75.6	72.6
AGAINST THE COMMUNITY	**100.0**	**100.0**
Animal Offences	2.6	0.3
Antisocial Behaviour	74.8	71.8
Disorder Offences	14.1	18.3
Firearm Offences	4.0	4.9
Other Weapon Offences	4.5	4.6
AGAINST PROPERTY	**100.0**	**100.0**
Burglary (Non-Residential)	6.2	5.8
Burglary (Residential)	20.5	18.3
Burglary (Tourist Accommodation)	0.5	0.5
Criminal Damage	11.8	11.8
Fraud and Deception	6.4	6.3
Motor Vehicle Theft	27.8	31.4
Theft of Property	26.9	26.0

Source: Bermuda Police Service

Table 1.1.4
Number of Crimes against Person, Property, and Community as a Proportion of Total Crimes, 2014 and 2015

CRIMES	2014	2015
AGAINST THE PERSON	**15.8**	**18.9**
Indecency	0.6	0.7
Manslaughter	-	-
Murder	15.8	0.1
Offences Against Children	0.3	0.7
Robbery	1.0	1.2
Serious Assaults	1.8	1.5
Sexual Assault	0.9	0.9
Other Assaults	11.1	13.7
AGAINST THE COMMUNITY	**14.9**	**15.6**
Animal Offences	-	0.1
Antisocial Behaviour	11.4	11.2
Disorder Offences	2.0	2.9
Firearm Offences	0.5	0.8
Other Weapon Offences	-	0.7
AGAINST PROPERTY	**69.3**	**65.5**
Burglary (Non-Residential)	2.3	3.8
Burglary (Residential)	13.0	12.0
Burglary (Tourist Accommodation)	0.1	0.3
Criminal Damage	6.6	7.7
Fraud and Deception	4.0	4.1
Motor Vehicle Theft	24.5	20.6
Theft of Property	18.7	17.0

Source: Bermuda Police Service

Table 1.1.5
Number and Proportion of Drug Enforcement Activity by Type of Activity and Annual Absolute and Percentage Change, 2014 and 2015

DRUG ENFORCEMENT ACTIVITY	2014		2015		Annual Change	
	n	%	n	%	n	%
Drug Offences (Importation)	52	15.0	98	26.7	46	88.5
Drug Offences (Local)	295	85.0	269	73.3	-26	-8.8
Total – Drug Enforcement Activity	**347**	**100.0**	**367**	**100.0**	**20**	**5.8**

Source: Bermuda Police Service

1.2 DRUG SEIZURES AND ARRESTS

In both 2014 and 2015, the highest proportion of seizure activity was at the street level followed by seizures occurring at the ports. The total number of seizures increased from 314 to 345 (see Table 1.2.1). On a whole, both arrests for importation and local drug offences decreased by 18.8% over the period under review, that is, from 276 in 2014 to 224 in 2015. The greater proportion of arrests, of about eight in 10 in 2014 and nine in 10 in 2015, was observed for local drug offences.

The total value of drugs seized rose sizably from $5.1 million in 2014 to $6.7 million in 2015. The year 2015 recorded a significant increase in the quantity of cannabis resin seized, from 761 g in 2014 to 1,981 g, with a corresponding increase in the value of this quantity seized. There was also a sharp increase in the quantities of crack cocaine and cocaine seizures in 2015 when compared to the previous year. In contrast, the quantity of cannabis seized declined in 2015, although this lower quantity was at higher valuation. Of all the drugs seized, cannabis and crack cocaine accounted

for the largest amount in terms of weight in both years under consideration; but in terms of value, cannabis and crack cocaine were valued more in 2015 versus cannabis and heroin in the previous year (see Table 1.2.2). The higher value of heroin in 2014 was due to the BPS using a higher per unit price for its valuation of seizures. In both 2014 and 2015, most seizure activity was at the ports, yielding much of the cannabis and crack cocaine that was seized (see Tables 1.2.3 and 1.2.4).

Table 1.2.1
Drug Seizures by Location and Arrests for Drug Offences, 2014 and 2015

SEIZURES	2014	2015
Location		
Street	237	251
Port	76	91
Overseas	1	3
Total Seizures	**314**	**345**
Annual Percentage Change	**0.0**	**9.9**
ARRESTS		
Drug Offences (Importation)	49	24
Drug Offences (Local)	227	200
Total Arrests – Drug Offences	**276**	**224**
Annual Percentage Change	**36.3**	**-18.8**

Source: Bermuda Police Service

Table 1.2.2
Drug Seizures by Type of Drug, Total Weight, and Total Street Value, 2014 and 2015

DRUG	2014		2015	
	Total Weight (g)	Total Value ($)	Total Weight (g)	Total Value ($)
Cannabis	78,265	3,913,274	67,735	4,402,769
Cannabis (Resin)	761	76,106	1,981	188,173
Cocaine	645	154,855	5,430	874,180
Crack Cocaine	485	151,491	6,104	1,123,138
Heroin	281	827,895	240	96,684
Total*	**80,437**	**5,123,621**	**81,490**	**6,684,944**

Source: Bermuda Police Service

Note: * In grams, and does not include cannabis plants and ecstasy tablets.

Table 1.2.3
Drug Seizures by Type of Drug, Location, Weight, and Street Value, 2014

DRUG	Street		Port		Overseas	
	Weight (g)	Value ($)	Weight (g)	Value ($)	Weight (g)	Value ($)
Cannabis (Plants)	792	..	-	..	-	..
Cannabis	11,987	599,343	65,729	3,286,432	550	27,500
Cannabis (Resin)	4	407	757	75,696	-	-
Cocaine	641	153,725	5	1,130	-	-
Crack Cocaine	176	54,916	309	96,575	-	-
Heroin	31	92,145	250	735,750	-	-
TOTAL*	**12,839**	**900,536**	**67,050**	**4,195,583**	**550**	**27,500**

Source: Bermuda Police Service

Note: * In grams, and does not include cannabis plants and ecstasy tablets.

Table 1.2.4
Drug Seizures by Type of Drug, Location, Weight, and Street Value, 2015

DRUG	Street		Port		Overseas	
	Weight (g)	Value ($)	Weight (g)	Value ($)	Weight (g)	Value ($)
Cannabis (Plants)	168	-	-	-	-	-
Cannabis	1,740	113,121	65,995	4,289,648	-	-
Cannabis (Resin)	84	7,949	717	68,125	1,180	112,100
Cocaine	141	2,2767	3,788	609,913	1,500	241,500
Crack Cocaine	19	3,437	1,545	284,340	4,540	835,360
Heroin	4	1,781	235	94,902	-	-
Total*	**1,988**	**149,055**	**72,280**	**5,346,928**	**7,220**	**1,188,960**

Source: Bermuda Police Service

Note: * In grams, and does not include cannabis plants and ecstasy tablets.

1.3 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 1.3.1 and 1.3.2). Criminal trials for drug-related offences increased from 183 cases in 2014 to 222 in 2014 (Table 1.3.1). In both years, the majority of drug-related trails were for possession of cannabis, and increased from 55 trials in 2014 to 68 in 2015. Criminal trials for the possession of cocaine with the intent to supply, conspiracy to import other drugs, and possession of drug equipment almost doubled from 2014 to 2015; while that for the importation of cannabis dropped by almost half (see Table 1.3.1).

In contrast, the number of criminal trials for alcohol-related offences saw a sharp increase, climbing from 323 cases in 2014 to 432 in 2015 (see Table 1.3.2). In both 2014 and 2015, of all alcohol-related offences, a significant number of these trials were the result of impaired driving of a motor vehicle, refusing the breathalyser test, and excessive alcohol in operating a motor vehicle.

In terms of acquittals and convictions, there were more acquittals in 2015 than in 2014 for criminal drug-related offence and fewer for alcohol-related offences (see Tables 1.3.3 and 1.3.4). On the other hand, there were more convictions in 2015 for both criminal drug- and alcohol-related offences when compared with 2014 (see Tables 1.3.5 and 1.3.6). For drug-related offences, most of the acquittals were for possession of drug equipment (see Table 1.3.3), while for alcohol-related offences, the majority of acquittals were for impaired driving of a motor vehicle (see Table 1.3.4). An increase in criminal convictions for drug-related offences was observed in 2015; although, in both years under review, these convictions were mainly for the possession of cannabis, followed by possession of drug equipment and possession of cannabis with intent to supply. In 2015, the number of criminal convictions for the possession of cannabis increased to 59, up from 45 in the previous year. In comparison, criminal convictions for alcohol-related offences on the whole increased considerably in 2015, increasing from 155 cases in 2014 to 210 cases in 2015. Convictions for impaired driving of a motor vehicle represented the largest proportion of these convictions; though decreasing from 88 cases in 2014 to 45 cases in 2015, while convictions for refusing the breathalyser test increased from 27 in 2014 to 73 in 2015 and from 22 to 54 for operating a motor vehicle while being under the influence of excess alcohol.

…there were more criminal convictions in 2015 for both drug- and alcohol-related offences.

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 increased from the 27 cases recorded in 2014 to 40 cases in 2015 (see Table 1.3.7). However, when it came to alcohol-related cases, overall, there were fewer cases classified as results 'unknown' in 2014 as compared to 2015, 136 and 197 cases, respectively.

Table 1.3.1
Criminal Trials for Drug-Related Offences by Sex of Offender, 2014 and 2015

JEMS Code	Description	2014				2015			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	50[r]	3	2	55[r]	62	3	3	68
2304	Possession of Cocaine	8	-	2	10	8	1	-	9
2308	Possession of Diamorphine	4	-	-	4	3	-	-	3
2312	Possession of Other Drugs	1	-	-	1	-	-	-	-
2313	Possession of Other Drugs With Intent to Supply	1[r]	-	-	1[r]	-	-	-	0
2316	Possession of Cannabis With Intent to Supply	22	4	-	26	22	4	2	28
2320	Possession of Cocaine With Intent to Supply	7	2	-	9	14	2	-	16
2324	Possession of Diamorphine With Intent to Supply	5	-	-	5	3	-	-	3
2332	Handle Cannabis With Intent to Supply	2	-	-	2	-	-	-	-
2336	Handle Cocaine With Intent to Supply	-	-	-	-	-	-	-	-
2340	Handle Diamorphine With Intent to Supply	-	-	-	-	-	-	-	-
2344	Handle Other Drugs With Intent to Supply	-	-	-	-	-	-	-	-
2348	Supply Cannabis	-	-	-	-	-	-	-	-
2352	Supply Cocaine	-	-	-	-	-	-	-	-
2356	Supply Diamorphine	-	-	-	-	-	-	-	-
2357	Supply Other Drugs	-	-	-	-	-	-	-	-
2364	Import Cannabis	8	5	-	13	4	2	1	7
2368	Import Cocaine	1	2	-	3	-	-	-	-
2372	Import Diamorphine	1	-	-	1	-	1	-	1
2373	Import Other Drugs	1[r]	-	-	1[r]	-	-	-	-
2380	Conspiracy to Import Other Drugs	3	3	-	6	7	-	4	11
2381	Conspiracy to Supply a Controlled Drug	-	-	-	-	1	1	-	2
2383	Export Drug Attempt	-	-	-	-	-	-	-	-
2384	Misuse Controlled Drug	-	-	-	-	-	-	-	-
2388	Possession of Drug Equipment	24[r]	-	-	24[r]	31	6	3	40
2392	Possession of Drug Equipment Prepare	15	-	-	15	21	1	-	22
2396	Cultivate Cannabis	3	-	-	3	8	1	-	9
2400	Permit on Premises Drug Use	-	-	-	-	1	1	-	2
2404	Obstruction	4	-	-	4	1	-	-	1
Total Trials: Drug-Related Offences		**160[r]**	**19**	**4**	**183[r]**	**186**	**23**	**13**	**222**

Source: Supreme Court

Table 1.3.2
Criminal Trials for Alcohol-Related Offences by Sex of Offender, 2014 and 2015

JEMS Code	Description	2014				2015			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	127[r]	20	9	156[r]	162	23	8	193
3059	Impaired Driving (>100 mgs Alcohol)	10	5	-	15	22	2	3	27
3060	Impaired Driving Not Motor Vehicle	-	-	-	-	-	-	-	-
3061	Care and Control of Motor Vehicle Whilst Impaired	9	-	-	9	18	2	-	20
3062	Refuse Breath Test	58	8	3	69	84	10	4	98
3063	Impaired Driving Drug In Body	-	-	-	-	-	-	-	-
3064	Excess Alcohol Motor Vehicle	54[r]	6	7	67[r]	70	12	1	83
3065	Impaired Driving – GBH	-	-	1	1	4	1	-	5
3066	Excess Alcohol Not Motor Vehicle	-	-	-	-	3	1	-	4

Table 1.3.2 cont'd

Criminal Trials for Alcohol-Related Offences by Sex of Offender, 2014 and 2015

JEMS Code	Description	2014				2015			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3069	Causing Death by Impaired Driving	-	-	-	-	-	-	-	-
3842	Excess Alcohol – Power Craft	1[r]	-	-	1[r]	-	-	-	-
3843	Impaired Driving – Power Craft	2	-	-	2	-	-	-	-
4020	Drunk and Incapable	-	-	-	-	-	-	-	-
4022	Drunk in Public Street	1	-	-	1	2	-	-	2
8403	Drunkenness in Aircraft Contrary to Air Navigation	2	-	-	2	-	-	-	-
4500	Liquor Licence Offences	-	-	-	-	-	-	-	-
4556	On Premises Outside Permitted Hours	-	-	-	-	-	-	-	-
4599	Breach of Liquor Licence	-	-	-	-	-	-	-	-
Total Trials: Alcohol-Related Offences		**264[r]**	**39**	**20**	**323[r]**	**365**	**51**	**16**	**432**

Source: Supreme Court

Table 1.3.3

Criminal Acquittals for Drug-Related Offences by Sex of Offender, 2014 and 2015

JEMS Code	Description	2014			2015			
		Male	Female	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	5[r]	-	5[r]	5	-	-	5
2304	Possession of Cocaine	-	-	-	-	-	-	-
2308	Possession of Diamorphine	-	-	-	-	-	-	-
2312	Possession of Other Drugs		-	-	-	-	-	-
2313	Possession of Other Drugs With Intent to Supply	-	-	-	-	-	-	-
2316	Possession of Cannabis With Intent to Supply	1	-	1	1	-	-	1
2320	Possession of Cocaine With Intent to Supply	-	-	-	3	-	-	3
2324	Possession of Diamorphine With Intent to Supply	-	-	-	-	-	-	-
2332	Handle Cannabis With Intent to Supply	2	-	2	-	-	-	-
2336	Handle Cocaine With Intent to Supply	-	-	-	-	-	-	-
2340	Handle Diamorphine With Intent to Supply	-	-	-	-	-	-	-
2344	Handle Other Drugs With Intent to Supply	-	-	-	-	-	-	-
2348	Supply Cannabis	-	-	-	-	-	-	-
2352	Supply Cocaine	-	-	-	-	-	-	-
2356	Supply Diamorphine	-	-	-	-	-	-	-
2357	Supply Other Drugs	-	-	-	-	-	-	-
2364	Import Cannabis	-	1	1	-	-	-	-
2368	Import Cocaine	-	-	-	-	-	-	-
2372	Import Diamorphine	-	-	-	-	1	-	1
2373	Import Other Drugs	-	-	-	-	-	-	-
2380	Conspiracy to Import Other Drugs	2	-	2	6	-	-	6
2381	Conspiracy to Supply a Controlled Drug	-	-	-	-	-	-	-
2383	Export Drug Attempt	-	-	-	-	-	-	-
2384	Misuse Controlled Drug	-	-	-	-	-	-	-
2388	Possession of Drug Equipment	6[r]	-	6[r]	5	1	2	8
2392	Possession of Drug Equipment Prepare	4	-	4	-	-	-	-
2396	Cultivate Cannabis	-	-	-	1	-	-	1
2400	Permit on Premises Drug Use	-	-	-	-	1	-	1
2404	Obstruction	1	-	1	-	-	-	-
Total Acquittals: Alcohol-Related Offences		**21[r]**	**1**	**22[r]**	**21**	**3**	**2**	**26**

Source: Supreme Court

Table 1.3.4
Criminal Acquittals for Alcohol-Related Offences by Sex of Offender, 2014 and 2015

JEMS Code	Description	2014				2015			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	10	5	2	17	8	3	1	12
3059	Impaired Driving (>100 mgs Alcohol)	-	-	-	-	1	-	-	1
3060	Impaired Driving Not Motor Vehicle	-	-	-	-	-	-	-	-
3061	Care and Control of Motor Vehicle Whilst Impaired	1	-	-	1	2	-	-	2
3062	Refuse Breath Test	6	2	1	9	5	-	-	5
3063	Impaired Driving Drug In Body	-	-	-	-	-	-	-	-
3064	Excess Alcohol Motor Vehicle	3	1	-	4	2	1	1	4
3065	Impaired Driving – GBH	-	-	-	-	-	-	-	-
3066	Excess Alcohol Not Motor Vehicle	-	-	-	-	-	-	-	-
3069	Causing Death by Impaired Driving	-	-	-	-	-	-	-	-
3843	Impaired Driving – Power Craft	1	-	-	1	-	-	-	-
4020	Drunk and Incapable	-	-	-	-	-	-	-	-
4022	Drunk in Public Street	-	-	-	-	1	-	-	1
8403	Drunkenness in Aircraft Contrary to Air Navigation	-	-	-	-	-	-	-	-
4500	Liquor Licence Offences	-	-	-	-	-	-	-	-
4556	On Premises Outside Permitted Hours	-	-	-	-	-	-	-	-
4599	Breach of Liquor Licence	-	-	-	-	-	-	-	-
Total Acquittals: Alcohol-Related Offences		**21**	**8**	**3**	**32**	**19**	**4**	**2**	**25**

Source: Supreme Court

Table 1.3.5
Criminal Convictions for Drug-Related Offences by Sex of Offender, 2014 and 2015

JEMS Code	Description	2014				2015			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	41[r]	2	2	45[r]	55	2	2	59
2304	Possession of Cocaine	7	-	2	9	8	1	-	9
2308	Possession of Diamorphine	4	-	-	4	2	-	-	2
2312	Possession of Other Drugs	1	-	-	1	-	-	-	-
2313	Possession of Other Drugs With Intent to Supply	-	-	-	-	-	-	-	-
2316	Possession of Cannabis With Intent to Supply	18	2	-	20	19	2	1	22
2320	Possession of Cocaine With Intent to Supply	6	2	-	8	8	1	-	9
2324	Possession of Diamorphine With Intent to Supply	5	-	-	5	3	-	-	3
2332	Handle Cannabis With Intent to Supply	-	-	-	-	3	1	1	5
2336	Handle Cocaine With Intent to Supply	-	-	-	-	-	-	-	-
2340	Handle Diamorphine With Intent to Supply	-	-	-	-	-	-	-	-
2344	Handle Other Drugs With Intent to Supply	-	-	-	-	-	-	-	-
2348	Supply Cannabis	-	-	-	-	-	-	-	-
2352	Supply Cocaine	-	-	-	-	-	-	-	-
2356	Supply Diamorphine	-	-	-	-	-	-	-	-
2357	Supply Other Drugs	-	-	-	-	-	-	-	-
2364	Import Cannabis	5	3	-	8	-	-	-	-
2368	Import Cocaine	1	2	-	3	-	-	-	-
2372	Import Diamorphine	-	-	-	-	-	-	-	-
2373	Import Other Drugs	1[r]	-	-	1[r]	-	-	-	-

Table 1.3.5 cont'd
Criminal Convictions for Drug-Related Offences by Sex of Offender, 2014 and 2015

JEMS Code	Description	2014				2015			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2380	Conspiracy to Import Other Drugs	-	2	-	2	1	-	-	1
2381	Conspiracy to Supply a Controlled Drug	-	-	-	-	-	-	-	-
2383	Export Drug Attempt	-	-	-	-	-	-	-	-
2384	Misuse Controlled Drug	-	-	-	-	-	-	-	-
2388	Possession of Drug Equipment	16	-	-	16	20	3	1	24
2392	Possession of Drug Equipment Prepare	6	-	-	6	14	-	-	14
2396	Cultivate Cannabis	3	-	-	3	7	-	-	7
2400	Permit on Premises Drug Use	-	-	-	-	-	-	-	-
2404	Obstruction	3	-	-	3	1	-	-	1
Total Convictions: Drug-Related Offences		117[r]	13	4	134[r]	141	10	5	156

Source: Supreme Court

Table 1.3.6
Criminal Convictions for Drug-Related Offences by Sex of Offender, 2014 and 2015

JEMS Code	Description	2014				2015			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	72[r]	10	6	88[r]	40	5	-	45
3059	Impaired Driving (>100 mgs Alcohol)	5	2	-	7	16	2	3	21
3060	Impaired Driving Not Motor Vehicle	-	-	-	-	-	-	-	-
3061	Care and Control of Motor Vehicle Whilst Impaired	6	-	-	6	10	-	-	10
3062	Refuse Breath Test	24	2	1	27	61	8	4	73
3063	Impaired Driving Drug In Body	-	-	-	-	-	-	-	-
3064	Excess Alcohol Motor Vehicle	19	2	1	22	45	9	-	54
3065	Impaired Driving – GBH	-	-	1	1	3	1	-	4
3066	Excess Alcohol Not Motor Vehicle	-	-	-	-	2	-	-	2
3069	Causing Death by Impaired Driving	-	-	-	-	-	-	-	-
3843	Impaired Driving – Power Craft	1	-	-	1	-	-	-	-
4020	Drunk and Incapable	-	-	-	-	-	-	-	-
4022	Drunk in Public Street	1	-	-	1	1	-	-	1
8403	Drunkenness in Aircraft Contrary to Air Navigation	2	-	-	2	-	-	-	-
4500	Liquor Licence Offences	-	-	-	-	-	-	-	-
4556	On Premises Outside Permitted Hours	-	-	-	-	-	-	-	-
4599	Breach of Liquor Licence	-	-	-	-	-	-	-	-
Total Convictions: Alcohol-Related Offences		130[r]	16	9	155[r]	178	25	7	210

Source: Supreme Court

Table 1.3.7
Unknown Results for Drug-Related Offences by Sex of Offender, 2014 and 2015

JEMS Code	Description	2014				2015			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	4	1	-	5	2	1	1	4
2304	Possession of Cocaine	1	-	-	1	-	-	-	-
2308	Possession of Diamorphine	-	-	-	-	1	-	-	1
2312	Possession of Other Drugs	-	-	-	-	-	-	-	-
2313	Possession of Other Drugs With Intent to Supply	1[r]	-	-	1[r]	-	-	-	-
2316	Possession of Cannabis With Intent to Supply	3	2	-	5	2	2	1	5
2320	Possession of Cocaine With Intent to Supply	1	-	-	1	3	1	-	4
2324	Possession of Diamorphine With Intent to Supply	-	-	-	-	-	-	-	-
2332	Handle Cannabis With Intent to Supply	-	-	-	-	-	-	-	-
2336	Handle Cocaine With Intent to Supply	-	-	-	-	-	-	-	-
2340	Handle Diamorphine With Intent to Supply	-	-	-	-	-	-	-	-
2344	Handle Other Drugs With Intent to Supply	-	-	-	-	-	-	-	-
2348	Supply Cannabis	-	-	-	-	-	-	-	-
2352	Supply Cocaine	-	-	-	-	-	-	-	-
2356	Supply Diamorphine	-	-	-	-	-	-	-	-
2357	Supply Other Drugs	-	-	-	-	-	-	-	-
2364	Import Cannabis	3	1	-	4	1	1	-	2
2368	Import Cocaine	-	-	-	-	-	-	-	-
2372	Import Diamorphine	1	-	-	1	-	-	-	-
2373	Import Other Drugs	-	-	-	-	-	-	-	-
2380	Conspiracy to Import Other Drugs	1	1	-	2	-	-	4	4
2381	Conspiracy to Supply a Controlled Drug	-	-	-	-	1	1	-	2
2383	Export Drug Attempt	-	-	-	-	-	-	-	-
2384	Misuse Controlled Drug	-	-	-	-	-	-	-	-
2388	Possession of Drug Equipment	2[r]	-	-	2[r]	6	2	-	8
2392	Possession of Drug Equipment Prepare	5	-	-	5	7	1	-	8
2396	Cultivate Cannabis	-	-	-	-	-	1	-	1
2400	Permit on Premises Drug Use	-	-	-	-	1	-	-	1
2404	Obstruction	-	-	-	-	-	-	-	-
Total Unknown Results: Drug-Related Offences		**22[r]**	**5**	**-**	**27[r]**	**24**	**10**	**6**	**40**

Source: Supreme Court

Table 1.3.8
Unknown Results for Alcohol-Related Offences by Sex of Offender, 2014 and 2015

JEMS Code	Description	2014				2015			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	45	5	1	51	114	15	7	136
3059	Impaired Driving (>100 mgs Alcohol)	5	3	-	8	5	-	-	5
3060	Impaired Driving Not Motor Vehicle	-	-	-	-	-	-	-	-
3061	Care and Control of Motor Vehicle Whilst Impaired	2	-	-	2	6	2	-	8
3062	Refuse Breath Test	28	[4]	1	33	18	2	-	20
3063	Impaired Driving Drug In Body	-	-	-	-	-	-	-	-
3064	Excess Alcohol Motor Vehicle	32[r]	3	6	41[r]	23	2	-	25
3065	Impaired Driving – GBH	-	-	-	-	1	-	-	1
3066	Excess Alcohol Not Motor Vehicle	-	-	-	-	1	1	-	2
3069	Causing Death by Impaired Driving	-	-	-	-	-	-	-	-
3842	Excess Alcohol – Power Craft	1	-	-	1	-	-	-	-
3843	Impaired Driving – Power Craft	-	-	-	-	-	-	-	-
4020	Drunk and Incapable	-	-	-	-	-	-	-	-
4022	Drunk in Public Street	-	-	-	-	-	-	-	-
8403	Drunkenness in Aircraft Contrary to Air Navigation	-	-	-	-	-	-	-	-
4500	Liquor Licence Offences	-	-	-	-	-	-	-	-
4556	On Premises Outside Permitted Hours	-	-	-	-	-	-	-	-
4599	Breach of Liquor Licence	-	-	-	-	-	-	-	-
Total Unknown Results: Alcohol-Related Offences		113[r]	15	8	136[r]	168	22	7	197

Source: Supreme Court

1.4 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 an increase, by over a third (35%), in SARs received from 2014 (331) to 2015 (447) (see Table 1.4.1). All four quarters in 2015 saw an increase over the corresponding quarters in 2014, by some 19% to 47%. Activities within banks and money service businesses account for the bulk of the SARs in both 2014 (234 and 47, respectively) and 2015 (306 and 77, respectively). SARs received from banks increased by 30.8% year over year. Similarly, the number of SARs received from the money service businesses increased even more considerably, by 63.8%, in 2015. Although relatively few, it is worthy to note that, in both 2014 and 2015, there were SARs involving a law firms, trust companies, investment providers, and long-term insurers; though in 2015, there were relatively more in numbers than in the previous year. For instance, there were 10 SARs received from law firms and seven from investment service providers in 2015 compared to one from each sector in 2014. Further, in 2015, a SAR was received from a fund administrator, a sector that previously did not report any SARs, and from corporate service providers.

