

2018

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



GOVERNMENT OF BERMUDA

**Department for National Drug Control**

Copyright© 2018 Department for National Drug Control

Authors:

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

Published by:

Government of Bermuda, Ministry of Social Development and Sports, Department for National Drug Control  
P. O. Box 480, HM CX, Bermuda

Telephone: (441) 292-3049

Fax: (441) 295-2066

E-mail: [dndc@gov.bm](mailto:dndc@gov.bm)

Website: [www.gov.bm](http://www.gov.bm)

October 2018

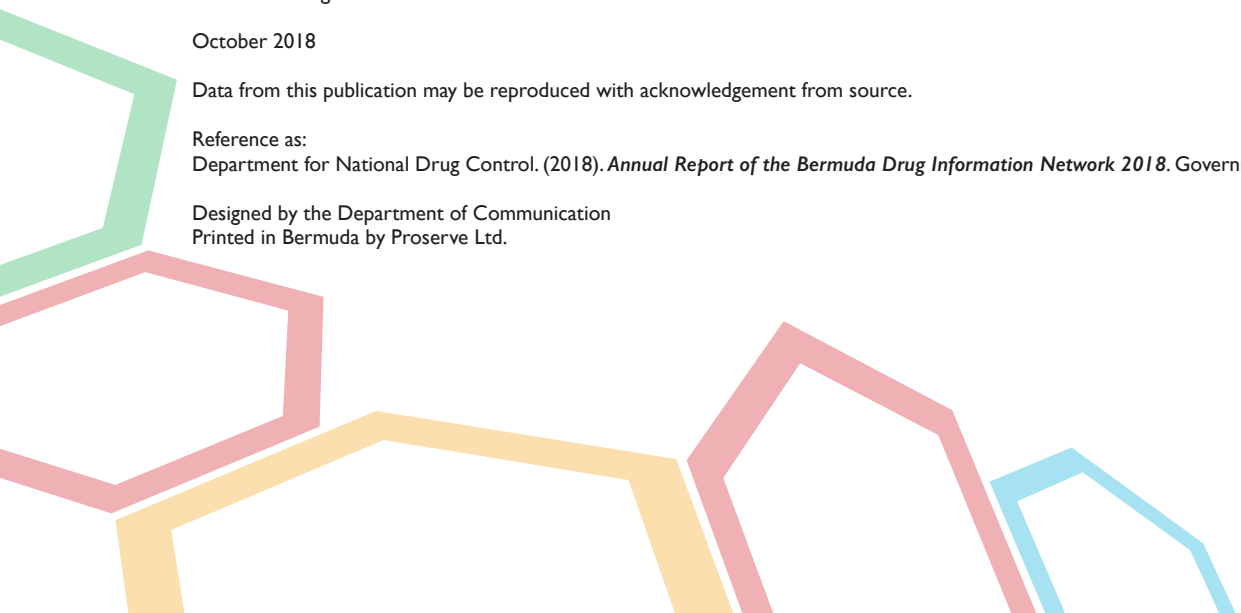
Data from this publication may be reproduced with acknowledgement from source.

Reference as:

Department for National Drug Control. (2018). *Annual Report of the Bermuda Drug Information Network 2018*. Government of Bermuda.

Designed by the Department of Communication

Printed in Bermuda by Proserve Ltd.



2018 Annual Report of the  
**BERMUDA  
DRUG  
INFORMATION  
NETWORK**  
(BerDIN)




GOVERNMENT OF BERMUDA

**Department for National Drug Control**



## 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

*"We cannot accomplish all that we need to do without working together."  
~ Bill Richardson*

I am proud to say that this year we are marking eight years of the Annual Report of Bermuda Drug Information Network (BerDIN). Over the past eight years, the Department for National Drug Control (DNDC) has been at the forefront of local research into areas of drug use; supported collaboration with key stakeholders; informed policy choices with the latest data; and provided information on trends and analysis. Each year the complexity of the drug situation changes. With these changes comes the need for increased monitoring and an establishment of indicators that need to be tracked.

The 2018 report comes at a time when the Island is exploring reforms to legislation, governing both alcohol and drugs; whilst the DNDC is in the process of planning and implementing a new National Drug Control Master Plan. The Annual Report of the BerDIN 2018 clearly shows that there is still much work to be done in addressing the many harms inflicted by drugs to the health and safety of the Island's residents and to ensure access to treatment for the people who desperately need it. Recent attention focused on the threats posed by Fentanyl and synthetic substances; however, as the report shows, the demand for traditional drugs continue for substances such as cannabis, heroin, and cocaine. These drugs remain of serious concern, and show little sign of diminishing.

In spite of the many evolving challenges in drug control, we need to highlight the importance of drug prevention. Illicit drug abuse prevention continues to be a critical task of health promotion and stopping use before it starts. Several school-based programmes have been reliably evaluated to show positive impacts on reducing drug use in students, leading to a strong recommendation of adopting interactive programmes that focus on life skills and/or refusal skills. National policy goals need to be adapted to changing circumstances, such as the emergence of synthetic drugs, the medical use of cannabis, and the opiate crisis. There remains a need for capacity building and technical assistance in the area of drug control and funding continues to fall far short of political commitment. Further resources are needed to help key stakeholders implement the goals and objectives contained within the National Drug Strategy.

Capitalizing on the enthusiasm at last year's annual meeting, I ask all stakeholders to help us improve the evidence base for these reports. Areas such as drug market prices, alcohol and tobacco sales information, and the overall number of persons across the Island with substance abuse addiction, are some areas requiring further research. Finally, I hope this year's annual report will further inspire cooperation, multilayered strategies, multi-sectorial efforts, and action by our strategic partners and the community at large. Together, we can move closer to improving the well-being of residents across the Island.



**Joanne Dean**  
*Director*  
**Department for National Drug Control**  
*October 2018*

Illicit drug abuse prevention continues to be a critical task of health promotion and stopping it before it starts.



# CONTENTS

Foreword.....	i
Data Notes.....	1
Introduction.....	2
Bermuda Drug Information Network (BerDIN).....	6
Chapter 1: Criminal and Suspicious Activities.....	13
Chapter 2: Imports, Exports, and Licensing.....	29
Chapter 3: Training for Intervention Procedures (TIPS).....	37
Chapter 4: Substance Abuse Treatment and Counselling.....	41
Chapter 5: Drug Screening Surveillance.....	61
Chapter 6: Impaired Driving.....	69
Chapter 7: Health.....	75
Chapter 8: Drug Prevention Programmes.....	99
Chapter 9: Certified Professionals.....	105
Chapter 10: Survey Data.....	109
Chapter 11: Financing Drug Control.....	123
Looking Ahead.....	127
Appendix I: Summary of Sources and Data.....	128
Appendix II: Implications of the Present Drug Situation.....	129
Appendix III: Duty Rates for Alcohol, Alcoholic Beverages, Tobacco, and Tobacco Products.....	130
Appendix IV: Definitions of Terms and Concepts.....	131
References.....	134

# LIST OF TABLES

## CHAPTER 1: CRIMINAL AND SUSPICIOUS ACTIVITY

### 1.1 Crime and Drug Enforcement Activity

Table 1.1.1	Number and Proportion of Crimes by Type of Crime and Annual Absolute and Percentage Change, 2016 and 2017
Table 1.1.2	Number of Crimes against Person, Community, and Property by Type of Crimes and Annual Absolute Change, 2016 and 2017
Table 1.1.3	Number of Crimes against Person, Property, and Community as a Proportion of each Crime Category, 2016 and 2017
Table 1.1.4	Number of Crimes against Person, Property, and Community as a Proportion of Total Crimes, 2016 and 2017

### 1.2 Drug Seizures and Arrests

Table 1.2.1	Drug Seizures by Arrests for Drug Offences, 2016 and 2017
Table 1.2.2	Drug Seizures by Type of Drug, Total Count, and Total Weight, 2016
Table 1.2.3	Drug Seizures by Type of Drug, Total Count, and Total Weight, 2017

### 1.3 Prosecutions

Table 1.3.1	Criminal Trials for Drug-Related Offences by Sex of Offender, 2016 and 2017
Table 1.3.2	Criminal Trials for Alcohol-Related Offences by Sex of Offender, 2016 and 2017
Table 1.3.3	Criminal Acquittals for Drug-Related Offences by Sex of Offender, 2016 and 2017
Table 1.3.4	Criminal Acquittals for Alcohol-Related Offences by Sex of Offender, 2016 and 2017
Table 1.3.5	Criminal Convictions for Drug-Related Offences by Sex of Offender, 2016 and 2017
Table 1.3.6	Criminal Convictions for Alcohol-Related Offences by Sex of Offender, 2016 and 2017
Table 1.3.7	Unknown Results for Drug-Related Offences by Sex of Offender, 2016 and 2017
Table 1.3.8	Unknown Results for Alcohol-Related Offences by Sex of Offender, 2016 and 2017

### 1.4 Financial Intelligence

Table 1.4.1	Suspicious Activity Reports (SARs) by Sector, 2016 and 2017
-------------	---

### 1.5 Financial Crime

Table 1.5.1	Cash Seizures, 2016 and 2017
-------------	------------------------------

## CHAPTER 2: IMPORTS, EXPORTS, AND LICENSING

### 2.1 Imports and Exports

Table 2.1.1	Quantity, Value, and Duty of Alcohol and Alcoholic Beverages for Home Consumption (Imports and Removals from Bonded Warehouses), 2016 and 2017
Table 2.1.2	Quantity and Value of Bonded Alcohol and Alcoholic Beverages Placed in Bonded Warehouses Upon Arrival, 2016 and 2017
Table 2.1.3	Quantity, Value, and Duty of Alcohol and Alcoholic Beverages Exported from Bonded Warehouses, 2016 and 2017
Table 2.1.4	Quantity, Value, and Duty of Tobacco and Tobacco Products for Home Consumption (Imports and Removals from Bonded Warehouses), 2016 and 2017
Table 2.1.5	Quantity and Value of Bonded Tobacco and Tobacco Products Placed in Bonded Warehouses Upon Arrival, 2016 and 2017
Table 2.1.6	Quantity, Value, and Duty of Tobacco and Tobacco Products Exported from Bonded Warehouses, 2016 and 2017

### 2.2 Liquor Licences

Table 2.2.1	Liquor Licenses Issued by District and Type of Licence, 2016 and 2017
-------------	---



## CHAPTER 3: TRAINING INTERVENTION PROCEDURES (TIPS)

Table 3.1.1 Training for Intervention ProcedureS (TIPS) Programme Statistics, 2016 and 2017

## CHAPTER 4: SUBSTANCE ABUSE TREATMENT AND COUNSELLING

### 4.1 Bermuda Assessment and Referral Centre (BARC) Statistics

Table 4.1.1 BARC Programme Statistics for New Referrals, 2016 and 2017  
 Table 4.1.2 BARC Programme Statistics for Existing Referrals, 2016 and 2017  
 Table 4.1.3 Clinical Diagnosis (Abuse or Dependence) of New and Existing Clients' Drug Use by Drug(s) of Choice, 2016  
 Table 4.1.4 Clinical Diagnosis (Abuse or Dependence) of New and Existing Clients' Drug Use by Drug(s) of Choice, 2017  
 Table 4.1.5 DAST Results (Number of Clients by Level of Severity of Drug Abuse) of New Clients from the BARC Programme, 2016 and 2017  
 Table 4.1.6 ADS Results (Number of Clients by Level of Severity of Alcohol Dependence) of New Clients from the BARC Programme, 2016 and 2017  
 Table 4.1.7 DAST Results (Number of Clients by Level of Severity of Drug Abuse) of Existing Clients from the BARC Programme, 2016 and 2017  
 Table 4.1.8 ADS Results (Number of Clients by Level of Severity of Alcohol Dependence) of Existing Clients from the BARC Programme, 2016 and 2017

### 4.2 Counselling and Life Skills Services (CLSS) Statistics

Table 4.2.1 CLSS Statistics, 2016 and 2017

### 4.3 Drug Treatment Court Statistics

Table 4.3.1 Drug Treatment Court Statistics, 2016 and 2017

### 4.4 Men's Treatment Statistics

Table 4.4.1 Drug Screening Results among Men in Treatment, 2016 and 2017  
 Table 4.4.2 Primary Drug Used by Men Prior to Treatment, 2016 and 2017  
 Table 4.4.3 Number of Cases of Poly Drug Use among Clients at Men's Treatment, 2016 and 2017

### 4.5 Women's Treatment Centre Statistics

Table 4.5.1 Drug Screening Results among Women in Treatment, 2016 and 2017  
 Table 4.5.2 Primary Drug Used by Women Prior to Treatment, 2016 and 2017  
 Table 4.5.3 Number of Cases of Poly-Drug Use among Clients at Women's Treatment Centre, 2016 and 2017

### 4.6 Turning Point Substance Abuse Programme Statistics

Table 4.6.1 Proportion of Positive Drug Screens and Poly Drug Use by Turning Point Clients, 2016 and 2017  
 Table 4.6.2 Positive Screens as a Proportion of Total Specimens Provided by Year and Type of Drug Detected at Turning Point, 2016 and 2017  
 Table 4.6.3 Positive Screens as a Proportion of Total Positive Screens by Year and Type of Drug Detected at Turning Point, 2016 and 2017  
 Table 4.6.4 Number of Methadone Clients, Inpatient, and Outpatient Detoxifications at Turning Point, 2016 and 2017

### 4.7 Right Living House Statistics

Table 4.7.1 Right Living House Programme Statistics, 2016  
 Table 4.7.2 Right Living House Programme Statistics, 2017

### 4.8 Salvation Army Harbour Light Residential Treatment Programme

Table 4.8.1 Salvation Army Harbour Light Residential Treatment Programme Performance, 2016/2017 and 2017/2018

## LIST OF TABLES

Table 4.8.2	Salvation Army Community Life Skills Recovery Programme Performance, 2016/2017 and 2017/2018
<b>4.9</b>	<b>Focus Counselling Services Supportive Residency Programme</b>
Table 4.9.1	Focus Counselling Services Supportive Residence Programme Performance, 2016/2017 and 2017/2018
<b>4.10</b>	<b>Clients in Treatment</b>
Table 4.10.1	Number of New Treatment Admissions, 2016 and 2017
Table 4.10.2	Number of Persons in Treatment, 2016 and 2017

## CHAPTER 5: DRUG SCREENING SURVEILLANCE

<b>5.1</b>	<b>Bermuda Sport Anti-Doping Authority (BSADA) Statistics</b>
Table 5.1.1	Drug Testing Results at BSADA, 2016 and 2017
Table 5.1.2	Illicit Drug Tests by Sport, 2016 and 2017
Table 5.1.3	Performance Enhancement Testing by National Anti-Doping Organisations (Testing Missions Issued by BSADA), 2016
Table 5.1.4	Performance Enhancement Testing by National Anti-Doping Organisations (Testing Missions Issued by BSADA), 2017
Table 5.1.5	Performance Enhancing Tests by Sport (Testing Missions Issued by BSADA), 2016
Table 5.1.6	Performance Enhancing Tests by Sport (Testing Missions Issued by BSADA), 2017
<b>5.2</b>	<b>Department of Corrections Statistics: Westgate Correctional Facility</b>
Table 5.2.1	Screening Results at Reception by Number and Proportion of Inmates, 2016 and 2017
Table 5.2.2	Percentage of Positive Illicit Drug Screens among Prison Reception Inmates, 2016 and 2017
Table 5.2.3	Drug Prevalence (Urinalysis) at Reception by Number and Proportion of Screened Offenders, 2016 and 2017
Table 5.2.4	Random Positive Urine Screens by Substance and Number and Proportion of Inmates, 2016 and 2017
Table 5.2.5	Drug Prevalence at Reception by Number and Proportion of Positive Illicit Drug Screens, 2016 and 2017
Table 5.2.6	Number and Proportion of First-Time and Repeat Offenders by Year, 2016 and 2017
Table 5.2.7	Any Illicit Drug Prevalence (Urinalysis) by Number and Proportion of First-Time and Repeat Offenders, 2016 and 2017
Table 5.2.8	Number of First-Time and Repeat Offenders with Poly Drug Use, 2016 and 2017
<b>5.3</b>	<b>Department of Corrections Statistics: Prison Farm</b>
Table 5.3.1	Drug Screening Results for Persons at the Prison Farm, 2016
Table 5.3.2	Drug Screening Results for Persons at the Prison Farm, 2017
<b>5.4</b>	<b>Department of Corrections Statistics: Co-Ed Facility</b>
Table 5.4.1	Drug Screening Results for Persons at the Co-Ed Facility, 2016
Table 5.4.2	Drug Screening Results for Persons at the Co-Ed Facility, 2017

## CHAPTER 6: IMPAIRED DRIVING

<b>6.1</b>	<b>Blood Alcohol Concentration (BAC)</b>
Table 6.1.1	Impaired Driving Incidences by Sex and Breathalyser Results, 2016 and 2017
Table 6.1.2	Breathalyser Readings for Impaired Driving Incidences, 2016 and 2017
Table 6.1.3	Number of Breathalyser Sample Readings by Limit, 2016 and 2017
<b>6.2</b>	<b>DUI Educational Programme Statistics</b>
Table 6.2.1	DUI Education Classes' Inquiries and Participants, 2016 and 2017

Table 6.2.2	DUI Programme Participants' Statistics, 2016 and 2017
Table 6.2.3	Triage Assessment for Addictive Disorders Results by Number of Participants, 2016 and 2017

## CHAPTER 7: HEALTH

### 7.1 Drug-Related Infectious Diseases

Table 7.1.1	Drug-Related Infectious Diseases, 2016 and 2017
-------------	---

### 7.2 Inpatient Cases Related to Drugs, Poisoning, and Toxic Effects of Substances

Table 7.2.1	Primary Diagnoses of Inpatient Drug-Related Cases, 2016
Table 7.2.2	Primary Diagnoses of Inpatient Drug-Related Cases, 2017
Table 7.2.3	Primary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2017
Table 7.2.4	Secondary Diagnoses of Inpatient Drug-Related Cases, 2016
Table 7.2.5	Secondary Diagnoses of Inpatient Drug-Related Cases, 2017
Table 7.2.6	Secondary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2016
Table 7.2.7	Secondary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2017

### 7.3 Emergency Room (ER) Cases Related to Drugs, Poisoning, and Toxic Effects of Substances

Table 7.3.1	Primary Diagnoses of Emergency Room Drug-Related Cases, 2016
Table 7.3.2	Primary Diagnoses of Emergency Room Drug-Related Cases, 2017
Table 7.3.3	Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2016
Table 7.3.4	Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2017
Table 7.3.5	Secondary Diagnoses of Emergency Room Drug-Related Cases, 2016
Table 7.3.6	Secondary Diagnoses of Emergency Room Drug-Related Cases, 2017
Table 7.3.7	Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2016
Table 7.3.8	Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2017

### 7.4 MWI Drug-Related Cases Related to Drugs, Poisoning, and Toxic Effects of Substances

Table 7.4.1	Primary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2016
Table 7.4.2	Primary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2017
Table 7.4.3	Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2016
Table 7.4.4	Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2017

### 7.5 Mortality: Suspicious Deaths

Table 7.5.1	Toxicology Screens, Substances Detected, and Causes of Death, 2016 and 2017
-------------	---

### 7.6 Prenatal Drug Use

Table 7.6.1	Drug Screening Results of Pregnant Women Attending the Maternal Health Clinic, 2016 and 2017
-------------	--

## CHAPTER 8: DRUG PREVENTION PROGRAMMES

### 8.1 Botvin's LifeSkills Training Programme

Table 8.1.1	Pride Bermuda's LifeSkills Programme Statistics, 2016/2017 and 2017/2018
Table 8.1.2	CADA's LifeSkills Programme Statistics, 2016/2017 and 2017/2018

### 8.2 Promoting Alternative Thinking Strategies Programme

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

# LIST OF TABLES

Table 8.2.2 Pride Bermuda's PATHS Programme Statistics, 2017/2018

## CHAPTER 9: CERTIFIED PROFESSIONALS

### 9.1 Treatment and Prevention Professionals

Table 9.1.1 Certified Prevention and Treatment Professionals by Occupation, 2016 and 2017

Table 9.1.2 Certified Treatment and Prevention Professionals by Type of Certification, 2016 and 2017

## CHAPTER 10: SURVEY DATA

### 10.1 Public Perception of Crime and Health

Table 10.1.1 How Safe Do You Feel In Your Neighbourhood?

Table 10.1.2 Which of the Following Crimes Do You Know to Have Occurred in Your Neighbourhood in the Past 12 Months?

### 10.2 Public Perceptions of Substance Abuse and Misuse

Table 10.2.1 Substances Most Likely To Be Used By Various Age Groups (% of Respondents), 2018

Table 10.2.2 Ease of Access to Substances (% of Respondents), 2018

### 10.3 Drug Prevalence: Criminal Offenders

Table 10.3.1 Lifetime and Current Prevalence of Substance Use by Proportion of Respondents, 2017/2018

Table 10.3.2 Drug and Alcohol Connection with Offence, 2017/2018

Table 10.3.3 Drug Prices and the Drug Market, 2017/2018

### 10.4 Treatment Demand Indicators

Table 10.4.1 Demographic Characteristics of Clients Seeking Treatment, 2016 to 2017

Table 10.4.2 Primary Drug of Impact of Clients Seeking Treatment, 2016 to 2017

Table 10.4.3 Frequency of Drug Use, 2016 to 2017

Table 10.4.4 Primary Route of Drug Administration, 2016 to 2017

Table 10.4.5 Age of First Use of Primary Drug, 2016 to 2017

Table 10.4.6 Average Age of Initiation by Type of (Secondary) Drug, 2016 to 2017

Table 10.4.7 Drug Market (Availability, Supplier, and Proceeds), 2016 to 2017

Table 10.4.8 Drug Market (Packaging of Drugs), 2016 to 2017

## CHAPTER 11: FINANCING DRUG CONTROL

### 11.1 Government Expenditure

Table 11.1.1 Government Expenditure on Drug Treatment and Prevention, 2016/2017 and 2017/2018

Table 11.1.2 Government Expenditure on Enforcement and Interdiction, 2016/2017 and 2017/2018

# DATA NOTES

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

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

# INTRODUCTION

The Annual Report of the BerDIN aims to improve our understanding of the drug situation in Bermuda and to provide a platform for debate in the coming years. This report presents the top-level overview of the drug phenomenon in Bermuda, covering drug supply, use, and public health problems, as well as drug policy and responses. The statistical data reported relate to 2017 (most recent year) and are directly provided to the BerDIN by various stakeholders, unless stated otherwise. An overview of the drug market, drug use and harms, as well as how drug markets are related to other criminal activities, forms the body of this report. This introductory section features a short analytical comment on some of the key themes emerging from this year's data. As the drug problems facing Bermuda are increasingly influenced by, and interact with, developments occurring internationally, two important topics, cannabis use and Fentanyl, are nationally relevant today.

The drug control system remains burdened by a lack of information with respect to key areas...

As the National Drug Control Master Plan and Action Plan 2013-2017 expired during the last calendar year, demand reduction activities remained focused on stabilizing substance abuse prevention and treatment services. Supply reduction agencies, met with challenges, continue to interdict drugs both overseas and at the border, with the objective of prosecuting and seizing drugs and assets associated with the sale of illicit drugs. The drug control system remains burdened by a lack of information with respect to key areas of the drug market, a lack of sufficient and accessible treatment beds, drug intelligence on concealment methods, adulteration steps and the distribution from wholesale all the way down to the retail level and, finally, consumption.

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

This annual report continues as a set of interlinked elements that allows for access to available data and analysis of the drug situation in Bermuda. The BerDIN remains the primary source of statistical information on the use of illegal drugs, alcohol, tobacco, and drug-related services provided to the civilian population in Bermuda. The report provides an analysis of the most recent two-year period (2017 data with comparisons to 2016) and description of the changes over this specified period; contained within the 11 chapters. The BerDIN Report continues to evolve as new information becomes available. Caveats and qualifications relating to the data are found in each chapter of this report. Also included in each chapter, are detailed information on methodology, qualifications on analysis, and comments on the limitations in the available information. Some of the information contained within

this report is derived from self-reported data provided in surveys, while other information is based on record review, psychometric testing, and biological screening results. No one piece of information stands alone. As such, in its totality, the data presented in this report seeks to inform the reader on the current drug situation in Bermuda.

## The Drug Situation in Bermuda

### Extent of Drug Use

Over the last several years, cannabis and alcohol have remained the most widely used drugs on the Island. They are the drugs of choice for most persons seeking treatment assessment at BARC over the past year. Additionally, surveys and intake information at the treatment centre level continue to provide evidence of the use of other narcotic drugs, such as cocaine and opiates. Often times, narcotic drug use is tied to drug-related or drug-induced crimes, which is discussed in relevant chapters of this publication. However, the Department of Corrections has reported an increase in the number of reception inmates testing positive for THC, cocaine, and opiates, and a significant increase in poly drug use amongst reception inmates. Random drug screens revealed the use of THC and opiates while inmates were incarcerated and an increase in positive tests for Benzodiazepines is indicative of a changing drug market.

Poly drug use remains a constant among users of narcotic drugs and with the introduction of fentanyl into the drug market, poly drug use poses an even greater health and safety issue for users. The use of fentanyl presents challenges for not just the user but for those in secondary contact, such as anyone trafficking or handling it. This is likely to have implications on the creation of workplace and other policies for people who may be exposed to the substance, such as police, customs, and corrections officers.

In 2017, the Department of Health reported an increase in drug-related Hepatitis C cases, along with a 100% increase in the number of pregnant women testing positive for THC in their third trimester, which is a cause for concern. All too common is the use of alcohol and/or drugs in road traffic accidents. This past year saw an increase in toxicology screens, which showed an increase in the proportion of cases that exceeded the legal limit for alcohol and drugs. There were two drug-induced deaths and two alcohol-induced deaths, along with 10 road traffic fatalities for which alcohol and drugs were present. These numbers, coupled with information suggesting that there were five cases in 2017 of death by homicide, in which alcohol or drugs were present, and 49 tobacco-related deaths, confirm the need for a public health approach to substance abuse reduction.

## ***Substance Abuse Treatment and Level of Severity***

On a whole, treatment network agencies saw an overall decrease in the number of clients admitted to their respective programmes during 2017. However, amongst new people seeking treatment services in 2017 for any substance, a large proportion was diagnosed as having severe and moderate substance abuse dependence. Reports indicate that more people new to drug treatment were likely to not be poly drug users, but more likely meet the criteria for abuse of alcohol, cannabis, and opiates, while persons who have been in treatment before were likely to be poly drug users and more likely to be dependent on cocaine, alcohol, and opiates. The majority of persons referred for substance abuse treatment between 2016 and 2017 were repeat cases.

## ***Alcohol, Drugs, Morbidity and Mortality***

Alcohol misuse continues to be relevant in several areas of public health. Increases were observed in the number of persons who operated a motor vehicle while impaired, as well as those who were in excess of the legal limit. Although there were 35 road traffic accidents with breath tests above the legal limit, interestingly fewer persons went to the DUI class in 2017. Additionally, when it came to toxicology screens, there were some deaths that were mainly a result of traffic accidents while other deaths in 2017 saw the presence of drugs at the time of toxicology screening.

## ***Ever-Present Drug Market***

Significant effort and resources continue to be dedicated to restricting the supply of drugs into Bermuda as part of an integrated and evidence-based balanced approach that also recognises the parallel importance of reducing the demand for drugs. The justification for these investments is that activities in this area benefit both public health and community safety as well as contributing, more generally, to economic and social well-being. Criminal trials for drug possession have decreased over the past year. The vulnerability of Bermuda to drugs and crime remains a concern. Together with these, the decreasing crime rates against the person, property and the community as well as an increase in seizures of cocaine, crack cocaine, 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.

## ***Legislation***

Law enforcement and the criminal justice system are still, in many ways, not in a position to deal effectively with controlling the drug market. Outdated legislation, a lack of enforcement of current laws and insufficient budget allocation, have made supply reduction more challenging.

During 2017, drug-related crimes marginally increased; the demand for drugs remain unchanged; all while significant challenges persist in adequately addressing the needs of substance users, their families, and the community. A significant gap in the drug control system continues to exist with the unaddressed enforcement of current legislation coupled with the continued high demand for treatment services.

The cannabis caution policy, issued from the Director of Public Prosecution to the Bermuda Police Service, was implemented in February 2017 and repealed with the passing of the Cannabis Decriminalization Act of 2017, allowing for possession of less than seven grams of marijuana.

## ***Cost of Treating Drug Problems***

The balance between demand and supply reduction cannot occur unless interdiction agencies have sufficient funds to execute operations, secure necessary equipment, and have available the training and technical assistance for their officers. It is imperative that supply and demand reduction have the necessary resources to adequately support and reduce the availability of drugs.

Substance abuse treatment remains the largest component of drug control expenditure. All budgets, including those for interdiction, saw a decrease in funding during FY 2016/2017. The government grant-funded agencies all saw level funding. Transitional housing, however, was operational in 2017 with the provision of a grant to the agency Focus Counselling Services, after two years of no government funding.

## ***Existence of a “Treatment Gap”***

The year 2017 saw a continuation of waiting lists for treatment services due to staffing shortages and streamlined budgets. The treatment gap persisted for persons seeking substance abuse assessment in that, while a person may go through the assessment phase, he/she may not follow through with the recommended level of care, leaving a “treatment gap” between the persons needing and receiving treatment.

An understanding and knowledge of substance users and abusers who are not in care is limited and requires further discussion and research.

The Mental Health Treatment Court, a programme of the Department of Court Services, remains without a viable treatment option for clients with substance use disorders. Bermuda lacks an inpatient medically-monitored drug treatment facility that makes placing dual-diagnosed clients even more difficult.

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.

## Demand and Supply Reduction Activities and Initiatives During 2017

During 2017, 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.

### Management and Coordination

- The DNDC was consulted on special licenses for terminally ill patients requiring medical marijuana; the processes to make medical marijuana available to the community; CBD oil accessibility; and a request to import Kratom. Advice was provided in collaboration with the Department of Health.
- Amendment of the Misuse of Drugs and Pharmacy Acts' schedules to include synthetic drugs and update the formulary.
- Secured approval to recruit for multiple vacant posts throughout the DNDC and successfully recruited for them.
- Secured a new site for Transitional Housing for the Women's Treatment programme in a Government-owned facility and arranged for required renovations in collaboration with the Department of Public Works.
- Successfully distributed and monitored the utilisation of grant funding to CADA, PRIDE, BACB, Salvation Army Harbour Light, and The Community LifeSkills Programme.
- Successfully negotiated for the return of grant funding for Focus Counselling Services.
- Advocated for the enactment of the NDC Act 2013 with official gazetting.

### Substance Abuse Treatment

- Supported preparations for CARF re-accreditation by establishing and implementing new policies and procedures in the Women's Treatment Centre (WTC) and Turning Point Programmes.
- WTC and Turning Point received Gold Star three-year CARF international accreditation.
- Conformance reports submitted to CARF in August 2017 for Men's Treatment (MT).
- September – Recovery Month – was a success with radio interviews, a newspaper supplement, Salvation

- Army Recovery walk, and Focus annual recovery cruise.
- Assisted BACB in presenting evidence-based workshops to local treatment and prevention professionals.
- Organised Training for Non-Violent Crisis Intervention (NCI) procedures for MT and WTC staff as well as on-call relief workers.
- Substance abuse treatment leadership group met regularly.
- Eleven substance abuse treatment facilities submitted their licensure documents.
- WTC census – admissions running at 33%.
- WTC program was able to acquire a new vehicle for transport of clients.
- MT census – admissions running at 60%.
- MT staff participated in weekly Drug Court staffing and courts.
- WTC saw successful recruitment of on-call relief Cook and two Junior Addiction Counsellors.

