

2017

Annual Report of the
**BERMUDA
DRUG
INFORMATION
NETWORK**
(BerDIN)



GOVERNMENT OF BERMUDA
Ministry of Social Development and Sports

Department for National Drug Control

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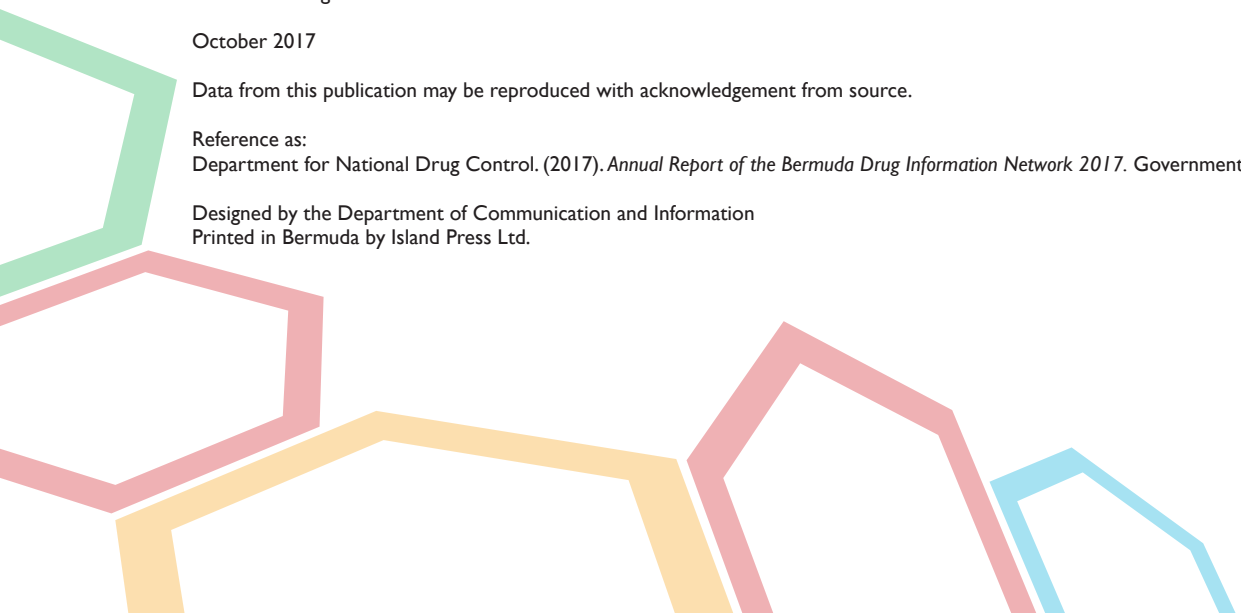
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BERDIN'S MISSION

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

“Individual commitment to a group effort – that is what makes a team work, a company work, a society work, a civilization work.”
Vince Lombardi

It is our great pleasure to release the 2017 Annual Report of the Drug Information Network (BerDIN), the Department for National Drug Control’s (DNDC) main publication, which provides the latest data on the drug situation in Bermuda. We offer you this compendium of information and analysis that is rich and multi-layered, based on the most recent data and statistics provided by our strategic partners.

The 2017 report provides an annual update of the drug phenomenon in Bermuda and builds on the report published in 2016. Later this year, the information reported in this year’s publication will provide the basis for measurement against performance indicators established in the National Drug Control Master Plan and Action Plan 2013-2017.

At the DNDC, we are tasked with collecting data and ensuring that it is fit for purpose. In doing so, we strive to provide the best possible evidence that will contribute to realising our vision of a healthier and more secure Bermuda. As a top-level overview and analysis of drug-related trends and developments, we intend this report to be a useful tool for policy-makers and planners who wish to base their strategies and interventions on the most recent information available. In line with our objective to deliver high quality information to our stakeholders, this publication provides access to data that can be used for multiple purposes: as baseline and follow-up data for policy and programme evaluations; to give context and help define priorities for strategic planning, as with the National Drug Strategy, to enable comparisons to be made between national situations and datasets; and to highlight emerging threats and issues.

This year’s report highlights some potentially worrying changes in the market for opioids, namely fentanyl, the substance that continues to be associated with a high level of morbidity and mortality in other jurisdictions. We note the overall increase in reports of drug seizures linked with fentanyl and the continued consumption of crack cocaine and heroin. As the drug phenomenon continues to evolve, so too must Bermuda’s response to drugs. The framework for concerted action, set out in the National Drug Control Master Plan and Action Plan 2013-2017 is nearing expiration. The anticipated new strategic focus will allow for the inclusion of emerging synthetic drugs. A new drug strategy and action plan for the period 2019-2023 is anticipated after discussions with the Minister of Social

Development and Sports. It will build on the findings of the evaluation for the 2013-2017 Plan.

In conclusion, we wish to thank our partners in the BerDIN Network of national focal points, who provide most of the data that underpin this publication. It is the contribution and investment made by Member agencies that not only make this report possible, but without which this analysis would be less rich.



Joanne Dean
Director
Department for National Drug Control
October 2017

...a useful tool for policy-makers and planners who wish to base their strategies and interventions on the most recent information available.

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DATA NOTES

ACAD	Associate Alcohol and Drug Counsellor	kg	Kilograms
ADS	Alcohol Dependence Scale	L	Litre
APP	Associate Prevention Professional	LA	Litre of Alcohol
ATOD	Alcohol, Tobacco, and Other Drugs	LLA	Liquor Licence Authority
BAC	Blood Alcohol Concentration	LST	LifeSkills Training Programme
BACB	Bermuda Addiction Certification Board	mg	milligrams
BARC	Bermuda Assessment and Referral Centre	MT	Men's Treatment
BPCS	Bermuda Professional Counselling Services	MWI	Mid-Atlantic Wellness Institute
BPS	Bermuda Police Service	n	Number
BSADA	Bermuda Sport Anti-Doping Authority	NADO	National Anti-Doping Organisation
BYCS	Bermuda Youth Counselling Services	NAMLC	National Anti-Money Laundering Committee
CAF	Confiscation Assets Fund	OAS	Organisation of American States
CARIDIN	Caribbean Drug Information Network	OECD	Organised and Economic Crime Department
CCS	Certified Clinical Supervisor	OID	Inter-American Observatory on Drugs
CCES	Canadian Center for Ethics in Sport	PATHS	Promoting Alternative THinking Strategies
CICAD	Inter-American Drug Abuse Control Commission	POCA	Proceeds of Crime Act
CLSS	Counselling and Life Skills Services	PWC	Professional Worldwide Controls
CMIT	Cross-Ministry Team	Q	Quarter
CPS	Certified Prevention Specialist	r	Revised
Co-Ed	Coeducational	RLH	Right Living House
DAST	Drug Abuse Screening Test	SAR	Suspicious Activity Report
Detox	Detoxification	TAAD	Triage Assessment for Addictive Disorders
dl	Decilitres	TC	Therapeutic Community
DNDC	Department for National Drug Control	THC	Tetrahydrocannabinol
DPP	Department of Public Prosecutions	TIPS	Training for Intervention Procedures by Servers of Alcohol
DSM	Diagnostic and Statistical Manual of Mental Disorders	u	Units
DTC	Drug Treatment Court	UKAD	United Kingdom Anti-Doping
DUI	Driving Under the Influence	UNDCP	United Nations Drug Control Programme
EAP	Employee Assistance Programme	UNODC	United Nations Office on Drugs and Crime
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction	USADA	United States Anti-Doping
ER	Emergency Room	WTC	Women's Treatment Centre
FCU	Financial Crime Unit	%	Percentage
FIA	Financial Intelligence Agency	000	Thousands
FY	Financial/Fiscal Year	-	Zero or unit less than 0.1
g	Grams	\$	Bermuda Dollar
GBH	Grievous Bodily Harm	..	Not Applicable
HM	Her Majesty	...	Not Available
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		

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.

This report offers a snapshot of the Bermuda drug situation based on the latest available information from local monitoring activities. An overview of the drug market, drug use and harms, as well as how drug markets are related to other criminal activities, form the body of this report. This introductory section features a brief analytical overview on some of the key themes emerging from this year's data. As the drug problems facing Bermuda are increasingly influenced by, and interact with, developments occurring internationally, two important topics, cannabis use and changes in the opioid market, are relevant today in Bermuda. A majority of reported indicators remain relevant and are monitored and tracked by reporting agencies.

With the year 2017 marking the end of the National Drug Control Master Plan and Action Plan 2013-2017, demand reduction activities remained focused on preventing and reducing the harms associated with alcohol and drug misuse. Supply reduction agencies continue to interdict drugs both overseas and at the border, with the objective of prosecuting and seizing drugs and assets associated with the illicit drug trade. Some of the gaps in data that were identified in 2016 remain, these include, but are 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; and the distribution from wholesale all the way down to the retail level and, finally, consumption. This report however, aims to improve the understanding of the drug situation in Bermuda and to provide a platform for debate in the coming years.

This annual report continues as a set of interlinked elements that allows for ease of 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. The report contains 11 thematic chapters and provides an analysis of the most recent two-year period (2016 data with comparisons to 2015) based on the available data provided by reporting agencies to describe changes over this specified period. 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 BerDIN

Annual Report continues to evolve as new information becomes available.

The Drug Situation in Bermuda

Extent of Drug Use

Cannabis and alcohol remain the most widely used drugs on the Island. Trends in cannabis use appear to be more stable in the general population, as evidenced by data available in the recently conducted 2017 National Household Survey. Although cannabis is less likely to be reported than tobacco use, multiple sources report that it remains the illegal drug of choice. Both alcohol and tobacco use on a whole have declined. However, cannabis use increased slightly over the past four years. Poly drug use remains ever present amongst persons involved in the criminal justice system, who report using some combination of crack cocaine, opiates (heroin), and marijuana. Understanding what has led to the reductions in tobacco and alcohol use may offer insights in addressing the use of other substances, such as cannabis; although cannabis is often smoked in combination with tobacco. This is likely to have implications for public health policies.

Both alcohol and tobacco use on a whole have declined.

Substance Dependence/Abuse and Treatment

The National Drug Strategy has as one of its tenets, the provision of diversified approaches to demand reduction. During 2016, however, waiting lists still existed for residential treatment services. Continued austerity measures put in place by the Government have resulted in significant staffing reductions and a decrease in service provision by agencies in the treatment network.

Assessments done by the Bermuda Assessment and Referral Centre (BARC) continue to show that opiates, cocaine, and alcohol are the primary substances of choice amongst persons seeking treatment services in 2016. Many of these persons have met the clinical criteria for abuse of or dependence on such substances (problems related to their use), more so than persons assessed in 2015. Reports indicate that more persons new to drug treatment were more likely to meet the criteria for abuse of alcohol, cannabis, and cocaine; while persons that have been in treatment sometime prior were more likely to be dependent on opiates (heroin), alcohol, and cocaine. The majority of persons referred for substance abuse treatment between 2015 and 2016 were repeat cases. When it came to the level of severity of substance abuse or dependence, most persons assessed for treatment services were between a low to intermediate level of severity.

Ever-Present Drug Market

Significant effort and resources continue to be dedicated to restricting the supply of drugs entering 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 contribute more generally to economic and social well-being. Although criminal trials for drug possession have changed very little over the past year, and while the vulnerability of Bermuda to drugs and crime remains a concern, decreasing crime rates against the person, property, and the community, coupled with an increase in seizures of cannabis and cannabis resin indicate that interdiction agencies are working to reduce the availability of drugs on the market. The drug market, however, 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.

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.

Synthetic Drug Use

The year 2016 saw more seizures of the synthetic drug fentanyl by the Bermuda Police Service (BPS). There still remains, however, no formal reporting system for alerting relevant parties to its presence and availability on the drug market. Very little evidence of the presence and or use of other synthetic drugs exists.

Legislation

During 2016, drug-related crimes have decreased, demand for drugs remain 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.

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. While recent drafting of amendments to include synthetic drugs as part of the Misuse of Drugs Act occurred in 2016, these changes have yet to be tabled in the House of Assembly. Until such time, prosecuting cases of persons caught with synthetic drugs becomes

...prosecuting cases of persons caught with synthetic drugs becomes even more problematic.

even more problematic.

Cost of Treating Drug Problems

On a whole demand reduction activities, specifically substance abuse 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 2016. Other treatment agencies or programmes saw slight decreases in funding while the DNDC's Treatment Unit saw a marginal increase in FY 2016/2017. Level funding was provided to government grant recipients with the exception of FOCUS Counseling Services, which saw an 86.3% decrease in funding over the previous fiscal year. Substance abuse prevention services expenditure for the Prevention Unit of the DNDC saw an increase in funding, while prevention grant-recipient agencies saw level funding in 2016.

Supply reduction agencies saw a slight increase in funding by 0.8% during 2016. 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 necessary training and technical assistance for officers engaged in interdiction and enforcement efforts.

Existence of a "Treatment Gap"

The year 2016 saw the continued existence 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.

The Mental Health Treatment Court, a programme of the Department of Court Services, continues to be challenged with the provision of drug treatment services for dual-diagnosed clients. Bermuda lacks an inpatient medically-monitored drug treatment facility, which makes the placement of dual-diagnosed clients even more difficult.

Demand and Supply Reduction Activities and Initiatives During 2016

During 2016, there were many demand and supply reduction activities and initiatives implemented by the DNDC, other government departments, and community partners. In many cases, these initiatives are supported by the data compiled in this report. Other activities, especially those of supply reduction, may be captured elsewhere as a part of the respective agencies' annual report.

1. The DNDC and HM Customs continued their very successful cross-ministry initiative that sought to integrate the agency's efforts at providing a balanced approach to national drug control.
2. The Bermuda Police Service (BPS) has worked with its international law enforcement partners from the Caribbean region, Canada, USA, England, and Europe in interdicting drugs from reaching Bermuda's shores. Some of the interdictions led to international controlled deliveries, which resulted in several arrests.
3. The BPS has worked with its external partners like HM Customs, the General Post Office, and the local couriers' facilities in interdicting drug packages.
4. Local drug enforcement activities were executed by various units within the BPS. These enforcements were done at the street-level and house searches via search warrants under the various Bermuda legislations.
5. DNDC and the BPS continued to work together by having the Community Action Team (CAT) involved in drug prevention initiatives.
6. The Research Unit Provided the BPS with available data on drug prices.
7. The DNDC liased with HM Customs and BPS to provide funding for interdiction training.
8. Continued preparations for CARF accreditation by establishing and implementing new policies and procedures in the Men's Treatment (MT) programme. MT received Gold Star 3-year CARF international Accreditation.
9. Conformance reports submitted to CARF submitted in January 2016 for Turning Point (MWI) and Women's Treatment Centre (WTC).
10. Accucare Utilisation: BARC 0%; MTC 100% , WTC 10% , FOCUS 25%.
11. Prevention Unit coordinated the 2016 Recovery Month observance with the Treatment Officer. The Recovery Month theme was Join the Voices for Recovery: Our Families, Our Stories, Our Recovery!, which highlighted the value of family support throughout recovery. A calendar of events was formulated which outlined the activities of each of the six substance abuse treatment facilities. A public forum on preventing inter-generational transmission of addiction. The Bermuda Addiction Certification Board (BACB) counsellor of the year honours, radio interviews, and treatment stats highlights featured in Royal Gazette, WTC walk, Faith-based summit, public forum on family emotional health and recovery, as well as a community movie showing of the Anonymous People.
12. MT maintained an average of seven clients in residential program. Completed two Family Education Programs for about 10 individuals. Bed capacity of MT to returned to 12 persons. Three clients from MT participated in completion exercises in September.
13. WTC staff participated in weekly Drug Court staffing and courts. Temporary replacement of Clinical Coordinator. New Counsellor completed ICADC. One staff promoted to Addiction Counsellor. Census – admission are up with waiting list. Admitted Mental Health Court/Drug Court clients.
14. WTC retained CARF Accreditation-Conformance to quality standards. Bermuda Health Council Health Service Provider registration.
15. The Prevention Unit spearheaded the two-day Faith-based summit which included a cross-section of clergy from various denominations. Nearly 100 persons attended this event.
16. Celebrated Healthy Me Day, which is designated to develop young children's physical activity and healthy eating habits. A total of 91 3- to 5-year olds participated.
17. Substance abuse resource information for community stakeholders: Restoration Fellowship Community Health Fair; Butterfield and Vallis Staff Health Fair; and Victorious Women Breaking Chains of Addiction.
18. In collaboration with the Police Community Action Team, "What is a Drug Presentation" was held at the Victor Scott Primary School for students at the P5/P6 level.
19. "Boys Night In" drug prevention presentation at the Whitney Institute Middle School.
20. "Get in Gear, Real Life Strategies" information and awareness education on marijuana, alcohol, tobacco, other illicit drugs and paraphernalia for parents, educators, and persons interacting with young people, specifically those under 18.
21. Berkeley Institute PTSA presentation on risk factors at the biological, psychological, family, community and cultural level that puts adolescents at risk for substance abuse. Data on the results of the 2015 National School Drug Survey was also shared with those present.

22. Attended Club PRIDE completion at West Pembroke Primary. The Clubs' goal is to promote healthy, positive, drug free living through education and activities and to help others be drug-free by example and leadership.
23. The Underage Drinking Campaign, Youth and Alcohol Don't Mix concluded for the fiscal year 2016/2017 as education on Marijuana phased in. Advertisements were placed via local print media. Placements included the Cup-Match supplement, Back-to-School supplement, Parent Magazine and the avenue of the local workshops and presentations.
24. The Teen Peace End of Year fun event was hosted June 2016 at T N Tatem Middle School. Students from all of five middles schools attended. The event acknowledged those students who were most committed and independent thinkers, community minded and whose behaviors improved. Those in attendance enjoyed a Bermuda picnic and played games. All parents were invited. There were 63 students who participated in the programme for the year school ending 2017. The Prevention Unit focused on programme improvement.
25. In collaboration with the BACB, presented workshop on Environmental Change. The workshop reviewed the necessary resources needed to promote positive change in our community regarding the perceptions of drug and alcohol use and abuse via a public health model. There were 21 participants.
26. In collaboration with Bermuda Coalition presented the 2015 National School Drug Survey data at the first central Underage Drinking Town Hall Meeting. This community event including presenters from King Edward Memorial Hospital EMT's, Bermuda Police Service and Director of Health were in attendance. There were fewer than 10 persons in attendance.
27. Implemented the DNDC's first Persons in Recovery Programme. Ten persons from MT, Harbour Light, and NA/AA membership registered to attend the programme. The presenter focused on problem ownership and problem-solving styles and being an effective communicator as a parent.
28. Conducted primary research on general population through a household survey and commissioned the Omnibus Survey on public amenity. Implemented the Employee Climate Survey with DNDC staff.
29. Drafted, published and disseminated the 2015 Annual Report of the Bermuda Drug Information Network.
30. Institutionalized Training for Intervention Procedures (TIPS) for all servers and waiters of alcohol in licensed establishments continues to be tracked and monitored.
31. Continued quality monitoring and reporting of programmes that received grants and contributions.
32. Completed the data collection phase toward the estimation of the contribution of alcohol and illegal drugs to the GDP.
33. Prepared Cabinet Paper on Social Host Liability.
34. Increased quality improvement mechanisms with the implementation of Consumer Feedback Survey and Stakeholder Surveys at Men's Treatment, Women's Treatment Center, and the Right Living House.
35. Completed development of the National Drug Information Network, BerDIN, to identify prevention indicators and a data management system.
36. Continued to work NOVA Ltd. to develop database for the BerDIN.

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; more recently through the BerDIN data repository mechanism. 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 2016 Annual Report marks the sixth year in a row 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 the previous year's data

by May 15th of the current year to allow sufficient time for data cleaning, verification, and follow-up in preparation for pre-press layout and design.

New Data Sources and Report Items

Since the 2016 Annual Report, one periodic survey on drug prevalence among the general household population was updated with another round administered in 2017. In addition, the Financial Crimes subsection was expanded to include the number of civil recovery cases and the monies recovered from these orders.

During the past year, efforts have been made to obtain additional information on prescription drug use, characteristics of drug use by the offender population, concealment methods, and drug prices and consumption; but the information gathered thus far is presently insufficient or incomplete to make a meaningful contribution and be included in this report.



Photo courtesy of DCI

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)

The BerDIN Data Management System

In order to provide reliable, accurate, and timely information, a central, web-based data management system was created,



...an electronic solution that is centralised, effort- and time-efficient, and allows for ease of reporting

with the assistance of NOVA Ltd., to collate and manage information collected by each BerDIN agency in a central repository. This data management solution allows stakeholders to input data directly into the system; thereby providing an electronic solution that is centralised, effort- and time-efficient, and allows for ease of reporting. Further, such a mechanism allows the Government of Bermuda to maintain services and information sharing beyond changes in personnel or human expiration.

The year 2017, marks the second year in which the data management system has been operational. The system, created to assist with the transmittal and storage of drug-related data from agencies across the island, provides a collective focal point to retrieve drug control information.

This web-based data management system has the capacity to facilitate public access to archived and current DNDC information collated from over 20 agencies or about 35 data providers. The final phase of the database is the creation is a public interfacing application, which will allow the public to run data queries and retrieve information related to any of the over 150 indicators collected through the BerDIN. This phase awaits the identification of capital funding.

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 on an on-going basis. During 2016 there were fewer organisational challenges than in previous years, mitigated, in part, by steps taken over the years to ensure standardisation in monitoring, collating, and reporting. The majority of the agencies were able to log into the BerDIN data management system; allowing for a more seamless transfer of data between agencies and the DNDC. Although not all of the agencies inputted their data by the stipulated and mutually agreed upon May 15th deadline, the majority was able to provide their information within a reasonable time beyond the deadline.

During 2016, the few challenges encountered with the provision of the requested information by the established submission date ranged from: 1) not having personnel to collate and provide recent information; 2) changes in contact staff resulted in the need to advocate, forge, and build new relationships to obtain buy-in; 3) incompleteness of the data being captured and reported; and 4) inability of a few Member agencies to log into the BerDIN data management system to input data.

Despite these issues, this Annual BerDIN Report includes an overall total of about 36 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 2016

The 2016 Annual Meeting of the Bermuda Drug Information Network (BerDIN) was held on the 27th and 28th of October, 2016, in the Gardenia Rooms 1 and 2 of the Fairmont Southampton (Hotel) Bermuda. Ms. Melody Lightbourne, a BerDIN Member who represented HM Customs, called the meeting to order and introduced both the Minister of National Security, The Hon. Jeffrey C. Baron, JP, and the Shadow Minister of the Ministry of Health and Community Affairs, The Hon. Michael Weeks, JP, MP. The Hon.

Jeffrey C. Baron, JP, Minister of National Security, extended a welcome to the meeting's participants and invited guests. He briefly shared his pro-drug prevention views with the meeting's audience.

The Hon. Michael Weeks, JP, MP, Shadow Minister of the Ministry of Health and Community Affairs, brought Opening Remarks to the meeting. He noted the vital role of the BerDIN within the healthcare system in the provision of needed data and the uniqueness of the Network's annual publication in terms of its collaborative representation. Mr. Weeks called for continued deliberations that can lend to a better understanding of the nature of the problems faced and the need to embrace a national drug policy agenda that is supported by the BerDIN's data.

Participants were reminded of the meeting's objectives by Ms. Nadine Kirkos, Senior Government Analyst of the Central Government Laboratory, Ministry of Health; who also informed the participants of the meeting's objectives: to update the BerDIN members on the current drug situation; to provide a forum for dialogue on drug-related special interest topics; and to enhance the well-being of the BerDIN members through team building activity and wellness presentation. Specifically, the objectives of the second day were outlined as: to develop good working relationships among all Members by providing the experience of working together as a team; and to obtain knowledge regarding the connection between physical, emotional, and spiritual health.

The keynote address was brought by the Director of Public Prosecutions, Mr. Larry Mussenden. This was the third year in succession that the meeting has had a keynote speaker. Mr. Mussenden was introduced by BerDIN Member, Mr. Calon Hollis, who represented the Financial Intelligence Agency. Mr. Mussenden stated the need for academic or practical studies on drugs and put forward quite a few interesting questions to be answered or studied. He challenged the Network "to be real and dig deep" when researching these matters. He called for programmes on partnering, guiding, and mentoring young people. He also put forward the case for Social Inquiry Reports (SIRs) to be done at an earlier stage rather than at arrest for a criminal trial; given the extent of the information that is covered in a SIR about a person. He also called for a caution policy where he felt that drug control follows more a public health model than a punitive one. His in-depth remarks to the meeting was overwhelmingly well-received and thought provoking. Mr. Mussenden also shared with the participants an informative presentation on how a crime scene evolves. He ended by pledging his Department's support as a partner to the BerDIN.

The 2016 meeting also received a presentation from Dr. Kyla Raynor, BerDIN Coordinator and Senior Research Officer/Policy Analyst, DNDC, on the BerDIN update on the current

drug situation in Bermuda: brief background; importance; new developments including changes, work-in-progress, and new initiatives; monitoring mechanism including coverage, challenges, data gaps, and unresolved areas; the BerDIN data management system; network and institutional strengthening proposals; and keys to sustainability over the next five years, given that this year marked fifth meeting since the group reengaged.

The meeting also invited Dr. Cecilia Younger to share of her expertise in the Caribbean region with working on alcohol policy with respect to advertisements in Grenada. In her presentation, Dr. Younger outlined the uniqueness of the alcohol commodity; the long reach and purpose of alcohol advertising; and the developmental stages of youth. She then shared the Caribbean summary results from the 2013 Secondary School Drug Prevalence Study and the corresponding public health significance. Dr. Younger further showed a historical perspective of how alcohol is embedded in the Caribbean culture. She shared with the meeting some of the follow-up initiatives, such as focus groups and observational study, to better understand the school survey results; especially pertaining to underage drinking.

As a follow-up from the 2015 meeting and the call to have more information on prescription drug use in Bermuda, the 2016 meeting received a presentation from the Government Pharmacy Inspector, Mrs. Antoinette Cannonier, supported by a clinical pharmacist, Dr. Kareema Sharrieff. Mrs. Cannonier briefly provided a background of the laws governing the operation of pharmacies in Bermuda along with the duties and responsibilities of the Pharmacy Inspector. She outlined how controlled drugs are managed on the Island, the importation and dispensation of controlled drugs, and the disposal of pharmaceuticals.

