

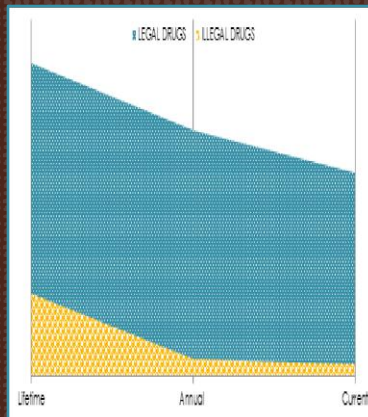


GOVERNMENT OF BERMUDA
Ministry of National Security

Department for National Drug Control

2013 NATIONAL HOUSEHOLD SURVEY

REPORT OF THE NATIONAL HOUSEHOLD SURVEY
ON DRUG USE AND HEALTH
AMONG THE ADULT POPULATION IN BERMUDA





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Ministry of Public Safety

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2013

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DEPARTMENT FOR NATIONAL DRUG CONTROL

MISSION STATEMENT

Lead efforts to reduce alcohol and drug misuse through research, education, advocacy, service delivery, and inter-agency/department coordination.

“The framing of a problem is often far more essential than its solution.”

~ *Albert Einstein*

FOREWORD

This report presents the results from the 2013 National Household Survey (NHS) on Drug Use and Health; a survey of adult residents of households in Bermuda aged 16 years or older. The current survey report serves to update information collected in the last survey conducted in 2009 and seeks to provide information related to drug consumption, risk behaviours, and goes as far as evaluating opinions on a range of policy items. Presented in a similar format as previous versions, this report aims to allow different audiences easy access to specific information that they may require. It provides an analysis that is timely and proportional to the greater populace.

The enclosed contents provide a summary of trends and developments in the drug situation in Bermuda. The tables present national estimates of rates-of-use, numbers of users, and other measures related to illicit drugs, alcohol, and tobacco products, with a focus on trends between 2009 and 2013, as well as differences across population subgroups in 2013. This information allows the Department for National Drug Control (DNDC) to keep abreast with both the rapidly shifting drug situation and the growing needs and changing expectations of our varied audience.

Like many other countries, Bermuda is in the midst of an economic downturn. Alcohol and other drugs are sometimes consumed to minimise the effects of stress and/or economic hardships. We are aware of the challenges that lie ahead. The renewed drug strategy, the National Drug Control Master Plan 2013-2017, will have to address a new policy landscape, many dimensions of which are elaborated in the Master Plan publication, including the necessary improvement of service provision for drug users and their families, while at the same time dealing with the increasing incidence of poly drug use, that is, the combined use of illicit and prescription drugs. The strategy will be implemented during a period of economic uncertainty and considerable global developmental and

social change. Globalisation and technological innovation have an impact on all areas of modern life; not surprisingly, they affect the drug problems we face.

As an information agency, we are responding to this with up-to-date and comprehensive information covering a broad perspective. We believe that the Report of the 2013 National Household Survey on Drug Use and Health, in both substance and form, represents an important step forward in addressing the challenges presented to us. Whether it is quick access to a strategic overview of the drug situation or an in-depth analysis of the data that is required, we hope that this Report will be a valuable and user-friendly access point for the considerable resources that are now available in this area.



JOANNE DEAN

Director

Department for National Drug Control

January, 2014

EXECUTIVE SUMMARY

The NHS is administered every five years in Bermuda. It endeavours to provide accurate data on the level and patterns of licit and illicit drug use (prevalence) and track trends in the use of alcohol, tobacco, marijuana, and various types of other drugs among the adult population at three reference points (lifetime, past year, and past month). This survey, therefore, allows for the assessment and monitoring of the nature of alcohol, tobacco, and other drug (ATOD) use. Further, it helps to identify groups with a high risk for drug misuse and measures community support for various alcohol and drug-related policies.

In addition to demographic questions, this survey contains questions on age of first use, recency of use, lifetime use, past year use, and past month use of marijuana, cocaine (and crack), hallucinogens, heroin (and opium), ecstasy, hash, inhalants, alcohol, tobacco, and nonmedical or prescription drugs among respondents aged 16 and older. In addition, questions were asked on the perception of the harm associated with ATOD use and ease of access to drugs, as well as participation in the drug market. In the current round, this survey was expanded to include questions on the perception of proposed alcohol and marijuana policy changes.

Patterned after national household prevalence studies conducted regionally and internationally, the survey was designed to collect information from a scientifically selected random sample of adult residents in Bermuda, 16 years or older. Each was asked to voluntarily complete a telephone web-based survey during the survey administration period of November 4th to 20th, 2013. The response rate was 100%, with a statistically representative sample of 1,200 individuals providing information. The data were weighted by population size to reflect the 2013 projected population.

Overall, 53.3% females and 46.7% males were represented in the sample; 51.1% were Blacks, 33.1% Whites, and 15.8% were of other races. Most of the respondents were employed or self-employed, finished at least a secondary-level education, and worked in the financial services industry.

Key findings include:

- Drinking alcoholic beverages sometimes, doing so often, and becoming drunk are perceived to be the most harmful of the risky behaviours – even more so than smoking marijuana often.
- Marijuana was reported to be the easiest drug to obtain of the illegal drugs.
- Almost nine in 10 participants indicated use of at least one drug in their lifetime; with consumption of a legal substance being higher than that of an illegal drug. More than half of the respondents (57.5%) were current users of at least one drug.
- Alcohol remained the substance of choice among Bermuda's adults along with cigarettes for all reference periods; and marijuana was still the most commonly used illegal drug and limited use of other illegal drugs was also reported. More females drank alcohol while more males smoked cigarettes and marijuana.
- Average age of first use of any drug was as early as 12 years (for use of inhalants by males) but ranges from 16.1 years (for inhalants) to 43.7 years (for non-

prescribed tranquilisers) for the overall population; with most persons beginning using drugs more than a year ago.

- Most drinking is reported to occur on the weekends; males mainly drank beverages with low alcoholic content and females mainly drank beverages of medium alcohol content.
- Binge drinking (having five or more drinks at once) was more prevalent among males.
- Problem drinking was evident in that persons reported having memory lapses because of their alcohol use among other measured indicators. In addition, one in 10 persons were drunk on at least one day in the past month.
- There was the higher tendency for persons to drink alcohol if they have friends or family members who get drunk. Likewise, a significant proportion of the respondents (42.4%) have friends or family members who take illicit drug(s).
- Persons smoked more than 100 cigarettes in one month and second hand smoking existed in workplaces.
- In terms of population characteristics and drug use, Whites represented the largest proportion of current users of alcohol; drug use was most prevalent among participants who finished only a secondary-level education; married people drank the most; and substance use was most prevalent among persons working over 40 hours per week.
- While 18.4% of the participants were curious to try an illegal drug, 91.0% reported that they would not try it if given the opportunity.
- Most of the respondents were never offered to buy or use illicit drugs during the past year.
- 3.1% of the respondents did not know a person should be 18 years or older to be sold alcohol by a licensed establishment in Bermuda.
- 68.4% of the respondents admitted being in favour of laws preventing persons from serving alcohol to minors in their homes or on their premises.
- Most of the respondents were in favour of roadside sobriety check points.
- 62.5% of respondents said they were not in favour of lowering the blood alcohol legal limit from 0.08 to 0.01.
- Of all respondents, 49.2% said that they had “never/not at all” observed the legally required health warning “Excessive alcohol consumption may be harmful to your health” on alcohol advertisements.
- Results showed that most surveyed residents were in favour of the decriminalisation of marijuana (48.6%); 41.3% were not in favour of decriminalisation, and 9.4% said they did not know/did not care.

Although the NHS provides useful information, it has certain limitations: 1) the data are self-reports of drug use, and their value depends on respondents' willingness to provide information and their ability to recall past experiences; 2) a cross-sectional survey design was used rather than longitudinal; that is, individuals were interviewed only once and were not followed for subsequent interviews and: 3) because the survey population is defined as the Bermudian civilian, non-institutionalized population, a small proportion is excluded: those living in institutional group quarters (for example, prisons, nursing homes, treatment centers), and homeless people.

I. INTRODUCTION

This report presents the main findings of the 2013 National Household Survey on Drug Use and Health. Previous household surveys of the adult population began in 1995 under the direction of the former National Drug Commission. The last adult population survey was conducted in 2009. The purpose of this survey is to monitor changes in the use of licit and illicit substances and evaluate public opinions on risk, health, and policy. This information is intended to be used by the Department for National Drug Control and others to improve and design substance abuse prevention, intervention, and treatment programmes.

The year 2013 marked the administration of the fifth adult population survey, and the second under the direction of the DNDC. This report, which includes four sections, presents the survey results under the following topics: 1) demographics, 2) risk of harm, 3) access to drugs, 4) prevalence-of-use, 5) drug market, and 6) alcohol and marijuana policy.

BACKGROUND

Drug surveys can do well to track changing levels of drug prevalence. Research indicates that household surveys serve two general purposes: 1) any survey, even if carried out only once, can provide information on prevalence of drug use and 2) when surveys are repeated using the same methods, they can track changing levels of drug use. On the other hand, comparatively small groups of people, such as the homeless or those living in communal establishments, are excluded from household surveys. Additionally, the more chaotic drug users may be under-represented, either because they do not live in households or because they are never available for an interview. Therefore, the results presented should be interpreted with caution as the prevalence of alcohol, tobacco, and other drug use may be understated.

This survey targets a wide segment of the population over 16 years of age. The 2009 survey limited the age of participation to residents 16 to 65 years. However, this survey sought to obtain responses from a more diverse population and, therefore, anyone over the age of 16 years could have participated. The topics covered include consumption of alcohol, tobacco, and other drugs, but also health and risk behaviour, in general. New items added to the 2013 survey include questions related to second hand smoke at home and in the workplace, number of occasions of binge drinking, that is, drinking five or more standard alcoholic drinks in a single drinking occasion, and support for current alcohol and marijuana policies. While these new items provide valuable information on alcohol and drug using behaviours and perceptions, they also affect the ability to make direct comparisons of measures in that trends cannot be evaluated until subsequent (2017) rounds of this survey.

PURPOSE

The 2013 National Household Survey represents the latest information on drug consumption in Bermuda, among its adult population, and serves many purposes. Foremost is the provision of accurate and reliable national-level data to monitor the drug situation in Bermuda. Additional objectives of the NHS are to:

- Provide data on the level, patterns, and trends in the use of alcohol, tobacco, and other substances;
- Identify groups with a high risk for drug misuse, and;
- Measure community support for various alcohol and drug-related policies.

SURVEY LIMITATIONS

The NHS is the only survey that regularly produces estimates of drug use among residents of the Bermuda civilian, noninstitutionalised population aged 16 or older. The survey is an appropriate vehicle for estimating prevalence rates for different drugs because it reports drug use that does not ordinarily come to the attention of administrative, medical, or correctional authorities.

Although the NHS provides useful information, it has certain limitations. First, the data are self-reports of drug use, and their value depends on respondents' willingness to provide information and their ability to recall past experiences. However, over the years, studies have established the validity of self-reported data (Harrison, 1997). Second, the survey is cross-sectional rather than longitudinal; that is, individuals were interviewed only once and were not followed for subsequent interviews. Therefore, the survey provides an overview of the prevalence of drug use at specific points in time, rather than a view of how the drug use behaviour of individuals changes over time. Third, because the survey population is defined as the Bermudian civilian, non-institutionalized population, a small proportion is excluded: those living in institutional group quarters (for example, prisons, nursing homes, and treatment centers), hospitalised persons, homeless people, residents living abroad, and residents travelling abroad during the data collection period. If the drug use of these groups differs from that of the household population, the NHS may provide slightly inaccurate estimates of drug use in the total population. This may be particularly true for prevalence estimates of drugs such as heroin, cocaine, and crack cocaine.

The information obtained from this survey provides partial insight into current substance use and misuse in Bermuda. However, to better understand current substance users, studies of sub-groups within this population, will provide more accurate information, along with supporting data from other studies and reports. While the methodology applied to the NHS has good construct validity, nevertheless, the results should be interpreted with caution as underreporting of prevalence of use is possible and the findings, therefore, can be viewed as conservative.

II. METHODOLOGY

SURVEY DESIGN

The 2013 NHS was web-based telephone survey, administered during the period of November 4th to 20th, 2013, targeting a representative sample of 1,200 adults age 16 years and older residing in Bermuda. A sample size of 1,200 households was selected as it was statistically established that this size was large enough to produce sufficiently reliable estimates with a low margin of error and that reflect true values of the population (that is, within $\pm 3\%$ error at the 95% confidence interval). Sampling error was further reduced by utilising an efficient sample design as outlined below.

As in previous rounds of the survey, a three-stage probability sample design was used:

- **Stage one:** a systematic sample of 6,058 households or residential addresses was selected from the 245 census districts (CDs) in Bermuda, proportional to the total number of households in each CD. This accounted for 25 households in each CD or all the households in CDs with less than 25 households; or about one-quarter of the total number of valid households (25,138 or 80.8%) in Bermuda (with a random start and every fourth household thereafter). That is, before the sampling frame was drawn, the total number of households in Bermuda (31,109), as of the 2010 Census, was adjusted to exclude 5,971 or 19.2% of the households [those without an address or CD identifier (3,996 or 12.8%) and those without a telephone contact (1,975 or 6.3%)]. It was drawn by the Department of Statistics from a its Population Frame Repository, which is a combined list of information obtained from Land Valuation, Parliamentary Registry, and Transport Control Department. This sampling method ensured that households from each Parish were represented in the sample.
- **Stage two:** a random sample of 1,200 households was then selected by the DNDC from the sampling frame of 6,058, with replacement; that is, if the household could not be reached or there was a refusal, the next randomly selected household was chosen to participate in the survey. This sampling method allowed for each household to have an equally likely chance of being surveyed.
- **Stage three:** a random choice of a household member from the selected household, 16 years or older, to participate in the survey, using the Kish grid selection method (Appendix 4). This stage was done by the survey interviewers. Again, this method allowed each household member, who met the selection criteria, to have an equally likely chance of being chosen to participate in the survey.

POPULATION COVERAGE AND PARTICIPANTS

The survey targeted 1,200 residents (persons who were residing, or intended to live, at the sampled house address for at least six months) of Bermuda who were 16 years and older. Persons (nationals or foreigners) who did not meet the six-month criterion were not included in the survey. The target population also excluded the non-civilian, institutionalised population, such as persons living in hotels, boarding houses, hospices, and senior residential care facilities as their lifestyle, environment, and living arrangements differ from the non-institutionalized or household population, whose responses could confound and skew the results obtained. In addition, persons with a known disability or illness that could affect their responses were also excluded, for example, persons with a hearing disability, mental illness, or the similar issues.

DATA COLLECTION

Prior to commencement of the data collection period, letters were mailed to 1,700 households (an additional 500 in the event of non-participation) in the sample that were randomly selected to participate in the survey. The letter explained the purpose of the survey, when it will be administered, the random selection of the household to participate, that participation of a randomly selected household member, though voluntary, was encouraged; the expectation of the participant in terms of the time requirement; and the confidentiality of the responses. Additionally, a press release was sent out to all media the week prior to the survey along with an advertisement in each of the two local newspapers days before the launch of the survey. In addition, an announcement was placed on the DNDC's website.

Questionnaire Design

The survey questionnaire, with the actual wording of the questions and response options, is included in Appendix 5 of this report. It comprised of standard questions on alcohol, tobacco, and other drug use that the Inter-American System of Uniform Data on Drug Use (SIDUC) utilises to assess prevalence in the general adult population and is commonly used in countries worldwide.

While the main questions in the questionnaire are repeated in each round of the survey, review, modifications, and update of some questions during the planning stage of the current survey by DNDC Research staff can occasionally affect comparison to previous surveys. In the current round of this survey, questions were introduced on the perception of proposed alcohol and marijuana policy changes, specific to Bermuda, but which are trending around the world. The instrument consisted of 111 questions with coverage of prevalence of 15 substances at three reference periods: lifetime, past year, and past month.

The online method was utilised to design a web-based questionnaire on Survey Monkey; thereby offering the benefits of convenient data collection while at the

same time populating the dataset. In addition, non-sampling errors were also minimised by including automated skipping of questions that were not to be responded to by an individual if they were irrelevant to their experiences. This method proved to enhance the timeliness of data collection and the accuracy of the data.

Survey Administration

The data collection methodology was changed from computer-assisted telephone interviews (CATI) used in the last survey to a web-based questionnaire administered via telephone interviews. The sample was maintained at a statistically representative level of the population.