### Substance Abuse Prevention

- Prevention Unit of DNDC spearheaded the first LGBT training for service providers.
- Conducted training Challenge Masters problem-solving and communication programme for Teen Peace staff.
- Drug prevention education has been implemented in all government preschools through the AI's Pals programme. Eight government schools use the programme at the lower primary school level. Two schools in the private sector received additional training online.
- Public education was provided on fentanyl, alcohol, and marijuana. Print, audio, and social media outlets included the Royal Gazette, Inter Island Communications, Bermuda Broadcasting, Harper Digital, Bermuda Real, and Bernews.
- Parenting skills for persons in recovery was implemented with parents from the Right Living House.
- The Teen Peace Programme has been implemented in five schools.
- Substance abuse resource information for community stakeholders included:
  - Mens Health Fair sponsored by the Ministry of Health.
  - Participated in the HM Customs Department Customs Week events, which educated the public on security measures and drug trafficking.
  - In collaboration with the Bermuda Sport Anti-doping Authority, over 500 drug prevention items were distributed at the KAPPA Soccer Classic.



## Research

- Commissioned the Omnibus Survey on public perceptions.
- Drafted, published, and disseminated the 2016 Annual Report of the Bermuda Drug Information Network.
- Institutionalised Training for Intervention ProcedureS (TIPS) for all servers and waiters of alcohol in licensed establishments continues to be tracked and monitored.
- Continued quality monitoring and reporting of programmes that received grants and contributions.
- Increased quality improvement mechanisms with the implementation of the Consumer Feedback Surveys and Stakeholder Surveys at Men's Treatment, Women's Treatment Center, and the Right Living House.
- Completed the development of the National Drug Information Network, BerDIN, to identify and include the Prevention Unit indicators in the data management system.
- Liaised with HM Customs and BPS given that they received funding for interdiction training.
- Continued to work with NOVA Ltd. to continue to develop the database for BerDIN Phase 3 (public access).
- Reported on National Household Survey 2017.
- Completed data collection of Prison Drug Abuse Monitoring Survey 2017/2018.
- Hired new Research Officer and consultant to review the National Drug Control Master Plan, 2013-2017.

## Coordination Mechanism

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

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

been adopted, depending on the priority given to the drug problem within each member agency.

Stability of the BerDIN relies strongly on the participation and cooperation of respective agencies. This 2017 Annual Report marks the eighth year in which over 18 sources of drug-related information were provided to inform the drug situation in Bermuda (see Appendix I). The information continues to be presented in table format and represents the most up-to-date data on the Island in this field. Reporting agencies submitted data by May 15th of the current year to allow sufficient time for data cleaning, verification, and follow-up in preparation for pre-press layout and design.

## New Data Sources and Report Items

Since the 2017 Annual Report, an ad-hoc survey on substance misuse and abuse perceptions was implemented and a survey report on the drug abuse monitoring programme amongst the prison population was updated with another round having been administered in FY 2017/2018.

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

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

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

## Definition of the BerDIN

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

## Mission of the BerDIN

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

## Importance of the BerDIN

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

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

## Purpose of the BerDIN

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

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

- Stimulate further discussions on drug demand reduction or drug supply restriction policies and challenges; and
- Serve as a useful methodology for integrating agencies involved in drug reduction or control.

## Core Functions of the BerDIN

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

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

## Contribution to Programme Development

The information collected provides a background for:

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

## Network Members

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

1. Bermuda Hospitals Board
  - i King Edward VII Memorial Hospital
  - ii Turning Point Substance Abuse Programme
2. Bermuda Police Service
3. Bermuda Sport Anti-Doping Authority
4. Counselling and Life Skills Services
5. CADA

6. Department of Corrections
  - i Westgate Correctional Facility
  - ii Right Living House
7. Department of Court Services
  - i Bermuda Assessment and Referral Centre
  - ii Drug Treatment Court
8. Department of Health
  - i Central Government Laboratory
  - ii Epidemiology and Surveillance
9. Department for National Drug Control
  - i Men's Treatment
  - ii Research and Policy Unit
  - iii Women's Treatment Centre
10. Financial Intelligence Agency
11. HM Customs
12. Liquor License Authority
13. Supreme Court

## Common Sources of Data

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

### Quantitative

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

### Qualitative

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

(See Summary of Sources and Data in Appendix I)



## Data Gaps

Despite the continued challenges facing Network member agencies, the provision of information, even though delayed at times, continued. There remain gaps in our understanding of the drug phenomena related to the environment in which substance use occurs, alcohol and drug use, prevention, treatment and support activities, criminal justice, and drug-related harms. Information gaps also include, but 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 social and economic environment; 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 that dedicate time, resources, and human capital for the long-term utilisation and maintenance of that information often provide accurate and reliable data. During 2017, the organizational challenges were due primarily to reduced funding leading to staff shortages and an inability to offer the full complement of services. At times, this meant the provision of information was delayed. Another main challenge for the BerDIN was the provision of information from the BPS, specifically statistics related to drug seizures. Drug-related seizure information is one piece of information that is used to monitor the drug market and drug availability; therefore, not having this information readily available contributes to a gap in understanding of the drug situation in Bermuda. Further discussion regarding this issue is necessary in order to ensure that the 2018 data will be made available in a timely manner.

From a data perspective, the majority of the agencies were able to log into the BerDIN data management system; allowing for a more seamless transfer of data. Although not all of the agencies inputted their data by the May 15th deadline, the majority were able to provide their information within a reasonable time beyond the deadline.

Despite these issues, this Annual BerDIN Report includes an overall total of about 38 drug control areas being monitored with over 150 indicators. The DNDC continues to work with organisations to build capacity that will allow them to organise, maintain, and effectively utilise data gathered to inform polices and programme direction.

## Joining the BerDIN

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

## Meeting 2017

The 2017 Annual Meeting of the Bermuda Drug Information Network (BerDIN) was held on the 26<sup>th</sup> and 27<sup>th</sup> of October, 2017 in the Poinciana Room 3 of the Fairmont Southampton (Hotel) Bermuda.

Dr. Kyla Raynor, a BerDIN Member who represented the Department of National Drug Control, called the meeting to order. Dy-Juan DeRoza, a BerDIN Member, representing the Ministry of Health then extended a welcome to the meeting's participants and invited guests. The Hon. Zane DeSilva, JP, MP, Minister of the Ministry of Social Development and Sports, gave opening remarks. He noted the vital role of the BerDIN within the drug research field in the provision of needed data and the uniqueness of the Network's annual publication in terms of its collaborative representation. Mr. DeSilva highlighted some of the challenges ahead and called for continued dialogue that can lead to a better understanding of the issues that continue to affect our community. He also shared his view that academic research into drug topics needs to become a higher priority at the tertiary level with students needing to pursue studies in statistics and research. In closing, Minister DeSilva emphasised that with the expiration of the National Drug Control Master Plan 2013-2017, Government must determine the direction it takes to achieve the shared vision of a drug free Bermuda. Following the Opening Remarks, Mr. DeSilva officially declared the meeting open.

Participants were reminded of the meeting's objectives by Mr. Duncan Barclay, Results, Compliance & Investigations Manager, Bermuda Sport Anti-Doping Authority; 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 activities and wellness presentations. 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. Housekeeping matters were also conveyed.

The meeting received a presentation from Dr. Kyla Raynor, BerDIN Coordinator and Senior Research Officer/Policy Analyst, DNDC, 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 the sixth meeting since the group reengaged. Further, the BerDIN Coordinator provided a snapshot of Bermuda's drug situation as presented within the 2017 Annual Report of the BerDIN, using some available data such as: access and availability of alcohol and other drugs; youth, inmates, and prenatal drug use; treatment referrals; clients in treatment; and the cost of drug control efforts, to highlight the current state.

BerDIN Member, Mr. Dean Lema, who represented HM Customs, introduced the keynote speaker, the Collector of HM Customs, Mrs. Lucinda Pearman. This was the fifth year in succession that the meeting has had a keynote speaker.

The Collector, in her remarks, took participants on a trip down memory lane recalling the processes, structure and responsibilities of the Customs Department in the 70s and 80s. Despite the challenges she raised, Mrs. Pearman felt that HM Customs has improved its business standards and processes over the last fifteen years. Some of these advancements included: the introduction of the Customs Automated Processing System (CAPS) databases, the institution of a Dual Channel System, and the ability to scan full containers.

Through much collaboration, HM Customs has provided support to other local and overseas Government agencies, such as the Department of Immigration, Bermuda Police Service, and U.S. Customs and Border Protection (CBP) to stem the flow of drugs and illegal weapons into Bermuda and the import and export of currency in and out of Bermuda. To date, their interdiction rates of illicit drugs have been steady, ranging from small personal quantities to larger "intent to supply" quantities. Mrs. Pearman congratulated the Department on its ability to be continuously at the

forefront of recent surges of illegal activity, ranging from the importation of Hemp products to weapon seizures. She shared that this is only done through the ongoing training and awareness of staff by a variety of essential service organizations.

The meeting then invited Assistant Collector of Customs Richard Amos to share of his expertise on commercial cannabis/hemp products. His presentation covered information on the financial profits driving the hemp business and the broad range of hemp products that are currently on the market. Mr. Amos mentioned that there are several wholesalers and grocery stores that have imported hemp-based products, inclusive of health and beauty products. He discussed some of the challenges with importation by retail outlets and shared HM Customs current policy on Hemp products. This policy seeks to detain all imports of hemp-based or CBD products (except those made with stalk fibre); secure detained product at point of importation; review detention reports for hemp based or CBD products; and restore hemp-based or CBD products.

Principle Customs Officer (PCO) Kelly Trott informed the group about the role of the Joint Intelligence Unit (JIU). Her presentation gave a brief history of the JIU, which was formally known as the Passenger Analysis Unit and has been in operation since 18th May 2002. Ms. Trott also shared some of the JIU's duties, which range from: monitoring the movements of known or suspected criminals; detecting and preventing the illicit cross-border transportation of cash and bearer negotiable instruments (BNIs); and preventing the removal of children who are subjects of a Supreme Court Order. Lastly, PCO Trott explained that the capabilities of the JIU are far-reaching as the Unit is able to liaise with other enforcement agencies and place lookouts in the Bermuda Immigration Database and access all airline manifests, just to name a few.

The meeting then invited PCO Sharmette Pond and SCO Andrea McKey to give participants an opportunity to see and handle a variety of the products that are considered illegal to import. This hands-on presentation gave participants a first-hand look at some of the pseudo-drugs and paraphernalia used by the HM Customs training Unit to educate their officers and, to some extent, school students along with the public throughout the year.

Mr. Larry Mussenden, Director of the Department of Prosecutions, gave the BerDIN participants an overview of the Cannabis Caution Policy. His presentation included highlights from the legislation that support the Caution Policy, such as the need for amendments to be made to the Police and Criminal Evidence Act 2016. Mr. Mussenden informed the meeting that in the finalisation of the Caution Policy there were many consultations conducted with public



and private sector agencies. Their feedback birthed factors to consider as reasons for creating the Caution Policy. Four main points of the policy are as follows: weight of cannabis must be less than three grams; offender must admit to possession of cannabis; no other drugs on person at time of search; and offenders under 18 years of age must be referred to Child and Family Services. Mr. Mussenden closed his presentation with data on the cautions that have been given out between 23<sup>rd</sup> February 2017 and 25<sup>th</sup> October 2017.

Sergeant David Bhagwan of the Bermuda Police Service gave an interesting presentation on the many drug concealment methods that his team has witnessed. Some of these methods shown included concealing the drugs in clothing, papers, and in false bottoms attached to machinery and built-in suitcases.

Senior Government Analyst, Nadine Kirkos, of the Central Government Laboratory, shared with the meeting a presentation on the dangers of fentanyl and its impact on the body if consumed incorrectly or if secondary exposure occurs. She discussed that fentanyl, whilst being a legal drug for things such as treatment for cancer patients, etc., it has deadly and almost instantaneous effects on the body if not used for its designated purposes. Ms. Kirkos advised that the lab has the antidote on hand for lab staff in case of accidental exposure, which can easily occur through skin contact with small quantities of the drug or breathing in particles.

The DNDC representative, Mrs. Stephanie Tankard, Research Officer, provided the meeting with an update on the DNDC's newest survey initiative since the last meeting, which was the 2017 National School Survey (NSS). The presentation provided an overview of the data collected in areas such as: risk of harm; access to drugs; prevalence-of-use; and the Alcohol Policy.

Mrs. Joanne Dean, Director of the DNDC updated the meeting on the National Control Master Plan 2013-2017 and Action Plan by highlighting what has been accomplished and a way forward with the outstanding items contained in the Master Plan.

There were 59 objectives, 27 or 45.8% were completed; nine or 15.3% were partially completed; four or 6.8% are considered as on-going; and 19 or 32.2 % were not completed.

Moving forward, Mrs. Dean noted that the DNDC intends to spend the next year evaluating the 2013-2017 Plan and building the 2019-2023 National Drug Control Master Plan.

Mrs. Fiona Elkinson, Head of the Driving Under the Influence (DUI) Education Programme addressed the meeting with her concerns surrounding the lack of communication

between Traffic Court and herself with regards to the incentive of participating in the DUI education programme. Mrs. Elkinson called for greater dialogue concerning how the initiative of participating in the DUI programme and traffic sentences were passed down by the courts.

Mr. Larry Mussenden ended the Network's updates by sharing a presentation on Decriminalization Confiscations. He began with a brief background in Bermuda's context using the Cannabis Reform Debate in the House of Assembly 2014 as a basis for the presentation. Constitutionally, Mr. Mussenden shared the extent of his powers as the Director of Prosecutions as well as the problem with decriminalizing cannabis. He noted that, currently, Bermuda is awaiting political direction with regards to the decriminalisation of cannabis. Lastly, he touched on the benefits of the Proceeds of Crime Act 1997 in reference to forfeitures/confiscations. At present, the funds from forfeitures/confiscations are put into the confiscated assets fund, which have been used to assist community-based organisations with their funding.

At the conclusion of the meeting, there was again the call by Dr. Raynor for there to be more problem-solving by collaborating with each other outside of the annual meeting. Mr. Christopher Clarke, a BPS representative, mentioned that the information presented on the Cannabis Caution Policy seemed to be incomplete. He advised Dr. Raynor to follow-up with him regarding the total number of cautions given since February 2017. It was suggested by members that the administration within agencies that are first responders to incidents, for example the BPS, be informed of the necessity to purchase the antidote used for fentanyl exposure.

Dr. Raynor made brief closing remarks and thanked the participants for contributing to, what she deemed as, another successful meeting, and was grateful for their invaluable contribution. She also acknowledged the contribution over the past six years of the Graphics and Design team of the Department of Communication and Information, who have designed and laid out the BerDIN Annual Report and meeting items. She encouraged participants to continue the collaboration beyond the meeting. The members of the planning team were acknowledged for their contribution to the meeting preparation. Participants completed a short evaluation of the meeting on Day 1 and also for the wellness and team building (bowling) session on Day 2.





Photo courtesy of DC





# Chapter 1

## Criminal and Suspicious Activity

---

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



## 1.1 CRIMES

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.

'antisocial behaviour' saw the largest decline in the number of offences by 135 fewer cases. For property offences, there were significant decreases observed in all categories.

Between 2016 and 2017, Bermuda saw a decrease in overall crime by 68.7%; with crime against the person decreasing by 55.3%, against the community decreasing by 21.5%, and against property decreasing by 81.0% (see Table 1.1.1). In both years, there were mostly crimes against property characterised predominantly by theft of property, motor vehicle theft, and burglary (non-residential) (see Table 1.1.2). With regard to offences against the person, 'other assaults' have significantly decreased over the past year. In term of crimes against the community, for a second year, the category

...Bermuda saw a decrease in overall crime by 68.7%...

**Table 1.1.1**

*Number and Proportion of Crimes by Type of Crime and Annual Absolute and Percentage Change, 2016 and 2017*

CRIMES	2016		2017		Annual Change	
	n	%	n	%	n	%
Against the Person	740	20.6	331	29.5	409	-55.3
Against the Community	419	11.7	329	29.3	90	-21.5
Against Property	2,428	67.7	461	41.1	1,967	-81.0
<b>Total – All Crimes</b>	<b>3,587</b>	<b>100</b>	<b>1,121</b>	<b>100</b>	<b>2,466</b>	<b>-68.7</b>

Source: Bermuda Police Service

**Table 1.1.2**

*Number of Crimes against Person, Community, and Property by Type of Crime and Annual Absolute Change, 2016 and 2017*

CRIMES	2016	2017	Annual Absolute Change
<b>AGAINST THE PERSON</b>	<b>740</b>	<b>331</b>	<b>409</b>
Indecency	23	10	13
Manslaughter	1	3	-2
Murder	7	20	-13
Offences Against Children	27	20	7
Robbery	81	19	62
Serious Assaults	46	31	15
Sexual Assault	40	17	23
Other Assaults	515	211	304
<b>AGAINST THE COMMUNITY</b>	<b>419</b>	<b>329</b>	<b>90</b>
Animal Offences	2	-	2
Antisocial Behaviour	280	145	135
Disorder Offences	91	123	-32
Firearm Offences	21	29	-8
Other Weapon Offences	25	32	-7

**Table 1.1.2 cont'd***Number of Crimes against Person, Community, and Property by Type of Crime and Annual Absolute Change, 2016 and 2017*

CRIMES	2016	2017	Annual Absolute Change
<b>AGAINST PROPERTY</b>	<b>2,428</b>	<b>461</b>	<b>1,967</b>
Burglary (Residential)	551	31	520
Burglary (Non-Residential)	198	78	120
Burglary (Tourist Accommodation)	-	-	-
Criminal Damage	240	63	177
Fraud and Deception	87	71	16
Motor Vehicle Theft	770	51	719
Theft of Property	582	167	415

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, 2016 and 2017*

CRIMES	2016	2017
<b>AGAINST THE PERSON</b>	<b>100.0</b>	<b>100.0</b>
Indecency	3.1	3.0
Manslaughter	0.1	0.9
Murder	0.9	6.0
Offences Against Children	3.6	6.0
Robbery	10.9	5.7
Serious Assaults	6.2	9.4
Sexual Assault	5.4	5.1
Other Assaults	69.6	63.7
<b>AGAINST THE COMMUNITY</b>	<b>100.0</b>	<b>100.0</b>
Animal Offences	0.5	-
Antisocial Behaviour	66.8	44.1
Disorder Offences	21.7	37.4
Firearm Offences	5.0	8.8
Other Weapon Offences	6.0	9.7
<b>AGAINST PROPERTY</b>	<b>100.0</b>	<b>100.0</b>
Burglary (Non-Residential)	8.2	6.7
Burglary (Residential)	22.7	16.9
Burglary (Tourist Accommodation)	-	-
Criminal Damage	9.9	13.7
Fraud and Deception	3.6	15.4
Motor Vehicle Theft	31.7	11.1
Theft of Property	23.9	36.2

Source: Bermuda Police Service



**Table 1.1.4**

*Number of Crimes against Person, Property, and Community as a Proportion of Total Crimes, 2016 and 2017*

CRIMES	2016	2017
<b>AGAINST THE PERSON</b>	<b>20.6</b>	<b>29.5</b>
Indecency	0.6	0.9
Manslaughter	-	0.3
Murder	0.2	1.8
Offences Against Children	0.8	1.8
Robbery	2.3	1.7
Serious Assaults	1.3	2.8
Sexual Assault	1.1	1.5
Other Assaults	14.4	18.8
<b>AGAINST THE COMMUNITY</b>	<b>11.7</b>	<b>29.3</b>
Animal Offences	0.1	-
Antisocial Behaviour	7.8	12.9
Disorder Offences	2.5	11.0
Firearm Offences	0.6	2.6
Other Weapon Offences	0.7	2.9
<b>AGAINST PROPERTY</b>	<b>67.7</b>	<b>41.1</b>
Burglary (Non-Residential)	5.5	2.8
Burglary (Residential)	15.4	7.0
Burglary (Tourist Accommodation)	-	-
Criminal Damage	6.7	5.6
Fraud and Deception	2.4	6.3
Motor Vehicle Theft	21.5	4.5
Theft of Property	16.2	14.9

Source: Bermuda Police Service

## 1.2 DRUG SEIZURES AND ARRESTS

On a whole, both arrests for importation and local drug offences increased by 20.7% over the period under review, that is, from 347 in 2016 to 419 in 2017. The BPS made 784 drug seizures in 2017, resulting in separate drugs being recovered with a combined weight of 71,160.25 grams (Table 1.2.3). During 2017, Cannabis drugs continued to be

the most common drug type seized, with a total of 52,298.94 grams (Table 1.2.3). This however, was a significant decrease (48.0%) from the amount of cannabis seized in 2016. When it came to narcotic drug seizures, crack cocaine was seized more often than any other drug.

**Table 1.2.1**

*Drug Seizures by Arrests for Drug Offences, 2016 and 2017*

SEIZURES	2016	2017
<b>ARRESTS</b>		
Drug Offences (Importation)	41	43
Drug Offences (Local)	306	376
<b>Total Arrests – Drug Offences</b>	<b>347</b>	<b>419</b>
<b>Annual Percentage Change</b>	<b>54.9</b>	<b>20.7</b>

Source: Bermuda Police Service



**Table 1.2.2**  
*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 drugs	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
<b>Total*</b>	<b>443</b>	<b>112,825</b>

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, 2017*

DRUG	2017	
	Total Count (n)	Total Weight (g)
Cannabis	342	52,298.94
Cannabis (Resin)	69	7,012.23
Cannabis (Seeds)	20	49.76
Cannabis (Plant)	163	-
Cannabis (Edibles)*	-	778.8
Crack Cocaine	50	704
Cocaine*	31	6,341.27
Heroin/Diamorphine drugs	29	3,843.95
Not a controlled substance	78	18.9
Designer Drugs		
Fentanyl drugs	-	-
MDMA drugs	-	-
Synthetic cathinone derivative	2	131.3
<b>TOTAL</b>	<b>784</b>	<b>71,160.25</b>

Source: Bermuda Police Service

Note: \* Edibles are food products similar to candy or gummies.

\* Cocaine Hydrochloride



## 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 for a second year from 173 in 2016 to 155 in 2017 (Table 1.3.1). In both years, the majority of drug-related trials were for possession of cannabis, which decreased from 66 in 2016 to 56 in 2017, along with criminal trials for the possession of cannabis with intent to supply (see Table 1.3.1). There were, however, increases in the number of trials for possession of cocaine and importation of cannabis.

There was no change in the number of criminal trials for alcohol-related offences in 2017, although the breakdown differs by sex of the offender (see Table 1.3.2). In both 2016 and 2017, of all alcohol-related offences, a significant number of these trials were the result of impaired driving of a motor vehicle, excessive alcohol in operating a motor vehicle, and refusing the breathalyser test.

In terms of acquittals and convictions, there were significantly more acquittals in 2017 than in 2016 for criminal drug-related offences and for alcohol-related offences (see Tables 1.3.3 and 1.3.4). There were also more convictions in 2017 for both criminal drug- and alcohol-related offences when compared with 2016 (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 and breach of liquor license (see Table 1.3.4). An increase in criminal convictions for drug-related offences was observed in 2017. In both years under review, these convictions were mainly for the possession of cannabis. In 2017, the number of criminal convictions for importation of cannabis increased to 14, up from seven in the previous year. In comparison, criminal convictions for alcohol-related offences, on the whole, increased considerably in 2017, from 137 cases in 2016 to 151 cases in 2017. Impaired driving of a motor vehicle and excess alcohol motor vehicle represented the highest proportions of alcohol-related criminal convictions.

Lastly, there were some drug- and alcohol-related cases in which the result of the case was classified as 'unknown', meaning that the result of the case (conviction or acquittal) was not recorded. The number of drug-related unknown cases decreased from 39 cases in 2016 to 25 cases in 2017 (see Table 1.3.7). However, when it came to alcohol-related cases, more cases were classified as 'unknown' in 2017 (131 cases) as compared to 2016 (108 cases).

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

**Table 1.3.1**  
*Criminal Trials for Drug-Related Offences by Sex of Offender, 2016 and 2017*

JEMS Code	Description	2016				2017			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	55	4	7	66	46	6	4	56
2304	Possession of Cocaine	5	1	1	7	11	-	1	12
2308	Possession of Diamorphine	4	-	-	4	-	-	-	-
2312	Possession of Other Drugs	3	-	-	3	2	-	2	4
2313	Possession of Other Drugs With Intent to Supply	-	-	-	-	-	-	-	-
2316	Possession of Cannabis With Intent to Supply	14	4	4	22	13	3	2	18
2320	Possession of Cocaine With Intent to Supply	6	2	2	10	2	1	-	3
2324	Possession of Diamorphine With Intent to Supply	2	1	2	5	-	-	-	-
2332	Handle Cannabis With Intent to Supply	-	-	-	-	1	-	-	1
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	-	-	-	-	-	-	-	-

**Table 1.3.1 cont'd**  
**Criminal Trials for Drug-Related Offences by Sex of Offender, 2016 and 2017**

JEMS Code	Description	2016				2017			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2356	Supply Diamorphine	-	-	-	-	-	-	-	-
2357	Supply Other Drugs	-	-	-	-	-	-	-	-
2364	Import Cannabis	6	3	-	9	9	3	5	17
2368	Import Cocaine	-	-	-	-	-	1	2	3
2372	Import Diamorphine	1	-	-	1	-	-	-	-
2373	Import Other Drugs	-	1	-	1	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	14	3	-	17	12	2	2	16
2392	Possession of Drug Equipment Prepare	9	2	4	15	13	3	1	17
2396	Cultivate Cannabis	4	-	-	4	4	-	-	4
2400	Permit on Premises Drug Use	-	2	-	2	1	1	-	2
2404	Obstruction	4	-	-	4	-	-	-	-
<b>Total Trials: Drug-Related Offences</b>		<b>128</b>	<b>24</b>	<b>21</b>	<b>173</b>	<b>116</b>	<b>20</b>	<b>19</b>	<b>155</b>

Source: Supreme Court

**Table 1.3.2**  
**Criminal Trials for Alcohol-Related Offences by Sex of Offender, 2016 and 2017**

JEMS Code	Description	2016				2017			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	107	11	11	129	104	12	12	128
3059	Impaired Driving (>100 mgs Alcohol)	24	2	7	33	13	3	10	26
3060	Impaired Driving Not Motor Vehicle	-	-	-	-	1	-	-	1
3061	Care and Control of Motor Vehicle Whilst Impaired	10	-	-	10	11	5	1	17
3062	Refuse Breath Test	52	5	3	60	34	5	2	41
3063	Impaired Driving Drug In Body	1	1	-	2	1	-	-	1
3064	Excess Alcohol Motor Vehicle	41	4	2	47	64	7	1	72
3065	Impaired Driving – GBH	3	1	-	4	-	-	-	-
3066	Excess Alcohol Not Motor Vehicle	-	-	-	-	-	-	-	-
3069	Causing Death by Impaired Driving	-	-	-	-	-	-	-	-
3842	Excess Alcohol – Power Craft	1	-	-	1	1	-	-	1
3843	Impaired Driving – Power Craft	-	-	-	-	1	-	-	1
4020	Drunk and Incapable	2	-	-	2	-	-	-	-
4022	Drunk in Public Street	1	-	-	1	-	-	1	1
8403	Drunkness in Aircraft Contrary to Air Navigation	-	-	-	-	-	-	-	-
4500	Liquor Licence Offences	-	-	-	-	-	-	-	-
4556	On Premises Outside Permitted Hours	-	-	-	-	-	-	-	-
4599	Breach of Liquor Licence	-	-	-	-	-	-	-	-
<b>Total Trials: Alcohol-Related Offences</b>		<b>242</b>	<b>24</b>	<b>23</b>	<b>289</b>	<b>230</b>	<b>32</b>	<b>28</b>	<b>289</b>

Source: Supreme Court





**Table 1.3.3**  
Criminal Acquittals for Drug-Related Offences by Sex of Offender, 2016 and 2017

JEMS Code	Description	2016				2017			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	13	-	-	13	1	1	-	2
2304	Possession of Cocaine	2	-	-	2	-	-	-	-
2308	Possession of Diamorphine	1	-	-	1	-	-	-	-
2312	Possession of Other Drugs	-	-	-	-	1	-	2	3
2313	Possession of Other Drugs With Intent to Supply	-	-	-	-	-	-	-	-
2316	Possession of Cannabis With Intent to Supply	1	1	3	5	3	-	1	4
2320	Possession of Cocaine With Intent to Supply	1	1	1	3	-	-	-	-
2324	Possession of Diamorphine With Intent to Supply	-	-	1	1	-	-	-	-
2332	Handle Cannabis With Intent to Supply	-	-	-	-	1	-	-	1
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	-	-	-	-	9	2	3	14
2368	Import Cocaine	-	-	-	-	-	1	2	3
2372	Import Diamorphine	-	-	-	-	-	-	-	-
2373	Import Other Drugs	-	-	-	-	1	-	-	1
2380	Conspiracy to Import Other Drugs	-	-	-	-	1	-	-	1
2381	Conspiracy to Supply a Controlled Drug	-	-	-	-	-	-	-	-
2383	Export Drug Attempt	-	-	-	-	-	-	-	-
2384	Misuse Controlled Drug	-	-	-	-	-	-	-	-
2388	Possession of Drug Equipment	2	-	-	2	9	1	2	12
2392	Possession of Drug Equipment Prepare	2	1	1	4	10	2	1	13
2396	Cultivate Cannabis	1	-	-	1	2	-	-	2
2400	Permit on Premises Drug Use	-	-	-	-	-	-	-	-
2404	Obstruction	-	-	-	-	-	-	-	-
<b>Total Acquittals: Drug-Related Offences</b>		<b>23</b>	<b>3</b>	<b>6</b>	<b>32</b>	<b>38</b>	<b>7</b>	<b>11</b>	<b>56</b>

Source: Supreme Court

**Table 1.3.4**  
Criminal Acquittals for Alcohol-Related Offences by Sex of Offender, 2016 and 2017

JEMS Code	Description	2016				2017			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	19	1	1	21	41	4	4	49
3059	Impaired Driving (>100 mgs Alcohol)	2	-	1	3	6	2	6	14
3060	Impaired Driving Not Motor Vehicle	-	-	-	-	1	-	-	1
3061	Care and Control of Motor Vehicle Whilst Impaired	2	-	-	2	4	4	1	9
3062	Refuse Breath Test	4	-	-	4	27	5	2	34
3063	Impaired Driving Drug In Body	-	-	-	-	1	-	-	1
3064	Excess Alcohol Motor Vehicle	8	1	-	9	35	4	1	40
3065	Impaired Driving – GBH	2	-	-	2	-	-	-	-
3066	Excess Alcohol Not Motor Vehicle	-	-	-	-	-	-	-	-
3069	Causing Death by Impaired Driving	-	-	-	-	-	-	-	-

**Table 1.3.4 cont'd**  
**Criminal Acquittals for Alcohol-Related Offences by Sex of Offender, 2016 and 2017**

JEMS Code	Description	2016				2017			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3841	Ref Breath Test Powercraft S I I 4 F Mba62*	1	-	-	1	1	-	-	1
3843	Impaired Driving – Power Craft	-	-	-	-	1	-	-	1
4020	Drunk and Incapable	-	-	-	-	-	-	-	-
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	-	-	-	-	41	4	4	49
<b>Total Acquittals: Alcohol-Related Offences</b>		<b>40</b>	<b>2</b>	<b>2</b>	<b>44</b>	<b>117</b>	<b>19</b>	<b>15</b>	<b>151</b>