The Clinical Director of Pathways Bermuda, Mr. Roger Trott, made a presentation on Pathways Bermuda, a private substance abuse treatment service provider in Bermuda. For the BerDIN participants to better understand the clientele served by a private substance abuse treatment facility in Bermuda, Mr. Trott outlined Pathways Bermuda's vision, mission, and team of service providers. He also detailed the services provided, such as outpatient services for substance abuse and related disorders and characteristics of its clients such as both adolescents and adults of both sexes.

The Department for National Drug Control (DNDC) representative, Ms. Tashema Bholanath, Research Officer, provided the meeting with an update the DNDC's newest survey initiatives since the last meeting. These included the 2015 National School Survey (NSS) and the Survey of Substance Abuse Treatment Facilities (SSATS) 2016. In addition, Ms. Bholanath shared with the participants the work undertaken by the DNDC to validate drug prices and to be able to estimate drug consumption in Bermuda.

Chapter 1

Criminal and Suspicious Activity

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

I.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.

non-residential burglaries, which rose by 102 cases from the number of cases recorded in the previous year. With regard to offences against the person, 'robbery' has significantly increased over the past year (see Table I.1.2). In terms of crimes against the community, the classification 'antisocial behaviour' and 'disorder offences' saw the largest decreases in the number of offences with 141 and 16 fewer cases, respectively.

...significant increase in 2016 in the number of residential burglaries...

Between 2015 and 2016, Bermuda saw a gradual decline in overall crime by 4.4%; with crime against the person increasing by 4.4%, against the community decreasing by 28.5%, and against property decreasing by 1.1% (see Table I.1.1). In both years, there were mostly crimes against property characterised predominantly by motor vehicle theft and theft of property (see Table I.1.2). Noteworthy of mention, is the significant increase in 2016 in the number of

On the other hand, drug importation and local drug offences have decreased by 5.4% over the past year under review; with 20 less drug enforcement activities undertaken by the BPS; mainly for importation offences (57%) (see Tables I.1.5). While it was evident that drug enforcement activities have decreased in 2016 when compared to 2015, the data does not provide information as to why these differences were observed.

Table I.1.1
Number and Proportion of Crimes by Type of Crime and Annual Absolute and Percentage Change, 2015 and 2016

CRIMES	2015		2016		Annual Change	
	n	%	n	%	n	%
Against the Person	709 ^r	18.9	740	20.6	31	4.4
Against the Community	586	15.6	419	11.7	-167	-28.5
Against Property	2,456	65.5	2,428	67.7	-28	-1.1
Total – All Crimes	3,751^r	100.0	3,587	100	-164	-4.4

Source: Bermuda Police Service

Table I.1.2
Number of Crimes against Person, Community, and Property by Type of Crime and Annual Absolute Change, 2015 and 2016

CRIMES	2015	2016	Annual Absolute Change
AGAINST THE PERSON	709^r	740	31
Indecency	25	23	-2
Manslaughter	1	1	-
Murder	5 ^r	7	2
Offences Against Children	25	27	2
Robbery	46	81	35
Serious Assaults	58	46	-12
Sexual Assault	35	40	5
Other Assaults	514	515	1
AGAINST THE COMMUNITY	586	419	-167
Animal Offences	2	2	-
Antisocial Behaviour	421	280	-141
Disorder Offences	107	91	-16
Firearm Offences	29	21	-8
Other Weapon Offences	27	25	-2

Table 1.1.2 cont'd
Number of Crimes against Person, Community, and Property by Type of Crime and Annual Absolute Change, 2015 and 2016

CRIMES	2015	2016	Annual Absolute Change
AGAINST PROPERTY	2,456	2,428	-28
Burglary (Residential)	143	198	55
Burglary (Non-Residential)	449	551	102
Burglary (Tourist Accommodation)	12	-	-
Criminal Damage	289	240	-49
Fraud and Deception	154	87	-67
Motor Vehicle Theft	771	770	-1
Theft of Property	638	582	-56

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, 2015 and 2016

CRIMES	2015	2016
AGAINST THE PERSON	100.0	100.0
Indecency	3.5	3.1
Manslaughter	0.1	0.1
Murder	0.7	0.9
Offences Against Children	3.5	3.6
Robbery	6.5	10.9
Serious Assaults	8.2	6.2
Sexual Assault	4.9	5.4
Other Assaults	72.6	69.6
AGAINST THE COMMUNITY	100.0	100
Animal Offences	0.3	0.5
Antisocial Behaviour	71.8	66.8
Disorder Offences	18.3	21.7
Firearm Offences	4.9	5.0
Other Weapon Offences	4.6	6.0
AGAINST PROPERTY	100.0	100
Burglary (Non-Residential)	5.8	8.2
Burglary (Residential)	18.3	22.7
Burglary (Tourist Accommodation)	0.5	-
Criminal Damage	11.8	9.9
Fraud and Deception	6.3	3.6
Motor Vehicle Theft	31.4	31.7
Theft of Property	26.0	23.9

Source: Bermuda Police Service



Table 1.1.4

Number of Crimes against Person, Property, and Community as a Proportion of Total Crimes, 2015 and 2016

CRIMES	2015	2016
AGAINST THE PERSON	18.9	20.6
Indecency	0.7	0.6
Manslaughter	-	-
Murder	0.1	0.2
Offences Against Children	0.7	0.8
Robbery	1.2	2.3
Serious Assaults	1.5	1.3
Sexual Assault	0.9	1.1
Other Assaults	13.7	14.4
AGAINST THE COMMUNITY	15.6	11.7
Animal Offences	0.1	0.1
Antisocial Behaviour	11.2	7.8
Disorder Offences	2.9	2.5
Firearm Offences	0.8	0.6
Other Weapon Offences	0.7	0.7
AGAINST PROPERTY	65.5	67.7
Burglary (Non-Residential)	3.8	5.5
Burglary (Residential)	12.0	15.4
Burglary (Tourist Accommodation)	0.3	-
Criminal Damage	7.7	6.7
Fraud and Deception	4.1	2.4
Motor Vehicle Theft	20.6	21.5
Theft of Property	17.0	16.2

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, 2015 and 2016

DRUG ENFORCEMENT ACTIVITY	2015		2016		Annual Change	
	n	%	n	%	n	%
Drug Offences (Importation)	98	26.7	41	11.8	-57	-58.2
Drug Offences (Local)	269	73.3	306	88.2	37	13.8
Total – Drug Enforcement Activity	367	100.0	347	100.0	-20	-5.4

Source: Bermuda Police Service

1.2 DRUG SEIZURES AND ARRESTS

On a whole, both arrests for importation and local drug offences decreased by 54.9% over the period under review, that is, from 224 in 2015 to 347 in 2016. The BPS made 670 drug seizures in 2016, resulting in separate drugs being recovered with a combined weight of 112,825 grams (Table 1.2.3). Of these 670 seizures, 393 drug seizures had a drug weight and drug type attributed to them, 277 did not. Of the 393 drug seizures, a total of 443 different drugs were seized which have a weight. The tables below reference the type, number and weight of the 443 drug seizures (with a drug weight and drug type attributed), (Table 1.2.3).

Cannabis drugs was the most common drug type seized, with a total of 100,282 grams (Table 1.2.3). Of these 304 seizures, 21 were 1kg or greater with a combined weight of 83,383 grams. By comparison, the largest cannabis resin seizure was less than 600 grams. There was no data available on the value of drugs seized for 2016 from the BPS therefore no comparisons could be derived.

Table 1.2.1
Drug Seizures by Arrests for Drug Offences, 2015 and 2016

SEIZURES	2015	2016
ARRESTS		
Drug Offences (Importation)	24	41
Drug Offences (Local)	200	306
Total Arrests – Drug Offences	224	347
Annual Percentage Change	-18.8	54.9

Source: Bermuda Police Service

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

DRUG	2015	
	Total Weight (g)	Total Value (\$)
Cannabis	67,735	4,402,769
Cannabis (Resin)	1,981	188,173
Cocaine	5,430	874,180
Crack Cocaine	6,104	1,123,138
Heroin	240	96,684
Total*	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, Total Count and Total Weight, 2016

DRUG	2016	
	Total Count (n)	Total Weight (g)
Cannabis	304	100,282
Cannabis (Resin)	44	3,507
Cannabis (Seeds)	14	19.5
Crack Cocaine	40	632.4
Cocaine	23	6,468.6
Heroin/Diamorphine	9	1,885.2
Not a controlled substance	1	5
Designer Drugs		
Fentanyl drugs	1	6
MDMA drugs	6	18.9
Synthetic cathinone derivative	1	0.18
TOTAL*	443	112,825

Source: Bermuda Police Service

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

™ Drug type reclassified as of 2016

*Dollar value not available from the BPS

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	-	-	-	-	-
Ecstasy (Tablets)	-	-	-	-	-	-
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 decreased from 222 in 2015 to 173 in 2016 (Table 1.3.1). In both years, the majority of drug-related trials were for possession of cannabis, which, however, decreased slightly from 68 in 2015 to 66 in 2016. Criminal trials for conspiracy to import other drugs and possession of drug equipment significantly declined from 2015 to 2016; while that for the possession of cannabis and cocaine with intent to supply saw a slight decrease (see Table 1.3.1).

In contrast, the number of criminal trials for alcohol-related offences saw a sharp decline, decreasing from 432 in 2015 to 289 in 2016 (see Table 1.3.2). In both 2015 and 2016, 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, all of which recorded lower numbers in 2016.

In terms of acquittals and convictions, there were more acquittals in 2016, than in 2015, for alcohol-related offences,

and fewer for criminal drug-related offences (see Tables 1.3.3 and 1.3.4). On the other hand, there were less convictions in 2016 for both criminal drug- and alcohol-related offences when compared with 2015 (see Tables 1.3.5 and 1.3.6). For drug-related offences, most of the acquittals were for possession of cannabis (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). A decrease in criminal convictions for drug-related offences was observed in 2016; although, in both years under review, these convictions were mainly for the possession of cannabis, followed by possession of cannabis with intent to supply. In 2016, the number of criminal convictions for the possession of cannabis decreased to 46, down from 59 in the previous year. In comparison, criminal convictions for alcohol-related offences, on the whole, decreased considerably in 2016, from 210 cases in 2015 to 137 cases in 2016. Convictions for impaired driving of a motor vehicle and refusing the breathalyser test equally represented the largest proportion of these convictions, 44 cases each, respectively.

Lastly, there were some drug- and alcohol-related cases in which the result of the case was classified as 'unknown', meaning that the result of the case (conviction or acquittal) was not recorded. The number of drug-related unknown cases decreased by one case, from 40 cases recorded in 2015 to 39 cases in 2016 (see Table 1.3.7). However, when it came to alcohol-related cases, significantly fewer cases were classified as results 'unknown' in 2016 (108 cases) as compared to 2015 (197 cases). This would indicate that in 2016 more cases were classified as a trial, acquittal, or conviction, rather than as a case with unknown results.

...criminal convictions for alcohol-related offences, on the whole, decreased considerably in 2016...

Table 1.3.1
Criminal Trials for Drug-Related Offences by Sex of Offender, 2015 and 2016

JEMS Code	Description	2015				2016			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	62	3	3	68	55	4	7	66
2304	Possession of Cocaine	8	1	-	9	5	1	1	7
2308	Possession of Diamorphine	3	-	-	3	4	-	-	4
2312	Possession of Other Drugs	-	-	-	-	3	-	-	3
2313	Possession of Other Drugs With Intent to Supply	-	-	-	-	-	-	-	-
2316	Possession of Cannabis With Intent to Supply	22	4	2	28	14	4	4	22
2320	Possession of Cocaine With Intent to Supply	14	2	-	16	6	2	2	10
2324	Possession of Diamorphine With Intent to Supply	3	-	-	3	2	1	2	5
2332	Handle Cannabis With Intent to Supply	-	-	-	-	-	-	-	-
2336	Handle Cocaine With Intent to Supply	-	-	-	-	-	-	-	-
2340	Handle Diamorphine With Intent to Supply	-	-	-	-	-	-	1	1
2344	Handle Other Drugs With Intent to Supply	-	-	-	-	-	-	-	-
2348	Supply Cannabis	-	-	-	-	-	-	-	-
2352	Supply Cocaine	-	-	-	-	-	-	-	-
2356	Supply Diamorphine	-	-	-	-	-	-	-	-
2357	Supply Other Drugs	-	-	-	-	-	-	-	-
2364	Import Cannabis	4	2	1	7	6	3	-	9
2368	Import Cocaine	-	-	-	-	-	-	-	-
2372	Import Diamorphine	-	1	-	1	1	-	-	1
2373	Import Other Drugs	-	-	-	-	-	1	-	1
2380	Conspiracy to Import Other Drugs	7	-	4	11	-	1	-	1
2381	Conspiracy to Supply a Controlled Drug	1	1	-	2	1	-	-	1
2383	Export Drug Attempt	-	-	-	-	-	-	-	-
2384	Misuse Controlled Drug	-	-	-	-	-	-	-	-
2388	Possession of Drug Equipment	31	6	3	40	14	3	-	17
2392	Possession of Drug Equipment Prepare	21	1	-	22	9	2	4	15
2396	Cultivate Cannabis	8	1	-	9	4	-	-	4
2400	Permit on Premises Drug Use	1	1	-	2	-	2	-	2
2404	Obstruction	1	-	-	1	4	-	-	4
Total Trials: Drug-Related Offences		186	23	13	222	128	24	21	173

Source: Supreme Court

Table 1.3.2
Criminal Trials for Alcohol-Related Offences by Sex of Offender, 2015 and 2016

JEMS Code	Description	2015				2016			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	162	23	8	193	107	11	11	129
3059	Impaired Driving (>100 mgs Alcohol)	22	2	3	27	24	2	7	33
3060	Impaired Driving Not Motor Vehicle	-	-	-	-	-	-	-	-
3061	Care and Control of Motor Vehicle Whilst Impaired	18	2	-	20	10	-	-	10
3062	Refuse Breath Test	84	10	4	98	52	5	3	60
3063	Impaired Driving Drug In Body	-	-	-	-	1	1	-	2
3064	Excess Alcohol Motor Vehicle	70	12	1	83	41	4	2	47
3065	Impaired Driving – GBH	4	1	-	5	3	1	-	4
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, 2015 and 2016

JEMS Code	Description	2015				2016			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3069	Causing Death by Impaired Driving	-	-	-	-	-	-	-	-
3842	Excess Alcohol – Power Craft	-	-	-	-	1	-	-	1
3843	Impaired Driving – Power Craft	-	-	-	-	-	-	-	-
4020	Drunk and Incapable	-	-	-	-	2	-	-	2
4022	Drunk in Public Street	2	-	-	2	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 Trials: Alcohol-Related Offences		365	51	16	432	242	24	23	289

Source: Supreme Court

Table 1.3.3
Criminal Acquittals for Drug-Related Offences by Sex of Offender, 2015 and 2016

JEMS Code	Description	2015				2016			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	5	-	-	5	13	-	-	13
2304	Possession of Cocaine	-	-	-	-	2	-	-	2
2308	Possession of Diamorphine	-	-	-	-	1	-	-	1
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	3	5
2320	Possession of Cocaine With Intent to Supply	3	-	-	3	1	1	1	3
2324	Possession of Diamorphine With Intent to Supply	-	-	-	-	-	-	1	1
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	-	-	-	-	-	-	-	-
2368	Import Cocaine	-	-	-	-	-	-	-	-
2372	Import Diamorphine	-	1	-	1	-	-	-	-
2373	Import Other Drugs	-	-	-	-	-	-	-	-
2380	Conspiracy to Import Other Drugs	6	-	-	6	-	-	-	-
2381	Conspiracy to Supply a Controlled Drug	-	-	-	-	-	-	-	-
2383	Export Drug Attempt	-	-	-	-	-	-	-	-
2384	Misuse Controlled Drug	-	-	-	-	-	-	-	-
2388	Possession of Drug Equipment	5	1	2	8	2	-	-	2
2392	Possession of Drug Equipment Prepare	-	-	-	-	2	1	1	4
2396	Cultivate Cannabis	1	-	-	1	1	-	-	1
2400	Permit on Premises Drug Use	-	1	-	1	-	-	-	-
2404	Obstruction	-	-	-	-	-	-	-	-
Total Acquittals: Drug-Related Offences		21	3	2	26	23	3	6	32
RELATED OFFENCES									

Source: Supreme Court



Table 1.3.4
Criminal Acquittals for Alcohol-Related Offences by Sex of Offender, 2015 and 2016

JEMS Code	Description	2015				2016			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	8	3	1	12	19	1	1	21
3059	Impaired Driving (>100 mgs Alcohol)	1	-	-	1	2	-	1	3
3060	Impaired Driving Not Motor Vehicle	-	-	-	-	-	-	-	-
3061	Care and Control of Motor Vehicle Whilst Impaired	2	-	-	2	2	-	-	2
3062	Refuse Breath Test	5	-	-	5	4	-	-	4
3063	Impaired Driving Drug In Body	-	-	-	-	-	-	-	-
3064	Excess Alcohol Motor Vehicle	2	1	1	4	8	1	-	9
3065	Impaired Driving – GBH	-	-	-	-	2	-	-	2
3066	Excess Alcohol Not Motor Vehicle	-	-	-	-	-	-	-	-
3069	Causing Death by Impaired Driving	-	-	-	-	-	-	-	-
3841	Ref Breath Test Powercraft S I I 4 F Mba62*	-	-	-	-	1	-	-	1
3843	Impaired Driving – Power Craft	-	-	-	-	-	-	-	-
4020	Drunk and Incapable	-	-	-	-	-	-	-	-
4022	Drunk in Public Street	1	-	-	1	2	-	-	2
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		19	4	2	25	40	2	2	44

Source: Supreme Court

Note: * Category not available in 2015

Table 1.3.5
Criminal Convictions for Drug-Related Offences by Sex of Offender, 2015 and 2016

JEMS Code	Description	2015				2016			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	55	2	2	59	39	1	6	46
2304	Possession of Cocaine	8	1	-	9	2	1	1	4
2308	Possession of Diamorphine	2	-	-	2	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	19	2	1	22	7	1	1	9
2320	Possession of Cocaine With Intent to Supply	8	1	-	9	3	-	1	4
2324	Possession of Diamorphine With Intent to Supply	3	-	-	3	1	-	1	2
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	2	-	7
2368	Import Cocaine	-	-	-	-	-	-	-	-

Table 1.3.5 cont'd
Criminal Convictions for Drug-Related Offences by Sex of Offender, 2015 and 2016

JEMS Code	Description	2015				2016			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2372	Import Diamorphine	-	-	-	-	1	-	-	1
2373	Import Other Drugs	-	-	-	-	-	1	-	1
2380	Conspiracy to Import Other Drugs	1	-	-	1	-	1	-	1
2381	Conspiracy to Supply a Controlled Drug	-	-	-	-	1	-	-	1
2383	Export Drug Attempt	-	-	-	-	-	-	-	-
2384	Misuse Controlled Drug	-	-	-	-	-	-	-	-
2388	Possession of Drug Equipment	20	3	1	24	7	1	-	8
2392	Possession of Drug Equipment Prepare	14	-	-	14	6	-	1	7
2396	Cultivate Cannabis	7	-	-	7	3	-	-	3
2400	Permit on Premises Drug Use	-	-	-	-	-	1	-	1
2404	Obstruction	1	-	-	1	4	-	-	4
Total Convictions: Drug-Related Offences		141	10	5	156	82	9	11	102

Source: Supreme Court

Table 1.3.6
Criminal Convictions for Alcohol-Related Offences by Sex of Offender, 2015 and 2016

JEMS Code	Description	2015				2016			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	40	5	-	45	38	3	3	44
3059	Impaired Driving (>100 mgs Alcohol)	16	2	3	21	12	1	6	19
3060	Impaired Driving Not Motor Vehicle	-	-	-	-	-	-	-	-
3061	Care and Control of Motor Vehicle Whilst Impaired	10	-	-	10	5	-	-	5
3062	Refuse Breath Test	61	8	4	73	37	5	2	44
3063	Impaired Driving Drug In Body	-	-	-	-	1	1	-	2
3064	Excess Alcohol Motor Vehicle	45	9	-	54	18	3	-	21
3065	Impaired Driving – GBH	3	1	-	4	1	-	-	1
3066	Excess Alcohol Not Motor Vehicle	2	-	-	2	-	-	-	-
3069	Causing Death by Impaired Driving	-	-	-	-	-	-	-	-
3843	Impaired Driving – Power Craft	-	-	-	-	-	-	-	-
4020	Drunk and Incapable	-	-	-	-	1	-	-	1
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 Convictions: Alcohol-Related Offences		178	25	7	210	113	13	11	137

Source: Supreme Court

Table 1.3.7
Unknown Results for Drug-Related Offences by Sex of Offender, 2015 and 2016

JEMS Code	Description	2015				2016			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	2	1	1	4	3	3	1	7
2304	Possession of Cocaine	-	-	-	-	1	-	-	1
2308	Possession of Diamorphine	1	-	-	1	1	-	-	1
2312	Possession of Other Drugs	-	-	-	-	2	-	-	2
2313	Possession of Other Drugs With Intent to Supply	-	-	-	-	-	-	-	-
2316	Possession of Cannabis With Intent to Supply	2	2	1	5	6	2	-	8
2320	Possession of Cocaine With Intent to Supply	3	1	-	4	2	1	-	3
2324	Possession of Diamorphine With Intent to Supply	-	-	-	-	1	1	-	2
2332	Handle Cannabis With Intent to Supply	-	-	-	-	-	-	-	-
2336	Handle Cocaine With Intent to Supply	-	-	-	-	-	-	-	-
2340	Handle Diamorphine With Intent to Supply	-	-	-	-	-	-	1	1
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	-	2	1	1	-	2
2368	Import Cocaine	-	-	-	-	-	-	-	-
2372	Import Diamorphine	-	-	-	-	-	-	-	-
2373	Import Other Drugs	-	-	-	-	-	-	-	-
2380	Conspiracy to Import Other Drugs	-	-	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	6	2	-	8	5	2	-	7
2392	Possession of Drug Equipment Prepare	7	1	-	8	1	1	2	4
2396	Cultivate Cannabis	-	1	-	1	-	-	-	-
2400	Permit on Premises Drug Use	1	-	-	1	-	1	-	1
2404	Obstruction	-	-	-	-	-	-	-	-
Total Unknown Results: Drug-Related Offences		24	10	6	40	23	12	4	39

Source: Supreme Court

Table 1.3.8
Unknown Results for Alcohol-Related Offences by Sex of Offender, 2015 and 2016

JEMS Code	Description	2015				2016			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	114	15	7	136	50	7	7	64
3059	Impaired Driving (>100 mgs Alcohol)	5	-	-	5	10	1	-	11
3060	Impaired Driving Not Motor Vehicle	-	-	-	-	-	-	-	-
3061	Care and Control of Motor Vehicle Whilst Impaired	6	2	-	8	3	-	-	3
3062	Refuse Breath Test	18	2	-	20	11	-	1	12
3063	Impaired Driving Drug In Body	-	-	-	-	-	-	-	-
3064	Excess Alcohol Motor Vehicle	23	2	-	25	15	-	2	17
3065	Impaired Driving – GBH	1	-	-	1	-	1	-	1
3066	Excess Alcohol Not Motor Vehicle	1	1	-	2	-	-	-	-

Table 1.3.8 cont'd
Unknown Results for Alcohol-Related Offences by Sex of Offender, 2015 and 2016

JEMS Code	Description	2015				2016			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3069	Causing Death by Impaired Driving	-	-	-	-	-	-	-	-
3842	Excess Alcohol – Power Craft	-	-	-	-	-	-	-	-
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		168	22	7	197	89	9	10	108

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 a slight increase (6.9%) in SARs received from 2015 (447) to 478 in 2016 (see Table 1.4.1). Quarters three and four in 2016 saw an increase over the corresponding quarters in 2015. Activities within banks and money service businesses account for the bulk of the SARs in both 2015 (306 and 77, respectively) and 2016 (246 and 139, respectively). SARs received from banks, however, decreased by 19.6% over the previous year. In contrast, in 2016, the number of SARs received from investment providers and money service businesses increased considerably, by 85.7% and 80.5%, respectively. There were also increases in the number of SARs received from long-term insurers and fund administrators than in the

previous year. Fund administrators, which can be found in most investment companies, manage investment accounts. Although relatively few, it is worthy to note that, in both 2015 and 2016, there were SARs involving law firms, trust companies, and legal regulators; though in 2016, they were relatively less in numbers than in the previous year. For instance, there were 10 SARs received from law firms and two from trust company providers in 2015 compared to one in both categories in 2016.

The FIA recorded a total of 169 SARs filed in 2015 as compared to 174 SARs in 2016 (a 3.0% increase), involving the exchange of Bermuda currency to US dollar and other foreign currency. The majority of these cash exchanges were exchanges for US dollars.² The FIA also recorded the filing of 73 SARs in 2015 as compared to 139 SARs in 2016 (a 90.4% increase) that were related to suspicious wire transfers of money out of Bermuda, using money service businesses as the transmitter. This activity continues to be the one of 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 2016, 112 local and overseas disclosures contained information from 447 SARs compared to 142 disclosures from 426 SARs in 2015, representing a 21.1% decrease in disclosures from the 4.9% rise in total SARs disclosed.

In 2015, there were four convictions for money laundering in the Bermuda courts, while in 2016 there was one

...the number of SARs received from investment providers and money service businesses increased considerably...

¹ FIA website: <http://www.fia.bm/index-2.html>

² FIA.

³ Ibid.

conviction of money laundering in the Supreme Court⁴. The Department of Public Prosecutions, however, cautioned that not all of these convictions have a predicate offence directly related to drugs.

⁴ Department of Public Prosecutions.

