2015

Annual Report of the

BERMUDA DRUG INFORMATION NETWORK

(BerDIN)

GOVERNMENT OF BERMUDA
Ministry of National Security

Department for National Drug Control

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BERDIN'S MISSION

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

FOREWORD

The secret is to work less as individuals and more as a team. – Knute Rockne

We are proud to present the 2015 annual analysis of the drug situation in Bermuda in the form of the Annual Report of the Bermuda Drug Information Network (BerDIN) 2015. This year's report contains a comprehensive overview of Bermuda's drug problem and the measure being taken to tackle it. Building on national-level data provides insights into key trends, responses, and policies, together with in-depth analyses of topical issues.

The integrated report of today, sits in contrast to the National Drug Information Network (previous name) annual report on the drug situation released in 2010. For the Department for National Drug Control (DNDC), five years ago, the challenge of establishing a surveillance system, harmonised among seven agencies, must have seemed daunting. It is, therefore, an impressive achievement that the fledgling monitoring mechanisms, established in 2008, have now matured into a national system, encompassing about 30 data providers, and is recognised both locally and internationally.

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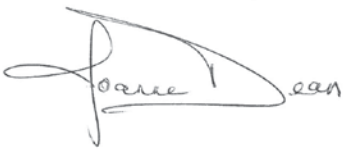
While we believe the DNDC has made a valuable contribution to the progress that has been achieved, we also acknowledge that our work is dependent on close collaboration with our partners. Fundamentally, it is the investment made by Member agencies in developing robust national drug information that makes the BerDIN analysis provided in this report possible. This report is based on data collected by the BerDIN, a network of national focal points, working closely with subject matter experts without whose work our report would be far less rich.

Not only has our report changed beyond recognition in the last five years; so too has the extent and nature of the drug problem. When the BerDIN was established, Bermuda was in the middle of a heroin epidemic, and the need to reduce drug-related and drug-induced crimes, as well as treat addicted men and women, were the main drivers of drug policy. Today, both heroin use and crack cocaine problems remain central to our reporting, but they sit in a context that is more optimistic in terms of developments and more informed in terms of what constitutes effective public health responses. The complexity of the problem, however, is now far greater.

Today, the Bermuda drug market remains as it has over the past decade, constant. This is illustrated by the fact that, in 2014, no psychoactive substances were detected, and no new drugs reported. To keep pace with changes, however, and to ensure that the analysis we provide is informed by new developments, the BerDIN continues to work closely with researchers and practitioners, both locally and internationally. As an agency, the DNDC has always recognised the importance of delivering sound and policy-relevant information in a timely fashion. We remain committed to this goal, and to ensuring that whatever the nature of the drug problem we face, Bermuda's responses will be supported by an information system that remains viable, relevant, and fit for purpose.



Joanne Dean
Director
Department for National Drug Control
October 2015

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DATA NOTES

ACAD	Associate Alcohol and Drug Counsellor
ADS	Alcohol Dependence Scale
APP	Associate Prevention Professional
ATOD	Alcohol, Tobacco, and Other Drugs
BAC	Blood Alcohol Concentration
BACB	Bermuda Addiction Certification Board
BARC	Bermuda Assessment and Referral Centre
BHB	Bermuda Hospitals Board
BPCS	Bermuda Professional Counselling Services
BPS	Bermuda Police Service
BSADA	Bermuda Sport Anti-Doping Authority
BYCS	Bermuda Youth Counselling Services
CARF	Commission on Accreditation of Rehabilitation Facilities
CARIDIN	Caribbean Drug Information Network
CAT	Community Action Team
CCS	Certified Clinical Supervisor
CICAD	Inter-American Drug Abuse Control Commission
CLSS	Counselling and Life Skills Services
CPS	Certified Prevention Specialist
Co-Ed	Coeducational
DAST	Drug Abuse Screening Test
Detox	Detoxification
dl	Decilitres
DNDC	Department for National Drug Control
DPP	Department of Public Prosecutions
DSM	Diagnostic and Statistical Manual of Mental Disorders
DTC	Drug Treatment Court
DUI	Driving Under the Influence
EAP	Employee Assistance Programme
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ER	Emergency Room
ERD	Earliest Release Date
FCU	Financial Crime Unit
FIA	Financial Intelligence Agency
FY	Financial/Fiscal Year
g	Grams
GBH	Grevious Bodily Harm
HM	Her Majesty
ICADC	International Certified Alcohol and Drug Counselor
IC&RC	International Certification and Reciprocity Consortium
ICD	International Statistical Classification of Diseases and Related Health Problems
IDU	Injecting/Intravenous Drug User
IOP	Intensive Outpatient Programme
KEMH	King Edward VII Memorial Hospital
kg	Kilograms
L	Litre
LA	Litre of Alcohol
LST	LifeSkills Training Programme
mg	milligrams
MT	Men's Treatment
MWI	Mid-Atlantic Wellness Institute
n	Number
NAMLC	National Anti-Money Laundering Committee
NPS	New Psychoactive Substances
OAS	Organisation of American States
OID	Inter-American Observatory on Drugs
PATHS	Promoting Alternative THinking Strategies
POCA	Proceeds of Crime Act
Q	Quarter
r	Revised
RLH	Right Living House
SAR	Suspicious Activity Report
TAAD	Triage Assessment for Addictive Disorders
TC	Therapeutic Community
THC	Tetrahydrocannabinol
TIPS	Training for Intervention Procedures by Servers of Alcohol
u	Units
UNDCP	United Nations Drug Control Programme
UNODC	United Nations Office on Drugs and Crime
WTC	Women's Treatment Centre

%	Percentage
000	Thousands
–	Zero or unit less than 0.1
$	Bermuda Dollar
..	Not Applicable
…	Not Available

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

INTRODUCTION

In the year since the 2014 Annual Report of the Bermuda Drug Information Network (BerDIN) there has been little change in the drug market in Bermuda. The year 2014 marked the first calendar year of the implementation of the National Drug Control Master Plan and Action Plan 2013-2017. Later in 2015, the data gathered to produce the Annual Report of the BerDIN, will provide information to evaluate and monitor national-level indicators, which assess demand and supply reduction initiatives and will, therefore, provide a mid-way assessment of the implementation of the objectives of the Plan. Polices, however, cannot be pursed in isolation, and drug control is no exception.