Source: Supreme Court

**Table 1.3.5**  
**Criminal Convictions for Drug-Related Offences by Sex of Offender, 2016 and 2017**

JEMS Code	Description	2016				2017			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	39	1	6	46	40	3	4	47
2304	Possession of Cocaine	2	1	1	4	10	-	1	11
2308	Possession of Diamorphine	2	-	-	2	-	-	-	-
2312	Possession of Other Drugs	1	-	-	1	1	-	2	3
2313	Possession of Other Drugs With Intent to Supply	-	-	-	-	-	-	-	-
2316	Possession of Cannabis With Intent to Supply	7	1	1	9	7	2	1	10
2320	Possession of Cocaine With Intent to Supply	3	-	1	4	2	-	-	2
2324	Possession of Diamorphine With Intent to Supply	1	-	1	2	-	-	-	-
2332	Handle Cannabis With Intent to Supply	-	-	-	-	1	-	-	1
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	9	2	3	14
2368	Import Cocaine	-	-	-	-	-	1	2	3
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	7	1	-	8	9	1	2	12
2392	Possession of Drug Equipment Prepare	6	-	1	7	10	2	1	13
2396	Cultivate Cannabis	3	-	-	3	2	-	-	2
2400	Permit on Premises Drug Use	-	1	-	1	-	-	-	-
2404	Obstruction	4	-	-	4	-	-	-	-
<b>Total Acquittals: Drug-Related Offences</b>		<b>82</b>	<b>9</b>	<b>11</b>	<b>102</b>	<b>92</b>	<b>11</b>	<b>16</b>	<b>119</b>

Source: Supreme Court



**Table 1.3.6**  
Criminal Convictions for Alcohol-Related Offences by Sex of Offender, 2016 and 2017

JEMS Code	Description	2016				2017			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	38	3	3	44	41	4	4	49
3059	Impaired Driving (>100 mgs Alcohol)	12	1	6	19	6	2	6	14
3060	Impaired Driving Not Motor Vehicle	-	-	-	-	1	-	-	1
3061	Care and Control of Motor Vehicle Whilst Impaired	5	-	-	5	4	4	1	9
3062	Refuse Breath Test	37	5	2	44	27	5	2	34
3063	Impaired Driving Drug In Body	1	1	-	2	1	-	-	1
3064	Excess Alcohol Motor Vehicle	18	3	-	21	35	4	1	40
3065	Impaired Driving – GBH	1	-	-	1	-	-	-	-
3066	Excess Alcohol Not Motor Vehicle	-	-	-	-	-	-	-	-
3069	Causing Death by Impaired Driving	-	-	-	-	-	-	-	-
3843	Impaired Driving – Power Craft	-	-	-	-	1	-	-	1
4020	Drunk and Incapable	1	-	-	1	1	-	-	1
4022	Drunk in Public Street	-	-	-	-	-	-	-	-
8403	Drunkenness in Aircraft Contrary to Air Navigation	-	-	-	-	-	-	1	1
4500	Liquor Licence Offences	-	-	-	-	-	-	-	-
4556	On Premises Outside Permitted Hours	-	-	-	-	-	-	-	-
4599	Breach of Liquor Licence	-	-	-	-	-	-	-	-
<b>Total Convictions: Alcohol-Related Offences</b>		<b>113</b>	<b>13</b>	<b>11</b>	<b>137</b>	<b>117</b>	<b>19</b>	<b>15</b>	<b>151</b>

Source: Supreme Court

**Table 1.3.7**  
Unknown Results for Drug-Related Offences by Sex of Offender, 2016 and 2017

JEMS Code	Description	2016				2017			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	3	3	1	7	5	2	-	7
2304	Possession of Cocaine	1	-	-	1	1	-	-	1
2308	Possession of Diamorphine	1	-	-	1	-	-	-	-
2312	Possession of Other Drugs	2	-	-	2	1	-	-	1
2313	Possession of Other Drugs With Intent to Supply	-	-	-	-	-	-	-	-
2316	Possession of Cannabis With Intent to Supply	6	2	-	8	3	1	-	4
2320	Possession of Cocaine With Intent to Supply	2	1	-	3	-	1	-	1
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	-	-	-	-	-	-	-	-

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

JEMS Code	Description	2016				2017			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2381	Conspiracy to Supply a Controlled Drug	-	-	-	-	-	-	-	-
2383	Export Drug Attempt	-	-	-	-	-	-	-	-
2384	Misuse Controlled Drug	-	-	-	-	-	-	-	-
2388	Possession of Drug Equipment	5	2	-	7	3	1	-	4
2392	Possession of Drug Equipment Prepare	1	1	2	4	2	1	-	3
2396	Cultivate Cannabis	-	-	-	-	1	-	-	1
2400	Permit on Premises Drug Use	-	1	-	1	1	-	-	1
2404	Obstruction	-	-	-	-	-	-	-	-
<b>Total Unknown Results: Drug-Related Offences</b>		<b>23</b>	<b>12</b>	<b>4</b>	<b>39</b>	<b>17</b>	<b>7</b>	<b>1</b>	<b>25</b>

Source: Supreme Court

**Table 1.3.8**  
**Unknown Results for Alcohol-Related Offences by Sex of Offender, 2016 and 2017**

JEMS Code	Description	2015				2016			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	50	7	7	64	60	7	8	75
3059	Impaired Driving (>100 mgs Alcohol)	10	1	-	11	7	1	4	12
3060	Impaired Driving Not Motor Vehicle	-	-	-	-	-	-	-	-
3061	Care and Control of Motor Vehicle Whilst Impaired	3	-	-	3	7	1	0	8
3062	Refuse Breath Test	11	-	1	12	6	0	0	6
3063	Impaired Driving Drug In Body	-	-	-	-	-	-	-	-
3064	Excess Alcohol Motor Vehicle	15	-	2	17	28	2	0	30
3065	Impaired Driving – GBH	-	1	-	1	0	0	0	-
3066	Excess Alcohol Not Motor Vehicle	-	-	-	-	-	-	-	-
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	-	-	-	-	-	-	-	-
<b>Total Unknown Results: Alcohol-Related Offences</b>		<b>89</b>	<b>9</b>	<b>10</b>	<b>108</b>	<b>108</b>	<b>11</b>	<b>12</b>	<b>131</b>

Source: Supreme Court

## I.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.<sup>1</sup> In addition to the FIA Act, it is guided by other legislations such as: Proceeds of Crime Act 1997, Proceeds of Crime Regulations (Anti-Money Laundering and Anti-Terrorist Financing Supervision and Enforcement) Act 2008, Anti-Terrorism (Financial and Other Measures) (Business in Regulated Sector) Order 2008; Proceeds of Crime (Designated Countries and Territories) Order 1998, Anti-Terrorism (Financial and Other Measures) Act 2004, and Proceeds of Crime Appeal Tribunal Regulations 2009.

Data on financial intelligence showed a significant increase (97.1%) in the SARs received; up from the 478 in 2016 to 942 in 2017 (see Table I.4.1). All quarters in 2017 saw an increase over the corresponding quarters in 2016. Activities within banks and long term insurers account for the bulk of the SARs in both 2016 (246 and 52, respectively) and 2017 (554 and 184, respectively). The number of SARs received from the Fund Administrators decreased considerably in 2017 by 71.4%. Although relatively few, it is worthy to

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

note that, in 2017, there were SARs involving the following categories: Real Estate, Jeweler, Registered Charity, and Asset Recovery/Insolvency.

The FIA recorded the filing of 139 SARs in 2016 as compared to 143 SARs in 2017 (a 2.9% increase) that were related to suspicious wire transfers of money out of Bermuda, using money service business as the transmitter.<sup>2</sup> This activity continues to be the most prevalent trend seen by the FIA through its analysis over the past few years. The FIA continues to believe that the transactional activity concerning foreign currency exchange is intimately connected with Bermuda's drug trade and firearm activity.<sup>3</sup>

Also in 2017, 72 local and overseas disclosures contained information from 144 SARs compared to 112 disclosures from 447 SARs in 2016, representing a 35.7% decrease in disclosures from the 67.8% decrease in total SARs disclosed.

In 2017, there were two convictions for money laundering in the Supreme Court as compared to six in 2016.<sup>4</sup> The Department of Public Prosecutions, however, cautioned that not all of these convictions have a predicate offence directly related to drugs.

<sup>2</sup> FIA

<sup>3</sup> Ibid

<sup>4</sup> Department of Public Prosecutions

Data on financial intelligence showed a significant increase, by SARs received in 2017.

**Table I.4.1**  
*Suspicious Activity Reports (SARs) by Sector, 2016 and 2017*

SECTOR	2016					2017					Annual Percentage Change
	Q1	Q2	Q3	Q4	TOTAL	Q1	Q2	Q3	Q4	TOTAL	
<b>SARs Received</b>											
Banks (includes a Credit Union)	72	62	63	49	246	72	120	91	271	554	125.2
Investment Providers	1	2	4	6	13	3	4	7	4	18	38.5
Money Service Businesses	26	26	41	46	139	42	40	44	17	143	2.9
Corporate Service Providers	2	3	2	3	10	1	2	1	5	9	-10.0
Law Firm	-	1	-	-	1	-	-	3	-	3	200.0
Trust Company	1	-	-	-	1	1	3	-	-	4	300.0
Local Regulators	-	1	-	-	1	2	-	-	5	7	600.0
Long-Term Insurers	13	11	19	9	52	3	91	38	52	184	253.8
Other (Metal Dealers)	-	-	-	-	-	-	-	1	-	1	-
Accounting Firm	-	-	-	-	-	-	1	-	1	2	-
Fund Administrators	1	5	4	4	14	1	3	-	-	4	-71.4
Insurance Company/Manager	-	-	-	1	1	7	-	1	-	8	700.0
Real Estate <sup>†</sup>	...	...	...	...	...	...	1	...	...	1	...

**Table 1.4.1 cont'd**  
**Suspicious Activity Reports (SARs) by Sector, 2016 and 2017**

SECTOR	2016					2017					Annual Percentage Change
	Q1	Q2	Q3	Q4	TOTAL	Q1	Q2	Q3	Q4	TOTAL	
Jeweler*	...	...	...	...	...	...	...	...	1	1	...
Registered Charity*	...	...	...	...	...	...	...	...	1	1	...
Asset Recovery/Insolvency*	...	...	...	...	...	...	...	...	2	2	...
<b>TOTAL SARs RECEIVED</b>	<b>116</b>	<b>111</b>	<b>133</b>	<b>118</b>	<b>478</b>	<b>132</b>	<b>265</b>	<b>186</b>	<b>359</b>	<b>942</b>	...
<b>ANNUAL PERCENTAGE CHANGE</b>	<b>-5.7</b>	<b>-0.9</b>	<b>30.4</b>	<b>7.3</b>	<b>6.9</b>	<b>13.8</b>	<b>138.8</b>	<b>39.8</b>	<b>204.2</b>	<b>97.1</b>	<b>97.1</b>
<b>Total Local and Overseas Disclosures</b>	<b>32</b>	<b>21</b>	<b>29</b>	<b>30</b>	<b>112</b>	<b>17</b>	<b>10</b>	<b>31</b>	<b>14</b>	<b>72</b>	<b>-35.7</b>
Local Entities	25	15	26	27	93	17	5	27	8	57	-38.7
Overseas Entities	7	6	3	3	19	0	5	4	6	15	-21.1
<b>Total SARs Disclosed</b>	<b>126</b>	<b>119</b>	<b>118</b>	<b>84</b>	<b>447</b>	<b>50</b>	<b>14</b>	<b>188</b>	<b>6</b>	<b>144</b>	<b>-67.8</b>

Source: Financial Intelligence Agency

Note: \*Not available in 2016.  
 ...data unavailable

## 1.5 FINANCIAL CRIME

On April 1<sup>st</sup> 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 48 hours of the seizure, an application must be made to a Magistrate for a Detention Order which, if granted, authorises its further detention for up to three months, after which time 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, including 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 13 cash seizures in 2017 amounting to \$72,115 as compared to the considerably higher number (36) recorded in 2016, yielding \$545,985 (see Table 1.5.1). Although the number of cash seizures in 2017 was much lower, forfeitures accounted for the largest proportion (\$153,213) and was significantly lower than

in the previous year (\$213,245). No confiscations, civil recovery cases, or civil recovery orders were recorded in 2017.

**Table 1.5.1**  
*Cash Seizures, 2016 and 2017*

Year/ Quarter	Number of Seizures	Section 50 Cash Seizures (\$)	Forfeiture (\$)	Confiscation (\$)	Number of Civil Recovery Cases	Civil Recovery Orders (\$)	Total (\$)
<b>2016</b>							
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	826,000.00	1,106,702
<b>Total</b>	<b>36</b>	<b>545,985.27</b>	<b>213,245.45</b>	<b>19,830.00</b>	<b>4</b>	<b>11,252,902.51</b>	<b>12,032,003.23</b>
<b>2017</b>							
Q1	5	21,246.00	9,038.00	-	-	-	30,284.00
Q2	2	5,150.00	105,545.00	-	-	-	110,695.00
Q3	3	21,097.00	34,494.00	-	-	-	55,591.00
Q4	3	24,622.00	4,138.00	-	-	-	28,760.00
<b>Total</b>	<b>13</b>	<b>72,115.00</b>	<b>153,215.00</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>225,330.00</b>

Source: OECD, Bermuda Police Service

Note: ... data not available







# 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 2017, taxes related to the importation of alcohol and tobacco increased. A 35.0% duty was levied on imported cigarettes, while \$31.35 was the duty charged on one litre of hard liquor.<sup>5</sup> However, there were varying rates of duty applied to different alcoholic beverages and tobacco products (see Appendix III). These rates have been revised and became effective as of April 1, 2017 and were in use up until March 31, 2018; after which they have again been revised.

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

Alcohol and tobacco use continue to be a trend evidenced in Bermuda's society and the Island continues its trade, more so, the importation of alcohol and alcoholic beverages and tobacco and its products. It may be argued that most of these imported products are for tourists' consumption. However, this does not mean that Bermuda residents do not consume a portion of the imported alcohol and tobacco. However, Bermuda laws prohibit the sale or supply of these products to minors (under 18 years). According to the Tobacco Products (Public Health) Act 1987, a photo identification is required if a person appears to be under 25 years.<sup>6</sup>

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 2016, there were 6.17 million litres available for domestic consumption, valued at \$27.3 million, and contributed \$16.2 million in customs duty (see Table 2.1.1). Whereas, in 2017, there was an increase in the available quantity; 7.01 million litres of alcohol and alcoholic beverages were available for

local consumption, valued at \$31.0 million, and contributed \$20.0 million in customs duty. Beer and wine in containers holding two litres or less accounted for a significant portion of the beverages available for consumption.

An additional 2.7 million litres, valued at \$16.7 million in 2016 and 2.9 million litres valued at \$19.4 million in 2017 were placed in bonded warehouses upon importation for future consumption (see Table 2.1.2). Rum and other spirits, gin and geneva, and wine in containers holding more than 2L but not more than 10L accounted for the bulk of alcohol and alcoholic beverages placed in bonded warehouses in both years under review.

At the same time, in 2016 1.4 million litres of alcohol and alcoholic beverages were exported from bonded warehouses, valued at \$5.1 million, with \$23,579 received in customs duty (see Table 2.1.3). Similar to 2016, the year 2017 saw 1.4 million litres of alcohol and alcoholic beverages exported from bonded warehouses, valued at \$5.3 million, with \$20,638 received in customs duty.

The value of tobacco and tobacco products available for domestic consumption was approximately \$3.3 million in both 2016 and 2017 (see Table 2.1.4). However, the duty received increased from \$9.1 million in 2016 to \$10.1 million in 2017. The major component of tobacco imports is that of cigarettes, with 41 thousand kilograms, valued at \$2.1 million, being brought to the Island in 2017 or removed from bonded warehouses, contributing \$9.7 million towards customs duty. In comparison, the year 2016 saw over 52 thousand kilograms and 36.0 million units, valued at \$2.8 million, brought to the Island or removed from bonded warehouses, contributing \$9.0 million towards customs duty.

<sup>5</sup> Customs Department. (2017). Bermuda Customs Tariff 2017. Government of Bermuda.)

<sup>6</sup> 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), 2016 and 2017*

Tariff Code	Description	2016			2017		
		Litreage	Value (\$)	Duty (\$)	Litreage	Value (\$)	Duty (\$)
2203.000	Beer	3,532,607.32	6,086,564.66	4,230,469.00	4,352,192.25	7,169,854.63	5,483,762.16
2204.100	Sparkling Wine	125,754.63	2,036,241.20	387,778.05	164,150.73	2,826,031.13	709,544.05
2204.210	Wine in containers holding 2 litres or less	1,297,463.52	11,506,957.96	4,011,709.31	1,345,170.52	12,668,907.28	5,790,028.44
2204.220	Wine in containers holding more than 2L but not more than 10L*	...	...	...	3802.75	66626.86	17872.93
2204.290	Wine in containers greater than 2 litres	60,006.24	796,460.02	187,464.18	63,537.53	1,020,209.08	275,905.65
2204.300	Other Grape Must	610.49	10,679.97	1,921.15	2,824.15	53,163.63	13,259.83
2205.100	Vermouth in containers holding 2 litres or less	5,811.90	31,347.56	18,299.14	8,941.00	49,567.22	40,969.06
2205.900	Vermouth in containers holding greater than 2 litres	11.00	137.56	34.98	-	-	-
2206.000	Other Fermented Beverages	245,487.87	489,913.62	400,090.86	176,752.27	387,313.78	241,578.45
2207.100	Undenatured Ethyl Alcohol	425.08	1,844.91	10,678.96	476.48	1,321.57	12,297.21
2207.200	Denatured Ethyl Alcohol	803.02	1,446.40	435.15	420.84	1,089.19	260.98
2208.200	Brandy and Cognac	31,488.51	675,754.71	347,550.85	38,459.09	807,858.18	462,014.67
2208.300	Whiskies	102,560.73	1,531,887.36	1,138,431.08	111,044.38	1,659,199.02	1,265,380.99
2208.400	Rum and Other Spirits Distilled from Sugar Cane	246,684.16	1,382,654.32	2,389,303.25	247,805.12	1,438,239.86	2,535,339.20
2208.500	Gin and Geneva	25,089.55	242,052.09	284,912.50	27,100.50	258,985.58	330,003.89
2208.600	Vodka	177,926.60	1,339,065.28	1,845,448.82	163,108.09	1,312,552.78	1,864,119.38
2208.700	Liqueur & Cordials	79,060.78	654,515.87	506,726.56	58,863.57	647,273.34	466,251.65
2208.900	Other Spirituous Beverages	240,010.31	556,324.30	434,066.28	245,484.80	597,236.87	514,558.06
	<b>TOTAL</b>	<b>6,171,812.21</b>	<b>27,343,913.31</b>	<b>16,195,350.47</b>	<b>7,010,134.07</b>	<b>30,965,430.00</b>	<b>20,023,146.60</b>

Source: HM Customs

Notes: \* Category not available in 2016  
... data not available**Table 2.1.2**  
*Quantity and Value of Bonded\* Alcohol and Alcoholic Beverages Placed in Bonded Warehouses Upon Arrival, 2016 and 2017*

Tariff Code	Description	2016		2017	
		Litreage	Value (\$)	Litreage	Value (\$)
2203.000	Beer	-	-	-	-
2204.100	Sparkling Wine	93,592.49	1,449,761.19	115,017.43	2,111,956.80
2204.210	Wine in containers holding 2 litres or less	860,457.24	8,131,434.69	858,193.37	9,020,024.62
2204.220	Wine in containers holding more than 2 litres but not more than 10 litres	-	-	102.00	7,431.43
2204.290	Wine in containers greater than 2 litres	14,850.00	42,262.79	12,903.00	33,114.99
2204.300	Other Grape Must	-	-	-	-
2205.100	Vermouth in containers holding 2 litres or less	1,818.00	5,231.24	1,842.00	5,767.24
2205.900	Vermouth in containers holding greater than 2 litres	-	-	-	-
2206.000	Other Fermented Beverages	2,367.12	23,180.93	1,415.88	15,401.20
2207.100	Undenatured Ethyl Alcohol	-	-	5,824.00	6,328.00
2207.200	Denatured Ethyl Alcohol	-	-	-	-
2208.200	Brandy and Cognac	34,458.90	775,169.53	48,078.90	1,148,227.84
2208.300	Whiskies	73,143.30	1,176,514.39	92,865.00	1,525,863.48
2208.400	Rum and Other Spirits Distilled from Sugar Cane	1,427,527.00	3,417,593.74	1,568,246.70	3,760,085.15
2208.500	Gin and Geneva	18,125.25	165,163.74	24,655.50	244,919.17
2208.600	Vodka	110,701.80	970,075.58	125,169.60	1,109,118.34
2208.700	Liqueur & Cordials	40,348.50	393,328.87	42,028.95	439,690.80

**Table 2.1.2 cont'd**

*Quantity and Value of Bonded\* Alcohol and Alcoholic Beverages Placed in Bonded Warehouses Upon Arrival, 2016 and 2017*

Tariff Code	Description	2016		2017	
		Litreage	Value (\$)	Litreage	Value (\$)
2208.900	Other Spirituous Beverages	11,634.45	173,047.48	20,940.75	276,463.60
	<b>TOTAL</b>	<b>2,689,024.05</b>	<b>16,722,764.17</b>	<b>2,917,283.08</b>	<b>19,704,392.66</b>

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\*, 2016 and 2017*

Tariff Code	Description	2016			2017		
		Litreage	Value (\$)	Duty (\$)	Litreage	Value (\$)	Duty (\$)
2203.000	Beer	384.00	82.33	-	2,662.00	716.90	-
2204.100	Sparkling Wine	633.75	24,900.66	108.97	1,310.25	48,487.02	222.59
2204.210	Wine in containers holding 2 litres or less	2,179.50	10,530.22	39.42	2,193.00	12,513.74	8.30
2204.290	Wine in containers greater than 2 litres	-	-	-	-	-	-
2204.300	Other Grape Must	-	-	-	-	-	-
2205.100	Vermouth in containers holding 2 litres or less	-	-	-	5.00	51.29	-
2205.900	Vermouth in containers holding greater than 2 litres	-	-	-	-	-	-
2206.000	Other Fermented Beverages	-	-	-	-	-	-
2207.100	Undenatured Ethyl Alcohol	15.14	52.65	3.79	-	-	-
2207.200	Denatured Ethyl Alcohol	-	-	-	-	-	-
2208.200	Brandy and Cognac	5,874.05	199,949.50	1,468.71	7,348.97	255,319.82	1,836.19
2208.300	Whiskies	3,087.80	89,894.46	772.01	2,964.00	91,943.84	730.32
2208.400	Rum and Other Spirits Distilled from Sugar Cane	1,384,583.20	4,603,166.55	15,924.99	1,375,732.65	4,771,593.83	13,725.53
2208.500	Gin and Geneva	2,139.00	22,827.70	534.75	1,825.62	19,098.56	375.59
2208.600	Vodka	3,425.25	47,445.43	856.4	2,740.74	37,442.10	649.88
2208.700	Liqueur & Cordials	5,080.05	39,455.46	1,270.08	4,254.05	36,408.06	1,061.06
2208.900	Other Spirituous Beverages	10,397.75	58,516.33	2,599.55	8,113.50	51,144.87	2,028.46
	<b>TOTAL</b>	<b>1,417,799.49</b>	<b>5,096,821.29</b>	<b>23,578.67</b>	<b>1,409,149.78</b>	<b>5,324,720.03</b>	<b>20,637.92</b>

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), 2016 and 2017

Tariff Code	Description	2016			2017		
		Quantity	Value (\$)	Duty (\$)	Quantity	Value (\$)	Duty (\$)
2401.100	Tobacco, Not Stemmed/Stripped	18.63 kg	1097.61	5.4	-	-	-
2401.200	Tobacco, Partly or Wholly Stemmed/Stripped	2,354.00 kg	30,800.00	682.66	9,391.40 kg	153,216.60	18,325.15
2401.300	Tobacco Refuse*	...	...	...	4.00 kg	220.82	77.29
2402.100	Cigars, Cheroots, etc. Containing Tobacco	2,964.61 kg	327,077.60	91,290.25	4,518.68 kg	400,120.91	125,493.46
2402.200	Cigarettes Containing Tobacco	51,574.56 kg 36,073,460 u	2,759,459.24	8,961,576.20	41,812.63 kg 29,786,000.00 u	2,117,894.05	9,740,650.00
2402.900	Other Tobacco Products; or Products of Tobacco Substitutes	35.00 kg	1,860.70	623.33	10.00 kg	5,303.50	1,856.23
2403.110	Water Pipe Smoking Tobacco	4,661.65 kg	88,528.15	29,656.92	3,814.19 kg	130,558.46	44,449.10
2403.190	Other Smoking Tobacco	28.00 kg	165.73	55.52	13,047.84 kg	165,224.97	57,828.75
2403.910	"Homogenised" or "Reconstituted" Tobacco	-	-	-	-	-	-
2403.990	Tobacco Extracts and Essences; Other Manufactured Products of Tobacco	3,064.00 kg	64,586.40	21,636.44	20,435.00 kg	344,116.27	120,440.39
9803.163	Smoking Tobacco; Cigars, Cheroots and Cigarillos, Containing Tobacco (Imported by Post or Courier)	- 1,863 u	10,719.67	3,591.07	- 8,940.00 u	16,023.47	5,552.07
2401.100	Tobacco, Not Stemmed/Stripped*	...	...	...	29.00 kg	1,398.00	8.41
9803.171	Cigarettes Containing Tobacco	6.05 kg					
	<b>TOTAL</b>	<b>64,706.50 kg 36,079,723 u</b>	<b>3,285,674.50</b>	<b>9,110,185.79</b>	<b>93,072.49 kg 29,802,740.00 u</b>	<b>3,335,902.68</b>	<b>10,117,526.85</b>

Source: HM Customs

Note: \* Category not available in 2016

... data not available

**Table 2.1.5**  
Quantity and Value of Bonded\* Tobacco and Tobacco Products Placed in Bonded Warehouses Upon Arrival\*\*, 2016 and 2017

Tariff Code	Description	2016		2017	
		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	119.36 kg	50,326.77	325.44	129,457.56
2402.200	Cigarettes Containing Tobacco	4,410.77 kg	229,041.30	6,695.23	298,520.20
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)	-	-	-	-
2401.100	Tobacco, Not Stemmed / Stripped	-	-	-	-
	<b>TOTAL</b>	<b>4,530.13 kg</b>	<b>279,368.07</b>	<b>7,020.67</b>	<b>427,977.76</b>

Source: HM Customs

Notes: \* Goods placed into a bonded warehouse are in duty suspension and no duty is collected until such time that the goods are removed from the bonded warehouse.

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

**Table 2.1.6**  
Quantity and Value of Tobacco and Tobacco Products Exported from Bonded Warehouses\*, 2016 and 2017

Tariff Code	Description	2016		2017	
		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	2,607.99kg	167,559.65	2,121.87 kg	146,472.00
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)	-	-	-	-
2401.100	Tobacco, Not Stemmed / Stripped+				
	<b>TOTAL</b>	<b>2,607.99 kg</b>	<b>167,559.65</b>	<b>2,121.87 kg</b>	<b>146,472.00</b>

Source: HM Customs

Note:

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

## 2.2 LIQUOR LICENCES

### Licensing of Establishments for Sale of Intoxicating Liquor

According to the Liquor Licence Act of 1974, persons or businesses engaged in the sale of intoxicating liquor, whether retail or wholesale, must first be licensed. Otherwise, there may be legal actions in the form of imprisonment or fines instituted by the Liquor Licence Authority.<sup>7</sup> 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).<sup>8</sup> Data is not currently collected on the number of new licences issued. However, the trend over the years has mainly been the renewal of licences by existing establishments rather than new or existing establishments applying for first-time licence. Data on liquor licences granted by the Liquor Licence Authority (LLA) to the various establishments located across the Island provides a representation of the ease of availability of, and access to, alcohol by residents.

In both 2016 and 2017, most licences were issued to establishments in the Central district, followed by the Western and Eastern districts. There has been an increase of 7.6% in the number of licences issued to establishments between 2016 and 2017, moving from 288 to 310; the vast

majority consisted of renewed liquor licences. Applications for licences primarily consisted of persons or companies that already had licences for other businesses. Therefore, in most instances, the LLA was satisfied that applicants were fit to manage a licensed premise.

The Liquor Licence Authority has also issued occasional liquor licences, which increased by 16.9%, from 267 in 2016 to 312 in 2017. There was no change, over the two years under review, in the number of liquor licences issued for al fresco (outdoors) events. Overall, there has been a sharp increase, by 12.1%, in the total number of licences issued, that is, from 555 granted in 2016 to 622 in 2017.

Overall, there has been a sharp increase, by 12.1%, in the total number of liquor licences issued...

<sup>7</sup> Laws of Bermuda. Liquor Licence Act 1974. p. 5.

<sup>8</sup> Ibid. p. 9.

**Table 2.2.1**  
*Liquor Licences Issued by District and Type of Licence, 2016 and 2017*

Districts and Type of Licence	2016	2017
<b>CENTRAL</b>	<b>181</b>	<b>187</b>
Class 'A'	49	49
Class 'B'	4	4
Tour Boat	30	31
Nightclub	5	12
Restaurant	55	57
Hotel	10	9
Member's Club	24	21
Alfresco	3	3
Proprietary club licence	-	-
Permit for Association or Organisation*	1	1
<b>WESTERN</b>	<b>54</b>	<b>69</b>
Class 'A'	21	26
Class 'B'	1	2
Tour Boat	-	-
Nightclub	-	2
Restaurant	17	22
Hotel	4	4
Member's Club	8	8
Alfresco	3	4
Proprietary club licence	-	1
Permit for Association or Organisation*	-	-
<b>EASTERN</b>	<b>53</b>	<b>54</b>
Class 'A'	15	15
Class 'B'	-	1
Tour Boat	-	-
Nightclub	-	-
Restaurant	20	20
Hotel	5	6
Member's Club	8	8
Alfresco	4	3
Proprietary club licence	-	-
Permit for Association or Organisation	1	1
<b>Total Licences Issues to Establishments</b>	<b>288</b>	<b>310</b>
<b>Annual Percentage Change in Total Licences Issued to Establishments (%)</b>	<b>4.3</b>	<b>7.6</b>
<b>Total Occasional Liquor Licences Island-Wide</b>	<b>267</b>	<b>312</b>
<b>Annual Percentage Change in Total Occasional Liquor Licences Island-Wide (%)</b>	<b>-29.4</b>	<b>16.9</b>
<b>Total Licences Issued</b>	<b>555</b>	<b>622</b>
<b>Annual Percentage Change in Total Licences Issued (%)</b>	<b>-15.1</b>	<b>12.1</b>

Source: Liquor Licence Authority, Magistrate's Court

Notes:

- Eastern District consists of the parishes of St. George's, Hamilton Parish, and Smith's and including the Town of St. George
- 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.
- Western District consists of the parishes of Warwick, Southampton, and Sandy's.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- A holder of one class of licence is not precluded from obtaining concurrently a different class of licence in respect of the same premises.