Table 1.4.1
Suspicious Activity Reports (SARs) by Sector, 2015 and 2016

SECTOR	2015					2016					Annual Percentage Change
	Q1	Q2	Q3	Q4	TOTAL	Q1	Q2	Q3	Q4	TOTAL	
SARs Received											
Banks (includes a Credit Union)	83	88	70	65	306	72	62	63	49	246	-19.6
Investment Providers	-	4	3	-	7	1	2	4	6	13	85.7
Money Service Businesses	29	6	16	26	77	26	26	41	46	139	80.5
Corporate Service Providers	1	-	1	1	3	2	3	2	3	10	233.3
Law Firm	4	2	3	1	10	-	1	-	-	1	-90.0
Trust Company	-	2	-	-	2	1	-	-	-	1	-50.0
Local Regulators	-	-	2	2	4	-	1	-	-	1	-75.0
Long-Term Insurers	6	10	7	14	37	13	11	19	9	52	40.5
Other (Metal Dealers)	-	-	-	-	-	-	-	-	-	-	-
Accounting Firm	-	-	-	-	-	-	-	-	-	-	-
Fund Administrators	-	-	-	1	1	1	5	4	4	14	1,300.0
Insurance Company*	-	-	-	-	-	-	-	-	1	1	-
Total SARs Received	123	112	102	110	447	116	111	133	118	478	6.9
Annual Percentage Change	33.7	19.1	45.7	46.7	35.0	-5.7	-0.9	30.4	7.3	6.9	
Total Local and Overseas Disclosures	40	52	23	27	142	32	21	29	30	112	-21.1
Local entities	32	30	23	24	109	25	15	26	27	93	-14.7
Overseas entities	8	22	-	3	33	7	6	3	3	19	-42.4
Total SARs Disclosed	98	145	36	147	426	126	119	118	84	447	4.9

Source: Financial Intelligence Agency

Note: *Category did not exist in 2015.

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 36 cash seizures in 2016 amounting to \$12.0 million as compared to a relatively lower number (25) recorded in 2015, yielding \$1.2 million (see Table 1.5.1). Specifically, the larger number of seizures in 2016 amounted to cash seized of \$545,985, the second largest proportion of seizures, and \$19,830 in confiscations. However, forfeitures was significantly higher in 2016 (\$213,245) than in the previous year (\$169,625).

Additionally, the OECD captures data on civil recovery orders. These orders represented the largest portion of cash seizures in 2016 (\$11.3 million). Data was either not captured or unavailable for the 2015 year and therefore does not lend to comparison.

In 2014 legislation was passed under Section 36 of the Proceeds of Crime Act (PoCA) which introduced Civil Recovery Orders. The Attorney General and Ministry of Legal Affairs are the enforcement authority for these matters as they are civil proceedings heard before the Supreme Court. The investigations are conducted by OECD in partnership with the Attorney General. This addition to the PoCA was introduced to address property held in Bermuda from unlawful conduct committed in other jurisdictions (i.e. Mexican drug cartels). The recoverable property must not be less than \$25,000. Once there is sufficient information about the recoverable property and its location the Attorney General applies to the Supreme Court for a property freezing order preventing the dissipation of the property. The case is heard at Supreme Court and if satisfied an order can be made that all or part of the recoverable property can be forfeited to the Government of Bermuda.

These orders represented the largest portion of cash seizures in 2016 (\$11.3 million).

Table 1.5.1
Cash Seizures, 2015 and 2016

Year/ Quarter	Number of Seizures	Section 50 Cash Seizures (\$)	Forfeiture (\$)	Confiscation (\$)	Number of Civil Recovery Cases	Civil Recovery Orders (\$)	Total (\$)
2015							
Q1	2	31,152.15	158,522.03	-	...	...	189,676.18
Q2	4	50,856.50	11,103.00	-	...	...	61,963.50
Q3	8	533,736.00	...	...	...	...	533,744.00
Q4	11	77,229.83	...	381,261.08	...	...	458,501.91
Total	25	692,974.48	169,625.03	381,261.08	...	...	1,243,885.59
2016							
Q1	10	164,614.00	20,960.45	-	3	10,426,902.51	10,612,489.96
Q2	6	123,673.52	-	-	-	-	123,679.52
Q3	9	103,307.75	85,815.00	-	-	-	189,131.75
Q4	11	154,390.00	106,470.00	19,830.00	1	826,000	1,106,702.00
Total	36	545,985.27	213,245.45	19,830	4	11,252,902.51	12,032,003.23

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. During 2016, a 33.5% duty was levied on imported cigars and \$0.27 per cigarette, while \$29.23 was 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 31st, 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, particularly in the importation of alcohol and alcoholic beverages and tobacco and its products. It may be argued that most of these imported products are for tourists' consumption. However, this does not mean that 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 In 2015 the Tobacco Control Act 2015 was enacted banning smoking of tobacco in enclosed spaces. The Tobacco Products (Public Health) Act 1987 was therefore repealed. The Tobacco Control Act 2015 was implemented to "create updated provisions to protect minors and others from inducements to use tobacco products; to protect the health of minors by restricting access to cigarette products and tobacco products; to control the sale and use of electronic cigarettes."

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 2015, 6.5 million litres of alcohol and alcoholic beverages were available for local consumption, valued at \$27.4 million, and contributed \$14.6 million in customs duty (see Table 2.1.1). In contrast, 2016 saw a marginal decline in this quantity where 6.2 million litres were available for domestic consumption, valued at \$27.3 million, and contributed \$16.2 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 2.3 million litres in 2015 valued at \$15.2 million, and 2.6 million litres valued at \$16.7 million in 2016 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 2015, 1.1 million litres of alcohol and alcoholic beverages were exported from bonded warehouse, valued at \$3.9 million, with \$20,805 received in customs duty. In 2016, 1.4 million litres of alcohol and alcoholic beverages were exported from bonded warehouses, valued at \$5.1 million, with \$23,578 received in customs duty (see Table 2.1.3), slightly more 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 \$3.2 million recorded in 2015 to \$3.3 million in 2016 (see Table 2.1.4), consequently increasing the duty received from \$8.4 million to \$9.1 million. The major component of tobacco imports is that of cigarettes, with 52 thousand kilograms and 36.1 million units, valued at \$2.8 million, being brought to the Island in 2016 or removed from bonded warehouses, contributing \$9.0 million towards customs duty. In comparison, the year 2015 saw 43 thousand kilograms and 35.5 million units, valued at \$2.5 million, were brought to the Island or removed from bonded warehouses, contributing \$8.2 million towards customs duty. In both 2015 and 2016, although less than the previous year, 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), 2015 and 2016

Tariff Code	Description	2015			2016		
		Litreage	Value (\$)	Duty (\$)	Litreage	Value (\$)	Duty (\$)
2203.000	Beer	3,878,057.87	6,624,127.91	3,839,277.29	3,532,607.32	6,086,564.66	4,230,469.00
2204.100	Sparkling Wine	118,781.28	1,837,589.57	338,264.95	125,754.63	2,036,241.20	387,778.05
2204.210	Wine in containers holding 2 litres or less	1,296,697.70	11,643,510.84	3,718,464.64	1,297,463.52	11,506,957.96	4,011,709.31
2204.290	Wine in containers greater than 2 litres	89,401.52	943,943.87	258,318.58	60,006.24	796,460.02	187,464.18
2204.300	Other Grape Must	518.75	8,873.46	1,499.20	610.49	10,679.97	1,921.15
2205.100	Vermouth in containers holding 2 litres or less	5,206.65	32,159.13	15,012.56	5,811.90	31,347.56	18,299.14
2205.900	Vermouth in containers holding greater than 2 litres	4,377.50	39,518.55	12,650.98	11	137.56	34.98
2206.000	Other Fermented Beverages	171,374.24	393,786.24	241,637.79	245,487.87	489,913.62	400,090.86
2207.100	Undenatured Ethyl Alcohol	471.96	1,930.98	9,432.08	425.08	1,844.91	10,678.96
2207.200	Denatured Ethyl Alcohol	456.03	879.15	307.39	803.02	1,446.40	435.15
2208.200	Brandy and Cognac	25,987.18	532,080.01	269,109.30	31,488.51	675,754.71	347,550.85
2208.300	Whiskies	96,025.63	1,397,081.57	980,520.33	102,560.73	1,531,887.36	1,138,431.08
2208.400	Rum and Other Spirits Distilled from Sugar Cane	236,922.41	1,259,024.63	2,185,897.24	246,684.16	1,382,654.32	2,389,303.25
2208.500	Gin and Geneva	22,909.30	193,960.69	239,117.30	25,089.55	242,052.09	284,912.50
2208.600	Vodka	160,506.29	1,183,454.13	1,604,940.45	177,926.60	1,339,065.28	1,845,448.82
2208.700	Liqueur & Cordials	62,210.45	669,429.74	421,024.16	79,060.78	654,515.87	506,726.56
2208.900	Other Spirituous Beverages	291,313.22	672,745.69	450,887.14	240,010.31	556,324.30	434,066.28
9802.001	Wine of Fresh Grape*	-	-	-	10.5	65.52	30.35
	TOTAL	6,461,217.98	27,434,096.16	14,586,361.38	6,171,812.21	27,343,913.31	16,195,350.47

Source: HM Customs

Notes: *Category not available in 2015.

Table 2.1.2
Quantity and Value of Bonded* Alcohol and Alcoholic Beverages Placed in Bonded Warehouses Upon Arrival**, 2015 and 2016

Tariff Code	Description	2015		2016	
		Litreage	Value (\$)	Litreage	Value (\$)
2203.000	Beer	6,000.00	6,836.00	-	-
2204.100	Sparkling Wine	85,503.97	1,185,231.87	93,592.49	1,449,761.19
2204.210	Wine in containers holding 2 litres or less	823,793.17	7,674,057.92	860,457.24	8,131,434.69
2204.290	Wine in containers greater than 2 litres	16,297.00	37,934.01	14,850.00	42,262.79
2204.300	Other Grape Must	-	-	-	-
2205.100	Vermouth in containers holding 2 litres or less	4,248.00	12,635.43	1,818.00	5,231.24
2205.900	Vermouth in containers holding greater than 2 litres	-	-	-	-
2206.000	Other Fermented Beverages	8,110.68	34,757.95	2,367.12	23,180.93
2207.100	Undenatured Ethyl Alcohol	-	-	-	-
2207.200	Denatured Ethyl Alcohol	-	-	-	-
2208.200	Brandy and Cognac	29,331.60	661,831.74	34,458.90	775,169.53
2208.300	Whiskies	74,644.50	1,225,832.24	73,143.30	1,176,514.39
2208.400	Rum and Other Spirits Distilled from Sugar Cane	1,097,508.50	2,664,733.85	1,427,527.00	3,417,593.74
2208.500	Gin and Geneva	21,314.25	191,347.88	18,125.25	165,163.74
2208.600	Vodka	112,173.00	863,211.28	110,701.80	970,075.58
2208.700	Liqueur & Cordials	46,753.70	445,273.77	40,348.50	393,328.87
2208.900	Other Spirituous Beverages	13,772.25	153,134.16	11,634.45	173,047.48
	TOTAL	2,339,450.62	15,156,818.10	2,689,024.05	16,722,764.17

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, 2015 and 2016*

Tariff Code	Description	2015			2016		
		Litreage	Value (\$)	Duty (\$)	Litreage	Value (\$)	Duty (\$)
2203.000	Beer	-	-	-	384	82.33	-
2204.100	Sparkling Wine	532.50	25,091.14	103.12	633.75	24,900.66	108.97
2204.210	Wine in containers holding 2 litres or less	1,455.00	12,432.36	23.26	2,179.50	10,530.22	39.42
2204.290	Wine in containers greater than 2 litres	-	-	-	-	-	-
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	15.14	52.65	3.79
2207.200	Denatured Ethyl Alcohol	-	-	-	-	-	-
2208.200	Brandy and Cognac	4,948.30	162,906.77	1,237.26	5,874.05	199,949.50	1,468.71
2208.300	Whiskies	3,741.70	103,992.27	935.50	3,087.80	89,894.46	772.01
2208.400	Rum and Other Spirits Distilled from Sugar Cane	1,066,810.00	3,482,831.94	14,495.67	1,384,583.20	4,603,166.55	15,924.99
2208.500	Gin and Geneva	2,597.00	26,558.72	649.25	2,139.00	22,827.70	534.75
2208.600	Vodka	4,045.50	52,799.78	1,011.45	3,425.25	47,445.43	856.4
2208.700	Liqueur & Cordials	3,549.80	34,415.13	887.58	5,080.05	39,455.46	1,270.08
2208.900	Other Spirituous Beverages	5,840.75	35,443.92	1,460.29	10,397.75	58,516.33	2,599.55
	TOTAL	1,093,535.69	3,936,524.68	20,805.20	1,417,799.49	5,096,821.29	23,578.67

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), 2015 and 2016

Tariff Code	Description	2015			2016		
		Quantity	Value (\$)	Duty (\$)	Quantity	Value (\$)	Duty (\$)
2401.100	Tobacco, Not Stemmed/Stripped	22.28 kg	1,295	6.47	18.63 kg	1097.61	5.4
2401.200	Tobacco, Partly or Wholly Stemmed/Stripped	-	-	-	2,354.00 kg	30,800.00	682.66
2402.100	Cigars, Cheroots, etc. Containing Tobacco	5,913.82 kg	531,001.44	160,948.36	2,964.61 kg	327,077.60	91,290.25
2402.200	Cigarettes Containing Tobacco	42,805.88 kg 38,509,722 u	2,499,173.61	8,174,390.84	51,574.56 kg 36,073,460.00 u	2,759,459.24	8,961,576.20
2402.900	Other Tobacco Products; or Products of Tobacco Substitutes	50.91 kg	2,012.10	674.06	35 kg	1,860.70	623.33
2403.110	Water Pipe Smoking Tobacco	5,331.28 kg	85,056.66	28,493.98	4,661.65 kg	88,528.15	29,656.92
2403.190	Other Smoking Tobacco	110.00 kg	1,553.04	520.27	28 kg	165.73	55.52
2403.910	"Homogenised" or "Reconstituted" Tobacco	-	-	-	-	-	-
2403.990	Tobacco Extracts and Essences; Other Manufactured Products of Tobacco	2,576.00 kg	51,372.32	17,209.73	3,064.00 kg	64,586.40	21,636.44
9803.163	Smoking Tobacco; Cigars, Cheroots and Cigarillos, Containing Tobacco (Imported by Post or Courier)	2,050 u	12,250.21	4,103.81	- 1,863.00 u	10,719.67	3,591.07

Table 2.1.4 cont'd

Quantity, Value, and Duty of Tobacco and Tobacco Products for Home Consumption (Imports and Removals from Bonded Warehouses), 2015 and 2016

Tariff Code	Description	2015			2016		
		Quantity	Value (\$)	Duty (\$)	Quantity	Value (\$)	Duty (\$)
9803.171	Cigarettes Containing Tobacco*	-	-	-	6.05 kg 4,400 u	1,379.40	1,068.00
	TOTAL	56,810.17 kg 38,511,772 u	3,183,714.38	8,386,347.52	64,706.5 kg 36,079,723 u	3,285,674.5	9,110,185.79

Source: HM Customs

Note: * Category not available in 2015

Table 2.1.5

Quantity and Value of Bonded^a Tobacco and Tobacco Products Placed in Bonded Warehouses Upon Arrival^a, 2015 and 2016

Tariff Code	Description	2015		2016	
		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	528.10 kg	124,941.57	119.36 kg	50,326.77
2402.200	Cigarettes Containing Tobacco	5,110.85 kg 3,985,000 u	260,528.80	4,410.77kg 2,950,000.00 u	229,041.30
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	5,638.95 kg 3,985,000 u	385,470.37	4,530.13kg 2,950,000 u	279,368.07

Source: HM Customs

Notes: ^a 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.

^b 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^a, 2015 and 2016

Tariff Code	Description	2015		2016	
		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	-	-	-	-
2402.200	Cigarettes Containing Tobacco	2,379.71 kg 1,985,600 u	163,243.80	2,607.99kg 1,997,400.00 u	167,559.65
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	2,379.71 kg 1,985,600 u	163,243.80	2,607.99 kg 1,997,400 u	167,559.65

Source: HM Customs

Note: ^a 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.

⁷ Laws of Bermuda, Liquor Licence Act 1974, p. 5.

⁸ Ibid, p. 9.

In both 2015 and 2016, most licences were issued to establishments in the Central district, followed by the Western and Eastern districts. There has been a marked increase of 4.3% in the number of licences issued to establishments between 2015 and 2016, moving from 276 to 288; 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 declined by 29.4%, decreasing from 378 in 2015 to 267 in 2016. There was ten instances in 2016 where a licence was issued for an al fresco (outdoors) event across districts as compared to one in the previous year. Overall, there has been a sharp decrease by 15.1% in the total number of licences issued, that is, from 654 being granted in 2015 to 555 in 2016.

There has been a marked increase of 4.3% in the number of licences issued to establishments...

Table 2.2.1
Liquor Licences Issued by District and Type of Licence, 2015 and 2016

Districts and Type of Licence	2015	2016
CENTRAL	170	181
Class 'A'	48	49
Class 'B'	2	4
Tour Boat	34	30
Nightclub	4	5
Restaurant	51	55
Hotel	9	10
Member's Club	20	24
Proprietary Club License	-	-
Permit for Association or Organisation*	1	1
Alfresco	1	3
WESTERN	57	54
Class 'A'	20	21
Class 'B'	1	1
Restaurant	23	17
Hotel	4	4
Member's Club	8	8
Tour boat	-	-
Alfresco	-	3
Nightclub	-	-
Proprietary Club License	1	-
Permit for association or Organisation*	-	-

Table 2.2.1 cont'd
Liquor Licences Issued by District and Type of Licence, 2015 and 2016

Districts and Type of Licence	2015	2016
EASTERN	49	53
Class 'A'	16	15
Class 'B'	1	-
Tour boat*	-	-
Restaurants	17	20
Hotel	5	5
Member's Club	8	8
Night Club	-	-
Al Fresco	-	4
Permit for Association or Organisation	-	1
Proprietary club license*	-	-
Total Licences Issues to Establishments	276	288
Annual Percentage Change in Total Licences Issued to Establishments	15.0	4.3
Total Occasional Liquor Licences Island-Wide	378	267
Annual Percentage Change in Total Occasional Liquor Licences Island-Wide	15.6	-29.4
Total Licences Issued	654	555
Annual Percentage Change in Total Licences Issued	11.8	-15.1

Source: Liquor Licence Authority, Magistrate's Court

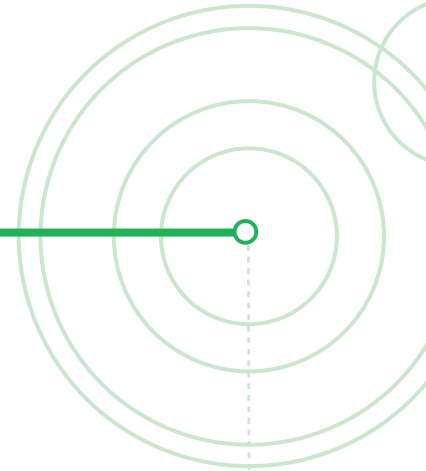
Notes: *Category not available in 2015

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 2016, the number of TIPS training sessions almost doubled from 2015, that is, from 19 to 32, increasing the number of participants from 249 in 2015 to 467 in 2016. This increase, both in the number of sessions and participants, was primarily due to the America's Cup events, which were held in Bermuda during the period 2016 to 2017. The representation by participating licenced establishments (an establishment could have been represented by different participants over the year and hence the number of establishments is not unique) increased markedly in 2016 (see Table 3.1.1). Specifically, during 2016, participants (managers, owners, and supervisors) were from 177 licenced establishments as compared to 109 in the previous year; averaging 13 participants per session in 2015 and 15 in 2016. In terms of training outcome, more persons passed the TIPS training in 2016 than in 2015 and there were also less failures in the most recent year when compared to the previous year.

Table 3.1.1
Training for Intervention ProcedureS (TIPS) Programme Statistics, 2015 and 2016

Year/Quarter	Number of TIPS Sessions	Number of Participants	Average Number of Participants Per Session	Outcome		Number of Participated Establishments
				Passed	Failed	
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
2016	32	467	60	437	30	177
Q1	11	182	17	174	8	60
Q2	9	95	11	90	5	42
Q3	4	63	16	58	5	33
Q4	8	127	16	115	12	42

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 appropriate 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 2016, a total of 220 clients were seen by BARC as compared to 207 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) decreased by 13.4% from 97 cases in 2015 to 84 cases in 2016 (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) increased by 23.6% from 110 in 2015 to 136 in 2016 (see Table 4.1.2). However, in both years, repeat clients accounted for the greater proportion of all referrals. For instances, 136 (61.8%) of the 220 referrals in 2016 were cases of existing referrals compared to 84 (38.2%), 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 (68.6% or 151 in 2016). Blacks were also more likely to 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 (33.2% or 73 in 2016). 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).

Opiates, alcohol, heroin, cocaine, and cannabis 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 2015 and 2016, as compared to existing clients, who primarily sought treatment for opiates and alcohol in 2016 (cannabis and opiates in 2015). Nonetheless, there was a decrease in the number of new clients who sought treatment for cannabis and an increase, by one person, for those seeking treatment for alcohol in 2016. 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 in 2016.

Most of both the new and existing referrals tended to be dependent or have abused one drug or two drugs. 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 (129 clients in 2015 and 145 in 2016) on their drug(s) of choice versus being abusers (97 clients in 2015 and 125 in 2016) (see Tables 4.1.3 and 4.1.4), with new clients in 2016 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-referred), 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 agency to which the person was referred 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 2015 and 2016, about one out of every four (29 or 22.7%) in 2015 and one in every three in 2016 (56 or 34.8%), was classified as having substantial to severe substance (drug) abuse disorders (see Tables 4.1.5 and 4.1.6). Similarly, the Alcohol Dependence Scale (ADS) scores indicate that of all clients to whom this test was administered, 7.3% (9) in 2015 and 11.6% (18) in 2016 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, 2015 and 2016

	2015	2016
Total New Referrals:	97	84
Annual Percentage Change	26.0	-13.4
Sex:		
Males	77	69
Females	20	15
Age (Years):		
16 & Under	-	-
17–30	26	24
31–45	27	33
46–60	17	14
61–75	7	11
76+	-	-
Not stated	20	-
Not Available*	-	2
Race:		
Black	82	47
White	10	17
Portuguese	-	1
Mixed	-	1
Other	1	-
Not stated	4	-
Not Available*	-	18
Drug of Choice (Dependence Or Abuse): Type		
Alcohol	27	28
Cannabis	34	12
Opiates	9	6
Cocaine	10	4
Other	1	-
None	1	2
Not stated/No Show	17	-
Not Available*	-	20
Deferred*	-	12
Drug of Choice (Dependence Or Abuse): Combination*		
One drug	57	42
Two drugs	15	19
Three drugs	4	1
Not stated	21	-
Not Available*	-	22

Source: Bermuda Assessment and Referral Centre

Table 4.1.1 cont'd

Bermuda Assessment and Referral Centre Programme Statistics for New Referrals, 2015 and 2016

	2015	2016
Level of Care:		
Level I – Outpatient	30	13
Level II – IOP	28	26
Level III & IV – Residential (Medically Monitored/Managed Intensive Inpatient Treatment)	3	10
None	7	5
Not stated/No Show	29	-
Not Available*	-	21
Deferred*	-	7
Other	-	2
Referred From:		
Magistrate's Court	30	19
Self-Referral	11	12
EAP	4	12
Turning Point	6	10
Court Services (including DTC, Probation Team, Parole Officer)	10	8
Other/Other Community	3	2
Supreme Court	2	1
MWI	1	1
Family Services	4	-
Private Practice	2	-
Not Stated	24	-
Not Available*	-	19
Referred To:		
Turning Point	37	34
Men's Treatment	2	6
Court Services	3	4
EAP	3	2
WTC	-	2
Other	2	1
Harbour Light	-	1
Pathways Bermuda*	-	1
Private Practice	1	-
None	12	3
Refusal	2	-
Not Available*	-	21
Not Stated/ No Show	35	6
Deferred*	-	3

Source: Bermuda Assessment and Referral Centre

Note: *Category was not available in 2015.

Table 4.1.2
Bermuda Assessment and Referral Centre Programme Statistics for Existing Referrals, 2015 and 2016

	2015	2016
Total New Referrals:	110	136
Annual Percentage Change	-14.7	23.6
Sex:		
Males	95	113
Females	15	23
Age (Years):		
16 & Under	-	1
17–30	15	19
31–45	39	40
46–60	36	68
61–75	8	8
76+	-	-
Not stated	9	-
Not Available*	3	-
Race:		
Black	105	104
White	4	6
Portuguese	-	-
Mixed	-	3
Not Stated	1	-
Not Available*	-	23
Other*	-	-
Drug of Choice (Dependence Or Abuse): Type		
Opiates	45	51
Alcohol	31	26
Cocaine	36	21
Cannabis	48	9
None	-	1
Not Stated/No Show	17	1
Not Available*	-	24
Deferred*	-	3
Drug of Choice (Dependence Or Abuse): Combination*		
One Drug	45	45
Two Drugs	29	33
Three Drugs	19	33
More than three drugs*	-	1
Not Stated	17	-
Not Available*	-	24
Level of Care:		
Level I – Outpatient	16	17
Level II – IOP	40	15
Level III & IV – Residential (Medically Monitored/Managed Intensive Inpatient Treatment)	17	45
None	3	1
Not Stated/ No Show	11	1
Not Available*	-	54
Other*	-	3

Table 4.1.2 cont'd
Bermuda Assessment and Referral Centre Programme Statistics for Existing Referrals, 2015 and 2016

	2015	2016
Referred From:		
Self-Referral	23	30
Magistrate's Court	11	23
Turning Point	18	19
Court Services (including DTC, Probation Team, Parole Officer)	17	12
Family Services	1	4
Family Court	1	3
MWI	2	3
Supreme Court	2	3
Corrections	3	2
EAP	1	2
Financial Assistance	-	2
Focus	-	2
Harbour Light	1	-
CMIT	1	-
Men's Treatment	1	-
Mental Health Treatment Court	2	-
Not Available*	-	29
Not Stated/ No Show	22	2
Other/Other Community	1	-
Private Practice	3	-
Referred To:		
Turning Point	61	43
Men's Treatment	5	18
Residential (including RLH)	3	14
WTC	2	9
Court Services	1	5
Deferred*	-	1
Harbour Light	3	1
None	5	3
Not Available*	-	41
Not Stated/ No Show	28	1
Other	2	-

Source: Bermuda Assessment and Referral Centre

Note: *Category was not available in 2015.