The FIA recorded a total of 156 SARs filed in 2014 as compared to 169 SARs in 2015 (an 8.3% increase), involving the exchange of Bermuda currency to US dollar. The majority of these cash exchanges were exchanges for US dollars.[2] The FIA also recorded the filing of 47 SARs in 2014 as compared to 73 SARs in 2015 (a 55.3% increase) that were related to suspicious wire transfers of money out of Bermuda, using money service business as the transmitter.

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

[2] FIA.

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.[3]

Also in 2015, 142 local and overseas disclosures contained information from 426 SARs compared to 107 disclosures from 230 SARs in 2014, representing a 32.7% increase in disclosures from the 77.5% rise in total SARs disclosed

In 2014, there were three convictions for money laundering in the Bermuda courts, while in 2015 there were four convictions.[4] The Department of Public Prosecutions, however, cautioned that not all of these convictions have a predicate offence directly related to drugs

[3] Ibid.

[4] Department of Public Prosecutions.

Table 1.4.1
Suspicious Activity Reports (SARs) by Sector, 2014 and 2015

SECTOR	2014					2015					Annual Percentage Change
	Q1	Q2	Q3	Q4	TOTAL	Q1	Q2	Q3	Q4	TOTAL	
SARs Received											
Banks (includes a Credit Union)	70	59	54	51	234	83	88	70	65	306	30.8
Investment Providers	-	-	-	1	1	-	4	3	-	7	600.0
Money Service Businesses	9	14	11	13	47	29	6	16	26	77	63.8
Corporate Service Providers	-	-	-	-	-	1	-	1	1	3	-
Law Firm	-	-	1	-	1	4	2	3	1	10	900.0
Trust Company	-	1	-	-	1	-	2	-	-	2	100.0
Local Regulators	-	-	-	1	1	-	-	2	2	4	300.0
Long-Term Insurers	13	20	4	8	45	6	10	7	14	37	-17.8
Other (Metal Dealers)	-	-	-	-	-	-	-	-	-	-	-
Accounting Firm	-	-	-	1	1	-	-	-	-	-	-100.0
Fund Administrators	-	-	-	-	-	-	-	-	1	1	-
Total SARs Received	92	94	70	75	331	123	112	102	110	447	35.0
Annual Percentage Change	8.2	-2.1	-20.5	-27.9	-11.3	33.7	19.1	45.7	46.7	35.0	
Total Local and Overseas Disclosures	31	23	21	32	107	40	52	23	27	142	32.7
Local entities	27	20	18	30	95	32	30	23	24	109	14.7
Overseas entities	4	3	3	2	12	8	22	-	3	33	175.0
Total SARs Disclosed	64	53	51	72	240	98	145	36	147	426	77.5

Source: Financial Intelligence Agency

1.5 FINANCIAL CRIME

On April 1st 2016, the Bermuda Police Service reorganised the structure of departments and, as a result, the Financial Crime Unit (FCU) was amalgamated into the newly named Organised and Economic Crime Department (OECD). The OECD encompasses: drug crime, financial crime, organised crime, corruption, and cyber-crime.

As part of its role, the OECD 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 forty-eight 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 the OECD 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, the OECD 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.

The OECD 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 who include the Financial Action Task Force; the International Criminal Police Organisation, the United States Department of Justice and the United Kingdom National Crime Agency.

The OECD has reported a total of eight cash seizures in 2014 amounting to $623,116 compared to the considerably higher number (25) in the most recent year yielding $1.2 million (see Table 1.5.1). Specifically, the larger number of seizures in 2015 amounted to cash seized of $692,974, the largest proportion of seizures, and $381,264 in confiscations. However, forfeitures was significantly lower in 2015 ($169,625) than in the previous year ($535,134).

Table 1.5.1
Cash Seizures, 2014 and 2015

Year/Quarter	Number of Seizures	Section 50 Cash Seizures ($)	Forfeiture ($)	Confiscation ($)	Total ($)
2014	**8**	**87,982.00**	**535,133.96**		**623,115.96**
Q1	1	13,900.00	469,427.96	-	483,327.96
Q2	4	24,253.00	-	-	24,253.00
Q3	-	-	65,706.00	-	65,706.00
Q4	3	49,829.00	-	-	49,829.00
2015	**25**	**692,974.48**	**169,625.03**	**381,261.08**	**1,243,885.59**
Q1	2	31,152.15	158,522.03	-	185,676.18
Q2	4	50,856.50	11,103.00	-	533,744.00
Q3	8	533,736.00	…	…	458,501.91
Q4	11	77,229.83	…	381,261.08	1,243,885.59

Source: Financial Crime Unit, Bermuda Police Service

Note: … means that the breakdown had not been provided by the BPS.

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. In Bermuda, a 33.5% duty is levied on imported cigarettes, while $26.57 is the duty charged on one litre of hard liquor.[5] However, there are varying rates of duty applied to different alcoholic beverages and tobacco products (Appendix III). These rates have been revised and became effective as of April 1, 2013 and were in use up until March 31. 2016; after which they have been revised. In addition, 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, 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 residents of Bermuda do not consume a portion of the imported alcohol and tobacco. Sale or supply of these products to minors (under 18 years) is prohibited by law. According to the Tobacco Products (Public Health) Act 1987, a photo identification is required if a person appears to be under 25 years.[6]

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 2014, 6.53 million litres of alcohol and alcoholic beverages were available for local consumption, valued at $27.2 million, and contributed $14.5 million in customs duty (see Table 2.1.1). In contrast, 2015 saw a marginal decline in this quantity where 6.46 million litres were available for domestic consumption, however, valued slightly higher at $27.4 million, and contributed $14.6 million in 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 2.31 million litres in 2014, valued at $15.8 million, and 2.34 million litres in 2015, valued at $15.2 million, were placed in bonded warehouses upon importation for future consumption (see Table 2.1.2). Wine in containers holding two litres or less and rum and other spirits accounted for the bulk of alcohol and alcoholic beverages placed in bonded warehouses in both years under review.

At the same time, in 2014, 923 thousand litres of alcohol and alcoholic beverages were exported from bonded warehouses, valued at $3.6 million, with $21,864 received in customs duty (see Table 2.1.3). In 2015, however, a larger quantity of 1.1 million litres were exported from bonded warehouse, valued at $3.9 million, with $20,805 received in customs duty, which was slightly lower than the duty amount received in the previous year.

The value of tobacco and tobacco products available for domestic consumption saw an increase from the $3.0 million recorded in 2014 to $3.2 million in 2015 (see Table 2.1.4), consequently increasing the duty received from $8.1 million to $8.4 million. The major component of tobacco imports is that of cigarettes, with 43 thousand kilograms and 38.5 million units, valued at $2.5 million, being brought to the Island in 2015 or removed from bonded warehouses, contributing $8.2 million towards customs duty. In comparison, the year 2014 saw 53 thousand kilograms and 37.1 million units, valued at $2.3 million, were brought to the Island or removed from bonded warehouses, contributing $7.9 million towards customs duty. In both 2014 and 2015, there were quantities of cigarettes that were placed into bonded warehouses and some that were removed for export (see Tables 2.1.5 and 2.1.6).

[5] Customs Department. (2014). Bermuda Customs Tariff 2014. Government of Bermuda. p. 77-78, 81.

[6] 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), 2014 and 2015

Tariff Code	Description	2014			2015		
		Litreage	Value ($)	Duty ($)	Litreage	Value ($)	Duty ($)
2203.000	Beer	3,970,900.56	7,036,353.91	3,931,191.63	3,878,057.87	6,624,127.91	3,839,277.29
2204.100	Sparkling Wine	102,098.53	1,653,043.09	289,459.67	118,781.28	1,837,589.57	338,264.95
2204.210	Wine in containers holding 2 litres or less	1,284,566.06	11,175,220.20	3,684,983.99	1,296,697.70	11,643,510.84	3,718,464.64
2204.290	Wine in containers greater than 2 litres	86,790.55	1,094,136.31	250,579.19	89,401.52	943,943.87	258,318.58
2204.300	Other Grape Must	572.50	2,745.92	1,654.54	518.75	8,873.46	1,499.20
2205.100	Vermouth in containers holding 2 litres or less	3,604.40	12,510.58	10,416.73	5,206.65	32,159.13	15,012.56
2205.900	Vermouth in containers holding greater than 2 litres	23.73	255.12	68.59	4,377.50	39,518.55	12,650.98
2206.000	Other Fermented Beverages	131,834.47	341,214.27	185,886.80	171,374.24	393,786.24	241,637.79
2207.100	Undenatured Ethyl Alcohol	352.62	1,787.44	8,632.58	471.96	1,930.98	9,432.08
2207.200	Denatured Ethyl Alcohol	-	-	-	456.03	879.15	307.39
2208.200	Brandy and Cognac	23,710.88	469,840.56	243,385.32	25,987.18	532,080.01	269,109.30
2208.300	Whiskies	97,606.13	1,400,974.55	1,000,048.45	96,025.63	1,397,081.57	980,520.33
2208.400	Rum and Other Spirits Distilled from Sugar Cane	263,166.82	1,298,101.54	2,282,957.83	236,922.41	1,259,024.63	2,185,897.24
2208.500	Gin and Geneva	23,312.40	184,739.84	248,578.50	22,909.30	193,960.69	239,117.30
2208.600	Vodka	166,391.72	1,147,684.11	1,501,773.58	160,506.29	1,183,454.13	1,604,940.45
2208.700	Liqueur & Cordials	63,883.58	641,728.55	428,221.75	62,210.45	669,429.74	421,024.16
2208.900	Other Spirituous Beverages	308,312.87	727,825.97	468,735.79	291,313.22	672,745.69	450,887.14
	TOTAL	**6,527,127.82**	**27,188,161.96**	**14,536,574.94**	**6,461,217.98**	**27,434,096.16**	**14,586,361.38**

Source: HM Customs

Table 2.1.2
Quantity and Value of Bonded Alcohol and Alcoholic Beverages Placed in Bonded Warehouses Upon Arrival**, 2014 and 2015*

Tariff Code	Description	2014		2015	
		Litreage	Value ($)	Litreage	Value ($)
2203.000	Beer	3,578.40	7,933.80	6,000.00	6,836.00
2204.100	Sparkling Wine	80,132.27	1,401,277.75	85,503.97	1,185,231.87
2204.210	Wine in containers holding 2 litres or less	833,484.48	8,114,113.61	823,793.17	7,674,057.92
2204.290	Wine in containers greater than 2 litres	11,616.00	26,883.53	16,297.00	37,934.01
2204.300	Other Grape Must	-	-	-	-
2205.100	Vermouth in containers holding 2 litres or less	2,106.00	5,626.05	4,248.00	12,635.43
2205.900	Vermouth in containers holding greater than 2 litres	-	-	-	-
2206.000	Other Fermented Beverages	4,171.86	28,208.10	8,110.68	34,757.95
2207.100	Undenatured Ethyl Alcohol	-	-	-	-
2207.200	Denatured Ethyl Alcohol	-	-	-	-
2208.200	Brandy and Cognac	23,926.10	537,892.31	29,331.60	661,831.74
2208.300	Whiskies	76,889.10	1,089,788.51	74,644.50	1,225,832.24
2208.400	Rum and Other Spirits Distilled from Sugar Cane	1,092,450.70	2,958,432.01	1,097,508.50	2,664,733.85
2208.500	Gin and Geneva	15,972.00	114,105.77	21,314.25	191,347.88
2208.600	Vodka	108,828.30	863,043.95	112,173.00	863,211.28
2208.700	Liqueur & Cordials	43,917.85	439,839.93	46,753.70	445,273.77
2208.900	Other Spirituous Beverages	17,202.75	222,571.81	13,772.25	153,134.16
	TOTAL	**2,314,275.81**	**15,809,717.13**	**2,339,450.62**	**15,156,818.10**

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, 2014 and 2015*

Tariff Code	Description	2014			2015		
		Litreage	Value ($)	Duty ($)	Litreage	Value ($)	Duty ($)
2203.000	Beer	-	-	-	-	-	-
2204.100	Sparkling Wine	646.00	27,931.50	126.42	532.50	25,091.14	103.12
2204.210	Wine in containers holding 2 litres or less	-	-	-	1,455.00	12,432.36	23.26
2204.290	Wine in containers greater than 2 litres	12.00	22.52	3.00	-	-	-
2204.300	Other Grape Must	-	-	-	-	-	-
2205.100	Vermouth in containers holding 2 litres or less	-	-	-	-	-	-
2205.900	Vermouth in containers holding greater than 2 litres	-	-	-	-	-	-
2206.000	Other Fermented Beverages	-	-	-	-	-	-
2207.100	Undenatured Ethyl Alcohol	-	-	-	15.14	52.65	1.82
2207.200	Denatured Ethyl Alcohol	-	-	-	-	-	-
2208.200	Brandy and Cognac	4,467.05	146,078.71	1,116.96	4,948.30	162,906.77	1,237.26
2208.300	Whiskies	5,503.15	138,723.63	1,375.90	3,741.70	103,992.27	935.50
2208.400	Rum and Other Spirits Distilled from Sugar Cane	890,053.50	3,058,316.57	13,557.90	1,066,810.00	3,482,831.94	14,495.67
2208.500	Gin and Geneva	2,985.00	29,401.74	746.25	2,597.00	26,558.72	649.25
2208.600	Vodka	5,441.50	66,214.41	1,360.46	4,045.50	52,799.78	1,011.45
2208.700	Liqueur & Cordials	5,367.80	51,243.55	1,342.09	3,549.80	34,415.13	887.58
2208.900	Other Spirituous Beverages	8,940.85	56,283.11	2,235.28	5,840.75	35,443.92	1,460.29
	TOTAL	**923,416.85**	**3,574,215.74**	**21,864.26**	**1,093,535.69**	**3,936,524.68**	**20,805.20**

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.

Table 2.1.4

Quantity, Value, and Duty of Tobacco and Tobacco Products for Home Consumption (Imports and Removals from Bonded Warehouses), 2014 and 2015

Tariff Code	Description	2014			2015		
		Quantity	Value ($)	Duty ($)	Quantity	Value ($)	Duty ($)
2401.100	Tobacco, Not Stemmed/Stripped	22.73 kg	763.38	6.59	22.28	1,295	6.47
2401.200	Tobacco, Partly or Wholly Stemmed/ Stripped	2 kg	37.96	0.58	-	-	-
2402.100	Cigars, Cheroots, etc. Containing Tobacco	41,200.82 kg	509,849.98	153,318.31	5,913.82 kg	531,001.44	160,948.36
2402.200	Cigarettes Containing Tobacco	52,555.27 kg 37,137,140 u	2,349,569.59	7,864,414.80	42,805.88 kg 38,509,722 u	2,499,173.61	8,174,390.84
2402.900	Other Tobacco Products; or Products of Tobacco Substitutes	22 kg	77.95	16.06	50.91 kg	2,012.10	674.06
2403.110	Water Pipe Smoking Tobacco	2,280.35 kg	52,813.52	17,692.54	5,331.28 kg	85,056.66	28,493.98
2403.190	Other Smoking Tobacco	355 kg	5,236.38	1,754.19	110.00 kg	1,553.04	520.27
2403.910	"Homogenised" or "Reconstituted" Tobacco	-	-	-	-	-	-
2403.990	Tobacco Extracts and Essences; Other Manufactured Products of Tobacco	3,651.16 kg	69,929.19	23,426.28	2,576.00 kg	51,372.32	17,209.73
9803.163	Smoking Tobacco; Cigars, Cheroots and Cigarillos, Containing Tobacco (Imported by Post or Courier)	4,117 u	20,380.15	6,827.34	2,050 u	12,250.21	4,103.81
	TOTAL	**100,089.33 kg 37,141,257 u**	**3,008,658.10**	**8,067,456.69**	**56,810.17 kg 38,511,772 u**	**3,183,714.38**	**8,386,347.52**

Source: HM Customs

Table 2.1.5
Quantity and Value of Bonded Tobacco and Tobacco Products Placed in Bonded Warehouses Upon Arrival**, 2014 and 2015*

Tariff Code	Description	2014		2015	
		Quantity	Value ($)	Quantity	Value ($)
2401.100	Tobacco, Not Stemmed/Stripped	-	-	-	-
2401.200	Tobacco, Partly or Wholly Stemmed/Stripped	-	-	-	-
2402.100	Cigars, Cheroots, etc. Containing Tobacco	36,189.20 kg	76,833.38	528.10 kg	124,941.57
2402.200	Cigarettes Containing Tobacco	3,041.28 kg 2,400,000 u	147,143.05	5,110.85 kg 3,985,000 u	260,528.80
2402.900	Other Tobacco Products; or Products of Tobacco Substitutes	-	-	-	-
2403.110	Water Pipe Smoking Tobacco	-	-	-	-
2403.190	Other Smoking Tobacco	-	-	-	-
2403.910	"Homogenised" or "Reconstituted" Tobacco	-	-	-	-
2403.990	Tobacco Extracts and Essences; Other Manufactured Products of Tobacco	-	-	-	-
9803.163	Smoking Tobacco; Cigars, Cheroots and Cigarillos, Containing Tobacco (Imported by Post or Courier)	-	-	-	-
	TOTAL	**39,230.48 kg 2,400,000 u**	**223,976.43**	**5,638.95 kg 3,985,000 u**	**385,470.37**

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, 2014 and 2015*

Tariff Code	Description	2014		2015	
		Quantity	Value ($)	Quantity	Value ($)
2401.100	Tobacco, Not Stemmed/Stripped	-	-	-	-
2401.200	Tobacco, Partly or Wholly Stemmed/Stripped	-	-	-	-
2402.100	Cigars, Cheroots, etc. Containing Tobacco	32.51 kg	12,290.16	-	-
2402.200	Cigarettes Containing Tobacco	2,608.21 kg 2,451,620 u	156,377.46	2,379.71 kg 1,985,600 u	163,243.80
2402.900	Other Tobacco Products; or Products of Tobacco Substitutes	-	-	-	-
2403.110	Water Pipe Smoking Tobacco	-	-	-	-
2403.190	Other Smoking Tobacco	-	-	-	-
2403.910	"Homogenised" or "Reconstituted" Tobacco	-	-	-	-
2403.990	Tobacco Extracts and Essences; Other Manufactured Products of Tobacco	-	-	-	-
9803.163	Smoking Tobacco; Cigars, Cheroots and Cigarillos, Containing Tobacco (Imported by Post or Courier)	-	-	-	-
	TOTAL	**2,640.72 kg 2,451,620 u**	**168,667.62**	**2,379.71 kg 1,985,600 u**	**163,243.80**

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.[7] 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).[8] 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 2014 and 2015, most licences were issued to establishments in the Central district, followed by the Western and Eastern districts. There has been a marked increase of 15% in the number of licences issued to establishments between 2014 and 2015, moving from 240 to 276; the vast majority consisted of renewed liquor licences. Applications for licences primarily consisted of persons or companies which already had licences for other businesses. Therefore, in most instances, the LLA was satisfied that applicants were fit to manage a licensed premise.

The Liquor Licence Authority has also issued occasional liquor licences, which climbed by 15.6%, increasing from 327 in 2014 to 378 in 2015. Unlike in 2014, there was only one instance in 2015 where a licence was issued for an al fresco (outdoors) event. Overall, there has been a sharp rise, by 11.8%, in the total number of liquor licences issued, that is, from 585 being granted in 2014 to 654 in 2015.

Overall, there has been a sharp rise, by 11.8%, in the total number of liquor licences issued…

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

[8] Ibid. p. 9.

Table 2.2.1
Liquor Licenses Issued by District and Type of Licence, 2014 and 2015

Districts and Type of Licence	2014	2015
CENTRAL	**157**	**170**
Class 'A'	40	48
Class 'B'	3	2
Tour boat	29	34
Nightclub	4	4
Restaurant	49	51
Hotel	9	9
Members' club	20	20
Permit for association or organisation	1	1
Al fresco	2	1
WESTERN	**37[r]**	**57**
Class 'A'	19	20
Class 'B'	1	1
Restaurant	1	23
Hotel	4[r]	4
Members' club	3	8
Nightclub	8	-
Proprietary club licence	1	1

Table 2.2.1 cont'd

Liquor Licenses Issued by District and Type of Licence, 2014 and 2015

Districts and Type of Licence	2014	2015
EASTERN	**46**	**49**
Class 'A'	15	16
Class 'B'	-	1
Restaurants	17	17
Hotel	4	5
Member's Club	7	8
Night Club	1	-
Al Fresco	1	-
Permit for Association or Organisation	**1**	**-**
Total Licences Issues to Establishments	**240[r]**	**276**
Annual Percentage Change in Total Licences Issued to Establishments	**-2.3**	**15.0**
Total Occasional Liquor Licences Island-Wide	**327**	**378**
Annual Percentage Change in Total Occasional Liquor Licences Island-Wide	**-3.3**	**15.6**
Total Licences Issued	**585**	**654**
Annual Percentage Change in Total Licences Issued	**-2.8**	**11.8**

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 2015, there was one additional TIPS training sessions than in 2014 (from 18 to 19). However, the number of participants slightly increased from 2014 to 2015, while the number of participating establishments declined markedly year over year (see Table 3.1.1). A total of 249 participants (managers, owners, and supervisors) from 109 licenced establishments were trained (an establishment could have been represented by different participants over the year and hence the number of establishments is not unique) in 2015 compared to 47 participants from 126 licenced establishments in the previous year; averaging 13 participants per session in 2015 and 14 in 2014. In terms of training outcome, fewer persons passed the TIPS training in 2015 than in 2014 and there were also more failures in the most recent year when compared to the previous year.

Table 3.1.1
Training for Intervention ProcedureS (TIPS) Programme Statistics, 2014 and 2015

Year/Quarter	Number of TIPS Sessions	Number of Participants	Average Number of Participants Per Session	Outcome		Number of Participated Establishments
				Passed	Failed	
2014	**18**	**247**	**14**	**225**	**22**	**126**
Q1	5	75	15	67	8	42
Q2	5	74	15	68	6	39
Q3	5	64	13	58	6	26
Q4	3	34	11	32	2	19
2015	**19**	**249**	**13**	**209**	**40**	**109**
Q1	5	42	8	36	6	22
Q2	5	74	14	60	14	30
Q3	5	86	17	71	15	42
Q4	4	47	12	42	5	15

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.

The number of persons who accessed services at BARC remained stable over the last two years. In 2015, a total of 207 clients were seen by BARC as compared to 206 in the previous year (see Tables 4.1.1 and 4.1.2). Over the two-year period, the number of new clients accessing services at BARC (assessments and referrals of persons seeking treatment for the first time) increased by 26% from 77 cases in 2014 to 97 in 2015 (see Table 4.1.1); while, at the same time, the number of existing or repeat cases (assessments and referrals of clients who previously accessed services at BARC) decreased by 14.7% from 129 in 2014 to 110 in 2015 (see Table 4.1.2). However, in both years, repeat clients accounted for the greater proportion of all referrals. For instances, 110 (53.1%) of the 206 referrals in 2015 were cases of existing referrals compared to 97 (46.9%), which were cases of new 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 reenter 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 (90.3% or 187 in 2015). Blacks were also more likely be seeking assessment for yet another time(s) compared to Whites or persons of other races (see Tables 4.1.1 and 4.1.2).

Overall, while the largest number of all referred persons were between the ages of 31 to 45 years (31.9% or 66 in 2015), persons newly referred to BARC were more likely to be within this age group or younger, that is 17 to 30 years; as compared to repeat clients, who tended to be in this age group or older, that is, 46 to 60 years (see Tables 4.1.1 and 4.1.2).

…new clients sought treatment mainly for cannabis and alcohol; existing clients primarily sought treatment for cannabis and opiates…

Cannabis, alcohol, opiates or heroin, and cocaine remained the primary drugs of choice for which persons were seeking treatment during the past two years (see Tables 4.1.1 and 4.1.2). However, new clients sought treatment mainly for cannabis and alcohol in both 2014 and 2015, as compared to existing clients, who primarily sought treatment for cannabis and opiates in 2015, but for opiates and cocaine in the previous year. Nonetheless, there was a decrease in the number of new clients who sought treatment for cannabis and alcohol in contrast to those who sought treatment for cocaine and opiates, which increased marginally, year over year. In terms of repeat clients, there was a noticeable decrease in the number of clients who sought treatment for any of the drugs under consideration.

Most of both the new and existing referrals tended to be dependent or have abused one drug. There were also instances where persons reported dependence or abuse 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).

A consistent observation over the years is that, collectively, a larger proportion of both the new and existing clients tended to be clinically dependent on their drug(s) of choice versus being abusers (see Tables 4.1.3 and 4.1.4). However, in the two years under review this was not the case in that there were slightly more persons who were diagnosed as being clinical abusers (160 clients in 2014 and 226 in 2015) of their drug(s) of choice rather than being dependent (157 clients in 2014 and 129 in 2015); with new clients more likely to be abusers and repeat clients more likely to be dependent on their drug(s) of choice (see Tables 4.1.3 and 4.1.4). It should be noted that clients might have indicated the use of one or more drug and consequently could be diagnosed as being dependent on one and abusing the other, dependent on all, or abusing all. Hence, the categories of abuse and dependence will exceed the total number of clients but records the drug(s) on which the client is dependent or abusing.

A greater number of referrals to BARC was made through the Magistrate's Court, directly by the persons who were seeking treatment (self-referral), Turning Point, or via the Department of Court Services. Most of the new referrals came from the Magistrate's Court, while most of the repeat clients were self-referred. This trend remained unchanged from previous years. The pattern of referral was similar as

in previous years where most of the referrals to treatment services were made to the Turning Point Substance Abuse Programme, for either outpatient or intensive outpatient care (IOP), and, in some instances, to be followed by residential care.

The Drug Abuse Screening Test (DAST) scores showed that of all clients to whom the assessment was administered in both 2014 and 2015, about one out of every four was classified as having substantial to severe substance (drug) abuse disorders, that is, 47 or 27% in 2014 and 27 or 22.7% in 2015 (see Tables 4.1.5 and 4.1.6). Similarly, the Alcohol Dependence Scale scores indicate that of all clients to whom this test was administered, 5.4% (nine) in 2014 and 7.3% (nine) in 2015 were classified as having substantial to severe alcohol dependence (see Tables 4.1.7 and 4.1.8). The tests were not administered in a number of instances where clients self-reported no use of alcohol or drugs in the days preceding his/her assessment.