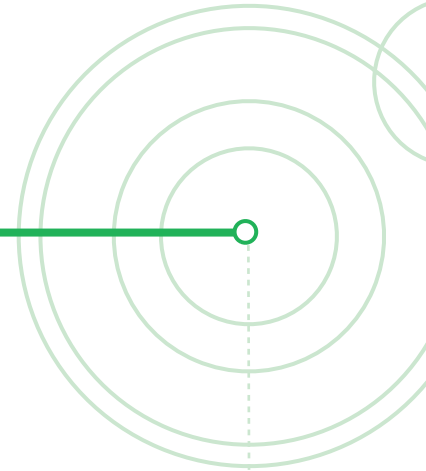


# Chapter 3

## 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 2017, there was a major drop, by 50%, in the number of TIPS training sessions from the previous year (down from 32 to 16), thereby decreasing the number of participants from 467 in 2016 to 427 in 2017. As such, the number of participating establishments in 2017 declined significantly by 57.6% from 2016 (see Table 3.1.1). During 2017, participants (managers, owners, and supervisors) were from 75 licenced establishments (an establishment could have been represented by different participants over the year and, hence, the number of establishments is not unique) compared to 177 licenced establishments in the previous year; averaging 15 participants per session in 2016 and 27 in 2017. In terms of training outcome, fewer persons (399) passed the TIPS training in 2017 than in 2016 (437) and there were also less failures (28) in the most recent year when compared to the previous year (30).

**Table 3.1.1**  
*Training for Intervention ProcedureS (TIPS) Programme Statistics, 2016 and 2017*

Year/Quarter	Number of TIPS Sessions	Number of Participants	Average Number of Participants Per Session	Outcome		Number of Participated Establishments
				Passed	Failed	
<b>2016</b>	<b>32</b>	<b>467</b>	<b>60</b>	<b>437</b>	<b>30</b>	<b>177</b>
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
<b>2017</b>	<b>16</b>	<b>427</b>	<b>108</b>	<b>399</b>	<b>28</b>	<b>75</b>
Q1	4	162	41	148	14	20
Q2	4	135	34	127	8	22
Q3	4	58	15	55	3	18
Q4	4	72	18	69	3	15

Source: CADA



# Chapter 4

## Substance Abuse Treatment and Counselling

---

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



## 4.1 BARC STATISTICS

### Treatment Assessment and Referral

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

The number of persons who accessed services at BARC has increased over the last two years. In 2017, BARC saw 310 clients as compared to 220 in the previous year (see Tables 4.1.1 and 4.1.2). Over the two-year period, the number of new clients accessing services at BARC (assessments and referrals of persons seeking treatment for the first time) increased by 20.2%, from 84 cases in 2016 to 101 cases in 2017 (see Table 4.1.1). At the same time, the number of existing or repeat cases (assessments and referrals of clients who previously accessed services at BARC) increased by 53.7%, from 136 in 2016 to 209 in 2017 (see Table 4.1.2). However, in both years, repeat clients accounted for the greater proportion of all referrals. For instance, 209 (67.4%) of the 310 referrals in 2017 were cases of existing clients as compared to 101 (32.6%) new clients.

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

Most of the persons being referred considered themselves Black (56.1% or 174 in 2017). Blacks were also more likely to be seeking assessment for yet another year 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 (21.3%), persons newly referred to BARC were more likely to be within this age group or younger, that is 17 to 45 years. On the other

hand, repeat clients tended to be in this age group or older, that is, 46 to 76+ years for the current year under review (see Tables 4.1.1 and 4.1.2).

Opiates, alcohol, heroin, cocaine, and cannabis remained the primary drugs of choice for which persons sought 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 2016 and 2017, as compared to existing clients, who primarily sought treatment for cocaine and alcohol in 2017 (opiates and alcohol in 2016). Nonetheless, there was a significant increase in the number of new and existing clients who sought treatment for cannabis and alcohol in 2017.

Most of both the new and existing referrals tended to consume one drug or two drugs. There were also instances where persons reported the use of three or more drugs; where reports of more than two drugs in use were likely to be seen among repeat clients (see Tables 4.1.1 and 4.1.2). When it came to clinical diagnosis, most of the clients assessed in 2017 had a clinical diagnosis of “severe” followed by the category “moderate” (see Table 4.5.1).

A greater number of referrals to BARC was made through the Magistrate’s Court, directly by the persons who sought treatment (self-referral), Turning Point, or via the Department of Court Services. Most of the new referrals came from self-referrals (27), whereas Court Services referred the majority (18) of existing clients. The pattern of the 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, followed by residential care.

The Drug Abuse Screening Test (DAST) scores showed that of all clients to whom the assessment was administered in both 2016 and 2017, 56 or 34.8% and 67 or 43.8%, respectively, were classified as having substantial to severe substance abuse dependence (see Tables 4.1.5 and 4.1.7). Similarly, the Alcohol Dependence Scale (ADS) scores indicate that of all clients to whom this test was administered, 11.6% (18) in 2016 and 22.9% (30) in 2017 were classified as having substantial to severe alcohol dependence (see Tables 4.1.6 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.

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

**Table 4.1.1**  
*Bermuda Assessment and Referral Centre Programme Statistics for New Referrals, 2016 and 2017*

	2016	2017
<b>Total New Referrals:</b>	<b>84</b>	<b>101</b>
<b>Annual Percentage Change</b>	<b>-13.4</b>	<b>20.2</b>
<b>Sex:</b>		
Males	69	81
Females	15	19
<b>Age (Years):</b>		
16 & Under	-	1
17-30	24	20
31-45	33	27
46-60	14	17
61-75	11	7
76+	-	-
Not stated	2	8
<b>Total</b>	<b>84</b>	<b>80</b>
<b>Race:</b>		
Black	47	51
White	17	18
Portuguese	1	2
Mixed	1	3
Other	-	-
Not Stated	18	29
<b>Total</b>	<b>84</b>	<b>103</b>
<b>Drug of Choice (Dependence Or Abuse): Type</b>		
Cannabis	12	23
Alcohol	28	31
Cocaine	4	6
Opiates	6	9
Other	-	1
None	2	4
Not Available	20	-
Deferred	12	11
<b>Drug of Choice (Dependence Or Abuse): Combination</b>		
One Drug	42	54
Two Drugs	19	25
Three Drugs	1	8
More than three drugs	-	5
Not Stated	-	47
Not Available	22	54
<b>Total</b>	<b>84</b>	<b>193</b>

Source: Bermuda Assessment and Referral Centre





Table 4.1.1 cont'd

Bermuda Assessment and Referral Centre Programme Statistics for New Referrals, 2016 and 2017

	2016	2017
<b>Level of Care:</b>		
Level I – Outpatient	13	10
Level II – IOP	26	28
Level III & IV – Residential (Medically Monitored/Managed Intensive Inpatient Treatment)	10	8
None	5	7
Not stated/No Show	-	41
Not Available*	21	7
Deferred*	7	-
Other	2	-
<b>Total</b>	<b>84</b>	<b>101</b>
<b>Referred From:</b>		
Magistrate's Court	19	26
Self-Referral	12	27
Court Services (including DTC, Probation Team, Parole Officer)	8	1
Turning Point	10	12
Family Services	-	7
EAP	12	5
Parole Board	-	3
Other/Other Community	2	4
Private Practice	-	-
Supreme Court	1	1
Corrections	-	4
MWI	1	4
Financial Assistance	-	1
Focus	-	1
Family Court	-	1
Not Stated	19	1
<b>Referred To:</b>		
Turning Point	34	25
Court Services	4	-
EAP	2	2
Men's Treatment	6	1
Other	1	3
Harbour Light	1	1
WTC	2	-
None	3	56
Refused Care Level	-	9
Not Stated/No Show	27	3
Pathways Bermuda	1	-
Deferred	3	-

Source: Bermuda Assessment and Referral Centre

**Table 4.1.2**  
*Bermuda Assessment and Referral Centre Programme Statistics for Existing Referrals, 2016 and 2017*

	2016	2017
<b>Total Existing Referrals:</b>	<b>136</b>	<b>209</b>
<b>Annual Percentage Change</b>	<b>23.6</b>	<b>53.7</b>
<b>Sex:</b>		
Males	113	174
Females	23	35
<b>Age (Years):</b>		
16 & Under	1	-
17-30	19	18
31-45	40	39
46-60	68	50
61-75	8	6
76+	-	2
Not Stated	-	3
<b>Total</b>	<b>136</b>	<b>118</b>
<b>Race:</b>		
Black	104	123
White	6	9
Portuguese	-	1
Mixed	3	2
Not Stated	23	76
Not Available	23	76
<b>Total</b>	<b>159</b>	<b>287</b>
<b>Drug of Choice (Dependence Or Abuse): Type</b>		
Cannabis	9	57
Opiates	51	63
Cocaine	21	71
Alcohol	26	64
Other	-	5
None	1	10
Not Stated/No Show	25	-
Deferred*	3	24
<b>Drug of Choice (Dependence Or Abuse): Combination</b>		
One Drug	45	152
Two Drugs	33	98
Three Drugs	33	47
More than three drugs*	1	5
Not Stated	24	43
<b>Total*</b>	<b>136</b>	<b>345</b>
<b>Level of Care:</b>		
Level I – Outpatient	17	15
Level II – IOP	15	46
Level III & IV – Residential (Medically Monitored/Managed Intensive Inpatient Treatment)	17	45
None	1	3
Not Stated/ No Show	1	26
Not Available*	54	30
Other*	3	200
<b>Total</b>	<b>153</b>	<b>445</b>

**Table 4.1.2 cont'd**

*Bermuda Assessment and Referral Centre Programme Statistics for Existing Referrals, 2016 and 2017*

	2016	2017
<b>Referred From:</b>		
Corrections	2	15
Court Services (including DTC, Probation Team, Parole Officer)	12	18
EAP	2	6
Family Court	3	2
Family Services	4	4
Financial Assistance	2	5
Focus	2	2
Harbour Light	-	1
Magistrate's Court	23	43
MWI	3	1
Not Stated/No Show	31	5
Other/Other Community	-	2
Parole Board*	-	6
Self-Referral	30	66
Supreme Court	3	7
Turning Point	19	35
<b>Total</b>	<b>136</b>	<b>218</b>
<b>Referred To:</b>		
Court Services	5	-
Deferred	1	-
Harbour Light	1	14
Men's Treatment	18	18
None	3	24
Not Available*	41	11
Not Stated/ No Show	1	2
Other	-	71
Residential (including RLH)	14	32
Turning Point	43	79
WTC	9	5
<b>Total</b>	<b>136</b>	<b>256</b>

Source: Bermuda Assessment and Referral Centre

**Table 4.1.3**

*Clinical Diagnosis (Abuse or Dependence) of New and Existing Clients' Drug Use by Drug(s) of Choice, 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	-	-	-	-
<b>TOTAL</b>	<b>43</b>	<b>82</b>	<b>26</b>	<b>119</b>	<b>-</b>	<b>1</b>

Source: Bermuda Assessment and Referral Centre

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

**Table 4.1.4**  
Clinical Diagnosis (Abuse or Dependence) of New and Existing Clients' Drug Use by Drug(s) of Choice, 2017

Drug of Choice	Mild		Moderate		Severe	
	New Clients	Existing Clients	New Clients	Existing Clients	New Clients	Existing Clients
Alcohol	3	11	12	14	16	39
Cannabis	13	21	6	14	4	22
Cocaine	-	10	1	22	5	39
Heroin	-	1	1	2	8	60
Methadone	-	-	-	-	-	-
Other	1	1	-	2	-	2
<b>TOTAL</b>	<b>17</b>	<b>44</b>	<b>20</b>	<b>54</b>	<b>33</b>	<b>162</b>

Source: Bermuda Assessment and Referral Centre

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

**Table 4.1.5**  
DAST Results (Number of Clients by Level of Severity of Drug Abuse) of New Clients from the Bermuda Assessment and Referral Centre Programme, 2016 and 2017

Substance Abuse or Dependence	Level of Severity (DAST Score)	Number of Clients	
		2016	2017
	None (0)	10	1
	Low (1-5)	30	12
	Intermediate (6-10)	17	7
	Substantial (11-15)	2	1
	Severe (16-20)	1	-

Source: Bermuda Assessment and Referral Centre

Note: The DAST scores were not available for 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, 2016 and 2017

Substance Abuse or Dependence	Level of Severity (ADS Score)	Number of Clients	
		2016	2017
	None (0)	18	3
	Low (1-13)	30	11
	Intermediate (14-21)	7	4
	Substantial (22-30)	3	6
	Severe (31-47)	2	2

Source: Bermuda Assessment and Referral Centre

Note: The ADS scores were not available to 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, 2016 and 2017

Substance Abuse or Dependence	Level of Severity (DAST Score)	Number of Clients	
		2016	2017
	None (0)	10	-
	Low (1-5)	16	30
	Intermediate (6-10)	22	36
	Substantial (11-15)	35	40
	Severe (16-20)	18	26

Source: Bermuda Assessment and Referral Centre

Note: The DAST was not available to 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, 2016 and 2017*

	Level of Severity (ADS Score)	Number of Clients	
		2016	2017
Substance Abuse or Dependence	None (0)	28	15
	Low (1-13)	42	51
	Intermediate (14-21)	12	17
	Substantial (22-30)	11	14
	Severe (31-47)	2	8

Source: Bermuda Assessment and Referral Centre

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

## 4.2 COUNSELLING AND LIFE SKILLS SERVICES STATISTICS

### Youth Counselling

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

In comparing 2016 to 2017, there has been an increase in the number of referrals, from 71 to 94, and an increase in the number of assessments conducted, from 87 to 98, respectively (see Table 4.2.1). CLSS has seen 60 clients in 2017, 10 more clients than in 2016. Clients are usually referred for either behavioural or substance use reasons. Of the 94 referrals in 2017, substance screenings or assessments were completed for 49 people; 26 were referrals of males and 23 were of females.

CLSS also offers substance education groups that are short-termed, ranging from eight to 10 sessions, which uses evidence-based curriculums tailored to the needs of its clients. There were three substance groups facilitated during the 2017 year as compared to none in 2016.

At the same time, there has been a significant decline in the number of family conferences, moving from 16 in 2016 to none in 2017. CLSS facilitated two groups based on clients’ needs and referral trends. There was a four-session Active Parenting of Teens group, which provided the guidance

and support parents need to turn the challenges of raising a teenager into opportunities for growth. The curriculum also covers pressures, such as social media, bullying, and substances, geared at increasing parents’ awareness. The other, which was a six-session Cooperating Parenting and Divorce group, provided divorced or separated parents education about dealing with conflict and shifting their focus onto their child while building a positive co-parenting alliance. There were eight in 2016 and 16 in 2017.



**Table 4.2.1**  
*Counselling and Life Skills Services Statistics, 2016 and 2017*

Year	2016	2017
Number of Referrals	71	94
Number of Clients Seen	50	60
Number of Readmissions	-	11
Number of Assessments	87	98
Number of Family Conferences	16	-
Number of Discharges	27	88
Number of Group Participants	8	16

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

## 4.3 DRUG TREATMENT COURT STATISTICS

### Drug Treatment Court

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

The last year saw a decline in the number of new referrals to the programme, decreasing the number of cases being referred in 2017 to 38 from 44 in 2016 (see Table 4.3.1). I. Referrals are the number of persons that were sent to the programme for consideration, whereas, admissions are the number of persons accepted into the programme. Some persons are referred by another Magistrate or a Justice, but may be found ineligible or unsuitable for the programme, so they are not admitted.

It should be noted that as of 2014, the DTC programme was revised to make the completion of Phase V (a year-long programme consisting of monitoring and support) mandatory for all participants (prior to 2014, finishing

Phase IV was deemed as a programme completion and remaining in Phase V was voluntary). As such, since the DTC programme's inception in 2001, there has now been 37 programme completions with two people completing (Phase V) in 2017.

The DTC programme has not been able to retain all of its clients and see them through completion. In 2017, 16 persons did not complete the programme, two were referred to the Mental Health Treatment Court; 11 were incarcerated; one was sentenced to probation as the client's termination due to safety concerns following a high risk incident; two were remanded in custody and sentenced to time served; two persons observed for other reasons: one was required to observe three sessions as a result of another sentence and opted to continue to observe; and the other was reported to the DTC to provide the Court with status reports on the client's treatment progress after receiving fines. That individual was given a grace period on payment of fines for the duration of time in treatment. At the same time, there was a corresponding increase in the number of person who completed Phase IV of the programme in 2017 (four) than in 2016 (zero). Persons may apply to the programme multiple times. In 2017, one previous participant was allowed to re-enter the programme.

**Table 4.3.1**  
*Drug Treatment Court (DTC) Statistics, 2016 and 2017*

	2016	2017
New referrals	38	44
Programme admissions	13	6
Successful completion Phase IV	-	4
Successful completion Phase V	3	2

Source: Drug Treatment Court



## 4.4 MEN'S TREATMENT STATISTICS

### Drug Abuse among Men in Treatment

Men who were screened included all men who were admitted for services in addition to those who were still receiving treatment in the years under review. A total of five and 15 men were screened for drugs in 2016 and 2017, respectively. Drug screening is done randomly, on suspicion of drug use, for clients going on outings or requiring day passes, for work detail, and for Drug and Mental Health Treatment Court programmes.

Men's Treatment (MT) collected a total of 114 urine samples from its clients to test for drug use during 2017; decreasing significantly from the 493 recorded in the previous year (see Table 4.4.1). This corresponds to 1,368 drug screens in 2017, significantly down from 5,904 drug screens in 2016 (each test consists of 12 substances). Nonetheless, 0.1% in both

2016 and 2017 yielded positive results. The positive results observed in 2017 were for benzodiazepine, methadone, heroin, and THC. In 2017, cocaine, heroin and alcohol were the primary drugs used by men prior to treatment (see Table 4.4.2). None of the clients identified marijuana, in either year, to be their primary drug of choice prior to entering treatment.

As seen in 2016, poly drug use was prevalent in both years with drugs in highest combination in 2017 being heroin with alcohol and crack. Other two- and three-drug combinations included alcohol, 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, 2016 and 2017*

	2016	2017
Total Samples	493	114
Total Screens	5,904	1,368
<b>Number of Positive Screens</b>		
Benzodiazepine	2	2
Methadone	-	1
Opiates (Heroin)	1	1
THC	2	5
<b>Total</b>	<b>5</b>	<b>9</b>
<b>% POSITIVE SCREENS</b>	<b>0.1</b>	<b>0.1</b>

Source: Men's Treatment

**Table 4.4.2**  
*Primary Drug Used by Men Prior to Treatment, 2016 and 2017*

Drug	Number of Men	
	2016	2017
Alcohol	2	2
Crack	3	1
Heroin	4	4
Marijuana	-	-
Cocaine	-	7
Methadone	-	1
<b>TOTAL CLIENTS</b>	<b>9</b>	<b>15</b>

Source: Men's Treatment

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

**Table 4.4.3**  
Number of Cases of Poly-Drug Use among Clients at Men's Treatment, 2016 and 2017

Combinations	Number of Clients	
	2016	2017
Three-Drug Combination:		
Heroin, Crack, THC	1	2
Alcohol, Heroin, THC	-	1
Alcohol, Crack, THC	-	1
Alcohol, Heroine, Crack	3	3
Two-Drug Combination:		
Alcohol, THC	1	1
Alcohol, Cocaine	2	2
Alcohol, Crack	-	-
Crack, THC	-	-
Heroin, Crack	-	-
Heroin, Cocaine	-	1
Heroin, Alcohol	1	3
Heroin, THC	1	1
<b>TOTAL</b>	<b>9</b>	<b>8</b>

Source: Men's Treatment

## 4.5 WOMEN'S TREATMENT CENTRE STATISTICS

### Drug Abuse among Women in Treatment

Women who were randomly screened encompass: women referred for services but not admitted, women who entered WTC for treatment, women in transitional care, and those in after-care. The total number of random urine screens conducted by the WTC, which test for alcohol and illicit drug use, decreased from 1,212 in 2016 to 528 in 2017 (see Table 4.5.1). The number of positive screens accounted for 2.5% (13) in 2017, similar to the previous year (2.4% or 29). Of all the substances screened, cocaine was the drug most

often found during urinalysis in 2017 as compared to THC in 2016.

At the same time, alcohol, cocaine, and heroin were the primary drugs used by most of the women prior to treatment in 2017 versus cocaine in the prior year (see Table 4.5.2). Poly drug use was evident in both years with drugs in highest combination being alcohol and crack followed by heroin and crack (see Table 4.5.3). Other two- and three-drug combinations included alcohol and cocaine, and heroin, crack, THC among others (see Table 4.4.3).

**Table 4.5.1**  
Drug Screening Results among Women in Treatment, 2016 and 2017

	2016	2017
Total Samples	101	88
Total Screens	1,212	528
<b>Number of Positive Screens</b>		
Benzodiazepine	4	-
Buprenorphine	1	-
Cocaine	3	6
Methadone	1	-
Opiates	7	3
Oxycontin	1	-
THC	12	4
<b>Total</b>	<b>29</b>	<b>13</b>
<b>% POSITIVE SCREENS</b>	<b>2.4</b>	<b>2.5</b>





**Table 4.5.2**  
Primary Drug Used by Women Prior to Treatment, 2016 and 2017

Drug	Number of Women	
	2016	2017
Alcohol	4	3
Benzodiazepine	2	-
Buprenorphine	1	-
Cocaine	5	5
Heroin	3	3
Marijuana	4	-
Methadone	1	-
Oxycontin	1	-
Ecstasy	1	-
<b>TOTAL CLIENTS</b>	<b>22</b>	<b>11</b>

Source: Women's Treatment Centre

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

**Table 4.5.3**  
Number of Cases of Poly-Drug Use among Clients at Women's Treatment Centre, 2016 and 2017

Combinations	Number of Clients	
	2016	2017
Three-Drug Combination:		
Heroin, Crack, THC	1	1
Alcohol, Crack, THC	1	-
Crack, THC, Ecstasy	1	1
Crack, THC, ETOH	1	-
Two-Drug Combination:		
Alcohol, Crack	-	3
Alcohol, Cocaine	-	1
Heroin, Crack	1	2
Heroin, Alcohol	1	-
<b>TOTAL</b>	<b>6</b>	<b>6</b>

Source: Women's Treatment

## 4.6 TURNING POINT SUBSTANCE ABUSE PROGRAMME STATISTICS

### Drug Abuse among Turning Point Clients

Turning Point Substance Abuse Treatment Programme received a total of 6,169 specimens in 2017, a decrease from the 6,948 specimens in 2016 (see Table 4.6.1). Of the total specimens provided in 2017, 47.3% (2,756) tested positive for illicit drugs compared to 42.4% (2,730) in 2016. The number of positive specimens excludes those specimens that were tested positive for prescribed medications such as opiates, benzodiazepines, and methadone. In both years, male clients provided the larger number of tested specimens (5,663 in 2016 and 5,014 in 2017) as compared to females (780 in 2016 and 816 in 2017); although in 2017, there was an increase in the number of specimens provided by females. The majority of positive specimens tested positive for only

one drug (64.6% in 2016 and 55.4% in 2017) 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) (56.8% in 2016 and 74.5% in 2017), cocaine (45.6% in 2016 and 47.1% in 2017), and THC (marijuana) (23.9% in 2016 and 26.7% in 2017)) (see Table 4.6.3). Noticeably in 2017, positive screens for all drugs increased with the exception of benzodiazepines, which saw a decline over the previous year.

Over the two-year period under review, the total number of methadone clients decreased from an average of 117 in 2016 to 94 in 2017 (see Table 4.6.4). Similarly, inpatient

detoxes also decreased from 113 in 2016 to 88 in 2017; while, at the same time, outpatient detoxes remained at zero for both 2016 and 2017.

**Table 4.6.1**  
Proportion of Positive Drug Screens and Poly Drug Use by Turning Point Clients, 2016 and 2017

		2016	2017
<b>Total Specimens Requested</b>		<b>6,948</b>	<b>6,169</b>
	from Females	832	849
	from Males	6,116	5,320
<b>Total Specimens Provided</b>		<b>6,443</b>	<b>5,830</b>
	by Females	780	816
	by Males	5,663	5,014
<b>Total Positive Specimens for Illicit Drugs*</b>		<b>2,730</b>	<b>2,756</b>
<b>% Positive Specimens Of Total Specimens Provided</b>		<b>42.4</b>	<b>47.3</b>
<b>Positive Specimens for Drugs*</b>			
	for One Drug	1,764	1,528
<b>Poly Drug Use</b>	for Two Drugs	785	966
	for Three Drugs	141	292
	for More than Three Drugs	40	53

Source: Turning Point Substance Abuse Programme

Notes: \* Exclude positive urine results with substances such as opiates, benzodiazepines, methadone, creatinine, suboxone, due to prescribed medication.

\* Includes alcohol and medically prescribed drugs.

Only specimens for active patients are counted (pre-admission tests and tests that are unable to be obtained are ignored).

**Table 4.6.2**  
Positive Screens as a Proportion of Total Specimens Provided by Year and Type of Drug Detected at Turning Point, 2016 and 2017

Drug	2016	2017
Methadone	6,387 (99.1%)	5,764 (98.9%)
Opiates	1,550 (24.1%)	1,971 (33.8%)
Cocaine	1,246 (19.3%)	1,299 (22.3%)
Marijuana	652 (10.1%)	735 (23.6%)
Benzodiazepines	143 (2.2%)	135 (2.3%)
Alcohol	69 (1.1%)	76 (1.3%)
OxyContin	13 (0.2%)	22 (0.4%)
Other	135 (2.1%)	158 (2.7%)

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, 2016 and 2017

Drug	2016	2017
Opiates	1,550 (56.8%)	1,971 (71.5%)
Cocaine	1,246 (45.6%)	1,299 (47.1%)
Marijuana	652 (23.9%)	735 (26.7%)
Benzodiazepines	143 (5.2%)	135 (4.9%)
Alcohol	69 (2.5%)	76 (2.8%)
OxyContin	13 (0.5%)	22 (0.8%)
Other	135 (4.9%)	158 (5.7%)

Source: Turning Point Substance Abuse Programme



**Table 4.6.4**  
**Number of Methadone Clients, Inpatient, and Outpatient Detoxifications at Turning Point, 2016 and 2017**

Year	Methadone Clients*	Inpatient Detoxes	Outpatient Detoxes
2016	117	113	-
2017	94	88	-

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 2016 and 2017, the RLH had a maximum of 13 and 12 residents in care, respectively; however, in 2017, the average number of residents over the 12 months increased to 11 when compared to 10 in 2016 (see Tables 4.7.1 and 4.7.2). There was on average two persons who were placed on the waiting list for admissions in 2017 versus three persons in 2016. Persons from the wait list did not get into the residential programme immediately, although it was not full to capacity. This is mainly because some of these waitlisted persons would have had to first complete any outstanding requirement at the Westgate Correctional Facility, for example, a class such as anger management or the GED programme, before acceptance in the RLH residential treatment programme. Aftercare, a programme component, saw on average four clients in 2016 and one in 2017. 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, 180 screens were conducted in 2016 in comparison to 264 in 2017, with one positive substance abuse test result recorded in 2017 and none the previous year.

**Table 4.7.1**  
**Right Living House Programme Statistics, 2016**

Programme Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Number of Residents	8	10	12	11	13	13	10	10	9	9	9	9	10*
Total Programme Admissions	2	2	-	4	-	-	-	-	-	-	-	2	10
Number of Discharges	-	-	1	2	-	3	-	1	-	-	9	2	18
Number of Substance Abuse Tests													
Random Tests	10	8	14	15	19	13	9	19	12	7	7	11	144
Tests for Outings & Day Passes	3	2	-	5	5	2	3	-	1	3	3	2	29
Work Detail	-	-	-	-	-	-	-	-	-	-	-	-	-
Suspicious Tests	-	-	-	-	6	-	-	-	-	-	-	1	7
<b>Total</b>	<b>13</b>	<b>10</b>	<b>14</b>	<b>20</b>	<b>30</b>	<b>15</b>	<b>12</b>	<b>19</b>	<b>13</b>	<b>10</b>	<b>10</b>	<b>14</b>	<b>180</b>
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

**Table 4.7.2**  
Right Living House Programme Statistics, 2017

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

Source: Right Living House

Note: \*Average

## 4.8 SALVATION ARMY TREATMENT PROGRAMMES

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

Over the last two financial years (April to March), the Harbour Light programme was operating at capacity, during all of the quarters, ranging from eight to 13 (see Table 4.8.1). During 2017, one to five clients, on average, were admitted in each quarter while, at the same time, at most two clients completed the programme; but there were quarter(s) where there was one programme completion. 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 for its clients with a holistic approach.

Table 4.8.2 shows the performance of this programme over the last two fiscal years. During this time, the number of clients who participated in the programme ranged from a 20 clients in the fourth quarter of FY 2017/2018 to as many as 35 clients in the first quarter of that same year. As many as six referrals were made in FY 2016/2017 in Q4 as compared to none in Q3 of 2017/2018. During the past two years, eight life skills group sessions were conducted. Important to note for FY 2016/2017 Q4 is the cut in grant funding. However, a greater number of clients did receive crisis intervention, more so in FY 2017/2018 than in FY 2016/2017; while more families received relapse prevention education in 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 2017, three to 10 clients successfully reintegrated. At the same time, one to eight clients were in stable committed relationships for the two years under review. Another success measure of the programme is that of financial stability. A number of clients have either opened or reactivated bank accounts, have secured savings in a bank, and made regular payments towards outstanding bills. Most importantly of all, is the number of clients who abstained from substance abuse. The data shows that a significant number of clients did, in fact, abstain from drug use, averaging over 23 clients in any given quarter over the last two years under review.

**Table 4.8.1**

Salvation Army Harbour Light Residential Treatment Programme Performance, 2016/2017 and 2017/2018

Programme Indicators	FY 2016/2017				FY 2017/2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Intakes/Screenings/Assessments	11	6	3	3	5	5	3	7
Enrollment	4	3	2	1	2	3	1	2
Completions	1	1	-	-	1	2	2	1
Total Clients	13	10	11	11	11	13	7	8
Random Drug Tests	2	2	1	2	2	2	1	1
Positive Drug Tests	-	-	-	-	-	-	-	-
Departures	-	-	-	-	-	-	-	-
NA/AA Meetings (Mandatory)	36	36	36	36	36	36	36	36
Community Outreach: Volunteer Days	5	4	5	4	4	8	9	4
Community Outreach: Number of Client's Volunteering	6	5	11	5	11	13	7	8
Community Outreach: Other Activities	3	4	5	5	1	1	2	1

Source: Salvation Army

**Table 4.8.2**

Salvation Army Community Life Skills Recovery Programme Performance, 2016/2017 and 2017/2018

Programme Indicators	FY 2016/2017				FY 2017/2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total number of clients who participated in the programme	32	26	27	24	35	27	27	20
Number of new clients referred	2	2	1	6	4	3	-	2
New Care Plans	2	1	1	5	3	3	2	1
Care Plans reviewed	1	1	3	5	3	3	2	2
Number of intakes/screenings/ assessments	2	1	1	9	4	3	-	1
Number of evening groups	1	1	6	13	13	12	11	11
Life Skills training groups	-	-	1	2	2	2	1	-
Referrals for outside services	8	8	8	1	5	5	5	6
Case management sessions	10	10	10	13	12	12	10	12
Clients who received crisis intervention	16	15	7	5	15	17	15	10
Families who received relapse prevention	2	6	4	1	9	9	7	2
Clients who reintegrated with families, employment, education, community	9	7	3	3	9	10	9	3
Clients who were in stable committed relationships	8	6	6	1	8	6	6	4
Clients who obtained financial stability (financial planning and banking)	19	12	11	9	13	14	14	10
Clients who opened and reactivated bank accounts	-	-	1	1	0	4	4	2
Clients with secured savings in bank accounts	18	12	12	4	13	11	11	8
Clients who made regular payments towards outstanding bills	5	3	6	11	2	3	3	3
Clients who abstained from substance abuse	31	25	25	23	31	22	22	19

Source: Salvation Army

## 4.9 FOCUS COUNSELLING SERVICES SUPPORTIVE RESIDENCY PROGRAMME

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

Table 4.9.1 shows the performance of the programme over the last two fiscal years. During 2017, the programme operated two houses with a 14-bed capacity. There were about 11 to 14 clients who were accommodated by this programme, in any given quarter. There were, at most, 13 after-care sessions (with one exception) in both FY 2016/17 and FY 2017/2018. Each of these aftercare sessions provided

services to between 11 and 13 clients. Random drug tests of clients show a few positive results, especially for THC, opiates and alcohol.