Table 4.1.3
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	-	-
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.
 *Category was not available in 2015.

Table 4.1.4
Clinical Diagnosis (Abuse or Dependence) of New and Existing Clients' Drug Use by Drug(s) of Choice, 2016

Drug of Choice	Abuse		Dependence		Deferred Diagnosis	
	New Clients	Existing Clients	New Clients	Existing Clients	New Clients	Existing Clients
Alcohol	16	20	12	33	-	-
Cannabis	15	33	8	15	-	1
Cocaine	11	17	1	24	-	-
Heroin	1	9	5	47	-	-
Methadone	-	1	-	-	-	-
Ecstasy*	-	1	-	-	-	-
Amphetamine†	-	1	-	-	-	-
TOTAL	43	82	26	119	-	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.
*Category was not available in 2015.

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, 2015 and 2016

	Level of Severity (DAST Score)	Number of Clients	
		2015	2016
Substance Abuse or Dependence	None (0)	8	10
	Low (1–5)	28	30
	Intermediate (6–10)	13	17
	Substantial (11–15)	7	2
	Severe (16–20)	-	1

Source: Bermuda Assessment and Referral Centre

Note: The DAST scores were not available for 41 clients in 2015 and 24 clients in 2016.

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, 2015 and 2016

	Level of Severity (ADS Score)	Number of Clients	
		2015	2016
Substance Abuse or Dependence	None (0)	13	18
	Low (1–13)	37	30
	Intermediate (14–21)	8	7
	Substantial (22–30)	-	3
	Severe (31–47)	6	2

Source: Bermuda Assessment and Referral Centre

Note: The ADS scores were not available to 33 clients in 2015 and 24 clients in 2016.

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, 2015 and 2016

	Level of Severity (DAST Score)	Number of Clients	
		2015	2016
Substance Abuse or Dependence	None (0)	-	10
	Low (1–5)	22	16
	Intermediate (6–10)	28	22
	Substantial (11–15)	22	35
	Severe (16–20)	-	18

Source: Bermuda Assessment and Referral Centre

Note: The DAST was not available to 38 clients in 2015 and 35 in 2016.

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, 2015 and 2016

	Level of Severity (ADS Score)	Number of Clients	
		2015	2016
Substance Abuse or Dependence	None (0)	-	28
	Low (1-13)	44	42
	Intermediate (14-21)	13	12
	Substantial (22-30)	-	11
	Severe (31-47)	3	2

Source: Bermuda Assessment and Referral Centre

Note: The ADS was not available to 50 clients in 2015 and 41 clients in 2016.

4.2 COUNSELLING AND LIFE SKILLS SERVICES STATISTICS

Youth Counselling

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

The Department of Child and Family Services' establishment of a centralised intake and assessment system allows for a more coordinated assessment of client needs and integrated service delivery to clients. Referrals are presented and discussed at the weekly Coordinators' meeting.

In comparing 2015 to 2016, there has been a decrease in the number of referrals from 106 to 64 and an increase in the number of assessments conducted from 61 to 87, respectively (see Table 4.2.1). CLSS has seen 106 clients in 2016, which saw a drop from the 111 clients seen in 2015. Clients are usually referred for either behavioural or substance use reasons. There is a correlation between the number of referrals received and the time of the year; with increased referrals received when school is in session during the school year and a decline during the summer months when school is on break. Total number of clients for 2016 is 106 clients. The breakdown of clients is: seventy-four (74) youth and thirty-two (32) parents received counseling services. Over seventy percent of the CLSS' clients receiving

services are adolescents between the ages of 14-18 years; 65% of this age group is adolescent females. It is important to note that clients/families present with multi-problem issues such as: high risk behaviours, adolescent substance misuse, parent/child relational issues; parental relationship issues; trauma; and emotional/behavioral issues. Family issues and emotional/behavioural issues are the leading trend. In addition, there were two substance groups conducted in 2016. The numbers of groups held was impacted by the internal restructuring for CLSS. It should be noted that the last group of participants for the AIOP groups was done in 2014-2015. These groups are no longer being offered under CLSS at this time.

At the same time, there has been a significant decline in the number of family conferences, moving from 111 in 2015 to 16 in 2016. CLSS facilitated two groups based on client needs and referral trends. In both years, 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. In 2015, there were 15 group participants and 8 in 2016.

Table 4.2.1
Counselling and Life Skills Services Statistics, 2015 and 2016

Year	2015	2016
Number of Referrals	106	64
Number of Clients Seen	111	106
Number of Consultations	111	-
Number of Readmissions	-	-
Number of Assessments	61	87
Number of Family Conferences	111	16
Number of Discharges	42	27
Number of Group Participants	15	8

Source: Department of Child and Family Services - Counselling and Life Skills Services (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 decline in the number of new referrals to the programme, decreasing from 53 in 2015 to 44 in 2016 (see Table 4.3.1). Of the new referrals, six persons were admitted to the DTC programme in 2016 compared to 14 in 2015. Some of the reasons provided for persons being referred to the programme in 2016 but not admitted include: client declined to participate in the DTC (7); client refused residential treatment (2); client had significant medical issues that inhibited participation in treatment (1); client was found to be unsuitable (7); client had specific issues for which no local treatment is available (2);

client was refused due to non-compliance during observation (3); client was sentenced to Probation and was reviewed in DTC (1); and client received suspended prison sentence with a fine and was reviewed in DTC (1). There was one instance where an individual was referred twice.

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 five persons who completed Phase IV in 2015 and the four in 2016 are not counted as programme completions in 2015 or 2016 until they would have completed the mandatory Phase V; only one person finished this Phase in 2015 and four in 2016. As such, since the DTC programme's inception in 2001, there has now been a total of 35 programme completions with two people completing (Phase V) in 2016.

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 the case of 2016, two people did not complete the programme. Both were for treatment programme violations. As a result of being terminated from treatment, they were no longer able to participate in the DTC.

Table 4.3.1
Drug Treatment Court (DTC) Statistics, 2015 and 2016

	2015	2016
New referrals	53	44
Programme admissions	14	6
Successful completion Phase IV	5	4
Successful completion Phase V	1	4

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 21 and 9 men were screened for drugs in 2015 and 2016, 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 493 urine samples from its clients to test for drug use during 2016; increasing significantly from the 319 recorded in the previous year (see Table 4.4.1). This corresponds to 5,904 drug screens in 2016, significantly up from 3,828 drug screens in 2015 (each test consists of 12 substances). Nonetheless, no drug

screen yielded positive results in 2015 and 0.1% in 2016. The positive results observed in 2016 were for benzodiazepines, opiates, and THC. At the same time, in both years under review, heroin, crack, alcohol, and to a lesser extent 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 2016 being heroin with alcohol and crack, as well alcohol and cocaine. Other two- and three-drug combinations included heroin, crack and marijuana and heroin and alcohol among others (see Table 4.4.3).

Table 4.4.1
Drug Screening Results among Men in Treatment, 2015 and 2016

	2015	2016
Total Samples	319	493
Total Screens	3,828	5,904
Number of Positive Screens		
Barbiturates	-	-
Benzodiazepine	-	2
Buprenorphine	-	-
Creatinine (adulterant)	-	-
Cocaine	-	-
Methodone	-	-
Opiates (Heroin)	-	1
THC	-	2
Total	-	5
% POSITIVE SCREENS	-	0.1

Source: Department for National Drug Control- Men's Treatment Centre

Table 4.4.2
Primary Drug Used by Men Prior to Treatment, 2015 and 2016

Drug	Number of Men	
	2015	2016
Alcohol	5	2
Crack	4	3
Heroin	9	4
Marijuana	3	-
TOTAL CLIENTS	21	9

Source: Men's Treatment Centre

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, 2015 and 2016

Combinations	Number of Clients	
	2015	2016
Three-Drug Combination:		
Heroin, Crack, THC	5	1
Alcohol, Heroin, THC	4	-
Alcohol, Crack, THC	1	-
Alcohol, Heroin, Crack ^a	-	3
Two-Drug Combination:		
Alcohol, THC	1	1
Alcohol, Cocaine ^a	-	2
Alcohol, Crack	1	-
Crack, THC	1	-
Heroin, Crack	5	-
Heroin, Alcohol	2	1
Heroin, THC	1	1
TOTAL	21	9

Source: Men's Treatment

Note: ^aCategory was not available in 2015.

4.5 WOMEN'S TREATMENT CENTRE STATISTICS

Drug Abuse among Women in Treatment

Women who were randomly screened encompass: women referred for services but not admitted, women who entered WTC for treatment, women in transitional care, and those in after-care. The total number of random urine screens conducted by the WTC, which test for alcohol and illicit drug use, increased from 525 in 2015 to 1,212 in 2016 (see Table 4.5.1). However, there was a decrease in the number of positive screens, which accounted for 2.4% (29) in 2016, down from 7.2% (or 38) in the previous year. Of all the substances screened, THC was the drug most often found

during urinalysis in 2016 as compared to methadone in 2015.

At the same time, cocaine, marijuana, and alcohol were the primary drugs used by most of the women prior to treatment in 2016 versus cocaine in the previous 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, 2015 and 2016

	2015	2016
Total Samples	105	101
Total Screens	525	1,212
Number of Positive Screens		
Barbiturates	1	-
Benzodiazepine	1	4
Buprenorphine	1	1
Creatinine (adulterant)	3	-
Cocaine	3	3
Methadone	26	1
Opiates	1	7
Oxycontin ^a	-	1

Table 4.5.1 cont'd
Drug Screening Results among Women in Treatment, 2015 and 2016

	2015	2016
Number of Positive Screens		
THC	2	12
Total	38	29
% POSITIVE SCREENS	7.2	2.4

Source: Women's Treatment

Note: *Category was not available in 2015.

Table 4.5.2
Primary Drug Used by Women Prior to Treatment, 2015 and 2016

Drug	Number of Men	
	2015	2016
Adulterant	3	-
Alcohol	2	4
Benzodiazepine*	-	2
Buprenorphine*	-	1
Cocaine	3	5
Heroin	1	3
Marijuana	2	4
Methadone	1	1
Oxycontin*	-	1
Ecstasy*	-	1
TOTAL CLIENTS	12	22

Source: Women's Treatment

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

*Category was not available in 2015.

Table 4.5.3
Number of Cases of Poly-Drug Use among Clients at Women's Treatment Centre, 2015 and 2016

Combinations	Number of Clients	
	2015	2016
Three-Drug Combination:		
Heroin, Crack, THC	4	1
Alcohol, Crack, THC	2	1
Crack, THC, Ecstasy*	-	1
Crack, THC, ETOH*	-	1
Two-Drug Combination:		
Alcohol, Crack	3	-
Crack, THC	1	-
Heroin, Crack	1	1
Heroin, Alcohol*	-	1
TOTAL	11	6

Source: Women's Treatment

Note: *Category was not available in 2015.

4.6 TURNING POINT SUBSTANCE ABUSE PROGRAMME STATISTICS

Drug Abuse among Turning Point Clients

Turning Point Substance Abuse Treatment Programme received a total of 6,948 specimens in 2016, a decrease from the 7,083 specimens in 2015 (see Table 4.6.1). Of these specimens in 2016, 39.3% (2,730) tested positive for illicit drugs compared to 41.7% (2,862) in 2015. 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 (6,128 in 2015 and 5,663 in 2016) as compared to females (734 in 2015 and 780 in 2016); although in 2016 there was an increase in the number of specimens provided by females. The majority of positive specimens tested positive for only one drug (59.9% in 2015 and 64.6% in 2016) 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) (62.6% in 2015 and 56.8% in 2016), cocaine (47.9% in 2015 and 45.6% in 2016), and

THC (marijuana) (25.3% in 2015 and 23.9% in 2016) (see Table 4.6.3). In 2016, positive screens for opiates, cocaine, marijuana, and OxyContin declined, while positive screens for benzodiazepines and alcohol increased over the previous year.

Over the two-year period under review, the total number of methadone clients decreased from an average of 125 in 2015 to 117 in 2016 (see Table 4.6.4). Similarly, inpatient detoxes also rose from 103 in 2015 to 113 in 2016; while, at the same time, outpatient detoxes remained at zero for both 2015 and 2016.

Table 4.6.1
Proportion of Positive Drug Screens and Poly-Drug Use by Turning Point Clients, 2015 and 2016

		2015	2016
Total specimens requested		7,083	6,948
	from females	768	832
	from males	6,315	6,116
Total specimens provided		6,868	6,443
	by females	734	780
	by males	6,128	5,663
Total positive specimens for illicit drugs*		2,862	2,730
% Positive specimens of total specimens provided		41.7	42.4
Positive Specimens for Drugs*			
	for one drug	1,713	1,764
Poly Drug Use	for two drugs	888	785
	for three drugs	206	141
	for more than three drugs	55	40

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, 2015 and 2016*

Drug	2015	2016
Methadone	6,730 (98.0%)	6,387 (99.1%)
Opiates	1,793 (26.1%)	1,550 (24.1%)
Cocaine	1,371 (20.0%)	1,246 (19.3%)
Marijuana	724 (10.5%)	652 (10.1%)
Benzodiazepines	128 (1.9%)	143 (2.2%)
Alcohol	67 (1.0%)	69 (1.1%)
OxyContin	18 (0.3%)	13 (0.2%)
Other	140 (2.0%)	135 (2.1%)

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, 2015 and 2016*

Drug	2015	2016
Opiates	1,793 (62.6%)	1,550 (56.8%)
Cocaine	1,371 (47.9%)	1,246 (45.6%)
Marijuana	724 (25.3%)	652 (23.9%)
Benzodiazepines	128 (4.5%)	143 (5.2%)
Alcohol	67 (2.3%)	69 (2.5%)
OxyContin	18 (0.6%)	13 (0.5%)
Other	140 (4.9%)	135 (4.9%)

Source: Turning Point Substance Abuse Programme

Table 4.6.4*Number of Methadone Clients, Inpatient, and Outpatient Detoxifications at Turning Point, 2015 and 2016*

Year	Methadone Clients*	Inpatient Detoxes	Outpatient Detoxes
2015	125	103	-
2016	117	113	-

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 2015 and 2016, the RLH had a maximum of 15 and 13 residents in care, respectively; however, in 2016, the average number of residents over the 12 months dropped to 10 when compared to 11 in 2015 (see Tables 4.7.1 and 4.7.2). There was one person who was placed on the waiting list for admissions in 2016 versus five persons in 2015. 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 seven clients in 2015 and four in 2016. 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, 211 screens were conducted in 2015 compared to 180 in 2016, with one positive substance abuse test result recorded in 2016 and none in 2015.

Table 4.7.1
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
<i>Random Tests</i>	12	10	13	8	9	5	22	4	7	8	8	6	112
<i>Tests for Outings & Day Passes</i>	6	3	4	6	9	6	9	9	9	9	3	3	76
<i>Work Detail</i>	-	-	-	-	-	-	-	6	12	-	-	-	18
<i>Suspicious Tests</i>	-	5	-	-	-	-	-	-	-	-	-	-	5
Total	18	13	17	14	18	11	31	19	28	17	11	9	23
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

Table 4.7.2
Right Living House Programme Statistics, 2016

Programme Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2016
Number of Residents	8	10	12	11	13	13	10	10	9	9	9	9	10*
Total Programme Admissions	2	2	-	4	-	-	-	-	-	-	-	2	1*
Number of Discharges	-	-	1	2	-	3	-	1	-	-	9	2	2*
Number of Substance Abuse Tests	13	10	14	20	30	15	12	19	13	10	10	14	15*
<i>Random Tests</i>	10	8	14	15	19	13	9	19	12	7	7	11	12*
<i>Tests for Outings & Day Passes</i>	3	2	-	5	5	2	3	-	1	3	3	2	2*
<i>Work Detail</i>	-	-	-	-	-	-	-	-	-	-	-	-	-
<i>Suspicious Tests</i>	-	-	-	-	6	-	-	-	-	-	-	1	1*
Total	13	10	14	20	30	15	12	19	13	10	10	14	15*
Number of Positive Substance Abuse Tests	-	-	-	-	-	-	-	-	-	-	-	-	-
Wait Listed for Admission	4	3	4	2	2	2	2	2	2	3	3	3	3*
Residents in Aftercare	5	5	5	5	5	5	4	4	4	3	3	3	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 (FY) (April to March), the Harbour Light programme was operating slightly below capacity, during all of the quarters of both FY 2015/2016 and 2016/2017, ranging from eight to 10 clients (see Table 4.8.1). During 2016, one to four clients were admitted in each quarter while, at the same time, at most two clients completed the programme; but there were quarter(s) where there were no programme completions. The programme randomly conducts drug tests with its clients and none of the tests administered to clients were found 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 24 clients in the fourth quarter of FY 2016/2017 to as many as 38 clients in the second quarter of FY 2015/2016. The FY 2016/2017 started with 32 clients participating in the programme and ended with 24 clients in the fourth quarter. As many as three referrals were made in Q1 of FY 2015/2016 while in FY 2016/2017 six referrals were made in Q4. 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 2016; while more families received relapse prevention education in FY 2016/2017. The programme's success can be judged by the fact that a number of clients successfully reintegrated with their families and into the community. For instance, in any given quarter during 2016, three to 9 clients successfully reintegrated. At the same time one to eight 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 26 clients in any given quarter over the last two years under review.

Table 4.8.1

Salvation Army Harbour Light Residential Treatment Programme Performance, 2015/2016 and 2016/2017

Programme Indicators	FY 2015/2016				FY 2016/2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Intakes/Screenings/Assessments	5	3	3	2	11	6	3	3
Enrollment	1	1	3	2	4	3	2	1
Completions	3	-	-	1	1	1	-	-
Total Clients	8	9	10	9	13	10	11	11
Random Drug Tests	2	-	-	10	2	2	1	2
Positive Drug Tests	-	-	-	-	-	-	-	-
NA/AA Meetings (Mandatory)	36	36	36	36	36	36	36	36
Community Outreach: Volunteer Days	5	5	5	5	5	4	5	4
Community Outreach: Number of Client's Volunteering	2	6	6	4	6	5	11	5
Community Outreach: Other Activities	2	2	2	2	3	4	5	5

Source: Salvation Army

Table 4.8.2
Salvation Army Community Life Skills Recovery Programme Performance, 2015/2016 and 2016/2017

Programme Indicators	FY 2015/2016				FY 2016/2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total number of clients who participated in the programme	34	38	33	31	32	26	27	24
Number of new clients referred	3	2	1	2	2	2	1	6
New care plans	3	2	1	2	2	1	1	5
Care plans reviewed	3	1	1	1	1	1	3	5
Number of intakes/screenings/ assessments	3	2	2	2	2	1	1	9
Number of evening groups	2	2	2	2	1	1	6	13
LifeSkills training groups	1	1	1	1	-	-	1	2
Referrals for outside services	8	8	8	8	8	8	8	1
Case management sessions	10	10	10	10	10	10	10	13
Clients who received crisis intervention	16	25	13	10	16	15	7	5
Families who received relapse prevention	2	1	2	3	2	6	4	1
Clients who reintegrated with families, employment, education, community	3	6	2	9	9	7	3	3
Clients who were in stable committed relationships	5	5	6	5	8	6	6	1
Clients who obtained financial stability (financial planning and banking)	11	10	10	16	19	12	11	9
Clients who opened and reactivated bank accounts	-	-	3	2	-	-	1	1
Clients with secured savings in bank accounts	7	7	7	9	18	12	12	4
Clients who made regular payments towards outstanding bills	3	3	3	3	5	3	6	11
Clients who abstained from substance abuse	34	36	36	31	31	25	25	23

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.

most 13 aftercare sessions in both FY 2015/2016 and FY 2016/17. Each of these aftercare sessions provided services to between 14 and 17 clients. Random drug tests of clients show a few positive results especially for cocaine, alcohol, THC and, to a lesser extent, opiates.

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. There were at

Table 4.9.1

Focus Counselling Services Supportive Residence Programme Performance, 2015/2016 and 2016/2017

Programme Indicators	FY 2015/2016				FY 2016/2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Houses	4	3	3	2	2	2	2	2
Number of Beds	22	15	22	22	22	22	22	22
Number of Clients/Occupancy	16	14	16	18	19	19	18	18
Number of Drug Tests	28	18	28	22	26	24	28	18
THC	-	-	1	1	4	1	3	3
Opiates	1	-	1	-	-	1	-	2
Cocaine	3	4	3	2	1	-	2	1
Alcohol	3	1	3	2	3	2	4	3
Number of After-Care sessions	13	13	13	13	13	13	13	13
Number of Aftercare Sessions	16	16	15	14	16	12	15	17
Average Number of Participants in Aftercare	-	-	-	-	26	26	15	16
House meetings*	-	-	-	-	1	1	2	3
Number of residents employed*	-	-	-	-	1	1	2	3
Number of Drug Court clients*	-	-	-	-	1	1	1	1
Number of Probation/Parole clients*	-	-	-	-	3	3	3	2

Source: Focus Counselling Services

Note: * Category was not available in 2015.

4.10 CLIENTS IN TREATMENT

Tables 4.10.1 and 4.10.2 show the number of ‘unique’ individuals admitted to treatment during 2015 and 2016 and the numbers of different persons who received treatment during that year, respectively. This is the third year these indicators are being monitored, and there is now a three-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 receiving 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 2016 number of new treatment admissions and persons in treatment saw a decline from the previous year where there were 172 new treatment admissions and 365 persons in treatment (see Tables 4.10.1 and 4.10.2). Specifically, the number of new clients admitted to treatment in 2016 was 152 (121 men and 31 women) and the number of persons who were in treatment, which includes any person(s) still in treatment from a previous year, together with the newly admitted persons, amounted to 315 (264 men and 51 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

..new treatment admissions and persons in treatment saw a decline...

treatment services, the majority was seen by the Turning Point Substance Abuse Programme mainly for inpatient detoxification or methadone maintenance. Approximately one out of every four persons who were in treatment received residential care.

Table 4.10.1
Number of New Treatment Admissions, 2015 and 2016

Treatment Agency	2015			2016		
	Male	Female	Total	Male	Female	Total
WTC	..	5	5	..	8	8
MT	21	..	21	9	..	9
Turning Point (Methadone, Inpatient, Outpatient/Detox)	96	24	120	60	19	79
Salvation Army Harbour Light*	11	..	11	15	..	15
Salvation Army Life Skills	7	3	10	18	4	22
Focus	-	..	-	9	..	9
RLH	5	..	5	10	..	10
TOTAL	140	32	172	121	31	152

Source: Treatment Agencies

Note: * In 2015, an additional 10 just did intake and assessment.

Table 4.10.2
Number of Persons in Treatment, 2015 and 2016

Treatment Agency	2015			2016		
	Male	Female	Total	Male	Female	Total
WTC	..	7	7	..	9	9
MT	16 ^a	..	16	21	..	21
Turning Point (Methadone, Inpatient, Outpatient/Detox)	228	40	268	174	38	212
Salvation Army Harbour Light*	18	..	18	18	..	18
Salvation Army Life Skills	33	3	36	19	4	23
Focus	.. ^b	..	-	9	..	9
RLH	20	..	20	23 ^c	..	23
TOTAL	315	50	365	264	51	315

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.

^c Number includes those in Aftercare outpatient treatment.

Chapter 5

Drug Screening Surveillance

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



5.1 BERMUDA SPORT ANTI-DOPING AUTHORITY STATISTICS

Anti-Doping and Illicit Drug Use in Sports

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

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

The year 2016 saw a decline to 201 (from 538 in 2015) in the number of illicit drug tests administered by BSADA (see Table 5.1.1). Five positive test results for THC (marijuana)

were observed in 2016 compared to none in 2015. On the other hand, the number of anti-doping tests (of both urine and blood) increased from 87 in 2015 to 102 in 2016.