The purpose of the current report is to provide an overview and summary of the Bermuda drug situation and responses to it. The statistical data reported here relate to 2014 (or the most recent year available). Analysis of trends is based only on those agencies providing sufficient data to describe changes over the period specified. The reader should also be aware that monitoring patterns and trends in a hidden and stigmatised behaviour like drug use is both practically and methodologically challenging. For this reason, multiple sources of data are used for the purposes of analysis in this report. Although considerable improvements can be noted, both nationally and in respect to what is possible to achieve in a local-level analysis, the methodological difficulties in this area must be acknowledged. Caution is therefore required in interpretation, in particular when indicators are compared on any single measure. Caveats and qualifications relating to the data are found in each chapter of this report. Also included in each chapter is detailed information on methodology, qualifications on analysis, and comments on the limitations in the available information. As no data system is perfect, some of the information contained within this report is derived from self-reported data provided in surveys, while other information is based on record review, psychometric testing, and biological screening results. No one piece of information stands alone. As such, in its totality, the data presented in this report seeks to inform the reader on the current drug situation in Bermuda.

…focus remained on prevention of underage drinking and the continued residential and outpatient treatment services for persons with addiction issues.

In the past year's demand reduction activities, highlighted in the following pages, focus remained on prevention of underage drinking and the continued residential and outpatient treatment services for persons with addiction issues. Alcohol is still the substance of choice for both youths and adults with marijuana being the most commonly used illegal drug. Information presented here demonstrated a persistence of alcohol and illegal drug misuse. The impact of substance misuse, while not immediately evident, will be harder to ignore in the future as the health and social consequences of drug misuse are often widespread, and long lasting. During 2014, drug-related crimes have continued, demand for drugs remain unchanged; all while significant challenges persist in adequately addressing the needs of drug users and their families. With the enforcement of current legislation still remaining unaddressed, and demand for treatment remaining high, there is a significant gap in the drug control system. Waiting lists for residential treatment services continue to lengthen during this reporting period due to facilities being occupied or unable to accommodate a full complement of clients because of staffing shortages.

This annual report continues as a set of interlinked elements that allows for access to available data and analysis of the drug situation in Bermuda. The BerDIN remains the primary source of statistical information on the use of illegal drugs, alcohol, tobacco, and drug-related services provided to the civilian population in Bermuda. It provides analysis of the most recent two-year period (2014 data with comparisons to 2013) based on the available data provided by reporting agencies to describe changes over this specified period; contained within the 11 chapters of this report. There are, of course, some limitations with this reporting system; some of which have already been discussed, while others may require further dialogue to address how particular agencies collect and report information.

The Government of Bermuda remains committed to *"Healthy, drug-free communities"*. As 2016 approaches, the DNDC will continue to collect, analyse, and provide high quality, official national information that is user-friendly and updates the drug situation in Bermuda.

The Drug Situation in Bermuda

Unchanging Drug Situation

The central finding in the 2015 Annual Report is that the drug problem in Bermuda has remained consistent with the 2014 report in that the overall situation is generally stable. In this latest analysis of the drug problem in Bermuda, evidence points to a situation where long-term patterns and trends continue, with no new developments in patterns of use. There are, however, many risk factors and circumstances that render people more vulnerable to illegal drugs, such as poverty and unemployment, a reality experienced by many residents. Internationally, the boundary between the market categories of 'old' and new drugs is becoming harder to define, and just as new drugs increasingly mimic established substance types, so too are the responses to new drugs, which may mirror evidence-based responses to problems with established drugs. Bermuda, however, has seen little evidence of the use of synthetic drugs.

…many risk factors and circumstances that render people more vulnerable to illegal drugs, such as poverty and unemployment, a reality experienced by many residents.

Substance Dependence/Abuse and Treatment

The need for integrated responses encompasses adequate and accessible treatment services, especially health-based approaches to prevention and treatment. Clearly, more work needs to be done to promote the importance of understanding and addressing drug dependence as a public health condition requiring long-term, sustained treatment and care.

Bermuda Assessment Referral Centre (BARC) assessments continue to show that cocaine and heroin, often accompany THC and alcohol, and are the primary substances of choice amongst persons seeking treatment services in 2014. Further, many of these persons have met the clinical criteria for dependence or abuse (problems related to their use) of such substances. However, on average, the rates of alcohol or drug dependence/abuse have declined over the years. Reports indicate that more people meet the criteria for abuse of alcohol, cannabis and cocaine, while an increasing number of heroin abusers have been classified as dependent.

The Cannabis Issue

Cannabis continues to present formidable challenges for Bermuda and the international community. Legalisation reached its highest level during 2014 with a number of countries passing legislation, for various reasons, to legalise this popular drug. During 2014, a number of advocates rallied for legalisation of marijuana in Bermuda. Additionally, the 2014 legislative agenda gave way to the legalisation of cannabinoid prescription drugs.

Ever-Present Drug Market

The vulnerability of Bermuda to drugs and crime remains a grave concern, with increasing seizures of crack cocaine and cannabis; indicating the continued demand for these illegal drugs. The drug market is still very much active in Bermuda as persons who sought drug treatment, or have been offenders of the law, have reported that their primary drug of choice remains available and accessible. Another indication of environmental change has been seen with access to alcohol in that there was more alcohol in circulation than in 2013.

Alcohol and marijuana remain the substances most used by residents. Marijuana prevalence appears to be heading down the same trajectory as alcohol in that its use has increased and stabilised. On the other hand, persons involved in the criminal justice system continue to report prevalence-of-use of some combination of crack cocaine, opiates, and marijuana. Drug enforcement activities has yielded more prosecutions for local and importation drug offences leading to an increase in trials for cannabis possession and cannabis possession with intent to supply offences and more forfeitures.

No Signs of Stimulants and New Psychoactive Substances

There has not been any formal indication of the use of new psychoactive substances (NPS) in Bermuda, However, while there is no evidence of the presence and or use of these substances, we must not be complacent. Previously, an alert system has been mentioned and, in the near future, a warning system will be developed to inform public health officials if there is suspected use of these substances. The community, therefore, must continue to be vigilant. NPS present an ever-increasing public health threat as much is unknown about the chemical compounds used to create these drugs.

Drug-Induced Deaths

An unacceptable number of drug users worldwide continue to lose their lives prematurely. Bermuda has been fortunate to have no instances in 2014 where drug use was the underlying cause of death. There were, however, a couple of deaths in 2014 that were alcohol-related. A number of deaths were classified as tobacco-related, in that the deaths occurred as a result of coming into contact with a tobacco product. There were 206 instances in 2014 where this occurred with malignant neoplasm of trachea, bronchus, and lung, major cardiovascular diseases, and chronic lower respiratory diseases being recorded as the causes of death. There were also a few (nine) road traffic fatalities in 2014 for which alcohol and or drugs were present.

In the absence of complete data on causes of deaths, toxicology data, together with data from the Department of Health, showed that there were no reported cases of deaths caused by drug overdoses.