Table 4.1.1
Bermuda Assessment and Referral Centre Programme Statistics for New Referrals, 2014 and 2015

	2014	2015
Total New Referrals:	**77**	**97**
Annual Percentage Change	**-37.9**	**26.0**
Sex:		
Males	58	77
Females	19	20
Age (Years):		
16 & Under	-	-
17–30	26	26
31–45	25	27
46–60	21	17
61–75	4	7
76+	1	-
Not stated	-	20
Race:		
Black	65	82
White	8	10
Portuguese	4	-
Mixed	-	-
Other	-	1
Not stated	-	4
Drug of Choice (Dependence Or Abuse):		
Cannabis	44	34
Alcohol	46	27
Cocaine	9	10
Opiates	6	9
Other	-	1
None	1	1
Not stated	9	18
One drug	34	57
Two drugs	28	15
Three drugs	5	4
Not stated	10[r]	21

Source: Bermuda Assessment and Referral Centre

Table 4.1.1 cont'd

Bermuda Assessment and Referral Centre Programme Statistics for New Referrals, 2014 and 2015

	2014	2015
Level of Care:		
Level I –- Outpatient	27	30
Level II – IOP	32	28
Level III & IV – Residential (Medically Monitored/Managed Intensive Inpatient Treatment)	1	3
None	16	7
Not stated	1	29
Referred From:		
Magistrate's Court	21	30
Self-Referral	14	11
Court Services (including DTC, Probation Team, Parole Officer)	9	10
Turning Point	6	6
Family Services	7	4
EAP	6	4
Other/Other Community	1	3
Private Practice	4	2
Supreme Court	2	2
Corrections	1	-
MWI	1	1
Financial Assistance	3	-
Family Court	2	-
Not stated	-	24
Referred To:		
Turning Point	50	37
Court Services	-	3
EAP	-	3
Men's Treatment	2	2
Other	2	2
Private Practice	-	1
BYCS/CLSS	3	-
Harbour Light	-	-
WTC	1	-
None	16	12
Refusal	-	2
Not stated	3	35

Source: Bermuda Assessment and Referral Centre

Table 4.1.2
Bermuda Assessment and Referral Centre Programme Statistics for Existing Referrals, 2014 and 2015

	2014	2015
Total New Referrals:	**129**	**110**
Annual Percentage Change	**-29.5**	**-14.7**
Sex:		
Males	103	95
Females	26	15
Age (Years):		
16 & Under	-	-
17–30	18	15
31–45	47	39
46–60	62	36
61–75	2	8
76+	-	-
Not stated	-	9
Race:		
Black	120	105
White	7	4
Portuguese	2	-
Mixed	-	-
Not stated	-	1
Drug of Choice (Dependence Or Abuse):		
Cannabis	56	48
Opiates	73	45
Cocaine	64	36
Alcohol	50	31
Methadone	1	-
None	1	-
Not stated	-	17
One drug	39	45
Two drugs	62	29
Three Drugs	27	19
Not stated	-	17
Level of Care:		
Level 1 – Outpatient	22	16
Level II – IOP	50	40
Level III and IV – Residential (medically monitored/managed intensive inpatient treatment)	42	17
None	4	3
Not stated	11	24
Referred From:		
Self-Referral	49	23
Turning Point	15	18
Court Services (including DTC, Probation Team, Parole Officer)	22	17
Magistrate's Court	19	11
Corrections	5	3
Private Practice	-	3
Supreme Court	2	2
MWI	-	2

Table 4.1.2 cont'd
Bermuda Assessment and Referral Centre Programme Statistics for Existing Referrals, 2014 and 2015

	2014	2015
Referred From:		
Other/Other Community	6	1
Family Services	5	1
Family Court	1	1
EAP	-	1
CMIT	-	1
Harbour Light	-	1
Men's Treatment	-	1
Mental Health Treatment Court	-	2
Focus	1	-
Financial Assistance	3	-
Not stated	1	22
Referred To:		
Turning Point	95	61
Men's Treatment	6	5
WTC	7	2
Residential (including RLH)	10	3
Harbour Light	1	3
Other	1	2
Court Services	-	1
Focus	1	-
None	4	5
Not stated	4	28

Source: Bermuda Assessment and Referral Centre

Table 4.1.3
Clinical Diagnosis (Abuse or Dependence) of New and Existing Clients' Drug Use by Drug(s) of Choice, 2014

Drug of Choice	Abuse		Dependence		Deferred Diagnosis	
	New Clients	Existing Clients	New Clients	Existing Clients	New Clients	Existing Clients
Alcohol	23	20	13	23	10	7
Cannabis	25	40	14	10	5	6
Cocaine	3	36	5	27	1	1
Heroin	-	13	6	59	-	1
Methadone	-	-	-	-	-	1
TOTAL	**51**	**109**	**38**	**119**	**16**	**16**

Source: Bermuda Assessment and Referral Centre

Note: A client might indicate the use of more than one drug and could therefore be diagnosed as abusing one and dependent on the other or various combinations of abuse and dependence.

Table 4.1.4
Clinical Diagnosis (Abuse or Dependence) of New and Existing Clients' Drug Use by Drug(s) of Choice, 2015

Drug of Choice	Abuse		Dependence		Deferred Diagnosis	
	New Clients	Existing Clients	New Clients	Existing Clients	New Clients	Existing Clients
Alcohol	10	16	15	20	1	-
Cannabis	20	32	10	14	-	-
Cocaine	4	8	5	20	-	-
Heroin	1	6	5	39	-	-
Methadone	-	-	-	-	-	-

Table 4.1.4 cont'd
Clinical Diagnosis (Abuse or Dependence) of New and Existing Clients' Drug Use by Drug(s) of Choice, 2015

Drug of Choice	Abuse		Dependence		Deferred Diagnosis	
	New Clients	Existing Clients	New Clients	Existing Clients	New Clients	Existing Clients
Other	-	-	1	-	-	-
TOTAL	**35**	**62**	**36**	**93**	**1**	**-**

Source: Bermuda Assessment and Referral Centre

Note: A client might indicate the use of more than one drug and could therefore be diagnosed as abusing one and dependent on the other or various combinations of abuse and dependence.

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, 2014 and 2015

		Number of Clients	
	Level of Severity (DAST Score)	2014	2015
Substance Abuse or Dependence	None (0)	4	8
	Low (1–5)	30	28
	Intermediate (6–10)	14	13
	Substantial (11–15)	5	7
	Severe (16–20)	-	-

Source: Bermuda Assessment and Referral Centre

Note: The DAST was not administered to 24 clients in 2014 and 41 clients in 2015.

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, 2014 and 2015

		Number of Clients	
	Level of Severity (ADS Score)	2014	2015
Substance Abuse or Dependence	None (0)	22	13
	Low (1–13)	37	37
	Intermediate (14–21)	8	8
	Substantial (22–30)	2	-
	Severe (31–47)	-	6

Source: Bermuda Assessment and Referral Centre

Note: The ADS was not administered to eight clients in 2014 and 33 clients in 2015.

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, 2014 and 2015

		Number of Clients	
	Level of Severity (DAST Score)	2014	2015
Substance Abuse or Dependence	None (0)	4	-
	Low (1–5)	36	22
	Intermediate (6–10)	40	28
	Substantial (11–15)	39	22
	Severe (16–20)	3	-

Source: Bermuda Assessment and Referral Centre

Note: The DAST was not administered to seven clients in 2014 and 38 clients in 2015.

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, 2014 and 2015

		Number of Clients	
	Level of Severity (ADS Score)	2014	2015
Substance Abuse or Dependence	None (0)	31	-
	Low (1–13)	55	44
	Intermediate (14–21)	5	13
	Substantial (22–30)	5	-
	Severe (31–47)	2	3

Source: Bermuda Assessment and Referral Centre

Note: The ADS was not administered to 31 clients in 2014 and 50 clients in 2015.

4.2 COUNSELLING AND LIFE SKILLS SERVICES STATISTICS

Youth Counselling

The Bermuda Youth Counselling Services (BYCS) is now called Counselling and Life Skills Services (CLSS), and 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 and after care. 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.

In comparing 2015 to 2014, there has been an increase in the number of referrals and assessments, which increased from 87 to 106 and 23 to 61 in 2015, respectively (see Table 4.2.1). CLSS has seen 111 clients in 2015, which saw a drop from the 126 clients seen in 2014. Clients are usually referred for either behavioural or substance use reasons. Of the 106 referrals received for counselling services, 34, were for substance misuse/education for adolescents; 27 of whom were engaged in services. Substance screenings or assessments were completed initially for these 27 clients, with an additional seven screenings completed over the course of the counselling process to measure progress of clients, some of whom warranted additional screening. Counsellors met with the parent(s) or legal guardians of these 27 clients for orientation to services as well as during the assessment and development of their service plan.

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 no substance groups facilitated during the 2015 year. Substance education occurred individually with clients who presented with substance misuse as an identifying need.

At the same time, there has been a marked drop in the number of family conferences, moving from 190 in 2014 to 111 in 2015. CLSS facilitated two groups based on client needs and referral trends. There was a four-session Active Parenting of Teens group, which provided 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, substances to increase parents' awareness. The other, which was a six-session Cooperating Parenting and Divorce group, provided divorced or separated parents education about dealing with conflict and shifting their focus onto their child while building a positive co-parenting alliance. There were a total of 15 group participants in both 2014 and 2015.

Table 4.2.1
Counselling and Life Skills Services Statistics, 2014 and 2015

Year	2014	2015
Number of referrals	87	106
Number of clients seen	126	111
Number of consultations	126	111
Number of readmissions	-	-
Number of assessments	23*	61
Number of family conferences	190	111
Number of discharges	66	42
Number of group participants	15	15

Source: CLSS

Note: * The Department of Child and Family Services has implemented a centralised intake and assessment process for all its services; therefore, the number of assessments has decreased for 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 a sharp increase in the number of new referrals to the programme, climbing from 32 cases being referred in 2014 to 53 in 2015 (see Table 4.3.1). Despite the climb in the number of new referrals, the programme admitted more persons in previous year than it did in 2015. In addition, persons may apply to the programme multiple times. In both 2014 and 2015, one previous participant was allowed to re-enter the programme. In 2015, one previous applicant was sentenced to probation and reviewed in DTC. Of the new referrals, 19 persons were admitted to the DTC programme in 2014 compared to only 14 in 2015. Some of the reasons provided for persons being referred to the programme in 2015 but not admitted include: four offenders were referred to the Mental Health Treatment Court programme; three offenders were sentenced to probation and released; three offenders were sentenced to probation and reviewed in DTC; two persons were deemed eligible but not suitable as their criminality superseded their substance abuse as determined during the assessment phase; three persons opted to receive other sentences rather than participate in the DTC programme; and two persons remained in observation at the end of 2015. At the same time, there was a corresponding drop in the number persons who completed Phase IV of the programme in 2015 (five) than in 2014 (nine).

It should be noted that as of 2014, the DTC programme was revised to make 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). Hence, the nine persons who completed Phase IV in 2014 and the five in 2015 are not counted as programme completions in 2014 or 2015 until they would have completed the mandatory Phase V; only one person each has finished this Phase in 2014 and 2015, respectively. As such, since the DTC programme's inception in 2001, there has now been a total of 33 programme completions with the one other person completing (Phase V) in 2015.

The DTC programme has not been able to retain all of its clients and see them through completion in either of the two years. In 2014, for instance, four persons did not complete the programme. One was released outright due to legal matters, one was sentenced to time served following a period of remand, and two were incarcerated. In the case of 2015, thirteen persons did not complete the programme. Nine were sentenced, one was sentenced to probation as that individual's index offence was deemed insufficient for the rigorous nature of the programme, and three were released as they had completed Phase IV and were deemed voluntary participants in Phase V having entered under the previous conditions of voluntary Phase V placement.

Table 4.3.1
Drug Treatment Court (DTC) Statistics, 2014 and 2015

	2014	2015
New referrals	32	53
Programme admissions	19	14
Successful completion Phase IV	9	5
Successful completion Phase V	1	1

Source: Drug Treatment Court

4.4 MEN'S TREATMENT STATISTICS

Drug Abuse among Men in Treatment

Men who were screened include all men who were admitted for services in addition to those who were still receiving treatment in the years under review. A total of 17 and 21 men were screened for drugs in 2014 and 2015, respectively. Drug screening is done randomly, on suspicion of drug use, for clients going on outings or requiring day passes, for work detail, and also for Drug and Mental Health Treatment Court programmes.

Men's Treatment (MT) collected a total of 319 urine samples of its clients to test for drug use during 2015; decreasing marginally from the 322 recorded in the previous year (see Table 4.4.1). This corresponds to 3,828 drug screens in 2015, down from 3,864 in 2014, given that each test consists of 12 substances. Nonetheless, only a small proportion of total drug screens yielded positive results (0.1%) in 2014 and none in 2015. The positive results observed in 2014 were for benzodiazepines and opiates. At the same time, in both years under review, alcohol and heroin, and to a lesser extent crack and marijuana, were the primary drugs used by men prior to treatment (see Table 4.4.2). None of the clients identified cocaine, in either year, to be their primary drug of choice prior to entering treatment.

Poly drug use was prevalent in both years with drugs in highest combination in 2015 being heroin with THC (marijuana) and crack and heroin with crack. Other two- and three-drug combinations included alcohol, heroin, and marijuana and heroin and alcohol among others (see Table 4.4.3).

Table 4.4.1
Drug Screening Results among Men in Treatment, 2014 and 2015

	2014	2015
Total Samples	322	319
Total Screens	3,864	3,828
Number of Positive Screens		
Barbiturates	-	-
Benzodiazepine	1	-
Buprenorphine	-	-
Creatinine (adulterant)	-	-
Cocaine	-	-
Methadone	-	-
Opiates (Heroin)	1	-
THC	-	-
Total	2	-
% POSITIVE SCREENS	0.1	-

Source: Men's Treatment

Table 4.4.2
Primary Drug Used by Men Prior to Treatment, 2014 and 2015

Drug	Number of Men	
	2014	2015
Alcohol	4	5
Crack	2	4
Heroin	10	9
Marijuana	1	3
TOTAL CLIENTS	**17**	**21**

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, 2014 and 2015

Combinations	Number of Clients	
	2014	2015
Three-Drug Combination:		
Heroin, Crack, THC	8	5
Alcohol, Heroin, THC	2	4
Alcohol, Crack, THC	1	1
Two-Drug Combination:		
Alcohol, THC	2	1
Alcohol, Crack	-	1
Crack, THC	1	1
Heroin, Crack	-	5
Heroin, Alcohol	-	2
Heroin, THC	-	1
TOTAL	**14**	**21**

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, decreased from 575 in 2014 to 525 in 2015 (see Table 4.5.1). However, there was an increase in the number of positive screens, which accounted for 7.2% (38) in 2015, up from 3.7% (or 21) in the previous year. Of all the substances screened, methadone was the drug most often found during urinalysis in 2015 as compared to marijuana in 2014.

At the same time, an adulterant and cocaine were the primary drugs used by most of the women prior to treatment in 2015 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 marijuana (THC) and alcohol and crack (see Table 4.5.3). Other two- and three-drug combinations included alcohol, crack, and marijuana and heroin and crack among others (see Table 4.4.3).

Table 4.5.1
Drug Screening Results among Women in Treatment, 2014 and 2015

	2014	2015
Total Samples	111	105
Total Screens	575	525
Number of Positive Screens		
Barbiturates	-	1
Benzodiazepine	-	1
Buprenorphine	-	1
Creatinine (adulterant)	1	3
Cocaine	6	3
Methadone	2	26
Opiates	4	1
THC	8	2
Total	21	38
% POSITIVE SCREENS	3.7	7.2

Source: Women's Treatment

Table 4.5.2
Primary Drug Used by Women Prior to Treatment, 2014 and 2015

Drug	Number of Men	
	2014	2015
Adulterant	1	3
Alcohol	2	2
Cocaine	6	3
Heroin	3	1
Marijuana	3	2
Methadone	1	1
TOTAL CLIENTS	**16**	**12**

Source: Women's Treatment

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, 2014 and 2015

Combinations	Number of Clients	
	2014	2015
Three-Drug Combination:		
Heroin, Crack, THC	3	4
Alcohol, Heroin, THC	2	-
Alcohol, Crack, THC	-	2
Two-Drug Combination:		
Alcohol, Crack	1	3
Crack, THC	-	1
Heroin, Crack	2	1
TOTAL	**8**	**11**

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 7,083 specimens in 2015, an increase from the 6,920 specimens in 2014 (see Table 4.6.1). Of these specimens in 2015, 41.7% (2,862) tested positive for illicit drugs compared to 37.8% (2,578) in 2014.The number of positive specimens excludes those specimens that were tested positive for prescribed medications such as opiates, benzodiazepines, and methadone. In both years, the larger number of tested specimens were provided by male clients (6,195 in 2014 and 6,128 in 2015) as compared to females (624 in 2014 and 734 in 2015); although in 2015 there was an increase in the number of specimens provided by females. The majority of positive specimens tested positive for only one drug (60.7% in 2014 and 59.9% in 2015) 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) (63.1% in 2014 and 62.6% in 2015), cocaine (49.8% in 2014 and 47.9% in 2015), and THC (marijuana) (26.5% in 2014 and 25.3% in 2015) (see Table 4.6.3). Noticeably, positive screens for opiates, cocaine, marijuana, and benzodiazepines increased from 2014 but those for alcohol and OxyContin dropped year over year.

Over the two-year period under review, the total number of methadone clients increased from an average of 113 clients in 2014 to 125 in 2015 (see Table 4.6.4). Similarly, inpatient detoxes also rose from 79 clients in 2014 to 103 in 2015; while, at the same time, outpatient detoxes remained low to non-existent with only one client in 2014 and none in 2015.

Table 4.6.1
Proportion of Positive Drug Screens and Poly Drug Use by Turning Point Clients, 2014 and 2015

		2014	2015
Total specimens requested		**6,920**	**7,083**
	from females	647	768
	from males	6,273	6,315
Total specimens provided		**6,819**	**6,868**
	by females	624	734
	by males	6,195	6,128
Total positive specimens for illicit drugs*		2,578	2,862
% Positive specimens of total specimens provided		37.8	41.7
Positive Specimens for Drugs+			
	for one drug	1,565	1,713
Poly Drug Use	for two drugs	878	888
	for three drugs	209	206
	for more than three drugs	46	55

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, 2014 and 2015

Drug	2014	2015
Methadone	6,616 (97.0%)	6,730 (98.0%)
Opiates	1,628 (23.9%)	1,793 (26.1%)
Cocaine	1,284 (18.8%)	1,371 (20.0%)
Marijuana	683 (10.0%)	724 (10.5%)
Benzodiazepines	27 (0.4%)	128 (1.9%)
Alcohol	101 (1.5%)	67 (1.0%)
OxyContin	23 (0.3%)	18 (0.3%)
Other	168 (2.5%)	140 (2.0%)

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, 2014 and 2015

Drug	2014	2015
Opiates	1,628 (63.1%)	1,793 (62.6%)
Cocaine	1,284 (49.8%)	1,371 (47.9%)
Marijuana	683 (26.5%)	724 (25.3%)
Benzodiazepines	27 (1.0%)	128 (4.5%)
Alcohol	101 (3.9%)	67 (2.3%)
OxyContin	23 (0.9%)	18 (0.6%)
Other	168 (6.5%)	140 (4.9%)

Source: Turning Point Substance Abuse Programme

Table 4.6.4
Number of Methadone Clients, Inpatient, and Outpatient Detoxifications at Turning Point, 2014 and 2015

Year	Methadone Clients*	Inpatient Detoxes	Outpatient Detoxes
2014	113	79	1
2015	125	103	-

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 both 2014 and 2015, the RLH had a maximum of 18 residents in care; however, in 2015, the average number of residents over the 12 months dropped to 11 when compared to 15 in 2014 (see Tables 4.7.1 and 4.7.2). There were at most five persons who were placed on the waiting list for admissions in 2015 versus eight persons in 2014. Persons from the wait list did not get into the residential programme immediately, although it was not full to capacity, 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 at most nine clients in 2014 and seven in 2015. 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, 256 screening tests were conducted in 2014 versus 211 in 2015, with no positive substance abuse test result recorded in 2015 but one in 2014.

Table 4.7.1
Right Living House Programme Statistics, 2014

Programme Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2014
Number of Residents	18	18	18	18	17	14	13	12	11	13	12	15	15*
Total Programme Admissions	2	1	-	-	-	-	1	-	2	-	3	2	11
Number of Discharges	-	1	-	1	3	1	2	1	-	1	-	2	12
Number of Substance Abuse Tests	36	19	24	36	29	24	22	12	7	12	19	16	256
Random Tests	17	-	4	7	2	5	8	4	-	5	12	-	64
Tests for Outings & Day Passes	19	19	20	29	25	16	6	8	7	7	7	16	179
Work Detail	-	-	-	-	2	2	8	-	-	-	-	-	12
Suspicious Tests	-	-	-	-	-	1	-	-	-	-	-	-	1
Number of Positive Substance Abuse Tests	-	-	-	-	-	-	-	-	-	-	-	1	1
Wait Listed for Admission	3	4	4	4	2	4	3	3	8	8	6	4	4*
Residents in Aftercare	9	9	8	8	6	6	8	8	7	7	7	7	8*

Source: Right Living House

Note: *Average

Table 4.7.2
Right Living House Programme Statistics, 2015

Programme Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2015
Number of Residents	15	14	13	11	10	12	10	11	11	11	8	8	11*
Total Programme Admissions	-	-	-	-	2	-	2	-	-	-	1	-	5
Number of Discharges	1	1	2	1	-	2	1	-	-	1	3	-	12
Number of Substance Abuse Tests	18	18	17	14	18	11	31	19	28	17	11	9	211
Random Tests	12	10	13	8	9	5	22	4	7	8	8	6	112
Tests for Outings & Day Passes	6	3	4	6	9	6	9	9	9	9	3	3	76
Work Detail	-	-	-	-	-	-	-	6	12	-	-	-	18
Suspicious Tests	-	5	-	-	-	-	-	-	-	-	-	-	5
Number of Positive Substance Abuse Tests	-	-	-	-	-	-	-	-	-	-	-	-	-
Wait Listed for Admission	4	4	5	5	5	5	3	4	4	4	4	4	4*
Residents in Aftercare	7	7	4	4	3	3	2	3	2	3	5	5	4*

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 slightly below capacity, during all of the quarters of both FY 2014/2015 and 2015/2016, ranging from eight to 11 (see Table 4.8.1). On average, one to three clients were admitted in each quarter while, at the same time at most three clients completed the programme; but there were quarter(s) in both years where there were no programme completions. The programme randomly conducts drug tests with its clients and only one of the tests administered to clients in the fourth quarter of the FY 2014/2015 year proved to be positive for an illicit substance.

On the other hand, 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 to 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 as low as 30 clients in the first quarter of FY 2014/2015 to as many as 38 clients in the fourth quarter of that same year and second quarter of FY 2015/2016. The FY 2015/2016 started with 34 clients participating in the programme and ended with 31 clients in the fourth quarter. As many as five new referrals were made in the fourth quarter of 2014/2015 but in Q3 of FY 2015/2016 there was only one referral. During the past two years only two group sessions were conducted in each quarter because of the cut in grant funding. However, a number of clients did receive crisis intervention, more so in FY 2015/2016 than in the previous year; and quite a few families also received relapse prevention education. 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, two to 14 clients successfully reintegrated. At the same time five to six clients were in stable committed relationships. 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 and the data shows that a significant number of clients did, in fact, abstain from drug use, averaging over 30 clients in any given quarter over the last two years under review.

Table 4.8.1
Salvation Army Harbour Light Residential Treatment Programme Performance, 2014/2015 and 2015/2016

Programme Indicators	FY 2014/2015				FY 2015/2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Intakes/Screenings/Assessments	2	6	6	4	5	3	3	2
Enrollment	2	2	2	3	1	1	3	2
Completions	[2]	1	-	2	3	-	-	1
Total Clients	10	9	8	11	8	9	10	9
Random Drug Tests	10	-	-	11	2	-	-	10
Positive Drug Tests	-	-	-	1	-	-	-	-
NA/AA Meetings (Mandatory)	36	36	36	36	36	36	36	36
Community Outreach: Volunteer Days	5	5	5	5	5	5	5	5
Community Outreach: Number of Client's Volunteering	5	3	3	2	2	6	6	4
Community Outreach: Other Activities	2	1	3	3	2	2	2	2

Source: Salvation Army

Table 4.8.2
Salvation Army Community Life Skills Recovery Programme Performance, 2014/2015 and 2015/2016

Programme Indicators	FY 2014/2015[r]				FY 2015/2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total number of clients who participated in the programme	30	31	32	38	34	38	33	31
Number of new clients referred	2	3	2	5	3	2	1	2
New care plans	2	3	2	5	3	2	1	2
Care plans reviewed	2	2	2	3	3	1	1	1
Number of intakes/screenings/ assessments	2	3	2	5	3	2	2	2
Number of evening groupsr	2	2	2	2	2	2	2	2
LifeSkills training groups	-	-	1	1	1	1	1	1
Referrals for outside services	8	8	8	8	8	8	8	8
Case management sessions	10	10	10	10	10	10	10	10
Clients who received crisis intervention	4	10	8	13	16	25	13	10
Families who received relapse prevention	2	1	2	4	2	1	2	3
Clients who reintegrated with families, employment, education, community	14	8	6	11	3	6	2	9
Clients who were in stable committed relationships	5	5	6	5	5	5	6	5
Clients who obtained financial stability (financial planning and banking)	7	6	6	11	11	10	10	16
Clients who opened and reactivated bank accounts	-	2	-	-	-	-	3	2
Clients with secured savings in bank accounts	7	7	7	7	7	7	7	9
Clients who made regular payments towards outstanding bills	3	3	3	3	3	3	3	3
Clients who abstained from substance abuse	28	28	26	35	34	36	36	31

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 this time, the programme operated four houses with 15- to 22-bed capacity. There were about 14 to 19 clients who were accommodated by this programme, in any given quarter. No one was in pre-treatment in either of the two years under review. However, there were at most 17 after-care sessions in Q1 of FY 2014/2015, which then dropped to 13 sessions in the subsequent quarters, where the number of sessions remained unchanged from quarter to quarter. Each of these after-care sessions provided services to between 10 and 17 clients. Random drug tests of clients show a few positive results especially for cocaine and alcohol and to a lesser extent for opiates and THC (marijuana).