The figures in Table 5.1.2 show the breakdown of illicit drug tests conducted in each sport for the years 2015 and 2016. 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 5.1.3 and 5.1.4). In 2016, one test screened positive for performance enhancing drugs (see Table 5.1.1) compared to none in 2015. There were more performance enhancing tests done in 2016 than in 2015; mainly by urine samples than by blood. These tests were for a number of sports but mainly for athletics, aquatics, 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, 2015 and 2016

Year	Number of Tests	Illicit Tests		Anti-Doping Tests	
		Number of Positive		Number of Tests	Positive
		THC	Cocaine		
2015	538	-	-	87	-
2016	501	5	-	102	1

Source: BSADA

Table 5.1.2
Illicit Drug Tests by Sport, 2015 and 2016

Sport	2015	2016
Archery	9	1
Athletics	23	13
Badminton	7	-
Baseball	-	-
Basketball	26	16
Bicycling	9	4
Bicycling Academy	6	-
Boccia (Para Sport)	5	2
Body Building	5	-
Bowling	-	4

Source: BSADA

Table 5.1.2 cont'd
Illicit Drug Tests by Sport, 2015 and 2016

Sport	2015	2016
Boxing	-	-
Canoe	-	-
Cricket	33	59
Darts	-	-
Equestrian	1	1
Fencing	-	-
Football	130	128
Golf	10	11
Gymnastics	50	-
Hockey	-	-
Lacrosse	-	-
Lawn Tennis	19	3
Luge	-	-
Martial Arts	3	14
Motorsports	-	-
Netball	14	14
Paralympics	-	-
Powerboat	-	-
Rowing	-	-
Rugby	88	99
Sailing	4	33
Sail Boarding	4	-
Softball	-	-
Squash	19	20
Swimming	31	25
Table Tennis	-	-
Target Shooting	10	-
Triathlon	6	2
Volleyball	26	52
Total	538	501

Source: BSADA

Table 5.1.3
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

Source: BSADA

Table 5.1.4*Performance Enhancement Testing by National Anti-Doping Organisations (Testing Missions Issued by BSADA), 2016*

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)	62	10	-	-
United States Anti-Doping (USADA)	4	19	-	19
Professional Worldwide Controls (PWC)	-	1	-	-
United Kingdom Anti-Doping (UKAD)	-	1	-	1
Canadian Center for Ethics in Sport (CCES)	-	2	-	2
Total	66	33	-	22

Source: BSADA

Table 5.1.5*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

Source: BSADA

Table 5.1.6*Performance Enhancing Tests by Sport (Testing Missions Issued by BSADA), 2016*

National Anti-Doping Organisations/ Service Provider	Urine In Competition	Urine Out of Competition	Blood In Competition	Blood Out of Competition
Aquatics	20	6	-	6
Athletics	25	10	-	5
Body Building	4	-	-	-
Cycling	14	3	-	-
Equestrian	-	1	-	-
Gymnastics	-	-	-	-
Sailing	-	3	-	-
Squash	-	-	-	-
Triathlon	3	9	-	10
Skiing	-	-	-	-
Sanshou	-	-	-	-
Para Sport*	-	3	-	1
Rowing*	-	1	-	1
Total	66	36	-	23

Source: BSADA

Note: *Category not available in 2015

5.2 DEPARTMENT OF CORRECTIONS STATISTICS: WESTGATE CORRECTIONAL FACILITY

Drug Use among Criminal Offenders

Monthly the provision of urinalysis screening results from the Westgate Correctional Facility⁹ 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 2016, 91.5% of reception inmates were screened for illicit drugs (see Table 5.2.1), 5.4% refused to participate in screening (7.3% refused in 2015), and 3.1% were released prior to specimen collection (1.2% in 2015). However, drug screening of offenders on reception decreased slightly in 2016 by 10.9% from the previous year, which saw 91.3% of specimens screened. The overall number of positive screens for illicit drugs decreased in 2016 to 131 from 148 recorded in 2015 (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 2016, a decrease by 14.3% 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) and opiate use among offenders serving a sentence at Westgate Correctional Facility (see Table 5.2.4).

Of the reception inmates, the number of first-time offenders decreased from 55 (21.8%) in 2015 to 35 (15.6%) in 2016 (see Table 5.2.6). The proportion of repeat offenders received into Westgate increased by 20.2% over the last year moving from 70.2% in 2015 to 84.4%. The urinalysis screens revealed that most first-time and repeat offenders used THC, cocaine, or opiates (see Table 5.2.7). The highest prevalence-of-use was recorded for marijuana, followed by cocaine and opiates (heroin). In both 2015 and 2016, with regard 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, 2015 and 2016

Year	Reception Inmates	Screened	Refused	Released
2015	252	230 (91.3)	19 (7.3)	3 (1.2)
2016	224	205 (91.5)	12 (5.4)	7 (3.1)

Source: Westgate Correctional Facility

Table 5.2.2
Percentage of Positive Illicit Drug Screens among Prison Reception Inmates, 2015 and 2016

Year	Number of Positive Illicit Drug Screens	Percentage of Total Screens
2015	148	64.3
2016	131	63.9

Source: Westgate Correctional Facility

Table 5.2.3
Drug Prevalence (Urinalysis) at Reception by Number and Proportion of Screened Offenders, 2015 and 2016

Year	Marijuana	Cocaine	Opiates	Poly Drug Use
2015	114 (49.6)	48 (20.9)	30 (13.0)	42 (18.3)
2016	91 (44.4)	33 (16.1)	30 (14.6)	36 (17.6)

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, 2015 and 2016

	2015	2016
Overall Positive	16 (6.3)	21 (9.4)
Marijuana	11 (4.4)	19 (8.5)
Opiates	4 (1.6)	2 (0.9)
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, 2015 and 2016

Year	Marijuana	Opiates	Cocaine	Poly-Drug Use
2015	114 (77.0)	48 (32.4)	30 (20.3)	42 (28.4)
2016	91 (69.5)	33 (25.2)	30 (22.9)	-

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, 2015 and 2016

Year	Category of Offenders		
	Reception inmates	First time offenders	Repeat offenders
2015	252	55 (21.8)	197 (70.2)
2016	224	35 (15.6)	189 (84.4)

Source: Westgate Correctional Facility

Table 5.2.7
Any Illicit Drug Prevalence (Urinalysis) by Number and Proportion of First-Time and Repeat Offenders, 2015 and 2016

Year	Offender	Marijuana	Cocaine	Opiates
2015	Repeat offender	101 (51.3)	42 (21.3)	27 (13.7)
	First-time offender	22 (40.0)	5 (9.1)	4 (7.3)
2016	Repeat offender	89 (47.1)	31 (16.4)	27 (14.3)
	First-time offender	16 (45.7)	6 (17.1)	5 (14.3)

Source: Westgate Correctional Facility

Table 5.2.8
Number of First-Time and Repeater Offenders with Poly-Drug Use, 2015 and 2016

Year	First-Time Offender	Repeat Offender
2015	8	34
2016	5	31

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 2016, the Prison Farm requested and collected 331 urine specimens, similar to 2015 (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, 0.9% (three) were found to be positive for an illicit substance in 2016 and 3.9% (13) in 2015. Specifically, 11 of the 13 positive

specimens and three of the six positive specimens, in 2015 and 2016, respectively, tested positive for THC. There were positive tests for opiates in both years (one in 2015 and 2016), and two positive cocaine tests in 2016.

Table 5.3.1
Drug Screening Results for Persons at the Prison Farm, 2015

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens			
			Total	THC	Opiates	Cocaine
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

Table 5.3.2
Drug Screening Results for Persons at the Prison Farm, 2016

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens			
			Total	THC	Opiates	Alcohol
Random	222	222	4	2	1	1
Day Pass	6	6	-	-	-	-
Pre-Parole	-	-	-	-	-	-
Suspicion	8	8	1	1	-	-
Work Detail	95	95	1	-	-	1
Spiritual Pass	-	-	-	-	-	-
Work Release	-	-	-	-	-	-
Other	-	-	-	-	-	-
Total	331	331	6	3	1	2

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 2016, the Co-Ed facility requested and collected 62 urine specimens as compared to 66 requests and specimens received in 2015 (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 2016, 8.1% (five) were found to be positive for an illicit

substance versus 2.6% (two) in 2015. All five of the positive specimens tested positive for THC in 2016 compared to one of two, which tested positive in 2015 for THC (see Table 5.4.2).

Table 5.4.1
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
Random	70	70	2	1	1
Day Release	1	1	-	-	-
Parole	-	-	-	-	-
Suspicion	-	-	-	-	-
Work Detail	-	-	-	-	-
School Pass	-	-	-	-	-
Work Release	6	-	-	-	-
Total	77	77	2	1	1

Source: Department of Corrections

Table 5.4.2
Drug Screening Results for Persons at the Co-Ed Facility, 2016

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens		
			Total	THC	Opiates
Random	43	43	2	2	-
Day Release	1	1	-	-	-
Parole	-	-	-	-	-
Suspicion	11	11	3	3	-
Work Detail	-	-	-	-	-
School Pass	-	-	-	-	-
Work Release	7	7	-	-	-
Total	62	62	5	5	-

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 2016, there has been a decrease in the number of persons who were stopped to undertake a breathalyser test, when compared to 2015. Specifically, in 2016, 119 persons were stopped to undertake a breathalyser test as compared to 170 in the previous 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. It should be noted that the year 2015 was the only one in a series of years in which there was an increase in the number of persons who were stopped for such a test.

A larger number of males (123 in 2015 and 81 in 2016) provided a sample for testing as compared to females (16 in 2015 and 7 in 2016); 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, 113 out of 139 and 71 out of 109 failed in 2015 and 2016, respectively (with 22 in 2015 and 16 in 2016 passing the breathalyser test). Overall, the mean BAC reading for all samples provided increased from 149 mg/dl in 2015 to 157 mg/dl in 2016 to (see Table 6.1.2). Similarly, the mean BAC reading for individuals who failed the breathalyser test also increased slightly from 177 mg/dl in 2015 to 185 mg/dl in 2016. In instances where there were accidents, the average BAC was significantly above the legal limit. In 2015, the mean failed BAC, in cases where there were accidents, was recorded at 179 mg/dl and higher in 2016 at 201 mg/dl. There were also instances where accidents occurred and the average BAC was under the legal limit, 17 mg/dl in 2015 and 26 mg/dl in 2016. As a reminder, the alcohol limit in Bermuda is less than 80 mg/dl. Breathalyser readings, nonetheless, ranged from 0 to 1,122 mg/dl in 2015 and 0 to 316 mg/dl in 2016; where the upper end of the range in 2015 is equivalent to as much as over fourteen times the legal limit and about four times over in 2016. On average, the majority of persons who failed the breathalyser test were two to three times above the legal limit in both 2015 and 2016 (see Table 6.1.3). Only 19% (26) of those who were tested in 2015 were within the legal limit as compared to 14% (12) in 2016. In both 2015 and 2016, there were a few instances where accidents occurred and the corresponding breathalyser readings were as much as three to four times or more above the legal limit.

...there has been a decrease in the number of persons who were stopped to undertake a breathalyser test...

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, 2015 and 2016

Year	Number of Persons Stopped	Gave Sample						Male			Female		
		Total	Male	Female	Failed	Passed	Refusals	Failed	Passed	Refusals	Failed	Passed	Refusals
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	-
2016	119	109	99	10	71	17	21	65	16	18	6	1	3
Q1	32	30	28	2	22	3	5	20	3	5	2	-	-
Q2	30	28	25	3	14	7	7	12	7	6	2	-	1
Q3	23	20	18	2	11	5	4	11	4	3	-	1	1
Q4	34	31	28	3	24	2	5	22	2	4	2	-	1

Source: Bermuda Police Service

Table 6.1.2
Breathalyser Readings for Impaired Driving Incidences, 2015 and 2016

	2015					2016				
	Q1	Q2	Q3	Q4	Year	Q1	Q2	Q3	Q4	Year
Mean Reading: All Breathalyser Samples	150	135	140	171	149	169	115	147	195	157
Mean Reading: Failed Breathalyser Samples	166	18	160	206	177	186	148	195	211	185
Mean Reading: Failed Breathalyser Samples of Males	166	178	166	214	179	194	158	195	211	190
Mean Reading: Failed Breathalyser Samples of Females	176	176	99	169	154	107	94	-	205	102
Mean Reading: Accident with Failed Breathalyser Samples	193	163	161	196	179	174	216	213	198	201
Mean Reading: Accident with Passed Breathalyser Samples	77	19	1	-	17	55	49	-	-	26
Range of Reading: Failed Breathalyser Samples	85-279	94-291	93-331	95-1,122	85-1,122	84-292	91-253	94-293	131-316	84-316
Range of Reading: Passed Breathalyser Samples	12-77	0-71	0-68	78	0-78	24-55	14-83	13-70	0-25	0-83

Source: Bermuda Police Service

Notes:
Readings in mg/dl.

Table 6.1.3
Number of Breathalyser Sample Readings by Limit, 2015 and 2016

Year	Within Limit	1-2 Times Above Limit	2-3 Times Above Limit	3-4 Times Above Limit	4+ Times Above Limit
2015	26	51	54	6	-
Q1 [*]	5	14	17	1	-
Q2 [*]	9	9	11	2	1
Q3	5	17	12	1	1
Q4	7	11	14	2	2
Male	22	45	48	6	2
Female	4	6	6	-	-
Accident [*]	10	10	19	3	-
2016	12	27	35	13	-
Q1	3	8	9	5	-
Q2	5	11	4	1	-
Q3	3	4	8	1	-
Q4	1	4	14	6	-

Table 6.1.3 cont'd
Number of Breathalyser Sample Readings by Limit, 2015 and 2016

Year	Within Limit	1-2 Times Above Limit	2-3 Times Above Limit	3-4 Times Above Limit	4+ Times Above Limit
Male	11	22	35	12	-
Female	1	5	-	1	-
Accident	5	9	10	6	-

Source: Bermuda Police Service

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, 32 in 2015 and 28 in 2016 (see Table 6.2.1). However, of these inquiries, only 27 and 24 persons participated in the programme in 2015 and 2016, respectively. Most of the participants in either year were males (see Table 6.2.2). In 2015 most of the participants were 31 to 35 years as compared to 2016 where most participants were between 26 and 30 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, as compared to 2016, where the majority was classified as moderate to severe. The majority of persons in the severe category in both 2015 and 2016 were assessed to be in the mid to late dependence stage of alcohol abuse or misuse, the most severe diagnosis (using the DSMV criteria) (see Table 6.2.3). Specifically, in 2015, 22% (six) of the participants were diagnosed as mild, another 15% (four) as moderate, and 33% (9) were judged to be in the mid to late dependence stage. In comparison, in 2016, 21% (five) of the participants were diagnosed as mild, 38% (nine) as moderate, and 25% (six) were assessed 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 I DUI Programme.

Table 6.2.1
DUI Education Classes' Inquiries and Participants, 2015 and 2016

	2015	2016
Number of inquiries	32	28
Number of participants	27	24

Source: Bermuda Professional Counselling Services

Table 6.2.2
DUI Programme Participants' Statistics, 2015 and 2016

Year	Sex		Age							
	Male	Female	17 – 21	22 – 25	26 – 30	31 – 35	36 – 40	41 – 45	46 – 50	50+
2015	23	4	-	3	5	7	3	4	-	5
2016	19	5	2	2	7	6	2	1	1	3

Source: Bermuda Professional Counselling Services

Table 6.2.3
Triage Assessment for Addictive Disorders Results by Number of Participants, 2015 and 2016

TAAD Scores*	2015	2016
No Diagnosis	3	3
Mild	6	5
Moderate	4	9
Severe	Early Dependence	1
	Mid to Late Dependence	6
TOTAL	27	24

Source: Bermuda Professional Counselling Services

Chapter 7

Health

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



7.1 DRUG-RELATED INFECTIOUS DISEASES

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

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.

Drug-related infectious diseases were existent in both 2015 and 2016. In particular, the Epidemiology and Surveillance Unit reported five drug-related cases of hepatitis C in 2015 and three in 2016. 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).

The 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 associated with injected drug use. In addition, there may also be under-reporting of some of these infections.

...reported five drug-related cases of hepatitis C in 2015 and three in 2016.

Table 7.1.1
Drug-Related Infectious Diseases, 2015 and 2016

Infection	2015		2016	
	Number of Cases	Number of ATOD-Related Cases	Number of Cases	Number of ATOD-Related Cases
HIV	5	-	6	-
AIDS	1	-	3	-
Hepatitis B ^a	5	-	4	-
Hepatitis C ^b	6	5	6	3
Chlamydia	356	...	418	...
Gonorrhoea	27	...	14	...
Herpes ^c	92	...	80	...
Syphilis	8	...	2	...
Total	500	5	533	3

Source: Epidemiology & Surveillance

Notes: ^a Hepatitis B is a vaccine-preventable disease in Bermuda and is in Bermuda's immunization schedule; therefore, the vast majority of hepatitis B cases is imported from countries where hepatitis B is endemic and is not related to local drug-use.

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

^c Data on genital herpes should not be used for trends as there were differences in reporting practices from prior years.

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

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

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

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

The general guideline to determine a secondary diagnosis is if a clinical evaluation is provided, diagnostic procedures may be performed, and the patient may require an extended length of hospital stay or increased nursing care or monitoring. The definition of a secondary diagnosis is

"all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay." Diagnoses that relate to an earlier episode, which have no bearing on the current hospital stay, are excluded.

Inpatient cases for which drugs were the primary diagnosis was very low to non-existent as reported by the King Edward Memorial VII Hospital as evidenced by the one case in 2015 and no cases seen in 2016 (see Tables 7.2.1 and 7.2.2). Similarly, inpatient cases in which poisoning and toxic effects were the primary diagnosis, declined significantly from the 25 cases observed in 2015 to no cases in 2016 (see Tables 7.2.3 and 7.2.4). Regarding the secondary diagnosis of cases, 1,076 cases in 2015 were recorded as inpatient drug-related cases compared to 1,181 cases in 2016 (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 2015 and 2016 were more prevalent among males (1,634) than females (623). In 2015, there were 19 cases of secondary diagnosis of inpatient cases of poisoning and toxic effects of substances, whereas, in 2016, there were nine cases (see Tables 7.2.7 and 7.2.8).

Table 7.2.1
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	Mixed**	Asian**	Other
Acute Alcoholic Intoxication In Alcoholism, In Remission**	-	-	-	-	-	-	-	-	-	-	-	-	-
Other And Unspecified Alcohol Dependence, Continuous Drinking Behavior**	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Type Dependence – Continuous	|	-	-	-	-	|	-	-	|	-	-	-	-
Alcohol Abuse, Continuous Drinking Behavior**	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	|	-	-	-	-	|	-	-	|	-	-	-	-

Source: King Edward VII Memorial Hospital

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

** Category was not available in 2015.

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

Table 7.2.2
Primary Diagnoses of Inpatient Drug-Related* Cases, 2016

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Acute Alcoholic Intoxication In Alcoholism, In Remission**	|	-	-	-	-	-	|	-	-	|	-	-	-
Other And Unspecified Alcohol Dependence, Continuous Drinking Behavior**	-	|	-	-	-	-	|	-	|	-	-	-	-
Opioid Type Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse, Continuous Drinking Behavior**	|	-	|	-	-	-	-	-	-	|	-	-	-
TOTAL	2	|	|	-	-	-	2	-	|	2	-	-	-

Source: King Edward VII Memorial Hospital

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

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

Table 7.2.3
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	Mixed*	Asian*	Other*
Poisoning – Antiviral Drugs	-	|	-	-	-	-	-	|	|	-	-	-	-
Poisoning – Adrenal Cortical Steroids	-	|	-	-	-	-	-	|	|	-	-	-	-
Poisoning - Antihypertensive agents*	-	-	-	-	-	-	-	-	-	-	-	-	-
-Poisoning – Insulin & Antidiabetic Agents	-	|	-	-	-	-	-	|	|	-	-	-	-
Poisoning – Antiallergic and Antiemetic Drugs	-	|	-	-	-	-	-	|	-	|	-	-	-
Poisoning - Uric acid metabolism drugs*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Antitussives*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Salicylates	|	-	-	-	-	-	|	-	|	-	-	-	-
Poisoning – Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Aromatic Analgesics*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Aromatic Analgesics Not Elsewhere Classified	4	5	3	4	-	|	|	-	5	4	-	-	-
Poisoning - Cardiotonics glycosides*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Propionic Acid Derivatives	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Other Antirheumatics	-	-	-	-	-	-	-	-	-	-	-	-	-

Table 7.2.3 cont'd
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	Mixed*	Asian*	Other*
Poisoning – Other and Unspecified Anticonvulsants	1	-	-	-	-	1	-	-	-	1	-	-	-
Poisoning – Central Nervous System Muscle Depressants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Central Nervous System stimulant – crack ²	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Phenothiazine-Based Tranquillisers	1	-	1	-	-	-	-	-	1	-	-	-	-
Poisoning – Antipsychotic Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antipsychotic, neuroleptic, and major tranquilisers ³	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Benzodiazepine-Based Tranquillisers	-	1	-	1	-	-	-	-	1	-	-	-	-
Poisoning By Other Diuretics	-	1	1	-	-	-	-	-	1	-	-	-	-
Poisoning – Hallucinogens	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Selective Serotonin Reuptake Inhibitors	-	1	1	-	-	-	-	-	1	-	-	-	-
Poisoning – Antidepressant Not Elsewhere Classified	1	-	1	-	-	-	-	-	1	-	-	-	-
Poisoning By Other Antidepressants ⁴	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other sedative and hypnotics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - other specified drugs or medicinal substances ⁵	-	-	-	-	-	-	-	-	-	-	-	-	-
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	-	-	-
Toxic Effect Of Other Substances, Chiefly Nonmedicinal As To Source, Not Elsewhere Classified ⁶	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	12	13	8	5	2	4	2	4	18	7	-	-	-

Source: King Edward VII Memorial Hospital

Notes: ²Category was not available in 2015.

³ Includes Portuguese, and persons of 'Other' races.

Table 7.2.4
Primary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2016

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning – Antiviral Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Adrenal Cortical Steroids	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antihypertensive agents	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Insulin & Antidiabetic Agents	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Antiallergic and Antiemetic Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Uric acid metabolism drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antitussives	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Salicylates	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Aromatic Analgesics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Aromatic Analgesics Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cardiotonics glycosides	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Propionic Acid Derivatives	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Other Antirheumatics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Other and Unspecified Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Central Nervous System Muscle Depressants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Central Nervous System stimulant - crack	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Phenothiazine-based Tranquillisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Antipsychotic Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antipsychotic, neuroleptic, and major tranquilisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Benzodiazepine-Based Tranquillisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Other Diuretics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Hallucinogens	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Selective Serotonin Reuptake Inhibitors	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Antidepressant Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Other Antidepressants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other sedative and hypnotics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other specified drugs or medicinal substances	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Cocaine	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Parasympathomimetic	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Gastrointestinal Agents Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Caustic Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Ethyl Alcohol	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Carbon Monoxide	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Berry/Plant Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect Of Pesticides, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-



Table 7.2.4 cont'd
Primary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2016

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Toxic Effect Of Soap and Detergents	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Other Substances Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect Of Other Substances, Chiefly Nonmedicinal As To Source, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	-	-	-	-	-	-	-	-	-	-	-	-	-

Source: King Edward VII Memorial Hospital

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

Table 7.2.5
Secondary Diagnoses of Inpatient Drug-Related* Cases, 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	Mixed	Asian	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	-	-	-
Other And Unspecified Alcohol Dependence, Unspecified Drinking Behavior**	-	-	-	-	-	-	-	-	-	-	-	-	-
Sedative, Hypnotic Or Anxiolytic Dependence, Continuous**	-	-	-	-	-	-	-	-	-	-	-	-	-
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	-	-	-
Cocaine Dependence- Unspecified**	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Dependence - Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Dependence- Unspecified**	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid/Other Dependence - Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Dependence, Unspecified Use**	-	-	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Dependence- Continuous	1	1	-	1	-	1	-	-	-	2	-	-	-
Unspecified drug dependence - In remission**											-	-	
Other specified drug dependence - unspecified**													
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	-	-	-	-

Table 7.2.5 cont'd
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	Mixed	Asian	Other*
Opioid Abuse - Unspecified	1	2	-	1	-	-	-	2	3	-	-	-	-
Opioid Abuse - Continuous	6	-	-	-	1	-	5	-	4	2	-	-	-
Opioid Abuse – Episodic**	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse - In Remission	8	-	-	-	1	-	4	3	7	1	-	-	-
Cocaine Abuse**	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse, Unspecified Use	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**	-	-	-	-	-	-	-	-	-	-	-	-	-
Amphetamine Abuse - Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Amphetamine Or Related Acting Sympathomimetic Abuse, Unspecified Use**	-	-	-	-	-	-	-	-	-	-	-	-	-
Amphetamine Or Related Acting Sympathomimetic Abuse, Episodic**	-	-	-	-	-	-	-	-	-	-	-	-	-
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.