The data collection process was carried out by a team of 17 temporary interviewers, which ended up being a team of 14 after three interviewers elected to no longer be part of the data collection. A two-hour training session on one day, prior to the launch of the survey, was conducted by the DNDC's Research Unit staff. This training prepared the interviewers for data collection in terms of their role and responsibility; understanding important information such as the purpose of the survey, concepts and definitions; interviewing techniques; selection of household participant; web-based platform; and how to consistently administer the survey questionnaire across individuals. They were also instructed that for participants under 18 years of age, verbal consent had to be obtained from a parent or guardian. Each interviewer adhered to a signed confidentiality agreement. The NHS was launched on November 4th 2013 and lasted until the 20th and was administered using computers and telephones in the offices of the DNDC under the supervision of the Research Unit staff.

Each interviewer was provided with a survey kit that included a list of household telephone numbers to be contacted, copies of the Kish grid, and the hyperlink to the survey for data capture.

During the data collection phase of the survey, interviewers were faced with minimal challenges, mainly on account of telephone numbers being out of service, duplicate telephone numbers but to a different house assessment number, establishing contact with a household, and the Internet being unresponsive at times. There were a few instances where the selected household member was unavailable, even after multiple attempts, or did not want to participate in the survey.

DATA PROCESSING

The data were collected from 1,200 adults from all parts of the Island and have been statistically adjusted (weighted) to reflect all residents 16 years and older projected to be living in Bermuda in 2013, using 2010 Census figures. Responses were captured by Survey Monkey and exported to an SPSS file that was available for download and data processing.

The DNDC's Research Unit staff reviewed the data for completeness and accuracy. Where necessary the data were cleaned. This included, but not limited to replacing words with numbers for the ages of participants and age of first use as these were open-ended questions, categorising industry of employment which was written in as an "Other" response when it in fact matched a response option, and checking for inconsistencies and anomalies, such as questions that should be answered were answered and vice versa. In addition, the responses to the open-ended questions, such as age, number of days engaged in binge drinking, number of days drunk, and number of family members who got drunk, were recoded into categories for more convenient analysis and reporting. Next, appropriate tables and descriptive statistics were generated for inclusion in this final report. In some instances, responses from more than one question were combined to produce the required rates, for example, prevalence of licit and illicit drug use at each of the three reference points.

Imputations were not made for missing data since it would be difficult to assign responses founded on self-report. However, the only missing data were those where persons chose not to respond to a question and these were categorized and reflected in the Results section of this report as "Not Stated". Nonetheless, no critical data such as respondent characteristic or prevalence-of-use was unreported (unless there was intentional nondisclosure of drug use).

Weighting

In an effort to ensure that the responses of the reporting group (sample), in fact, represented the target population, and given that the individual was the main unit of analysis, a weighting factor was used to adjust the sample to be representative of the actual population from which it was drawn. The purpose of this weighting is not to compensate for individuals who did not participate but rather to ensure that the proportion of the population in the sample matches the population, at least on key demographic characteristics. In this instance, the population was weighted on age and sex. In the sample, males were under represented and females were over represented, while the same was evident for the various age groups. Consequently, national-level estimates reported in this publication are representative of Bermuda's adult population. Appendix 1 presents the distribution of the sample on key demographic characteristics for the raw data, whereas Table III-1 shows the characteristics of the weighted proportion of adults.

A household weight was also calculated at the CD level if analysis were to be done at the household level rather than at the population level. The number of households in all the CDs within a Parish was used to adjust the basic weights based on the probability of selection of households in each CD within that Parish. The weight adjustment factor is, therefore, different for each Parish. The weights also varied considerably by CD based on the number of households in the given CD. Then, for each CD, the person weights were computed as the household weight multiplied by the number of persons, 16 years and older, in all the sampled households in that CD.

DATA QUALITY

New population data from 2010 decennial census was used for sampling weights; therefore, due to this methodological change the prevalence rates in the current survey should not be compared to data collected in 2009 and prior to access trends over time unless used for illustrative purposes.

Response Rate

The intended sample of one adult at 1,200 valid addresses was attained since sampling with replacement was utilised. Therefore, there was a 100.0% response rate to this survey.

However, in 402 instances, the selected household member refused to participate and only the listing information on number of persons in the household and their ages was obtained. Further, 243 contacts yielded outright refusals to participate in the survey. Additionally, 240 of the selected contact numbers ended up being telephone number of business establishments and 1,614 were not in service. There were also 1,096 instances where no contact was made with a household member. Consequently, sampling with replacement enabled the required sample size to be attained.

Validation

In order to ensure that a high level of accuracy was attained, checks were made for logical inconsistencies. For example, a person who reported current use of alcohol should be able to respond to the question on the frequency and content of alcohol consumed. Another example is the report of age of first use, which was checked against the participant's response to the question on recency of first use.

DATA ANALYSIS

The tables and figures in the subsequent section present the percentage of the sample that reported a certain behaviour, experience, or view. They can be interpreted as the percentage of adults on the Island who engaged in a certain behaviour, had a certain experience, or held such a view. However, some experiences, behaviours, or views were sufficiently rare that only a small proportion reported them in the survey; say less than 1.6% (equivalent to fewer than 20¹ responses). In such cases, the proportions should be used as illustrative information rather than firm facts; because they do not meet the minimum degree of accuracy nor do they provide meaningful information and as such are viewed as unstable from a statistical perspective. When prevalence rates are based on only a few responses,

¹ P. A. Buescher. (2008). Problems with rated based on small numbers. *Statistical Primer*, (12), 4. http://www.schs.state.nc.us/schs/pdf/primer12_2.pdf (accessed January 14, 2014)

it is almost impossible to distinguish random fluctuation from true changes in the underlying behaviour. Further, comparisons over time or between groups of respondents that are based on unstable rates can lead to spurious conclusions about differences in prevalence, which may or may not be valid. Therefore, these proportions should be interpreted with caution. As such, discussion on unstable proportions was limited in this report to avoid placing undue emphasis on them.

For the purpose of this report, the data analysis of the survey results was limited to descriptive analysis of the responses to all questions by the participants. Analyses were done for each section of the questionnaire. Frequencies of percentages were generated for all variables as well as relevant cross tabulations of certain key variables of perceived association. The results are presented for the overall population and, in some instances, by specific population characteristic; illustrated by using tables and charts accompanied by summary statements. All figures represent percentages of weighted survey respondents (that is, the number of survey respondents adjusted to represent the population). The data was analysed using SPSS v. 21, Charts were created in Microsoft Excel and tables were prepared in Microsoft Word.

It should be noted that no inferences were made of causation and some of the bivariate associations depicted could be influenced by other variables not taken into consideration. A more comprehensive analysis would require adjustment of these factors or covariates.

Further, the analysis in this report is not all encompassing of the complete NHS dataset. Data users are encouraged to contact the DNDC, Research Unit at (441) 294-9702 or 294-9705 to request customised data tables for specific user needs.

III. RESULTS

DEMOGRAPHICS

The characteristics of the respondents were assessed by soliciting information on a number of key variables such as sex, age, education, among others (Table III-1). The results revealed that there were slightly more female (53.3%) survey respondents compared to males (46.7%) and, at the same time, most persons (61.2%) identified themselves as the head of the household. The largest proportion of respondents (10.6) was between 50 to 54 years followed by 45 to 49 years (10.0%). About eight out of 10 respondents (or 82.9%) were younger than 65 years. The average age of all survey respondents was 46.6 years while the median age was 47 years, indicating that half of the survey respondents were either younger or older than this age.

In terms of race, slightly over half of the respondents (51.1%) identified themselves as "Black or African" while around one-third (33.1%) said they were "White". All other races, including Portuguese, Asian, and Mixed accounted for the remaining 16.0% of the respondents.

Although a question on parish of residence was not asked in the survey, the sampling frame provided this information. Almost one-quarter (24.6%) of the respondents reside in Pembroke parish, followed by 13.4% who live in Warwick, while 6.2% had a Southampton address.

A look at the marital status of respondents revealed that most respondents were married (45.2%) followed by 34.2% who were never married.

In terms of the highest level of education completed, the majority of the participants had at least a high school leaving or high school certificate. Only 6.0% of the participants did not complete any level of formal education. Most of the respondents indicated that they finished high school (31.7%) or were holders of a Bachelor's degree (23.3%). At the same time, 42.7% of the respondents indicated that they worked 40 hours or more per week either being employed or self-employed while slightly less than one-quarter or 24.3% worked between one to 39 hours per week and 17.4% said they were retired. Of those who were employed or self-employed, most of them (12.4%) indicated that they worked in the financial intermediation industry, which includes banking and insurance. A combined 14.8% of the respondents were not working at the time of the survey (9.2% were not looking for work and 5.6% were looking for work).

Table III-1
DEMOGRAPHIC CHARACTERISTICS

Characteristic	Percentage of Survey Respondents (Weighted)
Head of Household	
Yes	61.2
No	38.5
Not Stated	0.3
Sex	
Male	46.7
Female	53.3
Age (Years)	
16 – 19	5.4
20 – 24	6.8
25 – 29	8.3
30 – 34	8.2
35 – 40	8.1
40 – 44	9.2
45 – 49	10.0
50 – 54	10.6
55 – 59	9.0
60 – 64	7.3
65 – 69	5.8
70 – 74	4.2
75 – 79	3.2
80 – 84	2.2
85+	1.7
Race	
Black or African	51.1
White	33.1
Mixed	5.9
Portuguese	5.1
Asian	3.3
Not Stated	1.0
Other	0.7
Parish	
St. Georges	9.2
Hamilton	6.5
Smiths	9.2
Devonshire	10.3
Pembroke	24.6
Paget	9.5
Warwick	13.4
Southampton	6.2
Sandys	11.1

Table III-1 cont'd
DEMOGRAPHIC CHARACTERISTICS

Characteristic	Percentage of Survey Respondents (Weighted)
Marital Status	
Never Married	34.2
Married	45.2
Divorced	9.6
Widowed	7.4
Living Together/Cohabitation/ Common Law	2.4
Separated	1.0
Not Stated	0.2
Highest Level of Education Completed	
None	6.0
School Leaving Certificate/High School Diploma	31.7
Technical/Vocational Certificate (Bermuda College)	15.5
Associate's Degree	8.4
Bachelor's Degree	23.3
Master's Degree	9.7
Doctorate Degree	1.5
Professional Designation (With or Without Prior Academic Qualification)	2.6
Other	0.1
Not Stated	0.1
Employment Status	
Employed/Self-Employed, working 1-39 hours per week	24.3
Employed/Self-Employed, working 40 or more hours per week	42.7
Not employed, looking for work	5.6
Not employed, not looking for work (e.g., housewife, student, etc.)	9.2
Retired	17.4
Disabled, not able to work	0.2
Not Stated	0.6

Table III-1 cont'd
DEMOGRAPHIC CHARACTERISTICS

Characteristic	Percentage of Survey Respondents (Weighted)
Industry² of Employment	
Agriculture, Hunting, & Fishing	1.1
Manufacturing	0.3
Electricity, Gas, Water Supply	2.1
Construction	6.5
Wholesale & Retail Trade; Repair of Motor Vehicles, Motor Cycles, & Personal and Household Goods	6.8
Hotels and Restaurants	5.8
Transport, Storage, and Communication	3.3
Financial Intermediation	12.4
Real Estate, Renting, & Business Activities	3.6
Public Administration (Government) and Defence, Compulsory Social Security	7.2
Education	4.4
Health and Social Work	4.5
Other Community, Social, & Personal Service Activities	5.4
Private Households with Employed Persons	1.5
Not Stated	2.3

² Using the International Standard Industrial Classification of All Economic Activities (ISIC).

RISK OF HARM

Drinking alcohol was perceived to be most harmful – even more than smoking marijuana

Perception of harm associated with ATOD used was evaluated by asking respondents their opinion on a number of risky behaviours such as sometimes or often times using a particular substance (Table III-2 and Chart III-1). The level of risk was categorized as no risk, low risk, moderate risk, high risk, or did not know the risk. It was made clear by the interviewers, to the respondents, that this was a perception question and the response they provided was in terms of how the respondent viewed each behaviour, in his/her estimation. A significant proportion of respondents indicated that since they do not partake in many of the behaviours, they do not view them as being of any risk to them. Hence, the responses “no risk” category may seem high on account of this reason.

Nonetheless, the three behaviours related to alcohol were ranked highest in terms of risk with “drinking alcohol beverages sometimes” being perceived by 78.3% of the respondents to be the highest ranked behaviour with “some level of risk” (low, moderate, or high), followed by drinking alcoholic beverages often (67.4%), and becoming drunk (61.6%). About one-third of the respondents (34.9%) said that “drinking alcoholic beverages sometimes” was of “low risk”, while 29.6% and 35.2% indicated that “drinking alcoholic beverages often” and “becoming drunk”, respectively, were perceived as “high risk”.

At the same time, about half of the respondents indicated that “smoking cigarette sometimes” (50.5%) and “smoking cigarettes often” (49.6) were perceived to be harmful.

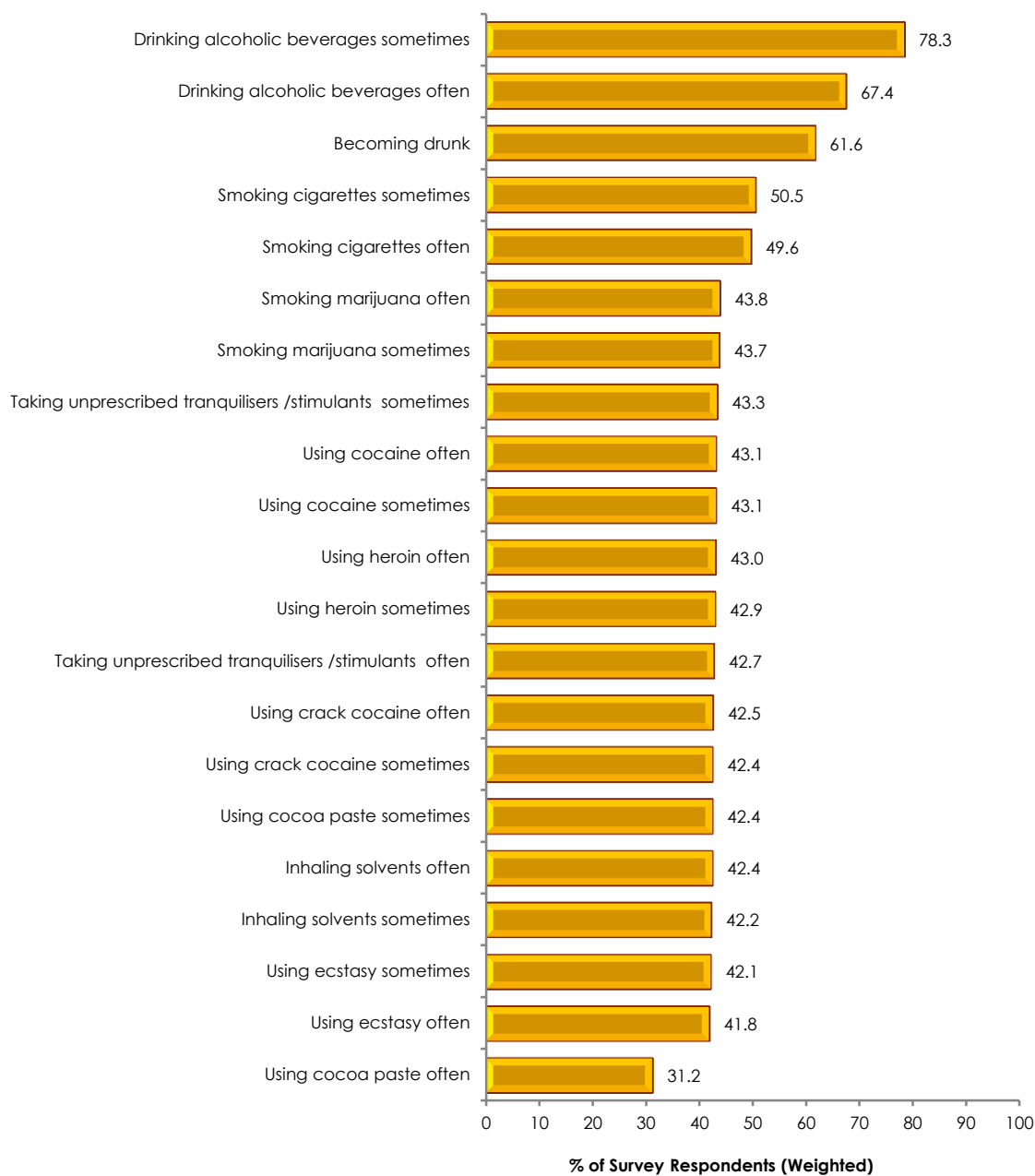
On the other hand, 43.8% and 43.7% of the respondents reported that “smoking marijuana often” and “smoking marijuana sometimes”, respectively, were of some level of risk.