Cost of Treating Drug Problems

Concerning demand reduction activities, substance use treatment remains the largest component of drug control expenditure. The DNDC's treatment programmes, along with grant agencies, saw level funding in 2014. Other treatment agencies saw slight increases in funding with the exception of the Right Living House, and Turning Point whose budget remained unchanged over the last two fiscal years. Decreased funding over the years, therefore, resulted in lessened client services and, by extension, a number of persons seeking care were unable to get into treatment, while others waited for longer periods than usual.

Substance use prevention expenditure for the Prevention Unit of the DNDC saw a decrease in funding while prevention grant-recipient agencies saw level funding in 2014. As a result, for the second fiscal year in a row, programmes with government oversight and many agencies that receive grants were faced with the provision of limited services to its clients and the public at large because of an inability to maintain staffing levels.

Existence of a "Treatment Gap"

Worldwide only one out of six problem drug users has access to treatment. In Bermuda, women seem to face more barriers to treatment, despite the availability of (residential) treatment. The treatment gap continues for persons seeking substance abuse assessment in that while a person may go through assessment he/she may not follow through with the recommended level of care, leaving a "treatment gap" between the persons needing and receiving treatment.

Demand and Supply Reduction Activities and Initiatives During 2014

During 2014, there were many demand and supply reduction activities and initiatives implemented by the DNDC, other government departments, and community partners. In many cases, these initiatives are supported by the data compiled in this report. Other activities, especially those of supply reduction, may be captured elsewhere as a part of the respective agencies' annual report.

1. Continued preparations for CARF accreditation by establishing and implementing new policies and procedures in the Men's Treatment (MT) programme. Process is being completed with help from a US-based consultant.
2. The Women's Treatment Centre (WTC) and Turning Point Substance Abuse Programme received the Gold Standard award for CARF re-accreditation.
3. As of 2014, the Bermuda Addiction Certification Board (BACB) had a total of 32 certified addiction counselors and eight clinical supervisors. During 2014, there were five new addiction counselors certified, and one prevention specialist.
4. Recovery Month was a success with television interviews, newspaper supplement, walks, radio interviews, and annual recovery cruise.
5. All treatment providers continue to work in collaboration with Court Services, Drug Treatment Court, Corrections, and Parole Board to provide services to clients within the criminal justice system.
6. DNDC continues to provide technical support and training of the AccuCare system, which is the internet-based client tracking system and documentation programme. Bermuda Assessment and Referral Centre – 100% use; Men's Treatment – 100% use; Women's Treatment Centre - 30% utilisation, and FOCUS Counseling - 95% utilisation.
7. Men's Treatment census – admission are up with waiting list.
8. Men's Treatment admitted its first two Mental Health Court clients.
9. The Teen Peace (Bermuda) Afterschool Programme operated every Wednesday and Thursday from 3:45 p.m. to 5:45 p.m. on location at the Sandys, TN Tatem, Dellwood, Whitney, and Clearwater Middle Schools.
10. Al's Pals: Kids Making Healthy Choices programme was implemented at the primary levels one and two.
11. First draft of the National Policy for Drug-Free Schools created.
12. Public Education:
    a. Underage Drinking Campaign
    b. Observed:
        i. Alcohol Awareness Month – April 2014
        ii. National Prevention Week – May 2014 (first time observing)
        iii. International Day against Drug Abuse and Illicit Trafficking – June 2014
        iv. Recovery Month – September 2014
13. Prevention Trainings held:
    a. Social Emotional Learning
    b. Nabiximols, Nabilone, and Dronabinol: Use of Cannabinoids in Modern Medicine
    c. Botvin's LifeSkills Online Training
14. Prevention presentations:
    a. Parents Academy

b. Marijuana: Its Impact on Youth
c. Curious Minds

15. Conducted primary research on pregnant women and homeless population.
16. Implemented Prison Survey between April 1, 2014 and March 31, 2015.
17. Institutionalised Training for Intervention Procedures (TIPS) for all servers and waiters of alcohol in licensed establishments continue to be tracked and monitored.
18. Continuous quality monitoring and reporting for all grants and contributions.
19. Completion of the report and dissemination of the Household Survey on Alcohol, Drugs and Health.
20. Increased quality improvement mechanisms with the implementation of Consumer Feedback Survey and Stakeholder Surveys at Men's Treatment, Women's Treatment Centre, and the Right Living House
21. Worked to determine the feasibility of implementing an economic impact of illicit drug use study.
22. Continued development of the National Drug Information Network, BerDIN, to identify prevention indicators and a data management system.
23. Drafted, arranged publication and printing for the National Drug Control Master Plan 2013-2017.
24. The Salvation Army Harbour Light programme continued to provide primary residential treatment serving 12 residential clients during the 2014/2015 fiscal year. Salvation Army continued to provide the Community Life Skills programme and provided training for addicts in recovery. The programme served 131 persons during the 2014/2015 fiscal year.
25. Transitional Housing for men was provided by Focus Counseling Services in community-based housing units in various parishes across the Island. During the last fiscal year, client occupancy was at most 19 persons. The Focus Club House provides a safe environment with engagement and motivational activities for those contemplating entering treatment. During the FY 2014/2015, over 60 hours per week were provided for one-on-one counselling.
26. The Turning Point Substance Abuse Programme continued to offer inpatient detox services, methadone maintenance, intensive day treatment, and family and individual outpatient counselling.
27. The DNDC and HM Customs continued their very successful cross-ministry initiative that sought to integrate the agency's efforts at providing a balanced approach to national drug control.
28. The Bermuda Police Service (BPS) has worked with its international law enforcement partners from the Caribbean region, Canada, USA, England, and Europe in interdicting drugs from reaching Bermuda's shores. Some of the interdictions led to international controlled deliveries, which resulted in several arrests.
29. The BPS has worked with its external partners like HM Customs, the General Post Office, and the local couriers' facilities in interdicting drug packages.
30. Local drug enforcement activities were executed by various units within the BPS. These enforcements were done at the street-level and house searches via search warrants under the various Bermuda legislations.
31. DNDC and the BPS continued to work together by having the Community Action Team (CAT) involved in drug prevention initiatives.
32. Institutionalised Training for Intervention Procedures (TIPS) for all servers and waiters of alcohol in licensed establishments continued to be implemented, tracked, and monitored by CADA.
33. Drafted and disseminated national drug-related survey reports and policy papers:
    a. 2015 Survey of Substance Use Among the Homeless Population in Bermuda
    b. 2014-2015 Prison Survey
    c. 2015 Survey of Pregnant Women
34. Continued development of the Bermuda Drug Information Network, BerDIN.