**Table 4.9.1**

*Focus Counselling Services Supportive Residence Programme Performance, 2016/2017 and 2017/2018*

Programme Indicators	FY 2016/2017				FY 2017/2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Houses	2	2	2	2	2	2	2	2
Number of Beds	22	22	22	22	14	14	14	14
Average Number of Clients/ Occupancy	19	19	18	18	14	12	13	11
Number of Drug Tests	26	24	28	18	25	31	28	30
THC	4	1	3	3	3	2	2	1
Opiates	-	1	-	2	2	1	1	2
Cocaine	1	-	2	1	2	1	-	2
Alcohol	3	2	4	3	1	1	2	1
Number of After-Care Sessions	13	13	13	13	13	14	13	13
Average Number of Participants in Aftercare	16	12	15	17	13	11	12	13
House meetings	26	26	15	16	13	13	12	13
Number of residents employed*	1	1	2	3	2	2	2	2
Number of Drug Court clients*	1	1	1	1	3	3	3	3
Number of Probation/Parole clients*	3	3	3	2	2	3	3	3

Source: Focus Counselling Services

## 4.10 CLIENTS IN TREATMENT

Tables 4.10.1 and 4.10.2 show the number of ‘unique’ individuals admitted to treatment during 2016 and 2017 and the numbers of different persons who received treatment during that year, respectively. This is the fourth year these indicators are being monitored and there is now a four-year series of available data on treatment admissions and persons receiving substance abuse treatment services. They provide an indication of access to and availability of treatment services in Bermuda for persons with substance abuse and dependence problems. Further, they can serve as an indication as to whether or not persons assessed and referred by BARC are actually engaged in the recommended level of care. These numbers do not include any person who sought treatment or were in treatment more than once in the given year. It should be noted, however, that there were in fact a few repeat clients who received treatment services.

Clients received publicly- or grant-funded services from any one of the seven programmes listed on the tables below. This list of facilities/programmes has remained unchanged for the past several years with no new service provider added. These programmes offered three major types of care: outpatient, including the opioid treatment programme,

inpatient, or residential (including in-prison) non-hospital services to residents of Bermuda. Persons usually receive treatment for three broad categories of substance abuse problems: both alcohol and drug abuse, drug abuse only, or alcohol abuse only. However, there are clients known to have co-occurring disorders; but data using this level of disaggregation is currently not collated, though available.

The 2017 number of new treatment admissions and persons in treatment saw a decline from the previous year where there were 152 new treatment admissions and 315 persons in treatment (see Tables 4.10.1 and 4.10.2). Specifically, the number of new clients admitted to treatment in 2017 was 82 (68 men and 14 women) and number of persons who were in treatment, which includes any person(s) still in treatment from a previous year, together with the newly admitted persons, totaled to 309 (263 men and 46 women). As is quite noticeable, the number of males in treatment far outweigh their female counterparts. This does not mean that there were no females who needed treatment; it may simply mean that fewer women are accessing the treatment services provided for any number of reasons. It is, however, known that women face certain distinctive barriers to treatment than do men. At the same time, treatment facilities also conduct intake and assessment of other persons seeking services but who may not meet the

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

criteria for admission into a programme and those who do meet the criteria, but cannot be accommodated because of the facility's capacity, are placed on a waiting list. These numbers are not accounted for on the tables below. In terms of capacity and utilisation of the treatment services,

the majority was seen by the Turning Point Substance Abuse Programme for mainly inpatient detoxification or methadone maintenance. Approximately two out of every four persons who were in treatment received residential care in 2017.

**Table 4.10.1**  
Number of New Treatment Admissions, 2016 and 2017

Treatment Agency	2016			2017		
	Male	Female	Total	Male	Female	Total
WTC	..	8	8	-	3	3
MT	9	..	9	10	-	10
Turning Point (Methadone, Inpatient, Outpatient/Detox)	60	19	79	17	6	23
Salvation Army Harbour Light	15	..	15	10	-	10
Salvation Army Life Skills	18	4	22	7	5	12
Focus	9	..	9	17	-	17
RLH	10	..	10	7	-	7
<b>TOTAL</b>	<b>121</b>	<b>31</b>	<b>152</b>	<b>68</b>	<b>14</b>	<b>82</b>

Source: Treatment Agencies

**Table 4.10.2**  
Number of Persons in Treatment, 2016 and 2017

Treatment Agency	2016			2017		
	Male	Female	Total	Male	Female	Total
WTC	..	9	9	-	8	8
MT	21	..	21	15	-	15
Turning Point (Methadone, Inpatient, Outpatient/Detox)	174	38	212	155	33	188
Salvation Army Harbour Light*	18	..	18	21	-	21
Salvation Army Life Skills	19	4	23	29	5	34
Focus	9	..	9	17	-	17
RLH	23 <sup>a</sup>	..	23	26	-	26
<b>TOTAL</b>	<b>264</b>	<b>51</b>	<b>315</b>	<b>263</b>	<b>46</b>	<b>309</b>

Source: Treatment Agencies

Notes: \* Number includes those in aftercare outpatient treatment.







# Chapter 5

## Drug Screening Surveillance

---

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





## 5.1 BERMUDA SPORT ANTI-DOPING AUTHORITY STATISTICS

### Anti-Doping and Illicit Drug Use in Sports

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

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

The year 2017 saw an increase to 571 (from 501 in 2016) in the number of illicit drug tests administered by BSADA (see Table 5.1.1). Four positive test results for THC (marijuana)

were observed in 2017 compared to five in 2016. On the other hand, the number of anti-doping tests (of both urine and blood) decreased from 102 in 2016 to 82 in 2017.

The figures in Table 5.1.2 show the breakdown of illicit drug tests conducted in each sport for the years 2016 and 2017. Most of these tests were done for the sports of football and rugby and to a lesser extent basketball and the other sports. On the other hand, most of the anti-doping tests were administered for competition purposes by BSADA (see Tables 5.1.3 and 5.1.4). In 2017, two tests screened positive for performance enhancing drugs (see Table 5.1.1) compared to one in 2016. There were more performance enhancing tests done in 2016 than in 2017, mainly by urine samples than by blood. These tests were for a number of sports but mainly for athletics, aquatics, bodybuilding, cycling, and triathlon in both years under review (see Tables 5.1.5 and 5.1.6).

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

**Table 5.1.1**  
*Drug Testing Results at BSADA, 2016 and 2017*

Year	Illicit Tests			Anti-Doping Tests	
	Number of Tests	Number of Positive		Number of Tests	Positive
		THC	Cocaine		
2016	501	5	-	102	1
2017	571	4	-	82	2

Source: BSADA

**Table 5.1.2**  
*Illicit Drug Tests by Sport, 2016 and 2017*

Sport	2016	2017
Archery	1	3
Athletics	13	30
Badminton	-	7
Basketball	16	46
Bicycling	4	20
Boccia (Para Sport)	2	-
Bowling	4	6
Cricket	59	24
Equestrian	1	1
Football	128	150

Source: BSADA

**Table 5.1.2 cont'd**  
*Illicit Drug Tests by Sport, 2016 and 2017*

Sport	2016	2017
Golf	11	10
Gymnastics	-	5
Hockey	-	12
Lawn Tennis	3	12
Martial Arts	14	11
Netball	14	14
Rugby	99	122
Sailing	33	11
Squash	20	9
Swimming	25	23
Triathlon	2	10
Volleyball	52	45
<b>Total</b>	<b>501</b>	<b>571</b>

Source: BSADA

**Table 5.1.3**  
*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
<b>Total</b>	<b>66</b>	<b>33</b>	<b>-</b>	<b>22</b>

Source: BSADA

**Table 5.1.4**  
*Performance Enhancement Testing by National Anti-Doping Organisations (Testing Missions Issued by BSADA), 2017*

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

Source: BSADA

**Table 5.1.5**  
*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	-	-

Source: BSADA

**Table 5.1.5 cont'd**  
*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
Sailing	-	3	-	-
Triathlon	3	9	-	10
Para Sport	-	3	-	1
Rowing	-	1	-	1
<b>Total</b>	<b>66</b>	<b>36</b>	<b>-</b>	<b>23</b>

**Table 5.1.6**  
*Performance Enhancing Tests by Sport (Testing Missions Issued by BSADA), 2017*

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

Source: BSADA

## 5.2 DEPARTMENT OF CORRECTIONS STATISTICS: WESTGATE CORRECTIONAL FACILITY

### Drug Use among Criminal Offenders

Monthly provision of urinalysis screening results from the Westgate Correctional Facility<sup>9</sup> has yielded data that allows for comparison of patterns of use amongst offenders. The data is analysed according to type of drug used and whether or not persons were first-time or repeat offenders.

In 2017, 87.0% of reception inmates were screened for illicit drugs (see Table 5.2.1), 8.5% refused to participate in screening (5.4% refused in 2016), and 4.5% were released prior to specimen collection (3.1% in 2016). However, drug screening of offenders on reception decreased slightly in 2017 by 4.5% from the previous year, which saw 91.5% of specimens screened. The overall proportion of positive screens for illicit drugs increased in 2017 to 158 compared to 131 in 2016 (see Table 5.2.2). Screening results indicated that marijuana, cocaine, and opiates, in sequential order, remained the most prevalent drugs amongst this population (see Tables 5.2.3 and 5.2.5). In 2017, an increase, by 50%, 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 increased from 35 (15.6%) in 2016 to 40 (17.9%) in 2017 (see Table 5.2.6). The proportion of repeat offenders received into Westgate decreased by 2.3% from the last year, moving from 189 (84.4%) in 2016 to 183 (82.1%) in 2017. 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 2017 and 2016, when it came to poly drug use, there were significantly more repeat offenders that were multiple substance users, at least at the time of reception (see Table 5.2.8).

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

<sup>9</sup> 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, 2016 and 2017

Year	Reception Inmates	Screened	Refused	Released
2016	224	205 (91.5)	12 (5.4)	7 (3.1)
2017	223	194 (87.0)	19 (8.5)	10 (4.5)

Source: Westgate Correctional Facility

**Table 5.2.2**  
Percentage of Positive Illicit Drug Screens among Prison Reception Inmates, 2016 and 2017

Year	Number of Positive Illicit Drug Screens	Percentage of Total Screens
2016	131	63.9
2017	158	81.4

Source: Westgate Correctional Facility

**Table 5.2.3**  
Drug Prevalence (Urinalysis) at Reception by Number and Proportion of Screened Offenders, 2016 and 2017

Year	Marijuana	Cocaine	Opiates	METH	ECS	MET*	BUP*	BEN*	PROP*	PHEN*	Poly Drug Use
2016	91 (44.4)	33 (16.1)	30 (14.6)	-	-	...	...	...	...	...	36 (17.6)
2017	133 (68.6)	46 (23.7)	45 (23.2)	10 (5.2)	-	9 (4.6)	1 (0.5)	16 (8.2)	1 (0.5)	1 (0.5)	54 (27.8)

Source: Westgate Correctional Facility

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

**Table 5.2.4**  
Random Positive Urine Screens by Substance and Number and Proportion of Inmates, 2016 and 2017

	2016	2017
Overall Positive	21 (9.4)	26 (11.7)
Marijuana	19 (8.5)	15 (6.7)
Opiates	2 (0.9)	11 (4.9)

Source: Westgate Correctional Facility

**Table 5.2.5**  
Drug Prevalence at Reception by Number and Proportion of Positive Illicit Drug Screens, 2016 and 2017

Year	Marijuana	Cocaine	Opiates	METH	ECS	MET*	BUP*	BEN*	PROP*	PHEN*	Poly Drug Use
2016	91 (69.5)	33 (22.9)	30 (25.2)	-	-	...	...	...	...	...	36 (28.4)
2017	133 (84.2)	46 (29.1)	45 (28.5)	10 (6.3)	-	9 (5.7)	1 (0.6)	16 (10.1)	1 (0.6)	1 (0.6)	54 (34.2)

Source: Westgate Correctional Facility

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

**Table 5.2.6**  
Number and Proportion of First-Time and Repeat Offenders by Year, 2016 and 2017

Year	Category of Offenders		
	Reception inmates	First time offenders	Repeat offenders
2016	224	35 (15.6)	189 (84.4)
2017	223	40 (17.9)	183 (82.1)

Source: Westgate Correctional Facility



**Table 5.2.7**  
Any Illicit Drug Prevalence (Urinalysis) by Number and Proportion of First-Time and Repeat Offenders, 2016 and 2017

Year	Offender	Marijuana	Cocaine	Opiates
2016	Repeat offender	89 (47.1)	31 (16.4)	27 (14.3)
	First-time offender	16 (45.7)	6 (17.1)	5 (14.3)
2017	Repeat offender	110 (49.3)	42 (18.8)	40(17.9)
	First-time offender	23 (10.3)	4 (1.8)	5 (2.2)

Source: Westgate Correctional Facility

**Table 5.2.8**  
Number of First-Time and Repeater Offenders with Poly Drug Use, 2016 and 2017

Year	First-Time Offender	Repeat Offender
2016	5	31
2017	4	44

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 2017, the Prison Farm requested and collected 289 urine specimens, which was below the number (331) requested in 2016 (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, 1.8% (four) tested positive for an illicit substance in 2017 and 1.8% (six) in 2016. Specifically, three of the six positive specimens and two of the four positive specimens, in 2016 and 2017, respectively, tested positive for THC. There were positive tests for opiates in both years (one in 2016 and two in 2017) and two positive cocaine tests in 2016 and none in 2017.

**Table 5.3.1**  
Drug Screening Results for Persons at the Prison Farm, 2016

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens			
			Total	THC	Opiates	Cocaine
Random	222	222	4	2	1	1
Day Pass	6	6	-	-	-	-
Suspicion	8	8	1	1	-	-
Work Detail	95	95	1	-	-	1
<b>Total</b>	<b>331</b>	<b>331</b>	<b>6</b>	<b>3</b>	<b>1</b>	<b>2</b>

Source: Department of Corrections

**Table 5.3.2**  
Drug Screening Results for Persons at the Prison Farm, 2017

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

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 2017, the Co-Ed facility requested and collected 61 urine specimens as compared to 62 requests and specimens received in 2016 (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 2017, 3.3% (two) were found to be positive for an illicit substance versus 8.1% (five) in 2016. Both of the positive specimens tested positive for THC in 2017 compared to five in 2016 (see Table 5.4.2).

**Table 5.4.1**  
*Drug Screening Results for Persons at the Co-Ed Facility, 2016*

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens	
			Total	THC
Random	43	43	2	2
Day Release	1	1	-	-
Suspicion	11	11	3	3
Work Detail	-	-	-	-
Work Release	7	7	-	-
<b>Total</b>	<b>62</b>	<b>62</b>	<b>5</b>	<b>5</b>

Source: Department of Corrections

**Table 5.4.2**  
*Drug Screening Results for Persons at the Co-Ed Facility, 2017*

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

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.<sup>10</sup>

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 2017, there has been a sharp increase in the number of persons who were stopped to undertake a breathalyser test, when compared to 2016. This is a reversal in the trend observed over the last few years. Specifically, in 2017, 194 persons were stopped to undertake a breathalyser test as compared to 119 in the previous year (see Table 6.1.1). However, not all of the persons who were stopped have agreed to undertake a breathalyser test; 32 persons refusing

to do so in 2017. Breathalyser testing is not mandatory, not even when there has been an accident.

Nonetheless, a larger number of males (173 in 2017 and 99 in 2016) provided a sample for testing as compared to females (21 in 2017 and 10 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, 134 out of 194 and 71 out of 109 failed in 2017 and 2016, respectively (with 32 in 2017 and 17 in 2016 passing the breathalyser test).

Overall, the mean BAC reading for all samples provided decreased from 157 mg/dl in 2016 to 154 mg/dl in 2017 (see Table 6.1.2). At the same time, the mean BAC reading for individuals who failed the breathalyser test increased slightly from 185 mg/dl in 2016 to 187 mg/dl in 2017. In instances where there were accidents, the average BAC was significantly above the legal limit. In 2016, the mean failed BAC, in cases where there were accidents, was recorded at 201 mg/dl and somewhat lower at 170 mg/dl in 2017. There were also instances where accidents occurred and the average BAC was under the legal limit – 26 mg/dl in 2016 and 23 mg/dl in 2017. As a reminder, the alcohol limit in Bermuda is less than 80 mg/dl. Breathalyser readings, nonetheless, ranged from 0 to 316 mg/dl in 2016 and 0 to 333 mg/dl in 2017; where the upper end of the range in 2017 is equivalent to as much as over four times the legal limit. On average, the majority of persons who failed the breathalyser test were two to three times above the legal limit in both 2016 and 2017 (see Table 6.1.3). Of those who were tested in 2016, only 12 were within the legal limit when compared to 33 in 2017. In both 2016 and 2017, 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 were few instances where accidents occurred and the corresponding breathalyser readings were as much as three to four times or more above the legal limit.

<sup>10</sup> 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, 2016 and 2017

Year	Number of Persons Stopped	Gave Sample						Male			Female		
		Total	Male	Female	Failed	Passed	Refusals	Failed	Passed	Refusals	Failed	Passed	Refusals
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
2017	194	194	173	21	134	32	28	117	29	27	17	3	1
Q1	41	44	42	2	31	2	11	30	2	10	1	-	1
Q2	41	39	34	5	25	10	4	21	9	4	4	1	-
Q3	42	42	38	4	31	9	2	28	8	2	3	1	-
Q4	70	69	59	10	47	11	11	38	10	11	9	1	-

Source: Bermuda Police Service

**Table 6.1.2**  
Breathalyser Readings for Impaired Driving Incidences, 2016 and 2017

	2016					2017				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Mean Reading: All Breathalyser Samples	169	115	147	195	157	148	148	155	164	154
Mean Reading: Failed Breathalyser Samples	186	148	195	211	185	174	192	185	195	187
Mean Reading: Failed Breathalyser Samples of Males	194	158	195	211	190	173	149	156	198	169
Mean Reading: Failed Breathalyser Samples of Females	107	94	-	205	102	178	132	170	181	166
Mean Reading: Accident with Failed Breathalyser Samples	174	216	213	198	201	192	136	166	186	170
Mean Reading: Accident with Passed Breathalyser Samples	55	49	-	-	26	57	-	17	18	23
Range of Reading: Failed Breathalyser Samples	84-292	91-253	94-293	131-316	84-316	86-333	87-307	90-285	90-280	86-333
Range of Reading: Passed Breathalyser Samples	24-55	14-83*	13-70	0-25	0-83*	35-80	0-78	0-79	0-76	0-80

Source: Bermuda Police Service

Notes: Readings in mg/dl.

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

**Table 6.1.3**  
Number of Breathalyser Sample Readings by Limit, 2016 and 2017

Year	Within Limit	1-2 Times Above Limit	2-3 Times Above Limit	3-4 Times Above Limit	4+ Times Above Limit
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	-
Male	11	22	35	12	-
Female	1	5	-	1	-
Accident	5	9	10	6	-
2017	33	46	48	14	1
Q1	4	12	6	2	1
Q2	11	10	10	4	-
Q3	8	11	16	4	-
Q4	10	13	16	4	-

**Table 6.1.3 cont'd**  
**Number of Breathalyser Sample Readings by Limit, 2016 and 2017**

Year	Within Limit	1-2 Times Above Limit	2-3 Times Above Limit	3-4 Times Above Limit	4+ Times Above Limit
Male	31	41	43	12	1
Female	2	5	5	2	-
Accident	21	19	11	4	1

Source: Bermuda Police Service

## 6.2 DUI EDUCATIONAL PROGRAMME STATISTICS

### Counselling and Treatment for DUI Offenders

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

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

Over the last two years, a declining number of inquiries has been made into this programme, 28 in 2016 and 15 in 2017 (see Table 6.2.1). However, of these inquiries, majority of the persons (24 and 12) participated in the programme in 2016 and 2017, respectively. Most of the participants in either year were males (see Table 6.2.2). In 2016, most of the participants were 26 to 30 years as compared to 2017 where most were 31 to 35 years (see Table 6.2.2).

The programme uses the Triage Assessment for Addictive Disorders (TAAD) to assess participants for chemical dependency and addictive behaviours. The results of the TAAD showed that 41.7% of the programme participants in 2017 were diagnosed as moderate when compared to just over one-third (37.5%) in the previous year. No persons in 2017 were assessed to be in mid to late dependence stage of alcohol abuse or misuse, the most severe diagnosis, as compared to the programme participants in 2016, where six persons were considered to be in the mid-late stage of dependence (see Table 6.2.3). Specifically, in 2016, 20.8% (five) of the participants were diagnosed as mild, another 37.5% (nine) as moderate, and 4.2% (1) were judged to be in the early dependence stage. In comparison, 33.3% (four) of the participants in 2017 were diagnosed as mild, another 41.7% (five) as moderate, and 8.3% (1) were judged to be in the early dependence stage. Each person received a certificate for programme attendance and completion, indicating that he/she has completed all aspects of the Level I DUI Programme.

**Table 6.2.1**  
DUI Education Classes' Inquiries and Participants, 2016 and 2017

	2016	2017
Number of inquiries	28	15
Number of participants	24	12

Source: Bermuda Professional Counselling Services

**Table 6.2.2**  
DUI Programme Participants' Statistics, 2016 and 2017

Year	Sex		Age							
	Male	Female	17 – 21	22 – 25	26 – 30	31 – 35	36 – 40	41 – 45	46 – 50	50+
2016	19	5	2	2	7	6	2	1	1	3
2017	9	3	1	1	2	4	1	-	-	3

Source: Bermuda Professional Counselling Services

**Table 6.2.3**  
Triage Assessment for Addictive Disorders Results (TAAD) by Number of Participants, 2016 and 2017

TAAD Scores	2016	2017
No Diagnosis	3	2
Mild	5	4
Moderate	9	5
Severe	Early Dependence	1
	Mid to Late Dependence	6
<b>TOTAL</b>	<b>24</b>	<b>12</b>

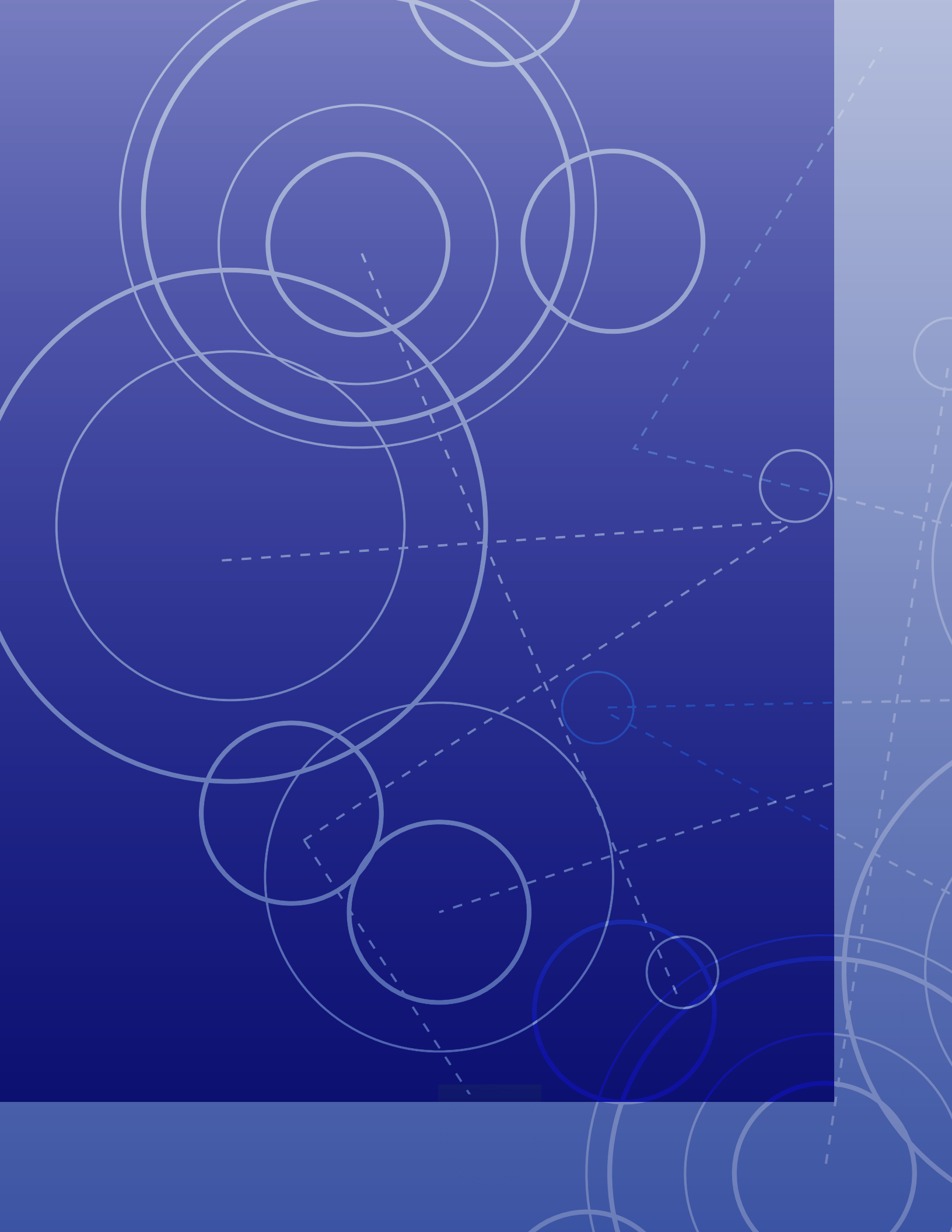
Source: Bermuda Professional Counselling Services

# 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.<sup>11</sup>

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

Prevalence of drug-related infectious diseases were existent

in both 2016 and 2017. In particular, the Epidemiology and Surveillance Unit reported three drug-related cases of hepatitis C in 2016 and doubled to six in 2017. Reports on these cases indicate a history or current use of injection drugs. No case of HIV or AIDS, related to drug use, was recorded in either of the years under review (see Table 7.1.1).

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

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

<sup>11</sup> EMCDDA. (2006). Annual Report 2006: The State of the Drug Problem in Europe. Luxembourg: Office for Official Publications of the European Communities, p. 75.

Table 7.1.1  
Drug-Related Infectious Diseases, 2016 and 2017

Infection	2016		2017	
	Number of Cases	Number of ATOD-Related Cases	Number of Cases	Number of ATOD-Related Cases
HIV	6	-	-	-
AIDS	3	-	-	-
Hepatitis B <sup>a</sup>	4	-	7	-
Hepatitis C <sup>b</sup>	6	3	8	6
Chlamydia	418	...	333	...
Gonorrhoea	14	...	48	...
Herpes <sup>c</sup>	80	...	78	...
Syphilis	2	...	3	...
<b>Total</b>	<b>533</b>	<b>3</b>	<b>477</b>	<b>6</b>

Source: Epidemiology & Surveillance

Notes: <sup>a</sup> 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.

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

<sup>c</sup> 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 Admitting Diagnosis. In the case of admission to the hospital-based ambulatory surgery service or freestanding ambulatory surgery center, the principal/primary diagnosis is that diagnosis established to be chiefly responsible for occasioning the admission to the service or center for the specific procedure. In the case of emergency room visits, the principal/primary diagnosis code is that diagnosis established to be chiefly responsible for occasioning the visit to the Emergency Room. Physicians "sequence" all of the diagnoses, complications and comorbidities in the following order: 1) principal diagnosis; 2) complication; and 3) comorbidity.

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

The general guideline to determine a secondary diagnosis is if a clinical evaluation is provided, diagnostic procedures may be performed, and the patient may require an

extended length of hospital stay or increased nursing care or monitoring. The definition of a secondary diagnosis is "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay." Diagnoses that relate to an earlier episode, which have no bearing on the current hospital stay, are excluded.

Inpatient cases for which drugs were the primary diagnosis was very low as reported by King Edward Memorial VII Hospital. There were only three cases reported in 2016 and 2017 (see Tables 7.2.1 and 7.2.2). In 2017, there were 19 inpatient cases in which poisoning and toxic effects were the primary diagnosis. It is important to note, that due to no historical data being captured in 2016 for inpatient cases in which poisoning and toxic effects were the primary diagnosis this table was not shown. (see Table 7.2.3). Regarding secondary diagnosis cases, 1,181 cases were reported for inpatient drug-related cases in 2016 as compared to 1,214 cases in 2017 (see Tables 7.2.5 and 7.2.6). Secondary diagnoses of greatest occurrence were for conditions such as tobacco use disorder, chronic alcohol dependence, cannabis, and opioid and cocaine abuse. A similar trend was observed as in previous years. Secondary diagnoses for inpatient drug-related cases over the combined years of 2016 and 2017 were more prevalent to males (1,715) than females (680). In 2016, there were nine cases of secondary diagnosis of inpatient cases of poisoning and toxic effects of substances; whereas, in 2017, there were 11 cases (see Tables 7.2.7 and 7.2.8).

Secondary diagnoses of greatest occurrence were for conditions such as tobacco use disorder, chronic alcohol dependence, cannabis, opioid and cocaine abuse...

**Table 7.2.1**  
**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	1	-	-	-	-	-	1	-	-	1	-	-	-
Other And Unspecified Alcohol Dependence, Continuous Drinking Behavior	-	1	-	-	-	-	1	-	1	-	-	-	-
Opioid Type Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse, Continuous Drinking Behavior	1	-	1	-	-	-	-	-	-	1	-	-	-
<b>TOTAL</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>2</b>	<b>-</b>	<b>1</b>	<b>2</b>	<b>-</b>	<b>-</b>	<b>-</b>

Source: King Edward VII Memorial Hospital

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

**Table 7.2.2**  
**Primary Diagnoses of Inpatient Drug-Related\* Cases, 2017**

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed**	Asian**	Other*
Acute Alcoholic Intoxication In Alcoholism, In Remission**	-	-	-	-	-	-	-	-	-	-	-	-	-
Other And Unspecified Alcohol Dependence, Continuous Drinking Behavior**	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse – Continuous	1	-	-	-	-	-	1	-	-	1	-	-	-
Alcohol Abuse- Continuous Drinking Behavior**	2	-	-	-	-	-	1	1	1	1	-	-	-
<b>TOTAL</b>	<b>3</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>-</b>	<b>-</b>	<b>-</b>

Source: King Edward VII Memorial Hospital

Note: \* Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.  
 \*\* Category not available in 2017  
 \* Includes Portuguese, and persons of 'Other' races.