Most of the behaviours involving the use of illicit drugs, whether sometimes or frequently, were perceived to be of “high risk” by a majority of survey respondents. For instance, 40.3% of the respondents indicated that “using heroin often” was of “high risk” and 37.6% reported the same level of risk for “using cocaine sometimes”.

Table III-2
PERCEPTION OF RISK OF HARM ASSOCIATED WITH ATOD USE
(Percentage of Weighted Survey Respondents)

Risk	No Risk	Some Level of Risk	Low Risk	Moderate Risk	High Risk	Don't Know	Not Stated
Smoking cigarettes sometimes	48.6	50.5	8.2	9.9	32.4	0.9	0.1
Smoking cigarettes often	49.5	49.6	5.0	6.0	38.6	0.7	0.1
Drinking alcoholic beverages sometimes	21.1	78.3	34.9	27.3	16.1	0.4	0.2
Drinking alcoholic beverages often	32.0	67.4	18.9	18.9	29.6	0.6	0.2
Becoming drunk	37.8	61.6	17.6	8.8	35.2	0.6	0.1
Taking unprescribed tranquilisers /stimulants sometimes	55.3	43.3	5.4	5.5	32.4	1.3	0.2
Taking unprescribed tranquilisers /stimulants often	55.8	42.7	4.1	2.1	36.5	1.4	0.2
Inhaling solvents sometimes	56.0	42.2	4.0	3.6	34.6	1.6	0.1
Inhaling solvents often	56.2	42.4	3.5	1.2	37.7	1.4	0.1
Smoking marijuana sometimes	54.5	43.7	12.3	11.6	19.8	1.5	0.2
Smoking marijuana often	54.6	43.8	8.3	8.9	26.6	1.2	0.2
Using cocaine sometimes	56.1	43.1	2.6	2.9	37.6	0.8	0.1
Using cocaine often	56.2	43.1	1.9	1.1	40.1	0.5	0.1
Using heroin sometimes	56.2	42.9	2.3	1.1	39.5	0.8	0.1
Using heroin often	56.1	43.0	2.1	0.6	40.3	0.8	0.1
Using ecstasy sometimes	56.2	42.1	2.8	2.4	36.9	1.6	0.1
Using ecstasy often	56.2	41.8	2.6	1.0	38.2	1.9	0.2
Using cocoa paste sometimes	56.3	42.4	2.2	1.3	38.9	1.1	0.2
Using cocoa paste often	55.9	31.2	2.3	0.7	28.2	12.5	0.4
Using crack cocaine sometimes	56.3	42.4	2.2	1.3	38.9	1.1	0.2
Using crack cocaine often	56.3	42.5	2.2	0.3	40.0	1.1	0.1

Chart III-1
PERCEPTION OF 'SOME LEVEL OF RISK' (LOW, MODERATE, AND HIGH)
BY ATOD BEHAVIOUR



ACCESS TO DRUGS

Marijuana was the easiest drug to obtain

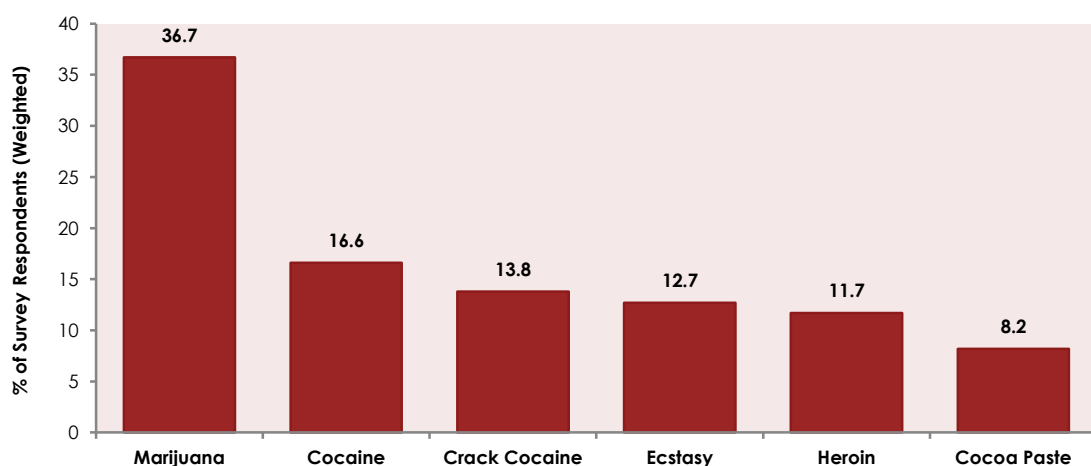
Research has shown that perceived availability of drugs is related to drug use and that more drug users than non-users believe that drugs are readily available. While views on drug availability are consistently strongly associated with substance use and abuse, a causal connection between them cannot be established with survey data. Survey respondents' perceptions of the ease of access to illegal drugs revealed that they are of the view that marijuana is the easiest drug to obtain as reported by 36.7% of them (Table III-3 and Chart III-2). In contrast, only 11.7% viewed heroin as the easiest drug to obtain. Most of the respondents either did not know how to access the various drugs or said they could not have access to them. For instance, 38.5% of the respondents indicated that they "don't know" how easy it would be to access heroin and 30.8% said they "cannot access" crack cocaine, ecstasy, or heroin.

Table III-3
PERCEPTION OF EASE OF ACCESS TO DRUGS
(Percentage of Weighted Survey Respondents)

Drugs	Cannot Access	Easy	Difficult	Don't Know	Not Stated
Marijuana	22.7	36.7	11.9	28.5	0.2
Cocaine	29.6	16.6	18.0	35.9	-
Crack Cocaine	30.8	13.8	18.5	36.9	-
Cocoa Paste	31.5	8.2	17.5	42.2	0.5
Ecstasy	30.8	12.7	18.6	37.9	-
Heroin	30.8	11.7	18.8	38.5	0.1

- means zero or unit less than 0.1.

Chart III-2
PERCEPTION OF 'EASY' ACCESS BY TYPE OF DRUG



PREVALENCE-OF-USE

This section of the report presents the ATOD use prevalence rates. The term prevalence refers to the proportion of the population who has used a drug over a particular time period. In this NHS of the adult population, drug prevalence was measured by a set of questions (see Appendix 3) similar to those commonly used to assess drug consumption among general adult populations. Prevalence-of-use of 15 different substances (Table III-4), both legal and illegal, was evaluated at three standard reference points to ascertain whether a person reported ever having used a drug – even once (lifetime use), whether he/she used it in the last year or 12 months (annual use), and whether there was use in the past 30 days (current use). Lifetime prevalence is a good measure of experimentation, while past 30-days prevalence-of-use is a good measure of current use. Respondents were asked to recall their use of drugs at these three recall periods.

Consumption includes the frequency (how often a person uses) and quantity (how much a person uses) of substance use. Frequency of consumption refers to the number of days, or sometimes, occasions that an individual has consumed alcoholic beverages, smoked cigarettes, or used drugs during a specified interval (for example, week, month, and year). Quantity of consumption refers to the amount of alcohol, tobacco, or drugs ingested on a given occasion.

The overall results are shown for all questions in the prevalence section of the survey questionnaire and, in other cases, the results are presented by sex disaggregation. Other main findings of comparisons for the key population characteristics associated with differing prevalence rates, such as employment status and education, were also analyzed for the most widely used drugs of alcohol, tobacco, and marijuana.

Lifetime, Annual, and Current Prevalence

Lifetime prevalence is the proportion of survey respondents who reported ever having used the named drug at the time they were interviewed, 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.

Since last-year prevalence is the proportion of survey respondents who reported a named drug in the year prior to the survey, it is often referred to as recent use; and is also classified as lifetime prevalence. Likewise, current use is also classified as lifetime and recent prevalence. A proportion of those reporting current use may be occasional (first-time) users who happen to have used the named drug in the period leading up to the survey and, therefore, current use is not synonymous with regular use.

The appeal of a substance is determined by a number of factors, such as personal disposition, peer and affinity group norms, ethnic and sub-cultural norms, and

popular culture images, among others. Monitoring lifetime prevalence-of-use provides a sense of the attractiveness of various substances over time, while substance use in the past 12 months can be indicative of intervention and prevention efforts occurring during that time as well as cultural themes and social and political events that might have influenced the behaviour. Current prevalence rates provide estimates of the level of drug use and abuse at the present time.

More than half of the respondents were current users of at least one drug

Almost nine out of 10 survey respondents or 87.8% have indicated use of at least one drug in their lifetime (including alcohol and cigarettes) while only 0.1% of survey respondents reported that they have never use any of the drugs surveyed. In current terms, over half (57.5%) of the survey respondents or about six out of 10 indicated use of at least one drug in the past month.

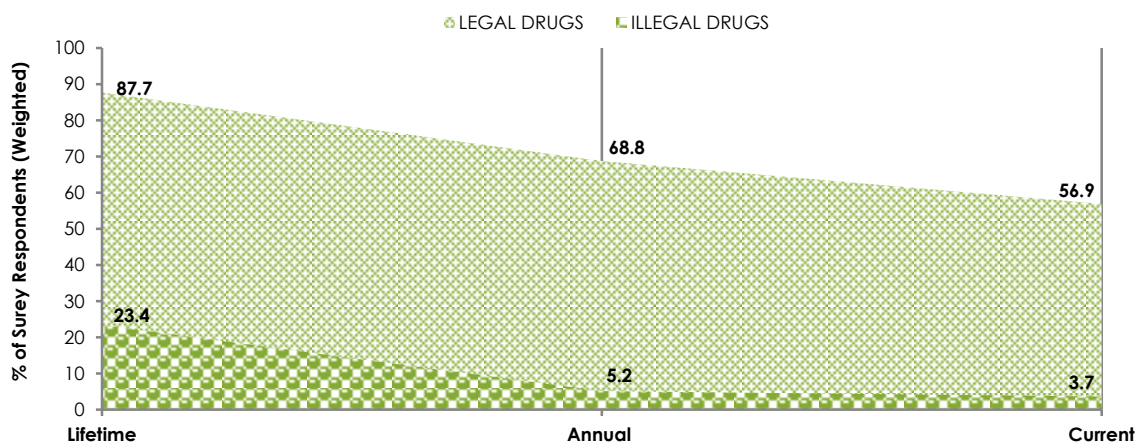
Comparing the prevalence of legal and illegal drug use, prevalence of legal drug use was higher than that of illegal drug use, as expected, (Table III-4 and Chart III-3). Lifetime prevalence-of-use of a legal substance, such as alcohol and cigarettes, stood at 87.7%, annual use at 68.8%, and current use was 56.9%. In terms of illicit drug use, slightly less than one-quarter (23.4%) of the survey respondents have used an illegal drug in their lifetime (8.8% other than marijuana), 5.2% in the past year (1.5% other than marijuana), and 3.7% were current users of illegal drugs (0.7% other than marijuana).

Table III-4
LIFETIME, ANNUAL, AND CURRENT PREVALENCE OF ATOD USE

Substances	Percentage of (Weighted) Survey Respondents								
	Lifetime Use			Annual Use			Current Use		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
LEGAL DRUGS	41.6	46.1	87.7	33.1	35.7	68.8	28.5	28.4	56.9
Alcohol	41.5	45.2	86.7	32.4	34.7	67.1	27.3	27.5	54.8
Cigarettes	26.0	21.7	47.7	9.4	5.0	14.4	7.6	4.1	11.7
Inhalants	0.3	0.5	0.8	-	0.1	0.1	-	0.1	0.1
ILLEGAL DRUGS	14.1	9.3	23.4	4.0	1.2	5.2	3.0	0.7	3.7
Marijuana	13.6	9.0	22.6	4.0	1.2	5.2	3.0	0.7	3.7
Hash	4.9	1.4	6.3	1.1	0.1	1.2	0.5	-	0.5
Cocaine	2.1	1.1	3.2	-	0.1	0.1	-	0.1	0.1
Hallucinogens	1.4	0.7	2.1	0.1	0.1	0.2	0.1	0.1	0.2
Ecstasy	1.1	0.3	1.4	0.3	0.0	0.3	0.1	-	0.1
Crack	0.9	0.4	1.3	-	-	-	-	-	-
Non-Prescribed Stimulants	0.5	0.3	0.8	-	-	-	-	-	-
Opium	0.4	0.3	0.7	-	-	-	-	-	-
Heroin	0.2	0.3	0.5	-	-	-	-	-	-
Non-Prescribed Tranquilisers	0.1	0.1	0.2	-	-	-	-	-	-
Non-Prescribed Morphine	0.1	-	0.1	-	-	-	-	-	-
Cocoa Paste	-	-	-	-	-	-	-	-	-

- means zero or unit less than 0.1.

Chart III-3
COMPARISON OF LEGAL AND ILLEGAL DRUG USE



Alcohol remained the substance of choice among Bermuda's adults

Table III-4 shows the lifetime, annual, and current prevalence of substance use among Bermuda's adult population. Alcohol was the drug of choice among survey respondents, used by more persons than either tobacco or illicit drugs. In terms of current use, 54.8% of the survey participants reported that they used alcohol at least once within the 30 days prior to completing the survey (Chart III-5). Within the last year, 67.1% of the respondents indicated that they used alcohol and 86.7% have used alcohol in their lifetime (Chart III-4).

Experimentation with tobacco, as revealed by lifetime use, was reported by 47.7% of the survey participants (Chart III-4); while 14.4% have used it in the past year and 11.7% were current tobacco users (Chart III-5).

The use of inhalants, in any of the reference periods, was reported by a small proportion of the survey respondents (0.8% were lifetime users; 0.1% annual users; and 0.1% current users).

Marijuana remained the most commonly used illegal drug

In terms of illicit drug use, about one in five (22.6%) of the survey respondents have used marijuana in their lifetime (Chart III-4) and 5.2% have used it in the past year. A small proportion of the participants (3.7%) reported using marijuana in the 30 days prior to the survey (Chart III-5). The most frequently reported illegal drugs used in the past 30 days were: 3.7% marijuana, 0.5% hash, 0.2% hallucinogens, and 0.2% other illegal drugs.

Prevalence rates for the other drugs are considerably lower than those for alcohol, cigarettes, and marijuana at all three reference points; ranging from 0.1% for non-prescribed morphine to 6.3% for hash in the lifetime reference period; and 0.1% for cocaine and ecstasy to 0.5% for hash in the current-use period. There was no reported annual or current use of either crack or heroin (Chart III-5).