Coordination Mechanism

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

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

Stability of the BerDIN relies strongly on the participation and cooperation of respective agencies. This 2015 Annual Report marks the third year in which over 20 sources of drug-related information were provided to inform the drug

situation in Bermuda (see Appendix I). The information continues to be presented in table format and represents the most up-to-date data on the Island in this field. Reporting agencies submitted data by May 15th of current year to allow sufficient time for data cleaning, verification, and follow-up in preparation for pre-press layout and design.

New Data Sources and Report Items

Since the 2014 Annual Report, four new substance use-related data source has been added, that of the PATHS drug prevention education programme statistics, clinical classification of drug use (abuse or dependence) by BARC's clients, drug screening results of persons at the Co-Ed facility, and total clients in treatment. One new survey was also added during this period studying drug prevalence and behaviours among the homeless population. Additionally, one periodic surveys on drug prevalence among pregnant women was updated with another round administered in 2015.

BERMUDA DRUG INFORMATION NETWORK (BerDIN)

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

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

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

Definition of the BerDIN

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

Mission of the BerDIN

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

Importance of the BerDIN

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

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

Purpose of the BerDIN

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

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

reduction or drug supply restriction policies and challenges; and

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

Core Functions of the BerDIN

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

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

Contribution to Programme Development

The information collected provides a background for:

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

Network Members

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

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

Common Sources of Data

Data was obtained from a variety of quantitative and qualitative sources:

Quantitative

- Government records/Secondary sources
- Primary surveys/Studies
- Psychometric tests
- Biological screens
- Indirect estimation or derivation

Qualitative

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

(See Summary of Sources and Data in Appendix I)

Data Gaps

The Network will continue to develop with additional drug-related information and statistics on drug availability

and environment, use, prevention, treatment and support activities, criminal justice, and drug-related harms. These will include, but not limited to: data on drug-related accidents; programme statistics of private treatment service providers, for example, Employee Assistance Programme (EAP), Pathways (formerly Caron) Bermuda; problem drug use; availability of illicit drugs and drug markets; the economic cost of the drug problem; and outcomes related to prevention and treatment programmes.

DNDC's Role

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

Organisational Challenges

The quality of information contained in this report is determined largely by the stability and infrastructure of the agencies providing the information. Organisations which dedicate time, resources, and human capital for the long-term utilisation and maintenance of that information often provide accurate and reliable data.

During 2014, there were a number of challenges with the provision of requested information by the established submission date. Issues ranged from: 1) some agencies changed how they collected data from the previous year rendering data no longer available; 2) programmes did not run for two years, therefore, no data was available; 3) not having personnel to research and provide recent information; and 4) changes in management and contact staff resulting in a need for relationship building to obtain buy-in.

Despite these issues, the Annual BerDIN Report includes an overall total of about 45 drug control areas being monitored with over 150 indicators (36 currently being report in this publication). The DNDC continues to work with organisations to build capacity to organise, maintain, and effectively utilise data gathered to inform polices and programme direction.

Joining the BerDIN

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

Meeting 2014

The 2014 Annual Meeting of the BerDIN was held on November 13th and 14th in the Bermuda Room of the Elbow Beach Hotel. Mr. Anthony Santucci, a BerDIN Member who represented CADA, extended welcome to the meeting participants and introduced the Junior Minister of National Security. Senator Jeffrey Baron, JP, Junior Minister of National Security, brought Opening Remarks to the meeting in the absence of the Premier and Minister of National Security. He stated that the BerDIN is well-positioned and has proven its worth in ensuring the effective monitoring of the drug situation in Bermuda, based on the best available data. He also acknowledged the importance of ensuring that sufficient resources are made available for maintaining and strengthening work in this area, and highlight the added value that the BerDIN and, by extension, the Department for National Drug Control, provides to the Bermuda community as a whole. The Senator further remarked that the Government is proud of the comprehensive breakdown of developments provided by the Annual Report of the BerDIN and that its work and that of the Network Members continues to provide a bedrock of evidence for informing policies and responses. He encouraged the meeting to continue to strive for the provision of a timely, objective, and balanced analysis of today's complex and changing drug problem. He commended the work of the BerDIN and the DNDC. Following the Opening Remarks, the meeting was officially declared open by Senator Baron.

The first day of the meeting saw the keynote address brought by the Commissioner of the Bermuda Police Service (BPS), Mr. Michael DeSilva. This was the first year the meeting has a keynote speaker. The Commissioner was introduced by BerDIN Member, Dr. Zina Woolridge, who represents the Drug Treatment Court. The Commissioner provided the BerDIN members and other invited stakeholders a unique insight of the drug interdiction and enforcement efforts of the BPS over the past years. Specifically, he informed the meeting about the difficulty of drug interdiction such as numerous smuggling routes, along with geographic and economic challenges. In addition, the Commissioner highlighted the trends seen in enforcement activity, seizures, stop and search, and other activities undertaken by the BPS and offered a qualitative understanding of the data presented. His presentation ended with an explanation of the life cycle of crime and the BPS' strategy and operations

as they relate to drugs and crimes. It was stressed that in the life cycle of crime, the BPS is mainly involved in the 'catch and convict' component but there is opportunity for education and prevention at the beginning that can change experiences and then there is the phase of rehabilitation and resettlement that occurs after a conviction.

An update on the BerDIN was presented followed by an update from the following: 1) PRIDE Bermuda and CADA, 2) Bermuda Police Service, 3) Central Government Laboratory, and 4) E-Government. There were a number of conclusions and recommendations made toward the end of the meeting such as identifying ways to address gaps in information, stability and continuity of representatives from member agencies, and the provision of a data management system. Day 1 concluded with any other business, closing remarks, and an evaluation of the meeting.

On Day 2, a one-day session on Franklin Covey's "The 5 Choices to Extraordinary Productivity – Essentials" was offered to all BerDIN members and representatives. It was facilitated by Ms. Martha Kirkland, Director of FranklinCovey Bermuda. This professional development session continued to be welcomed by participants as an addition to the BerDIN Annual Meeting format.

Prior to the work session participants were asked to complete a benchmark assessment on their productivity. A one-hour follow-up post assessment session was scheduled with all participants for either January 13th or 14th, 2015.

Each participant was provided with a kit which included the guidebook, technical guide, and three bonus DVD modules on wildly important goals, office nirvana, and brain-care basics.

In achieving the learning objectives, participants were exposed to the five choices and learned how to: discern between important and urgent; identify and set goals for most important roles; implement weekly and daily planning processes to identify, schedule, and execute on priorities; design a system to manage tasks and appointments aligned with their technology; and understand the impact of brain health and energy on day-to-day performance.

Members and representatives were provided with a certificate of participation upon completion of the session. An evaluation of the session concluded the day. More information on the BerDIN can be found on DNDC's website at www.dndc.gov.bm.