** Category was not available in 2015.

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

Table 7.2.6
Secondary Diagnoses of Inpatient Drug-Related* Cases, 2016

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Acute Alcohol Intoxication - Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Acute Alcoholic Intoxication - Continuous	13	2	-	-	1	2	10	2	10	5	-	-	-
Acute Alcoholic Dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Other And Unspecified Alcohol Dependence, Unspecified Drinking Behavior	11	4	-	-	1	-	4	10	10	5	-	-	-
Sedative, Hypnotic Or Anxiolytic Dependence, Continuous	1	-	-	-	-	-	1	-	1	-	-	-	-
Chronic Alcohol Dependence - Continuous	48	3	-	-	2	8	16	25	32	18	-	-	1
Chronic Alcohol Dependence - In Remission	7	-	-	-	-	1	1	5	6	1	-	-	-
Opioid Type Dependence - Unspecified	4	1	-	-	-	-	2	3	4	1	-	-	-
Opioid Dependence - Continuous	15	2	-	-	-	3	11	3	15	2	-	-	-
Opioid Type Dependence - In Remission	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Dependence - Continuous	5	-	-	-	-	-	2	3	5	-	-	-	-
Cocaine Dependence - In Remission	1	-	-	-	-	-	1	-	1	-	-	-	-
Cocaine Dependence- Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Dependence - Continuous	1	-	-	-	-	-	1	-	1	-	-	-	-
Cannabis Dependence- Unspecified	-	1	-	-	1	-	-	-	1	-	-	-	-
Opioid/Other Dependence - Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-

Table 7.2.6 cont'd
Secondary Diagnoses of Inpatient Drug-Related* Cases, 2016

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Unspecified Drug Dependence, Unspecified Use	-	1	-	1	-	-	-	-	1	-	-	-	-
Unspecified Drug Dependence- Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Unspecified drug dependence - In remission	-	-	-	-	-	-	-	-	-	-	-	-	-
Other specified drug dependence - unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse - Unspecified	46	19	-	4	12	8	18	23	50	14	-	-	1
Alcohol Abuse - Continuous	78	26	-	3	10	8	30	53	59	44	1	-	-
Alcohol Abuse - Episodic	5	6	-	1	2	1	2	5	8	2	-	1	-
Alcohol Abuse - In Remission	66	13	-	-	1	2	15	61	60	19	-	-	-
Tobacco Use Disorder	320	180	1	11	48	64	175	201	350	135	2	4	9
Cannabis Abuse - Unspecified	43	17	-	7	16	10	17	10	54	6	-	-	-
Cannabis Abuse - Continuous	80	28	-	10	26	18	33	21	94	13	1	-	-
Cannabis Abuse - Episodic	8	9	-	2	4	2	7	2	14	3	-	-	-
Cannabis Abuse - In Remission	18	5	-	-	1	1	10	11	16	7	-	-	-
Opioid Abuse - Unspecified	9	1	-	-	-	-	9	1	10	-	-	-	-
Opioid Abuse - Continuous	7	-	-	-	-	-	6	1	6	1	-	-	-
Opioid Abuse - Episodic	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse - In Remission	8	2	-	-	-	1	8	1	10	-	-	-	-
Cocaine Abuse	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse, Unspecified Use	21	4	-	-	4	1	12	8	22	3	-	-	-
Cocaine Abuse - Continuous	8	3	-	-	-	-	8	3	9	2	-	-	-
Cocaine Abuse - Episodic	1	-	-	-	-	-	-	1	1	-	-	-	-
Cocaine Abuse - In Remission	19	6	-	-	-	1	19	5	22	3	-	-	-
Amphetamine Abuse	-	-	-	-	-	-	-	-	-	-	-	-	-
Amphetamine Abuse - Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Amphetamine Or Related Acting Sympathomimetic Abuse, Unspecified Use	-	1	-	-	1	-	-	-	-	1	-	-	-
Amphetamine or related acting sympathomimetic abuse – Episodic	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse - Unspecified	2	-	-	-	1	-	-	1	2	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse - Continuous	-	1	1	-	-	-	-	-	1	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse - In Remission	1	-	-	-	-	-	1	-	-	1	-	-	-
TOTAL	846	335	2	39	131	131	419	459	875	286	4	5	11

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, 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	Mixed	Asian	Other*
Poisoning - Insulin Antidiabetic	1	-	1	-	-	-	-	-	1	-	-	-	-
Poisoning - Thyroid Derivative	1	-	1	-	-	-	-	-	-	1	-	-	-
Poisoning By Anti-Infectives And Other Drugs And Preparations For Ear, Nose, And Throat*	-	-	-	-	-	-	-	-	-	-	-	-	-

Table 7.2.7 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	Mixed	Asian	Other*
Poisoning By Unspecified Drug Or Medicinal Substance*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antiallergic and Antiemetic Drugs	-	|	-	|	-	-	-	-	-	|	-	-	-
Poisoning - Antineoplastic & Immunosuppressive Drugs	-	|	|	-	-	-	-	-	|	-	-	-	-
Poisoning – Heroin	|	-	-	-	-	|	-	-	-	|	-	-	-
Poisoning - Hydantoin Derivatives*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Methadone	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Opium*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Antirheumatics*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticoagulants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Salicylates	|	-	|	-	-	-	-	-	|	-	-	-	-
Poisoning - Codeine, Meperidine, Morphine	|	-	|	-	-	-	-	-	|	-	-	-	-
Poisoning - Propionic Acid Derivatives	|	-	|	-	-	-	-	-	|	-	-	-	-
Poisoning - Phenothiazine-based tranquilisers*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Sympathomimetics*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticonvulsants Not Elsewhere Classified	|	-	|	-	-	-	-	-	|	-	-	-	-
Poisoning – Anticonvulsants Nec/Nos*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Unspecified Sedative or Hypnotics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Central Nervous System Muscle Depressants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressants Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Other Antidepressants*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Antitussives*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Benzodiazepine-Based Tranquilisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Psychotropic Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Diuretics Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Electrolytic, Caloric, and Water-Balanced Agents	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Butyrophenone Tranquilliser	|	-	-	-	-	|	-	-	-	|	-	-	-
Poisoning - Cocaine	|	-	-	-	-	|	-	-	-	|	-	-	-
Poisoning - Sympatholytics	-	|	|	-	-	-	-	-	|	-	-	-	-
Poisoning - Cardiovascular Rhythm Regulation	|	-	-	-	-	|	-	-	-	|	-	-	-
Poisoning - Antilipemics	|	|	|	-	-	-	-	|	2	-	-	-	-
Poisoning - Antihypertensive Agent	-	|	-	-	-	-	-	|	|	-	-	-	-
Poisoning - Cardiovascular Agent Not Elsewhere Classified	-	|	-	-	-	|	-	-	-	|	-	-	-
Toxic Effect - Ethyl Alcohol	|	|	-	-	-	|	-	|	|	|	-	-	-
Toxic Effect - Alcohol Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Benzene	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Fish and shellfish*	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect –Venom*	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect Of Unspecified Substance, Chiefly Nonmedicinal As To Source*	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	12	7	9	1	-	5	-	4	13	6	-	-	-

Source: King Edward VII Memorial Hospital

Notes: * Category was not available in 2015.

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



Table 7.2.8
Secondary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2016

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning - Insulin Antidiabetic	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Thyroid Derivative	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Anti-Infectives And Other Drugs And Preparations For Ear, Nose, And Throat	-	1	1	-	-	-	-	-	1	-	-	-	-
Poisoning By Unspecified Drug Or Medicinal Substance	2	1	-	1	-	-	-	2	1	2	-	-	-
Poisoning - Antiallergic and Antiemetic Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antineoplastic & Immunosuppressive Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Heroin	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Hydantoin derivatives	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Methadone	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Opium	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Antirheumatics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticoagulants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Salicylates	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Codeine, Meperidine, Morphine	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Propionic Acid Derivatives	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Phenothiazine-based tranquilisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Sympathomimetics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticonvulsants Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticonvulsants Nec/Nos	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Unspecified Sedative or Hypnotics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Central Nervous System Muscle Depressants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressants Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Other Antidepressants	-	1	-	-	-	1	-	-	-	1	-	-	-
Poisoning - Antitussives	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Benzodiazepine-Based Tranquilisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Psychotropic Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Diuretics Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Electrolytic, Caloric, and Water-Balanced Agents	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Butyrophenone Tranquilliser	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cocaine	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Sympatholytics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cardiovascular Rhythm Regulation	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antilipemics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antihypertensive Agent	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cardiovascular Agent Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Ethyl Alcohol	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Alcohol Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Benzene	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic effect - Fish and shellfish	-	-	-	-	-	-	-	-	-	-	-	-	-

Table 7.2.8 cont'd
Secondary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2016

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Toxic effect - Venom	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect Of Unspecified Substance, Chiefly Nonmedicinal As To Source	2	2	2	1	-	-	-	1	1	3	-	-	-
TOTAL	4	5	3	2	-	1	-	3	3	6	-	-	-

Source: King Edward VII Memorial Hospital

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

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

The emergency room saw 86 cases in 2015 in which the primary diagnosis was related to drugs, and increased to 111 cases in 2016 (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 saw 142 cases in 2015 as compared to 181 cases in 2016 (see Tables 7.3.3 and 7.3.4). In 2015, there was an overall total of 500 cases reported to the emergency room for which there was a drug-related secondary diagnosis as

compared to 572 cases in 2016 (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 2016 were due to alcohol abuse, tobacco use disorder, and opioid abuse. When it came to secondary diagnosis of emergency room cases of poisoning and toxic effects of substances, 26 cases presented in 2015 and 15 cases in 2016 (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, 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	Mixed	Asian	Other*
Acute Alcoholic Intoxication	-	-	-	-	-	-	-	-	-	-	-	-	-
Acute Alcoholic Intoxication – Continuous	3	1	-	-	-	-	1	3	3	1	-	-	-
Acute Alcoholic Intoxication In Alcoholism, Unspecified Drinking Behavior**	-	-	-	-	-	-	-	-	-	-	-	-	-
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	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Dependence- Unspecified use**	-	-	-	-	-	-	-	-	-	-	-	-	-
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 - Episodic**	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse – Continuous Drinking Behaviour	3	-	-	-	1	1	-	1	1	2	-	-	-
Alcohol Abuse – Unspecified Drinking Behaviour**	-	-	-	-	-	-	-	-	-	-	-	-	-
Tobacco Use Disorder**	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Abuse**	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Abuse – Unspecified Use	-	2	-	1	-	1	-	-	2	-	-	-	-
Opioid Abuse**	-	-	-	-	-	-	-	-	-	-	-	-	-

Table 7.3.1
Primary Diagnoses of Emergency Room (ER) 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	Mixed	Asian	Other*
Opioid Abuse – Unspecified Use	5	-	-	-	-	4	1	-	4	1	-	-	-
Cocaine Abuse	3	5	-	1	2	-	5	-	5	3	-	-	-
Cocaine Abuse, Unspecified Use**	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse	-	-	-	-	-	-	-	1	1	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse – Continuous Use	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, Unspecified 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.

** Category was not available in 2015.

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

Table 7.3.2
Primary Diagnoses of Emergency Room Drug-Related* Cases, 2016

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Acute Alcoholic Intoxication	-	-	-	-	-	-	-	-	-	-	-	-	-
Acute Alcoholic Intoxication – Continuous	1	-	-	-	-	-	1	-	-	1	-	-	-
Acute Alcoholic Intoxication In Alcoholism, Unspecified Drinking Behaviour	8	3	1	6	3	-	-	1	6	5	-	-	-
Acute Alcoholic Dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Other & Unspecified Alcohol Dependence	1	-	-	-	-	-	1	-	-	1	-	-	-
Other and Unspecified Alcohol Dependence – Continuous Drinking Behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Type Dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Dependence- Unspecified use	-	1	-	-	-	1	-	-	1	-	-	-	-
Other Specified Drug Dependence – Unspecified Use	-	-	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Dependence – Unspecified Use	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse - Episodic	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse – Continuous Drinking Behaviour	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse – Unspecified Drinking Behaviour	60	24	5	8	11	14	28	18	45	36	-	-	3
Tobacco Use Disorder	1	-	-	-	-	-	1	-	-	1	-	-	-
Cannabis Abuse	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Abuse – Unspecified Use	1	1	2	-	-	-	-	-	2	-	-	-	-
Opioid Abuse	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse – Unspecified Use	5	1	-	-	-	2	4	-	6	-	-	-	-
Cocaine Abuse	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse, Unspecified Use	3	-	-	-	-	-	2	1	2	1	-	-	-
Other, Mixed, or Unspecified Drug Abuse	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse – Continuous Use	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, Unspecified Use	1	-	-	-	-	1	-	-	1	-	-	-	-
TOTAL	81	30	8	14	14	18	37	20	63	45	-	-	3

Source: King Edward VII Memorial Hospital

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

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

Table 7.3.3
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 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	Mixed	Asian	Other*
Poisoning - Penicillins	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Specified Antibiotics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Sulfonamides	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anthelmintics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anti-Infectives*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Antineoplastic And Immunosuppressive Drugs*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anti-Parkinson drug*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Ovarian Hormone	-	-	-	-	-	-	-	-	-	-	-	-	-
Poison - Insulin & Antidiabetic Agents	-	3	-	-	-	-	1	2	3	-	-	-	-
Poisoning - Thyroid Derivatives	1	-	1	-	-	-	-	-	1	-	-	-	-
Poisoning - Antiallergic & Antiemetic Drugs	1	-	1	-	-	-	-	-	-	-	-	-	1
Poisoning - Vitamins	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticoagulants	-	2	1	-	-	-	1	-	2	-	-	-	-
Poisoning - Opium	1	-	-	-	-	1	-	-	1	-	-	-	-
Poisoning - Other Agents Affecting Skin and Mucous Membrane*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Tricyclic Antidepressants	1	-	-	1	-	-	-	-	1	-	-	-	-
Poisoning - Other Antidepressant	1	-	1	-	-	-	-	-	1	-	-	-	-
Poisoning By Other Psychostimulants*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antipsychotic, Neuroleptic, & Major Tranquilisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antitussives*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Benzodiazepine-Based Tranquilisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Butyrophenome-Based Tranquilisers*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cardiac Rhythm Regulators*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cardiotonics Glycosides*	-	-	-	-	-	-	-	-	-	-	-	-	-
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 - Heroin	2	-	-	-	-	-	2	-	2	-	-	-	-
Poisoning - Codeine, Meperidine, Morphine	-	1	1	-	-	-	-	-	1	-	-	-	-
Poisoning - Dietetics*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Electrolytic, Caloric, and Water-balance agents*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Emollients, Demulcents and Protectants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - ENT preparation*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Salicylates	2	1	-	2	-	-	1	-	3	-	-	-	-
Poisoning - Saluretics*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Sedative and Hypnotics*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Skeletal Muscle Relaxants*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Aromatic Analgesics	2	6	2	3	-	2	1	-	5	3	-	-	-

Table 7.3.3 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	Mixed	Asian	Other*
Poisoning - Propionic Acid Derivatives	4	2	3	1	-	-	2	-	5	1	-	-	-
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 - Antidepressants*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Central Nervous System Muscle Depressants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cocaine*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Selective Serotonin Reuptake Inhibitors	-	1	1	-	-	-	-	-	1	-	-	-	-
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 - Methadone*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antipruritics	-	-	-	-	-	-	-	-	-	-	-	-	-
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	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Uric Acid Metabolism Drugs*	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Isopropyl Alcohol	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic effect - Non-Medicinal Substances*	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Unspecified Alcohol	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Petroleum Products	1	1	-	-	2	-	-	-	2	-	-	-	-
Toxic effect - Silicone*	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Non-Petroleum-Based Solvents	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Caustic Alkalis	1	-	-	-	-	1	-	-	1	-	-	-	-
Toxic Effect Of Acids*	1	-	-	-	-	1	-	-	1	-	-	-	-
Toxic Effect - Caustic Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2015	5	5	1	-	4	1	2	2	10	-	-	-	-
Toxic Effect - Carbon Monoxide	1	2	-	-	1	-	1	1	3	-	-	-	-
Toxic Effect Of Other Specified Metals*	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Liquefied Petroleum Gases	-	1	-	-	1	-	-	-	1	-	-	-	-
Toxic Effect - Chlorine gas*	-	-	-	-	-	-	-	-	-	-	-	-	-

Table 7.3.3 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	Mixed	Asian	Other*
Toxic Effect - Ethyl alcohol [†]	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Fish and Shellfish [†]	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Other Hydrocarbon Gas	1	1	-	-	2	-	-	-	1	1	-	-	-
Toxic Effect - Other Specified Gases, Fumes, or Vapours	-	2	-	1	-	-	1	-	1	1	-	-	-
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 - Unspecified substances [†]	-	-	-	-	-	-	-	-	-	-	-	-	-
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 - Pesticides [†]	-	-	-	-	-	-	-	-	-	-	-	-	-
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: [†] Category was not available in 2015.

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

Table 7.3.4
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2016

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning - Penicillins	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Specified Antibiotics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Sulfonamides	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anthelmintics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anti-Infectives	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Antineoplastic And Immunosuppressive Drugs	-	2	-	-	-	-	2	-	2	-	-	-	-
Poisoning - Anti-Parkinson Drug	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Ovarian Hormone	-	-	-	-	-	-	-	-	-	-	-	-	-
Poison - Insulin & Antidiabetic Agents	-	4	-	-	-	-	-	4	2	2	-	-	-
Poisoning - Thyroid Derivatives	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antiallergic & Antiemetic Drugs	-	1	1	-	-	-	-	-	1	-	-	-	-
Poisoning - Vitamins	-	1	1	-	-	-	-	-	1	-	-	-	-
Poisoning - Anticoagulants	-	2	-	-	-	-	1	1	1	1	-	-	-
Poisoning - Opium	1	-	-	-	-	-	-	1	1	-	-	-	-
Poisoning - Other Agents Affecting Skin and Mucous Membrane	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Heroin	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Codeine, Meperidine, Morphine	-	1	-	-	1	-	-	-	1	-	-	-	-
Poisoning - Dietetics	-	-	-	-	-	-	-	-	-	-	-	-	-

Table 7.3.4 cont'd
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2016

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning - Electrolytic, Caloric, and Water-Balance agents	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Emollients, Demulcents and Protectants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - ENT preparation	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Salicylates	1	1	-	1	-	-	1	-	2	-	-	-	-
Poisoning - Saluretics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Sedative and hypnotics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Skeletal Muscle Relaxants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Aromatic Analgesics	2	1	1	-	-	1	1	-	1	2	-	-	-
Poisoning - Propionic Acid Derivatives	1	3	2	2	-	-	-	-	3	1	-	-	-
Poisoning - Other and Unspecified Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Anti-Rheumatics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Hydantoin Derivatives	2	-	-	-	1	1	-	-	2	-	-	-	-
Poisoning - Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Sedative or Hypnotics	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning - Antidepressants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Central Nervous System Muscle Depressants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cocaine	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Selective Serotonin Reuptake Inhibitors	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Tricyclic Antidepressants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Antidepressant	-	1	-	-	-	-	-	1	-	1	-	-	-
Poisoning By Other Psychostimulants	1	-	1	-	-	-	-	-	1	-	-	-	-
Poisoning - Antipsychotic, Neuroleptic, & Major Tranquilisers	1	-	-	-	-	-	-	1	-	1	-	-	-
Poisoning - Antitussives	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Benzodiazepine-Based Tranquilisers	1	3	-	-	1	3	-	-	-	3	-	-	1
Poisoning - Butyrophenome-based tranquilisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cardiac rhythm regulators	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cardiotonics glycosides	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Hallucinogens	-	1	-	1	-	-	-	-	1	-	-	-	-
Poisoning - Caffeine	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Parasympatholytics and Spasmolytics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Sympatholytics (Antiadrenergics)	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antilipemic & Antiarteriosclerotic Drugs	1	-	-	-	-	1	-	-	1	-	-	-	-
Poisoning - Coronary Vasodilators	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Antihypertensive Agents	1	-	1	-	-	-	-	-	-	1	-	-	-
Poisoning - Other and Unspecified Agents Primarily Affecting the Cardiovascular System	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning - Antidiarrheal Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Gastrointestinal Agents	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Purine Derivative Diuretics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Expectorants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anti-Asthmatics	-	-	-	-	-	-	-	-	-	-	-	-	-

Table 7.3.4 cont'd
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2016

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning - Local Anti-Infective & Anti-Inflammatory Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Methadone	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antipruritics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Keratolytics, Keratoplastics, Other Hair Treatment Drugs and Preparations	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anti-Infectives and Other Drugs and Preparations for Ear, Nose, and Throat	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Alcohol Deterrents	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Specified Drugs or Medicinal Substances	7	6	8	1	-	-	2	2	7	4	-	-	2
Poisoning - Unspecified Drugs or Medicinal Substances	3	2	1	1	-	1	-	2	4	1	-	-	-
Poisoning - Uric Acid Metabolism Drugs	-	1	-	-	-	-	1	-	-	1	-	-	-
Toxic Effect - Isopropyl Alcohol	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic effect - Non-Medicinal Substances	2	1	1	-	1	-	1	-	3	-	-	-	-
Toxic Effect - Unspecified Alcohol	1	-	-	-	-	-	-	1	1	-	-	-	-
Toxic Effect - Petroleum Products	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic effect - Silicone	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Non-Petroleum-Based Solvents	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect Of Acids	1	-	-	-	-	-	1	-	1	-	-	-	-
Toxic Effect - Caustic Alkalis	-	1	1	-	-	-	-	-	1	-	-	-	-
Toxic Effect - Caustic Unspecified	5	3	3	-	3	1	-	1	7	1	-	-	-
Toxic Effect - Carbon Monoxide	1	-	-	1	-	-	-	-	1	-	-	-	-
Toxic Effect Of Other Specified Metals	1	-	1	-	-	-	-	-	1	-	-	-	-
Toxic Effect - Liquefied Petroleum Gases	-	1	-	-	-	-	1	-	1	-	-	-	-
Toxic effect - Chlorine gas	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic effect - Ethyl alcohol	1	-	-	1	-	-	-	-	1	-	-	-	-
Toxic effect - Fish and shellfish	3	7	5	-	2	1	1	1	5	4	-	-	1
Toxic Effect – Other Hydrocarbon Gas	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Other Specified Gases, Fumes, or Vapours	2	1	-	-	1	1	1	-	3	-	-	-	-
Toxic Effect - Unspecified Gas, Fumes, or Vapour	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Berries and Other Plants Eaten as Food	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Other Pesticides, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic effect - Unspecified substances	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Venom	40	52	19	12	11	10	27	13	49	38	-	-	5
Toxic Effect - Soap & Detergent	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Other Substances, Chiefly Nonmedical	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic effect - Pesticides	-	1	-	-	-	-	-	1	1	-	-	-	-
Toxic Effect - Unspecified Substances, Chiefly Nonmedical	2	1	1	-	-	-	-	2	3	-	-	-	-
TOTAL	83	98	47	20	21	20	42	31	109	63	-	-	9

Source: King Edward VII Memorial Hospital

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



Table 7.3.5
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	Mixed	Asian	Other [*]
Acute Alcoholic Intoxication	3	1	-	1	1	-	2	-	3	1	-	-	-
Acute Alcoholic Intoxication In Alcoholism, Unspecified Drinking Behavior ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
Acute Alcoholic Intoxication - Continuous	3	-	-	-	-	-	3	-	3	-	-	-	-
Other And Unspecified Alcohol Dependence, Unspecified Drinking Behavior ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
Acute Alcoholic Dependence	25	8	-	6	5	4	8	10	20	11	-	-	2
Chronic Alcohol Dependence - Continuous	3	1	-	-	-	-	4	-	3	1	-	-	-
Chronic Alcohol Dependence - Episodic ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
Chronic Alcohol Dependence - In Remission ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Type Dependence - Unspecified	14	2	-	-	-	4	9	3	12	4	-	-	-
Opioid Type Dependence - In Remission ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Dependence - Continuous	4	-	-	-	-	2	1	1	3	1	-	-	-
Cocaine Dependence - Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Dependence - Continuous Use	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Dependence - In Remission ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Dependence, Unspecified Use ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Specified Drug Dependence, Unspecified Use ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Dependence, Unspecified Use ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
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 - Episodic ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
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	-	-	-	-	-	-	-	-	-	-	-	-	-
Sedative, Hypnotic or Anxiolytic Dependence ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
Amphetamine Abuse ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse - Unspecified	39	2	-	1	-	12	23	5	28	13	-	-	-
Opioid Abuse - Continuous	3	-	-	-	-	2	1	-	3	-	-	-	-
Opioid Abuse - In Remission	-	-	-	-	-	-	-	-	-	-	-	-	-
Combinations of opioid type drug with any other - continuous ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
Combinations of opioid type drug with any other - in remissions ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse	15	5	-	1	5	1	12	1	13	7	-	-	-
Cocaine Abuse - Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse, Unspecified Use ^{**}	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse - In Remission	-	-	-	-	-	-	-	-	-	-	-	-	-

Table 7.3.5 cont'd
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	Mixed	Asian	Other*
Other, Mixed, or Unspecified Drug Abuse	15	3	1	2	1	2	10	2	15	3	-	-	-
Other, Mixed, or Unspecified Drug Abuse, Unspecified Use	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse - Continuous Use	-	1	-	-	-	-	1	-	-	1	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, In Remission**	-	-	-	-	-	-	-	-	-	-	-	-	-
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.

** Category was not available in 2015.

Includes Portuguese, and persons of 'Other' races.

Table 7.3.6
Secondary Diagnoses of Emergency Room Drug-Related[#] Cases, 2016

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Acute Alcoholic Intoxication	-	-	-	-	-	-	-	-	-	-	-	-	-
Acute Alcoholic Intoxication In Alcoholism, Unspecified Drinking Behavior	9	4	-	1	2	1	6	3	8	5	-	-	-
Acute Alcoholic Intoxication - Continuous	1	-	-	-	-	-	1	-	-	1	-	-	-
Other And Unspecified Alcohol Dependence, Unspecified Drinking Behavior	26	7	-	1	-	3	16	13	20	11	-	-	2
Acute Alcoholic Dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Chronic Alcohol Dependence - Continuous	4	1	-	-	-	2	3	-	2	3	-	-	-
Chronic Alcohol Dependence - Episodic	-	-	-	-	-	-	-	-	-	-	-	-	-
Chronic Alcohol Dependence - In Remission	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Type Dependence - Unspecified	5	1	-	-	1	1	2	2	6	-	-	-	-
Opioid Type Dependence- In Remission	-	1	-	-	-	-	1	-	1	-	-	-	-
Opioid Dependence - Continuous	3	-	-	-	-	-	3	-	3	-	-	-	-
Cocaine Dependence - Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Dependence - Continuous Use	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Dependence - In Remission	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Dependence, Unspecified Use	1	-	-	-	-	1	-	-	-	1	-	-	-
Other Specified Drug Dependence, Unspecified Use	1	-	-	-	-	1	-	-	1	-	-	-	-
Unspecified Drug Dependence, Unspecified Use	1	1	-	-	-	-	2	-	1	1	-	-	-
Unspecified Drug Depend - Not Otherwise Specified	-	-	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Dependence - Continuous Use	-	-	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Dependence - In Remission	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse - Unspecified	150	32	1	26	28	27	58	42	128	46	-	2	6
Alcohol Abuse - Continuous	2	1	-	1	-	-	-	2	2	1	-	-	-
Alcohol abuse - Episodic	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse - In Remission	-	-	-	-	-	-	-	-	-	-	-	-	-
Tobacco Use Disorder	110	80	1	10	25	34	71	49	123	59	1	2	5
Cannabis Abuse - Unspecified	39	10	2	13	16	8	5	5	41	7	-	-	1

Table 7.3.6 cont'd
Secondary Diagnoses of Emergency Room Drug-Related* Cases, 2016

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other†
Cannabis Abuse - Continuous	2	1	-	2	-	1	-	-	3	-	-	-	-
Sedative, Hypnotic or Anxiolytic Abuse	-	-	-	-	-	-	-	-	-	-	-	-	-
Sedative, Hypnotic or Anxiolytic Dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Amphetamine abuse	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse - Unspecified	46	3	-	-	1	9	32	7	36	13	-	-	-
Opioid Abuse - Continuous	1	-	-	-	-	-	-	1	-	1	-	-	-
Opioid Abuse - In Remission	-	-	-	-	-	-	-	-	-	-	-	-	-
Combinations of opioid type drug with any other - continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Combinations of opioid type drug with any other - in remissions	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse, Unspecified Use	10	-	-	-	2	1	6	1	8	2	-	-	-
Cocaine Abuse - In Remission	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse, Unspecified Use	16	2	-	4	2	2	7	3	14	4	-	-	-
Other, Mixed, or Unspecified Drug Abuse - Continuous Use	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, In Remission	-	1	-	-	-	-	1	-	1	-	-	-	-
TOTAL	427	145	4	58	77	91	214	128	398	155	1	4	14

Source: King Edward VII Memorial Hospital

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

† Includes Portuguese, and persons of 'Other' races.