Table 4.9.1
Focus Counselling Services Supportive Residence Programme Performance, 2014/2015 and 2015/2016

Programme Indicators	FY 2014/2015				FY 2015/2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Houses	4	4	4	4	4	3	3	2
Number of Beds	22	22	22	22	22	15	22	22
Number of Clients/Occupancy	19	19	17	15	16	14	16	18
Number of Drug Tests	38	22	36	21	28	18	28	22
MDMA	-	-	-	-	-	-	-	-
THC	-	-	-	-	-	-	1	1
Opiates	2	2	1	1	1	-	1	-
Cocaine	3	-	5	2	3	4	3	2
Alcohol	2	1	3	2	3	1	3	2
Number of After-Care sessions	17	13	13	13	13	13	13	13
Average Number of Participants in After-Care	13	10	17	14	16	16	15	14

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 2014 and 2015 and the numbers of different persons who received treatment during that year, respectively. This is the second year these indicators are being monitored, and there is now a two-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, it 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, and this list of facilities/programmes has remained unchanged for the past several years with no new service provider added. These programmes offer 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 are 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 2015 number of new treatment admissions and persons in treatment saw a decline from the previous year where there were 236 new treatment admissions and 497 persons in treatment (see Tables 4.10.1 and 4.10.2). Specifically, the number of new clients admitted to treatment in 2015 was 172 (140 men and 32 women) and 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, amounted to 365 (315 men and 50 women) during this same period. As is quite noticeable, the number of males in treatment far outweigh their female counterparts. This does not mean that there are no females who need 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, for those who do meet the criteria, but cannot be accommodated because of the facility's capacity, are placed on waiting lists. These numbers are not accounted for on the tables below. In terms of capacity and utilisation of the treatment services, the majority, of almost two-thirds, was seen by the Turning Point Substance Abuse Programme for mainly inpatient detoxification or methadone maintenance. Approximately one out of every five persons who were in treatment received residential care.

…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, 2014 and 2015

Treatment Agency	2014			2015		
	Male	Female	Total	Male	Female	Total
WTC	..	10	10	..	5	5
MT	17	..	17	21	..	21
Turning Point (Methadone, Inpatient, Outpatient/Detox)	134	20	154	96	24	120
Salvation Army Harbour Light	16	..	16	11	..	11
Salvation Army Life Skills	9	3	12	7	3	10
Focus	16	..	16	-	..	-
RLH	11	..	11	5	..	5
TOTAL	203	33	236	140	32	172

Source: Treatment Agencies

Note: * An additional 10 just did intake and assessment.

Table 4.10.2
Number of Persons in Treatment, 2014 and 2015

Treatment Agency	2014			2015		
	Male	Female	Total	Male	Female	Total
WTC	..	12	12	..	7	7
MT	27	..	27	16[a]	..	16
Turning Point (Methadone, Inpatient, Outpatient/Detox)	304	44	348	228	40	268
Salvation Army Harbour Light	18	..	18	18	..	18
Salvation Army Life Skills	36	3	39	33	3	36
Focus	26	..	26	-[b]	..	-
RLH	27	..	27	20	..	20
TOTAL	438	59	497	315	50	365

Source: Treatment Agencies

Notes: [a] Fewer persons were in treatment although there were more admissions. This happened in the instances where a client did not stay beyond a certain time to receive services and therefore was not considered as being in treatment, although admitted to treatment.
[b] Due to a lack of funding, Focus Counselling Services did not run its 'Genesis' inpatient programme, which was put on hold.

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 2015 saw a decline (from 653 in 2014 to 538) 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 2014 compared to none in 2015. On the other hand, the number of anti-doping tests (of both urine and blood) increased from 68 in 2014 to 87 in 2015.

The figures in Table 5.1.2 show the breakdown of illicit drug tests conducted in each sport for the years 2014 and 2015. Most of these tests were done for the sports of football and rugby and to a lesser extent gymnastics and the other sports. On the other hand, most of the anti-doping tests were administered for competition purposes by BSADA (see Tables 5.1.4 and 5.1.4). However, no test in either year screened positive for performance enhancing drugs (see Table 5.1.1). There were more performance enhancing tests done in 2015 than in 2014; mainly by urine samples than by blood. These tests were for a number of sports but mainly for athletics, aquatics, body building 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 attend these sessions.

Table 5.1.1
Drug Testing Results at BSADA, 2014 and 2015

Year	Illicit Tests			Anti-Doping Tests	
	Number of Tests	Number of Positive		Number of Tests	Positive
		THC	Cocaine		
2014	653[r]	4	-	68	-
2015	538	-	-	87	-

Source: BSADA

Table 5.1.2
Illicit Drug Tests by Sport, 2014 and 2015

Sport	2014	2015
Archery	-	9
Athletics	30	23
Badminton	-	7
Baseball	-	-
Basketball	56	26
Bicycling	24	9
Bicycling Academy	-	6
Boccia (Para Sport)	-	5
Body Building	12	5
Bowling	36	-

Table 5.1.2 cont'd
Illicit Drug Tests by Sport, 2014 and 2015

Sport	2014	2015
Boxing	-	-
Canoe	-	-
Cricket	40	33
Darts	-	-
Equestrian	1	1
Fencing	-	-
Football	125	130
Golf	15	10
Gymnastics	61	50
Hockey	12	-
Lacrosse	-	-
Lawn Tennis	20	19
Luge	-	-
Martial Arts	7	3
Motorsports	-	-
Netball	-	14
Paralympics	-	-
Powerboat	-	-
Rowing	-	-
Rugby	155	88
Sailing	14	4
Sail Boarding	-	4
Softball	-	-
Squash	2	19
Swimming	13	31
Table Tennis	5	-
Target Shooting	-	10
Triathlon	3	6
Volleyball	22	26
Total	**653**	**538**

Table 5.1.3
Performance Enhancement Testing by National Anti-Doping Organisations (Testing Missions Issued by BSADA), 2014

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)	36	9	-	-
United States Anti-Doping (USADA)	-	16	-	3
Professional Worldwide Controls (PWC)	-	3	-	1
United Kingdom Anti-Doping (UKAD)	-	-	-	-
Canadian Center for Ethics in Sport (CCES)	-	-	-	-
Total	**36**	**28**	**-**	**4**

Table 5.1.4
Performance Enhancement Testing by National Anti-Doping Organisations (Testing Missions Issued by BSADA), 2015

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)	51	14	-	-
United States Anti-Doping (USADA)	2	15	-	5
Professional Worldwide Controls (PWC)	-	2	-	-
United Kingdom Anti-Doping (UKAD)	-	2	-	-
Canadian Center for Ethics in Sport (CCES)	-	-	-	-
Total	**53**	**33**	**-**	**5**

Table 5.1.5
Performance Enhancing Tests by Sport (Testing Missions Issued by BSADA), 2014

National Anti-Doping Organisations/ Service Provider	Urine In Competition	Urine Out of Competition	Blood In Competition	Blood Out of Competition
Aquatics	7	5	-	-
Athletics	24	13	-	-
Body Building	5	-	-	-
Cycling	-	3	-	-
Equestrian	-	-	-	-
Gymnastics	-	-	-	-
Sailing	-	-	-	-
Squash	-	1	-	-
Triathlon	-	5	-	3
Skiing	-	1	-	1
Sanshou	-	-	-	-
Total	**36**	**28**	**-**	**4**

Table 5.1.6
Performance Enhancing Tests by Sport (Testing Missions Issued by BSADA), 2015

National Anti-Doping Organisations/ Service Provider	Urine In Competition	Urine Out of Competition	Blood In Competition	Blood Out of Competition
Aquatics	15	3	-	2
Athletics	25	11	-	1
Body Building	5	6	-	-
Cycling	-	3	-	-
Equestrian	-	1	-	-
Gymnastics	4	-	-	-
Sailing	-	1	-	-
Squash	-	2	-	-
Triathlon	4	4	-	3
Skiing	-	-	-	-
Sanshou	-	3	-	-
Total	**53**	**34**	**-**	**6**

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[9] has yielded data allowing for comparison of patterns of use amongst offenders with stratified analysis according to type of drug used and whether or not persons were first-time or repeat offenders.

In 2015, 91.3% of reception inmates were screened for illicit drugs (see Table 5.2.1), 7.3% refused to participate in screening (4.1% refused in 2014), and 1.2% were released prior to specimen collection (3.7% in 2014). However, drug screening of offenders on reception increased in 2015 by 9.5% from the previous year, which saw 95.9% of specimens screened. The overall proportion of positive screens for illicit drugs increased slightly in 2015 to 148 compared to 143 positive screens in 2014 (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 2015, an increase by 35.5% in poly drug use, at the time of reception, was observed over the previous year (see Table 5.2.5). Random urine results provided evidence of mostly THC (marijuana), opiate and cocaine use (one positive screen) among offenders serving a sentence at Westgate Correctional Facility (see Table 5.2.4).

Of the reception inmates, the number of first-time offenders increased from 45 (20.5%) in 2014 to 55 (21.8%) in 2015 (see Table 5.2.6). The proportion of repeat offenders received into Westgate decreased by 9.3% over the last year moving from 79.5% in 2014 to 70.2% in 2015. 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). When it came to poly drug use, there were significantly more repeat offenders that were multiple substance users, at least at the time of reception (see Table 5.2.8).

The highest prevalence-of-use was recorded for marijuana, followed by cocaine and opiates (heroin).

[9] 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, 2014 and 2015

Year	Reception Inmates	Screened	Refused	Released
2014	219	210 (95.9)	9 (4.1)	8 (3.7)
2015	252	230 (91.3)	19 (7.3)	3 (1.2)

Source: Westgate Correctional Facility

Table 5.2.2
Percentage of Positive Illicit Drug Screens among Prison Reception Inmates, 2014 and 2015

Year	Number of Positive Illicit Drug Screens	Percentage of Total Screens
2014	143	68.1
2015	148	64.3

Source: Westgate Correctional Facility

Table 5.2.3
Drug Prevalence (Urinalysis) at Reception by Number and Proportion of Screened Offenders, 2014 and 2015

Year	Marijuana	Cocaine	Opiates	Methadone	Poly Drug Use
2014	124 (59.0)	34 (16.2)	14 (6.7)	3 (1.4)	31 (14.8)
2015	114 (49.6)	48 (20.9)	30 (13.0)	-	42 (18.3)

Source: Westgate Correctional Facility

Note: 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, 2014 and 2015

	2014	2015
Overall Positive	**13 (5.9)**	**16 (6.3)**
Marijuana	12 (5.5)	11(4.4)
Opiates	1(0.5)	4 (1.6)
Cocaine	-	1 (0.4)

Source: Westgate Correctional Facility

Table 5.2.5
Drug Prevalence at Reception by Number and Proportion of Positive Illicit Drug Screens, 2014 and 2015

Year	Marijuana	Opiates	Cocaine	Methadone	Poly Drug Use
2014	124 (86.7)	34 (23.8)	14 (9.8)	3 (2.1)	31 (21.7)
2015	114 (77.0)	48 (32.4)	30 (21.6)	-	42 (28.4)

Source: Westgate Correctional Facility

Note: Drug prevalence is derived from the number of positive results in each category compared to overall positive illicit drug screens.

Table 5.2.6
Number and Proportion of First-Time and Repeat Offenders by Year, 2014 and 2015

Year	Category of Offenders		
	Reception inmates	First time offenders	Repeat offenders
2014	219	45 (20.5)	174 (79.5)
2015	252	55 (21.8)	197 (70.2)

Source: Westgate Correctional Facility

Table 5.2.7
Any Illicit Drug Prevalence (Urinalysis) by Number and Proportion of First-Time and Repeat Offenders, 2014 and 2015

Year	Offender	Marijuana	Cocaine	Opiates
2014	Repeat offender	100 (57.4)	11 (6.3)	34 (19.5)
	First-time offender	24 (53.3)	3 (6.7)	-
2015	Repeat offender	101 (51.3)	42 (21.3)	27 (13.7)
	First-time offender	22 (40.0)	5 (9.1)	4 (7.3)

Source: Westgate Correctional Facility

Table 5.2.8
Number of First-Time and Repeater Offenders with Poly Drug Use, 2014 and 2015

Year	First-Time Offender	Repeat Offender
2014	4	27
2015	8	34

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 2015, the Prison Farm requested and collected 331 urine specimens as compared to 370 collected from 371 requested in 2014 (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, 3.9% (13) were found to be positive for an illicit substance in 2015 and

4.3% (16) in 2014. Specifically, 10 of the 16 and 11 of the 13 positive specimens, in 2014 and 2015, respectively, tested positive for THC. There were positive tests for opiates in both years (five in 2014 and one in 2015), a positive cocaine test in 2014, and a positive alcohol test in 2015.

Table 5.3.1
Drug Screening Results for Persons at the Prison Farm, 2014

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens			
			Total	THC	Opiates	Cocaine
Random	277	276	8	4	3	1
Day Pass	28	28	-	-	-	-
Pre-Parole	3	3	-	-	-	-
Suspicion	31	31	1	1	-	-
Work Detail	24	24	5	3	2	-
Spiritual Pass	-	-	-	-	-	-
Work Release	8	8	2	2	-	-
Total	**371**	**370**	**16**	**10**	**5**	**1**

Source: Department of Corrections

Table 5.3.2
Drug Screening Results for Persons at the Prison Farm, 2015

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens			
			Total	THC	Opiates	Alcohol
Random	226	226	8	8	-	-
Day Pass	13	13	-	-	-	-
Pre-Parole	2	2	-	-	-	-
Suspicion	11	11	1	-	-	1
Work Detail	73	73	4	3	1	-
Spiritual Pass	-	-	-	-	-	-
Work Release	-	-	-	-	-	-
Other	**6**	**6**	**-**	**-**	**-**	**-**
Total	331	331	13	11	1	1

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 2015, the Co-Ed facility requested and collected 77 urine specimens as compared to 58 requests and specimens received in 2014 (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 2015, 2.6% (two) were found to be positive for an illicit substance versus 17.2% (10) in 2014. Specifically, six of the 10 positive specimens tested positive for THC in 2014 while three tested positive for opiates, and one tested positive for cocaine (see Table 5.4.2). In comparison, THC was present in one of the two specimens tested to be positive in 2015 as were opiates (see Table 5.4.1).

Table 5.4.1
Drug Screening Results for Persons at the Co-Ed Facility, 2014

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens			
			Total	THC	Opiates	Cocaine
Random	41	41	7	5	2	-
Day Release	7	7	1	1	-	-
Parole	-	-	-	-	-	-
Suspicion	6	6	2	-	1	1
Work Detail	-	-	-	-	-	-
School Pass	-	-	-	-	-	-
Work Release	4	4	-	-	-	-
Total	**58**	**58**	**10**	**6**	**3**	**1**

Source: Department of Corrections

Table 5.4.2
Drug Screening Results for Persons at the Co-Ed Facility, 2015

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens			
			Total	THC	Opiates	Cocaine
Random	70	70	2	1	1	-
Day Release	1	1	-	-	-	-
Parole	-	-	-	-	-	-
Suspicion	-	-	-	-	-	1
Work Detail	-	-	-	-	-	-
School Pass	-	-	-	-	-	-
Work Release	6	-	-	-	-	-
Total	**77**	**77**	**2**	**1**	**1**	**1**

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.[10]

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 2015, there has been an increase in the number of persons who were stopped to undertake a breathalyser test…

In 2015, there has been an increase in the number of persons who were stopped to undertake a breathalyser test, when compared to 2014. This is a reversal in the trend observed over the last few years. Specifically, in 2015, 170 persons were stopped to undertake a breathalyser test compared to 131 in the year (see Table 6.1.1).

However, not all of the persons who were stopped agreed to undertake a breathalyser test; in fact, quite a number of them refused to do so, since breathalyser testing is not mandatory, not even when there has been an accident.

A larger number of males (88 in 2014 and 123 in 2014) provided a sample for testing compared to females (10 in 2014 and 16 in 2015); 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, 79 out of 98 and 113 out of 139 failed in 2014 and 2015, respectively (with 17 in 2014 and 26 in 2014 passing the breathalyser test).

Overall, the mean BAC reading for all samples provided decreased from 156 mg/dl in 2014 to 149 mg/dl in 2015 (see Table 6.1.2). At the same time, the mean BAC reading for individuals who failed the breathalyser test also decreased slightly from 181 mg/dl in 2014 to 177 mg/dl in 2015. In instances where there were accidents, the average BAC was significantly above the legal limit. In 2014, the mean failed BAC, in cases where there were accidents, was recorded at 168 mg/dl and somewhat higher at 179 mg/dl in 2015. There were also instances where accidents occurred and the average BAC was under the legal limit – 27 mg/dl in 2014 and 17 mg/dl in 2015. As a reminder, the alcohol limit in Bermuda is less than 80 mg/dl. Breathalyser readings, nonetheless, ranged from 0 to 316 mg/dl in 2014 and 0 to 1,122 mg/dl in 2015; where the upper end of the range in 2015 is equivalent to as much as over fourteen 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 2014 and 2015 (see Table 6.1.3). Only 16% (16) of those who were tested in 2014 were within the legal limit compared to 19% (26) in 2015. In both 2014 and 2015, there were a few instances where accidents occurred and the corresponding breathalyser readings were as much as three to four or times or more above the legal limit.

[10] National Highway Traffic Safety Administration. (1995). *Traffic safety facts 1994: A compilation of motor vehicle crash data from the fatal accident reporting system and the general estimates system*. Washington, DC: NHTSA, August 1995. p. 10.

Table 6.1.1
Impaired Driving Incidences by Sex and Breathalyser Results, 2014 and 2015

Year	Number of Persons Stopped	Gave Sample					Male		Female	
		Total	Male	Female	Failed	Passed	Failed	Passed	Failed	Passed
2014	**131**	**98**	**88[a]**	**10[a]**	79	17	70	17	9	-
Q1	22	14	10	4[a]	10	3	7	3	3	-
Q2	29	23	22[a]	1	19	3	18	3	1	-
Q3	42	35	34	1	28	7	27	7	1	-
Q4	38	26	22	4	22	4	18	4	4	-
2015	170	139	123	16	113	26	101	22	12	4
Q1	48	37	35	2	32	5	30	5	2	-
Q2	39	31	26	5	22	9	20	6	2	3
Q3	44	36	33	3	31	5	28	5	3	-
Q4	39	35	29	6	28	7	23	6	5	1

Source: Bermuda Police Service

Notes: [a] One incomplete reading.

Table 6.1.2
Breathalyser Readings for Impaired Driving Incidences, 2014 and 2015

	2014					2015				
	Q1	Q2	Q3	Q4	Year	Q1	Q2	Q3	Q4	Year
Mean Reading: All Breathalyser Samples	120	156*	155	175	**156***	150	135	140	171	**149**
Mean Reading: Failed Breathalyser Samples	148	167	190	195	**181**	166	18	160	206	**177**
Mean Reading: Failed Breathalyser Samples of Males	144	165	191	193	**180**	166	178	166	214	**179**
Mean Reading: Failed Breathalyser Samples of Females	156	204	167	209	**186**	176	176	99	169	**154**
Mean Reading: Accident with Failed Breathalyser Samples	120	150	176	201	**168**	193	163	161	196	**179**
Mean Reading: Accident with Passed Breathalyser Samples	9	-*	37	-	**27***	77	19	1	-	**17**
Range of Reading: Failed Breathalyser Samples	81-225	86-280	86-293	104-316	**81-316**	85-279	94-291	93-331	95-1,122	**0-78**
Range of Reading: Passed Breathalyser Samples	7-70	35-68	0-73	45-75	**0-75**	12-77	0-71	0-68	78	**85-1,122**

Source: Bermuda Police Service

Notes:
Readings in mg/dl.
* Reading was not recorded for one passed breathalyser test and therefore not included in the average.

Table 6.1.3
Number of Breathalyser Sample Readings by Limit, 2014 and 2015

Year	Within Limit	1-2 Times Above Limit	2-3 Times Above Limit	3-4 Times Above Limit	4+ Times Above Limit
2014	**16**	**27**	**40**	**12**	**-**
Q1^	3	6	4	-	-
Q2^	2*	8	8	3	-
Q3	7	8	16	4	-
Q4	4	5	12	5	-
Male	**16**	**25**	**34**	**11**	**-**
Female	**-**	**2**	**6**	**1**	**-**
Accident*	**3**	**12**	**13**	**2**	**-**
2015	**26**	**51**	**54**	**6**	**2**
Q1	5	14	17	1	-
Q2	9	9	11	2	-
Q3	5	17	12	1	1
Q4	7	11	14	2	1

Table 6.1.3 cont'd
Number of Breathalyser Sample Readings by Limit, 2014 and 2015

Year	Within Limit	1-2 Times Above Limit	2-3 Times Above Limit	3-4 Times Above Limit	4+ Times Above Limit
Male	22	45	48	6	2
Female	4	6	6	-	-
Accident	10	10	19	3	-

Source: Bermuda Police Service

Notes:
^ One reading was incomplete.
+ There were 11 other accidents in 2014 for which a result was not available (refused, incomplete, unrecorded result).

6.2 DUI EDUCATIONAL PROGRAMME STATISTICS

Counselling and Treatment for DUI Offenders

The driving under the influence (DUI) educational programme is offered by the Bermuda Professional Counselling Services (BPCS). 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, which is 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, a declining number of inquiries has been made into this programme, 37 in 2014 and 32 in 2015 (see Table 6.2.1). However, of these inquiries, only 31 and 27 persons participated in the programme in 2014 and 2015, respectively. Most of the participants in either year were males (see Table 6.2.2). In 2014 most of the participants were 31 to 35, 41 to 45, or over 50 years as compared to 2015 where most were 31 to 35 years (see Table 6.2.2).

Participants of the programme are assessed for chemical dependency and addictive behaviours using the Triage Assessment for Addictive Disorders (TAAD). The results of the TAAD showed that over half of the programme participants in 2015 were diagnosed as severe compared to slightly less than half in the previous year. More persons in 2015 were assessed to be in mid to late dependence stage of alcohol abuse or misuse, the most severe diagnosis, compared to the programme participants in 2014, where the majority of persons were considered to be in the early dependence stage, an earlier component of the severe diagnosis (using the DSM V criteria) (see Table 6.2.3). Specifically, in 2014, 16% (five) of the participants were diagnosed as mild, another 16% (five) as moderate, and 39% (12) were judged to be in the early dependence stage. In comparison, 22% (six) of the participants in 2015 were diagnosed as mild, another 15% (four) as moderate, and 33% (nine) were judged to be in the mid to late dependence stage. All of the persons who attended the programme completed it at which time they were given a certificate, which indicates that he/she has completed all aspects of the Level 1 DUI Programme.

Table 6.2.1
DUI Education Classes' Inquiries and Participants, 2014 and 2015

	2014	2015
Number of inquiries	37	32
Number of participants	31	27

Source: Bermuda Professional Counselling Services

Table 6.2.2
DUI Programme Participants' Statistics, 2014 and 2015

Year	Sex		Age							
	Male	Female	17 – 21	22 – 25	26 – 30	31 – 35	36 – 40	41 – 45	46 – 50	50+
2014	25	6	-	4	1	7	5	7	-	7
2015	23	4	-	3	5	7	3	4	-	5

Source: Bermuda Professional Counselling Services

Table 6.2.3
Triage Assessment for Addictive Disorders Results by Number of Participants, 2014 and 2015

TAAD Scores*		2014	2015
No Diagnosis		6	3
Mild		5	6
Moderate		5	4
Severe	Early Dependence	12	5
	Mid to Late Dependence	3	9
TOTAL		**31**	**27**

Source: Bermuda Professional Counselling Services

Note: * In 2014, the BPCS has transitioned from using DSM IV (used in 2013) to DSM V. The categories: No Diagnosis, Misuse, Abuser, Early Dependence, and Alcoholic under DSM IV now correspond to No Diagnosis, Mild, Moderate, Early Dependence, and Mid to Late Dependence, in DSM V, with the latter two categories considered as Severe.

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. [11]

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 data for this indicator is collected by the Epidemiology and Surveillance Unit of the Department of Health and is tracked 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 was existent in both 2014 and 2015. In particular, there were reported cases of drug-related hepatitis B and C, as evident by the one of eight and four of eight reported cases, respectively, in 2014. Similarly, in 2015, there were five drug-related cases of hepatitis C reported by the Epidemiology and Surveillance Unit. 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 this indicator 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…

[11] 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, 2014 and 2015

Infection	2014		2015	
	Number of Cases	Number of ATOD-Related Cases	Number of Cases	Number of ATOD-Related Cases
HIV	7	-	5	-
AIDS	1	-	1	-
Hepatitis B*	8	1	5	-
Hepatitis C**	8	4	6	5
Chlamydia	312	…	356	…
Gonorrhoea	25	…	27	…
Herpes	72	…	92	…
Syphilis	7	…	8	…

Source: Epidemiology & Surveillance

Notes: * 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.
** Almost all (>90%) of Hepatitis C cases are local and related to injection drug use.

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 in-patient 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 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.