Chart III-4
LIFETIME PREVELANCE-OF-USE BY TYPE OF DRUG

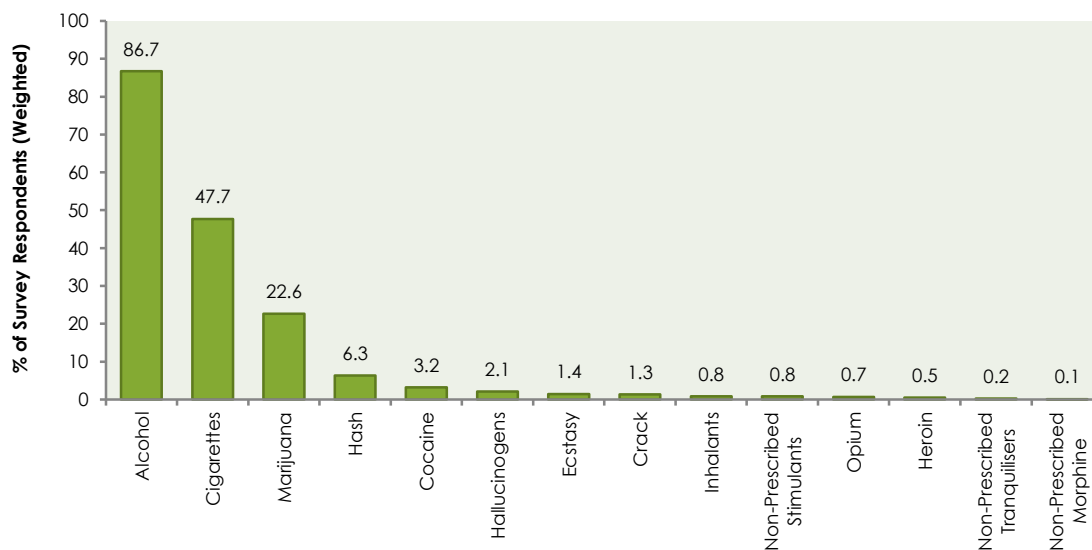
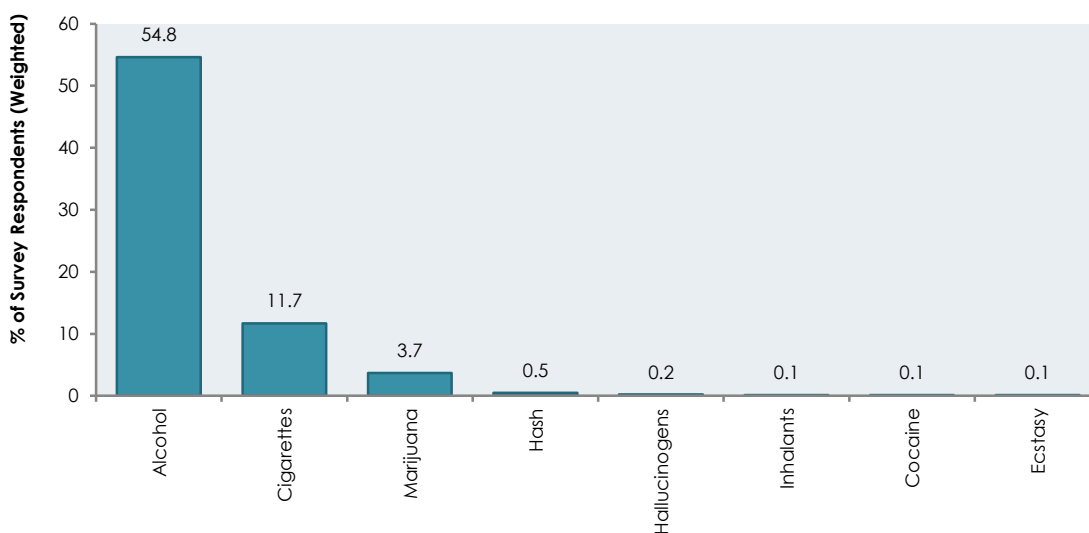


Chart III-5
CURRENT PREVELANCE-OF-USE BY TYPE OF DRUG



Trends in Consumption by Sex

More females drank alcohol; more males smoked cigarettes and marijuana

Table III-5 shows sex disaggregation of substance use at the three reference points. A larger proportion of females reported lifetime, annual, and current use of alcohol compared to their male counterparts, who reported higher prevalence for cigarettes, marijuana, hash, and ecstasy at all three reference points (Charts III-6 and III-7). For instance, the 86.7% of lifetime users of alcohol consisted of 45.2% females and 41.5% males; the 67.1% annual users included 34.7% females versus 32.4% males, and in the 54.8% current users, 27.5% were female and 27.3% were males. In contrast, the 22.6% lifetime users of marijuana comprised 13.6% males versus 9.0% females and the 3.7% current users comprised of 3.0% males and 0.7% females.

Chart III-6
LIFETIME USE OF ATODs BY SEX OF RESPONDENT

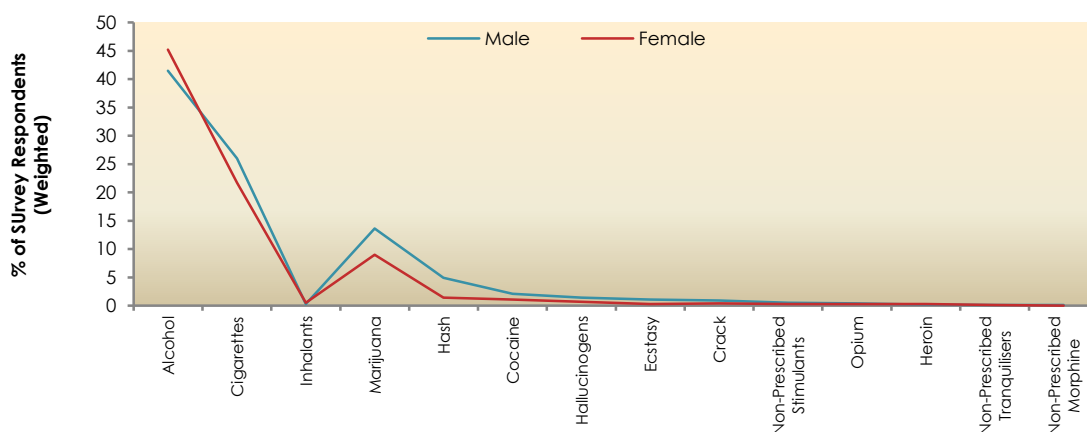
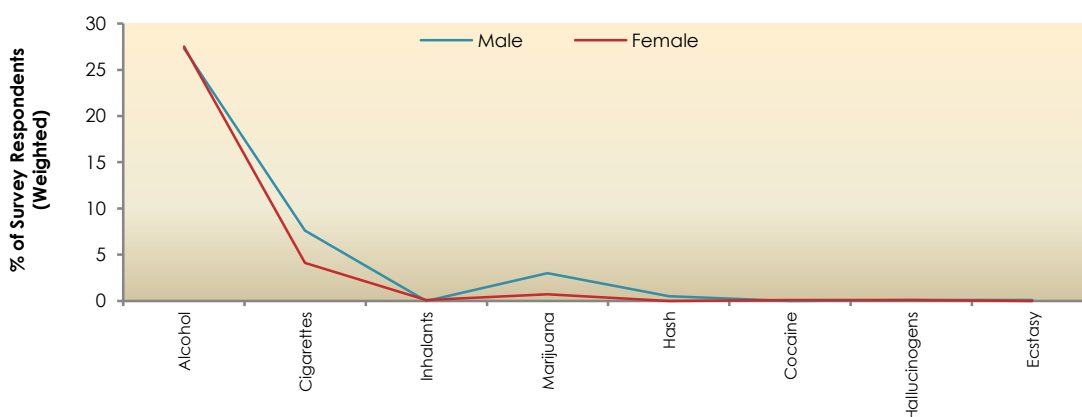


Chart III-7
CURRENT USE OF ATODs BY SEX OF RESPONDENT



Age of First Use

Substance use began as early as 12 years

The results in Table III-5 show the average age of initiation of substance use for persons who experimented with drugs. This type of data is useful in coordinating the timing of prevention efforts to maximise programme effectiveness. A programme, for instance, may have limited impact if it is delivered after the majority of potential drug users have already initiated the behaviour. Very early intervention, on the other hand, might prove less effective if it is not delivered close to the critical initiation period.

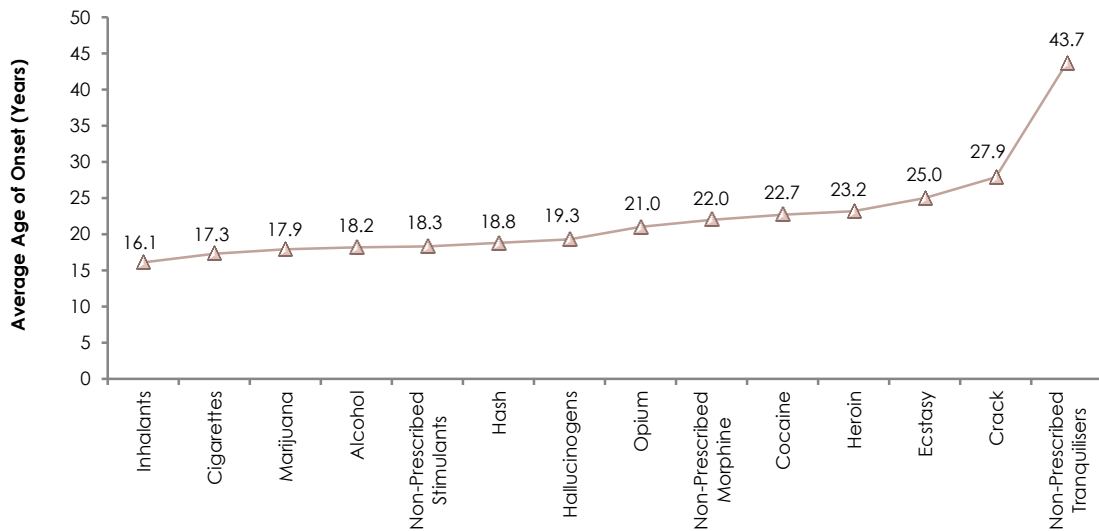
Survey participants were asked to report the age at which they first used a number of specified substances – both legal and illegal. Some of these substances such as alcohol, tobacco, and marijuana, are commonly considered as major gateway drugs, which usually precede the use of hard drugs such as cocaine and opiates. Average age of onset for all survey participants ranged from as young as 16.1 years for inhalants to as old as 43.7 years for tranquilisers without a medical prescription (Chart III-8), with marijuana use beginning at 17.9 years (illegal at all ages). Tobacco smoking began at 17.3 years, before the legal age to smoke.

Table III-5
AVERAGE AGE OF ONSET BY SEX OF SURVEY RESPONDENT

Substances	Average Age of Initiation (Years)		
	Males	Females	Total
Legal Drugs			
Inhalants	11.6	19.0	16.1
Cigarettes	17.0	17.7	17.3
Alcohol	17.4	18.9	18.2
Illegal Drugs			
Marijuana	17.0	19.1	17.9
Non-Prescribed Stimulants	18.4	18.1	18.3
Hash	18.9	18.2	18.8
Hallucinogens	20.2	17.4	19.3
Opium	21.1	20.7	21.0
Non-Prescribed Morphine	22.0	...	22.0
Cocaine	23.0	22.0	22.7
Heroin	30.8	16.1	23.2
Ecstasy	25.1	25.0	25.0
Crack	29.1	25.0	27.9
Non-Prescribed Tranquilisers	40.0	50.0	43.7

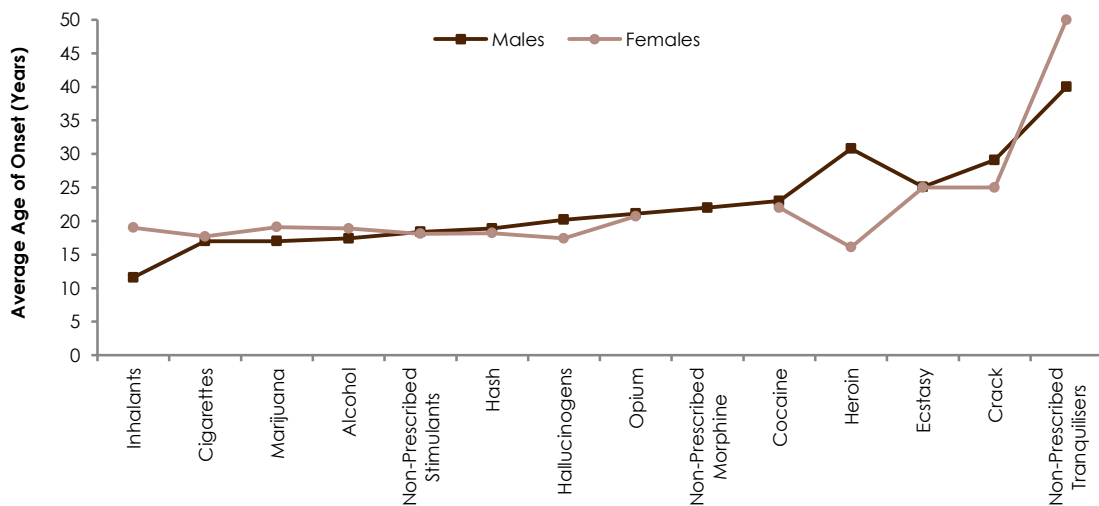
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Chart III-8
AVERAGE AGE OF INITIATION FOR ALL SURVEY RESPONDENTS BY TYPE OF DRUG



In terms of the sex of the respondent, average age of onset for males was much earlier at 11.6 years (for inhalants) than that of the overall population or their female counterparts, which stood at 16.1 years (for heroin) [Chart III-9]. Both males and females began smoking cigarettes before the legal age, at 17.0 years and 17.7 years, respectively. At the same time, males were more likely to be underage drinkers, since they reported first drinking alcohol at an average age of 17.4 years (with 18 years being the legal drinking age in Bermuda). Males also initiated using marijuana before females, 17.0 years versus 19.1 years. On the other hand, females indicated onset at an earlier age for other illicit drugs such as heroin (16.1 years vs. 30.8 years) and hallucinogens (17.4 years vs. 20.2 years).

Chart III-9
AVERAGE AGE OF INITIATION BY SEX OF SURVEY RESPONDENT AND TYPE OF DRUG



Recency of Initiation

Most persons began using drugs more than a year ago

Recency of initiation, together with age of initiation, provides information on substance use initiation, also known as incidence or first-time use. These are important for policymakers and researchers since measures of initiation are often leading indicators of emerging patterns of substance use. They provide valuable information that can be used in the assessment of the effectiveness of current prevention and intervention programmes and in the focusing of these efforts.

The results in Table III-6 show that most of the survey participants began their drug using behaviours more than a year prior to the survey. For example, 74.3% of persons who drank alcohol began doing so more than a year ago, 44.4% had already started smoking cigarettes, and 21.0% first used marijuana. On the other hand, there was more recent first use of alcohol, cigarettes, and marijuana – as recent as less than a year ago but more than a month ago and even in the past 30 days. For instance, 3.4% of the survey participants first used alcohol more than a month before the survey but within a year, 3.8% started smoking cigarettes, and 0.3% also smoked marijuana for the first time. Likewise, 8.0% of the respondents first drank alcohol in the past 30 days, 1.8% began smoking cigarettes, and 0.8% used marijuana during this same reference period. In other words, about one in 10 persons who never used a drug in their lifetime began substance using behaviours in the 30 days prior to the survey; and about 1% of the respondents could be considered as illicit drug (marijuana) initiates.

Table III-6
REGENCY OF FIRST USE BY TYPE OF DRUG
(Lifetime Users of Substance)

Substances	In the past 30 days	More than 1 month ago but less than 1 year ago	More than a year ago	Not Stated
Alcohol	8.0	3.4	74.3	1.0
Cigarettes	1.8	3.8	44.4	0.7
Marijuana	0.8	0.3	21.0	0.4
Cocaine	-	-	3.2	-
Crack	-	-	1.3	-
Heroin	-	-	0.5	-

- means zero or unit less than 0.1.

Frequency of Substance Use

Alcohol Consumption

Most drinking happens on the weekends

Respondents were asked to indicate with what frequency they drank alcohol and the type of alcoholic beverage they drank on these occasions, which was in terms of the alcoholic content (low, medium, and high). They were provided with relevant examples by the interviewer of what each category constituted. For instance beer was an example of a beverage with low alcohol content, Baileys for medium content, and whiskey was mentioned for high alcohol content.

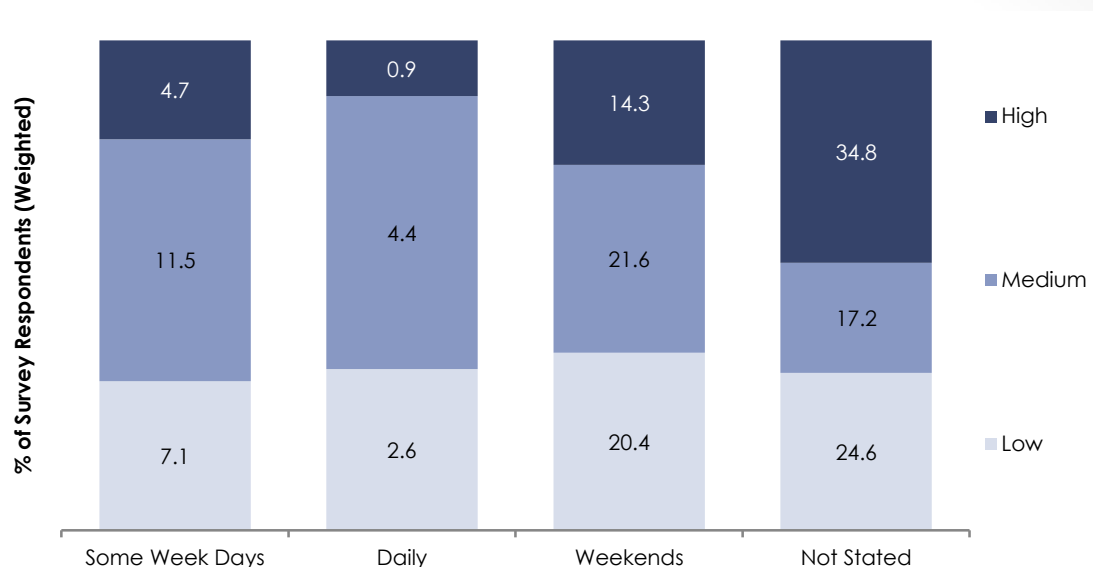
The frequency of alcohol use among respondents who were current users of alcohol ranged from use on weekends to everyday use (Table III-7 and Chart III-10). In the 30 days prior to the survey, most of the current users of alcohol reported that they drank on the weekends, whether it was alcohol of low (20.4% of the respondents), medium (21.6% of the respondents), or high (14.3% of the respondents) content. Fewer respondents indicated that they drank daily, with most of the daily users drinking alcohol of medium content (4.4% of the respondents). Only 0.9% of the respondents were daily drinkers of high-content alcoholic beverages, while 2.6% drank beverages with low alcohol content. At the same time, there were 11.5% of the survey participants who indicated that they drank medium-content alcohol on some week days while 7.1% and 4.7% drank low- and high-content alcoholic beverages, respectively.