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

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed*	Asian*	Other*
Poisoning – Adrenal Cortical Steroids	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antihypertensive agents	-	1	-	-	-	-	1	-	-	1	-	-	-
Poisoning – Insulin & Antidiabetic Agents	-	1	-	-	-	-	-	1	-	1	-	-	-
Poisoning – Antiallergic and Antiemetic Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Uric acid metabolism drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Antitussives	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Salicylates	1	2	1	-	-	2	-	-	3	-	-	-	-
Poisoning – Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning- Anticoagulants	-	1	-	-	-	-	-	1	1	-	-	-	-
Poisoning- Other Opiates and Related Narcotics	-	1	-	-	-	-	-	1	1	-	-	-	-
Poisoning-Opium (Alkaloids) Unspecified	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning- Antiasthmatics	-	1	-	-	-	-	1	-	1	-	-	-	-
Poisoning- Unspecified Drug or Medicinal Substance	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning – Aromatic Analgesics	1	2	1	1	1	-	-	-	3	-	-	-	-

**Table 7.2.3 cont'd**  
**Primary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2017**

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed*	Asian*	Other*
Poisoning - Cardiotonics glycosides	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Propionic Acid Derivatives	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Other and Unspecified Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Central Nervous System Muscle Depressants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Central Nervous System stimulant – crack	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Phenothiazine-Based Tranquillisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antipsychotic, neuroleptic, and major tranquilisers	-	1	1	-	-	-	-	-	1	-	-	-	-
Poisoning – Benzodiazepine-Based Tranquillisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Other Diuretics	2	-	-	-	-	-	1	1	2	-	-	-	-
Poisoning By Selective Serotonin Reuptake Inhibitors	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Other Antidepressants	1	-	-	-	-	1	-	-	-	-	-	-	1
Poisoning - Other sedative and hypnotics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - other specified drugs or medicinal substances	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Heroin	1	-	-	-	1	-	-	-	1	-	-	-	-
Toxic Effect – Caustic Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Pesticides Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Soap and Detergents	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Other Substances Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect Of Other Substances, Chiefly Nonmedicinal As To Source, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Other Pesticides Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect Of Unspecified Substances, Chiefly Nonmedicinal As To Source	1	-	-	-	-	-	1	-	1	-	-	-	-
<b>TOTAL</b>	<b>9</b>	<b>10</b>	<b>3</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>6</b>	<b>4</b>	<b>16</b>	<b>2</b>	<b>-</b>	<b>-</b>	<b>1</b>

Source: King Edward VII Memorial Hospital

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

**Table 7.2.4**  
**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	-	-	-
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	-	-	-

**Table 7.2.4 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*
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	-	-	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Dependence, Unspecified Use	-	1	-	1	-	-	-	-	1	-	-	-	-
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 - In Remission	8	2	-	-	-	1	8	1	10	-	-	-	-
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 - Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Amphetamine Or Related Acting Sympathomimetic Abuse, Unspecified Use	-	1	-	-	1	-	-	-	-	1	-	-	-
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	-	-	-
<b>TOTAL</b>	<b>846</b>	<b>335</b>	<b>2</b>	<b>39</b>	<b>131</b>	<b>131</b>	<b>419</b>	<b>459</b>	<b>875</b>	<b>286</b>	<b>4</b>	<b>5</b>	<b>11</b>

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

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other†
Acute Alcohol Intoxication-Unspecified	2	-	-	-	-	-	-	2	2	-	-	-	-
Acute alcoholic intoxication	-	-	-	-	-	-	-	-	-	-	-	-	-
Acute alcoholic intoxication - continuous	4	-	-	-	1	-	1	2	3	1	-	-	-
Alcohol Dependence NEC/Nos-Unspecified	29	13	-	1	2	4	14	21	30	11	-	-	1
Cannabis Dependence, Episodic Use	1	-	-	-	-	1	-	-	1	-	-	-	-
Amphetamine And Other Psychostimulant Dependence, In Remission	1	-	-	-	-	1	-	-	1	-	-	-	-
Cannabis Dependence, In Remission	1	-	-	-	-	1	-	-	1	-	-	-	-
Other And Unspecified Alcohol Dependence, Episodic Drinking Behavior	3	-	-	-	2	-	1	-	3	-	-	-	-
Alcohol abuse - continuous	55	15	-	2	5	5	25	33	38	31	-	-	1
Alcohol abuse - episodic	3	1	-	1	-	1	2	-	3	1	-	-	-
Alcohol abuse - in remission	17	3	-	-	-	-	6	14	11	9	-	-	-
Alcohol abuse - unspecified	49	9	-	7	15	4	13	19	45	11	-	-	2
Amphetamine Or Related Acting Sympathomimetic Abuse, Unspecified Use	-	1	-	-	-	-	1	-	1	-	-	-	-
Cannabis abuse - continuous	86	32	-	15	24	22	36	21	107	11	-	-	-
Cannabis abuse - episodic	19	7	-	3	5	5	9	4	23	3	-	-	-
Cannabis abuse - in remission	12	2	-	-	2	-	9	3	13	1	-	-	-
Cannabis abuse - unspecified	81	26	1	9	24	19	38	16	93	14	-	-	-
Cannabis dependence - continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis dependence - unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Chronic alcohol dependence - continuous	36	13	-	-	2	1	24	22	29	16	-	-	4
Chronic alcohol dependence - in remission	7	3	-	-	-	-	5	5	5	5	-	-	-
Cocaine abuse - continuous	7	-	-	-	1	-	6	-	7	-	-	-	-
Cocaine abuse - episodic	-	1	-	-	-	-	1	-	1	-	-	-	-
Cocaine abuse - in remission	23	5	-	-	-	-	17	11	26	2	-	-	-
Cocaine Abuse-Unspecified	28	7	-	-	-	-	23	12	33	2	-	-	-
Cocaine Depend-Remiss	4	-	-	-	-	2	1	1	4	-	-	-	-
Cocaine dependence - continuous	2	1	-	-	-	-	2	1	2	1	-	-	-
Cocaine dependence - remission	-	-	-	-	-	-	-	-	-	-	-	-	-
Cocaine dependence - unspecified	2	-	-	-	-	-	-	2	2	-	-	-	-
Drug Depend NOS-Unspecified	0	-	-	-	-	-	-	-	-	-	-	-	-
Opioid abuse - continuous	6	-	-	-	1	1	3	1	5	1	-	-	-
Opioid abuse - in remission	8	2	-	-	-	-	7	3	9	1	-	-	-
Opioid abuse - unspecified	13	2	-	-	-	1	7	7	14	1	-	-	-
Opioid dependence - continuous	6	2	-	-	-	2	4	2	7	1	-	-	-
Opioid type dependence - in remission	2	-	-	-	-	2	-	-	2	-	-	-	-
Opioid type dependence - unspecified	6	6	-	-	-	2	9	1	8	4	-	-	-
Other, mixed, or unspecified drug abuse - continuous													
Other, mixed, or unspecified drug abuse - in remission	1	-	-	-	-	-	1	-	-	1	-	-	-
Other, mixed, or unspecified drug abuse - unspecified	1	-	-	-	-	-	-	1	1	-	-	-	-
Tobacco use disorder	1	1	-	-	-	-	2	-	2	-	-	-	-
<b>TOTAL</b>	<b>869</b>	<b>345</b>	<b>1</b>	<b>48</b>	<b>143</b>	<b>144</b>	<b>453</b>	<b>425</b>	<b>913</b>	<b>280</b>	<b>-</b>	<b>2</b>	<b>19</b>

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 7.2.6**  
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 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 – Anticoagulants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Salicylates	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Codeine, Meperidine, Morphine	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticonvulsants Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressants Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Other Antidepressants	-	1	-	-	-	1	-	-	-	1	-	-	-
Poisoning - Benzodiazepine-Based Tranquilisers	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Psychotropic Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Diuretics Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Electrolytic, Caloric, and Water-Balanced Agents	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Alcohol Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Benzene	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect Of Unspecified Substance, Chiefly Nonmedicinal As To Source	2	2	2	1	-	-	-	1	1	3	-	-	-
<b>TOTAL</b>	<b>4</b>	<b>5</b>	<b>3</b>	<b>2</b>	<b>-</b>	<b>1</b>	<b>-</b>	<b>3</b>	<b>3</b>	<b>6</b>	<b>-</b>	<b>-</b>	<b>-</b>

Source: King Edward VII Memorial Hospital

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

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

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

Source: King Edward VII Memorial Hospital

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

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

The emergency room saw 111 cases in 2016 in which the primary diagnosis was related to drugs and dropped to 99 cases in 2017 (see Tables 7.3.1 and 7.3.2). The main primary diagnosis was for alcohol abuse. Emergency room cases in which poisoning and toxic effects were the primary diagnosis and saw 181 cases in 2016 as compared to 164 cases in 2017 (see Tables 7.3.3 and 7.3.4). In 2016, there was an overall total of 572 cases reported to the emergency room for which there was a drug-related secondary diagnosis as compared to 666 cases in 2017 (see Tables 7.3.5 and

7.3.6); with significantly more cases of males than females. The secondary diagnoses for the majority of drug-related cases in both years were due to tobacco use disorder, alcohol abuse, acute alcoholic dependence, opioid abuse, cocaine abuse, and opioid dependence. When it came to secondary diagnosis of emergency room cases of poisoning and toxic effects of substances, 15 cases presented in 2016 and 22 cases in 2017 (see Tables 7.3.7 and 7.3.8); with more incidents occurring to males versus females in 2016 and females versus males in 2017.

**Table 7.3.1**  
Primary Diagnoses of Emergency Room (ER) Drug-Related<sup>a</sup> 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 <sup>b</sup>
Acute Alcoholic Intoxication – Continuous	1	-	-	-	-	-	1	-	-	1	-	-	-
Acute Alcoholic Intoxication In Alcoholism, Unspecified Drinking Behavior	8	3	1	6	3	-	-	1	6	5	-	-	-
Other & Unspecified Alcohol Dependence	1	-	-	-	-	-	1	-	-	1	-	-	-
Opioid Dependence- Unspecified use	-	1	-	-	-	1	-	-	1	-	-	-	-
Other Specified Drug Dependence – Unspecified Use	-	-	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Dependence – Unspecified Use	-	-	-	-	-	-	-	-	-	-	-	-	-
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 – Unspecified Use	1	1	2	-	-	-	-	-	2	-	-	-	-
Opioid Abuse – Unspecified Use	5	1	-	-	-	2	4	-	6	-	-	-	-
Cocaine Abuse, Unspecified Use	3	-	-	-	-	-	2	1	2	1	-	-	-
Other, Mixed, or Unspecified Drug Abuse – Continuous Use	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, Unspecified Use	1	-	-	-	-	1	-	-	1	-	-	-	-
<b>TOTAL</b>	<b>81</b>	<b>30</b>	<b>8</b>	<b>14</b>	<b>14</b>	<b>18</b>	<b>37</b>	<b>20</b>	<b>63</b>	<b>45</b>	<b>-</b>	<b>-</b>	<b>3</b>

Source: King Edward VII Memorial Hospital

Notes: <sup>a</sup> Related to alcohol, tobacco, illicit drugs, prescription drugs, other drugs.

<sup>b</sup> Includes Portuguese, and persons of 'Other' races.

**Table 7.3.2**  
Primary Diagnoses of Emergency Room Drug-Related<sup>a</sup> Cases, 2017

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other <sup>b</sup>
Acute Alcoholic Intoxication In Alcoholism, Unspecified Drinking Behavior	10	-	-	-	2	-	2	6	8	2	-	-	-
Acute alcoholic intoxication - continuous	1	1	-	-	-	-	1	1	2	-	-	-	-
Alcohol Abuse, Continuous Drinking Behavior	1	1	-	-	1	-	-	1	2	-	-	-	-
Alcohol Abuse, Unspecified Drinking Behavior	49	23	6	14	14	8	18	12	47	23	-	-	2
Cannabis Abuse, Unspecified Use	2	2	2	1	-	-	1	-	3	1	-	-	-



**Table 7.3.2 cont'd**  
**Primary Diagnoses of Emergency Room Drug-Related\* Cases, 2017**

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Cocaine Abuse, Unspecified Use	2	-	-	-	-	-	1	1	2	-	-	-	-
Opioid Abuse, Unspecified Use	3	-	-	-	-	2	1	-	3	-	-	-	-
Other and unspecified alcohol dependence	-	-	-	-	-	-	-	-	-	-	-	-	-
Amphetamine Or Related Acting Sympathomimetic Abuse, Unspecified Use	1	-	-	-	1	-	-	-	-	1	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, Unspecified Use	2	-	-	-	-	-	1	1	1	1	-	-	-
<b>TOTAL</b>	<b>72</b>	<b>27</b>	<b>9</b>	<b>15</b>	<b>18</b>	<b>10</b>	<b>25</b>	<b>22</b>	<b>69</b>	<b>28</b>	<b>-</b>	<b>-</b>	<b>2</b>

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, 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 By Antineoplastic And Immunosuppressive Drugs	-	2	-	-	-	-	2	-	2	-	-	-	-
Poison - Insulin & Antidiabetic Agents	-	4	-	-	-	-	-	4	2	2	-	-	-
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 - Heroin	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Codeine, Meperidine, Morphine	-	1	-	-	1	-	-	-	1	-	-	-	-
Poisoning - Dietetics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Emollients, Demulcents and Protectants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - ENT preparation	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Salicylates	1	1	-	1	-	-	1	-	2	-	-	-	-
Poisoning - Aromatic Analgesics	2	1	1	-	-	1	1	-	1	2	-	-	-
Poisoning - Propionic Acid Derivatives	1	3	2	2	-	-	-	-	3	1	-	-	-
Poisoning - Other Anti-Rheumatics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Hydantoin Derivatives	2	-	-	-	1	1	-	-	2	-	-	-	-
Poisoning - Other Sedative or Hypnotics	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning - Selective Serotonin Reuptake Inhibitors	-	-	-	-	-	-	-	-	-	-	-	-	-
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 - Hallucinogens	-	1	-	1	-	-	-	-	1	-	-	-	-

**Table 7.3.3 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 - Antileptic & 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 - Purine Derivative Diuretics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Expectorants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anti-Asthmatics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Local Anti-Infective & Anti-Inflammatory Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Methadone	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antipruritics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anti-Infectives and Other Drugs and Preparations for Ear, Nose, and Throat	-	-	-	-	-	-	-	-	-	-	-	-	-
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 - Non-Medicinal Substances	2	1	1	-	1	-	1	-	3	-	-	-	-
Toxic Effect - Unspecified Alcohol	1	-	-	-	-	-	-	1	1	-	-	-	-
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 - 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	-	-	-	-
<b>TOTAL</b>	<b>83</b>	<b>98</b>	<b>47</b>	<b>20</b>	<b>21</b>	<b>20</b>	<b>42</b>	<b>31</b>	<b>109</b>	<b>63</b>	<b>-</b>	<b>-</b>	<b>9</b>

Source: King Edward VII Memorial Hospital

Note: \* Includes Portuguese.

**Table 7.3.4**

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

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning - Methadone	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning By Penicillins	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning - Antiallergic and antiemetic drugs	-	1	-	1	-	-	-	-	1	-	-	-	-
Poisoning - Anticoagulants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Other Psychostimulants	1	-	-	-	1	-	-	-	1	-	-	-	-
Poisoning By Coronary Vasodilators	-	1	-	-	-	-	-	1	-	1	-	-	-
Poisoning - Antilipemic and Antiarteriosclerotic drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antipsychotic, neuroleptic, and major tranquilisers	-	2	1	-	1	-	-	-	1	1	-	-	-
Poisoning - Antitussives	1	-	-	-	1	-	-	-	1	-	-	-	-
Poisoning - Aromatic Analgesics	2	5	3	1	3	-	-	-	3	2	-	-	2
Poisoning - Benzodiazepine-based tranquilisers	-	3	2	-	-	-	1	-	2	1	-	-	-
Poisoning - Codeine, meperidine, morphine	-	1	-	-	-	-	-	1	-	1	-	-	-
Poisoning By Antipruritics	2	-	2	-	-	-	-	-	2	-	-	-	-
Poisoning - Dietetics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Emollients, demulcents and protectants	-	2	2	-	-	-	-	-	-	-	-	-	2
Poisoning - ENT preparation	-	1	-	-	1	-	-	-	-	1	-	-	-
Poisoning - Hallucinogens	1	2	2	1	-	-	-	-	1	2	-	-	-
Poisoning - Hydantoin derivatives	1	-	-	-	1	-	-	-	1	-	-	-	-
Poisoning - Insulin and antidiabetic agents	-	2	-	-	-	-	1	1	2	-	-	-	-
Poisoning - Local anti-infective and antiinflammatory drugs	1	-	1	-	-	-	-	-	1	-	-	-	-
Poisoning By Other And Unspecified Agents Primarily Affecting The Cardiovascular System	1	-	-	-	-	-	-	1	1	-	-	-	-
Poisoning By Other Antidepressants	1	-	-	-	-	1	-	-	-	-	-	-	1
Poisoning By Other Antihypertensive Agents	-	1	-	-	-	-	-	1	1	-	-	-	-
Poisoning By Other Sedatives And Hypnotics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Other Specified Agents Primarily Affecting The Gastrointestinal System	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Selective Serotonin Reuptake Inhibitors	-	1	-	-	1	-	-	-	-	1	-	-	-
Toxic Effect - Caustic alkalis	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Caustic unspecified	-	3	-	-	1	-	-	2	2	1	-	-	-
Toxic Effect - Ethyl alcohol	-	3	-	1	2	-	-	-	1	1	-	1	-
Toxic Effect - Fish and shellfish	-	1	-	-	-	-	1	-	1	-	-	-	-
Toxic Effect - Non-medical substances	1	1	1	-	-	-	-	1	1	-	-	1	-
Toxic Effect - Non-petroleum-based solvents	-	1	1	-	-	-	-	-	1	-	-	-	-
Toxic Effect - Other specified gases, fumes, or vapours	1	2	-	-	1	-	2	-	3	-	-	-	-
Toxic Effect - Other specified metals	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Other substances	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Pesticides	-	1	-	-	1	-	-	-	-	-	-	-	1
Toxic Effect - Soap and detergent	1	-	1	-	-	-	-	-	1	-	-	-	-



**Table 7.3.4 cont'd**  
**Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2017**

Primary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Toxic Effect - Unspecified alcohol	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Unspecified gas, fumes, or vapour	-	1	-	-	-	-	-	1	1	-	-	-	-
Toxic Effect -Venom	40	39	14	8	13	9	24	11	33	38	-	2	6
Toxic Effect Of Carbon Monoxide	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect Of Liquefied Petroleum Gases	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect Of Other Hydrocarbon Gas	1	-	-	-	-	-	1	-	-	1	-	-	-
Toxic Effect Of Unspecified Substance, Chiefly Non-medical As To Source	1	1	1	-	1	-	-	-	2	-	-	-	-
<b>TOTAL</b>	<b>73</b>	<b>91</b>	<b>37</b>	<b>15</b>	<b>31</b>	<b>12</b>	<b>41</b>	<b>28</b>	<b>93</b>	<b>55</b>	<b>-</b>	<b>4</b>	<b>12</b>

Source: King Edward VII Memorial Hospital

Note: \* Includes Portuguese.

**Table 7.3.5**  
**Secondary Diagnoses of Emergency Room Drug-Related<sup>a</sup> 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 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
Chronic Alcohol Dependence - Continuous	4	1	-	-	-	2	3	-	2	3	-	-	-
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 – Continuous Use	-	-	-	-	-	-	-	-	-	-	-	-	-
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 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 - 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
Cannabis Abuse - Continuous	2	1	-	2	-	1	-	-	3	-	-	-	-
Opioid Abuse - Unspecified	46	3	-	-	1	9	32	7	36	13	-	-	-
Opioid Abuse - Continuous	1	-	-	-	-	-	-	1	-	1	-	-	-
Cocaine Abuse, Unspecified Use	10	-	-	-	2	1	6	1	8	2	-	-	-
Cocaine Abuse - In Remission	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse, Unspecified Use	16	2	-	4	2	2	7	3	14	4	-	-	-

**Table 7.3.5 cont'd**  
**Secondary Diagnoses of Emergency Room Drug-Related<sup>#</sup> 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*
Other, Mixed, or Unspecified Drug Abuse - Continuous Use	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, In Remission	-	1	-	-	-	-	1	-	1	-	-	-	-
<b>TOTAL</b>	<b>427</b>	<b>145</b>	<b>4</b>	<b>58</b>	<b>77</b>	<b>91</b>	<b>214</b>	<b>128</b>	<b>398</b>	<b>155</b>	<b>1</b>	<b>4</b>	<b>14</b>

Source: King Edward VII Memorial Hospital

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

**Table 7.3.6**  
**Secondary Diagnoses of Emergency Room Drug-Related<sup>#</sup> Cases, 2017**

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

Source: King Edward VII Memorial Hospital

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



**Table 7.3.7**  
**Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 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 - 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 and Unspecified Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressant, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Codeine, Meperidine, Morphine	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning - Heroin	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning By Opiate Antagonists	-	1	-	-	-	1	-	-	-	-	-	-	1
Poisoning By Skeletal Muscle Relaxants	-	1	-	-	1	-	-	-	1	-	-	-	-
Poisoning - Sympathomimetics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other and Unspecified Agents Primarily Affecting the Cardiovascular System	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Gastrointestinal Agents, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning- Antipruritics	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Emollients, Demulcents, and Protectants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Unspecified Drug or Medicinal Substance	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Ethyl Alcohol	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effects - Unspecified Alcohol	1	-	-	-	-	-	1	-	1	-	-	-	-
Toxic Effect - Acids	-	-	-	-	-	-	-	-	-	-	-	-	-
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 - Venom	2	2	-	-	2	-	1	1	1	3	-	-	-
Toxic Effect - Asbestos	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Unspecified Substance, Chiefly Nonmedical Source	-	-	-	-	-	-	-	-	-	-	-	-	-
<b>TOTAL</b>	<b>9</b>	<b>6</b>	<b>-</b>	<b>1</b>	<b>5</b>	<b>2</b>	<b>6</b>	<b>1</b>	<b>8</b>	<b>6</b>	<b>-</b>	<b>-</b>	<b>1</b>

Source: King Edward VII Memorial Hospital

Note: \* Includes Portuguese.



**Table 7.3.8**  
**Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2017**

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Poisoning By Antiallergic And Antiemetic Drugs	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning By Alkalizing Agents	-	1	-	-	-	-	-	1	1	-	-	-	-
Poisoning By Vitamins, Not Elsewhere Classified	1	-	-	-	-	-	1	-	-	1	-	-	-
Poisoning By Opium (Alkaloids), Unspecified	1	-	-	-	-	-	1	-	1	-	-	-	-
Poisoning-Anticonvulsants Nec/Nos	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning-Antidepressant Nec	-	1	-	1	-	-	-	-	1	-	-	-	-
Poisoning-Insulin/Antidiabetic	-	1	-	-	-	-	-	1	1	-	-	-	-
Poisoning - Anticoagulants	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Aromatic analgesics	-	3	2	1	-	-	-	-	3	-	-	-	-
Poisoning - Codeine, meperidine, morphine	-	1	1	-	-	-	-	-	1	-	-	-	-
Poisoning - Heroin	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning By Caffeine	1	-	-	1	-	-	-	-	1	-	-	-	-
Poisoning By Other Antihypertensive Agents	-	3	-	-	-	-	1	2	2	1	-	-	-
Poisoning - Propionic acid derivatives	-	-	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Salicylates	-	2	-	-	2	-	-	-	-	-	-	-	2
Poisoning- Gastrointestinal Agents Nec	-	2	1	-	-	-	-	1	2	-	-	-	-
Toxic Effect Gastrointestinal /Vapor Nos	-	-	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Acids	1	-	-	-	-	-	1	-	-	-	-	-	1
Toxic Effect Of Asbestos	1	-	-	-	-	-	-	1	1	-	-	-	-
Toxic Effect - Venom	-	2	-	-	-	1	1	-	1	1	-	-	-
Toxic Effects - Unspecified alcohol	-	-	-	-	-	-	-	-	-	-	-	-	-
<b>TOTAL</b>	<b>6</b>	<b>16</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>6</b>	<b>6</b>	<b>15</b>	<b>4</b>	<b>-</b>	<b>-</b>	<b>3</b>

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 96 in 2017 (see Tables 7.4.1 and 7.4.2). Males, blacks, and between 46 and 60 years accounted for the majority of these cases, with the primary diagnosis being opioid dependence, acute alcohol intoxication and cocaine abuse.

In terms of the secondary diagnoses, a total of 183 cases were reported in 2016 compared to 160 cases in 2017 (see Tables 7.4.3 and 7.4.4), with significantly more males versus females, diagnosed with cannabis dependence, a tobacco use disorder, cocaine dependence, acute alcohol intoxication, amongst other secondary diagnoses. As with the primary

diagnoses, blacks and persons between the ages of 46 and 60 accounted for the bulk of the secondary diagnoses. There were no reported case of poisoning and toxic effects of substances in either 2016 or 2017.

**Table 7.4.1**  
**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 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	-	-	-
Opioid Dependence – Continuous	56	13	-	3	-	18	38	10	65	4	-	-	-
Cocaine Dependence – Continuous	4	6	-	1	2	2	4	1	7	3	-	-	-
Cannabis Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Combinations Of Opioid Type Drug With Any Other Drug Dependence, Continuous Use	1	4	-	3	-	2	-	-	5	-	-	-	-
Drug Dependence Not Otherwise Specified - Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Cannabis Abuse, Unspecified Use	-	1	1	-	-	-	-	-	1	-	-	-	-
Opioid Abuse – Continuous	1	-	-	-	-	-	1	-	1	-	-	-	-
Other Specified Drug Dependence - Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse, Unspecified Use	-	-	-	-	-	-	-	-	-	-	-	-	-
<b>TOTAL</b>	<b>94</b>	<b>36</b>	<b>1</b>	<b>11</b>	<b>7</b>	<b>29</b>	<b>64</b>	<b>18</b>	<b>104</b>	<b>26</b>	<b>-</b>	<b>-</b>	<b>-</b>

Source: King Edward VII Memorial Hospital

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

+ Includes Portuguese.

**Table 7.4.2**  
**Primary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related\* Cases, 2017**

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

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, 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 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	-	-	-
Opioid Dependence – Unspecified	-	-	-	-	-	-	-	-	-	-	-	-	-
Opioid Dependence – Continuous	5	5	-	1	2	3	3	1	7	3	-	-	-
Cocaine Dependence – Continuous	15	10	-	3	3	6	12	1	25	-	-	-	-
Cannabis Dependence – Continuous	35	10	2	12	10	11	8	2	37	8	-	-	-
Other Specified Drug Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Specified Drug Dependence – Episodic	-	-	-	-	-	-	-	-	-	-	-	-	-
Combined Opioid Type Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
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	-	-	-
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	-	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, Unspecified Use	3	-	-	-	1	2	-	-	3	-	-	-	-
Other, Mixed, Or Unspecified Drug Abuse, Continuous Use	1	-	-	-	-	1	-	-	-	1	-	-	-
<b>TOTAL</b>	<b>139</b>	<b>44</b>	<b>3</b>	<b>19</b>	<b>33</b>	<b>47</b>	<b>65</b>	<b>16</b>	<b>146</b>	<b>37</b>	<b>-</b>	<b>-</b>	<b>-</b>

Source: King Edward VII Memorial Hospital

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

\* Includes Portuguese.

**Table 7.4.4**  
Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related\* Cases, 2017

Secondary Diagnosis	Sex		Age Group						Race				
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Mixed	Asian	Other*
Acute Alcoholic Intoxication In Alcoholism, Unspecified Drinking Behavior	1	-	-	-	-	-	1	-	1	-	-	-	-
Acute Alcohol Intoxication- continuous	24	5	-	3	6	9	9	2	22	7	-	-	-
Alcohol Dependence Nec/Nos- continuous	2	-	-	-	1	-	1	-	1	1	-	-	-
Cocaine Dependence, Unspecified Use	2	-	-	-	1	-	1	-	2	-	-	-	-
Cannabis Dependence, Unspecified Use	2	-	-	-	2	-	-	-	1	1	-	-	-
Amphetamine And Other Psychostimulant Dependence, Unspecified Use	1	-	-	-	1	-	-	-	1	-	-	-	-

**Table 7.4.4 cont'd**  
**Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related\* Cases, 2017**

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

Source: King Edward VII Memorial Hospitals

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

\* Includes Portuguese.

## 7.5 MORTALITY: SUSPICIOUS DEATHS

### Toxicology Screening Results

The concept of “drug-related” mortality is complex. The collection of data on drug-related mortality is technically demanding but extremely important. The difficulty often arises because of the fact that some deaths are attributed to multiple causes. Summarising the conditions that caused the death can be intricate and patterns or trends of death might be missed. A death can be directly attributable to drugs, for example, overdose, or indirectly by the use of drugs related to external circumstances, for example, traffic accidents. In addition, there are deaths attributable to problem drug use as well as deaths related to drugs but which are due to circumstantial reasons, for example, violence related to drug trafficking or drug-related crime.<sup>12</sup>

The challenge with drug-related deaths is that the causes of death recorded by physicians certifying the deaths in certain

cases are usually linked to causes other than substance or drug use overdose. For instance, a person may be involved in a fatal road traffic accident. In this case, the physician records or codes the death as “transport accident” using the ICD-10.<sup>13</sup> 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

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

<sup>13</sup> See <http://apps.who.int/classifications/icd10/browse/2010/en>

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 2017, 48 cases were screened compared to 39 in 2016 (see Table 7.5.1). Most of the cases forwarded for screening were for males, 31 in 2016 and 39 cases in 2017. 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 2016, 36% of the cases (14 of 39) screened positive for excess ethanol or illegal or non-prescribed drugs compared to 50% (24 of 48) in 2017. 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 was one drug-induced deaths (acute episode of poisoning or toxicity to drugs, for example, accidental overdose or intentional self-harm, or drug dependence) and no alcohol-induced death among those deaths with toxicology screens in 2017. Additionally, in 2017, there was one drug-induced death and two alcohol-induced deaths, for which toxicology screens were not conducted. This results in a total of two drug-induced and two alcohol-induced deaths for 2017. This is one less drug-induced death than in 2016, where there was three drug-induced and two alcohol-induced deaths. Alcohol- and drug-induced deaths do not include accidents, homicides, and other causes indirectly related to

alcohol and drug use. However, there were a number of 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); five cases in 2016 and ten in 2017 (see Table 7.5.1). Additionally, there were three cases in 2016 and five in 2017 of deaths by homicide in which alcohol and or drugs were present.

The Epidemiology and Surveillance Unit also calculates smoking-attributable mortality, which is an estimate of the number of deaths that are related to smoking. In 2017, there were 49 tobacco-related deaths as compared to 61 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 mainly transport accident or assault (see Table 7.5.1). However, there were also instances of deaths, which were caused as a result of other external causes, such as some disease of the circulatory system and drowning, where excess alcohol or drugs were detected. Epidemiological research has indicated that alcohol use increases the risk for many chronic health consequences (for example, diseases) and acute consequences (for example, traffic crashes). 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.