King Edward Memorial VII Hospital reported a small number of inpatient cases for which drugs were the primary diagnosis during 2014 (two) and 2015 (one) (see Tables 7.2.1 and 7.2.2). Similarly, inpatient cases in which poisoning and toxic effects were the primary diagnosis, declined slightly from the 30 cases recorded in 2014 to 25 cases in 2015 (see Tables 7.2.3 and 7.2.4). Regarding secondary diagnosis cases, 1,045 cases were reported for inpatient drug-related cases in 2014 as compared to 1,076 cases in 2015 (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, and cannabis abuse; a similar trend as in previous years. Secondary diagnoses for inpatient drug-related cases over the combined years of 2013 and 2014 were more prevalent to males (1,583) than females (538). In 2014 there were 16 cases of secondary diagnosis of inpatient cases of poisoning and toxic effects of substances, whereas in 2015 there were 19 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, and cannabis abuse…

Table 7.2.1
Primary Diagnoses of Inpatient Drug-Related Cases, 2014*

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	Other
Acute Alcoholic Intoxication – Continuous	-	-	-	-	-	-	-	-	-	-	-
Opioid Type Dependence – Continuous	-	1	-	-	1	-	-	-	1	-	-
Alcohol Abuse – Unspecified	1	-	-	-	1	-	-	-	1	-	-
TOTAL	**1**	**1**	**-**	**-**	**2**	**-**	**-**	**-**	**2**	**-**	**-**

Source: King Edward VII Memorial Hospital

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

Table 7.2.2
Primary Diagnoses of Inpatient Drug-Related Cases, 2015*

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	Other
Acute Alcoholic Intoxication – Continuous	-	-	-	-	-	-	-	-	-	-	-
Opioid Type Dependence – Continuous	1	-	-	-	-	1	-	-	1	-	-
Alcohol Abuse – Unspecified	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**1**	**-**	**-**	**-**	**-**	**1**	**-**	**-**	**1**	**-**	**-**

Source: King Edward VII Memorial Hospital

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

Table 7.2.3
Primary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2014

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	Other
Poisoning – Antiviral Drugs	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Adrenal Cortical Steroids	-	-	-	-	-	-	-	-	-	-	-
-Poisoning – Insulin & Antidiabetic Agents	1	2	-	-	-	-	2	1	2	-	-
Poisoning – Antiallergic and Antiemetic Drugs	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Salicylates	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Anticonvulsants	1	-	-	-	-	-	-	1	-	1	-
Poisoning – Aromatic Analgesics Not Elsewhere Classified	2	3	2	-	1	-	2	-	2	3	-
Poisoning – Propionic Acid Derivatives	-	1	1	-	-	-	-	-	1	-	-
Poisoning – Other Antirheumatics	1	-	-	-	-	-	1	-	-	1	-
Poisoning – Other and Unspecified Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Central Nervous System Muscle Depressants	2	-	-	-	-	1	-	1	1	1	-
Poisoning – Phenothiazine Tranquillisers	1	-	-	-	-	-	1	-	1	-	-
Poisoning – Antipsychotic Not Elsewhere Classified	1	-	-	-	-	-	-	1	1	-	-
Poisoning – Benzodiazepine-Based Tranquilisers	1	1	-	-	-	-	1	1	-	2	-
Poisoning – Other Diuretics	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Hallucinogens	-	1	1	-	-	-	-	-	1	-	-
Poisoning – Selective Serotonin Reuptake Inhibitors	-	1	1	-	-	-	-	-	1	-	-
Poisoning – Antidepressant Not Elsewhere Classified	-	3	-	-	1	-	2	-	1	1	1
Poisoning – Cocaine	-	1	-	-	-	-	-	1	1	-	-
Poisoning – Parasympathomimetic	-	1	-	-	-	-	-	1	1	-	-
Poisoning – Gastrointestinal Agents Not Elsewhere Classified	1	-	1	-	-	-	-	-	1	-	-
Toxic Effect – Caustic Unspecified	-	-	-	-	-	-	-	-	-	-	-

Table 7.2.3 cont'd
Primary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2014

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	Other
Toxic Effect – Ethyl Alcohol	-	1	-	-	-	-	-	1	1	-	-
Toxic Effect – Carbon Monoxide	1	1	-	-	-	-	-	2	2	-	-
Toxic Effect – Berry/Plant Not Elsewhere Classified	1	-	1	-	-	-	-	-	-	1	-
Toxic Effect – Pesticides Not Elsewhere Classified	1	-	-	-	-	-	1	-	1	-	-
Toxic Effect – Soap and Detergents	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Other Substances Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**14**	**16**	**7**	**-**	**2**	**1**	**10**	**10**	**18**	**11**	**1**

Source: King Edward VII Memorial Hospital

Table 7.2.4
Primary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2015

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	Other
Poisoning – Antiviral Drugs	-	1	-	-	-	-	-	1	1	-	-
Poisoning – Adrenal Cortical Steroids	-	1	-	-	-	-	-	1	1	-	-
Poisoning – Insulin & Antidiabetic Agents	-	1	-	-	-	-	-	1	1	-	-
Poisoning – Antiallergic and Antiemetic Drugs	-	1	-	-	-	-	-	1	-	1	-
Poisoning – Salicylates	1	-	-	-	-	-	1	-	1	-	-
Poisoning – Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Aromatic Analgesics Not Elsewhere Classified	4	5	3	4	-	1	1	-	5	4	-
Poisoning – Propionic Acid Derivatives	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Other Antirheumatics	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Other and Unspecified Anticonvulsants	1	-	-	-	-	1	-	-	-	1	-
Poisoning – Central Nervous System Muscle Depressants	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Phenothiazine Tranquillisers	1	-	1	-	-	-	-	-	1	-	-
Poisoning – Antipsychotic Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Benzodiazepine-Based Tranquilisers	-	1	-	1	-	-	-	-	1	-	-
Poisoning – Other Diuretics	-	1	1	-	-	-	-	-	1	-	-
Poisoning – Hallucinogens											
Poisoning – Selective Serotonin Reuptake Inhibitors	-	1	1	-	-	-	-	-	1	-	-
Poisoning – Antidepressant Not Elsewhere Classified	1	-	1	-	-	-	-	-	1	-	-
Poisoning – Cocaine	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Parasympathomimetic	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Gastrointestinal Agents Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Caustic Unspecified	1	-	-	-	-	1	-	-	1	-	-
Toxic Effect – Ethyl Alcohol	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Carbon Monoxide	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Berry/Plant Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Pesticides Not Elsewhere Classified	1	-	-	-	1	-	-	-	1	-	-
Toxic Effect – Soap and Detergents	1	-	-	-	-	1	-	-	1	-	-
Toxic Effect – Other Substances Not Elsewhere Classified	1	1	1	-	1	-	-	-	1	1	-
TOTAL	**12**	**13**	**8**	**5**	**2**	**4**	**2**	**4**	**18**	**7**	**-**

Source: King Edward VII Memorial Hospital

Table 7.2.5
Secondary Diagnoses of Inpatient Drug-Related[*] Cases, 2014

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	Other[+]
Acute Alcohol Intoxication - Unspecified	-	-	-	-	-	-	-	-	-	-	-
Acute Alcoholic Intoxication - Continuous	4	1	-	-	-	-	3	2	2	3	-
Acute Alcoholic Dependence	12	-	-	-	1	-	2	-	10	2	-
Chronic Alcohol Dependence - Continuous	148	29	-	4	28	25	65	55	118	56	3
Chronic Alcohol Dependence - In Remission	8	-	-	-	-	1	3	4	3	5	-
Opioid Type Dependence - Unspecified	2	3	-	-	2	-	2	1	4	1	-
Opioid Dependence - Continuous	19	3	-	-	2	4	14	2	18	4	-
Opioid Type Dependence - In Remission	7	-	-	-	-	2	4	1	7	-	-
Cocaine Dependence - Continuous	13	4	-	-	1	4	9	3	17	-	-
Cocaine Dependence - In Remission	1	1	-	-	-	-	2	-	2	-	-
Cannabis Dependence - Continuous	1	1	-	-	1	-	-	1	2	-	-
Opioid/Other Dependence - Continuous	1	-	-	-	-	1	-	-	1	-	-
Unspecified Drug Dependence - Continuous	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse - Unspecified	18	2	-	4	3	3	7	3	14	6	-
Alcohol Abuse - Continuous	28	2	1	1	8	4	13	3	17	10	3
Alcohol Abuse - Episodic	1	-	-	-	-	-	-	1	1	-	-
Alcohol Abuse - In Remission	3	1	-	-	-	-	3	1	2	2	-
Tobacco Use Disorder	368	152	1	18	55	68	194	184	385	123	12
Cannabis Abuse - Unspecified	18	6	-	6	6	2	8	2	21	3	-
Cannabis Abuse - Continuous	96	25	2	20	22	31	35	11	108	13	-
Cannabis Abuse - Episodic	11	8	-	5	4	2	5	3	15	4	-
Cannabis Abuse - In Remission	7	2	-	-	-	-	6	3	7	2	-
Opioid Abuse - Unspecified	3	1	-	1	-	-	3	-	3	1	-
Opioid Abuse - Continuous	2	-	-	-	-	-	2	-	2	-	-
Opioid Abuse - In Remission	4	-	-	-	-	-	2	2	4	-	-
Cocaine Abuse - Unspecified	5	1	-	-	-	-	5	1	6	-	-
Cocaine Abuse - Continuous	4	2	-	-	-	-	5	1	5	1	-
Cocaine Abuse - Episodic	1	1	-	-	-	-	2	-	2	-	-
Cocaine Abuse - In Remission	8	3	-	-	-	-	8	3	10	1	-
Amphetamine Abuse - Continuous	-	1	-	-	1	-	-	-	1	-	-
Other, Mixed, or Unspecified Drug Abuse - Unspecified	1	1	-	1	-	-	-	1	2	-	-
Other, Mixed, or Unspecified Drug Abuse - Continuous	1	-	-	-	-	1	-	-	1	-	-
Other, Mixed, or Unspecified Drug Abuse - In Remission	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**795**	**250**	**4**	**60**	**134**	**148**	**402**	**297**	**790**	**237**	**18**

Source: King Edward VII Memorial Hospital

Notes:

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

Table 7.2.6
Secondary Diagnoses of Inpatient Drug-Related[*] Cases, 2015

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	Other[+]
Acute Alcohol Intoxication - Unspecified	2	-	-	1	-	-	1	-	1	1	-
Acute Alcoholic Intoxication - Continuous	5	-	-	-	-	1	3	1	3	2	-
Acute Alcoholic Dependence	8	5	-	-	1	-	4	8	8	5	-
Chronic Alcohol Dependence - Continuous	111	17	-	3	8	17	57	43	86	39	3
Chronic Alcohol Dependence - In Remission	2	1	-	-	-	-	1	2	1	2	-
Opioid Type Dependence - Unspecified	4	1	-	-	-	1	3	1	5	-	-
Opioid Dependence - Continuous	25	2	-	1	-	9	12	5	22	5	-
Opioid Type Dependence - In Remission	6	-	-	-	-	3	3	-	6	-	-
Cocaine Dependence - Continuous	14	-	-	-	1	3	8	2	8	6	-
Cocaine Dependence - In Remission	1	1	-	-	-	1	1	-	1	1	-
Cannabis Dependence - Continuous	-	-	-	-	-	-	-	-	-	-	-
Opioid/Other Dependence - Continuous	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Dependence - Continuous	1	1	-	1	-	1	-	-	-	2	-
Alcohol Abuse - Unspecified	29	10	-	8	7	4	9	11	28	10	1
Alcohol Abuse - Continuous	15	1	-	2	3	2	6	3	9	6	1
Alcohol Abuse - Episodic	-	1	-	-	-	-	-	1	1	-	-
Alcohol Abuse - In Remission	4	3	-	-	-	1	5	1	6	1	-
Tobacco Use Disorder	352	177	-	27	42	85	200	175	377	146	6
Cannabis Abuse - Unspecified	32	22	-	6	17	7	18	6	47	6	1
Cannabis Abuse - Continuous	110	30	-	20	28	26	48	18	121	18	1
Cannabis Abuse - Episodic	14	6	-	4	4	3	5	4	14	6	-
Cannabis Abuse - In Remission	2	-	-	-	-	-	1	1	2	-	-
Opioid Abuse - Unspecified	1	2	-	1	-	-	-	2	3	-	-
Opioid Abuse - Continuous	6	-	-	-	1	-	5	-	4	2	-
Opioid Abuse - In Remission	8	-	-	-	1	-	4	3	7	1	-
Cocaine Abuse - Unspecified	11	4	-	1	1	-	11	2	14	1	-
Cocaine Abuse - Continuous	11	2	-	1	-	-	10	2	12	1	-
Cocaine Abuse - Episodic	2	-	-	-	-	1	-	1	2	-	-
Cocaine Abuse - In Remission	9	2	-	-	-	-	8	3	11	-	-
Amphetamine Abuse - Continuous	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse - Unspecified	2	-	-	-	-	-	1	1	2	-	-
Other, Mixed, or Unspecified Drug Abuse - Continuous	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse - In Remission	1	-	-	-	-	-	1	-	-	1	-
TOTAL	**788**	**288**	**-**	**76**	**114**	**165**	**425**	**296**	**801**	**262**	**13**

Source: King Edward VII Memorial Hospital

Notes:

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

Table 7.2.7
Secondary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2014

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	Other*
Poisoning - Insulin Antidiabetic	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Thyroid Derivative	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antiallergic and Antiemetic Drugs	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antineoplastic & Immunosuppressive Drugs	-	1	-	-	-	-	1	-	-	1	-
Poisoning - Heroin	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Methadone	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticoagulants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Salicylates	-	1	1	-	-	-	-	-	1	-	-
Poisoning - Codeine, Meperidine, Morphine	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Propionic Acid Derivatives	-	1	-	-	1	-	-	-	-	-	1
Poisoning - Anticonvulsants Not Elsewhere Classified	-	1	-	-	-	-	1	-	-	1	-
Poisoning - Unspecified Sedative or Hypnotics	-	1	-	-	-	-	1	-	-	1	-
Poisoning - Central Nervous System Muscle Depressants	-	1	1	-	-	-	-	-	1	-	-
Poisoning - Antidepressants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressants Not Elsewhere Classified	-	1	-	-	-	1	-	-	-	1	-
Poisoning - Benzodiazepine-Based Tranquilisers	-	2	-	-	-	1	1	-	-	2	-
Poisoning - Psychotropic Not Elsewhere Classified	-	1	-	-	-	1	-	-	-	1	-
Poisoning - Diuretics Not Elsewhere Classified	1	-	-	-	-	-	-	1	-	1	-
Poisoning - Electrollytic, Caloric, and Water-Balanced Agents	1	-	-	-	-	-	1	-	-	1	-
Poisoning – Butyrophenone Tranquilliser	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cocaine	1	-	-	-	-	-	1	-	1	-	-
Poisoning - Sympatholytics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cardiovascular Rhythm Regulation	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antilipemics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antihypertensive Agent	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cardiovascular Agent Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Ethyl Alcohol	1	-	-	-	-	1	-	-	1	-	-
Toxic Effect - Alcohol Not Elsewhere Classified	1	-	-	-	-	-	1	-	-	1	-
Toxic Effect - Benzene	1	-	-	-	-	-	1	-	1	-	-
TOTAL	**6**	**10**	**2**	**-**	**1**	**4**	**8**	**1**	**5**	**10**	**1**

Source: King Edward VII Memorial Hospital

Table 7.2.8
Secondary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2015

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	Other*
Poisoning - Insulin Antidiabetic	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Thyroid Derivative	1	-	1	-	-	-	-	-		1	-
Poisoning - Antiallergic and Antiemetic Drugs	-	1	-	1	-	-	-	-	-	1	-
Poisoning - Antineoplastic & Immunosuppressive Drugs	-	1	1	-	-	-	-	-	1	-	-
Poisoning - Heroin	1	-	-	-	-	1	-	-	-	1	-
Poisoning - Methadone	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticoagulants	-	-	-	-	-	-	-	-	-	-	-

Table 7.2.8 cont'd
Secondary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2015

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	Other+
Poisoning - Salicylates	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Codeine, Meperidine, Morphine	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Propionic Acid Derivatives	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Anticonvulsants Not Elsewhere Classified	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Unspecified Sedative or Hypnotics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Central Nervous System Muscle Depressants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressants Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Benzodiazepine-Based Tranquilisers	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Psychotropic Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Diuretics Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Electrollytic, Caloric, and Water-Balanced Agents	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Butyrophenone Tranquilliser	1	-	-	-	-	1	-	-	-	1	-
Poisoning - Cocaine	1	-	-	-	-	1	-	-	-	1	-
Poisoning - Sympatholytics	-	1	1	-	-	-	-	-	1	-	-
Poisoning - Cardiovascular Rhythm Regulation	1	-	-	-	-	1	-	-	-	1	-
Poisoning - Antilipemics	1	1	1	-	-	-	-	1	2	-	-
Poisoning - Antihypertensive Agent	-	1	-	-	-	-	-	1	1	-	-
Poisoning - Cardiovascular Agent Not Elsewhere Classified	-	1	-	-	-	1	-	-	-	1	-
Toxic Effect - Ethyl Alcohol	1	1	-	-	-	1	-	1	1	1	-
Toxic Effect - Alcohol Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Benzene	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**12**	**7**	**9**	**1**	**-**	**5**	**-**	**4**	**13**	**6**	**-**

Source: King Edward VII Memorial Hospital

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

The emergency room saw 125 cases in 2014 in which the primary diagnosis was related to drugs and dropped to 86 cases in 2015 (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 157 cases in 2014 as compared to 142 cases in 2015 (see Tables 7.3.3 and 7.3.4). In 2014, there was an overall total of 454 cases reported to the emergency room for which there was a drug-related secondary diagnosis as compared to 500 cases in 2015 (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, and acute alcoholic dependence. When it came to secondary diagnosis of emergency room cases of poisoning and toxic effects of substances, 26 cases presented in both 2014 and 2015 (see Tables 7.3.7 and 7.3.8); with more incidents occurring to males versus females.

Table 7.3.1
Primary Diagnoses of Emergency Room (ER) Drug-Related Cases, 2014*

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	Other+
Acute Alcoholic Intoxication	6	-	-	1	-	-	3	2	5	1	-
Acute Alcoholic Intoxication – Continuous	3	-	-	-	-	-	1	2	1	2	-
Acute Alcoholic Dependence	-	-	-	-	-	-	-	-	-	-	-
Other & Unspecified Alcohol Dependence	-	-	-	-	-	-	-	-	-	-	-
Other and Unspecified Alcohol Dependence – Continuous Drinking Behaviour	-	-	-	-	-	-	-	-	-	-	-
Opioid Type Dependence	1	-	-	-	-	-	-	1	-	1	-
Opioid Dependence – Continuous	4	-	-	-	-	3	-	1	2	2	-
Other Specified Drug Dependence – Unspecified Use	1	-	-	-	-	1	-	-	1	-	-
Unspecified Drug Dependence – Unspecified Use	1	-	-	-	-	-	1	-	1	-	-
Alcohol Abuse	61	31	7	22	21	12	19	11	59	28	5
Alcohol Abuse – Continuous Drinking Behaviour	2	-	-	-	-	-	1	1	2	-	-
Cannabis Abuse – Unspecified Use	1	2	-	3	-	-	-	-	2	1	-
Opioid Abuse – Unspecified Use	5	-	-	-	-	3	2	-	4	1	-
Cocaine Abuse	2	-	-	-	-	1	-	1	2	-	-
Other, Mixed, or Unspecified Drug Abuse	2	2	-	-	1	2	-	1	2	2	-
Other, Mixed, or Unspecified Drug Abuse – Continuous Use	1	-	-	1	-	-	-	-	1	-	-
TOTAL	**90**	**35**	**7**	**27**	**22**	**22**	**28**	**19**	**83**	**37**	**5**

Source: King Edward VII Memorial Hospital

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

Table 7.3.2
Primary Diagnoses of Emergency Room Drug-Related Cases, 2015*

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	Other+
Acute Alcoholic Intoxication	-	-	-	-	-	-	-	-	-	-	-
Acute Alcoholic Intoxication – Continuous	3	1	-	-	-	-	1	3	3	1	-
Acute Alcoholic Dependence	-	-	-	-	-	-	-	-	-	-	-
Other & Unspecified Alcohol Dependence	1	-	-	-	-	1	-	-	1	-	-
Other and Unspecified Alcohol Dependence – Continuous Drinking Behaviour	1	-	-	-	-	-	1	-	-	1	-
Opioid Type Dependence	-	-	-	-	-	-	-	-	-	-	-
Opioid Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-
Other Specified Drug Dependence – Unspecified Use	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Dependence – Unspecified Use	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse	38	23	5	11	10	8	13	14	36	24	1
Alcohol Abuse – Continuous Drinking Behaviour	3	-	-	-	1	1	-	1	1	2	-
Cannabis Abuse – Unspecified Use	-	2	-	1	-	1	-	-	2	-	-
Opioid Abuse – Unspecified Use	5	-	-	-	-	4	1	-	4	1	-
Cocaine Abuse	3	5	-	1	2	-	5	-	5	3	-
Other, Mixed, or Unspecified Drug Abuse	-	-	-	-	-	-	-	1	1	-	-
Other, Mixed, or Unspecified Drug Abuse – Continuous Use	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**55**	**31**	**5**	**13**	**13**	**15**	**21**	**19**	**52**	**33**	**1**

Source: King Edward VII Memorial Hospital

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

Table 7.3.3
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2014

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	Other*
Poisoning - Penicillins	-	1	1	-	-	-	-	-	1	-	-
Poisoning - Other Specified Antibiotics	-	1	-	-	-	1	-	-	-	-	1
Poisoning - Sulfonamides	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Ovarian Hormone	-	1	1	-	-	-	-	-	1	-	-
Poison - Insulin & Antidiabetic Agents	-	4	-	-	-	-	1	3	3	1	-
Poisoning - Thyroid Derivatives	-	1	-	1	-	-	-	-	1	-	-
Poisoning - Antiallergic & Antiemeticm Drugs	-	1	-	-	1	-	-	-	1	-	-
Poisoning - Vitamins	2	-	2	-	-	-	-	-	2	-	-
Poisoning - Anticoagulants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Opium	1	-	-	-	-	-	1	-	1	-	-
Poisoning - Heroin	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Codeine, Meperidine, Morphine	-	1	-	-	-	-	1	-	-	1	-
Poisoning - Salicylates	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Aromatic Analgesics	4	3	3	-	3	-	1	-	3	3	1
Poisoning - Propionic Acid Derivatives	1	2	2	-	-	1	-	-	1	1	1
Poisoning - Other and Unspecified Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Anti-Rheumatics	1	-	-	-	-	-	1	-	-	1	-
Poisoning - Hydantoin Derivatives	2	1	-	-	-	2	-	1	3	-	-
Poisoning - Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Sedative or Hypnotics	-	1	1	-	-	-	-	-	-	1	-
Poisoning - Central Nervous System Muscle Depressants	1	-	-	-	-	1	-	-	-	1	-
Poisoning - Selective Serotonin Reuptake Inhibitors	1	1	2	-	-	-	-	-	2	-	-
Poisoning - Tricyclic Antidepressants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Antidepressant	1	3	2	-	-	-	2	-	2	2	-
Poisoning - Antipsychotic, Neuroleptic, & Major Tranquilisers	-	2	-	-	-	1	-	1	1	1	-
Poisoning - Benzodiazepine-Based Tranquilisers	1	3	-	-	-	-	2	2	1	3	-
Poisoning - Hallucinogens	-	3	-	-	2	1	-	-	3	-	-
Poisoning - Caffeine	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Parasympatholytics and Spasmolytics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Sympatholytics (Antiadrenergics)	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antilipemic & Antiarteriosclerotic Drugs	1	-	-	-	-	-	-	1	1	-	-
Poisoning - Coronary Vasodilators	-	1	-	-	-	-	-	1	1	-	-
Poisoning - Other Antihypertensive Agents	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other and Unspecified Agents Primarily Affecting the Cardiovascular System	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidiarrheal Drugs	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Gastrointestinal Agents	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Purine Derivative Diuretics	1	-	-	-	-	-	-	1	1	-	-
Poisoning - Expectorants	-	1	1	-	-	-	-	-	1	-	-
Poisoning - Anti-Asthmatics	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Local Anti-Infective & Anti-Inflammatory Drugs	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Antipruritics	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Emollients, Demulcents & Protectants	2	-	2	-	-	-	-	-	2	-	-
Poisoning - Keratolytics, Keratoplastics, Other Hair Treatment Drugs and Preparations	-	2	1	-	-	1	-	-	2	-	-

Table 7.3.3 cont'd
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2014

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	Other*
Poisoning - Anti-Infectives and Other Drugs and Preparations for Ear, Nose, and Throat	2	-	2	-	-	-	-	-	2	-	-
Poisoning - Alcohol Deterrents	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Specified Drugs or Medicinal Substances	1	3	1	-	1	-	1	1	4	-	-
Poisoning - Unspecified Drugs or Medicinal Substances	2	2	1	-	-	-	1	2	4	-	-
Toxic Effect - Isopropyl Alcohol	1	-	-	-	1	-	-	-	1	-	-
Toxic Effect - Unspecified Alcohol	-	2	-	-	1	-	1	-	-	2	-
Toxic Effect - Petroleum Products	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Non-Petroleum-Based Solvents	1	1	1	-	-	-	1	-	2	-	-
Toxic Effect - Caustic Alkalis	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Caustic Unspecified	-	5	1	-	-	-	1	3	5	-	-
Toxic Effect - Carbon Monoxide	3	1	-	-	-	1	1	2	4	-	-
Toxic Effect - Liquefied Petroleum Gases	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Other Hydrocarbon Gas	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Other Specified Gases, Fumes, or Vapours	-	1	-	-	-	-	-	1	1	-	-
Toxic Effect - Unspecified Gas, Fumes, or Vapour	-	4	-	-	2	1	1	-	3	1	-
Toxic Effect - Berries and Other Plants Eaten as Food	1	1	2	-	-	-	-	-	-	2	-
Toxic Effect - Other Pesticides, Not Elsewhere Classified	-	1	-	-	-	1	-	-	-	-	1
Toxic Effect - Venom	32	28	14	3	9	9	16	9	37	20	3
Toxic Effect - Soap & Detergent	-	1	1	-	-	-	-	-	1	-	-
Toxic Effect - Other Substances, Chiefly Nonmedical	2	2	2	-	2	-	-	-	2	1	1
Toxic Effect - Unspecified Substances, Chiefly Nonmedical	1	2	1	-	1	1	-	-	2	-	1
TOTAL	**70**	**87**	**49**	**4**	**23**	**21**	**32**	**28**	**107**	**41**	**9**

Source: King Edward VII Memorial Hospital

Note: * Includes Asians and persons of 'Other' races.