The results also showed that differences exist between the two sexes when it came to the type of drinks consumed (Table III-7). Males mainly drank beverages with low alcoholic content despite when they drank them, as well as beverages with high alcoholic content, especially on weekends and some week days. In contrast, females mainly drank beverages of medium alcohol content, despite when they drank them, and high-content alcoholic beverages especially daily.

Table III-7
FREQUENCY OF ALCOHOL CONSUMPTION BY TYPE OF ALCOHOLIC BEVERAGE
AND SEX OF SURVEY RESPONDENT
(Percentage of Weighted Survey Respondents)

Frequency of Use	ALCOHOL CONTENT								
	Low			Medium			High		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
Some Week Days	4.9	2.2	7.1	5.5	5.9	11.5	3.6	1.6	4.7
Daily	2.2	0.4	2.6	2.1	2.3	4.4	0.4	0.5	0.9
Weekends	13.0	7.4	20.4	7.8	13.9	21.6	9.0	5.4	14.3
Not Stated	7.1	17.5	24.6	11.9	5.4	17.2	14.8	20.0	34.8
Total Current Users	27.3	27.5	54.8	27.3	27.5	54.8	27.3	27.5	54.8

Chart III-10
FREQUENCY OF ALCOHOL CONSUMPTION BY TYPE OF ALCOHOLIC BEVERAGE



Binge Drinking

Binge drinking was more prevalent among males

The survey interviewers informed the participants that binge drinking is the consumption of five or more standard alcoholic drinks in one sitting (successively drinking each beverage). The reference period for this question was the occurrence of this behaviour in the 30 days prior to the survey. Participants were also informed of what a standard alcoholic drink constitutes, for example, a canned beer, a glass of wine, a shot of rum, etc. Heavy drinking is frequently associated with damage to property, sexual assault, fighting, drunk driving, poor performance, and health risk behaviours.

Most of the respondents (36.4%) indicated they had not engaged in binge drinking (Table III-8). However, 16.3% of the participants indicated that they had binge drinking episodes about 1 to 5 times in the past month, while 0.3% said they binge drank 16-20 times in the past 30 days. In the latter case, this means approximately 80 to 100 drinks in one month solely from bingeing.

The results suggest that males were more likely to binge drink than females irrespective of the number of times in the past months. For instance, males (10.3%) accounted for a greater proportion of the participants who indicated binge drinking on one to five occasions in the past month.

Table III-8
NUMBER OF BINGE DRINKING EPISODES IN PAST 30 DAYS
(Current Users of Alcohol)

Number of Times in Past 30 Days	Percentage of Survey Respondents (Weighted)		
	Males	Females	Total
0	15.5	21.0	36.4
1 – 5	10.3	6.0	16.3
6 – 10	1.3	0.3	1.6
11 – 15	-	0.1	0.1
16 – 20	0.2	0.1	0.3
21 – 25	-	-	-
26 – 30	-	-	-
31+	0.1	-	0.1

- means zero or unit less than 0.1.

Problem Drinking

Persons reported having memory lapses because of alcohol

Current users of alcohol were also subsequently asked other questions related to their drinking. Table III-9 presents the findings to these questions. Most of the survey respondents never had trouble with a partner, lost friends or partners, experienced memory lapses on account of alcohol, or were bothered about being criticized for drinking. Nonetheless, there was a small proportion who encountered these outcomes because of their alcohol use. For instance, 15.5% of the respondents indicated they had memory lapses after waking up in the morning after drinking alcohol. However, 15.0% of the participants reported that they felt like decreasing the amount of alcohol they drink. At the same time, 4.3% of them said that they drank more than they wanted to without noticing and 0.5% said they had to drink alcohol in the morning. A noticeable result is that over one-third or 36.4% of the survey respondents indicated that they have friends or family members who get drunk.

Table III-9
PROBLEM DRINKING
(Current Users of Alcohol)

	Percentage of Survey Respondents (Weighted)		
	Yes	No	Not Stated/ Not Applicable
Had trouble with partner because alcohol	4.5	50.3	0.1
Lost friends of partners because of alcohol	6.0	49.0	-
Felt like decreasing the amount of alcohol drunk	15.0	40.0	-
Drank more than wanted without noticing	4.3	50.7	-
Had to drink alcohol in the morning	0.5	54.5	-
Experienced not remembering after waking up in the morning	15.5	39.3	0.1
Bothered about being criticized for drinking	2.8	32.1	20.0
Have friends or family members who get drunk	36.4	18.3	0.2

- means zero or unit less than 0.1.

One in 10 persons were drunk on at least one day in the past month

Current alcohol users were also asked to report the number of days in the month prior to the survey that they drank too much and got drunk. The results to this question (Table III-10) showed that most of the respondents (42.5%) did not get drunk on their drinking occasions. However, 11.9% of the participants indicated that they got drunk at least on one day because they had too much to drink. These survey participants were drunk on one to six days over the past month.

Table III-10
NUMBER OF DAYS DRUNK IN PAST MONTH
(Current Users of Alcohol)

Number of Days	Percentage of Survey Respondents (Weighted)
0 Day	42.5
1 Day	6.5
2 Days	3.1
3 Days	0.9
4 Days	0.9
5 Days	0.2
6 Days	0.2
Other*	0.1
Not Stated	0.4

* Respondents said "yes" instead of the number of days and therefore could not be imputed.

Higher tendency for persons to drink alcohol if they have friends or family members who get drunk

In addition to the survey participants being asked whether they had friends or family members who get drunk, they were also asked the number of them who, in fact, got drunk. About one-quarter or 26.1% of the respondents reported that they have about one to five friends or family members who get drunk, while 5% indicated that they have six to 10 such persons. The respondents indicated as many as over 20 friends or family members who get drunk.

Table III-11
NUMBER OF FRIENDS OR FAMILY MEMBERS WHO GET DRUNK
(Current Users of Alcohol)

Number of Friends/Family Members	Percentage of Survey Respondents (Weighted)
None	0.6
1 – 5	26.1
6 – 10	5.0
11 – 15	0.9
16 – 20	1.3
20+	0.2
Other*	1.0
Don't Know	0.9
Not Stated	18.8

* Includes responses such as "all ", "a few", and "lots".

A further analysis of the prevalence of alcohol use reveals that persons who reported having friends or family members who get drunk were more inclined to use alcohol in all three reference periods (Table III-12). For instance, lifetime (36.4%), annual (36.4%), and current (36.3%) use of alcohol were indicated by twice as many respondents who have friends or family members who drink compared to those who used alcohol but did not have such persons in their lives (18.2%).

Table III-12
PREVALENCE OF ALCOHOL USE
AND HAVING FRIENDS OR FAMILY MEMBERS WHO GET DRUNK
(Current Users of Alcohol)

Prevalence-of-Use	Have Friends or Family Members Who Get Drunk	
	Yes	No
Lifetime Use	36.4	18.2
Annual Use	36.4	18.2
Current Use	36.3	18.2

Tobacco Consumption

Some persons smoked more than 100 cigarettes in one month

Current smokers of cigarettes were asked to report on the quantity smoked, which ranged from one cigarette to more than five packs. A significant proportion of the 11.7% of current smokers indicated that they smoked more than five packs of cigarettes in the month prior to the survey (equivalent to 5.0% of all survey respondents) [Table III-13]. This means that they smoked about 100 cigarettes in one month.

Table III-13
QUANTITY OF CIGARETTES CONSUMED
(Current Users of Cigarettes)

Quantity of Cigarettes	Percentage of Survey Respondents (Weighted)
1 to 5	1.0
6 to 10	0.8
11 to 20 (Half to One Pack)	2.0
2 to 3 Packs	2.0
4 to 5 Packs	1.0
More than 5 Packs	5.0
Total Current Users	11.7

Second Hand Smoking

Second hand smoking existed in workplaces

In an effort to assess the public health dangers associated with smoking, participants were asked about smoking in their homes and workplaces (for those who were currently employed). Equally, about one in 10 respondents or 9.5% indicated that someone smoked in his/her home and in a closed area at the workplace (Table III-14).

Table III-14
SECOND HAND SMOKING
(Current Users of Cigarettes)

	Yes	No	Not Stated	Not Applicable
Someone smoked in home	9.5	90.4	0.2	-
Someone smoked in a closed area in workplace	9.5	57.4	0.1	33.0

Illicit Drug Consumption

Instances of daily use of illicit drugs

The frequency of illicit drug use was asked of respondents who indicated that they used an illegal drug in the year prior to the survey (recent users). Marijuana use ranged from only once in the year (0.3% of the respondents) to daily (1.4% of the respondents) [Table III-15]. There were others who indicated they used marijuana sometimes during the week (1.3%), sometimes during the month (0.8%), and sometimes in the past 12 months (1.0%). Additionally, 0.1% of the respondents indicated that they used cocaine sometimes during the month.

Table III-15
FREQUENCY OF ILLICIT SUBSTANCE USE BY TYPE OF DRUG
(Annual Users of Substance)

Frequency	Percentage of Survey Respondents (Weighted)	
	Marijuana	Cocaine
Daily	1.4	-
Sometimes during the week	1.3	-
Sometimes during the month	0.8	0.1
Sometimes in the past 12 months	1.0	-
Only once	0.3	-
Not Stated	0.2	-

Notes:

- means zero or unit less than 0.1.

There was no annual use of crack and heroin.

Race and Drug Use

Whites represented the largest proportion of current users of alcohol

Table III-16 shows that lifetime prevalence rates for cigarettes, alcohol, and marijuana, were highest among persons who indicated they were of the Black race. For instance, about four in 10 (42.8%) lifetime users of alcohol were Blacks compared to three in 10 (30.5%) Whites. One in five lifetime users of cigarettes (20.6%) was a person of Black race – slightly higher than the 19.5% who were Whites. Likewise, Blacks represent 11.2% of lifetime users of marijuana whereas Whites constitute 8.2%. A similar trend was observed for annual use; however, with a narrower gap between Blacks and Whites. For example, of recent alcohol users 28.8% were Blacks compared to 27.6% Whites; of recent cigarette users 6.4% were Blacks compared to 5.5% Whites; and of recent marijuana users 2.8% were Blacks and 1.6% Whites. This pattern held true for the current-use period for both cigarettes and marijuana, but not for alcohol. A noteworthy finding is that in the past 30 days Whites accounted for the greatest proportion of alcohol use – almost one in four respondents or 24.9%. In contrast, Blacks accounted for 21.2% of current alcohol use or about one in five respondents were current users of alcohol. Persons of other races, including Portuguese, Asian, and Mixed race, accounted for smaller proportions of lifetime, annual, and current use of cigarettes, alcohol, and marijuana.

Table III-16
LIFETIME, ANNUAL, AND CURRENT USE OF SELECTED SUBSTANCES BY RACE
(Percentage of Weighted Survey Respondents)

	RACE						
	Black	White	Portuguese	Asian	Mixed	Not Stated	Other
Lifetime Use							
Cigarettes	20.6	19.5	2.3	1.4	3.1	0.6	0.3
Alcohol	42.8	30.5	4.2	2.7	5.2	0.8	0.5
Marijuana	11.2	8.2	1.2	0.2	1.7	0.1	-
Annual Use							
Cigarettes	6.4	5.5	0.9	0.7	1.0	-	-
Alcohol	28.8	27.6	3.4	2.5	4.1	0.5	0.2
Marijuana	2.8	1.6	0.7	-	0.1	-	-
Current Use							
Cigarettes	5.5	3.9	0.9	0.7	0.8	-	-
Alcohol	21.2	24.9	2.6	2.0	3.5	0.5	0.2
Marijuana	2.3	0.7	0.6	-	0.1	-	-

- means zero or unit less than 0.1.

Marital Status and Drug Use

Married people drank the most

The results in Table III-17, of prevalence rates for cigarettes, alcohol, and marijuana by the marital status of the survey respondent, reveals that, irrespective of the reference period, persons who were married represented the largest proportion of respondents. About four in 10 lifetime users of alcohol (39.2%) were married compared to about three in 10 (29.6%) who were never married. In contrast, persons who were never married represented the largest proportion of recent and current users of marijuana; 3.3% vs. 1.7% and 2.6% vs. 1.0%, respectively. Persons who were living together or cohabitating, divorces, separated, or widowed represented smaller proportions of cigarettes, alcohol, and marijuana use in all three reference periods under consideration.

Table III-17
LIFETIME, ANNUAL, AND CURRENT USE OF SELECTED SUBSTANCES BY MARITAL STATUS
(Percentage of Weighted Survey Respondents)

	MARITAL STATUS						
	Never Married	Living Together	Married	Divorced	Separated	Widowed	Not Stated
Lifetime Use							
Cigarettes	13.4	0.9	22.8	5.8	0.8	3.9	0.1
Alcohol	29.6	2.2	39.2	8.6	0.9	6.1	0.1
Marijuana	9.0	0.7	9.4	2.5	0.4	0.6	-
Annual Use							
Cigarettes	6.5	0.2	5.3	1.2	0.3	0.9	-
Alcohol	25.5	1.7	29.6	5.7	0.7	3.8	0.1
Marijuana	3.3	0.0	1.7	0.1	-	0.1	-
Current Use							
Cigarettes	5.5	0.2	4.0	1.1	0.3	0.7	-
Alcohol	19.3	1.5	25.9	4.6	0.5	2.8	0.1
Marijuana	2.6	-	1.0	-	-	0.1	-

- means zero or unit less than 0.1.

Education Level and Drug Use

Drug use was most prevalent among participants who finished only a secondary-level education

Table III-18 reveals that mainly persons who have completed high school and a university undergraduate (Bachelor's) degree reported highest prevalence-of-use for cigarettes, alcohol, and marijuana, in all three reference periods, compared to respondents who completed other education levels. However, prevalence-of-use was highest among participants who only completed high school. For instance, 26.5% of the respondents indicated lifetime use of alcohol and completed high school, 20.2% of these persons used alcohol in the past year, and 16.4% in the past month. Similarly, 21.6% of holders of a Bachelor's degree had used alcohol in their lifetime, 18.3% in the past year, and 15.7% in the past 30 days.

Table III-18
LIFETIME, ANNUAL, AND CURRENT USE OF SELECTED SUBSTANCES
BY HIGHEST LEVEL OF EDUCATION COMPLETED
(Percentage of Weighted Survey Respondents)

	HIGHEST LEVEL OF EDUCATION COMPLETED									
	None	High School Diploma	Technical/Vocational Certificate	Associates Degree	Bachelor's Degree	Master's Degree	Doctorate Degree	Professional Designation	Not Stated	Other
Lifetime Use										
Cigarettes	2.8	14.2	7.3	4.1	12.1	4.9	0.5	1.6	0.1	0.1
Alcohol	4.7	26.5	14.0	7.6	21.6	8.2	1.4	2.4	0.1	0.1
Marijuana	0.8	6.3	3.9	1.9	6.1	2.4	0.4	0.6	0.1	-
Annual Use										
Cigarettes	0.8	5.2	2.1	1.0	3.7	1.1	0.2	0.4	-	-
Alcohol	2.6	20.2	10.2	5.9	18.3	6.5	1.2	2.1	0.1	-
Marijuana	0.2	2.7	0.5	0.4	1.0	0.2	-	0.1	-	-
Current Use										
Cigarettes	0.8	4.8	1.9	1.0	2.5	0.5	-	0.3	-	-
Alcohol	2.0	16.4	7.1	4.8	15.7	5.4	1.2	2.1	0.1	-
Marijuana	0.2	2.1	0.4	0.4	0.6	-	-	-	-	-

- means zero or unit less than 0.1.

Employment Status and Drug Use

Substance use was most prevalent among persons working over 40 hours per week

When substance use is looked at in terms of employment status, Table III-19 shows that employed and self-employed persons reported highest lifetime, annual, and current prevalence for cigarettes, alcohol, and marijuana. More specifically, participants who indicated that they work 40 or more hours per week reported the highest prevalence, more than even those who worked for between one to 39 hours per week. In many instances, prevalence almost doubled among those working for longer hours than their counterparts who worked less hours. For instance, current use of alcohol was reported by 26.4% of the respondents who also reported to have worked 40 hours or more per week compared to current alcohol use by 13.6% of respondents who also reported to have worked one to 39 hours per week.