Photo courtesy of DCI

Chapter 1
Criminal and Suspicious Activity

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

1.1 CRIME AND DRUG ENFORCEMENT ACTIVITY

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

Between 2013 and 2014, Bermuda saw a slight decline (2.5%) in overall crimes; with crime against the person decreasing by 13.0%, against the community dropping by 4.5%, and against property increasing marginally by 0.7% (see Table 1.1.1). In both years, there were mostly crimes against property with characterised predominantly by motor vehicle theft (see Table 1.1.2). With regard to offences against the person, 'other assaults' have significantly decreased over the past year. Concerning crimes against the community, the classification 'antisocial behaviour' saw a significant decline in the number of offences with 11 fewer cases. For property offences, a sizeable decrease was observed for non-residential burglary and criminal damage. At the same time, an increase in motor vehicle theft and theft of property was observed. In contrast, although a number of major offences were on the decline, others such as offences for serious assaults, other weapons offences, and indecency saw a slight increase in numbers. Similarly, drug importation and local drug offences have increased by 24.4% over the past year under review; with 68 additional drug enforcement activity undertaken by the BPS, mainly for local drug offences (see Tables 1.1.5). While it was evident that drug enforcement activities have increased in 2014 when compared to 2013, the data does not provide information as to why these differences were observed (increased activities possibly due to improved funding for drug-related enforcement, adequate intelligence, or simply because of greater supply on the market).

… drug importation and local drug offences have increased by 24.4% over the past year under review.

Table 1.1.1
Number and Proportion of Crimes by Type of Crime and Annual Absolute and Percentage Change, 2013 and 2014

CRIMES	2013		2014		Annual Change	
	n	%	n	%	n	%
Against the Person	615	17.7	535	15.8	-80	-13.0
Against the Community	531	15.3	507	14.9	-24	-4.5
Against Property	2,334	67.1	2,351	69.3	17	0.7
Total – All Crimes	**3,480**	**100.0**	**3,393**	**100.0**	**-87**	**-2.5**

Source: Bermuda Police Service

Table 1.1.2
Number of Crimes against Person, Community, and Property by Type of Crime and Annual Absolute Change, 2013 and 2014

CRIMES	2013	2014	Annual Absolute Change
AGAINST THE PERSON	**615**	**535**	**-80**
Murder	5	4	-1
Manslaughter	-	-	-
Serious Assaults	56	61	5
Other Assaults	465	377	-88
Sexual Assault	31	30	-1
Robbery	33	33	-
Offences Against Children	10	10	-
Indecency	15	20	5
AGAINST THE COMMUNITY	**531**	**507**	**-24**
Firearm Offences	21	17	-4
Other Weapon Offences	24	36	12
Disorder Offences	75	67	-8
Antisocial Behaviour	397	386	-11
Animal Offences	14	1	-13

Table 1.1.2 cont'd
Number of Crimes against Person, Community, and Property by Type of Crime and Annual Absolute Change, 2013 and 2014

CRIMES	2013	2014	Annual Absolute Change
AGAINST PROPERTY	**2,334**	**2,351**	**17**
Burglary (Residential)	479	442	-37
Burglary (Non-Residential)	144	78	-66
Burglary (Tourist Accommodation)	11	4	-7
Criminal Damage	275	224	-51
Motor Vehicle Theft	648	830	182
Theft of Property	627	636	9
Fraud and Deception	150	137	-13

Source: Bermuda Police Service

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

Table 1.1.3
Number of Crimes against Person, Property, and Community as a Proportion of Each Crime Category, 2013 and 2014

CRIMES	2013	2014
AGAINST THE PERSON	**100.0**	**100.0**
Murder	0.8	0.7
Manslaughter	-	-
Serious Assaults	9.1	11.4
Other Assaults	75.6	70.5
Sexual Assault	5.1	5.6
Robbery	5.4	6.2
Offences Against Children	1.6	1.9
Indecency	2.4	3.7
AGAINST THE COMMUNITY	**100.0**	**100.0**
Firearm Offences	4.0	3.4
Other Weapon Offences	4.5	7.1
Disorder Offences	14.1	13.2
Antisocial Behaviour	74.8	76.1
Animal Offences	2.6	0.2
AGAINST PROPERTY	**100.0**	**100.0**
Burglary (Residential)	20.5	18.8
Burglary (Non-Residential)	6.2	3.3
Burglary (Tourist Accommodation)	0.5	0.2
Criminal Damage	11.8	9.5
Motor Vehicle Theft	27.8	35.3
Theft of Property	26.9	27.1
Fraud and Deception	6.4	5.8

Source: Bermuda Police Service

Table 1.1.4
Number of Crimes against Person, Property, and Community as a Proportion of Total Crimes, 2013 and 2014

CRIMES	2013	2014
AGAINST THE PERSON	**17.7**	**15.8**
Murder	0.1	0.1
Manslaughter	-	-
Serious Assaults	1.6	1.8
Other Assaults	13.4	11.1
Sexual Assault	0.9	0.9
Robbery	09	1.0
Offences Against Children	0.3	0.3
Indecency	0.4	0.6
AGAINST THE COMMUNITY	**15.3**	**14.9**
Firearm Offences	0.6	0.5
Other Weapon Offences	0.7	1.1
Disorder Offences	2.2	2.0
Antisocial Behaviour	11.4	11.4
Animal Offences	0.4	-
AGAINST PROPERTY	**67.1**	**69.3**
Burglary (Residential)	13.8	13.0
Burglary (Non-Residential)	4.1	2.3
Burglary (Tourist Accommodation)	0.3	0.1
Criminal Damage	7.9	6.6
Motor Vehicle Theft	18.6	24.5
Theft of Property	18.0	18.7
Fraud and Deception	4.3	4.0

Source: Bermuda Police Service

Table 1.1.5
Number and Proportion of Drug Enforcement Activity by Type of Activity and Annual Absolute and Percentage Change, 2013 and 2014

DRUG ENFORCEMENT ACTIVITY	2013		2014		Annual Change	
	n	%	n	%	n	%
Drug Offences (Importation)	39	14.0	52	15.0	13	33.3
Drug Offences (Local)	240	86.0	295	85.0	55	22.9
Total – Drug Enforcement Activity	**279**	**100.0**	**347**	**100.00**	**68**	**24.4**

Source: Bermuda Police Service

1.2 DRUG SEIZURES AND ARRESTS

In both 2013 and 2014, the highest proportion of seizure activity was at the street level followed by seizures occurring at the ports. The total number of seizures remained constant over the two years at 314 (see Table 1.2.1). On a whole, both arrests for importation and local drug offences rose sharply by 36.3% over the period under review, that is, from 201 in 2013 to 274 in 2014. The greater proportion of arrests, of about eight in 10, was observed for local drug offences. The year 2014 recorded a significant increase in the quantity of cannabis seized, from 22.6 kg in 2013 to 78.3 kg, with a corresponding increase in the value of this quantity seized. Of all the drugs seized, cannabis, resin, and cocaine accounted for the largest amount in terms of weight in both years under consideration; but in terms of value, cannabis and heroin were valued more in 2014 versus cannabis, resin, and cocaine in the previous year (see Table 1.2.2). A striking observation is that of the higher value of heroin in 2014 for a smaller quantity when compared to a larger quantity

carrying a lower value 2013. This was due to the BPS using a higher per unit price for heroin in 2014 than in previous years. In both 2013 and 2014, although most seizure activity was at the street level, those seizures occurring at the ports amassed more drugs; and, in both years, activity at the port yielded much of the cannabis seized (see Tables 1.2.3 and 1.2.4).