Table 7.3.7
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	Mixed	Asian	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 - Analgesic and Antipyretic*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Aromatic Analgesics*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Aromatic Analgesics, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Propionic Acid Derivatives	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Salicylates*	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic effect - Caustic Agents	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Antirheumatics	-	1	-	-	-	1	-	-	1	-	-	-	-
Poisoning - Unspecified Analgesic and Antipyretic	-	1	-	-	-	-	-	1	1	-	-	-	-
Poisoning - Other and Unspecified Anticonvulsants	1	-	1	-	-	-	-	-	1	-	-	-	-

Table 7.3.7 cont'd
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	Mixed	Asian	Other*
Poisoning - Antidepressant*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressant, Not Elsewhere Classified	-	|	-	-	-	-	|	-	-	|	-	-	-
Poisoning - Antihypertensive Agent*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antineoplastic and Immunosuppressive drugs*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Phenothiazine- Based Tranquillisers	|	-	|	-	-	-	-	-	|	-	-	-	-
Poisoning - Butyrophenone Tranquillisers	|	-	-	-	-	|	-	-	-	|	-	-	-
Poisoning - Anti-Psychotic, Neuroleptics and Major Tranquillisers*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antipsychotic, Not Elsewhere Classified	-	|	-	-	-	-	|	-	-	|	-	-	-
Poisoning - Benzodiazepine-Based Tranquillisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Codeine, Meperidine, Morphine*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Glutethimide Group*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Hallucinogens*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Heroin*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Opiate Antagonists*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Skeletal Muscle Relaxants*	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Sympathomimetics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cardiotonics	-	|	-	-	-	-	-	|	|	-	-	-	-
Poisoning - Antilipemics	|	-	|	-	-	-	-	-	|	-	-	-	-
Poisoning - Other and Unspecified Agents Primarily Affecting the Cardiovascular System	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Gastrointestinal Agents, Not Elsewhere Classified	-	|	-	-	-	-	|	-	-	|	-	-	-
Poisoning - Diuretics, Not Elsewhere Classified	-	|	-	-	-	-	-	|	|	-	-	-	-
Poisoning - Antiasthmatics	-	|	|	-	-	-	-	-	-	|	-	-	-
Poisoning- Antipruritics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Emollients, Demulcents, and Protectants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Specified Drugs or Medicinal Substances	|	|	|	-	-	-	-	|	|	|	-	-	-
Poisoning - Unspecified Drug or Medicinal Substance	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Ethyl Alcohol	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effects - Unspecified Alcohol	|	-	-	-	-	|	-	-	-	|	-	-	-
Toxic Effect - Acids	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Caustic Agents	|	-	-	-	-	-	-	|	-	|	-	-	-
Toxic Effect - Other Specified Gases, Fumes, or Vapours	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Unspecified Gas, Fume, or Vapour	|	-	-	-	|	-	-	-	|	-	-	-	-
Toxic Effect Of Fish And Shellfish Eaten As Food*	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic effect - Latex*	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Venom	6	-	2	-	|	2	-	|	3	3	-	-	-



Table 7.3.7 cont'd
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	Mixed	Asian	Other*
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

Notes: * Includes Portuguese, and persons of 'Other' races.
 † Category was not available in 2015.

Table 7.3.8
Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2016

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning - Insulin Antidiabetic	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Thyroid Derivative	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antiviral Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antiallergic and Antiemetic Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticoagulants	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning - Opium (Alkaloids), Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Analgesic and Antipyretic	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Aromatic Analgesics	-	1	-	-	1	-	-	-	-	1	-	-	-
Poisoning - Aromatic Analgesics, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Propionic Acid Derivatives	1	1	-	1	1	-	-	-	1	1	-	-	-
Poisoning - Salicylates	1	-	-	-	-	1	-	-	1	-	-	-	-
Poisoning - Other Antirheumatics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Unspecified Analgesic and Antipyretic	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other and Unspecified Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressant	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressant, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antihypertensive agent	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antineoplastic and Immunosuppressive drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Phenothiazine –Based Tranquillisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Butyrophenone Tranquillisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anti-Psychotic, Neuroleptics and Major Tranquillisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antipsychotic, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Benzodiazepine-Based Tranquillisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Codeine, Meperidine, Morphine	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning - Glutethimide Group	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Hallucinogens	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Heroin	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning By Opiate Antagonists	-	1	-	-	-	1	-	-	-	-	-	-	1

Table 7.3.8 cont'd
Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2016

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning By Opiate Antagonists	-	1	-	-	-	1	-	-	-	-	-	-	1
Poisoning By Skeletal Muscle Relaxants	-	1	-	-	1	-	-	-	1	-	-	-	-
Poisoning - Sympathomimetics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cardiotonics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antilipemics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other and Unspecified Agents Primarily Affecting the Cardiovascular System	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Gastrointestinal Agents, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Diuretics, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antiasthmatics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning- Antipruritics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Emollients, Demulcents, and Protectants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Specified Drugs or Medicinal Substances	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Unspecified Drug or Medicinal Substance	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Ethyl Alcohol	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effects - Unspecified Alcohol	1	-	-	-	-	-	1	-	1	-	-	-	-
Toxic Effect - Acids	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Caustic Agents	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Other Specified Gases, Fumes, or Vapours	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Unspecified Gas, Fume, or Vapour	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect Of Fish And Shellfish Eaten As Food	1	-	-	-	-	-	1	-	1	-	-	-	-
Toxic effect - Latex	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Venom	2	2	-	-	2	-	1	1	1	3	-	-	-
Toxic Effect - Asbestos	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Unspecified Substance, Chiefly Nonmedical Source	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	9	6	-	1	5	2	6	1	8	6	-	-	1

Source: King Edward VII Memorial Hospital

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

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 2016, there were 130 cases with a primary diagnosis that was drug-related within the MWI as compared to 111 in 2015 (see Tables 7.4.1 and 7.4.2). Males, blacks, and between 46 and 60 years characterised 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 241 cases were recorded in 2015 (see Tables 7.4.3 and 7.4.4) as compared to 183 in 2016, 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 cases of poisoning and toxic effects of substances in either 2015 or 2016.

Table 7.4.1
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	Mixed	Asian	Other*
Acute Alcohol Intoxication – Continuous	19	5	-	3	4	6	10	1	14	10	-	-	-
Acute Alcoholic Intoxication In Alcoholism, Continuous Drinking Behavior**	-	-	-	-	-	-	-	-	-	-	-	-	-
Other And Unspecified Alcohol Dependence, Continuous Drinking Behavior**	-	-	-	-	-	-	-	-	-	-	-	-	-
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	-	-	-	-
Combinations Of Opioid Type Drug With Any Other Drug Dependence, Continuous Use**	-	-	-	-	-	-	-	-	-	-	-	-	-
Combinations Of Opioid Drugs With Others**	-	-	-	-	-	-	-	-	-	-	-	-	-
Combined Drug Dependence - Continuous**	-	-	-	-	-	-	-	-	-	-	-	-	-
Drug Dependence Not Otherwise Specified - Continuous**	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Abuse, Unspecified Use**	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse - Continuous	1	-	-	-	-	-	1	-	-	1	-	-	-
Tobacco Use Disorder	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse – Continuous	1	1	-	-	-	-	2	-	1	1	-	-	-
Other Specified Drug Dependence - Continuous**	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Specified Drug Dependence**	-	-	-	-	-	-	-	-	-	-	-	-	-
Sedative Dependence**	-	-	-	-	-	-	-	-	-	-	-	-	-
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

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

**Category was not available in 2015.

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

Table 7.4.2
Primary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2016*

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Acute Alcohol Intoxication – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Acute Alcoholic Intoxication In Alcoholism, Continuous Drinking Behavior	25	10	-	4	2	6	20	3	18	17	-	-	-
Other And Unspecified Alcohol Dependence, Continuous Drinking Behavior	7	2	-	-	3	1	1	4	7	2	-	-	-
Alcohol Dependence – Not Specified	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Alcohol Dependence – Episodic	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Dependence – Continuous	56	13	-	3	-	18	38	10	65	4	-	-	-

Table 7.4.2 cont'd
Primary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related* Cases, 2016

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Cocaine Dependence – Continuous	4	6	-	1	2	2	4	1	7	3	-	-	-
Cannabis Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid/Other Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Combinations Of Opioid Type Drug With Any Other Drug Dependence, Continuous Use	1	4	-	3	-	2	-	-	5	-	-	-	-
Combinations Of Opioid Drugs With Others	-	-	-	-	-	-	-	-	-	-	-	-	-
Combined Drug Dependence - Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Drug Dependence Not Otherwise Specified - Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Abuse, Unspecified Use	-	1	1	-	-	-	-	-	1	-	-	-	-
Alcohol Abuse - Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Tobacco Use Disorder	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse – Continuous	1	-	-	-	-	-	1	-	1	-	-	-	-
Other Specified Drug Dependence - Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Specified Drug Dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Sedative Dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse, Unspecified Use	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	94	36	1	11	7	29	64	18	104	26	-	-	-

Source: King Edward VII Memorial Hospital

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

Table 7.4.3
Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related* Cases, 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	Mixed	Asian	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	-	-	-
Amphetamine Dependence**	-	-	-	-	-	-	-	-	-	-	-	-	-
Acute Alcoholic Intoxication In Alcoholism, Continuous Drinking Behavior**	-	-	-	-	-	-	-	-	-	-	-	-	-
Other And Unspecified Alcohol Dependence, Continuous Drinking Behavior**	-	-	-	-	-	-	-	-	-	-	-	-	-
Amphetamine And Other Psychostimulant Dependence, Continuous Use**	-	-	-	-	-	-	-	-	-	-	-	-	-
Hallucinogen Dependence**	-	-	-	-	-	-	-	-	-	-	-	-	-
Hallucinogen Dependence, Continuous Use**	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Dependence – Unspecified	-	1	-	-	-	-	1	-	-	1	-	-	-
Opioid Dependence – Continuous	6	3	-	-	2	4	3	-	8	1	-	-	-
Opioid /other dependence – Continuous**	-	-	-	-	-	-	-	-	-	-	-	-	-
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	-	-	-
Sedative Dependence**	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Specified Drug Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Specified Drug Dependence – Episodic	-	-	-	-	-	-	-	-	-	-	-	-	-

Table 7.4.3 cont'd
Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related⁶ 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	Mixed	Asian	Other*
Combined Opioid Type Drugs	13	-	-	-	3	3	7	-	10	3	-	-	-
Combination Drug Dependence – Unspecified	1	-	-	-	-	1	-	-	1	-	-	-	-
Combinations Of Opioid Type Drug With Any Other Drug Dependence, Continuous Use**	-	-	-	-	-	-	-	-	-	-	-	-	-
Combination of Drug Dependence – Excluding Opioids	8	-	-	-	-	2	5	1	6	2	-	-	-
Combination of Drug Dependence – Excluding Opioids Type Drug, Continuous Use**	-	-	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Drug Dependence Not Otherwise Specified – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse – Continuous	1	2	-	-	1	-	2	-	3	-	-	-	-
Alcohol Abuse – Continuous Drinking Behaviour**	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse – Unspecified	1	1	-	-	-	-	2	-	1	1	-	-	-
Tobacco Use Disorder	40	10	-	3	9	15	28	3	46	12	-	-	-
Cannabis Abuse – Unspecified**	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Abuse – Continuous	5	-	-	2	1	1	1	-	3	2	-	-	-
Opioid Abuse – Unspecified	-	1	-	-	-	-	1	-	-	1	-	-	-
Opioid Abuse – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Sedative Abuse – Continuous**	-	-	-	-	-	-	-	-	-	-	-	-	-
Sedative, Hypnotic Abuse**	-	-	-	-	-	-	-	-	-	-	-	-	-
Drug Abuse – Continuous	-	1	1	-	-	-	-	-	1	-	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, Unspecified Use**	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, Continuous Use**	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	190	51	3	12	37	67	104	18	194	45	-	-	2

Source: King Edward VII Memorial Hospital

Notes: * Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.
 ** Category was not available in 2015.

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

Table 7.4.4
Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related⁶ Cases, 2016

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Acute Alcohol Intoxication – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Acute Alcohol Intoxication – In Remission	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Dependence – Not Specified	-	-	-	-	-	-	-	-	-	-	-	-	-
Amphetamine Dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Acute Alcoholic Intoxication In Alcoholism, Continuous Drinking Behavior	22	7	-	1	7	7	9	5	18	11	-	-	-
Other And Unspecified Alcohol Dependence, Continuous Drinking Behavior	2	1	-	-	1	1	-	1	2	1	-	-	-
Amphetamine And Other Psychostimulant Dependence, Continuous Use	1	-	-	-	-	-	1	-	1	-	-	-	-
Hallucinogen Dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Hallucinogen Dependence, Continuous Use	2	-	-	-	-	-	1	1	-	2	-	-	-

Table 7.4.4 cont'd
Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related⁶ Cases, 2016

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other [*]
Opioid Dependence – Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Dependence – Continuous	5	5	-	1	2	3	3	1	7	3	-	-	-
Opioid /other dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Dependence – Continuous	15	10	-	3	3	6	12	1	25	-	-	-	-
Cannabis Dependence – Continuous	35	10	2	12	10	11	8	2	37	8	-	-	-
Sedative Dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Specified Drug Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Specified Drug Dependence – Episodic	-	-	-	-	-	-	-	-	-	-	-	-	-
Combined Opioid Type Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Combination Drug Dependence – Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Combinations Of Opioid Type Drug With Any Other Drug Dependence, Continuous Use	16	3	-	1	3	4	10	1	18	1	-	-	-
Combination of Drug Dependence – Excluding Opioids	-	-	-	-	-	-	-	-	-	-	-	-	-
Combinations Of Drug Dependence Excluding Opioid Type Drug, Continuous Use	2	1	1	-	-	1	1	-	2	1	-	-	-
Unspecified Drug Dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Drug Dependence Not Otherwise Specified – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse, Continuous Drinking Behavior	1	1	-	-	1	-	1	-	1	1	-	-	-
Alcohol Abuse – Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Tobacco Use Disorder	32	6	-	1	3	11	19	4	30	8	-	-	-
Cannabis Abuse – Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Abuse – Continuous	2	-	-	-	2	-	-	-	2	-	-	-	-
Opioid Abuse – Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Sedative abuse - Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Sedative, Hypnotic Abuse	-	-	-	-	-	-	-	-	-	-	-	-	-
Drug Abuse – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, Unspecified Use	3	-	-	-	1	2	-	-	3	-	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, Continuous Use	1	-	-	-	-	1	-	-	-	1	-	-	-
TOTAL	139	44	3	19	33	47	65	16	146	37	-	-	-

Source: King Edward VII Memorial Hospitals

Notes:

⁶ Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.

^{*} Includes Portuguese, and persons of 'Other' races.

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-10¹³. 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 2016, 39 cases were screened compared to 38 cases in 2015 (see Table 7.5.1). Most of the cases forwarded for screening were for males, 35 cases in 2015 and 31 cases in 2016. In addition, the majority of the cases screened were of older persons, especially persons over 46 years.

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 2015, 39.5% of the cases (15 of 38) screened positive for excess ethanol or illegal or non-prescribed drugs as compared to 35.9% (14 of 39) in 2016. 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 three alcohol-induced deaths and no drug-induced deaths among those deaths with toxicology screens in 2016. In the previous year, a total of three drug-induced and two alcohol-induced deaths were recorded. 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), four cases in 2015 and five cases in 2016 (see Table 7.5.1).

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 2016, there were 61 tobacco-related deaths as compared to 60 in the previous year. 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 assault (see Table 7.5.1). However, there were also instances of deaths, which were caused as a result of other external causes such as intentional self-harm, accidental drowning and submersion, accidental poisoning by exposure to a noxious substance, and diseases of the circulatory 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).¹⁴ 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.

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>

¹⁴ 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, 2015 and 2016

	2015	2016
Total Number of Deaths (All Causes)	476	504
Proportion of Deaths with Toxicology Screens (%)	8.0	7.7
Total Number of Toxicology Screens	38	39
By Sex:		
Males	35	31
Females	3	8
By Age Group:		
< 18 Years	1	2
18 – 25 Years	6	5
26 – 35 Years	6	5
36 – 45 Years	1	8
46 – 60 Years	18	10
60+ Years	6	9
Not Stated	-	-
Substances Detected in Toxicology Screens (Number of Cases)		
Ethanol ^a (>80 mg)	8	6
Drugs ^b	11	10
Ethanol and Drugs	4	2
None/<80 mg Ethanol/Drugs in Therapeutic Range	23 ^c	25
Causes of Death (ICD-10)^d (Persons with Detected Substances)	15	14
Diseases of the Blood	1	-
Diseases of the Circulatory System	4	1
Transport Accident	4	5
Other External Causes of Accidental Injury	1	-
Assault	2	3
Intentional Self-Harm	-	2
Accidental Drowning and Submersion	-	1
Accidental Poisoning by Exposure to Noxious Substance	1	2
Pending	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, benzoylcgonine, 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.¹⁵ 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.¹⁶

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

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 half of all pregnant women in 2015 (50%) used one or more than one illicit drug over their gestational cycle as compared to 59% in 2016. In 2015, all of the 18 positive tests confirmed the presence of marijuana; whereas, in 2016, nine of the 10 positive tests confirmed the presence of marijuana

and one tested positive for cocaine. In the year 2015, most of the women (18) have used these drugs during their first trimester as compared to most women using them equally in their first and second trimester in 2016. Additionally, there was two cases in 2015 and no cases in 2016 of 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, 2015 and 2016

	Number of Pregnant Women	
	2015	2016
Total Number of Tests	34	17
Total Number of Positive Tests	18	10
Positive Tests by Gestation		
First Trimester	8	5
Second Trimester	7	5
Third Trimester	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.

¹⁵ 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.

¹⁶ 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.

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.¹⁷ 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 other 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 behavioural 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 in both school years 2015/2016 and 2016/2017, Pride has implemented the LST programme in classrooms at only the primary school level. Specifically, in the 2015/2016 school year, the LST programme was implemented in 22 classrooms across 10 primary schools. Similarly, the LST programme coverage in the 2015/2016 school year spanned 22 classrooms across 12 primary schools. There were several students who dropped out of the programme during the 2015/2016 school year (26) and even more in 2016/2017 (44); however, a total of 299 and 283 students completed the programme at this level during these two academic years, respectively.

Across all participating classrooms in the primary schools, students were engaged for 227 sessions in 2015/2016 and 229 in 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 this level was 58% versus

69% for the post-test in 2015/2016 as compared to 57% and 70%, respectively, in 2016/2017. This is equivalent to an average gain score (difference between post test and pre-test scores) of more than 10% in each of the two school years under review.

CADA, on the other hand, has 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 I middle-school programme, with 26 students completing the curriculum over 34 sessions in 2016/2017 and 31 students completing the same 34 sessions in 2015/2016 (see Table 8.1.2). There was a 100% completion rate of all the modules in both classes in both years. In 2015/2016, the average gain score was 9% where the average pre-test score was 68% and post test score was 77%; while in 2016/2017, the average gain score was 10% where the average pre-test score was 71% and post test score was 81%.

At the high-school level, three classes in one school received the programme over 26 sessions with a total of 53 students in 2015/2016 and 48 in 2016/2017. There was a 100.0% completion rate of the seven-module curriculum in both years under review. The programme improvement remained stable over the last two academic years at this level in terms of the gain score; although the 2016/2015 academic year recorded marginally higher average pre- and post test scores. Specifically, in the 2015/2016 school year, the average post-test score (82%) was 2% higher than the average pre-test score (80%). Similarly, the 2016/2017 school year recorded a the same gain of 2%, with an average pre-test score of 81%, increasing to an average post test score of 83%.

¹⁷ <http://lifesskillstraining.com/overview.php?t=overview>



Table 8.1.1*Pride Bermuda's LifeSkills Programme Statistics, 2015/2016 and 2016/2017*

Programme Indicators	School Year and Level	
	2015/2016	2016/2017
	Primary	Primary
Number of Schools Participated	12	10
Number of Classes Participated	22	22
Number of Students Engaged	325	327
Number of Students Dropped Out	26	44
Number of Students Retained	299	283
Number of Sessions	227	229
Number of Modules Completed	173	175
Total Number of Modules	176	176
Proportion of Curriculum Completed (%)	98.0	99
Average Pre-Test Score (%)	58.0	57
Average Post Test Score (%)	69.0	70

Source: PRIDE Bermuda

Table 8.1.2*CADA's LifeSkills Programme Statistics, 2015/2016 and 2016/2017*

Programme Indicators	School Year and Level			
	2015/2016		2016/2017	
	Middle	High	Middle	High
Number of Schools Participated	1	1	1	1
Number of Classes Participated	2	3	2	3
Number of Students Engaged	36	53	30	48
Number of Students Dropped Out	5	2	4	3
Number of Students Retained	31	51	26	45
Number of Sessions	34	26	34	29
Number of Modules Completed	28	21	28	21
Total Number of Modules	28	21	28	21
Proportion of Curriculum Completed (%)	100.0	100.0	100.0	100.0
Average Pre-Test Score (%)	68.0	80.0	71.0	81.0
Average Post Test Score (%)	77.0	82.0	81.0	83.0

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 three to four levels to one or two classes each. The data on Table 8.2.1 shows

that during the 2015/2016 school year, two classes each at the Primary 1 and 3 levels participated and only one class at the Primary 2 level; while in 2016/2017, two classes in each of the Primary 1 through Primary 3 participated in the programme and one class added at the Primary 5 level. The curriculum was delivered two times each week with each session being approximately 30 minutes in length. A total of 84 students were engaged in the entire programme in 2015/2016 (average class size was approximately 16 to 17 students) at the three primary levels, and 109 students at the four primary levels in 2016/2017. The students at the Primary 1 level completed 85 of 90 modules in 2015/2016 (94.4% curriculum completion) and 83 of 90 in 2016/2017 (92.2% curriculum completion). The Primary 2 level saw curriculum completion rates of 90% during 2015/2016 and 97% in 2016/2017. At the Primary 3 level, the classes completed 94% of the curriculum in both 2015/2016 and 2016/2017. In 2016/2017, P5 completed 98% of the curriculum.

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 (71% of Primary 1 students, 94% of Primary 2 students, and 83% of Primary 3 students in 2015/2016; 59% of Primary 1 students, 87% of Primary 2 students, and 59% of Primary 3 students in 2016/2017; P5 students were not evaluated on behaviour change). 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, in 2016/2017, 63% of the Primary 1 students, 6% of the Primary 2 students, and 50% 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 13% of the Primary 1 students in 2016/2017 whose behaviour on concentration/attention remained unchanged and the same for 6% of the Primary 2 students.

Table 8.2.1
Pride Bermuda's PATHS Programme Statistics, 2015/2016 and 2016/2017

Programme Indicators	2015/2016			2016/2017			
	Primary 1	Primary 2	Primary 3	Primary 1	Primary 2	Primary 3	Primary 5
Number of Schools	1	1	1	1	1	1	1
Number of Classes Participated	2	1	2	2	2	2	1
Number of Students Engaged	34	17	33	22	32	35	20
Number of Students Dropped Out	3	1	2	-	1	3	-
Number of Students Retained	31	16	31	22	31	32	20
Number of Sessions	85	50	98	83	104	94	39
Number of Modules Completed	85	45	94	83	101	94	39
Total Number of Modules	90	50	100	90	104	100	40
Proportion of Curriculum Completed (%)	94.0	90.0	94.0	92.0	97.0	94.0	98.0
Evaluation of Behaviours	(n = 31)	(n = 16)	(n = 29)	(n=22)	(n=31)	(n=32)	(n=20)
Improvement (% of students)							
Aggression/Disruptive Behaviours	45.0	56.0	62.0	27.0	64.0	28.0	..
Concentration/Attention	45.0	56.0	55.0	40.0	77.0	59.0	..
Social and Emotional Competence	71.0	94.0	83.0	59.0	87.0	59.0	..
Negative Change (% of students)							
Aggression/Disruptive Behaviours	32.0	31.0	35.0	63.0	6.0	50.0	..
Concentration/Attention	16.0	6.0	31.0	45.0	16.0	37.0	..
Social and Emotional Competence	19.0	-	17.0	22.0	12.0	34.0	..
No Change (% of students)							
Aggression/Disruptive Behaviours	23.0	13.0	3.0	9.0	29.0	21.0	..
Concentration/Attention	39.0	38.0	14.0	13.0	6.0	3.0	..
Social and Emotional Competence	10.0	6.0	-	18.0	-	6.0	..

Source: PRIDE Bermuda



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 2015 there were 53 certified persons in substance abuse treatment and prevention occupations, compared to 54 professionals in 2016; 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 and a few are CCS (Certified Clinical Supervisor) or Associate Alcohol and Drug Counsellor (ACAD) certified (see Table 9.1.2). The number of certified clinical supervisors and prevention specialists, all holders of the Certified Prevention Specialist (CPS) certification, 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, 2015 and 2016

Occupation	2015	2016
Treatment		
Alcohol/Drug Counsellors	34	34
Associate Counsellors	5	6
Clinical Supervisors	8	8
Prevention		
Prevention Specialists	6	6
Associate Prevention Professional	-	-
Total	53	54

Source: Bermuda Addiction Certification Board

Table 9.1.2
Certified Treatment and Prevention Professionals by Type of Certification, 2015 and 2016

Field of Certification	2015	2016
Treatment		
ICADC	34	34
CCS	8	8
ACAD	5	6
Prevention		
CPS	6	6
APP	-	-
Total	53	54

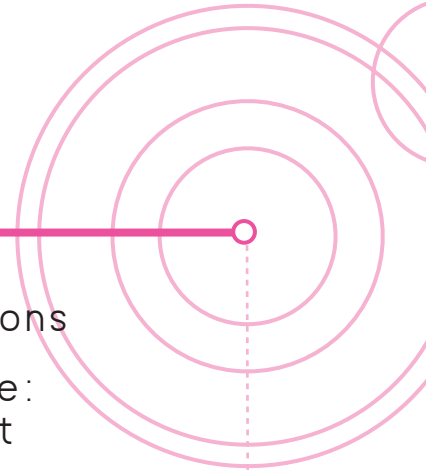
Source: Bermuda Addiction Certification Board



Chapter 10

Survey Data

- Public Perceptions
- Drug Prevalence:
Household Adult
Population



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 2017 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 (34% compared with 36% in July 2016) or mostly (63% compared with 61% in 2016) safe in their own neighbourhoods (see Table 10.1.1). There were only a few residents who reported feeling unsafe to any degree (2%, down from 3%). It is important to note, however, that the degree to which residents feel safe has steadily increased since monitoring began in 2012. Differences continue to be noted across the population, with women and higher income earners being less likely to report feeling extremely safe in their neighbourhoods. Across the Island, residents of Sandy's/Southampton (Warwick/Paget in 2016) were more likely, than those living in other parishes, to report feeling extremely safe in their respective neighbourhoods.