Table III-19
LIFETIME, ANNUAL, AND CURRENT USE OF SELECTED SUBSTANCES
BY EMPLOYMENT STATUS
(Percentage of Weighted Survey Respondents)

	EMPLOYMENT STATUS						
	Employed/ Self- Employed 1-39 hrs.	Employed/ Self- Employed 40+ hrs.	Not Employed & Looking	Not Employed & Not Looking	Retired	Disabled	Not Stated
Lifetime Use							
Cigarettes	11.9	21.6	2.7	2.0	9.1	0.2	0.2
Alcohol	22.1	37.4	4.8	7.1	14.7	0.2	0.4
Marijuana	6.5	12.3	1.1	1.2	1.5	-	-
Annual Use							
Cigarettes	4.0	7.5	1.4	0.1	1.3	0.1	0.1
Alcohol	16.4	31.5	3.9	6.0	8.8	0.2	0.4
Marijuana	1.4	2.8	0.7	0.2	0.1	-	-
Current Use							
Cigarettes	3.2	6.0	1.3	0.1	1.0	0.1	0.1
Alcohol	13.6	26.4	3.0	4.3	7.4	0.2	-
Marijuana	0.9	2.0	0.7	0.1	-	-	-

- means zero or unit less than 0.1.

Illicit Drug Use

A significant proportion of persons have friends or family members who take illegal drug(s)

Respondents were asked if they were curious to try an illicit drug and if presented with the opportunity, whether not they will try it. While 78.5% of the respondents indicated they were not curious to try an illegal drug, almost one in five respondents or 18.4% said that they were curious (Table III-20 and Chart III-11). However, overwhelmingly, 91.0% of the participants indicated they would not try an illegal drug if they had the chance while 4.8% said they would try it. Further, respondents were asked if they have friends or family members who take illegal drug(s). Approximately four out of 10 respondents said they do have friends or family members who use illegal drug(s) while 55.6% or about 6 out of ten said they did not have such persons.

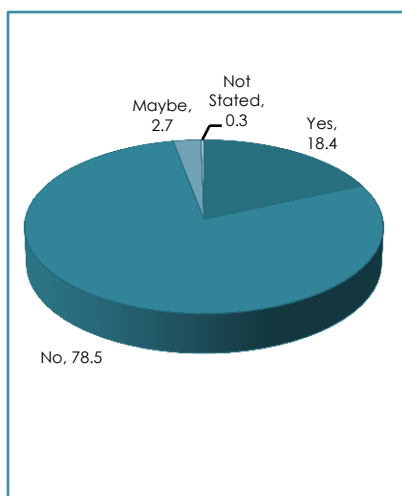
Table III-20
ILLICIT DRUG USE
(Percentage of Weighted Survey Respondents)

	Yes	No	Maybe	Not Stated
Curious to try an illegal drug	18.4	78.5	2.7	0.3
If had the chance, would try an illegal drug	4.8	91.0	4.0	0.2
Have friends or family members who take illegal drug(s)	42.4	55.6	...	2.0

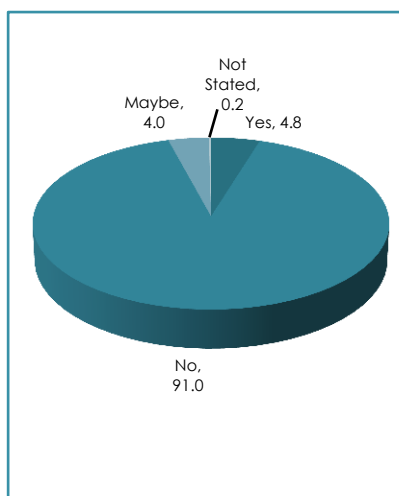
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Chart III-11
RESPONSES TO ILLICIT DRUG USE QUESTIONS
(Percentage of Weighted Survey Respondents)

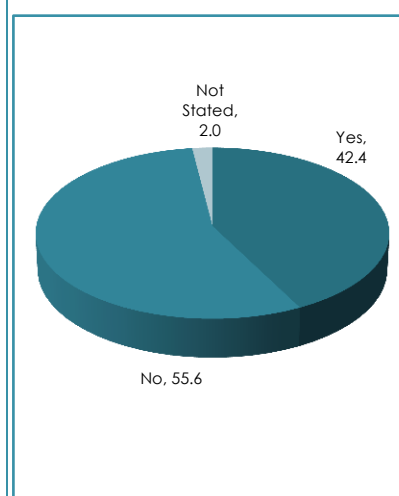
Curious to try an illegal drug



Would try an illegal drug if had the chance



Friend or family members who take illegal drug(s)



DRUG MARKET

Marijuana is the drug most likely to be offered for purchase or use

With the exception of marijuana, for the most part, respondents were never offered illicit drugs to buy or use during the past year. When it came to marijuana, however, 4.2% of the respondents said they were offered to buy or use it during the week of the survey; 11.4% said they were offered to buy or use marijuana as recent as more than a month ago; while 4.8% indicated it was less than a year ago that they were offered to buy or use this drug. As indicated in Table III-21, small proportions of illicit drugs were reportedly offered for purchase or use in the past year.

Table III-21
LAST OFFER TO BUY OR USE DRUGS
(Percentage of Weighted Survey Respondents)

Drugs	Never	During this week	During this month	More than a month ago	Less than a year ago	Don't know	Not Stated
Marijuana	70.4	4.2	3.3	11.4	4.8	4.7	1.3
Cocaine	93.0	0.2	0.3	2.2	1.2	2.7	0.4
Heroin	96.6	0.0	0.1	0.7	0.4	2.1	0.1
Ecstasy	95.5	0.1	0.1	1.3	0.7	2.2	0.1
Crack Cocaine	96.3	0.0	0.0	0.9	0.2	2.2	0.3

ALCOHOL AND MARIJUANA POLICY PERCEPTIONS

Lowering the blood alcohol legal limit is not a favorable option, but there is approval for roadside sobriety checkpoints

Survey respondents were asked six questions related to alcohol and marijuana policy – five questions related to alcohol policy and one question focused on marijuana. These questions were included in this round of the national household survey in response to international changes being made to alcohol and marijuana laws. The intent was to seek a better understanding of how residents of Bermuda perceive these topical issues.

When asked about the minimum drinking age in Bermuda, a large proportion (96.5%) of respondents knew the minimum drinking age in Bermuda to be 18 years or older while 3.1% did not know a person should be 18 years or older to be sold alcohol by a licensed establishment in Bermuda (Table III-22).

Respondents were asked if they favour laws preventing persons from serving alcohol to minors in their homes or on their premises. More than two-thirds or 68.4% of the survey respondents admitted to being in favour of such a policy.

When questioned about roadside sobriety checkpoints, the majority of respondents were in favor of these checkpoints (83.1%) while 13.0% of the respondents were not in favor.

However, the strong approval for laws preventing persons from serving alcohol to minors in their homes or on their premises and support for roadside sobriety checkpoints did not extend to lowering the blood alcohol legal limit. Only 25.7% of the respondents said they were in favour of lowering the blood alcohol legal limit from 0.08 to 0.01 (62.5% were not in favour).

Alcohol advertisements are lacking the legally required health warning

According to the Alcohol Advertising (Health Warning) Act 1993, all displayed alcohol advertisements must contain the health warning “Excessive alcohol consumption may be harmful to your health”. To assess whether or not such advertisements were in keeping with this legislation, respondents were asked if they had noticed alcohol advertisements with this health warning in the past 30 days. As observed in Table III-22, almost half of respondents or 49.2% said that they had “never/not at all” observed this warning. Whereas a combined 36.2% admitted to seeing the warning sometimes or a few or couple of times; while only 3.7% said they have noticed the health warning all the time.

Decriminalising marijuana is viewed favourably

The debate over marijuana decriminalisation has become an international headline as countries move toward determining the best approach to reducing penalties associated with possession of small amounts of this illicit substance. Similar conversations are currently being had in Bermuda. In this survey, respondents were asked “Are you in favour of decriminalising small amounts of marijuana for personal use by persons 18 years or older?” Results showed that most surveyed residents were in favour of decriminalisation (48.6%); 41.3% were not in favour of decriminalisation, and 9.4% said they did not know/did not care.

Table III-22
PERCEPTION OF PROPOSED ALCOHOL AND MARIJUANA POLICY CHANGES

Question	Percentage of Survey Respondents (Weighted)			
	Yes	No	Don't Know/ Don't Care	Not Stated
Are you aware that a person should be 18 years or older to be sold alcohol by a licenced establishment in Bermuda?	96.5	3.1	...	0.4
Are you in favour of laws preventing persons from servicing alcohol to minors in their homes or on their premises?	68.4	26.6	4.6	0.4
Are you in favour of lowering the blood alcohol legal limit from 0.08 to 0.01?	25.7	62.5	11.2	0.6
Are you in favour of roadside sobriety checkpoints?	83.1	13.0	3.6	0.3
Are you in favour of decriminalising small amounts of marijuana for personal use by persons 18 years or older?	48.6	41.3	9.4	0.7

... means 'Not Applicable' as Don't Know/Don't Care was not a response option for this question.

Chart III-12
AWARENESS OF LEGAL AGE TO PURCHASE ALCOHOL FROM LICENCED ESTABLISHMENT

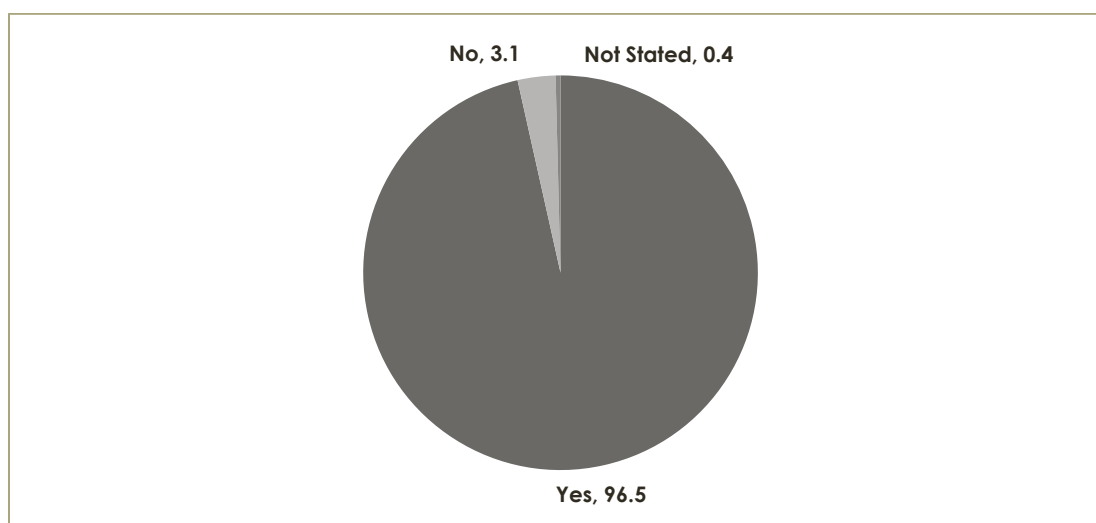
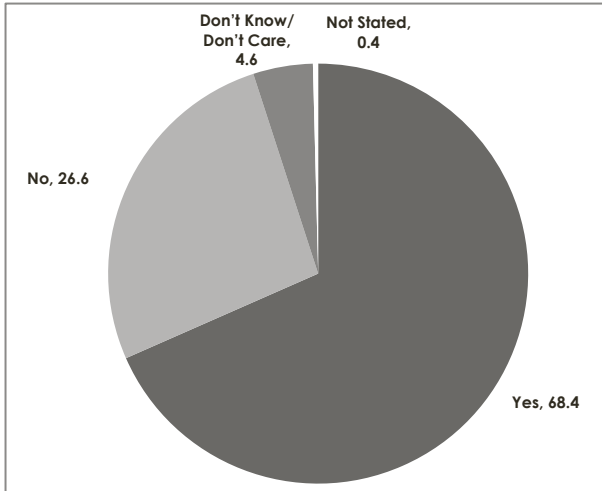
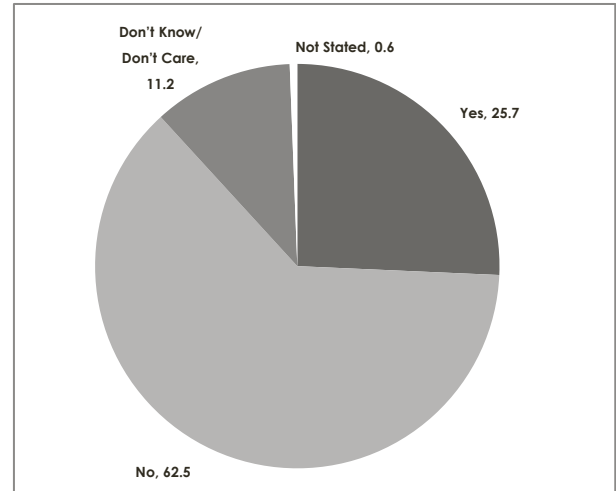


Chart III-13
SURVEY RESPONDENTS' PERCEPTIONS TO PROPOSED POLICY INITIATIVES
 (Percentage of Weighted Survey Respondents)

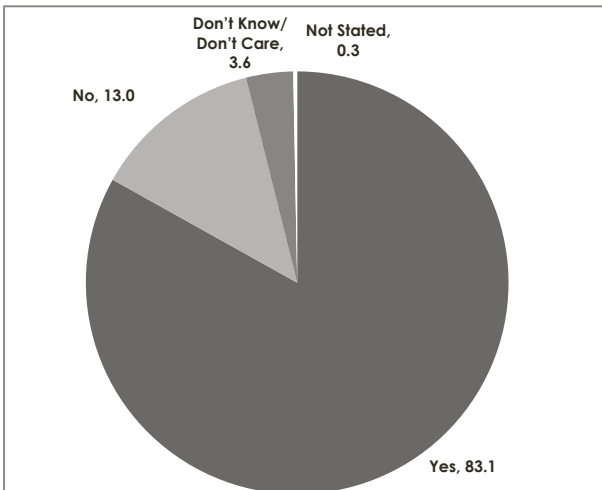
IN FAVOUR OF LAWS PREVENTING PERSONS FROM SERVING ALCOHOL TO MINORS IN THEIR HOMES OR ON THEIR PREMISES



IN FAVOUR OF LOWERING THE BLOOD ALCOHOL LEGAL LIMIT FROM 0.08 TO 0.01



IN FAVOUR OF ROADSIDE SOBRIETY CHECKPOINTS



IN FAVOUR OF DECRIMINALISING SMALL AMOUNTS OF MARIJUANA FOR PERSONAL USE BY PERSONS 18 YEARS OR OLDER

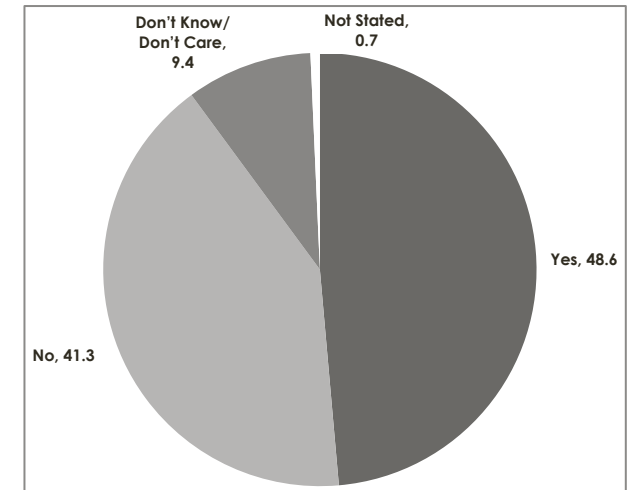
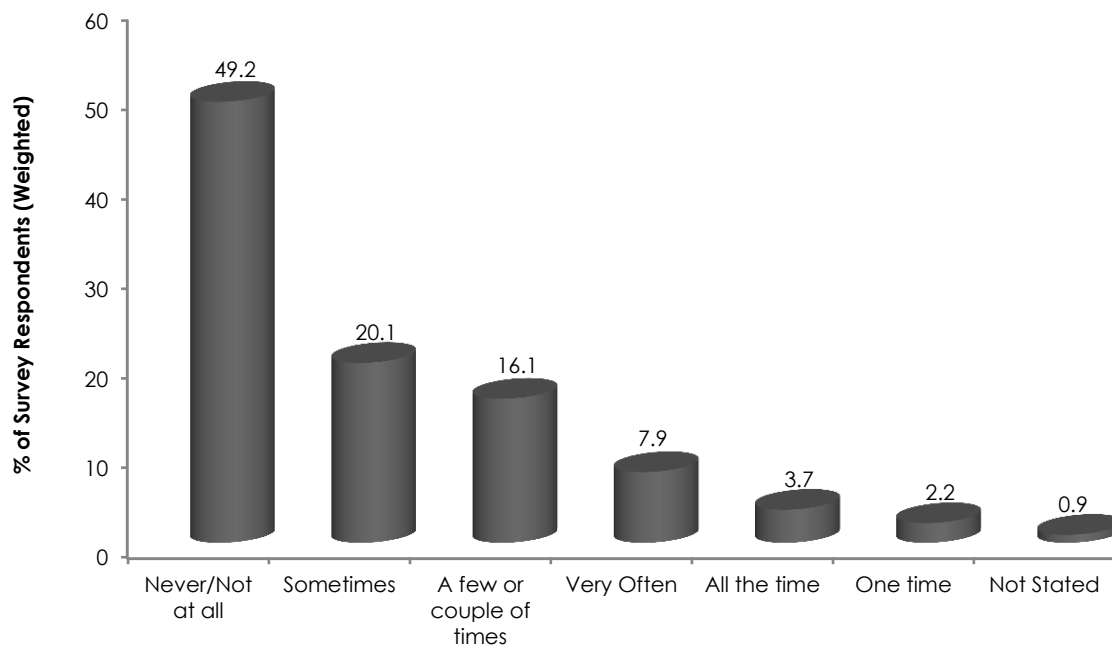


Table III-22 cont'd
PERCEPTION OF PROPOSED ALCOHOL AND MARIJUANA POLICY CHANGES

In the last 30 days, have you noticed alcohol advertisements with the health warning "Excessive alcohol consumption may be harmful to your health."?	Percentage of Survey Respondents (Weighted)
Never/Not at all	49.2
Sometimes	20.1
A few or couple of times	16.1
Very Often	7.9
All the time	3.7
One time	2.2
Not Stated	0.9

Chart III-14
NOTICE OF ALCOHOL ADVERTISEMENTS WITH HEALTH WARNING IN LAST 30 DAYS



IV. DISCUSSION

Alcohol, cigarettes, and marijuana remain the top three commonly used substances in Bermuda. Of all illicit drugs on the market marijuana remains the most popular drug being offered to buy or use in Bermuda. However, since 2009, a steady decline in the prevalence-of-use has been observed for these substances. Significant declines were observed for lifetime (-13.6%) and annual (5.7%) use of marijuana, with a smaller decline in current (-3.8%) marijuana use. While lifetime use of inhalants, opium, morphine, hallucinogens, hashish, and crack cocaine, was reported to some extent, few respondents reported current use of these substances. It was difficult, therefore, to obtain any useful information.