Table 1.2.1
Drug Seizures by Location and Arrests for Drug Offences, 2013 and 2014

SEIZURES	2013	2014
Location		
Street	217	237
Port	86	76
Overseas	11	1
Total Seizures	**314**	**314**
Annual Percentage Change	**-40.9**	**0.0**
ARRESTS		
Drug Offences (Importation)	37	49
Drug Offences (Local)	164	227
Total Arrests – Drug Offences	**201**	**274**
Annual Percentage Change	**-46.4**	**36.3**

Source: Bermuda Police Service

Table 1.2.2
Drug Seizures by Type of Drug, Total Weight, and Total Street Value, 2013 and 2014

DRUG	2013		2014	
	Total Weight (g)	Total Value ($)	Total Weight (g)	Total Value ($)
Cocaine	2,332	547,924	645	154,855
Crack Cocaine	60	18,703	485	151,491
Heroin	1,038	277,194	281	827,895
Cannabis	22,620	1,131,003	78,265	3,913,274
Cannabis Resin	9,161	916,119	761	76,106
Cannabis (Plants)	…	…	792	..
Ecstasy	…	…	-	-
Total*	**35,211**	**2,890,943**	**80,438**	**5,123,618**

Source: Bermuda Police Service

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

Table 1.2.3
Drug Seizures by Type of Drug, Location, Weight, and Street Value, 2013

DRUG	Street		Port		Overseas	
	Weight (g)	Value ($)	Weight (g)	Value ($)	Weight (g)	Value ($)
Cocaine	37	8,714	1,853	435,410	442	103,800
Crack Cocaine	60	18,703	-	-	-	-
Heroin	1	171	988	263,753	50	13,270
Cannabis	2,894	144,706	15,138	756,877	4,588	229,420
Cannabis Resin	12	1,206	3,240	323,963	5,910	590,950
Cannabis (Plants)	255	-	-	-	-	-
Ecstasy	1	44	-	-	-	-
Total*	**3,004**	**173,500**	**21,218**	**1,780,004**	**10,989**	**937,439**

Source: Bermuda Police Service

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

Table 1.2.4
Drug Seizures by Type of Drug, Location, Weight, and Street Value, 2014

DRUG	Street		Port		Overseas	
	Weight (g)	Value ($)	Weight (g)	Value ($)	Weight (g)	Value ($)
Cocaine	641	153,725	5	1,130	-	-
Crack Cocaine	176	54,916	309	96,575	-	-
Heroin	31	92,145	250	735,750	-	-
Cannabis	11,987	599,343	65,729	3,286,432	550	27,500
Cannabis Resin	4	407	757	75,696	-	-
Cannabis (Plants)	792	..	-	..	-	-
Ecstasy	-	-	-	-	-	-
Total*	**12,838**	**900,535**	**67,049**	**4,195,583**	**550**	**27,500**

Source: Bermuda Police Service

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

1.3 PROSECUTIONS

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

Criminal trials were for possessing drugs, possessing drugs with intent to supply, handling drugs with intent to supply, supplying drugs, importing or trafficking, conspiring to import other drugs, possessing drug equipment, cultivating cannabis, and several trials for alcohol-related offences (see Table 1.3.1 and Table 1.3.2). Criminal trials for drug-related offences increased from 158 cases in 2013 to 176 in 2014 (Table 1.3.1). Although a slight decrease was observed between 2013 and 2014, in both years, the majority of drug-related trails were for possession of cannabis. In contrast, the number of criminal trials for alcohol-related offences saw a marked decline, dropping from 440 cases in 2013 to 319 in 2014 (see Table 1.3.2). In both 2013 and 2014, of all alcohol-related offences, a significant number of these trials were the result of impaired driving of a motor vehicle, excessive alcohol in operating a motor vehicle, and refusing the breathalyser test.

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

In terms of acquittals and convictions, there were fewer acquittals in 2014 than in 2013 for both criminal drug- and alcohol-related offences; on the other hand, there were more convictions in 2014 for criminal drug-related offences and fewer for criminal alcohol-related offences when compared with 2013 (see Tables 1.3.3, 1.3.4, 1.3.5, and 1.3.6). For drug-related offences, most of

the acquittals were for possession of cannabis (see Table 1.3.3), while for alcohol-related offences, the majority of acquittals were for impaired driving of a motor vehicle (see Table 1.3.4). An increase in criminal convictions for drug-related offences was observed in 2014; although, in both years under review, these convictions were mainly for the possession of cannabis, followed by possession of cannabis with intent to supply and possession of drug equipment. In 2014, however, there were fewer criminal convictions for the possession of cannabis when compared to the previous year. In contrast, criminal convictions for alcohol-related offences on the whole decreased considerably in 2014, dropping from 234 cases in 2013 to 154 cases in 2014. Convictions for impaired driving of a motor vehicle represented the largest proportion of these convictions; though decreasing from 151 cases in 2013 to 87 cases in 2014.

Lastly, there were some drug- and alcohol-related cases in which the result of the case was classified as 'unknown', meaning that the result of the case (conviction or acquittal) was not recorded. The number of drug-related unknown cases almost doubled from the 13 cases recorded in 2013 reaching 25 cases in 2014 (see Table 1.3.7). However, when it came to alcohol-related cases, overall, there were fewer cases classified as results 'unknown' in 2014 compared to 2013, 164 and 133 cases, respectively.