Table 7.3.4
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2015

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	Other*
Poisoning - Penicillins	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Specified Antibiotics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Sulfonamides	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Ovarian Hormone	-	-	-	-	-	-	-	-	-	-	-
Poison - Insulin & Antidiabetic Agents	-	3	-	-	-	-	1	2	3	-	-
Poisoning - Thyroid Derivatives	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Antiallergic & Antiemeticm Drugs	1	-	1	-	-	-	-	-	-	-	1
Poisoning - Vitamins	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticoagulants	-	2	1	-	-	-	1	-	2	-	-
Poisoning - Opium	1	-	-	-	-	1	-	-	1	-	-
Poisoning - Heroin	2	-	-	-	-	-	2	-	2	-	-
Poisoning - Codeine, Meperidine, Morphine	-	1	1	-	-	-	-	-	1	-	-
Poisoning - Salicylates	2	1	-	2	-	-	1	-	3	-	-
Poisoning - Aromatic Analgesics	2	6	2	3	-	2	1	-	5	3	-
Poisoning - Propionic Acid Derivatives	4	2	3	1	-	-	2	-	5	1	-

Table 7.3.4 cont'd

Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2015

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	Other*
Poisoning - Other and Unspecified Anticonvulsants	2	1	-	1	-	2	-	-	1	2	-
Poisoning - Other Anti-Rheumatics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Hydantoin Derivatives	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Sedative or Hypnotics	-	1	-	-	-	-	-	1	1	-	-
Poisoning - Central Nervous System Muscle Depressants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Selective Serotonin Reuptake Inhibitors	-	1	1	-	-	-	-	-	1	-	-
Poisoning - Tricyclic Antidepressants	1	-	-	1	-	-	-	-	1	-	-
Poisoning - Other Antidepressant	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Antipsychotic, Neuroleptic, & Major Tranquilisers	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Benzodiazepine-Based Tranquilisers	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Hallucinogens	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Caffeine	-	1	-	-	1	-	-	-	1	-	-
Poisoning - Parasympatholytics and Spasmolytics	-	1	-	-	-	-	-	1	1	-	-
Poisoning - Sympatholytics (Antiadrenergics)	-	1	1	-	-	-	-	-	1	-	-
Poisoning - Antilipemic & Antiarteriosclerotic Drugs	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Coronary Vasodilators	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Antihypertensive Agents	1	1	1	-	-	-	-	1	2	-	-
Poisoning - Other and Unspecified Agents Primarily Affecting the Cardiovascular System	1	1	1	-	-	-	-	1	1	1	-
Poisoning - Antidiarrheal Drugs	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Gastrointestinal Agents	1	1	-	-	-	-	2	-	1	1	-
Poisoning - Purine Derivative Diuretics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Expectorants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anti-Asthmatics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Local Anti-Infective & Anti-Inflammatory Drugs	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antipruritics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Emollients, Demulcents & Protectants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Keratolytics, Keratoplastics, Other Hair Treatment Drugs and Preparations	-	1	-	-	-	-	1	-	1	-	-
Poisoning - Anti-Infectives and Other Drugs and Preparations for Ear, Nose, and Throat	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Alcohol Deterrents	-	1	-	-	-	-	1	-	1	-	-
Poisoning - Other Specified Drugs or Medicinal Substances	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Unspecified Drugs or Medicinal Substances	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Isopropyl Alcohol	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Unspecified Alcohol	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Petroleum Products	1	1	-	-	2	-	-	-	2	-	-
Toxic Effect - Non-Petroleum-Based Solvents	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Caustic Alkalis	1	-	-	-	-	1	-	-	1	-	-
Toxic Effect - Caustic Unspecified	5	5	1	-	4	1	2	2	10	-	-
Toxic Effect - Carbon Monoxide	1	2	-	-	1	-	1	1	3	-	-
Toxic Effect - Liquefied Petroleum Gases	-	1	-	-	1	-	-	-	1	-	-
Toxic Effect – Other Hydrocarbon Gas	1	1	-	-	2	-	-	-	1	1	-
Toxic Effect - Other Specified Gases, Fumes, or Vapours	-	2	-	1	-	-	1	-	1	1	-

Table 7.3.4 cont'd
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2015

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	Other+
Toxic Effect - Unspecified Gas, Fumes, or Vapour	-	1	-	-	-	-	1	-	1	-	-
Toxic Effect - Berries and Other Plants Eaten as Food	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Other Pesticides, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Venom	13	15	5	3	5	3	7	5	15	12	1
Toxic Effect - Soap & Detergent	4	2	2	-	-	2	-	2	5	1	-
Toxic Effect - Other Substances, Chiefly Nonmedical	4	5	4	-	3	1	1	-	8	1	-
Toxic Effect - Unspecified Substances, Chiefly Nonmedical	1	1	1	-	-	1	-	-	-	1	1
TOTAL	**65**	**77**	**39**	**16**	**19**	**17**	**29**	**22**	**103**	**35**	**4**

Source: King Edward VII Memorial Hospital

Note: + Includes Mixed, Asians, and persons of 'Other' races.

Table 7.3.5
Secondary Diagnoses of Emergency Room Drug-Related Cases, 2014*

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	Other+
Acute Alcoholic Intoxication	7	-	-	-	1	-	2	4	5	2	-
Acute Alcoholic Intoxication - Continuous	-	-	-	-	-	-	-	-	-	-	-
Acute Alcoholic Dependence	28	6	-	3	5	2	12	12	23	11	-
Chronic Alcohol Dependence - Continuous	6	1	-	-	-	-	4	3	5	2	-
Opioid Type Dependence - Unspecified	22	2	-	-	-	7	14	3	17	7	-
Opioid Dependence - Continuous	-	-	-	-	-	-	-	-	-	-	-
Cocaine Dependence - Unspecified	-	1	-	-	-	-	1	-	-	1	-
Cocaine Dependence – Continuous Use	1	-	-	-	-	-	-	1	1	-	-
Cannabis Dependence	1	1	-	-	1	-	1	-	2	-	-
Unspecified Drug Depend - Not Otherwise Specified	2	-	-	-	-	1	1	-	1	1	-
Unspecified Drug Dependence - Continuous Use	1	-	-	-	-	1	-	-	1	-	-
Unspecified Drug Dependence - In Remission	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse - Unspecified	90	35	1	15	26	8	54	21	87	33	5
Alcohol Abuse - Continuous	1	1	-	-	2	-	-	-	1	1	-
Alcohol Abuse - In Remission	1	-	-	-	-	-	-	1	1	-	-
Tobacco Use Disorder	106	50	-	7	24	30	60	35	100	45	11
Cannabis Abuse - Unspecified	16	10	1	5	12	5	3	-	22	3	1
Cannabis Abuse - Continuous	2	-	-	1	-	1	-	-	1	1	-
Sedative, Hypnotic or Anxiolytic Abuse	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse - Unspecified	22	3	-	-	-	6	15	4	15	10	-
Opioid Abuse - Continuous	2	-	-	-	-	1	1	-	2	-	-
Opioid Abuse - In Remission	1	1	-	-	-	-	2	-	2	-	-
Cocaine Abuse	11	2	-	-	-	1	10	2	13	-	-
Cocaine Abuse - Continuous	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse - In Remission	-	1	-	-	-	-	1	-	1	-	-
Other, Mixed, or Unspecified Drug Abuse	13	6	2	2	2	4	5	4	8	10	1
Other, Mixed, or Unspecified Drug Abuse - Continuous Use	-	1	1	-	-	-	-	-	1	-	-
TOTAL	**333**	**121**	**5**	**33**	**73**	**67**	**186**	**90**	**309**	**127**	**18**

Source: King Edward VII Memorial Hospital

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

Table 7.3.6
Secondary Diagnoses of Emergency Room Drug-Related Cases, 2015*

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	Other+
Acute Alcoholic Intoxication	3	1	-	1	1	-	2	-	3	1	-
Acute Alcoholic Intoxication - Continuous	3	-	-	-	-	-	3	-	3	-	-
Acute Alcoholic Dependence	25	8	-	6	5	4	8	10	20	11	2
Chronic Alcohol Dependence - Continuous	3	1	-	-	-	-	4	-	3	1	-
Opioid Type Dependence - Unspecified	14	2	-	-	-	4	9	3	12	4	-
Opioid Dependence - Continuous	4	-	-	-	-	2	1	1	3	1	-
Cocaine Dependence - Unspecified	-	-	-	-	-	-	-	-	-	-	-
Cocaine Dependence – Continuous Use	-	-	-	-	-	-	-	-	-	-	-
Cannabis Dependence	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Depend - Not Otherwise Specified	3	-	-	1	-	1	1	-	3	-	-
Unspecified Drug Dependence - Continuous Use											
Unspecified Drug Dependence - In Remission	1	-	-	-	-	-	1	-	1	-	-
Alcohol Abuse - Unspecified	107	31	2	15	22	21	43	35	101	33	4
Alcohol Abuse - Continuous	2	-	-	-	-	-	2	-	2	-	-
Alcohol Abuse - In Remission	-	-	-	-	-	-	-	-	-	-	-
Tobacco Use Disorder	112	56	-	6	20	21	72	49	101	61	6
Cannabis Abuse - Unspecified	29	10	2	12	11	3	11	-	34	3	2
Cannabis Abuse - Continuous	1	1	-	1	-	-	1	-	2	-	-
Sedative, Hypnotic or Anxiolytic Abuse											
Opioid Abuse - Unspecified	39	2	-	1	-	12	23	5	28	13	-
Opioid Abuse - Continuous	3	-	-	-	-	2	1	-	3	-	-
Opioid Abuse - In Remission	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse	15	5	-	1	5	1	12	1	13	7	-
Cocaine Abuse - In Remission	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse	15	3	1	2	1	2	10	2	15	3	-
Other, Mixed, or Unspecified Drug Abuse - Continuous Use	-	1	-	-	-	-	1	-	-	1	-
TOTAL	**379**	**121**	**5**	**46**	**65**	**73**	**205**	**106**	**347**	**139**	**14**

Source: King Edward VII Memorial Hospital

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

Table 7.3.7
Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2014

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	Other+
Poisoning - Insulin Antidiabetic	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Thyroid Derivative	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antiviral Drugs	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Antiallergic and Antiemetic Drugs	1	-	-	-	1	-	-	-	-	-	1
Poisoning - Anticoagulants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Opium (Alkaloids), Unspecified	1	-	-	-	-	-	-	1	-	1	-
Poisoning - Aromatic Analgesics, Not Elsewhere Classified	1	1	-	-	-	-	1	1	1	1	-
Poisoning - Propionic Acid Derivatives	1	-	-	-	-	-	1	-	-	1	-
Poisoning - Other Antirheumatics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Unspecified Analgesic and Antipyretic	-	-	-	-	-	-	-	-	-	-	-

Table 7.3.7 cont'd
Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2014

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	Other+
Poisoning - Unspecified Analgesic and Antipyretic	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other and Unspecified Anticonvulsants	-	1	-	-	-	-	1	-	-	1	-
Poisoning – Antidepressant, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Phenothiazine Tranquillisers	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Butyrophenone Tranquillisers	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antipsychotic, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Benzodiazepine-Based Tranquilisers	-	2	-	-	-	-	2	-	-	2	-
Poisoning - Sympathomimetics	1	-	-	-	1	-	-	-	-	-	1
Poisoning - Cardiotonics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antilipemics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other and Unspecified Agents Primarily Affecting the Cardiovascular System	-	1	-	-	-	-	-	1	1	-	-
Poisoning - Gastrointestinal Agents, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Diuretics, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antiasthmatics	-	-	-	-	-	-	-	-	-	-	-
Poisoning- Antipruritics	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Emollients, Demulcents, and Protectants	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Other Specified Drugs or Medicinal Substances	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Unspecified Drug or Medicinal Substance	1	1	-	-	-	-	1	1	2	-	-
Toxic Effect - Ethyl Alcohol	1	-	-	-	-	-	1	-	1	-	-
Toxic Effects - Unspecified Alcohol	1	-	-	-	1	-	-	-	-	1	-
Toxic Effect - Acids	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Caustic Agents	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Other Specified Gases, Fumes, or Vapours	-	1	1	-	-	-	-	-	1	-	-
Toxic Effect - Unspecified Gas, Fume, or Vaopur	-	1	-	-	-	-	-	1	1	-	-
Toxic Effect - Venom	3	2	-	2	-	1	2	-	3	2	-
Toxic Effect - Asbestos	1	-	-	-	-	-	-	1	1	-	-
Toxic Effect - Unspecified Substance, Chiefly Nonmedical Source	1	-	-	-	-	-	-	1	-	1	-
TOTAL	**16**	**10**	**4**	**2**	**3**	**1**	**9**	**7**	**14**	**10**	**2**

Source: King Edward VII Memorial Hospital

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

Table 7.3.8
Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2015

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	Other+
Poisoning - Insulin Antidiabetic	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Thyroid Derivative	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Antiviral Drugs	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antiallergic and Antiemetic Drugs	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticoagulants	-	1	-	-	-	-	-	1	1	-	-
Poisoning - Opium (Alkaloids), Unspecified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Aromatic Analgesics, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Propionic Acid Derivatives	-	-	-	-	-	-	-	-	-	-	-

Poisoning - Other Antirheumatics	-	1	-	-	-	1	-	-	1	-	-
Poisoning - Unspecified Analgesic and Antipyretic	-	1	-	-	-	-	-	1	1	-	-
Poisoning - Other and Unspecified Anticonvulsants	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Antidepressant, Not Elsewhere Classified	-	1	-	-	-	-	1	-	-	1	-
Poisoning - Phenothiazine Tranquillisers	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Butyrophenone Tranquillisers	1	-	-	-	-	1	-	-	-	1	-
Poisoning - Antipsychotic, Not Elsewhere Classified	-	1	-	-	-	-	1	-	-	1	-
Poisoning - Benzodiazepine-Based Tranquillisers	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Sympathomimetics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cardiotonics	-	1	-	-	-	-	-	1	1	-	-
Poisoning - Antilipemics	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Other and Unspecified Agents Primarily Affecting the Cardiovascular System	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Gastrointestinal Agents, Not Elsewhere Classified	-	1	-	-	-	-	1	-	-	1	-
Poisoning - Diuretics, Not Elsewhere Classified	-	1	-	-	-	-	-	1	1	-	-
Poisoning - Antiasthmatics	-	1	1	-	-	-	-	-	-	1	-
Poisoning- Antipruritics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Emollients, Demulcents, and Protectants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Specified Drugs or Medicinal Substances	1	1	1	-	-	-	-	1	1	1	-
Poisoning - Unspecified Drug or Medicinal Substance	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Ethyl Alcohol	-	-	-	-	-	-	-	-	-	-	-
Toxic Effects - Unspecified Alcohol	1	-	-	-	-	1	-	-	-	1	-
Toxic Effect - Acids	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Caustic Agents	1	-	-	-	-	-	-	1	-	1	-
Toxic Effect - Other Specified Gases, Fumes, or Vapours	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Unspecified Gas, Fume, or Vaopur	1	-	-	-	1	-	-	-	1	-	-
Toxic Effect - Venom	6	-	2	-	1	2	-	1	3	3	-
Toxic Effect - Asbestos	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Unspecified Substance, Chiefly Nonmedical Source	-	-	-	-	-	-	-	-	-	-	-
TOTAL	16	10	9	-	2	5	3	7	15	11	-

Source: King Edward VII Memorial Hospital

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 2015 there were 111 cases with a primary diagnosis that was drug-related within the MWI as compared to 86 in 2014 (see Tables 7.4.1 and 7.4.2). Males, blacks, and between 46 and 60 years 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 178 cases were reported in 2014 compared to 241 cases in 2015 (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, blacks and 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 2014 or 2015.

Table 7.4.1
Primary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2014*

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	Other*
Acute Alcohol Intoxication – Continuous	18	3	-	-	1	5	10	5	12	9	-
Alcohol Dependence – Not Specified	7	-	-	-	1	3	2	1	6	1	-
Other Alcohol Dependence – Episodic	1	-	-	-	-	1	-	-	-	1	-
Opioid Dependence – Continuous	33	6	-	-	3	15	20	1	34	5	-
Cocaine Dependence – Continuous	1	2	-	-	-	2	1	-	1	2	-
Cannabis Dependence – Continuous	-	1	-	-	1	-	-	-	1	-	-
Opioid/Other Dependence – Continuous	9	4	-	-	1	3	8	1	12	1	-
Alcohol Abuse - Continuous	-	-	-	-	-	-	-	-	-	-	-
Tobacco Use Disorder	-	1	-	1	-	-	-	-	1	-	-
Opioid Abuse – Continuous	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse, Unspecified Use	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**69**	**17**	**-**	**1**	**7**	**2**	**41**	**8**	**67**	**19**	**-**

Source: King Edward VII Memorial Hospital

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

Table 7.4.2
Primary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2015*

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	Other
Acute Alcohol Intoxication – Continuous	19	5	-	3	4	6	10	1	14	10	-
Alcohol Dependence – Not Specified	4	1	-	-	1	1	1	2	4	1	-
Other Alcohol Dependence – Episodic	-	-	-	-	-	-	-	-	-	-	-
Opioid Dependence – Continuous	61	6	-	1	3	24	29	10	60	7	-
Cocaine Dependence – Continuous	4	-	-	-	-	1	3	-	4	-	-
Cannabis Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-
Opioid/Other Dependence – Continuous	5	1	-	-	1	-	4	1	6	-	-
Alcohol Abuse - Continuous	1	-	-	-	-	-	1	-	-	1	-
Tobacco Use Disorder	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse – Continuous	1	1	-	-	-	-	2	-	1	1	-
Other, Mixed, or Unspecified Drug Abuse, Unspecified Use	2	-	-	-	-	2	-	-	-	2	-
TOTAL	**97**	**14**	**-**	**4**	**9**	**34**	**50**	**14**	**89**	**22**	**-**

Source: King Edward VII Memorial Hospital

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

Table 7.4.3
Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2014*

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	Other*
Acute Alcohol Intoxication – Continuous	19	7	1	-	3	9	12	1	20	5	1
Acute Alcohol Intoxication – In Remission	-	-	-	-	-	-	-	-	-	-	-
Alcohol Dependence – Not Specified	3	2	-	1	1	1	1	1	3	2	-
Opioid Dependence – Unspecified	-	-	-	-	-	-	-	-	-	-	-
Opioid Dependence – Continuous	4	2	-	-	1	2	1	2	2	4	-

Table 7.4.3 cont'd
Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related[*] Cases, 2014

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	Other[+]
Cocaine Dependence – Continuous	21	8	-	1	3	11	14	-	26	3	-
Cannabis Dependence – Continuous	26	2	1	4	5	13	5	-	26	2	-
Other Specified Drug Dependence – Continuous	2	-	-	-	-	-	2	-	2	-	-
Other Specified Drug Dependence – Episodic	1	-	-	-	-	-	1	-	1	-	-
Combined Opioid Type Drugs	19	5	-	-	4	5	15	-	20	3	1
Combination Drug Dependence – Unspecified	-	-	-	-	-	-	-	-	-	-	-
Combination of Drug Dependence – Excluding Opioids	7	3	-	1	1	2	6	-	9	1	-
Unspecified Drug Dependence	-	1	-	-	-	1	-	-	1	-	-
Drug Dependence Not Otherwise Specified – Continuous	1	-	-	-	-	1	-	-	1	-	-
Alcohol Abuse – Continuous	4	-	-	-	1	2	1	-	4	-	-
Alcohol Abuse – Unspecified	-	-	-	-	-	-	-	-	-	-	-
Tobacco Use Disorder	26	7	-	1	3	9	17	3	27	6	-
Cannabis Abuse – Continuous	4	-	-	-	1	2	1	-	4	-	-
Opioid Abuse – Unspecified	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse – Continuous	1	-	-	-	-	-	-	1	1	-	-
Cocaine Abuse – Continuous	-	1	-	-	1	-	-	-	-	-	1
Drug Abuse – Continuous	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**138**	**40**	**2**	**9**	**26**	**57**	**76**	**8**	**149**	**26**	**3**

Source: King Edward VII Memorial Hospital

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

Table 7.4.4
Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related[*] Cases, 2015

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	Other[+]
Acute Alcohol Intoxication – Continuous	28	7	-	1	3	8	19	4	28	6	1
Acute Alcohol Intoxication – In Remission	-	-	-	-	-	-	-	-	-	-	-
Alcohol Dependence – Not Specified	5	3	1	1	-	1	5	-	3	5	-
Opioid Dependence – Unspecified	-	1	-	-	-	-	1	-	-	1	-
Opioid Dependence – Continuous	6	3	-	-	2	4	3	-	8	1	-
Cocaine Dependence – Continuous	40	13	-	1	8	17	21	6	46	6	1
Cannabis Dependence – Continuous	34	9	1	4	10	15	9	4	38	5	-
Other Specified Drug Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-
Other Specified Drug Dependence – Episodic	-	-	-	-	-	-	-	-	-	-	-
Combined Opioid Type Drugs	13	-	-	-	3	3	7	-	10	3	-
Combination Drug Dependence – Unspecified	1	-	-	-	-	1	-	-	1	-	-
Combination of Drug Dependence – Excluding Opioids	8	-	-	-	-	2	5	1	6	2	-
Unspecified Drug Dependence	-	-	-	-	-	-	-	-	-	-	-
Drug Dependence Not Otherwise Specified – Continuous	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse – Continuous	1	2	-	-	1	-	2	-	3	-	-
Alcohol Abuse – Unspecified	1	1	-	-	-	-	2	-	1	1	-
Tobacco Use Disorder	40	10	-	3	9	15	28	3	46	12	-
Cannabis Abuse – Continuous	5	-	-	2	1	1	1	-	3	2	-

Table 7.4.4 cont'd
Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2015*

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	Other+
Opioid Abuse – Unspecified	-	1	-	-	-	-	1	-	-	1	-
Opioid Abuse – Continuous	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse – Continuous	-	-	-	-	-	-	-	-	-	-	-
Drug Abuse – Continuous	-	1	1	-	-	-	-	-	1	-	-
TOTAL	**190**	**51**	**3**	**12**	**37**	**67**	**104**	**18**	**194**	**45**	**2**

Source: King Edward VII Memorial Hospital

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

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.[12]

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[13]. 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 2015, 38 cases were screened compared to 36 in 2014 (see Table 7.5.1). Most of the cases forwarded for screening were for males, 27 in 2014 and 35 cases in 2015. In addition, the majority of the cases screened were of older persons, especially persons over 46 years. There were more cases sent for toxicology screening of younger persons, that is 25 years or younger, in 2015 (7) than in the previous year (4).

Ethanol in excess of the legal limit and drugs (illegal or psychoactive medicines above therapeutic range), were detected in many of the cases screened in each year under review. For instance, in 2014, 72.2% of the cases (26 of 36) screened positive for excess ethanol or illegal or non-prescribed drugs compared to 39.5% (15 of 38) in 2015. 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 2015. Additionally, in 2015, there was

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

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

one drug-induced deaths and one alcohol-induced deaths, for which toxicology screens were not conducted. This results in a total of three drug-induced and two alcohol-induced deaths for 2015. This is higher than in 2014, where there was no drug-induced deaths and two alcohol-induced deaths; with mental and behavioural disorders due to use of alcohol and alcoholic liver disease being the cause of death. Alcohol- and drug-induced deaths do not include accidents, homicides, and other causes indirectly related to alcohol and drug use. However, there were a few road traffic fatalities, in both years, for which alcohol and or drugs were present (and in excess of the legal limit in the case of alcohol), nine cases in 2014 and four in 2015 (see Table 7.5.1).

…there were a few road traffic fatalities, in both years, for which excess alcohol and or drugs were present, nine cases in 2014 and four in 2015.

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 2015, there were 60 tobacco-related deaths as compared to 64 in the previous year[14]. These include a portion of the deaths from various cancers, cardiovascular or heart diseases, and respiratory diseases, such as chronic obstructive pulmonary disease.

In general, of all cases where excess alcohol or drugs were detected in the toxicology screens, the cause of death was recorded as transport accident or some diseases of the circulatory system (see Table 7.5.1). However, there were also instances of deaths, which were caused as a result of other external causes such as assault, drowning, mental and behavioural disorders, and diseases of the respiratory or digestive system, 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).[15] 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.

[14] Revised

[15] 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, 2014 and 2015

	2014	2015
Total Number of Deaths (All Causes)	**469**	**476**
Proportion of Deaths with Toxicology Screens (%)	7.7	8.0
Total Number of Toxicology Screens	36	38
By Sex:		
Males	27	35
Females	9	3
By Age Group:		
< 18 Years	-	1
18 – 25 Years	4	6
26 – 35 Years	3	6
36 – 45 Years	2	1
46 – 60 Years	13	18
60+ Years	14	6
Not Stated	-	-
Substances Detected in Toxicology Screens (Number of Cases)		
Ethanol[a] (>80 mg)	10	8
Drugs[b]	22	11
Ethanol and Drugs	6	4
None/<80 mg Ethanol/Drugs in Therapeutic Range	10	23[c]

Table 7.5.1 cont'd
Toxicology Screens, Substances Detected, and Causes of Death, 2014 and 2015

	2014	2015
Causes of Death (ICD-10)[d] (Persons with Detected Substances)	**26**	**15**
Malignant Neoplasm	-	-
Mental and Behavioural Disorders	1	-
Endocrine, Nutritional, and Metabolic Diseases	1	-
Diseases of the Blood	-	1
Diseases of the Circulatory System	7	4
Diseases of the Respiratory System	1	-
Diseases of the Circulatory and Respiratory Systems	-	-
Diseases of the Digestive System	-	-
Diseases of the Skin and Subcutaneous Tissue	-	-
External Causes of Morbidity and Mortality	-	-
Transport Accident	9	4
Other External Causes of Accidental Injury	-	1
Assault	2	2
Intentional Self-Harm	1	-
Accidental Drowning and Submersion	2	-
Accidental Poisoning by Exposure to Noxious Substance	-	1
Hanging, Strangulation, and Suffocation – Undetermined Intent	1	-
Ill Defined and Unknown Causes of Death Not Elsewhere Classified	-	-
Pending	1	2

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] One sample (liver blood) tested positive for ethanol but the exact level was unable to be determined due to the advanced state of decomposition.
[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.[16] 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.[17]

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

[16] 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.

[17] 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.

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.

According to data reported by the Maternal Health Clinic in Bermuda (see Table 7.6.1), which only represents a proportion of pregnant women receiving pre-natal care, about four in 10 pregnant women in 2014 (42%) and half in 2015 (50%) used one or more than one illicit drug over their gestational cycle. In 2014, the 11 of the 13 positive tests were confirmed for marijuana while two were confirmed for cocaine; whereas, in 2015, all of the 18 positive tests were confirmed for marijuana. In the year 2014, most of the women (10) have used these drugs during their second trimester as compared to most women using them in their first trimester in 2015. Additionally, there was one reported case in 2014 and two in 2015 a pregnant woman using marijuana in her third trimester.

Table 7.6.1
Drug Screening for Marijuana among Pregnant Women Attending the Maternal Health Clinic, 2014 and 2015

	Number of Pregnant Women	
	2014	2015
Total Number of Tests	31*	34
Total Number of Positive Tests	13	18
Positive Tests by Gestation		
First Trimester	2	8
Second Trimester	10	7
Third Trimester	1	2

Source: Maternal Health Clinic

Note: * One of the samples to be tested was diluted; hence a negative or positive result could not be confirmed.

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.[18] 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 either at scheduled class times or times dedicated for this curriculum. This comprehensive programme provides adolescents and young teens with the confidence and skills necessary to successfully handle 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 behaviour 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.

The LST programme data is compiled by Pride and CADA as part of its programme performance monitoring. The data in Table 8.1.1 shows that for the school year 2014/2015, Pride has implemented the LST programme in classrooms at both the primary and high school levels, but not at the middle school level. Specifically, in the 2014/2015 school year, the LST programme was implemented in 19 classrooms across 10 primary schools. In addition, the programme was offered to two classes in one high school in the form of a teen summer camp during 2014 that is recorded as part of the school year 2014/2015 data. Similarly, the LST programme coverage in the 2015/2016 school year spanned 22 classrooms across 12 primary schools. While there were a couple students who dropped out of the programme at the primary school level during the 2014/2015 school year and even more in 2015/2016, a total of 272 and 299 students completed the programme at this level during these two academic year, respectively; with an additional 25 students completing the programme at the high-school level during 2014/2015.

…the LST programme coverage in the 2015/2016 school year spanned 22 classrooms across 12 primary schools.

Across all participating classrooms in the primary schools, students were engaged for 168 sessions in 2014/2015 and 227 in 2015/2016, averaging approximately 45 minutes, and 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 57.6% versus 71.2% at the post test in 2014/2015 and 58% versus 69% in 2015/2016. This is equivalent to an average gain score (difference between post test and pre-test scores) of more than 10.0% in each of the years under review.