Overall, females had a greater tendency to use legal drugs (alcohol, cigarettes, and inhalants), while males were more likely to engage in illegal drug use, especially that of marijuana, hash, cocaine, hallucinogens, ecstasy, and crack cocaine. The age of first use of the top three substances also increased between 2009 and 2013. In the science of substance abuse prevention, the intent is for age of first use or experimentation of substances to increase as an indication of delayed drug use. The observed differences in prevalence-of-use according to age, was most apparent with use of alcohol and marijuana. Respondents age 25 to 29 years all indicated current use of alcohol (90.0%) that was well-above the national average (54.8%). For marijuana, those respondents age 40 to 44 years were more likely to indicate current use (83.7%) that was also above the national average of 3.5%.

The current survey showed that the majority of participants said that they first started using alcohol more than a year ago. However, 8.0% said they first used or drank alcohol within the past 30 days. A number of current alcohol users said they used alcohol mostly on the weekends (56.3%), while 16.3% were keen to admit to six to 10 binge drinking episodes in the past 30 days (binge drinking is the consumption of five or more drinks in one sitting). Subsequently, 15.0% and 15.5% said they "felt like decreasing the amount of alcohol they drunk" and had "experienced not remembering after waking up in the morning".

Perceptions of harm associated with alcohol consumption appear to be somewhat skewed in that a comparatively small proportion of respondents considered that using alcohol sometimes (16.1%) and getting drunk (35.2%) represented a serious risk (high risk). One would have expected more residents would view these as high-risk behaviours. Participants readily admitted to having friends or family members who get drunk at 36.4%. Additionally, respondents who had no friends or family members who got drunk reported lower prevalence of lifetime, annual, and current alcohol use than those who had at least one, two, or more friends or family who did.

Women who are not substance abusers may be affected by problems related to substance abusing men. When asked about problem drinking in the current survey, 4.5% of respondents said that they had trouble with a partner because of alcohol. The problems of male partners may affect women in the form of difficulties in

interpersonal relationships, instability, violence, child abuse, economic insecurity, deprivation of schooling, and risk of sexually transmitted disease, including HIV infection.

The impact of drug use on the family unit cannot be overlooked. As evidenced here and elsewhere, many respondents admitted to having family and/or friends involved with drugs. Prevention of drug problems can employ knowledge about family dynamics to address personal and social concerns of family members that otherwise would lead to drug abuse, both with respect to dysfunctional as well as intact families. Lack of household stability, income or employment for a parent may increase stress on the family and its vulnerability, pushing marginal individuals to find "solutions" or solace in alcohol or drugs. Single-parent families may have increased difficulties, with the single parent being forced to function beyond his or her ability. Alcohol abuse, other substance abuse and psychopathology have been studied among family members. It is well known that having biological relatives with alcoholism increases the risk in unaffected individuals. Also, families with histories of psychological and social pathology may be at increased risk for alcohol problems.

Conventional wisdom and research suggest that drug use flourishes when people believe that the risk of harm in using them, either physically or in some other way is minimal. Nonetheless, alcohol, tobacco, and marijuana use were highest although their use is perceived to be of the highest risk.

Fewer residents indicated it was easier to obtain certain drugs than in 2009. For marijuana, 36.7% of respondents said it was easy to obtain marijuana compared with 53.0% in 2009. Differences were also seen with ease of obtaining cocaine (30.2% in 2009 vs. 16.6% in 2013), crack cocaine (27.7% in 2009 vs. 13.8% in 2013), and ecstasy (23.1% in 2009 vs. 12.7% in 2013). The factors responsible for driving down these rates are unknown. However, one might speculate that a decrease in supply or changing perceptions of availability may be responsible for the noticeable decrease in the ability to obtain drugs with ease. Although many respondents would not try an illegal drug when given a chance (4.8%), 18.4% said they were curious to try an illegal drug – a significant decrease since 2009 (31.1%); while respondents readily admitted having friends or family members who use drugs (42.4%).

The first and most worrisome impact of illicit drug use is on health. The United Nations Office on Drugs and Crime (UNODC) estimates that about 12% of annual users develop dependency and become problem drugs users, of whom there are currently fewer than 30 million. Additionally, according to the World Health Organisation (WHO), close to 250,000 people die every year from overdoses and drug-related illnesses. In comparison, alcohol claims some 2.3 million lives per year and tobacco some 5.1 million. Research shows that illicit drug use also has an important impact on society's productivity. Productivity losses generally occur through the incapacitation of individuals or by confinement in residential treatment programmes, hospitals or prisons. The costs arising from productivity losses due to drug use may be four to eight times higher than the health-related costs. Illicit drug use is

also closely linked to crime, in various ways. For example, drug users often resort to acquisitive crime to finance their drug habits, thus incurring substantial costs for society. Moreover, many criminals are under the influence of illicit drugs when they commit crime as noted in the 2011 Report of the Drug Abuse Monitoring Programme.

The drug control system has not averted the problem of drug consumption, but seems to have contained it to much lower levels of use than Bermuda has experienced previously. The findings show significant gender differences in the prevalence of alcohol, tobacco (cigarettes), and marijuana use. The use of legal substances tends, indeed, to be far more homogeneously distributed across age groups than the use of illegal substances. Another significant characteristic of illicit drug use is the disproportionate representation of males among the user population. Males reported higher prevalence of use rates than women when it came to use of illicit drugs. Prevalence of illicit drug use among females is only about one fourth of the prevalence of males.

Although the use of the top three substances appears to have decreased from the levels reported in 2009, it is possible that differences in the sample of respondents may have, in fact, led to the observed decline in use of alcohol, cigarettes, and marijuana; such that respondents of this survey may simply have used ATODs at lower rates than previous cohorts. As with all epidemiological data, this information should be used in combination with other evidence to determine a more accurate picture of the drug situation in Bermuda.

Sometimes considered a health problem, other times viewed as a crime, drug misuse presents unique and costly consequences to society. Education however is the principal means of preventing drug misuse. In addition to educational institutions, other settings are important for the contributions they make to learning and socialization. Home, workplace and religious institutions, are settings for the education of young and old alike. The short-term approach (to control the supply of drugs) and the long-term demand reduction approach by education are two ends of a continuum which are often placed in opposition to each other. In reality, both are essential parts of a comprehensive view of prevention of drug misuse.

While awareness is increasing, decision makers require better data; good policy and programmes require good analysis. No single measurement or data aggregate can reflect the complex nature of problems associated with substance misuse but basic indicators are needed for planning and action. All estimates are in some ways incomplete, but an incomplete estimate used well is better than none at all. Policy makers will continue to face difficult policy choices when tackling issues related to legal substances, illicit drugs and crime while ensuring public safety. This research and trend analysis is designed to evaluate the current drug situation in Bermuda. Future surveys will build on a number of indicators that are tracked, in an effort to provide an increasingly clear picture of prevalence of use and the level of the national responses to the use of legal and illegal substances.

APPENDICES

APPENDIX 1: UNWEIGHTED SAMPLE

BAISIC DEMOGRAPHIC CHARACTERISTICS OF SAMPLE RESPONDENTS

(n = 1,200)

Characteristic	Number of Survey Respondents	Percentage of Survey Respondents
Head of Household		
Yes	740	61.7
No	457	38.1
Not Stated	3	0.3
Sex		
Male	424	35.3
Female	776	64.7
Age (Years)		
16 – 19	49	4.1
20 – 24	52	4.3
25 – 29	61	5.1
30 – 34	95	7.9
35 – 40	108	9.0
40 – 44	111	9.3
45 – 49	111	9.3
50 – 54	106	8.8
55 – 59	129	10.8
60 – 64	125	10.4
65 – 69	88	7.3
70 – 74	68	5.7
75 – 79	46	3.8
80 – 84	36	3.0
85+	15	1.3
Race		
Black or African	605	50.4
White	415	34.6
Mixed	66	5.5
Portuguese	55	4.6
Asian	36	3.0
Not Stated	16	1.3
Other	7	0.6
Parish		
St. Georges	107	8.9
Hamilton	79	6.6
Smiths	110	9.2
Devonshire	130	10.8
Pembroke	288	24.0
Paget	117	9.8
Warwick	156	13.0
Southampton	78	6.5
Sandys	135	11.3

APPENDIX 2: HISTORICAL COMPARISON OF PREVALENCE

Substances	2001 ¹				2009 ²			
	Lifetime	Annual	Current	Average Age of Onset	Lifetime	Annual	Current	Average Age of Onset
Alcohol	85.9	63.7	54.2	17.3	89.2	72.0	58.9	15.9
Tobacco	66.5	21.0	18.0	16.5	49.3	15.0	12.3	16.7
Inhalants	1.1	0.2	0.2	13.6	1.0	0.1	0.1	14.0
Marijuana	35.8	9.4	7.4	17.8	37.0	10.9	7.5	17.0
Cocaine	4.7	0.4	0.3	21.8	4.6	-	-	21.2
Crack	2.7	0.6	0.6	24.5	1.0	-	-	24.7
Heroin	1.4	0.2	0.2	22.3	1.0	0.1	-	23.8
Hash	...	...	...	...	10.7	...	...	18.5
Ecstasy	...	...	...	...	2.5	0.1	-	22.3
Stimulants	...	...	...	...	1.7	0.1	-	22.7
Opium	...	...	...	...	1.1	...	...	21.7
Morphine	...	...	...	...	2.8	...	...	26.6
Hallucinogens	3.8	0.1	-	18.7	3.1	...	...	20.3
Tranquilisers	...	...	...	...	1.9	0.1	-	25.6
Prescription Medications ⁺	3.0	0.9	*	23.6	...	...	...	...

Notes:

– zero or no reported use

... not asked/not reported/not available

* current use was excluded from analysis because of a typographical error on the questionnaire for this question; therefore, data was deemed not useful

+ includes stimulants, tranquilisers, sedatives, and painkillers

Sources:

¹2001 NHS Dataset (NDC)

²2009 NHS Dataset (DNDC)

APPENDIX 3: SELECTED COUNTRY COMPARISON OF PREVALENCE

Lifetime Prevalence

Countries	Year	Cohort	Alcohol	Tobacco	Inhalants	Marijuana	Cocaine	Crack	Heroin
Barbados	2006	18-34 [^]	85.4	...	...	24.1	0.6	...	...
Uruguay	2006	18-34 [^]	86.9	...	...	24.2	8.5	...	...
Canada	2011	15+	89.7	43.0	...	39.4	6.2	...	0.5
Netherlands	2009	15-64	...	...	...	25.7	5.2	...	0.5
UK [^]	2011	16-59	...	...	...	31.0	9.6	...	1.1
USA	2012	18+	87.6	71.6	8.3	45.5	15.9	3.8	1.9*

Notes:

... not asked/not reported/not available

[^] reported for 12-64 years but available by age groups 12-17, 18-34, and 35-64. 18-34 was taken as the best approximation of the adult population.

[^] England and Wales

* available for cohort 26+. Estimate generated from data collected on a "noncore" module of the NSDUH questionnaire. Therefore, these estimates may be somewhat inconsistent with drug estimates based on data collected from the "core" modules because NSDUH data are not edited for consistency across the "core" and "noncore" modules of the interview.

For the USA, tobacco includes cigarettes, smokeless tobacco, cigars, pipe tobacco.

Current Prevalence

Countries	Year	Cohort	Alcohol	Tobacco	Inhalants	Marijuana	Cocaine	Crack	Heroin
Barbados	2006	18-34 [^]	40.3	...	...	11.1	0.1	...	...
Uruguay	2006	18-34 [^]	61.1	...	...	7.3	1.9	...	...
Canada	2011	15+	63.1	17.0	...	...	...	...	...
Netherlands	2009	15-64	...	...	...	...	...	...	...
UK [^]	2011	16-59	...	...	...	4.1	1.0	...	0.2
USA	2012	18+	56.3	28.6	0.1	7.3	0.7	0.2	...

Notes:

... not asked/not reported/not available

[^] reported for 12-64 years but available by age groups 12-17, 18-34, and 35-64. 18-34 was taken as the best approximation of the adult population.

[^] England and Wales

For the USA, tobacco includes cigarettes, smokeless tobacco, cigars, pipe tobacco.

Sources:

Barbados and Uruguay: OAS-CICAD Report on Drug Use in the Americas, 2011.

Canada: Canadian Alcohol and Drug Use Monitoring Survey (CADUMS), 2011. Summary of Results for 2011. (http://www.hc-sc.gc.ca/hc-ps/drugs-drogués/stat/_2011/summary-sommaire-eng.php#a4); Canadian Tobacco Use Monitoring Survey (CTUMS), 2011. (http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/ctums-esutc_2011-eng.php)

Netherlands: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Country Overview: Netherlands. Drug use among the general population and young people (<http://www.emcdda.europa.eu/publications/country-overviews/nl>)

USA: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012. Results from the 2012 National Survey on Drug Use and Health: Detailed Tables

(<http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/DetTabs/NSDUH-DetTabsIOC2012.htm>)

United Kingdom: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Country Overview: United Kingdom. Drug use among the general population and young people (<http://www.emcdda.europa.eu/publications/country-overviews/uk>)

APPENDIX 4: KISH GRID

KISH GRID

DATE:

TELEPHONE #:

INSTRUCTIONS

STEP 1:

- 1) In the table below, enter the first name of the household members who **live in Bermuda for six months or more, starting with the eldest.**
- 2) In the *Order Number* column, number sequentially the individuals who are **16 years or older.**

First Name	Age	Order Number

STEP 2:

- 1) Use this grid below to determine which household member will be interviewed.
- 2) Circle the household member and ask if he/she is available to complete the survey.

E.g. the ordered list ends at **4** then the person who was numbered **3** would be selected for the interview.

Household Size	1	2	3	4	5	6	7	8	9	10
Person to be Interviewed	1	2	3	3	5	4	2	5	8	10

NOTES:

Did you complete the household listing or the whole questionnaire?

☐ Household Listing Only☐ Household Listing and Questionnaire

To be filled in only if the questionnaire is complete:

INTERVIEWER'S NAME: _____

COMPLETION DATE __ / __ / ____

APPENDIX 5: SURVEY QUESTIONNAIRE

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CONTROL QUESTIONS

Interviewer, please enter the information in response to the following two questions before proceeding with the interview.