Table 1.3.1
Criminal Trials for Drug-Related Offences by Sex of Offender, 2013 and 2014

JEMS Code	Description	2013				2014			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of cannabis	63[r]	3	2[r]	68[r]	49	3	2	54
2304	Possession of cocaine	9[r]	1[r]	-	10[r]	8	-	2	10
2308	Possession of diamorphine	4	-	-	4	4	-	-	4
2312	Possession of other drugs	1	-	-	1	1	-	-	1
2313	Possession of other drugs with intent to supply	-	-	-	-	-	-	-	-
2316	Possession of cannabis with intent to supply	14[r]	3	-	17[r]	22	4	-	26
2320	Possession of cocaine with intent to supply	11[r]	-	2	13[r]	7	2	-	9
2324	Possession of diamorphine with intent to supply	1	-	-	1	5	-	-	5
2332	Handle cannabis with intent to supply	-	-	-	-	2	-	-	2
2336	Handle cocaine with intent to supply	-	-	-	-	-	-	-	-
2340	Handle diamorphine with intent to supply	-	-	-	-	-	-	-	-
2344	Handle other drugs with intent to supply	-	-	-	-	-	-	-	-
2348	Supply cannabis	-	-	-	-	-	-	-	-
2352	Supply cocaine	-	-	-	-	-	-	-	-
2356	Supply diamorphine	-	-	-	-	-	-	-	-
2357	Supply other drugs	-	-	-	-	-	-	-	-
2364	Import cannabis	2	2[r]	-	4[r]	8	5	-	13
2368	Import cocaine	-	1	-	1	1	2	-	3
2372	Import diamorphine	-	-	-	-	1	-	-	1
2373	Import other drugs	-	-	-	-	-	-	-	-
2380	Conspiracy to Import Other Drugs	1[r]	1	2	4[r]	3	3	-	6
2381	Conspiracy to Supply a Controlled Drug	-	1	-	1	-	-	-	-
2383	Export Drug Attempt	-	-	-	-	-	-	-	-
2384	Misuse Controlled Drug	-	-	-	-	-	-	-	-
2388	Possession of Drug Equipment	19[r]	-	-	19[r]	20	-	-	20
2392	Possession of Drug Equipment Prepare	7[r]	-	-	7[r]	15	-	-	15
2396	Cultivate Cannabis	5	-	-	5	3	-	-	3
2400	Permit on Premises Drug Use	-	-	-	-	-	-	-	-
2404	Obstruction	3	-	-	3	4	-	-	4
TOTAL TRIALS: DRUG-RELATED OFFENCES		140[r]	12[r]	6[r]	158[r]	153	19	4	176

Source: Supreme Court

Table 1.3.2
Criminal Trials for Alcohol-Related Offences by Sex of Offender, 2013 and 2014

JEMS Code	Description	2013				2014			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	182[r]	21[r]	4[r]	**207[r]**	126	20	9	**155**
3059	Impaired Driving (>100 mgs Alcohol)	2	1	-	**3**	10	5	-	**15**
3060	Impaired Driving Not Motor Vehicle	-	-	-	**-**	-	-	-	**-**
3061	Care and Control of Motor Vehicle Whilst Impaired	18[r]	3	2	**23[r]**	9	-	-	**9**
3062	Refuse Breath Test	71[r]	9	2	**82[r]**	58	8	3	**69**
3063	Impaired Driving Drug In Body	1	-	-	**1**	-	-	-	**-**
3064	Excess Alcohol Motor Vehicle	97[r]	9	4[r]	**110[r]**	52	6	7	**65**
3065	Impaired Driving – GBH	5[r]	-	-	**5[r]**	-	-	1	**1**
3066	Excess Alcohol Not Motor Vehicle	1	-	-	**1**	-	-	-	**-**
3069	Causing Death by Impaired Driving	-	-	-	**-**	-	-	-	**-**
3843	Impaired Driving – Power Craft	1	-	-	**1**	2	-	-	**2**
4020	Drunk and Incapable	4	1	-	**5**	-	-	-	**-**
4022	Drunk in Public Street	-	-	-	**-**	1	-	-	**1**
8403	Drunkenness in Aircraft Contrary to Air Navigation	-	1	1	**2**	2	-	-	**2**
4500	Liquor Licence Offences	-	-	-	**-**	-	-	-	**-**
4556	On Premises Outside Permitted Hours	-	-	-	**-**	-	-	-	**-**
4599	Breach of Liquor Licence	-	-	-	**-**	-	-	-	**-**
Total Trials: Alcohol-Related Offences		**382[r]**	**45[r]**	**13[r]**	**440[r]**	**260**	**39**	**20**	**319**

Source: Supreme Court

Table 1.3.3
Criminal Acquittals for Drug-Related Offences by Sex of Offender, 2013 and 2014

JEMS Code	Description	2013			2014		
		Male	Female	Total	Male	Female	Total
2300	Possession of cannabis	15[r]	1	16[r]	6	-	6
2304	Possession of cocaine	3[r]	-[r]	3[r]	-	-	-
2308	Possession of diamorphine	1	-	1	-	-	-
2312	Possession of other drugs	1	-	1	-	-	-
2313	Possession of other drugs with intent to supply	-	-	-	-	-	-
2316	Possession of cannabis with intent to supply	4[r]	-	4[r]	1	-	1
2320	Possession of cocaine with intent to supply	8[r]	-	8[r]	-	-	-
2324	Possession of diamorphine with intent to supply	1	-	1	-	-	-
2332	Handle cannabis with intent to supply	-	-	-	2	-	2
2336	Handle cocaine with intent to supply	-	-	-	-	-	-
2340	Handle diamorphine with intent to supply	-	-	-	-	-	-
2344	Handle other drugs with intent to supply	-	-	-	-	-	-
2348	Supply cannabis	-	-	-	-	-	-
2352	Supply cocaine	-	-	-	-	-	-
2356	Supply diamorphine	-	-	-	-	-	-
2357	Supply other drugs	-	-	-	-	-	-
2364	Import cannabis	1	-	1	-	1	1
2368	Import cocaine	-	-	-	-	-	-
2372	Import diamorphine	-	-	-	-	-	-
2373	Import other drugs	-	-	-	-	-	-
2380	Conspiracy to import other drugs	1[r]	-	1[r]	2	-	2
2381	Conspiracy to supply a controlled drug	-	1	1	-	-	-
2383	Export drug attempt	-	-	-	-	-	-
2384	Misuse controlled drug	-	-	-	-	-	-
2388	Possession of drug equipment	7[r]	-	7[r]	3	-	3
2392	Possession of drug equipment prepare	4[r]	-	4[r]	4	-	4
2396	Cultivate cannabis	1[r]	-	1[r]	-	-	-
2400	Permit on premises drug use	-	-	-	-	-	-
2404	Obstruction	1	-	1	1	-	1
Total Trials: Alcohol-Related Offences		48[r]	2[r]	50[r]	19	1	20

Source: Supreme Court

Table 1.3.4
Criminal Acquittals for Alcohol-Related Offences by Sex of Offender, 2013 and 2014