The seven-module curriculum was completed by 25 students in the two classrooms at the high-school level over 20 sessions. The average pre-test score was 73.6% in 2014/2015 compared to 76.1% at the post test – a gain score of 2.5%, on average. The programme was not delivered to at the high-school level in the previous academic year; thereby precluding comparisons to be made.

CADA, on the other hand, implemented the LST in only the middle- and high-school levels in both school years under review. In both years, two classes in one middle school received the 14-module Level 1 middle-school programme, with 35 and 36 students completing the curriculum over 31 and 34 sessions, respectively (see Table 8.1.2). There was a 100% completion rate of all the modules in both classes in both years. In 2014/2015 the average gain score at this level was 9.1% with an average pre-test score of 67.6% versus 76.7% at the post test; and, in 2015/2016, the gain score dropped slightly to 9% with an average pre-test score of 68% compared to 77% at the post test.

At the high-school level, two classes in one high school and three classes in one high school received the programme over 17 and 26 sessions with a total of 32 and 51 students, respectively, in 2014/2015 and 2015/2016. There was a 100.0% completion rate of the seven-module curriculum in both years under review. The programme showed improvement in the last two academic years at this level in terms of the gain score. Specifically, in the 2014/2015 school year at the high-school level the average post test score (77.6%) was 3.4% higher than the average pre-test score (81%). Similarly, the 2015/2016 school year recorded a slightly lower, but positive, gain score of 2% with average pre-test score of 80%, increasing to an average post test score of 82%.

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

Table 8.1.1
Pride Bermuda's LifeSkills Programme Statistics, 2014/2015 and 2015/2016

Programme Indicators	School Year and Level		
	2014/2015		2015/2016
	Primary	High*	Primary
Number of Schools Participated	10	1	12
Number of Classes Participated	19	2	22
Number of Students Engaged	274	25	325
Number of Students Dropped Out	2	-	26
Number of Students Retained	272	25	299
Number of Sessions	168	20	227
Number of Modules Completed	148	14	173
Total Number of Modules	152	14	176
Proportion of Curriculum Completed (%)	97.4	100.0	98.0
Average Pre-Test Score (%)	57.6	73.6	58.0
Average Post Test Score (%)	71.2	76.1	69.0

Source: PRIDE Bermuda

Note: * This was a teen summer camp ran in partnership with Sunshine League, July – August, 2014.

Table 8.1.2
CADA's LifeSkills Programme Statistics, 2014/2015 and 2015/2016

Programme Indicators	School Year and Level			
	2014/2015		2015/2016	
	Middle	High	Middle	High
Number of Schools Participated	1	1	1	1
Number of Classes Participated	2	2	2	3
Number of Students Engaged	35	32	36	53
Number of Students Dropped Out	-	-	5	2
Number of Students Retained	35	32	31	51
Number of Sessions	31	17	34	26
Number of Modules Completed	28	14	28	21
Total Number of Modules	28	14	28	21
Proportion of Curriculum Completed (%)	100.0	100.0	100.0	100.0
Average Pre-Test Score (%)	67.6	77.6	68.0	80.0
Average Post Test Score (%)	76.7	81.0	77.0	82.0

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 these lessons were received by students. 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 covering three key behavioural areas (aggression/disruptive behaviour, concentration or attention, and social and emotional competence) with a total of 30 (Primary 2 level) and 31 (Primary 1 level) individual behaviours on which students are evaluated using a numerical rating scale of 0 to 5 (never or almost never, rarely, sometime, often, very often, and almost always).

This programme is coordinated by Pride Bermuda and, in the last two academic years, the curriculum was delivered to one primary school in Bermuda but at two to three levels to

one or more classes. The data on Table 8.2.1 shows that two classes at each of the first two primary levels participated in the 2014/2015. The programme was also extended to the Primary 3 level in the 2015/2016 school year; which meant that students who received the curriculum in 2014/2015 at the Primary 2 level, now continued onto the next level of the curriculum in Primary 3. Two classes each at the Primary 1 and 3 levels participated and only one class at the Primary 1 level. The curriculum was delivered two times each week with each session being approximately 30 minutes in length. A total of 70 students were engaged for the entire programme in 2014/2015 at the two primary levels and 84 students at the three primary levels in 2015/2016 (average class size was approximately 16 to 17 students). The students at the Primary 1 level completed 44 of 45 modules in 2014/2015 (97% curriculum completion) and 42 in 2014/2015 (94% curriculum completion). The Primary 2 curriculum contains 50 modules and the students completed 26 modules (52% curriculum completion) in 2014/2015 and 45 modules (90% completion) in 2015/2016. At the Primary 3 level, the classes completed 47 of the 50 modules (94% completion).

In terms of behavioural maturity the average change results (difference between the post test and pre-test scores) showed that 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 (73.3% of Primary 1 students and 61.3% of Primary 2 students in 2014/2015; 71% of Primary 1 students, 94% of Primary 2 students, and 83% of Primary 3 students in 2015/2016). 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). For instance, 32% of the Primary 1 students, 31% of the Primary 2 students, and 35% of the Primary 3 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 other; indicating that for these students, their behaviours on this component worsened. Likewise, there were 39% of the Primary 1 students in 2015/2016 whose behaviour on concentration/attention remained unchanged and the same for 38% of the Primary 2 students.

Table 8.2.1
Pride Bermuda's PATHS Programme Statistics, 2014/2015 and 2015/2016

Programme Indicators	2014/2015		2015/2016		
	Primary 1	Primary 2	Primary 1	Primary 2	Primary 3
Number of Schools	1	1	1	1	1
Number of Classes Participated	2	2	2	1	2
Number of Students Engaged	35	35	34	17	33
Number of Students Dropped Out	-	-	3	1	2
Number of Students Retained	35	35	31	16	31
Number of Sessions	88	59	85	50	98
Number of Modules Completed	88	52	85	45	94
Total Number of Modules	90	100	90	50	100
Proportion of Curriculum Completed (%)	97.8	52.0	94.0	90.0	94.0
Evaluation of Behaviours	(n = 30)[a]	(n = 31)[a]	(n = 31)	(n = 16)	(n = 29)
Improvement (% of students)					
Aggression/Disruptive Behaviours	46.7	61.3	45.0	56.0	62.0
Concentration/Attention	70.0	51.6	45.0	56.0	55.0
Social and Emotional Competence	73.3	61.3	71.0	94.0	83.0
Negative Change (% of students)					
Aggression/Disruptive Behaviours	30.0	29.0	32.0	31.0	35.0
Concentration/Attention	20.0	22.6	16.0	6.0	31.0
Social and Emotional Competence	16.7	19.4	19.0	-	17.0
No Change (% of students)					
Aggression/Disruptive Behaviours	23.3	9.7	23.0	13.0	3.0
Concentration/Attention	10.0	25.8	39.0	38.0	14.0
Social and Emotional Competence	10.0	19.4	10.0	6.0	-

Source: PRIDE Bermuda

Note: [a] Although 35 students received the programme not all were pretested; hence the numbers for which the evaluation of behaviours are presented do not match the number of students engaged.

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.

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 four professionals were added to the fields of drug treatment and prevention since the last report. Specifically, in 2014 there were 49 certified persons in substance abuse treatment and prevention occupations, compared to 53 professionals in 2015; 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 and 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.

Table 9.1.1
Certified Treatment and Prevention Professionals by Occupation, 2014 and 2015

Occupation	2014	2015
Treatment		
Alcohol/Drug Counsellors	32	34
Associate Counsellors	3	5
Clinical Supervisors	8	8
Prevention		
Prevention Specialists	6	6
Associate Prevention Professional	-	-
Total	**49**	**53**

Source: Bermuda Addiction Certification Board

Table 9.1.2
Certified Treatment and Prevention Professionals by Type of Certification, 2014 and 2015

Field of Certification	2014	2015
Treatment		
ICADC	32	34
CCS	8	8
ACAD	3	5
Prevention		
CPS	6	6
APP	-	-
Total	**49**	**53**

Source: Bermuda Addiction Certification Board

Chapter 10
Survey Data

- Public Perceptions
- Youth Drug Prevalence
- Treatment Services
- Treatment Demand

10.1 PUBLIC PERCEPTIONS

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 2016 Omnibus Survey, a sample survey of 400 residents, to evaluate the community's perceptions of these issues.

Concerns relating to crime have been a common issue for Bermuda residents over the past number of years. In order to assess feelings of personal safety, residents were asked about how safe they felt in their own neighbourhoods. The majority of residents continue to feel safe in their neighbourhoods. Little change has been observed in residents' feeling of personal safety over the past year, with the vast majority feeling either extremely (35% compared with 36% in June 2015) or mostly (61% compared with 62%) safe in their own neighbourhood (see Table 10.1.1). There were only a few residents who reported feeling unsafe to any degree (3%, up from 1%). It is important to note, however, that the degree to which residents feel safe has steadily increased since monitoring began in 2012. Differences are noted across the population, with women and higher income earners being less likely to report feeling extremely safe in their neighbourhood. Across the Island, residents of Warwick/Paget were more likely, than those living in other parishes, to report feeling extremely safe in their respective neighbourhoods.

Despite widespread feelings of safety, there was a small, but growing portion, of residents who reported feeling less safe when compared with six months ago.

In addition, residents were asked about their current feeling of safety in their neighbourhoods, at the time of the survey, as compared to those from six months. Despite widespread feelings of safety, there was a small, but growing portion, of residents who reported feeling less safe when compared with six months ago. Specifically, three-quarters of the residents stated that they now feel as safe as they did (75%, down six points from 2015) and one in ten feel safer (9%, down one point). At the same time, nearly two in ten now feel less safe than they did six months ago, marking a notable increase from the past year's results (15%, up eight points). In light of this increase, the portion of residents who indicated worsened conditions was larger than the portion who reported improvements for the first time in four years. This shift is in contrast to the upward trend observed in each of the past years in the degree to which residents feel safe in their neighbourhoods.

Interestingly, lower income earners were more likely to describe a shift in their feelings of safety. Indeed greater portions of those with lower incomes stated both increased and decreased feelings of safety in their own neighbourhoods compared to their counterparts. Older residents were more likely to indicate that they felt safer and younger residents more commonly report feeling less safe. Differences were also observed across parishes, with Sandys/Southampton residents more often stating that they felt less safe and those in Hamilton/Smiths/St. George's were more likely to feel safer.

Residents were asked which types of crime they knew to have occurred in their neighbourhood in the past year. Their awareness of crimes having occurred in their neighbourhoods is decreasing, with marked declines in drug trafficking and crimes committed with guns. There were only a minority of residents who knew of any types of crime having occurred in their neighbourhoods in the past twelve months. As with previous findings, theft was most often reported (37%, down two points), closely followed by breaking and entering to steal personal property (35%, down one point) (see Table 10.1.2). Only a small number of residents knew of people openly selling or using drugs (13%, down eight points) or of crimes committed with guns (13%, down five points); both having declined notably since the last survey. Fewer than one in ten reported assaults (8%, no change) or murder (6%, down two points). Noteworthy of mention, is that each of the types of crimes are currently at a five-year low.

Some differences were evident between parishes and demographics. Across parishes, residents of Sandys/Southampton more often reported people openly selling or using drugs, crimes committed with guns, and murder compared to their counterparts. By comparison, women, higher earners, younger residents, and white residents were more aware of theft having occurred in their neighbourhoods. Awareness of crimes also differed across racial backgrounds, with black residents more often indicating crimes committed with guns and murder, while white residents more often indicated theft or breaking and entering to steal personal property.

Further, just under half of the residents were not aware of any type of crime having occurred in their neighbourhoods in the past year. Specifically, results showed that more than four in ten residents were not aware of any type of crime and the bulk of the remaining portion was aware of one or two types of crime, while knowledge of three or more types was less common. Middle income earners were more likely than their counterparts to indicate that they were not aware of any types of crimes in their neighbourhoods, as are older residents compared to those under the age of 55. In addition, black residents were less likely than white residents to be aware of any types of crimes having occurred in their community.

In order to measure perceptions of overall physical and mental well-being, respondents were asked how they would

rate their own health. Residents continued to rate their physical and mental well-being positively (96%, down one point). Indeed, one-half indicated that their health is good (49%, down one point from 2015), while slightly fewer residents described their health as being very good (46%, up two points). On the other hand, only a small proportion of residents rated their well-being poorly (5% stated poor/very poor; no change), consistent with previous findings. In particular, lower household income earners were less likely than higher earners to feel that that they are in very good health, while those under the age of 35 years were more likely than their older counterparts to rate their status of health as very good.

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	35	38	42	31	33	41	30	40	36	29	41	34	34	37	39	35	39
Mostly Safe	61	59	53	65	66	56	66	56	60	69	56	63	62	60	58	62	55
Mostly Unsafe	2	2	4	1	1	3	1	2	2	3	0	2	3	3	1	1	6
Extremely Unsafe	1	1	0	3	0	0	2	2	0	0	3	0	1	0	2	1	0
Don't Know/No Answer	1	0	2	0	0	0	1	0	2	0	0	1	0	0	0	1	0
Weighted Sample Size (#)	**400**	**76**	**107**	**103**	**109**	**190**	**210**	**152**	**110**	**105**	**79**	**190**	**131**	**215**	**127**	**347**	**53**
Unweighted Sample Size (#)	**400**	**66**	**106**	**111**	**112**	**141**	**259**	**150**	**105**	**98**	**32**	**124**	**244**	**166**	**170**	**360**	**40**
% Exremely/Mostly Safe	97	97	94	96	99	97	96	96	96	97	97	97	96	97	96	97	94
% Mostly/Extremely Unsafe	3	3	4	4	1	3	3	4	2	3	3	2	4	3	4	2	6

Source: DNDC's Commissioned Questions in 2nd Quarter 2016 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	13	28	11	11	7	12	14	15	15	12	13	15	10	14	12	15	4
No	85	69	88	87	91	88	83	84	83	88	87	83	87	84	86	83	95
Don't Know	2	3	1	2	1	0	3	1	2	0	0	2	3	2	2	2	1
Weighted Sample Size (#)	**400**	**76**	**107**	**103**	**109**	**190**	**210**	**152**	**110**	**105**	**79**	**190**	**131**	**215**	**127**	**347**	**53**
Unweighted Sample Size (#)	**400**	**66**	**106**	**111**	**112**	**141**	**259**	**150**	**105**	**98**	**32**	**124**	**244**	**166**	**170**	**360**	**40**

A theft (auto or personal property) having occurred?

	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	37	38	36	36	40	33	41	38	35	48	44	38	33	33	48	37	42
No	60	60	61	62	58	64	57	59	64	52	53	61	63	65	47	60	58
Don't Know	2	2	3	2	2	3	2	4	1	1	3	1	5	2	5	3	0
Weighted Sample Size (#)	**400**	**76**	**107**	**103**	**109**	**190**	**210**	**152**	**110**	**105**	**79**	**190**	**131**	**215**	**127**	**347**	**53**
Unweighted Sample Size (#)	**400**	**66**	**106**	**111**	**112**	**141**	**259**	**150**	**105**	**98**	**32**	**124**	**244**	**166**	**170**	**360**	**40**

Table 10.1.2 cont'd

Breaking and entering to steal personal property?

	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	35	38	34	33	37	35	35	36	37	38	38	37	31	32	47	34	42
No	64	60	66	66	62	64	64	64	62	62	62	63	67	67	52	65	58
Don't Know	1	2	0	1	2	1	1	1	1	0	0	1	2	1	1	1	0
Weighted Sample Size (#)	**400**	**76**	**107**	**103**	**109**	**190**	**210**	**152**	**110**	**105**	**79**	**190**	**131**	**215**	**127**	**347**	**53**
Unweighted Sample Size (#)	**400**	**66**	**106**	**111**	**112**	**141**	**259**	**150**	**105**	**98**	**32**	**124**	**244**	**166**	**170**	**360**	**40**

Crimes committed with guns?

	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	13	22	7	17	10	13	13	20	11	9	9	17	11	17	9	14	11
No	86	78	92	82	90	87	86	80	89	91	91	83	89	83	90	86	89
Don't Know	0	0	0	1	0	0	1	0	0	0	0	0	0	0	1	0	0
Weighted Sample Size (#)	**400**	**76**	**107**	**103**	**109**	**190**	**210**	**152**	**110**	**105**	**79**	**190**	**131**	**215**	**127**	**347**	**53**
Unweighted Sample Size (#)	**400**	**66**	**106**	**111**	**112**	**141**	**259**	**150**	**105**	**98**	**32**	**124**	**244**	**166**	**170**	**360**	**40**

Source: DNDC's Commissioned Questions in 2nd Quarter 2016 Bermuda Omnibus Survey©

10.2 YOUTH DRUG PREVALENCE

Surveys to assess drug consumption, as well as to identify the current levels of protection and risk among middle and senior school students, have indicated use of ATODs, both in the lifetime and current use periods. For instance, the 2015 National School Survey indicated that 71.3% of all survey respondents or seven in 10 (2,153 of 3,017) in M2 to S4 have reported use of at least one drug in their lifetime. This includes the use of tranquilizers and stimulants without medical prescriptions, as well as any "other" drug. However, if energy drink consumption were to be included in the substances used or tried, then the proportion of students who have reported experimentation of a substance increased to 85.3% (2,574).

In this survey, students recorded the highest lifetime prevalence-of-use (see Table 10.2.1) for energy drinks (61.1%), alcohol (52.6%), marijuana (26.2%), inhalants (15.1%), and cigarettes (12.0%). Other lifetime prevalence ranges from a low of 1.2% for heroin to a high of 5.3% for cannabis resin.

Students reported the highest current prevalence-of-use (see Table 10.2.2) for energy drinks (20.7%), alcohol (18.0%), and marijuana (10.8%). Other current use prevalence ranges from a low of 0.4% for heroin and ecstasy to a high of 3.1% for cigarettes.

Social factors are fundamental in promoting or deterring the initiation of substance use among adolescents and the engagement in problem behaviours. Influence can come from the community, family, school, peers, and the individuals' environments. While overall scores provide a general picture of the risk and protective factor profile, they can mask problems within individual grades. Tables 10.2.3 and 10.2.4 present individual-grade data for risk and protective factor scale scores. This detailed information provides prevention planners with a snapshot; revealing the risk and protective factor scales that are of greatest concern by grade level. It allows those prevention planners to focus on the most appropriate points in youth development for preventive intervention action – and to target their prevention efforts as precisely as possible.

Younger students reported different factors than older students as being the most elevated or suppressed, as seen in Tables 10.2.3 and 10.2.4. When it came to the three highest protection scales, M2 students reported highest levels for: Family Rewards for Prosocial Involvement (94), School Social Skills (92), and Interaction with Prosocial Peers (90). However, S4 students reported highest levels for: Prosocial Involvement (93), Interaction with Prosocial Peers (91), and Rewards for Prosocial Involvement (87). On the other hand, M2 students reported their three highest levels of risk as Sensation Seeking (57), Transitions and Mobility (49), and Early Initiation of Drug Use (30), similar to 2011 results. S4 students, on the other hand, reported their three highest levels of risk as Sensation Seeking (80), Friends Use of Drugs (80), and Perceived Availability of Drugs (66).

Table 10.2.1

Lifetime Use[a] of ATODs and Energy Drinks by Grade Level of Survey Respondents, 2015

Substance	Grade Level												Overall (n = 3,017)	
	M2 (n = 490)		M3 (n = 547)		S1 (n = 584)		S2 (n = 511)		S3 (n = 457)		S4 (n = 427)			
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
LEGAL DRUGS	**292**	**59.6**	**367**	**67.1**	**385**	**65.9**	**315**	**61.6**	**281**	**61.5**	**307**	**71.9**	**1,947**	**64.5**
Alcohol	239	48.8	320	58.5	322	55.1	255	49.9	223	48.8	228	53.4	1,587	52.6
Cigarettes	27	5.5	32	5.9	48	8.2	80	15.7	71	15.5	103	24.1	361	12.0
Inhalants	82	16.7	96	17.6	113	19.3	72	14.1	48	10.5	46	10.8	457	15.1
ILLEGAL DRUGS	**31**	**6.3**	**53**	**9.7**	**118**	**20.2**	**172**	**33.7**	**206**	**45.1**	**235**	**55.0**	**815**	**27.0**
Cannabis Resin	7	1.4	6	1.1	25	4.3	28	5.5	43	9.4	51	11.9	160	5.3
Cocaine	4	0.8	3	0.5	12	2.1	12	2.3	7	1.5	19	4.4	57	1.9
Crack	9	1.8	4	0.7	9	1.5	8	1.6	5	1.1	12	2.8	47	1.6
Ecstasy	5	1.0	3	0.5	9	1.5	11	2.2	8	1.8	17	4.0	53	1.8
Hashish	4	0.8	4	0.7	9	1.5	13	2.5	28	6.1	37	8.7	95	3.1
Heroin	6	1.2	2	0.4	9	1.5	3	0.6	4	0.9	13	3.0	37	1.2
Marijuana	26	5.3	46	8.4	111	19.0	168	32.9	205	44.9	233	54.6	789	26.2
Other Drugs	21	4.3	19	3.5	33	5.7	37	7.2	27	5.9	29	6.8	166	5.5
Energy Drinks	192	39.2	307	56.1	381	65.2	342	66.9	323	70.7	298	69.8	1,844	61.1

Source: DNDC's National School Survey 2015

Notes: [a] Students responding to "ever" consuming the substance (asked of all survey respondents). There was one student for whom the grade level was not reported; hence responses were not included in the table above.
[b] Percentages are computed with the number as a proportion of grade level total.

Table 10.2.2

Current Use[a] of ATODs and Energy Drinks by Grade Level of Survey Respondents, 2015

Substance[c]	Grade Level[b]												Overall (n = 3,017)	
	M2 (n = 490)		M3 (n = 547)		S1 (n = 584)		S2 (n = 511)		S3 (n = 457)		S4 (n = 427)			
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
LEGAL DRUGS	**106**	**21.6**	**143**	**26.1**	**136**	**23.3**	**95**	**18.6**	**95**	**20.8**	**115**	**26.9**	**690**	**22.9**
Alcohol	88	18.0	127	23.2	111	19.0	67	13.1	74	16.2	77	18.0	544	18.0
Cigarettes	6	1.2	6	1.1	8	1.4	19	3.7	18	3.9	37	8.7	94	3.1
Inhalants	14	2.9	14	2.6	26	4.5	17	3.3	7	1.5	13	3.0	91	3.0
ILLEGAL DRUGS	**3**	**0.6**	**12**	**2.2**	**38**	**6.5**	**70**	**13.7**	**85**	**18.6**	**130**	**30.4**	**338**	**11.2**
Cocaine	1	0.2	1	0.2	2	0.3	3	0.6	3	0.7	7	1.6	17	0.6
Crack	2	0.4	1	0.2	2	0.3	1	0.2	3	0.7	5	1.2	14	0.5
Ecstasy	-	-	-	-	4	0.7	1	0.2	1	0.2	7	1.6	13	0.4
Heroin	1	0.2	1	0.2	2	0.3	1	0.2	3	0.7	3	0.7	11	0.4
Marijuana	2	0.4	9	1.6	37	6.3	68	13.3	83	18.2	126	29.5	325	10.8
Other Drugs	5	1.0	3	0.5	10	1.7	8	1.6	9	2.0	9	2.1	44	1.5
Binge Drinking[d]	32	6.5	57	10.4	44	7.5	24	4.7	31	6.8	24	5.6	212	7.0
Energy Drinks	65	13.3	111	20.3	134	22.9	125	24.5	86	18.8	103	24.1	624	20.7

Source: DNDC's National School Survey 2015

Notes: [a] Of students who responded to "ever" consuming the substance, and reported use in the past 12 months, who then have consumed it in the "past 30 days" (asked only of all lifetime and recent users but reported as a proportion of all survey respondents). There was one student for whom the grade level was not reported; hence responses were not included in the table above.
[b] Survey did not measure current use of cannabis resin and hashish.
[c] Percentages are computed with the current use number as a proportion of total grade level survey respondents for each substance.
[d] Computed for current use but reported as a proportion of all survey respondents.

Table 10.2.3
Protective Factor Scale Proportions[a] Reported by Survey Respondents, by Grade Level, 2015

		M2	M3	S1	S2	S3	S4
		%	%	%	%	%	%
Community Domain	Community Rewards for Prosocial Involvement	79	73	68	64	65	66
	Community Opportunities for Prosocial Involvement	62	63	63	66	59	67
Family Domain	Family Attachment	89	83	78	76	76	75
	Family Opportunities for Prosocial Involvement	84	82	79	70	75	76
	Family Rewards for Prosocial Involvement	94	91	83	82	81	82
School Domain	School Opportunities for Prosocial Involvement	89	85	83	82	81	85
	School Rewards for Prosocial Involvement	87	84	80	79	79	82
Peer and Individual Domain	Rewards for Prosocial Involvement*	86	87	87	86	89	87
	Interaction with Prosocial Peers*	90	89	91	90	93	91
	Belief in the Moral Order	32	34	37	41	44	41
	Prosocial Involvement*	85	88	90	91	90	93
	Religiousity	45	44	41	33	35	33
	Social Skills	92	90	84	82	82	80
	Average	**78**	**76**	**74**	**73**	**73**	**74**

Source: DNDC's National School Survey 2015

Note: [a] Some scores are low because of the small number of responses to the survey items comprising the particular scale.

Table 10.2.4
Risk Factor Scale Scores[a] Reported by Survey Respondents, by Grade Level, 2015

		M2	M3	S1	S2	S3	S4
		%	%	%	%	%	%
Community Domain	Low Neighbourhood Attachment	18	18	22	21	17	18
	Community Disorganisation	6	8	11	12	9	11
	Transitions and Mobility	49	55	66	55	62	59
	Perceived Availability of Drugs	10	17	31	44	56	66
	Perceived Availability of Handguns	3	3	5	7	13	12
	Laws and Norms Favourable to Drug Use	18	23	29	34	36	37
	Laws and Norms Favourable to Handguns	24	30	41	47	55	53
Family Domain	Family History of Antisocial Behaviour	21	27	38	44	54	58
	Poor Family Management	4	5	8	10	9	12
	Family Conflict	29	30	42	41	44	37

Source: DNDC's Survey of Substance Use among the Homeless Population in Bermuda 2015.