***1. HOUSEHOLD ASSESSMENT NUMBER**

***2. INTERVIEWER'S NAME**

DEMOGRAPHICS

***3. Are you the head of household?**

☐ Yes☐ No☐ Not Stated

***4. Are you male or female?**

☐ Male☐ Female☐ Not Stated

5. What is your age?

***6. What is your race?**

☐ Black or African☐ White☐ Portuguese☐ Asian☐ Mixed (Black & White, Black & Other, White & Other)☐ Not Stated☐ Other

(Please specify)

***7. What is your marital status?**

☐ Never Married☐ Separated☐ Living Together/Cohabitation/Common Law☐ Widowed☐ Married☐ Not Stated☐ Divorced

2013 NATIONAL HOUSEHOLD SURVEY ON DRUG USE AND HEALTH***8. What is the highest level of education you have completed?**

- ☐ None
- ☐ School Leaving Certificate/High School Diploma
- ☐ Technical/Vocational Certificate (Bermuda College)
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate Degree
- ☐ Professional Designation (With or Without Any Prior Academic Qualification)
- ☐ Not Stated
- ☐ Other

(Please Specify)

EMPLOYMENT & STATUS***9. Which of the following categories best describes your employment status?**

- ☐ Employed/Self-Employed, working 1-39 hours per week
- ☐ Employed/Self-Employed, working 40 or more hours per week
- ☐ Not employed, looking for work
- ☐ Not employed, NOT looking for work (e.g. housewife, student, other)
- ☐ Retired
- ☐ Disabled, not able to work
- ☐ Not Stated

***10. What is your current occupation?**

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*11. What is the principal industry of your organization?

- ☐ Agriculture, Hunting, & Fishing
- ☐ Manufacturing
- ☐ Electricity, Gas, & Water Supply
- ☐ Construction
- ☐ Wholesale and Retail Trade; Repair of Motor Vehicles, Motor Cycles, & Personal and Household Goods
- ☐ Hotels and Restaurants
- ☐ Transport, Storage, & Communication
- ☐ Financial Intermediation
- ☐ Real Estate, Renting, & Business Activities
- ☐ Public Administration (Government) and Defence; Compulsory Social Security
- ☐ Education
- ☐ Health and Social Work
- ☐ Other Community, Social, & Personal Service Activities
- ☐ Private Households with Employed Persons
- ☐ Not Stated
- ☐ Other (please specify)

RISK OF HARM

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***12. In your opinion, what is your risk level of (...). Is (...) of no risk, low risk, moderate risk, high risk, or you don't know the risk?**

	No Risk	Low Risk	Moderate Risk	High Risk	I Don't Know the Risk	Not Stated
Smoking cigarettes sometimes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smoking cigarettes often	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drinking alcoholic beverages sometimes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drinking alcoholic beverages often	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Becoming drunk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking unprescribed tranquilisers/stimulants sometimes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking unprescribed tranquilisers/stimulants often	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inhaling solvents sometimes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inhaling solvents often	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smoking marijuana sometimes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smoking marijuana often	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using cocaine sometimes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using cocaine often	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using heroin sometimes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using heroin often	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking ecstasy sometimes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking ecstasy often	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using coca paste sometimes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using coca paste often	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using crack cocaine sometimes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Using crack cocaine
often

☐ ☐ ☐ ☐ ☐ ☐

ACCESS

***13. How easy would it be for you to have access to (...)? Could not have access to it, easy to access, difficult to access, don't know?**

	Could not have access	Easy	Difficult	Don't Know	Not Stated
Marijuana	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cocaine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crack Cocaine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coca Paste	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ecstasy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heroin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PREVALENCE-OF-USE: CIGARETTES

***14. Have you ever smoked cigarettes?**

☐ Yes ☐ No ☐ Not Stated

15. At what age did you start smoking cigarettes?

***16. When was the first time you smoked cigarettes?**

- ☐ In the past 30 days
☐ More than 1 month ago but less than 1 year ago
☐ More than a year ago
☐ Not Stated

***17. Have you smoked cigarettes in the past 12 months?**

☐ Yes ☐ No ☐ Not Stated

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***18. Have you smoked cigarettes in the past 30 days?**

- ☐ Yes
 ☐ No
 ☐ Not Stated

***19. About how many cigarettes do you smoke in a typical month?**

- ☐ 1 to 5
 ☐ 6 to 10
 ☐ 11 to 20
(Half - 1 Pack)
 ☐ 2 - 3 Packs
 ☐ 4 - 5 Packs
 ☐ More than 5 Packs
 ☐ Not Stated

***20. During the past 30 days, did someone smoke in your home?**

- ☐ Yes
☐ No
☐ Not Stated

***21. During the past 30 days, did someone smoke in a closed area in your workplace (in the building, in a work area, or specific office)?**

- ☐ Yes
☐ No
☐ Not Stated

PREVALENCE-OF-USE: ALCOHOL

***22. Have you ever drank alcoholic beverages?**

- ☐ Yes
 ☐ No
 ☐ Not Stated

23. At what age did you start drinking alcoholic beverages?

***24. When was the first time you drank alcoholic beverages?**

- ☐ In the past 30 days
☐ More than 1 month ago but less than 1 year ago
☐ More than a year ago
☐ Not Stated

***25. Have you drank alcoholic beverages in the past 12 months?**

- ☐ Yes
 ☐ No
 ☐ Not Stated

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***26. Have you drank alcoholic beverages in the past 30 days?**

☐ Yes ☐ No ☐ Not Stated

***27. During the past 30 days, how many times did you have five or more standard alcoholic drinks in a single drinking occasion? (e.g., 5 cans of beer, 5 shots of spirits, 5 glasses of wine).**

***28. In the past 30 days, what type(s) of alcoholic beverage did you drink, and with what frequency?**

	Some Week Days	Daily	Weekends	Not Stated
Low alcohol content such as beer, Guinness, or Smirnoff Ice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medium alcohol content such as wine, Bailey's, or Malibu	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High alcohol content such as whiskey, rum, or gin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

29. In the past month, how many days have you drank too much and got drunk?

***30. Have you had trouble with your partner because of alcohol?**

☐ Yes ☐ No ☐ Not Stated

***31. Have you lost friends or partners because of alcohol?**

☐ Yes ☐ No ☐ Not Stated

***32. Have you felt like decreasing the amount of alcohol you drink?**

☐ Yes ☐ No ☐ Not Stated

***33. Do you drink more than you want, without noticing?**

☐ Yes ☐ No ☐ Not Stated

***34. Did you have to drink alcohol in the morning?**

☐ Yes ☐ No ☐ Not Stated

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***35. When you wake up in the morning after having drunk the night before, have you ever experienced not remembering part of what happened?**

☐ Yes ☐ No ☐ Not Stated

***36. Does it bother you that you are criticised for the way you drink?**

☐ Yes ☐ No ☐ Not Applicable ☐ Not Stated

***37. Do you have friends or family members who get drunk?**

☐ Yes ☐ No ☐ Not Stated

38. How many of your friends or family members get drunk?

PREVALENCE-OF-USE: INHALANTS

***39. Have you ever used inhalants?**

☐ Yes ☐ No ☐ Not Stated

40. At what age did you start using inhalants?

***41. Have you used inhalants in the past 12 months?**

☐ Yes ☐ No ☐ Not Stated

***42. Have you used inhalants in the past 30 days?**

☐ Yes ☐ No ☐ Not Stated

PREVALENCE-OF-USE: ILLEGAL DRUGS

***43. Have you ever been curious to try an illegal drug?**

☐ Yes ☐ No ☐ Maybe ☐ Not Stated

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***44. If you had the chance, would you try and illegal drug?**

- ☐ Yes ☐ No ☐ Maybe ☐ Not Stated

***45. Do you have friends or family members who take illegal drugs such as marijuana or cocaine?**

- ☐ Yes ☐ No ☐ Not Stated

***46. Have you ever used an illegal drug such as marijuana, cocaine, crack, heroin, or drugs without a medical prescription like morphine, tranquilisers, and stimulants?**

- ☐ Yes
☐ No
☐ Not Stated

PREVALENCE-OF-USE: MARIJUANA

***47. Have you ever smoked marijuana?**

- ☐ Yes ☐ No ☐ Not Stated

48. At what age did you start smoking marijuana?

***49. When was the first time you smoked marijuana?**

- ☐ In the past 30 days
☐ More than 1 month ago but less than 1 year ago
☐ More than a year ago
☐ Not Stated

***50. Have you smoked marijuana in the past 12 months?**

- ☐ Yes ☐ No ☐ Not Stated

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***51. How often do you use marijuana?**

- ☐ Daily
- ☐ Sometimes during the week
- ☐ Sometimes during the month
- ☐ Sometimes in the past 12 months
- ☐ Only once
- ☐ Not Stated

***52. Have you smoked marijuana in the past 30 days?**

- ☐ Yes ☐ No ☐ Not Stated

PREVALENCE-OF-USE: COCAINE

***53. Have you ever used cocaine?**

- ☐ Yes ☐ No ☐ Not Stated

54. At what age did you start using cocaine?***55. When was the first time you tried cocaine?**

- ☐ In the past 30 days
- ☐ More than 1 month ago but less than 1 year ago
- ☐ More than a year ago
- ☐ Not Stated

***56. Have you used cocaine in the past 12 months?**

- ☐ Yes ☐ No ☐ Not Stated

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***57. How often do you use cocaine?**

- ☐ Daily
- ☐ Sometimes during the week
- ☐ Sometimes during the month
- ☐ Sometimes in the past 12 months
- ☐ Only once
- ☐ Not Stated

***58. Have you used cocaine in the past 30 days?**

- ☐ Yes ☐ No ☐ Not Stated

PREVALENCE-OF-USE: CRACK

***59. Have you ever used crack?**

- ☐ Yes ☐ No ☐ Not Stated

60. At what age did you start using crack?

***61. When was the first time you tried crack?**

- ☐ In the past 30 days
- ☐ More than 1 month ago but less than 1 year ago
- ☐ More than a year ago
- ☐ Not Stated

***62. Have you used crack in the past 12 months?**

- ☐ Yes ☐ No ☐ Not Stated

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***63. How often do you use crack?**

- ☐ Daily
- ☐ Sometimes during the week
- ☐ Sometimes during the month
- ☐ Sometimes in the past 12 months
- ☐ Only once
- ☐ Not Stated

***64. Have you used crack in the past 30 days?**

- ☐ Yes ☐ No ☐ Not Stated

PREVALENCE-OF-USE: HEROIN

***65. Have you ever used heroin?**

- ☐ Yes ☐ No ☐ Not Stated

66. At what age did you start using heroin?

***67. When was the first time you tried heroin?**

- ☐ In the past 30 days
- ☐ More than 1 month ago but less than 1 year ago
- ☐ More than a year ago
- ☐ Not Stated

***68. Have you used heroin in the past 12 months?**

- ☐ Yes ☐ No ☐ Not Stated

2013 NATIONAL HOUSEHOLD SURVEY ON DRUG USE AND HEALTH

***69. How often do you use heroin?**

- ☐ Daily
- ☐ Sometimes during the week
- ☐ Sometimes during the month
- ☐ Sometimes in the past 12 months
- ☐ Only once
- ☐ Not Stated

***70. Have you used heroin in the past 30 days?**

- ☐ Yes ☐ No ☐ Not Stated

PREVALENCE-OF-USE: COCA PASTE

***71. Have you ever used coca paste?**

- ☐ Yes ☐ No ☐ Not Stated

72. At what age did you start using coca paste?

***73. When was the first time you tried coca paste?**

- ☐ In the past 30 days
- ☐ More than 1 month ago but less than 1 year ago
- ☐ More than a year ago
- ☐ Not Stated

***74. Have you used coca paste in the past 12 months?**

- ☐ Yes ☐ No ☐ Not Stated

2013 NATIONAL HOUSEHOLD SURVEY ON DRUG USE AND HEALTH

***75. How often do you use coca paste?**

- ☐ Daily
- ☐ Sometimes during the week
- ☐ Sometimes during the month
- ☐ Sometimes in the past 12 months
- ☐ Only once
- ☐ Not Stated

***76. Have you used coca paste in the past 30 days?**

- ☐ Yes ☐ No ☐ Not Stated

PREVALENCE-OF-USE: TRANQUILISERS WITHOUT MEDICAL PRESCRIPTION

***77. Have you ever used tranquilisers without a medical prescription?**

- ☐ Yes ☐ No ☐ Not Stated

78. At what age did you start using tranquilisers without a medical prescription?

***79. Have you used tranquilisers without a medical prescription in the past 12 months?**

- ☐ Yes ☐ No ☐ Not Stated

***80. Have you used tranquilisers without a medical prescription in the past 30 days?**

- ☐ Yes ☐ No ☐ Not Stated

PREVALENCE-OF-USE: STIMULANTS WITHOUT MEDICAL PRESCRIPTION

***81. Have you ever used stimulants without a medical prescription?**

- ☐ Yes ☐ No ☐ Not Stated

82. At what age did you start using stimulants without a medical prescription?

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***83. Have you used stimulants without a medical prescription in the past 12 months?**

☐ Yes

☐ No

☐ Not Stated

***84. Have you used stimulants without a medical prescription in the past 30 days?**

☐ Yes

☐ No

☐ Not Stated

PREVALENCE-OF-USE: OPIUM

***85. Have you ever used opium?**

☐ Yes

☐ No

☐ Not Stated

86. At what age did you start using opium?

***87. Have you used opium in the past 12 months?**

☐ Yes

☐ No

☐ Not Stated

***88. Have you used opium in the past 30 days?**

☐ Yes

☐ No

☐ Not Stated

PREVALENCE-OF-USE: MORPHINE WITHOUT MEDICAL PRESCRIPTION

***89. Have you ever used morphine without a medical prescription?**

☐ Yes

☐ No

☐ Not Stated

90. At what age did you start using morphine without a medical prescription?

***91. Have you used morphine without a medical prescription in the past 12 months?**

☐ Yes

☐ No

☐ Not Stated

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***92. Have you used morphine without a medical prescription in the past 30 days?**

☐ Yes

☐ No

☐ Not Stated

PREVALENCE-OF-USE: HALLUCINOGENS

***93. Have you ever used hallucinogens?**

☐ Yes

☐ No

☐ Not Stated

94. At what age did you start using hallucinogens?

***95. Have you used hallucinogens in the past 12 months?**

☐ Yes

☐ No

☐ Not Stated

***96. Have you used hallucinogens in the past 30 days?**

☐ Yes

☐ No

☐ Not Stated

PREVALENCE-OF-USE: HASH

***97. Have you ever used hash?**

☐ Yes

☐ No

☐ Not Stated

98. At what age did you start using hash?

***99. Have you used hash in the past 12 months?**

☐ Yes

☐ No

☐ Not Stated

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***100. Have you used hash in the past 30 days?**

☐ Yes

☐ No

☐ Not Stated

PREVALENCE-OF-USE: ECSTASY

***101. Have you ever used ecstasy?**

☐ Yes

☐ No

☐ Not Stated

102. At what age did you start using ecstasy?

***103. Have you used ecstasy in the past 12 months?**

☐ Yes

☐ No

☐ Not Stated

***104. Have you used ecstasy in the past 30 days?**

☐ Yes

☐ No

☐ Not Stated

DRUG MARKET

***105. When was the last time you were offered any of these drugs, either to buy or to use?**

	Never	During this week	During this month	More than a month ago	Less than a year ago	Don't Know	Not Stated
Marijuana	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cocaine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heroin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ecstasy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crack Cocaine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ALCOHOL & MARIJUANA POLICY

2013 NATIONAL HOUSEHOLD SURVEY ON DRUG USE AND HEALTH

***106. Are you aware that a person should be 18 years or older to be sold alcohol by a licenced establishment in Bermuda?**

- ☐ Yes
☐ No
☐ Not Stated

***107. Are you in favour of laws preventing persons from serving alcohol to minors in their homes or on their premises?**

- ☐ Yes
☐ No
☐ Don't Know/Don't Care
☐ Not Stated

***108. Are you in favour of lowering the blood alcohol legal limit from .08 to .01?**

- ☐ Yes
☐ No
☐ Don't Know/Don't Care
☐ Not Stated

***109. Are you in favour of roadside sobriety checkpoints?**

- ☐ Yes
☐ No
☐ Don't Know/Don't Care
☐ Not Stated

***110. In the last 30 days, have you noticed local alcohol advertisements with the health warning "Excessive alcohol consumption may be harmful to your health."?**

- ☐ All the time
☐ Very often
☐ Sometimes
☐ A few or couple of times
☐ One time
☐ Never/Not at all
☐ Not Stated

2013 NATIONAL HOUSEHOLD SURVEY ON DRUG USE AND HEALTH

***111. Are you in favour of decriminalising small amounts of marijuana for personal use by persons 18 years or older?**

- ☐ Yes
- ☐ No
- ☐ Don't Know/Don't Care
- ☐ Not Stated

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