**Table 7.5.1**  
*Toxicology Screens, Substances Detected, and Causes of Death, 2016 and 2017*

	2016	2017
Total Number of Deaths (All Causes)	504	494
Proportion of Deaths with Toxicology Screens (%)	7.7	9.7
Total Number of Toxicology Screens	39	48
By Sex:		
Males	31	39
Females	8	9



**Table 7.5.1**  
*Toxicology Screens, Substances Detected, and Causes of Death, 2016 and 2017*

	2016	2017
<b>By Age Group:</b>		
< 18 Years	2	1
18 – 25 Years	5	6
26 – 35 Years	5	7
36 – 45 Years	8	6
46 – 60 Years	10	12
60+ Years	9	16
<b>Substances Detected in Toxicology Screens (Number of Cases)</b>		
Ethanol <sup>a</sup> (>80 mg)	4	7
Drugs <sup>b</sup>	8	10
Ethanol and Drugs	2	7
None/<80 mg Ethanol/Drugs in Therapeutic Range	25	24
<b>Causes of Death (ICD-10)<sup>c,d</sup> (Persons with Detected Substances)</b>	14	24
Diseases of the Circulatory System	1	2
Diseases of the Nervous System	...	1
<b>External Causes of Morbidity and Mortality</b>		
Transport Accident	5	10
Other External Causes of Accidental Injury	-	2
Assault	3	5
Intentional Self-Harm	2	1
Accidental Drowning and Submersion	1	1
Accidental Poisoning by Exposure to Noxious Substance	2	1
Defined and Unknown Causes of Death Not Elsewhere Classified	-	1

Source: Central Government Laboratory and Epidemiology and Surveillance

Notes:

<sup>a</sup> Whether in blood, vitreous, or urine.

<sup>b</sup> Drugs whether in blood, vitreous, urine, or liver and include: 6-MAM, amitriptyline, benzoylcegonine, BZE, cocaine, codeine, diphenhydramine, hydrocodone, ibuprofen, midazolam, morphine, paracetamol, THC, THC-OH, THC-COOH, or a combination.

<sup>c</sup> One sample (liver blood) tested positive for ethanol but the exact level was unable to be determined due to the advanced state of decomposition.

<sup>d</sup> 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.<sup>14</sup> 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,

<sup>14</sup> 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.

and paint thinner can all cause newborns to experience drug withdrawal.<sup>15</sup>

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, more than half of pregnant women in 2016 (58.8%) and all in 2017 used one or more than one illicit drug over their gestational cycle. In 2016, nine of the 10 confirmed positive tests were for marijuana and one tested positive for cocaine. In 2017, all of the 21 confirmed positive tests were for marijuana. In the year 2016, half (five) of the women tested positive have used these drugs during their first trimester. Similarly, in 2017, 52.4% of the women who have tested positive for using marijuana have done so in their third trimester.

In 2017, all of the 21 positive tests were confirmed for marijuana.

<sup>15</sup> 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.

**Table 7.6.1**  
*Drug Screening for Marijuana among Pregnant Women Attending the Maternal Health Clinic, 2016 and 2017*

	Number of Pregnant Women	
	2016	2017
Total Number of Tests	17	21
Total Number of Positive Tests	10	21
Positive Tests by Gestation		
First Trimester	5	5
Second Trimester	5	5
Third Trimester	-	11

Source: Maternal Health Clinic



# Chapter 8

## Drug Prevention Programmes

---

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





## 8.1 BOTVIN'S LIFESKILLS TRAINING PROGRAMME

Botvin's LifeSkills Training (LST) is a research-validated substance abuse prevention programme proven to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviours.<sup>16</sup> It is recognised as a model or exemplary programme and has been adopted for use in Bermuda in the past few years by drug prevention partners PRIDE Bermuda and CADA. The LST programme runs in selected classrooms at the primary, middle, and high school levels during the school year at either scheduled class times or times dedicated for this curriculum. This comprehensive programme provides adolescents and young teens with the confidence and skills necessary to handle successfully challenging situations. Rather than merely teaching information about the dangers of drug abuse, Botvin's LST consists of three major components – drug resistance skills, personal self-management skills, and general social skills – that cover the critical domains found to promote drug use. These skills help to promote healthy alternatives to risky behaviours through activities designed to: teach students the necessary skills to resist social (peer) pressures to smoke, drink, and use drugs; help students to develop greater self-esteem and self-confidence; enable students to effectively cope with anxiety; increase their knowledge of the immediate consequences of substance abuse; and enhance cognitive and behavioral competency to reduce and prevent a variety of health risk behaviours.

PRIDE and CADA, as part of their programme performance monitoring, compile LST programme data. The data in Table 8.1.1 shows that in both school years, 2016/2017 and 2017/2018, PRIDE has implemented the LST programme in classrooms at only the primary level. Specifically, in the 2016/2017 school year, 22 classrooms across 10 primary schools implemented the LST programme. Similarly, the LST programme coverage in the 2017/2018 school year spanned 20 classrooms across nine primary schools. While there were a large number of students (44) who dropped out of the programme at the primary school level during the 2016/2017 school year, there was a notable decrease in 2017/2018 of dropouts (13). A total of 283 and 296 students completed the programme at this level during the two academic years in review, respectively.

Across all participating classrooms in the primary schools, there were 229 sessions for students in 2016/2017 and 178 in 2017/2018. The notable decrease in the number of sessions from the 2016/2017 school year to the 2017/2018 school year can be attributed to a facilitator conducting 29 more sessions than the required 40 for the latter school

year. This extra facilitation took place due to the many issues that arose and needed to be addressed with the students. Each session, averaging approximately 45 minutes, covered all three levels of the primary curriculum, which is equivalent to each class completing the assigned eight modules in each school year under review. The average pre-test score for the students at the primary level was 57.0% versus 70.0% at the post test in 2016/2017 and 58.0% versus 72.0% in 2017/2018. This is equivalent to an average gain score (difference between post test and pre-test scores) of more than 10.0% in both years under review.

CADA, on the other hand, implemented the LST in only the middle- and high-school levels in both school years under review. In each year, two classes in one middle school received the 14-module Level 1 middle-school programme, with 26 students completing the curriculum over 34 sessions in 2016/2017 and 39 students completing the curriculum over 36 sessions in 2017/2018 (see Table 8.1.2). There was a 100.0% completion rate of all the modules in each of the two classes in both years. In 2016/2017, the average gain score at this level was 10.0% with an average pre-test score of 71.0% versus 81.0% at the post test; and, in 2017/2018, the gain score dropped to 3.0% with an average pre-test score of 72.0% compared to 75.0% at the post test.

At the high-school level, three classes in one high school received the programme over 29 sessions with a total of 48 students in 2016/2017 and 30 sessions with a total of 43 students in 2017/2018. There was a 100.0% completion rate of the seven-module curriculum in both years under review. The programme showed improvement in the last two academic years at this level in terms of the gain score. Specifically, in the 2016/2017 school year at the high-school level, the average post test score (83.0%) was 2.0% higher than the average pre-test score (81.0%). Similarly, the 2017/2018 school year recorded a positive gain score of 3.0% with average pre-test score of 83.0%, increasing to an average post test score of 86.0%.

...the LST programme coverage in the 2017/2018 school year spanned 21 classrooms across 9 primary schools.

<sup>16</sup> <http://lifeskillstraining.com/overview.php?t=overview>

**Table 8.1.1**  
PRIDE Bermuda's LifeSkills Programme Statistics, 2016/2017 and 2017/2018

Programme Indicators	School Year and Level	
	2016/2017	2017/2018
	Primary	Primary
Number of Schools Participated	10	9
Number of Classes Participated	22	20
Number of Students Engaged	327	309
Number of Students Dropped Out	44	13
Number of Students Retained	283	296
Number of Sessions	229	178
Number of Modules Completed	175	168
Total Number of Modules	176	168
Proportion of Curriculum Completed (%)	99	100
Average Pre-Test Score (%)	57	58
Average Post Test Score (%)	70	72

Source: PRIDE Bermuda

**Table 8.1.2**  
CADA's LifeSkills Programme Statistics, 2016/2017 and 2017/2018

Programme Indicators	School Year and Level			
	2016/2017		2017/2018	
	Middle	High	Middle	High
Number of Schools Participated	1	1	1	1
Number of Classes Participated	2	3	2	3
Number of Students Engaged	30	48	41	43
Number of Students Dropped Out	4	3	2	3
Number of Students Retained	26	45	39	40
Number of Sessions	34	29	36	30
Number of Modules Completed	28	21	28	21
Total Number of Modules	28	21	28	21
Proportion of Curriculum Completed (%)	100	100	100	100
Average Pre-Test Score (%)	71	81	72	83
Average Post Test Score (%)	81	83	75	86

Source: PRIDE Bermuda

## 8.2 PROMOTING ALTERNATIVE THINKING STRATEGIES PROGRAMME

The Promoting Alternative Thinking Strategies (PATHS) curriculum is a model social and emotional learning programme that was designed to help children develop self-control, positive self-esteem, emotional awareness, and interpersonal problem-solving skills; and it has been recognised for its effectiveness. An evaluation tool is used to assess the PATHS lessons to see how well students received these lessons. Students are evaluated at two different time points: at the beginning of the school year (pre-curriculum) with a pre-test and then again at the end of the school year (post curriculum) with a post test to monitor the progress that they have made during the school year. Both the pre-

and post tests contain questions on three key behavioural areas (aggression/disruptive behaviour, concentration or attention, and social and emotional competence). Students are evaluated using a numerical rating scale of 0 to 5 (never or almost never, rarely, sometime, often, very often, and almost always) on a total of 31 (Primary 1 level) and 30 (Primary 2 level) individual behaviours.

This programme is coordinated by PRIDE Bermuda and, in the last two academic years, the curriculum was delivered to one primary school in the 2016/2017 year and increased to two during the 2017/2018 school year. However, the PATHS

Developer indicated that, going forward, the number of students assessed should be reduced to alleviate the burden on teachers to assess every student. There were challenges noted with teachers being able to complete assessments for all of their students. Therefore, the suggestion from the PATHS Developer to randomly select 8 students per class began during the 2017/2018 school year. The data on Table 8.2.1 shows that two classes at each of the first three primary levels participated in the 2016/2017 and one class at the Primary 5 level. The programme extended to the Primary 4 and 6 levels in the 2017/2018 school year; which meant that students who received the curriculum in 2016/2017 at the Primary 3 and Primary 5 levels continued onto the next level of the curriculum in Primary 4 and Primary 6 in the subsequent school year. Three classes each at the Primary 1 to 6 levels were assessed in 2017/2018. The curriculum was delivered two times each week with each session being approximately 30 minutes in length. A total of 109 students at four different primary levels were engaged for the entire programme in 2016/2017 and 261 students at the six primary levels in 2017/2018 (average class size was approximately 19 students in 2017/2018). The students at the Primary 1 level completed 83 of 90 modules in 2016/2017 (92.0% curriculum completion) and 103 of 135 in 2017/2018 (76.0% curriculum completion). The Primary 2 level saw completion rates of 97.0% in 2016/2017 and 31.0% in 2017/2018. At the Primary 3 level, the classes completed 94.0% of the curriculum in 2016/2017 and 60.0%

in 2017/2018. In 2017/2018, Primary 4 completed 53.0% of the curriculum and Primary 6 completed 44.0%. At the Primary 5 level, the classes completed 98.0% in 2016/2017 and 36.0% in 2017/2018.

In terms of behavioural maturity for 2017/2018, the average change results (difference between the post test and pre-test scores) showed that, in most instances, about half or more of the students showed improvement in the three key behavioural areas with the largest proportion of students showing improvement in social and emotional competence. At the same time there was a fraction of the students who showed no change, on average, in any of the behaviours assessed or whose behaviours actually became worse (negative change). Students at the higher grades were more likely to show a negative average change on aggression/disruptive behaviours. For instance, in 2017/2018, 63% of the Primary 4 students, 91% of the Primary 5 students, and 62% of the Primary 6 students, showed a negative average change on aggression/disruptive behaviours, which include elements such as fights, handling disagreements negatively, and getting angry when provoked, among others. This indicates that, for these students, their behaviours on this component worsened. There were 3% of the Primary 3 students in 2016/2017 whose behaviour on concentration/attention remained unchanged and increased to 20% in the subsequent school year at the Primary 4 level.

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

**Table 8.2.1**  
PRIDE Bermuda's PATHS Programme Statistics, 2016/2017

Programme Indicators	2016/2017			
	Primary 1	Primary 2	Primary 3	Primary 5
Number of Schools	1	1	1	1
Number of Classes Participated	2	2	2	1
Number of Students Engaged	22	32	35	20
Number of Students Dropped Out	-	1	3	-
Number of Students Retained	22	31	32	20
Number of Sessions	83	104	94	39
Number of Modules Completed	83	101	94	39
Total Number of Modules	90	104	100	40
Proportion of Curriculum Completed (%)	92.0	97.0	94.0	98.0
Number of Students Evaluated	(n=22)	(n=31)	(n=32)	(n=20)
<b>Evaluation of Behaviours</b>				
Improvement (% of students)				
Aggression/Disruptive Behaviours	27.0	64.0	28.0	-
Concentration/Attention	40.0	77.0	59.0	-
Social and Emotional Competence	59.0	87.0	59.0	-

**Table 8.2.1 cont'd**  
PRIDE Bermuda's PATHS Programme Statistics, 2016/2017

Programme Indicators	2016/2017			
	Primary 1	Primary 2	Primary 3	Primary 5
<b>Negative Change (% of students)</b>				
Aggression/Disruptive Behaviours	63.0	6.0	50.0	-
Concentration/Attention	45.0	16.0	37.0	-
Social and Emotional Competence	22.0	12.0	34.0	-
<b>No Change (% of students)</b>				
Aggression/Disruptive Behaviours	9.0	29.0	21.0	-
Concentration/Attention	13.0	6.0	3.0	-
Social and Emotional Competence	18.0	-	6.0	-

Source: PRIDE Bermuda

**Table 8.2.2**  
PRIDE Bermuda's PATHS Programme Statistics, 2017/2018

Programme Indicators	2017/2018					
	Primary 1	Primary 2	Primary 3	Primary 4	Primary 5	PRIMARY 6
Number of Schools	2	2	2	2	2	2
Number of Classes Participated	3	3	3	3	3	3
Number of Students Engaged	42	37	39	46	44	53
Number of Students Dropped Out	-	1	2	-	1	-
Number of Students Retained	42	36	37	46	43	53
Number of Sessions	103	33	91	67	43	48
Number of Modules Completed	103	33	91	67	43	48
Total Number of Modules	135	104	150	126	120	108
Proportion of Curriculum Completed (%)	76.0	31.0	60.0	53.0	36.0	44.0
Number of Students Evaluated	(n=24)	(n=15) <sup>a</sup>	(n=22) <sup>b</sup>	(n=24)	(n=23) <sup>c</sup>	(n=24)
<b>Evaluation of Behaviours</b>						
<b>Improvement (% of students)</b>						
Aggression/Disruptive Behaviours	63.0	27.0	41.0	17.0	9.0	25.0
Concentration/Attention	54.0	67.0	86.0	42.0	57.0	58.0
Social and Emotional Competence	84.0	20.0	86.0	67.0	65.0	66.0
<b>Negative Change (% of students)</b>						
Aggression/Disruptive Behaviours	29.0	53.0	46.0	63.0	91.0	62.0
Concentration/Attention	29.0	20.0	9.0	38.0	30.0	21.0
Social and Emotional Competence	16.0	53.0	14.0	21.0	30.0	25.0
<b>No Change (% of students)</b>						
Aggression/Disruptive Behaviours	8.0	20.0	13.0	20.0	-	13.0
Concentration/Attention	17.0	13.0	5.0	20.0	13.0	21.0
Social and Emotional Competence	-	27.0	-	12.0	5.0	9.0

Source: PRIDE Bermuda

**Note:**

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



# Chapter 9

## Certified Professionals

---

- Occupation
- Type of Certification





## 9.1 CERTIFIED TREATMENT AND PREVENTION PROFESSIONALS

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

Certification of treatment and prevention professionals occurs every two years ending in May, at which time persons must be recertified. Statistics from the BACB showed that the fields of drug treatment and prevention gained seven professionals since the last report. Specifically, in 2017, there were 61 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, a few of whom may also be CCS (Certified Clinical Supervisor) certified (see Table 9.1.2). The number of certified clinical supervisors increased by two persons in 2017, while prevention specialists remained the same over the last two years. It should be noted that there are also private and other practitioners who have not yet been certified by the BACB.

...there were 61 certified persons in substance abuse treatment and prevention occupations; most of whom are alcohol or drug counsellors...

**Table 9.1.1**  
*Certified Treatment and Prevention Professionals by Occupation, 2016 and 2017*

Occupation	2016	2017
Treatment		
Alcohol/Drug Counsellors	34	37
Associate Counsellors	6	8
Clinical Supervisors	8	10
Prevention		
Prevention Specialists	6	6
Associate Prevention Professional	-	-
<b>Total</b>	<b>54</b>	<b>61</b>

Source: Bermuda Addiction Certification Board

**Table 9.1.2**  
*Certified Treatment and Prevention Professionals by Type of Certification, 2016 and 2017*

Field of Certification	2016	2017
Treatment		
ICADC	34	37
CCS	8	10
ACAD	6	8
Prevention		
CPS	6	6
APP	-	-
<b>Total</b>	<b>54</b>	<b>61</b>

Source: Bermuda Addiction Certification Board





# Chapter 10

## Survey Data

---

- Public Perceptions of Crime and Health
- Public Perceptions of Substance Abuse and Misuse
- Drug Prevalence: Criminal Offenders
- Treatment Demand Indicators



## 10.1 PUBLIC PERCEPTIONS OF CRIME AND HEALTH

Concerns relating to crime, drug prevalence, and health have been common issues for Bermuda's residents in recent years. The DNDC utilised the second quarter 2018 Omnibus Survey, a sample survey of 401 residents, to evaluate the community's perceptions of these issues.

Concerns relating to crime have been a common issue for Bermuda residents over the past number of years. In order to assess feelings of personal safety, residents were asked about how safe they felt in their own neighbourhoods. The majority of residents continue to feel safe in their neighbourhoods. Little change has been observed in residents' feeling of personal safety over the past year, with the vast majority feeling either extremely (35.0% compared with 34.0% in June 2017) or mostly (63.0%, no change) safe in their own neighbourhoods (see Table 10.1.1). There were only a few residents who reported feeling unsafe to any degree (2.0%, no change). It is important to note, however, that the degree to which residents feel safe has steadily increased since monitoring began in 2010. Differences are noted across the population, with males and lower income earners being less likely to report feeling extremely safe in their neighbourhoods. Across the Island, residents of Warwick/Paget (Sandys/Southampton in 2017) 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 ago. Despite widespread feelings of safety, there was a small, but growing portion, of residents who reported feeling less safe when compared with six months ago. Specifically, more than eight in 10 residents stated that they now feel as safe as they did (82.0%, down three points from 2017) compared with six months ago, marking a slight decrease from 2017. Alternatively, there has been a comparable increase in the proportion of residents who now feel less safe (6.0%, up two points), along with just over one in 10 now feeling safer (12.0%, up two points) than they did six months ago. Of note, younger black males with lower income are more likely, than their respective counterparts, to indicate increased feelings of safety in their own neighbourhoods.

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

that they felt less safe and those from Sandys to Paget 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 breaking and entering (31.0%, down nine points). There were just over one-half of residents indicating that there was knowledge of at least one type of crime committed in their neighbourhood, with fewer residents reporting awareness of three or more different types of crime within the past 12 months. As with previous findings, breaking and entering to steal personal property was most often reported (30.0%, down 10 points), closely followed by theft (30.0%, up one point) (see Table 10.1.2). Only a small number of residents knew of people openly selling or using drugs (22.0%, up three points) or of crimes committed with guns (11.0%, down one point). Finally, fewer than one in 10 reported assaults (7.0%, down two points) or murder (5.0%, down two points). Noteworthy of mention, is that each of these types of crimes is currently at a five-year low.

Some differences were evident between parishes and demographics. Across parishes, residents of Hamilton/St. George's 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 neighbourhoods. 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 continued to rate their

...the degree to which residents feel safe has steadily increased since monitoring began in 2010.

physical and mental well-being positively as very good/good (94.0%, no change). Indeed, one-half indicated that their health is good (54%, down four points from 2017), while slightly more residents described their health as being very good (40.0%, up four points). On the other hand, only a small proportion of residents rated their well-being poorly (6.0% stated poor/very poor; up one point). Across the population, residents positively evaluated their own well-being to varying degrees. In particular, male residents with higher income, under the age of 55 years old, and black were more likely, than their counterparts, to cite being in very good health. Meanwhile, residents of Pembroke/Devonshire are most likely to report being in very good health.

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?)

(n = 401)

	Bermuda Overall %	Parish				Gender		Household Income			Age			Race		Bermudian?	
		Sndy/Sthp	War/Paget	Pem/Devon	Ham/Sm/Sg	Male	Female	<\$75K	\$75K-\$150K	>150K	18-34	35-54	55+	Black	White	Yes	No
Extremely Safe	35	40	41	31	31	34	35	30	39	33	33	37	33	37	28	33	41
Mostly Safe	63	59	57	67	66	63	63	69	57	66	63	63	64	60	71	64	57
Mostly Unsafe	2	1	2	3	3	2	2	1	3	1	4	-	3	2	2	2	2
Extremely Unsafe	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Don't Know/No Answer	-	-	-	-	-	1	-	-	1	-	-	-	1	1	-	-	-
Weighted Sample Size (#)	401	76	95	107	114	190	211	124	414	101	95	175	131	216	128	331	69
Unweighted Sample Size (#)	401	73	96	110	114	161	240	120	141	101	77	161	163	194	135	337	62
% Extremely/Mostly Safe	35	40	41	31	31	34	35	30	39	33	33	37	33	37	28	33	41
% Mostly/Extremely Unsafe	63	59	57	67	66	63	63	69	57	66	63	63	64	60	71	64	57

Source: DNDC's Commissioned Questions in 2<sup>nd</sup> Quarter 2018 Bermuda Omnibus Survey<sup>®</sup>

Table 10.1.2

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

People openly selling or using drugs?

(n = 401)

	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	22	16	19	20	28	2	17	23	26	16	26	22	18	23	18	24	9
No	76	81	80	77	69	72	79	75	71	83	72	76	79	74	80	73	89
Don't Know	2	3	1	2	3	1	4	2	3	1	2	2	3	3	2	2	2
Weighted Sample Size (#)	401	76	95	107	114	190	211	124	141	101	95	175	131	216	128	331	69
Unweighted Sample Size (#)	401	73	96	110	114	161	240	120	141	101	77	161	163	194	135	337	62

Source: DNDC's Commissioned Questions in 2<sup>nd</sup> Quarter 2018 Bermuda Omnibus Survey<sup>®</sup>

**Table 10.1.2 cont'd**

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

A theft (auto or personal property) having occurred?

(n = 401)

	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	30	29	27	37	28	33	28	17	36	41	34	35	22	20	43	31	28
No	67	70	70	58	71	65	68	79	61	58	64	63	75	77	54	67	69
Don't Know	3	1	3	5	2	2	4	4	2	1	3	3	3	3	3	3	2
Weighted Sample Size (#)	401	76	95	107	114	190	211	124	141	101	95	175	131	216	128	331	69
Unweighted Sample Size (#)	401	73	96	110	114	161	240	120	141	101	77	161	163	194	135	337	62

Source: DNDC's Commissioned Questions in 2<sup>nd</sup> Quarter 2018 Bermuda Omnibus Survey<sup>®</sup>

Breaking and entering to steal personal property?

(n = 401)

	Bermuda Overall %	Parish				Gender		Household Income			Age			Race		Bermudian?	
		Sndy/Sthp	War/Paget	Pem/Devon	Ham/Sm/Sg	Male	Female	<\$75K	\$75K-\$150K	>150K	18-34	35-54	55+	Black	White	Yes	No
Yes	31	29	24	32	39	32	30	20	38	39	23	37	30	24	43	33	24
No	67	71	74	63	60	68	66	79	59	60	73	61	69	75	54	65	73
Don't Know	2	0	0	4	1	0	4	1	3	1	4	2	1	1	3	2	3
Weighted Sample Size (#)	401	76	95	107	114	190	211	124	141	101	95	175	131	216	128	331	69
Unweighted Sample Size (#)	401	73	96	110	114	161	240	120	141	101	77	161	163	194	135	337	62

Source: DNDC's Commissioned Questions in 2<sup>nd</sup> Quarter 2018 Bermuda Omnibus Survey<sup>®</sup>

Crimes committed with guns?

(n = 401)

	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	11	16	2	12	71	11	10	9	12	9	17	9	9	12	9	11	10
No	88	83	98	86	88	89	88	90	87	91	80	91	91	88	90	88	88
Don't Know	1	1	0	2	1	0	2	1	1	0	3	1	0	0	1	1	1
Weighted Sample Size (#)	401	76	95	10	114	190	211	124	141	101	95	175	131	216	128	331	69
Unweighted Sample Size (#)	401	73	96	110	114	161	240	120	141	101	77	161	163	194	135	337	62

Source: DNDC's Commissioned Questions in 2<sup>nd</sup> Quarter 2018 Bermuda Omnibus Survey<sup>®</sup>

## 10.2 PUBLIC PERCEPTIONS OF SUBSTANCE ABUSE AND MISUSE

The survey on public perceptions of substance abuse and misuse was implemented to gather information from the general public to utilise toward the “Green Paper on Substance Misuse and Abuse”. This survey is the first of its kind conducted by the DNDC and serves to inform policy makers of the public’s opinions and beliefs regarding prevention and treatment of substance abuse and misuse. It aimed to identify characteristics and social factors that are associated with drug misuse and abuse.

In addition to demographic questions, the survey contained questions on concern and awareness, social and retail availability, consequences of drug use, law enforcement, substance abuse treatment, and substance abuse prevention.

This survey was a web-based telephone survey, administered during the period of March 21<sup>st</sup> to 28<sup>th</sup>, targeting a

representative sample of 501 adults age 16 years and older residing in Bermuda.

Although the survey on public opinion of substance abuse and misuse provides useful information, it has certain limitations. Firstly, this survey is the first of its kind in Bermuda. It served to provide baseline information of the attitudes, opinions, and knowledge of a host of alcohol and drug related policy measures. Therefore, no data exists for comparison purposes. Secondly, the data are self-reports of opinion and attitudes, and their value depends on respondents’ willingness to provide information and their ability to recall past experiences. Finally, the survey is cross-sectional rather than longitudinal; that is, individuals were interviewed only once and were not followed for subsequent interviews.

In relation to substances most likely to be used by various age groups, youth 13-17 years were perceived to most likely use solvents (31.5%), followed by marijuana (16.7%) (see Table 10.2.1). Young adults 18-25 years were thought to most likely use marijuana (52.2%) and alcohol (48.0%). In contrast, adults 26-45 years were perceived to most likely use cocaine (52.6%) and heroin (50.4%). When it came to adults 46-64 years, non-prescription tranquilisers/stimulants (8.2%) and heroin (9.4%) were thought to most likely be used by this group. Older adults, those 65 years and older, were not perceived to most likely use any substance although non-prescription tranquilisers/stimulants (0.8%) and cocaine, ecstasy, and crack cocaine at 0.8%, respectively, were named as drugs most likely to be abused. Alcohol was not perceived to be used mostly by any of the age groups.

When asked about cannabis use, majority of the respondents said that use should result in no legal consequences, but in compulsory education or treatment.

When asked about cannabis use, the majority of the respondents said that use should result in no legal consequences; instead, there should be compulsory education or treatment (58.6%). Over half of those surveyed thought that cannabis use should be classified as a non-criminal offence and the penalty be a fine (55.6%). This was followed by those

who felt that cannabis use should be defined as a criminal offence and be subjected to criminal enforcement, criminal penalty, and a criminal record at 26.9%. Lastly, a smaller proportion of respondents (19.1%) said that cannabis use should result in no legal or other consequences at all.

When it came to ease of access, the top three substances that were perceived easy to access included alcohol (97.0%), solvents (52.2%), and marijuana (52.0%) (see Table 10.2.2). Whereas, the most difficult substances to access were heroin (31.7%) and ecstasy (31.1%).

Respondents offered many solutions to reducing drug and alcohol problems. The three most common and effective ways put forward focused on: providing the community with education and awareness, especially early education for youth; providing better control of alcohol and drug use through law enforcement; and tougher regulations.

It is important to note that the majority of the respondents were in favour of more severe legal penalties for drink driving (86.1%) and also supported the idea of having a visible police presence around licensed venues such as bars and nightclubs (85.7%).

## 10.2.1 TREATMENT

Participants were asked to what extent they agreed or disagreed with the statement, 'Treatment should be available to all drug users, according to their needs.' The majority (95.4%) were in favor of this statement. Over half (50.6%) of the respondents indicated that they do not know where to refer someone who is in need of treatment for substance abuse or misuse in Bermuda. Of the 228 persons who

reported that they know where to refer someone who is in need of treatment for substance abuse or misuse in Bermuda, they highlighted treatment facilities such as the Mid-Atlantic Wellness Institute (MWI), Turning Point, and Harbour Light – Salvation Army.

## 10.2.2 PREVENTION

Nearly three-quarters (71.7%) of the respondents stated that they are not aware of any substance abuse/misuse prevention strategies in Bermuda. Survey participants, who stated that they were aware of a substance abuse/misuse prevention strategy, identified a variety of them such as CADA and the Drive for Change Campaign. Whilst the majority of respondents identified not knowing

of any prevention strategies, in the last 12 months, it was reported that most (32.9%) participants have seen or heard information regarding alcohol prevention strategies in Bermuda. Prevention strategies regarding marijuana ranked second highest (18.3%) as seen by the respondents.

**Table 10.2.1**  
**Substances Most Likely To Be Used By Various Age Groups (% of Respondents), 2018**

Substance	Age Group (Years)				
	12-17	18-25	26-45	46-64	65+
Alcohol	10.2	48.0	32.3	4.8	0.4
Marijuana	16.7	52.2	20.9	2.6	0.2
NPT/S	3.8	20.1	26.9	8.2	0.8
Solvents	31.5	16.1	12.2	2.8	0.6
Cocaine	1.8	22.3	52.6	6.0	0.8
Heroin	1.4	19.7	50.4	9.4	0.4
Ecstasy	3.8	40.2	27.9	4.6	0.8
Crack Cocaine	1.4	21.9	51.9	6.8	0.8

Source: 2018 Public Perceptions of Substance Abuse and Misuse Survey

**Table 10.2.2**  
**Ease of Access to Substances (% of Respondents), 2018**

Substance	Could not have access	Easy	Difficult	Don't know
Alcohol	1.2	97.0	0.2	0.4
Marijuana	10.2	52.0	18.9	17.7
NPT/S	11.4	20.3	28.1	35.5
Solvents	5.0	52.2	10.4	29.3
Cocaine	12.5	26.5	30.9	28.9
Heroin	13.5	24.1	31.7	29.5
Ecstasy	12.4	21.9	31.1	33.5
Crack Cocaine	13.3	24.7	30.5	30.5

Source: 2018 Public Perceptions of Substance Abuse and Misuse Survey

## 10.3 DRUG PREVALENCE: CRIMINAL OFFENDERS

The Drug Abuse Monitoring Survey is conducted every three years with the survey conducted in 2017-2018 being the fifth of its kind. The survey lasted for one year, from April 1<sup>st</sup> 2017 through March 31<sup>st</sup> 2018 and was administered to offenders on reception at two correctional facilities in Bermuda.

The Drug Abuse Monitoring Programme serves several purposes. Surveillance of drug use in Bermuda is a focal point of the DNDC's Research Unit, especially monitoring drug consumption among high-risk populations, such as the inmate population. The collection of data related to drug of choice and length of use allows for the classification of offenders based on the level of severity of substance abuse problems, which is a good indicator of those requiring substance abuse treatment. The information provided also

highlights the type of crimes committed by substance users, especially by the type of drug consumed.