Table 10.2.4 cont'd
Risk Factor Scale Scores[a] Reported by Survey Respondents, by Grade Level, 2015

		M2	M3	S1	S2	S3	S4
		%	%	%	%	%	%
Family Domain	Parental Attitudes Favourable toward ATOD Use	2	2	4	8	11	14
	Parental Attitudes Favourable toward Antisocial Behaviour	6	6	9	9	10	9
School Domain	Poor Academic Performance	8	7	9	9	6	7
	Lack of Commitment to School	5	7	10	10	13	11
Peer and Individual Domain	Rebelliousness	15	14	24	25	25	30
	Gang Involvement	2	3	4	5	7	5
	Favourable Attitudes toward ATOD Use	3	4	11	21	28	37
	Favourable Attitudes toward Antisocial Behaviour	3	4	7	8	8	6
	Sensation Seeking	57	65	67	71	74	80
	Peer Rewards for Antisocial Behaviour	25	35	46	56	63	59
	Friends' Use of Drugs	12	24	44	61	76	80
	Friends Delinquent Behaviour	9	12	18	22	26	25
	Low Perceived Risks of Drug Use	2	4	9	14	16	21
	Early Initiation of Drug Use	30	17	19	21	17	12
	Intention to Use	3	4	10	13	18	22
	Average	**15**	**17**	**24**	**27**	**30**	**31**

Source: DNDC's National School Survey 2015

Note: [a] Some scores are low because of the small number of responses to the survey items comprising the particular scale.

10.3 SUBSTANCE ABUSE TREATMENT SERVICES

The Survey of Substance Abuse Treatment Services (SSATS) was conducted in the second quarter of 2016 among 14 facilities, both public and private, in Bermuda. A total of 13 facilities responded to the survey. The SSATS provides a mechanism for quantifying the dynamic character and composition of Bermuda's substance abuse treatment delivery system.

Type of care offered comprises three broad categories: outpatient, residential (non-hospital), or hospital inpatient, each with several subcategories. A facility could offer more than one type of care. Eight facilities reported that they provided outpatient care, five provided residential (non-hospital) care, and one provided hospital inpatient care (see Table10.3.1). Half of the facilities that provided either residential or outpatient care is government facilities and the other half is mainly private non-profit.

Although 10 facilities indicated that they provide substance abuse treatment services, only eight reported to have had clients in care on March 31st, 2016 (see Table 10.3.1). There were as many as 371 persons receiving substance abuse treatment services in the form of different types of care in eight facilities in Bermuda as on the reference date of March 31st, 2016. Most persons received outpatient care (n=307) and in the form of regular outpatient treatment (non-intensive) [n=166] followed by methadone/buprenorphine maintenance (n=117).

There were as many as 371 persons receiving substance abuse treatment services in the form of different types of care in eight facilities in Bermuda…

There were 59 clients in residential (non-hospital) care for substance abuse treatment and five persons received hospital inpatient care on the same reference date under consideration.

Five facilities indicated that, on average, during the March 2016 reference period, their outpatient substance abuse services were operating at or about total capacity (95 to 100%), while two facilities responded that their outpatient services were operating somewhat under capacity (80 to 94%) (see Table 10.3.2). There was one facility whose outpatient substance abuse services was operating well under capacity (under 80%).

Facilities were asked to report the number of residential (non-hospital) and hospital inpatient beds designated for substance abuse treatment. Residential (non-hospital) facilities generally had slightly higher utilisation rates than the one hospital inpatient facility. The five residential facilities reported having 86 residential (non-hospital) beds designated for substance abuse treatment on March 31st, 2016. The overall utilisation rate was 69%. All of the residential facilities, with the exception of one, reported operational capacity under 80% on March 31st, 2016; with an average of 12 clients. The one facility, Turning Point, which offered hospital inpatient services and reported having eight beds designated for substance abuse treatment on March 31st, 2016. The overall operational capacity under 80% as well, where its utilisation rate stood at 63%. There were five clients receiving hospital inpatient substance abuse treatment services as of March 31st, 2016.

Facilities were asked about the types of services they provided. Services were grouped into seven broad categories: assessment and pre-treatment services, testing, counselling, transitional services, pharmacotherapies, ancillary services, and other services. Some elements of assessment and pre-treatment, counselling, and ancillary services were offered by all of the facilities (see Table 10.3.3). For instance, screening for substance abuse was offered by all of the facilities, as well as social skills development and substance abuse education. Individual and group counselling was the most frequently reported form of counselling, by 10 facilities, and marital/couples counselling was reported least frequently, by five facilities. A majority of the facilities offered testing and transitional services such as drug and alcohol urine screening aftercare/continuing care, which was offered by nine of the facilities. Few of the facilities offered pharmacotherapies or other services. In terms of the pharmacotherapies provided, at least one was provided by two facilities, primarily focused on substance abuse treatment. No one pharmacotherapy was more common than the other. These facilities also utilised a variety of clinical or therapeutic approaches in the delivery of their services.

Table 10.3.1
Type of Care Offered by the Number of Treatment Facilities and Clients in Treatment by Type of Care Offered, 2016

Type of Care	Number of Facilities[1]	Clients in Treatment on March 31st, 2016
Outpatient	**8**	**307**
Regular[2]	8	166
Intensive	2	10
Day treatment/partial hospitalisation	1	2
Detoxification	1	12
Methadone/buprenorphine maintenance or Vivitrol®	1	117
Residential (non-hospital)	**5**	**59**
Short term (<30 days)	-	-
Long term (30+ days)	5	59
Detoxification	-	-
Hospital Inpatient	**1**	**5**
Treatment	1	-
Detoxification	1	5
Total	8	371

Source: DNDC's Survey of Substance Abuse Treatment Services, 2016

Notes: [1] Facilities may provide more than one type of care.
[2] Includes 50 aftercare clients considered by five reporting facilities as outpatients.

Table 10.3.2
Facility Capacity and Utilisation Rate, 2016

	Residential	Hospital Inpatient
Number of facilities	5	1
Number of clients[1]	59	5
Number of designated beds	86	8
Utilisation rate[2]	68.6	62.5
Average number of designated beds per facility	17	8

Source: DNDC's Survey of Substance Abuse Treatment Services, 2016

Notes: [1] Number of clients on March 31st, 2016.
[2] Computed as [{number of clients/number of beds) x 100]

Table 10.3.3
Types of Services Offered by Number of Facilities, 2016

Types of Services Offered	No. of Facilities
Assessment and Pre-Treatment Services	10
Testing	9
Counselling	10
Transitional Services	9
Pharmacotherapies	2
Ancillary Services	10
Other Services	4

10.4 TREATMENT DEMAND

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

The last publication of data from the Treatment Demand Indicators Survey, in the 2015 Annual Report of the BerDIN, included 87 records up to August 2015. However, this section of the report contains data on clients who sought treatment from January 2015 to August 2016; therefore, note there is an overlap in the reporting period. There were 66 persons who have sought substance abuse treatment over this period by these treatment facilities (see Table 10.4.1). A total of 47 males and 19 females have required the services of inpatient (including residential), outpatient, and in-prison (residential) treatment. An indication of the demand for treatment services, as reflected by the dates of assessment on the available data, showed that 32 clients sought substance abuse treatment services in 2015 and 23 up to August 2016. Most persons were clients of the Turning Point Substance Abuse Programme; although the data presented in this section does not represent the full coverage of this programme's provision of services to its clients. Data from this facility has not been consistently submitted to the DNDC.

Persons requiring treatment services ranged from 14 years to 68 years with more than half of these clients being 45 years or older and about one-fifth under 35 years. These persons who sought treatment were more likely to self-refer (53%) or, in other instances, sought treatment because of a court order or to complete probation or parole (27.3%). Over half of the clients (54.5%) who sought treatment during this period have received treatment sometime in the past, from as early as 2000 to more recent as earlier in 2015. However, only 12.1% 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 less than one-third (30.3%) of the persons sought treatment for heroin use, while fewer than one-fifth sought treatment for use of crack (19.7%) or alcohol (19.7%). Persons also sought treatment for cannabis, cocaine, opiates in general (including methadone).

Most of the persons (54.5%) have reported daily use of drugs whereas 15.1% indicated that they have not used any drugs in the past month prior to seeking treatment (see Table 10.4.3). Smoking or inhaling (47%) was reported as the main method of administering the drugs followed by sniffing (31.8%) (see Table 10.4.4).

The age of first use of the identified primary drug ranged from four years to 55 years, with an average age of onset being 23.4 years. However, slightly less than one-third (28.8%) of the persons who sought treatment indicated that they first used their primary drug between the ages of 13 to 17 years, while about one in 10 (7.6%) 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 13.6 years for MDMA and other derivatives to 39.5 years for methadone (see Table 10.4.6). The average age of at which smoking marijuana began was 14.6 year and 15.2 years for drinking alcohol. First use of harder drugs began later at about 27 years for cocaine and crack and 32.5 years for heroin.

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" (63.6%) or "mostly available" (16.7%); and about two-thirds (62.1%) indicated that they purchased their drugs from a regular supplier (see Table 10.4.7). At the same time, more than half of the persons (54.5%) stated that they made money or obtained 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 are 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, or the new initiative currently undertaken by the DNDC.

Table 10.4.1
Demographic Characteristics of Clients Seeking Treatment, 2015 to 2016

Characteristic	Number of Persons
Total	**66**
Sex	
Males	47
Females	19
Facility	
Men's Treatment	6
Women's Treatment Centre	15
Turning Point	17
Right Living House	12
Salvation Army Harbour Light	16
Type of Treatment Facility	
Inpatient	44
Outpatient	10
Treatment in Prison	12
Source of Referral	
Self-Referred	35
Court/Probation/Parole	18
Family/Friends	3
Other Drug-Treatment Centre	3
Social Service	2
Hospital/Other Medical	1
Other	3
Not Stated	1

Table 10.4.1 cont'd
Demographic Characteristics of Clients Seeking Treatment, 2015 to 2016

Characteristic	Number of Persons
Living Status (With Whom)	
Alone	14
With Parents	13
Alone with Child	3
Alone with Partner	4
With Partner and Child/Children	7
With Friends	4
Other	12
Not Known & Not Stated	9
Living Status (Where)	
Stable Accommodation	40
Unstable Accommodation	12
Institution (Prison/Clinic)	6
Not Known & Not Stated	8
Nationality	
National of Bermuda	57
National of Another Country	1
Not Known & Not Stated	8
Labour Status	
Regular Employment	17
Economically Inactive	2
Pupil/Student	1
Unemployed	29
Other	9
Not Stated	8
Highest Education Level Completed	
Never Went to School/Never Completed Primary School	1
Primary Level of Education	10
Secondary level of Education	31
Higher Level of Education	14
Not Known & Not Stated	10

Source: DNDC's Treatment Demand Indicators Survey

Table 10.4.2
Primary Drug of Impact of Clients Seeking Treatment, 2015 to 2016

Primary Drug of Impact	Number of Persons
Heroin	20
Crack (only)	13
Cocaine (only)	4
Alcohol	13
Cannabis	6
Opiates (Heroin, Methadone, Other Opiates)	4
Cocaine (including Crack)	5
Not Stated	1

Source: DNDC's Treatment Demand Indicators Survey

Table 10.4.3
Frequency of Drug Use, 2015 to 2016

Frequency	Number of Persons
Used daily	36
Not used in past month	10
Used 2-6 days per week or less	12
Used once per week or less	6
Not known	1
Not stated	1

Source: DNDC's Treatment Demand Indicators Survey

Table 10.4.4
Primary Route of Drug Administration, 2015 to 2016

Primary Route	Number of Persons
Smoke/Inhale	31
Sniff	21
Drink	11
Inject	1
Other	1
Not Stated	1

Source: DNDC's Treatment Demand Indicators Survey

Table 10.4.5
Age of First Use of Primary Drug, 2015 to 2016

Age	Number of Persons
Less than 13 years	5
13 – 17 Years	19
18 – 20 Years	7
21 – 24 Years	7
25 – 29 Years	7
30 – 34 Years	11
35 – 39 Years	1
40+ Years	7
Not Stated	2

Source: DNDC's Treatment Demand Indicators Survey

Table 10.4.6
Average Age of Initiation by Type of (Secondary) Drug, 2015 to 2016

Drug	Average Age of Initiation
Cannabis	14.6
Alcohol	15.2
Opiates (Total)	19.0
Heroin	32.5
Methadone	39.5
Cocaine (Total)	27.8
Cocaine	27.0
Crack	27.7
Stimulants (Total)	19.0
MDMA and Other Derivatives	13.0

Source: DNDC's Treatment Demand Indicators Survey

Table 10.4.7
Drug Market (Availability, Supplier, and Proceeds), 2015 to 2016

Availability of Primary Drug	Number of Persons
Always Available	42
Mostly Available	11
Sometimes Available	2
Not Stated	11
Purchased from Regular Supplier	
Yes	41
No	12
Not Stated	13
Made Money or Obtained Drugs by Selling Illegal Drugs or Being Involved in Manufacture or Transportation of Drugs	
Yes	36
No	31
Not Stated	9

Source: DNDC's Treatment Demand Indicators Survey

Table 10.4.8
Drug Market (Packaging of Drugs), 2015 to 2016

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
Opiates	**Alcohol**
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 majority of the supply reduction budget was allocated to HM Customs' interdiction efforts…

The majority of Bermuda's demand reduction programmes and activities are funded and overseen by the DNDC. A few treatment and prevention programmes are directly funded through the Department, while other initiatives are supported through an annual grant provision to community-based partners and stakeholders. Allocation of funding to drug control, like with many other government expenditure, has seen a decline with cuts across the board over the past few years.

In total, the government expended slightly less than $15 million on drug control in Bermuda in FY 2015/2016; however, slightly dropping from the previous FY 2014/2015, where drug control expenditure stood at $15.3 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; $9.3 million and $9.5 million vs. $6.0 million and $5.4 million, in FY 2014/2015 and FY 2015/2016, 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. However, funding for treatment services, in general, declined marginally by almost 1% from FY 2014/2015 to FY 2015/2016; funding for prevention services, at the same time, also decreased slightly by 1.7% (see Table 11.1.1).

In both fiscal years under review, the majority of the supply reduction budget was allocated to HM Customs' interdiction efforts and a smaller proportion to the Bermuda Police Service 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 decline by 9.4% year over year – moving from a $6.0 million in FY 2014/2015 to $5.4 million in FY 2015/2016.

Sufficient evidence exist 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 Department for National Drug Control and through the implementation of the National Drug Control Master Plan and Action Plan for 2013-2017, 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, 2014/2015 and 2015/2016

	2014/2015 ACTUAL ($000)	2015/2016 REVISED ($000)
TREATMENT	**8,546**	**8,475**
% Change	**-8.2**	**-0.8**
DNDC (MT, WTC, Treatment Unit)	2,357	2,290
Grantees		
Salvation Army	100	100
FOCUS Counselling Services	185	185
Other (BACB)	**100**	**100**
Other Agencies		
BARC	897	1,054
BYCS	817	948
Drug Court	404	424
Mandatory Drug Treatment (RLH)	1,318	1,354
Turning Point Substance Abuse Programme+	2,384	2,020
Capital Project++	-16	-

Table 11.1.1 cont'd
Government Expenditure on Drug Treatment and Prevention, 2014/2015 and 2015/2016

	2014/2015 ACTUAL ($000)	2015/2016 REVISED ($000)
PREVENTION	**694**	**682**
% Change	**0.6**	**-1.7**
DNDC (Prevention Unit & Community Education)	411	399
Grantees		
PRIDE	183	183
CADA	100	100
TOTAL DEMAND REDUCTION	**9,329**	**9,520**
% Change	**-6.7**	**2.0**

Source: Government of Bermuda Budget

Notes: [+] Sourced directly from Turning Point Substance Abuse Programme.
[++] New Substance Abuse Treatment Centre.

Table 11.1.2
Government Expenditure on Enforcement and Interdiction, 2014/2015 and 2015/2016

	2014/2015 ACTUAL ($000)	2015/2016 REVISED ($000)
ENFORCEMENT AND INTERDICTION		
Police – Enforcement (Drugs, Financial Crime, and Intelligence Divisions)	1,222	1,540
Customs – Interdiction	4,776	3,897
TOTAL SUPPLY REDUCTION	**5,998**	**5,437**
% Change	**4.5**	**-9.4**

Source: Government of Bermuda Budget

LOOKING AHEAD

This, the 2016 report of the BerDIN shows very little change in drug control over the past year. Information about people in treatment for drug use disorders continues to be used as a proxy for understanding the nature, as well as a latent indicator, of trends in drug use resulting in severe health consequences. Opioids, as observed in this report, stand out as a major drug of concern. More people are in treatment for the first time for opioid or cocaine use disorders than in 2014. The number of people in treatment for cocaine including crack cocaine, remains quite high, especially for those classified as being dependent; indicating that there remains a high demand for treatment. Access issues, however, remain a challenge and limited funding threatens the provision of a continuum of care.

Poly drug use and the increased complexity of shifts between the use of different drug combination pose challenges to people responding to emergencies related to drug use, as well as to those treating drug use disorders. In such instances poly drug use can compromise treatment efforts that are drug specific. Pharmacologically-assisted treatment of disorders related to opioid use has proved effective, whereas for other drugs such as stimulants and cannabis, the treatment interventions available are mostly psychosocial and behavioural. This situation requires policymakers and practitioners to be more aware of emerging trends in drug use and to have mechanisms in place to detect and diagnose a wider range of substances used. Obtaining emergency room information as it relates to drug use, inclusive of poly drug use, is a major challenge for the reporting system. The same can be said for prescription drug abuse, another area of very little reporting within the BerDIN system.

The recent data emerging from the report shows worrying information relating to drug use and youth, specifically the consumption of marijuana. There is little evidence of cannabis users driving under the influence, although a number of young people admitted to being in a vehicle operated by someone who was under the influence. Agencies such as CLSS and Pathways Bermuda that offer adolescent counselling and early intervention services do not provide substance treatment services. Tracking this indicator will provide the support needed to provide treatment to young people who could benefit from intensive substance abuse treatment.

As with any law carrying the potential of criminal punishment, the enforcement of drug-related laws may result in a corresponding burden on the criminal justice system and require resources dedicated to investigation, prosecution, adjudication, and incarceration in connection with drug-related offences. Drug-related offences recorded by the police, and offences related to personal consumption, have increased slightly over the past year. This, coupled with the increased demand for treatment, would indicate a need for adequate funding and human resources. Given the fact that the drug problem is intertwined with a vast array of factors, it is important that the existing partnerships are made stronger than ever before.

Despite the challenges facing the Network, as a whole, and the individual agencies within the Network, the BerDIN continues to evolve as the epicenter of drug-related information. Drug misuse can only be eliminated if the drug control community is steadfast to its mission. Through a shared vision and dedication to this cause, the work of preventing, treating, and interdicting drugs is possible. The BerDIN, through the coordination of the DNDC, will continue to provide accurate and timely information that will aid the collective understanding of the drug situation in Bermuda.

The recent data emerging from the report shows worrying information relating to drug use and youth, specifically the consumption of marijuana.

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, 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, Poly Drug Use First-Time and Repeat Offenders
– 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 Drug Prevalence: Pregnant Women Youth Drug Prevalence* Substance Abuse Treatment Services+ Treatment Demand Government Expenditure on Drug Prevention and Treatment; Enforcement and Interdiction Clients in Treatment+
– 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

+ New data source/report item.
* Updated/Expanded indicators.

IMPLICATIONS OF THE PRESENT DRUG SITUATION

Public Health, Programme, Policy, and Legislative Implications

New Indicators

DATA	IMPORTANCE OF THE INDICATORS	PUBLIC HEALTH/ PROGRAMME IMPLICATIONS	POLICY AND LEGISLATIVE IMPLICATIONS
Types of Care Offered	No one treatment method applies to all persons seeking substance abuse treatment. Effective treatment can occur when the service is tailored to the needs of the client. In Bermuda, there are several addiction therapies and services that are consistent with research-based practices and are integral to clinical programmes.	Individual paths to recovery differ and packages of treatments and supportive services for mental and substance use disorders should be tailored to fit individual needs. For many people with behavioural health problems the most effective approach often involves a combination of counselling and medication. Supportive services, such as case or care management, can also play an important role in promoting health and recovery.	Need for clinically-managed high-intensity residential services and medically-monitored intensive inpatient services.
Types of Substance Abuse Treatment Services Provided	Successful treatment has several steps: • detoxification (the process by which the body rids itself of a drug) • behavioural counselling • medication (for opioid, tobacco, or alcohol addiction) • evaluation and treatment for co-occurring mental health issues such as depression and anxiety • transitional housing • long-term follow-up to prevent relapse	Research studies on addiction treatment typically have classified programmes into several general types or modalities. Treatment approaches and individual programmes continue to evolve and diversify, and many programmes today do not fit neatly into traditional drug addiction treatment classifications.	Funding to support diversified continuum of care. Workforce development toward substance abuse addiction counselling certification.
Treatment Facility Capacity	The number of residential (non-hospital) and hospital inpatient beds designated for substance abuse treatment. Treatment facility capacity is needed to calculate utilisation rates.	The ability of substance abuse treatment facilities to serve persons with addiction issues is largely dependent on funding. Once service capacity is reached a waiting list in often implemented. Service capacity can sometimes change depending on both the financial and human resources of a programme.	There continues to be a need to increase funding and capacity for substance abuse services in order to avert the costs of untreated substance abuse and realise economic benefits through successful treatment.
Treatment Facility Utilisation Rates	Drug treatment facility use or utilisation is directly related to whether or not a person wants treatment for his/her condition.	In general, persons with substance dependence who receive treatment have been found to experience less disability related to substance use in their lifetime than untreated persons. Given the public health implications of substance use treatment, obtaining accurate counts of the number of persons who need and receive substance use treatment is critical.	Targeted outreach to clients to assess their readiness for change.
Illicit and Anti-Doping Tests by Sport	Provides guidelines on substances and methods that are prohibited at all times, both in-competition and out-of-competition.	Allows for the identification of illegal and illicit drugs and provides the foundation to plan for effective testing and to maintain the integrity and identity of samples, from notifying the athlete to transporting samples for analysis.	Alignment of Bermuda's anti-doping policies, rules, and regulations to those implemented worldwide.

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

TARIFF CODE	DESCRIPTION	2014 & 2015 (From April 1, 2013)
2203.000	Beer	$0.99 per L
2204.100	Sparkling Wine	$2.89 per L
2204.210	Wine in Containers Holding 2 Litres or Less	$2.89 per L
2204.290	Wine in Containers Greater Than 2 Litres	$2.89 per L
2204.300	Other Grape Must	$2.89 per L
2205.100	Vermouth in Containers Holding 2 Litres or Less	$2.89 per L
2205.900	Vermouth in Containers Holding Greater Than 2 Litres	$2.89 per L
2206.000	Other Fermented Beverages	$1.41 per L
2207.100	Undenatured Ethyl Alcohol	$26.57 per LA
2207.200	Denatured Ethyl Alcohol	$0.75 per LA
2208.200	Brandy and Cognac	$26.57 per LA
2208.300	Whiskies	$26.57 per LA
2208.400	Rum and Other Spirits From Sugar Cane	$26.57 per LA
2208.500	Gin and Geneva	$26.57 per LA
2208.600	Vodka	$26.57 per LA
2208.700	Liqueur and Cordials	$26.57 per LA
2208.900	Other Spirituous Beverages	$26.57 per LA
9802.001	Accompanied Personal Goods: Wine of Fresh Grapes	$2.89 per L
9802.002	Accompanied Personal Goods: Spirituous Beverages	$10.63 per L
2401.100	Tobacco, Not Stemmed/Stripped	$0.29 per KG
2401.200	Tobacco, Partly or Wholly Stemmed/Stripped	$0.29 per KG
2401.300	Tobacco Refuse	$0.29 per KG
2402.100	Cigars, Cheroots, etc. Containing Tobacco	33.5%
2402.200	Cigarettes Containing Tobacco	$0.22 per U
2402.900	Other Tobacco Products; or Products of Tobacco Substitutes	33.5%
2403.110	Water Pipe Smoking Tobacco	33.5%
2403.190	Other Smoking Tobacco	33.5%
2403.910	"Homogenised" or "Reconstituted" Tobacco	33.5%
2403.990	Tobacco Extracts and Essences; Other Manufactured Products of Tobacco	33.5%
9802.003	Accompanied Personal Goods: Cigarettes Containing Tobacco	$44.00 per 200 U
9803.163	Smoking Tobacco; Cigars, Cheroots and Cigarillos, Containing Tobacco (Imported by Post or Courier)	33.5%
9803.171	Cigarettes Containing Tobacco	$44.00 per 200 U

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 this 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.

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 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 12 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.

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 two to three 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 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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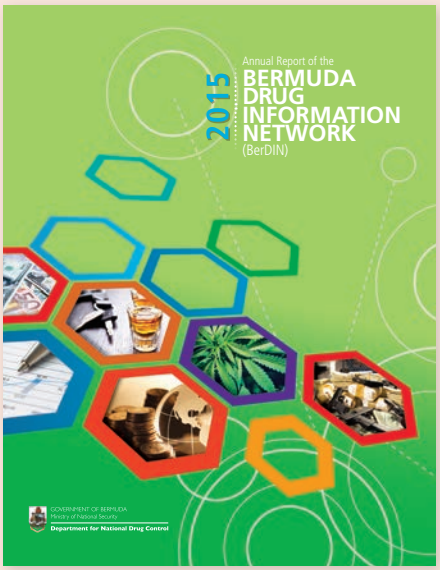
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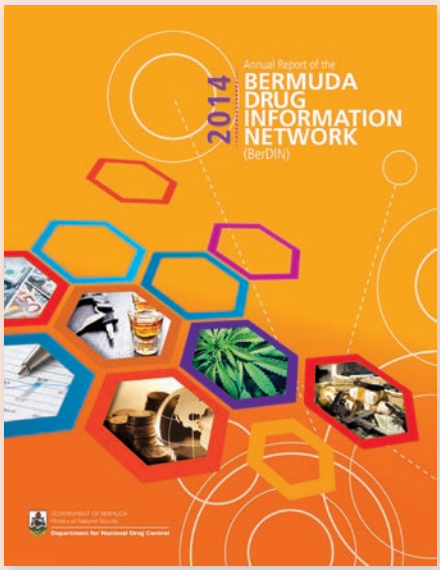
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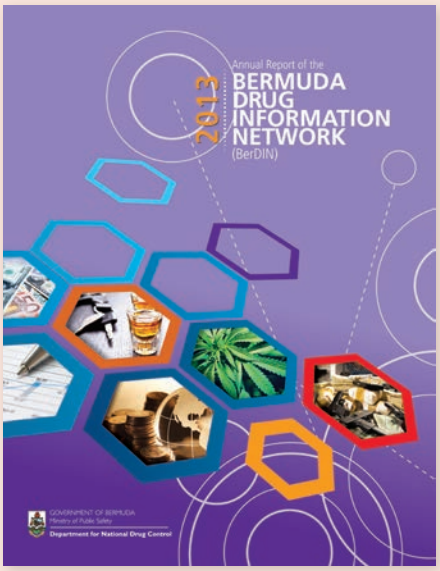
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