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, however declining, portion of residents who reported feeling less safe when compared with six months ago. Specifically, more than eight-in-ten residents stated that they now feel as safe as they did six months ago (85%, up 10 points from 2016), marking a notable increase from 2016. Alternatively, there has been a comparable decline in the proportion of residents who now feel less safe (4%, down 11 points), while one in ten now actually feel safer (10%, up one point) than they did six months ago. Of note, males, younger residents, and black residents are slightly more likely than their respective counterparts to indicate increased feelings of safety in their own neighborhoods.

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. Only a minority of residents report being aware of such crime occurring in their neighbourhood in the past twelve months. In a departure from historical results, personal property theft related to breaking and entering is now most often reported (40%, up five points), while there has been a notable decline in the portion of residents who were aware of theft (auto or personal property) happening in their neighbourhood (29%, down eight points) – marking a six-year low for this type of crime. Two-in-ten residents know of people openly selling or using drugs (19%, up six points), while slightly fewer were aware of crimes committed with guns (12%, down one point). Finally, fewer than one-in-ten report assaults (9%, up one point) or murder (7%, up one point), with awareness of both types of crime remaining generally consistent year-over-over.

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.

Overall, across age segments, older residents were less likely to cite awareness of a variety of crimes, including people openly selling or using drugs, breaking and entering to steal personal property, assault, and murder. Moreover, those with greater annual household incomes (earning \$150K or more) were more likely than their less affluent counterparts to report awareness of crimes related to theft and breaking and entering to steal personal property occurring in their neighbourhood. Awareness of crimes also differed across racial backgrounds, with black residents being more aware of the sale/usage of drugs, assault, and crimes committed with guns.

In order to measure perceptions of overall physical and mental well-being, respondents were asked how they would rate their own health. Residents positively evaluated their overall health in terms of their physical and mental well-being as very good/good (94%, down two points). Nonetheless, this year marks a notable decline in the portion of residents stating that their health is very good (36%, down 10 points), with more residents rating their health as good (58%, up nine points). Only a small proportion rated their well-being poorly (5% stating poor/very poor; no change), consistent

with the 2016 findings. Across the population, residents positively evaluated their own well-being to varying degrees. In particular, those with lower household incomes are less likely, than higher earners, to feel they are in very good health. Meanwhile, those under the age of 35 years and those living in Sandys/Southampton are also more likely than their respective 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?), 2017

(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	34	46	35	30	31	35	34	30	38	38	38	37	31	33	36	34	45
Mostly Safe	63	52	61	66	68	65	62	69	57	61	63	62	65	63	63	64	55
Mostly Unsafe	2	2	4	2	1	-	4	1	2	1	-	2	3	3	1	2	-
Extremely Unsafe	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Don't Know/No Answer	-	-	-	2	-	-	1	-	2	-	-	1	-	1	-	1	-
Weighted Sample Size (#)	400	86	82	114	108	190	210	135	105	100	99	170	131	215	127	377	23
Unweighted Sample Size (#)	400	79	95	105	110	163	237	128	109	93	40	113	247	138	194	378	22
% Extremely/Mostly Safe	97	98	96	96	99	100	95	99	96	99	100	97	96	96	99	97	100
% Mostly/Extremely Unsafe	2	2	4	2	1	-	4	1	2	1	-	2	4	3	1	2	-

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?, 2017

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	19	19	18	23	15	18	19	23	15	19	23	22	11	22	13	19	13
No	78	74	81	74	85	81	76	73	83	81	72	76	85	74	86	78	82
Don't Know	3	6	1	3	-	1	5	4	2	-	5	2	4	4	1	3	5
Weighted Sample Size (#)	400	86	82	114	108	190	210	135	105	100	99	170	131	215	127	377	23
Unweighted Sample Size (#)	400	79	95	105	110	163	237	128	109	93	40	113	247	138	194	378	22

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	29	23	35	34	27	31	28	22	35	37	22	36	26	30	30	29	29
No	68	75	63	64	72	68	69	75	64	63	75	64	69	67	69	68	71
Don't Know	2	2	2	2	1	1	3	2	1	-	3	-	5	2	1	2	-
Weighted Sample Size (#)	400	86	82	114	108	190	210	135	105	100	99	170	131	215	127	377	23
Unweighted Sample Size (#)	400	79	95	105	110	163	237	128	109	93	40	113	247	138	194	378	22

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	40	26	46	39	47	41	39	31	41	51	38	48	31	37	41	40	36
No	59	73	51	60	52	58	59	67	58	48	62	52	65	61	57	58	60
Don't Know	1	1	2	1	1	1	2	1	1	1	-	1	3	1	2	1	5
Weighted Sample Size (#)	400	86	82	114	108	190	210	135	105	100	99	170	131	215	127	377	23
Unweighted Sample Size (#)	400	79	95	105	110	163	237	128	109	93	40	113	247	138	194	378	22

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	12	14	7	23	2	10	15	10	14	13	8	17	10	16	7	12	18
No	86	85	89	76	98	88	85	88	86	85	92	81	88	82	91	87	77
Don't Know	1	1	4	1	-	2	1	3	-	2	-	2	2	1	2	1	5
Weighted Sample Size (#)	400	86	82	114	108	190	210	135	105	100	99	170	131	215	127	377	23
Unweighted Sample Size (#)	400	79	95	105	110	163	237	128	109	93	40	113	247	138	194	378	22

Source: DNDC's Commissioned Questions in 2nd Quarter 2016 Bermuda Omnibus Survey[®]

10.2 DRUG PREVALENCE: ADULTS

The National Household Survey on Drug Use and Health is administered every four years in Bermuda. It endeavours to provide accurate data on the level and patterns of licit and illicit drug use (prevalence) and track trends in the use of alcohol, tobacco, marijuana, and various types of other drugs among the adult population at three reference points (lifetime, past year, and past month). In addition to demographic questions, this survey contained questions on age of first use, recency of use, lifetime use, past year use, and past month use of marijuana, cocaine (and crack), hallucinogens, heroin (and opium), ecstasy, hash, inhalants, alcohol, tobacco, and nonmedical or prescription drugs among respondents. Patterned after national household prevalence studies conducted regionally and internationally, the survey was designed to collect information from a scientifically selected random sample of adult residents in Bermuda, 16 years or older. Each participant was asked to voluntarily complete a telephone web-based survey during the survey administration period of January 18 through February 4, 2017. The response rate was 100%, with a statistically representative sample of 1,270 individuals providing information.

In this survey, almost eight in 10 participants indicated the use of at least one drug in their lifetime; with consumption of a legal substance being higher than that of an illegal drug (see Table 10.2.1). About half of the respondents (52.3%) were current users of at least one drug. More females drank alcohol and smoked cigarettes while more males

used marijuana. In terms of the population characteristics and drug use, Blacks represented the largest proportion of users of alcohol, cigarettes, and marijuana at all reference periods; drug use was most prevalent among participants who finished only a secondary-level education; married people drank the most in comparison to those who were never married; and substance use was most prevalent among persons working over 40 hours per week. The average age of first use of any drug was as early as 16.3 years (for use of cigarettes by males) but ranges from 16.9 years (for cigarettes) to 30.1 years (for heroin) for the overall population (see Table 10.2.2); with most persons who said they used drugs starting drug use more than a year ago.

Alcohol remained the substance of choice among Bermuda's adults along with cigarettes for all reference periods; marijuana was still the most commonly used and most accessible illegal drug and limited use of other illegal drugs was also reported (see Table 10.2.1). Most drinking is reported to have occurred on the weekends (see Table 10.2.3); males mainly drank beverages with low or high alcoholic content and females mainly drank beverages of medium alcohol content. Binge drinking (having five or more drinks at once) was more prevalent among males (see Table 10.2.4).

Problem drinking was evident in that persons reported having memory lapses because of their alcohol use,

... persons reported having memory lapses because of their alcohol use...

among other measured indicators. In addition, about one in 10 persons was drunk on at least one day in the past month (see Table 10.2.5). There was a higher tendency for persons to drink alcohol if they have friends or family members

who got drunk. Likewise, about one-third (33.8%) of the respondents have friends or family members who take illicit drug(s).

Table 10.2.1
Lifetime, Annual, And Current Prevalence of ATOD Use, 2017

Substances	Percentage of (Weighted) Survey Respondents								
	Lifetime Use			Annual Use			Current Use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
LEGAL DRUGS	39.3	41.4	80.7	29.7	31.2	60.9	25.9	25.8	51.7
Alcohol	38.5	40.8	79.4	29.3	30.5	59.8	25.1	25.0	50.2
Cigarettes	23.5	17.7	41.2	7.1	3.5	10.6	5.8	3.0	8.8
Inhalants	0.2	-	0.2	-	-	-	-	-	-
ILLEGAL DRUGS	12.5	7.8	20.3	5.1	1.5	6.6	4.2	0.9	5.1
Marijuana	12.4	7.8	20.2	4.8	1.5	6.3	4.0	0.9	4.8
Hash	3.2	1.2	4.4	0.1	0.1	0.2	-	-	-
Cocaine	1.6	0.4	2.0	0.5	-	0.5	0.4	-	0.4
Hallucinogens	0.8	0.2	1.0	0.1	-	0.1	0.1	-	0.1
Ecstasy	0.5	0.4	0.9	0.1	-	0.1	-	-	-
Crack	0.7	0.1	0.8	0.2	-	0.2	0.2	-	0.2
Non-Prescribed Stimulants	0.5	0.1	0.6	-	-	-	-	-	-
Opium	0.1	-	0.1	-	-	-	-	-	-
Heroin	0.4	-	0.4	-	-	-	-	-	-
Non-Prescribed	0.1	-	0.1	-	-	-	-	-	-
Other illegal drug	0.5	0.2	0.7	..	..	..	..	..	..

Source: DNDC's 2017 National Household Survey

Notes: - means zero or unit less than 0.1

.. means not applicable as question was not asked for those reference periods

Table 10.2.2
Average Age of Onset by Sex of Survey Respondent, 2017

Substances	Average Age of First Use (Years)		
	Males	Females	Total
LEGAL DRUGS			
Cigarettes	16.3	17.7	16.9
Alcohol	16.9	18.7	17.8
Inhalants	26.6	..	26.6
ILLEGAL DRUGS			
Non-Prescribed Tranquilisers	18.0	..	18.0
Marijuana	17.2	19.6	18.2
Hash	19.3	19.0	19.2
Ecstasy	23.0	19.3	21.5
Cocaine	20.5	25.2	21.5
Non-Prescribed Stimulants	21.9	29.2	23.2
Hallucinogens	25.1	19.9	24.0
Crack	24.1	26.4	24.4
Opium	25.0	..	25.0
Heroin	30.1	..	30.1

Source: DNDC's 2017 National Household Surveys

Table 10.2.3

Frequency of Alcohol Consumption by Type of Alcoholic Beverage and Sex of Survey Respondent (Percentage of Weighted Survey Respondents), 2017

Frequency of Use	Alcohol Content								
	Low			Medium			High		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Some Week Days	4.0	1.7	5.7	4.8	4.6	9.4	2.1	1.4	3.4
Daily	0.9	0.3	1.2	1.3	1.6	2.9	0.8	0.3	1.2
Weekends	9.6	5.5	15.1	8.3	13.1	21.4	8.0	5.1	13.0
Not Applicable	10.6	17.5	28.1	10.7	5.8	16.5	14.2	18.3	32.6
Total Current Users	25.1	25.0	50.2	25.1	25.0	50.2	25.1	25.0	50.2

Source: DNDC's 2017 National Household Surveys

Table 10.2.4

Number of Binge Drinking Episodes in Past 30 Days (Current Users of Alcohol), 2017

Number of Times in Past 30 Days	Percentage of Survey Respondents (Weighted)		
	Males	Females	Total
0	15.6	19.7	35.3
1 – 5	7.8	4.3	12.1
6 – 10	0.8	0.2	1.0
11 – 15	0.2	0.2	0.4
16 – 20	0.3	0.1	0.4
21 – 25	0.1	-	0.1
26 – 30	0.1	-	0.1
Not Stated	0.2	0.5	0.8

Source: DNDC's 2017 National Household Surveys

Note: - means zero or unit less than 0.1.

Table 10.2.5

Problem Drinking (Current Users of Alcohol), 2017

	Percentage of Survey Respondents (Weighted)		
	Yes	No	Not Stated/ Not Applicable
Had trouble with partner because alcohol	3.4	46.3	0.5
Lost friends of partners because of alcohol	5.0	44.8	0.4
Felt like decreasing the amount of alcohol drunk	12.1	38.0	0.1
Drank more than wanted without noticing	3.1	46.8	0.3
Had to drink alcohol in the morning	0.4	49.4	0.3
Experienced not remembering after waking up in the morning	7.9	41.9	0.4
Bothered about being criticized for drinking	1.6	30.9	17.7
Have friends or family members who get drunk	27.2	22.6	0.4

Source: DNDC's 2017 National Household Surveys

Note: - means zero or unit less than 0.1.



Chapter 11

Financing Drug Control

- Drug Treatment and Prevention Expenditure
- Enforcement and Interdiction Expenditure

11.1 DRUG CONTROL EXPENDITURE

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 a little over \$15 million on drug control in Bermuda in FY 2016/2017; however, slightly increasing from the previous FY 2015/2016, where drug control expenditure stood just under \$15 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 \$9.7 million vs. \$5.44 million and \$5.48 million, in FY 2015/2016 and FY 2016/2017, 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 services receiving the greater proportion. However, both treatment and prevention services, in general, recorded an increase in funding. Specifically, funding for treatment services, on a whole, saw an increase of 6.57% from FY 2015/2016 to FY 2016/2017;

supported by increased funding allocated to most of the treatment service providers, with the exception of the RLH. Similarly, funding for prevention services also recorded an increase by 7.67% (see Table 11.1.1). In contrast, however, grant recipient agencies in both the treatment and prevention networks saw level funding, with the exception of FOCUS Counselling Services, which saw a significant decline.

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 meager increase of 0.8% year over year – moving from a \$5.44 million in FY 2015/2016 to \$5.48 million in FY 2016/2017.

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, the adequate funding of substance abuse prevention and drug addiction treatment and rehabilitation.

Table 11.1.1
Government Expenditure on Drug Treatment and Prevention, 2015/2016 and 2016/2017

	2015/2016 ACTUAL (\$000)	2016/2017 REVISED (\$000)
TREATMENT	8,626	9,193
% Change	0.94	6.57
DNDC (MT,WTC,Treatment Unit)	2,336	2,390
Grantees		
Salvation Army	100	100
FOCUS Counselling Services	185	25
Other (BACB)	100	100
Other Agencies		
BARC	955	1,050
BYCS	831	1,432
Drug Court	389	427
Mandatory Drug Treatment (RLH)	1,531	1,284
Turning Point Substance Abuse Programme*	2,199	2,340
Capital Project**	-	45

Table 11.1.1 cont'd
Government Expenditure on Drug Treatment and Prevention, 2015/2016 and 2016/2017

	2015/2016 ACTUAL (\$000)	2016/2017 REVISED (\$000)
PREVENTION	717	772
% Change	3.31	7.67
DNDC (Prevention Unit & Community Education)	434	489
Grantees		
PRIDE	183	183
CADA	100	100
TOTAL DEMAND REDUCTION	9,343	9,665
% Change	0.15	3.45

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, 2015/2016 and 2016/2017

	2015/2016 ACTUAL (\$000)	2016/2017 REVISED (\$000)
ENFORCEMENT AND INTERDICTION		
Police – Enforcement (Drugs, Financial Crime, and Intelligence Divisions)	1,260	1,547
Customs – Interdiction	3,862	3,934
TOTAL SUPPLY REDUCTION	5,437	5,481
% Change	-9.4	0.8

Source: Government of Bermuda Budget.

LOOKING AHEAD

The information presented in this 2017 Annual Report of the BerDIN point to a consistent pattern of substance misuse in the population. Synthetic opioids, specifically fentanyl, are a growing concern, however, the drug market has remained accessible and viable. While the drug market has remained viable, a contrasting observation from this year's report shows a decline in the number of new and existing clients seeking treatment during 2016. Little is known if the decrease was due to the reduction in the provision of client services by many of the substance abuse treatment agencies, whether persons were, in fact, substance users but did not seek treatment, or if some other anomaly was responsible. Despite fewer clients accessing treatment services, the number of persons in treatment and those seeking treatment for cannabis, alcohol, cocaine including crack cocaine, continued its trend of being ever-present, especially for those persons classified as being dependent on their substance of choice.

The efforts of the supply reduction branch of drug control continues to be impeded by a lack of human resources to ensure alcohol and drug-related laws are enforced. This would include, but not limited to, the investigation, prosecution, adjudication, and incarceration in connection with drug-related offences. The data shows that criminal convictions for drug-related offences decreased in 2016 and, while the drug market remained stable, the environment in which alcohol consumption takes place has seen some changes over the past year. One noticeable environmental factor is the reported decrease in the number of persons being stopped to undergo the breathalyser test. This is coupled with a decline in the number of criminal trials for alcohol-related offences in 2016 and an increase in the number of liquor licenses issued to establishments; all occurring while alcohol remains the primary substance of choice for many persons seeking or engaged in treatment services. This is cause for continued concern.

Regarding the provision of information for synthesis of the current drug situation, data with respect to persons 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. Obtaining emergency room information as it relates to drug use, inclusive of poly drug use, continues to be a challenge for the reporting system. During 2017, the DNDC collaborated with the government's Pharmacy Inspector to identify and collate the nature and magnitude of prescription drug use in Bermuda. At the time of this report, the DNDC is awaiting the provision of

information from the Department of Health. Gaps in data remain a challenge to the BerDIN's ability to understand the magnitude of the drug situation, thereby hindering its ability to devise a comprehensive response to the growing drug situation. A lack of services for adolescents and dual-diagnosed clients continue to challenge the treatment Network. Supply reduction agencies are challenged by a number of issues ranging from staff shortages and a lack of cross-agency information sharing to a reduction in funding toward continuing education and training of staff.

The take home message from this year's BerDIN Annual Report is that substance misuse is prevalent, there remain significant issues with the continuum of care, and supply reduction, which is equally important for a balanced approach to drug control, does not have the resources to adequately interdict drugs and enforce legislations. 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. The Island continues to be faced with health and social issues related to alcohol and drug use and despite the challenges facing demand and supply reduction agencies, the work to eradicate drug misuse continues steadfastly. Now, more than ever before, the BerDIN, through a shared vision and dedication to this cause, will continue to provide accurate and timely information, as well as expend effort in filling data gaps, that will assist the collective understanding of the drug situation in Bermuda.

This is cause for continued concern.



... it is important that the existing partnerships are made stronger than ever before.

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 – Mid-Atlantic Wellness Institute – Turning Point Substance Abuse Programme	Inpatient Cases Related to Drugs, Poisoning, and Toxic Effects of Substances Emergency Room Cases Related to Drugs, Poisoning, & Toxic Effects of Substances MWI Cases Related to Drugs, Poisoning, & Toxic Effects of Substances 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 – Prison Farm – Co-Ed Facility – Right Living House	Drug Screening Results (Reception and Random) Drug Prevalence Poly Drug Use First-Time and Repeat Offenders Drug Screening Results Drug Screening Results Residents, Admissions, Discharges, Drug Tests & Results
9. Department of Court Services – Bermuda Assessment and Referral Centre – Drug Treatment Court	New and Existing Referrals to Treatment Drug Abuse and Dependence Level of Severity of Substance Abuse (DAST and ADS Results) Referrals, Admissions, Completions
10. Department of Health – Central Government Laboratory – Epidemiology and Surveillance – Maternal Health Clinic	Mortality - Toxicology Results Road Traffic Fatalities Drug-Related Infectious Diseases, Cause of Deaths ATOD-Related Deaths Pre-natal Drug Use
11. Department for National Drug Control – Research and Policy Unit – Men's Treatment – Women's Treatment Centre	Public Perceptions Household Drug Prevalence* Government Expenditure on Drug Prevention and Treatment; Enforcement and Interdiction Drug Screening Results Primary Drug of Impact Poly Drug Use Clients in Treatment Drug Screening Results Primary Drug of Impact Poly Drug Use Clients in Treatment
12. Focus Counselling Services	Programme Outcomes Clients in Treatment
13. Financial Intelligence Agency	Suspicious Activity Reports
14. HM Customs	Alcohol and Tobacco Imports and Exports Duty Collected on Alcohol and Tobacco Imports
15. Magistrate's Court – Liquor Licence Authority	Licensing of Establishments
16. Pride Bermuda	Drug Prevention Education: Botvin's LifeSkills Programme Drug Prevention Education: PATHS Programme
17. Salvation Army	Programme Outcomes Clients in Treatment
18. Supreme Court	Prosecutions

* Updated/Expanded indicators.

APPENDIX II

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

TARIFF CODE	DESCRIPTION	2015 (From April 1, 2013)	2016 (From April 1, 2016)
2203.000	Beer	\$0.99 per L	\$0.99 per L
2204.100	Sparkling Wine	\$2.89 per L	\$2.89 per L
2204.210	Wine in Containers Holding 2 Litres or Less	\$2.89 per L	\$2.89 per L
2204.290	Wine in Containers Greater Than 2 Litres	\$2.89 per L	\$2.89 per L
2204.300	Other Grape Must	\$2.89 per L	\$2.89 per L
2205.100	Vermouth in Containers Holding 2 Litres or Less	\$2.89 per L	\$2.89 per L
2205.900	Vermouth in Containers Holding Greater Than 2 Litres	\$2.89 per L	\$2.89 per L
2206.000	Other Fermented Beverages	\$1.41 per L	\$1.41 per L
2207.100	Undenatured Ethyl Alcohol	\$26.57 per LA	\$26.57 per LA
2207.200	Denatured Ethyl Alcohol	\$0.75 per LA	\$0.75 per LA
2208.200	Brandy and Cognac	\$26.57 per LA	\$26.57 per LA
2208.300	Whiskies	\$26.57 per LA	\$26.57 per LA
2208.400	Rum and Other Spirits From Sugar Cane	\$26.57 per LA	\$26.57 per LA
2208.500	Gin and Geneva	\$26.57 per LA	\$26.57 per LA
2208.600	Vodka	\$26.57 per LA	\$29.23 per LA
2208.700	Liqueur and Cordials	\$26.57 per LA	\$29.23 per LA
2208.900	Other Spirituous Beverages	\$26.57 per LA	\$29.23 per LA
9802.001	Accompanied Personal Goods:Wine of Fresh Grapes	\$2.89 per L	\$2.89 per L
9802.002	Accompanied Personal Goods: Spirituous Beverages	\$10.63 per L	\$10.63 per L
2401.100	Tobacco, Not Stemmed/Stripped	\$0.29 per KG	\$0.29 per KG
2401.200	Tobacco, Partly or Wholly Stemmed/Stripped	\$0.29 per KG	\$0.29 per KG
2401.300	Tobacco Refuse	\$0.29 per KG	\$0.29 per KG
2402.100	Cigars, Cheroots, etc. Containing Tobacco	33.5%	33.5%
2402.200	Cigarettes Containing Tobacco	\$0.22 per U	\$0.27 per U
2402.900	Other Tobacco Products; or Products of Tobacco Substitutes	33.5%	33.5%
2403.110	Water Pipe Smoking Tobacco	33.5%	33.5%
2403.190	Other Smoking Tobacco	33.5%	33.5%
2403.910	"Homogenised" or "Reconstituted" Tobacco	33.5%	33.5%
2403.990	Tobacco Extracts and Essences; Other Manufactured Products of Tobacco	33.5%	33.5%
9802.003	Accompanied Personal Goods: Cigarettes Containing Tobacco	\$44.00 per 200 U	\$44.00 per 200 U
9803.163	Smoking Tobacco; Cigars, Cheroots and Cigarillos, Containing Tobacco (Imported by Post or Courier)	33.5%	33.5%
9803.171	Cigarettes Containing Tobacco	\$44.00 per 200 U	\$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 2016 will attract the 2016 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 an 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 termed a detoxification centre, detox centre, or sobering-up station. Typically, the individual is clinically intoxicated or already in withdrawal at the outset of detoxification. Detoxification may or may not involve the administration of medication. When it does, the medication given is usually a drug that shows cross-tolerance and cross-dependence to the substance(s).

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

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

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

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

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

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

DSM-V: The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, better known as DSM-V, is used to categorise psychiatric diagnoses. This updated version was first published May 18, 2013. 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 of more than one psychoactive drugs either simultaneously or at different times. The term is often used to distinguish persons with a more varied pattern of drug use from those who use one kind of drug exclusively. It usually is associated with the use of several illegal drugs. In many cases, one drug is used as a base or primary drug, with additional drugs to leaven or compensate for the side effects of the primary drug and make the experience more enjoyable with drug synergy effects, or to supplement for primary drug when supply is low.

PREVALENCE: The terms prevalence refers to the proportion of a population who has used a drug over a particular time period. Prevalence is measured by asking respondents to recall their use of drugs. Typically, the three most widely used recall periods are: lifetime (ever used a drug), last year (used a drug in the last twelve months), and last month (used a drug in the last 30 days).

PREVENTION: A proactive process that attempts to

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

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

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

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

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

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

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

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

TOXICITY: The extent to which a substance has the potential to cause toxic or poisonous effect. Any substance in

excessive amounts can act as a poison or toxin. With drugs, the margin between the dosage that produces beneficial effects and the dosage that produces toxic or poisonous effects varies with the drug and the person receiving it.

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

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

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