The survey targeted the incarcerated population who were housed at either the Westgate Correctional or the Co-Educational facility (reception offenders). Persons who are received at the Westgate Correctional facility would be offenders 18 years and above, whereas persons at the Co-Ed facility would be offenders below the age of 18 years. Therefore, the ages of the respondents are wide-ranging.

The questionnaire was administered by a staff attached to either of the two facilities, or a trained external interviewer in the form of a face-to-face interview, on reception of each inmate or within 48 hours.

### 10.3.1 DRUG USE

Respondents were asked to report if they have "ever taken or used (...) in their lifetime? Their negative responses ("No") to these questions provided the number of respondents

who reported that they have never tried any of the drugs surveyed. Overall, 98.7% of the total respondents (n = 230) have reported the use of at least one drug in their lifetime.

The results showed that respondents recorded the highest lifetime consumption for alcohol (78.7%), marijuana (76.5%), cigarettes/tobacco (70.4%), crack cocaine (25.7%), and cocaine powder (23.0%) (see Table 10.3.1). Other lifetime prevalence ranged from a low of 1.7% for methamphetamine to a high of 38.2% for heroin and ecstasy. In terms of current use, respondents indicated the highest consumption for alcohol (54.8%), and marijuana and cigarettes/tobacco (53.0%). Consumption of other substances in the current use period ranged from a low of 0% for LSD, methamphetamine, and valium or benzodiazepine to a high of 11.7% for crack cocaine.

The respondents used drugs, on average, as seldom as two days in the last month to as frequent as 22 days. On average, the respondents who reported current use of substances indicated use of three substances for more than half of the preceding 30-day period: cigarettes/tobacco (22.3 days), followed by heroin (20.8 days) and marijuana (18.4 days) (see Table 10.3.1).

Respondents were asked to report the age at which they first used 12 listed substances. Some of these substances are generally considered to be the major gateway drugs, usually preceding the use of hard drugs.<sup>17</sup> The average age of onset is based only on the ages of first use of respondents who indicated ever engaging in the behaviour, that is, lifetime users.

As can be seen from Table 10.3.1, the average age of initiation of drug use for the overall surveyed population ranges from a low of 14.3 years for Cigarettes/Tobacco to a high of 34.2 years for methadone. There were persons who began using marijuana around 14.0 years. Alcohol use began around 15.3 years while the use of methamphetamine began around 19.3 years, on average.

<sup>17</sup> National Center on Addiction and Substance Abuse. (1994). National Study Shows "Gateway" Drugs Lead to Cocaine Use. In R. J. Hackett (Ed.), *Columbia University Record*, 20(4). Columbia University, NY: Office of Public Information. [http://www.columbia.edu/cu/record/archives/vol20/vol20\\_iss10/record2010.24.html](http://www.columbia.edu/cu/record/archives/vol20/vol20_iss10/record2010.24.html) (accessed January 25, 2012).

**Table 10.3.1**  
*Lifetime and Current Prevalence of Substance Use by Proportion of Respondents, 2017/2018*

Substance	Lifetime Use (%) (n = 230)	Average Age of First Use (Years)	Current Use (%) (n = 230)	Average Number of Days Used In Last 30 Days
Cigarettes/Tobacco	70.4	14.3	53.0	22.3
Alcohol	78.7	15.3	54.8	11.4
Marijuana	76.5	14.0	53.0	18.4
Crack Cocaine	25.7	22.7	11.7	14.2
Cocaine Powder	23.0	21.7	3.0	6.5
Heroin	17.8	21.2	8.3	20.8
Ecstasy	20.4	22.3	1.7	5.2
LSD	6.5	19.9	-	-
Methamphetamine	1.7	19.3	-	-
Valium/Benzodiazepine	3.5	32.9	-	-
Methadone	7.8	34.2	2.2	14.6
Other Street Drugs	8.3	22.9	1.3	1.6

Source: DNDC's 2017-2018 Drug Abuse Monitoring Survey

## 10.3.2 DRUG AND ALCOHOL CONNECTION WITH OFFENCE

...over one-third of people reported that drugs were connected to their current, and past offences.

Respondents were asked specific questions to determine whether drugs and/or alcohol were in any way connected to their current or previous offence(s). Noteworthy of mention, is the number of drug-connected offences, in that over one-quarter of the inmates reported that drugs were connected to their current (27.4%) and past (27.8%) offence(s) (see Table 10.3.2). On the other hand, about one out of every five persons felt that alcohol was connected to their current (19.1%) and past (19.1%) offence(s).

Drugs were more connected to both past and current offence(s) than alcohol. When asked about the way(s) in which drugs and alcohol were connected to the offence(s), 19.1% of the respondents indicated that the offence was because of personal use or through being involved in the drug trade (12.2%). Likewise, 15.2% of the respondents indicated that the offence(s) was committed while under the influence of drugs and 12.2% of them indicated that the offence was committed to support their drug habit by providing money to buy drugs. The connection to the offence(s) being committed while under the influence of alcohol is equally as



concerning when compared to offences being committed while under the influence of drugs. The results show that alcohol played a significant role in respondents offending,

in that there were about one-fifth (21.3%) or one out of every five respondents who reported that the offence(s) was committed while under the influence of alcohol.

**Table 10.3.2**  
*Drug and Alcohol Connection with Offence, 2017/2018*

(n = 230)

Drug Connection To Offence(s)	Respondents (%)
Drug connection to current offence(s) (Yes)	27.4
Drug connection to previous offence(s) (Yes)	27.8
<b>Ways Drugs Were Connected To Offence(s)</b>	
Offence committed while under the influence of drugs	15.2
Offence committed to support drug habit (for money to buy drugs)	12.2
Through being involved with the drug trade	12.2
Personal use of drugs (possession)	19.1
Other	2.6
No answer	0.4
<b>Alcohol Connection To Offence(s)</b>	
Alcohol connection to current offence(s) (Yes)	19.1
Alcohol connection to previous offence(s) (Yes)	19.1
<b>Ways Alcohol Was Connected To Offence(s)</b>	
Offence committed while under the influence of alcohol	21.3
Offence committed to support alcohol habit (for money to buy alcohol)	3.5
Drunk driving	3.5
Other <sup>1</sup>	0.9
No answer	0.4

Source: DNDC's 2017-2018 Drug Abuse Monitoring Survey

Note:

<sup>1</sup> Includes: stealing alcohol and was intoxicated when the police were called

### 10.3.3 DRUG PRICES AND DRUG MARKET

Reported prices paid for drugs seemed very volatile. At the same time, not all of the reception inmates were able to provide answers to the questions in this section of the questionnaire. While there was, in fact, extremities in the prices reported for the various quantities of the different substances, an average price was evident for some commonly purchased quantities of drugs.

For instance, the mean prices paid for an ounce of cannabis was reported to be about \$634 as indicated by the 85 persons who provided an answer to this question (see Table 10.3.3). Other modal prices, as reported by respondents, include: \$58 for a gram of cannabis (74 respondents); \$99 for a gram of cannabis resin (34 respondents); \$2,632 for an ounce of cocaine (30 respondents); \$65 for a rock of cocaine (10 respondents); \$78 for a rock of crack (14 respondents); \$374 for a gram of heroin (22 respondents); and \$48 for a deck of heroin (8 respondents).

Despite the instability of drug prices reported in this survey, they do, however, add to the existing data on drug prices from other primary and secondary sources.

Respondents were asked to indicate if they bought any illegal drugs, for “yourself” or “others” over the past month and year. Interestingly, over half of survey respondents (57.5%) said that they had in the past 12 months, while 77.6% reported buying illegal drugs for themselves or others during the past 30 days prior to being arrested (see Table 10.3.3). When asked if they had sold illegal drugs to make money in the past 12 months, 22.6% or 42 people indicated they had sold drugs. On the other hand, when it came to selling illegal drugs during the past 30 days prior to being arrested, 66.7% (n = 34) admitted that they had sold drugs.



**Table 10.3.3**  
**Drug Prices and the Drug Market, 2017/2018**

Substance	Mean Price (\$)
Cannabis (ounce)	634
Cannabis (gram)	58
Cannabis Resin (gram)	99
Cocaine (ounce)	2,632
Cocaine (rock)	65
Crack (rock)	78
Heroin (gram)	374
Heroin (deck)	48
Drug Market in Past Year and Month	Proportion of Survey Respondents (%)
Brought illegal drug in past year	57.5
Sold illegal drug in past year	22.6
Brought illegal drug in past month	77.6
Sold illegal drug in past month	66.7

Source: DNDC's 2017-2018 Drug Abuse Monitoring Survey

## 10.4 TREATMENT DEMAND INDICATORS

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

This section of the report contains data on the clients who sought treatment from January 2016 to December 2017. There were 39 persons who sought substance abuse treatment over this period at these treatment facilities and for whom a questionnaire was completed (see Table 10.4.1). A total of 33 males and 6 females required inpatient (including residential), outpatient, and in-prison (residential) treatment services. Most persons were clients of the Salvation Army Harbour Light (15) Programme; the data presented in this section, however, does not represent the full coverage of this programme's provision of services to its clients.

Persons requiring treatment services ranged from 22 years to 69 years with the majority (51.3%) of these clients being 50 old. These persons who sought treatment were more likely to self-refer (57.9%) or, in other instances, sought treatment because of a court order or to complete probation or parole (21.1%). Slightly over seven in 10 clients (71.8%) who sought treatment during this period have received treatment sometime in the past, from as early as the year 2000 to as recent as 2015. However, only 9.7% of persons who sought

treatment have been receiving substitution treatment such as methadone.

In terms of the primary drug of impact for which persons sought treatment (see Table 10.4.2), slightly less than one-third (31.6%) of the persons sought treatment for crack use, while fewer than one-quarter sought treatment for use of alcohol (23.7%) or heroin (21.1%). Persons also sought treatment for cannabis, cocaine, and opiates in general (including methadone).

Most of the persons (60.5%) have reported daily use of drugs, whereas 18.4% indicated that they have used drugs in the two to six days per week or less prior to seeking treatment (see Table 10.4.3). Smoking or inhaling (48.7%) was reported as the main method of administering the drugs followed by eating or drinking (28.2%) (see Table 10.4.4).

The age of first use of the identified primary drug ranged from 4 years to 55 years, with an average age of onset being 24.2 years. However, less than one quarter (23.7%) of the persons who sought treatment indicated that they first used their primary drug between the ages of 13 to 17 years, while about one in 10 (13.2%) used drugs before becoming a teenager (see Table 10.4.5). Apart from the main drug of choice, some persons also reported the use of a secondary drug, for which the age of initiation ranged from an average of 15.5 years for alcohol to 31.0 years for methadone (see Table 10.4.6). The average age at which smoking marijuana began was 16.7 years. First use of harder drugs began later at about 27.0 years for cocaine and 24.0 years for crack, opiates, MDMA, and other derivatives..

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

The drug market is still operational in Bermuda as reflected by the demand for and availability or supply of drugs. A significant proportion of the persons who sought treatment reported that their primary drug was “always available” (80.0%) or “mostly available” (17.1%) and about two-thirds (69.9%) indicated that they purchased their drugs from a regular supplier (see Table 10.4.7). At the same time, more than half of the persons (60.6%) stated that they made money or obtained drugs by selling illegal drugs or being involved in the manufacture or transportation of drugs.

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

**Table 10.4.1**  
*Demographic Characteristics of Clients Seeking Treatment, 2016 and 2017*

Characteristic	Number of Persons
<b>Total</b>	<b>39</b>
<b>Sex</b>	
Males	33
Females	6
<b>Facility</b>	
Men's Treatment	5
Women's Treatment Centre	5
Turning Point	7
Right Living House	7
Salvation Army Harbour Light	15
<b>Type of Treatment Facility</b>	
Inpatient	4
Outpatient	28
Treatment in Prison	7
<b>Source of Referral</b>	
Self-Referral	22
Court/Probation/Parole	8
Family/Friends	2
Other Drug-Treatment Centre	1
Social Service	2
Hospital/Other Medical	1
Other	2
Not Known	1
<b>Living Status (With Whom)</b>	
Alone	7
With Parents	8
Alone with Child	-
Alone with Partner	3
With Partner and Child/Children	5
With Friends	1
Other	11
Not Known	4



**Table 10.4.1 cont'd**  
**Demographic Characteristics of Clients Seeking Treatment, 2016 and 2017**

Characteristic	Number of Persons
<b>Living Status (Where)</b>	
Stable Accommodation	21
Unstable Accommodation	11
Institution (Prison/Clinic)	5
Not Known	2
<b>Nationality</b>	
National of Bermuda	36
National of Another Country	1
<b>Labour Status</b>	
Regular Employment	11
Economically Inactive	1
Pupil/Student	1
Unemployed	18
Other	6
Not Known	2
<b>Highest Education Level Completed</b>	
Never Went to School/Never Completed Primary School	-
Primary Level of Education	8
Secondary level of Education	19
Higher Level of Education	8
Not Known	4

Source: DNDC's Treatment Demand Indicators Survey

**Table 10.4.2**  
**Primary Drug of Impact of Clients Seeking Treatment, 2016 to 2017**

Primary Drug of Impact	Number of Persons
Heroin	8
Crack (only)	12
Alcohol	9
Cannabis	2
Opiates (Heroin, Methadone, Other Opiates)	5
Cocaine (including Crack)	1

Source: DNDC's Treatment Demand Indicators Survey

**Table 10.4.3**  
**Frequency of Drug Use, 2016 to 2017**

Frequency	Number of Persons
Used daily	23
Not used in past month	5
Used 2-6 days per week or less	7
Used once per week or less	2
Not Known	2

Source: DNDC's Treatment Demand Indicators Survey



**Table 10.4.4**  
**Primary Route of Drug Administration, 2016 to 2017**

Primary Route	Number of Persons
Smoke/Inhale	19
Sniff	8
Eat/Drink	11
Inject	1

Source: DNDC's Treatment Demand Indicators Survey

**Table 10.4.5**  
**Age of First Use of Primary Drug, 2016 to 2017**

Age	Number of Persons
Less than 13 years	5
13 – 17 Years	9
18 – 20 Years	4
21 – 24 Years	5
25 – 29 Years	3
30 – 34 Years	7
35 – 39 Years	1
40+ Years	4
Not Known	1

Source: DNDC's Treatment Demand Indicators Survey

**Table 10.4.6**  
**Average Age of Initiation by Type of (Secondary) Drug, 2016 to 2017**

Drug	Average Age of Initiation
Cannabis	16.7
Alcohol	15.5
Opiates (Total)	24.3
Heroin	30.0
Methadone	31.0
Cocaine (Total)	20.8
Cocaine	27.0
Crack	24.0
Stimulants (Total)	17.5
MDMA and Other Derivatives	24.4

Source: DNDC's Treatment Demand Indicators Survey

**Table 10.4.7**  
**Drug Market (Availability, Supplier, and Proceeds), 2016 to 2017**

Availability of Primary Drug	Number of Persons
Always Available	28
Mostly Available	6
Sometimes Available	1
Not Known	4
<b>Purchased from Regular Supplier</b>	
Yes	23
No	10
Not Known	6



**Table 10.4.7 cont'd**  
**Drug Market (Availability, Supplier, and Proceeds), 2016 to 2017**

Made Money or Obtained Drugs by Selling Illegal Drugs or Being Involved in Manufacture or Transportation of Drugs	Number of Persons
Yes	20
No	15
Not Known	4

Source: DNDC's Treatment Demand Indicators Survey

**Table 10.4.8**  
**Drug Market (Packaging of Drugs), 2016 to 2017**

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

Source: DNDC's Treatment Demand Indicators Survey



# Chapter 11

## Financing Drug Control

---

- Drug Treatment and Prevention Expenditure
- Enforcement and Interdiction Expenditure





## 11.1 DRUG CONTROL EXPENDITURE

The DNDC funds and oversees the majority of Bermuda's demand reduction programmes and activities. The Department directly funds a few treatment and prevention programmes, while it supports other initiatives through an annual grant provision to community-based partners and stakeholders. Allocation of funding for drug control, 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 just over \$15 million on drug control in Bermuda in FY 2017/2018, dropping from the previous FY 2016/2017, where drug control expenditure stood at \$19.1 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; \$9.9 million and \$9.8 million vs. \$5.1 million and \$5.7 million in FY 2016/2017 and FY 2017/2018, respectively (see Tables 11.1.1 and 11.1.2).

On the demand reduction side, in particular, disparity in allotment continued to exist between treatment and prevention, with treatment receiving the greater proportion. However, funding for treatment services, in general, declined marginally by almost 1.8% from FY 2016/2017 to FY 2017/2018; funding for prevention services, increased by 11.6% (see Table 11.1.1).

In both fiscal years under review, HM Customs received the majority allocation of the supply reduction budget for its interdiction efforts and the BPS received a smaller proportion for its drugs and intelligence division (see Table 11.1.2). Government expenditure on supply reduction, which entails enforcement, interdiction, and intelligence, saw a considerable increase by 12.5% year over year – moving from a \$5.1 million in FY 2016/2017 to \$5.7 million in FY 2017/2018.

Sufficient evidence exist that point to the fact that Bermuda continues to witness a constant presence of illicit drug use and drug-related criminal activities such as violence and illicit trafficking. In response to this growing threat, the Government of Bermuda has initiated and continued to operationalise a complementary battery of measures to combat the problem, on both the demand and supply reduction sides. With the technical support from the DNDC and through the implementation of the National Drug Control Master Plan and Action Plan for 2018-2022, the Government will continue to make a commitment to, and have a strategy for, the adequate funding of substance abuse prevention and drug addiction treatment and rehabilitation.

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

Table 11.1.1  
Government Expenditure on Drug Treatment and Prevention, 2016/2017 and 2017/2018

	2016/2017 ACTUAL (\$000)	2017/2018 REVISED (\$000)
<b>TREATMENT</b>	<b>9,184</b>	<b>9,023</b>
% Change	6.5	-1.8
<b>DNDC (MT,WTC,Treatment Unit)</b>	<b>2,368</b>	<b>2,374</b>
<b>Grantees</b>		
Salvation Army	100	100
FOCUS Counselling Services	-	-
<b>Other (BACB)</b>	<b>100</b>	<b>100</b>
<b>Other Agencies</b>		
BARC	1,099	1,064
BYCS	1,298	1,070
Drug Court	423	430
Mandatory Drug Treatment (RLH)	1,517	1,352
Turning Point Substance Abuse Programme*	2,379	2,533

**Table 11.1.1 cont'd**  
**Government Expenditure on Drug Treatment and Prevention, 2016/2017 and 2017/2018**

	2016/2017 ACTUAL (\$000)	2017/2018 REVISED (\$000)
<b>PREVENTION</b>	<b>690</b>	<b>770</b>
<b>% Change</b>	<b>-3.8</b>	<b>11.6</b>
DNDC (Prevention Unit & Community Education)	407	487
<b>Grantees</b>		
PRIDE		
CADA	183	183
	100	100
<b>TOTAL DEMAND REDUCTION</b>	<b>9,874</b>	<b>9,793</b>
<b>% Change</b>	<b>5.7</b>	<b>-0.8</b>

Source: Government of Bermuda Budget.

Notes: \* Sourced directly from Turning Point Substance Abuse Programme.

**Table 11.1.2**  
**Government Expenditure on Enforcement and Interdiction, 2016/2017 and 2017/2018**

	2016/2017 ACTUAL (\$000)	2017/2018 REVISED (\$000)
<b>ENFORCEMENT AND INTERDICTION</b>		
Police – Enforcement (Drugs, Financial Crime, and Intelligence Divisions)	1,032	1,443
Customs – Interdiction	4,019	4,259
<b>TOTAL SUPPLY REDUCTION</b>	<b>5,051</b>	<b>5,682</b>
<b>% Change</b>	<b>-7.1</b>	<b>12.5</b>

Source: Government of Bermuda Budget.



## LOOKING AHEAD

This, the 2018 Report of the BerDIN shows the demand for alcohol and drugs remain unchanged, all while significant challenges persist in adequately addressing the needs of substance users, their families, and the community at large. Despite the severity of Bermuda's penalties for illicit drug use, they apparently fail to deter criminal behaviour as evidenced by information provided by the courts and the Bermuda Police Service. With the enforcement (sales to minors) and regulation (TIPS) of some legislations remaining a challenge 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. The environment in which drug control takes place is ever-changing. Although there is a significant and growing body of knowledge documenting that addiction is a preventable, treatable, and manageable disease, and despite the proven efficacy of prevention and treatment techniques, substance abuse and addiction continue to cause illness, injury, death and crime, destroy our children, overwhelm social service systems, and impede education.

This year's report demonstrates that now, more than ever, a public health approach must be used to successfully prevent and treat people who abuse alcohol and/or drugs. For the first time, there were more people this past year in treatment for opioid or cocaine use disorders than in 2016. The demand for treatment services also remained high because of the continued flow of persons in treatment for cocaine, including crack cocaine, especially for those diagnosed as being severely dependent. Even so, access and sufficient resources still posed significant challenges to the continuum of care.

Demand reduction, however, cannot exist independently. Interdiction agencies, whose main tenet is reducing the supply of drugs, must be adequately equipped with staff and resources to strategically interdict drugs and interrupt its financing. Adequate funding of interdiction activities, especially continuing education and training in behavioural observance, financial crime, and other specialized areas, is required.

Gaps still exist in our understanding of the nature of substance abuse addiction. A lack of information related to emergency room cases as it relates to drug use and data related to cannabis users driving under the influence is not available, with the exception of toxicology cases related to road traffic fatalities. Gaps persist in diverse services for women, adolescents, and dual-diagnosed persons and these

remain unaddressed. With youth continuing to be involved with alcohol and cannabis, the call for wrap-around services is urgent. This situation requires policy-makers and practitioners to advocate for change. Lastly, little is known of the actual number of drug addicts that exist in the Bermuda population. Research into this area is key in order to determine the treatment needs of the substance using population.

The Network, has done a tremendous job this past year in fine tuning existing indicators and ensuring that the information available provides the best evidence for decision-making in Bermuda at the present moment. Through the efforts of many, this publication stands, with other empirical evidence, as one of the principal pieces of information to inform the drug situation in Bermuda. The DNDC, the Coordinator of BerDIN, will strive to continue to provide locally based, timely information concerning substance misuse and abuse in Bermuda.



...now more than ever, a public health approach must be used to successfully prevent and treat people who abuse alcohol and/or drugs.

# 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 and Arrests Breathalyser Results and Blood Alcohol Concentration
4. Bermuda Professional Counselling Services	DUI Educational Programme Statistics
5. Bermuda Sport Anti-Doping Authority	Illicit and Anti-Doping Tests
6. CADA	Training for Intervention ProcedureS
7. Department of Child and Family Services – Counselling and Life Skills Services	CLSS Programme Statistics
8. Department of Corrections – Westgate Correctional Facility  – Prison Farm – Co-Ed Facility – Right Living House	Drug Screening Results (Reception and Random) Drug Prevalence First-Time and Repeat Offenders Poly Drug Use  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* Drug Prevalence: Criminal Offenders* Treatment Demand 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.

IMPLICATIONS OF THE PRESENT DRUG SITUATION

Public Health, Programme, Policy, and Legislative Implications

Updated/New Indicators

Data	Importance of the Indicators	Public Health/Programme Implications	Policy and Legislative Implications
Classification of Drug Abuse and Dependence (DSM-V)	DSM-V is an update or revised version to DSM-IV.	Handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders. DSM contains descriptions, symptoms, and other criteria for diagnosing mental disorders.	This instrument is sensitive to change after a given point in time. Provides a clinical diagnosis for clients seeking treatment and may be able to detect the effects of alcohol and substance abuse treatment more readily than other instruments.
Perceptions of Substance Misuse and Abuse	This ad-hoc survey is used to gauge the community's feeling about alcohol and drug use and policy options.	Opinions about the problem of drug abuse differ little across most demographic and political groups. Little is known, however, about the opinions of residents regarding these topics. This survey provides one source of evidence. Information collected included data by race, local drug abuse, and views on potential new drug policy.	Alcohol and drug policy reform and legislative changes on substance abuse reduction and increasing rehabilitation.
Drug Abuse Monitoring Programme (Prison Survey)	Can distinguish alcohol and drug users from non-users, make initial treatment recommendations, make case management decisions, and provide information for a continuum of services.	Assessment occurs during reception throughout the year-long administration of the survey, in this case, 2017-2018. Coordination of assessment strategies and the sharing of information is vital to ensure that the incarcerated receive the continuum of services needed.	Assessment information must be integrated, evaluated, and used appropriately in decision-making regarding individual inmates, such as drug resistance classes, counselling, and in-prison substance abuse treatment.

# APPENDIX III

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

TARIFF CODE	DESCRIPTION	2016	2017
		(From April 1, 2016)	(From April 1, 2017)
2202.910	Non-alcoholic beer	\$0.99 per L	15% per L
2202990	Other	\$2.89 per L	15% per L
2203.000	Beer	\$2.89 per L	\$0.99 per L
2204.100	Sparkling Wine	\$2.89 per L	\$4.70 per L
2204.210	Wine in Containers Holding 2 Litres or Less	\$2.89 per L	\$4.70 per L
2204.290	Wine in Containers Greater Than 2 Litres	\$2.89 per L	\$4.70 per L
2204.220	Wine in containers holding more than 2 l but not more than 10 l	\$2.89 per L	\$4.70 per L
2204.300	Other Grape Must	\$2.89 per L	\$4.70 per L
2205.100	Vermouth in Containers Holding 2 Litres or Less	\$2.89 per L	\$4.70 per L
2205.900	Vermouth in Containers Holding Greater Than 2 Litres	\$2.89 per L	\$4.70 per L
2206.000	Other fermented beverages (for example, cider, perry, mead, saké); mixtures of fermented beverages and mixtures of fermented beverages	\$1.41 per L	\$1.26 per L
2207.100	Undenatured Ethyl Alcohol	\$1.41 per L	\$31.35 per LA
2207.200	Denatured Ethyl Alcohol	\$26.57 per LA	\$0.75 per LA
2208.200	Brandy and Cognac	\$26.57 per LA	\$31.35 per LA
2208.300	Whiskies	\$26.57 per LA	\$31.35 per LA
2208.400	Rum and Other Spirits From Sugar Cane	\$26.57 per LA	\$31.35 per LA
2208.500	Gin and Geneva	\$26.57 per LA	\$31.35 per LA
2208.600	Vodka	\$29.23 per LA	\$31.35 per LA
2208.700	Liqueur and Cordials	\$29.23 per LA	\$31.35 per LA
<b>2401.100</b>			
2401.100	Tobacco, Not Stemmed/Stripped	\$0.29 per KG	35.0% per KG
2401.200	Tobacco, Partly or Wholly Stemmed/Stripped	\$0.29 per KG	35.0% per KG
2401.300	Tobacco Refuse	\$0.29 per KG	35.0% per KG
2402.100	Cigars, Cheroots, etc. Containing Tobacco	33.5%	35.0% per KG
2402.200	Cigarettes Containing Tobacco	\$0.27 per U	\$0.37 per U
2402.900	Other Tobacco Products; or Products of Tobacco Substitutes	33.5%	35.0%
2403.110	Water Pipe Smoking Tobacco	33.5%	35.0%
2403.190	Other Smoking Tobacco	33.5%	35.0%
2403.910	"Homogenised" or "Reconstituted" Tobacco	33.5%	35.0%
2403.990	Tobacco Extracts and Essences; Other Manufactured Products of Tobacco	33.5%	35.0%
9802.003	Accompanied Personal Goods: Cigarettes Containing Tobacco	\$44.00 per 200 U	\$44.00 per 200 U
9803.163	Smoking Tobacco; Cigars, Cheroots and Cigarillos, Containing Tobacco (Imported by Post or Courier)	33.5%	35.0%
9803.171	Cigarettes Containing Tobacco	\$44.00 per 200 U	\$74 per carton

Notes:

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

<sup>2</sup> 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).

<sup>3</sup> 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.

<sup>4</sup> 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-IV:** The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, better known as DSM-IV, is used to categorise psychiatric diagnoses. The manual is published by the American Psychiatric Association and covers all mental health disorders for both children and adults. It also lists known causes of these disorders, statistics in terms of gender, age at onset, and prognosis as well as some research concerning the optimal treatment approaches. The DSM uses a multi-axial or multidimensional approach to diagnosing because rarely do other factors in a person's life not impact their mental health. It assesses five dimensions: Axis I – Clinical Syndromes; Axis II – Developmental Disorders and Personality Disorders; Axis III – Physical Conditions which play a role in the development, continuance, or exacerbation of Axis I and II Disorders; Axis IV – Severity of Psychosocial Stressors; and Axis V – Highest Level of Functioning.

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

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

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

also provide the basis for the compilation of national mortality and morbidity statistics by WHO Member States.

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

**TAAD:** The Triage Assessment for Addictive Disorders is a brief structured face-to-face interview or triage instrument designed to identify current alcohol and drug problems related to the DSM-IV criteria for substance abuse and dependence. The interview consists of 31 items and takes 10 minutes to administer and 2-3 minutes to score. The TAAD addresses both alcohol and other drug issues to discriminate among those with no clear indications of a diagnosis, those with definite,

current indications of abuse or dependence, and those with inconclusive diagnostic indications. The user can document negative findings for those who deny any problems or focus further assessment on positive diagnostic findings.

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

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

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

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

# REFERENCES

- Corporate Research Associates Inc. & Total Research Associates Limited. (2016). *Bermuda Omnibus Survey. A syndicated quarterly survey of the Bermuda community. Results for Department of National Drug Control.*
- Customs Department. (2014). *Bermuda customs tariff 2014.* Government of Bermuda.
- Department for National Drug Control. (2012). *Annual report of the Bermuda Drug Information Network 2012.* Government of Bermuda.
- Department for National Drug Control. (2016). *Survey of Substance Abuse Treatment Services 2016.* Government of Bermuda.
- EMCDDA. (2006). *Annual report 2006: the state of the drug problem in Europe.* Luxembourg: Office for Official Publications of the European Communities.
- EMCDDA. (2009). *Statistical Bulletin 2008. Drug related deaths – methods and definitions.* Retrieved September 13, 2012 from <http://www.emcdda.europa.eu/stats08/drd/methods>
- EMCDDA. (2012). *Building a national drugs observatory: a joint handbook.* Luxembourg: Publications Office of the European Union.
- Fried, P.A. & Makin, J. E. (1987). Neonatal behavioural correlates of prenatal exposure to marijuana, cigarettes and alcohol in a low risk population. *Neurotoxicology and Teratology.* p. 5.
- Ministry of Legal Affairs & The Attorney General's Chambers. (1987). *Laws of Bermuda. Liquor Licence Act 1974.* Retrieved August 20, 2014, from <http://www.bermudalaws.bm>
- National Highway Traffic Safety Administration (NHTSA). (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.
- Rehm, J., Gerhard, G., Sempos, C. T., & Trevisan, M. (2003). *Alcohol-related morbidity and mortality.* National Institute on Alcohol Abuse and Alcoholism.
- United Nations Office for Drug Control and Crime Prevention & Commonwealth Department of Health and Aged Care. (2000). *Demand reduction. A glossary of terms.* New York: United Nations.
- World Health Organisation. (1994). *Lexicon of alcohol and drug terms.* Geneva, WHO.
- Zuckerman, B., Frank, D.A., Hingson, R., Amaro, H., et al. (1989). Effects of maternal marijuana and cocaine use on fetal growth. *New England Journal of Medicine,* 32, 762-768. p. 765.

# OTHER NETWORK PUBLICATIONS