JEMS Code	Description	2013				2014			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired driving motor vehicle	23[r]	1[r]	1[r]	25[r]	10	5	2	17
3059	Impaired driving (>100 mgs alcohol)	-	-	-	-	-	-	-	-
3060	Impaired driving not motor vehicle	-	-	-	-	-	-	-	-
3061	Care and control of motor vehicle whilst impaired	2[r]	-	1	3[r]	1	-	-	1
3062	Refuse breath test	5[r]	-[r]	-	5[r]	6	2	1	9
3063	Impaired driving drug in body	-	-	-	-	-	-	-	-
3064	Excess alcohol motor vehicle	6[r]	1	-[r]	7[r]	3	1	-	4
3065	Impaired driving – GBH	-	-	-	-	-	-	-	-
3066	Excess alcohol not motor vehicle	-	-	-	-	-	-	-	-

Source: Supreme Court

Table 1.3.4 cont'd

Criminal Acquittals for Alcohol-Related Offences by Sex of Offender, 2013 and 2014

JEMS Code	Description	2013				2014			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3069	Causing Death by Impaired Driving	-	-	-	-	-	-	-	-
3843	Impaired Driving – Power Craft	-	-	-	-	1	-	-	1
4020	Drunk and Incapable	2	-	-	2	-	-	-	-
4022	Drunk in Public Street	-	-	-	-	-	-	-	-
8403	Drunkenness in Aircraft Contrary to Air Navigation	-	-	-	-	-	-	-	-
4500	Liquor Licence Offences	-	-	-	-	-	-	-	-
4556	On Premises Outside Permitted Hours	-	-	-	-	-	-	-	-
4599	Breach of Liquor Licence	-	-	-	-	-	-	-	-
Total Acquittals: Alcohol-Related Offences		**38**[r]	**2**[r]	**2**[r]	**42**[r]	**21**	**8**	**3**	**32**

Source: Supreme Court

Table 1.3.5

Criminal Convictions for Drug-Related Offences by Sex of Offender, 2013 and 2014

JEMS Code	Description	2013				2014			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of Cannabis	45	2	3[r]	50[r]	39	2	2	43
2304	Possession of Cocaine	6	-	-	6	7	-	2	9
2308	Possession of Diamorphine	1	-	-	1	4	-	-	4
2312	Possession of Other Drugs	-	-	-	-	1	-	-	1
2313	Possession of Other Drugs With Intent to Supply	-	-	-	-	-	-	-	-
2316	Possession of Cannabis With Intent to Supply	9	1	-	10	18	2	-	20
2320	Possession of Cocaine With Intent to Supply	3	-	2	5	6	2	-	8
2324	Possession of Diamorphine With Intent to Supply	-	-	-	-	5	-	-	5
2332	Handle Cannabis With Intent to Supply	-	-	-	-	-	-	-	-
2336	Handle Cocaine With Intent to Supply	-	-	-	-	-	-	-	-
2340	Handle Diamorphine With Intent to Supply	-	-	-	-	-	-	-	-
2344	Handle Other Drugs With Intent to Supply	-	-	-	-	-	-	-	-
2348	Supply Cannabis	-	-	-	-	-	-	-	-
2352	Supply Cocaine	-	-	-	-	-	-	-	-
2356	Supply Diamorphine	-	-	-	-	-	-	-	-
2357	Supply Other Drugs	-	-	-	-	-	-	-	-
2364	Import Cannabis	1	2[r]	-	3[r]	5	3	-	8
2368	Import Cocaine	-	1	-	1	1	2	-	3
2372	Import Diamorphine	-	-	-	-	-	-	-	-
2373	Import Other Drugs	-	-	-	-	-	-	-	-
2380	Conspiracy to Import Other Drugs	-	-	2	2	-	2	-	2
2381	Conspiracy to Supply a Controlled Drug	-	-	-	-	-	-	-	-
2383	Export Drug Attempt	-	-	-	-	-	-	-	-
2384	Misuse Controlled Drug	-	-	-	-	-	-	-	-
2388	Possession of Drug Equipment	10	-	-	10	16	-	-	16
2392	Possession of Drug Equipment Prepare	1	-	-	1	6	-	-	6
2396	Cultivate Cannabis	4	-	-	4	3	-	-	3

Source: Supreme Court

Table 1.3.5 cont'd
Criminal Convictions for Drug-Related Offences by Sex of Offender, 2013 and 2014

JEMS Code	Description	2013				2014			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2400	Permit on Premises Drug Use	-	-	-	-	-	-	-	-
2404	Obstruction	2	-	-	2	3	-	-	3
Total Convictions: Drug-Related Offences		**82**	**6[r]**	**7[r]**	**95[r]**	**114**	**13**	**4**	**131**

Source: Supreme Court

Table 1.3.6
Criminal Convictions for Alcohol-Related Offences by Sex of Offender, 2013 and 2014

JEMS Code	Description	2013				2014			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	135[r]	13	3	151[r]	71	10	6	87
3059	Impaired Driving (>100 mgs Alcohol)	2	-	-	2	5	2	-	7
3060	Impaired Driving Not Motor Vehicle	-	-	-	-	-	-	-	-
3061	Care and Control of Motor Vehicle Whilst Impaired	13	2	1	16	6	-	-	6
3062	Refuse Breath Test	22	5	1	28	24	2	1	27
3063	Impaired Driving Drug In Body	-	-	-	-	-	-	-	-
3064	Excess Alcohol Motor Vehicle	23	3	1	27	19	2	1	22
3065	Impaired Driving – GBH	4[r]	-	-	4[r]	-	-	1	1
3066	Excess Alcohol Not Motor Vehicle	1	-	-	1	-	-	-	-
3069	Causing Death by Impaired Driving	-	-	-	-	-	-	-	-
3843	Impaired Driving – Power Craft	1	-	-	1	1	-	-	1
4020	Drunk and Incapable	1	1	-	2	-	-	-	-
4022	Drunk in Public Street	-	-	-	-	1	-	-	1
8403	Drunkenness in Aircraft Contrary to Air Navigation	-	1	1	2	2	-	-	2
4500	Liquor Licence Offences	-	-	-	-	-	-	-	-
4556	On Premises Outside Permitted Hours	-	-	-	-	-	-	-	-
4599	Breach of Liquor Licence	-	-	-	-	-	-	-	-
Total Convictions: Alcohol-Related Offences		**202[r]**	**25**	**7**	**234[r]**	**129**	**16**	**9**	**154**

Source: Supreme Court

Table 1.3.7
Unknown Results for Drug-Related Offences by Sex of Offender, 2013 and 2014

JEMS Code	Description	2013				2014			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2300	Possession of cannabis	2	-	-	2	4	1	-	5
2304	Possession of cocaine	-	1	-	1	1	-	-	1
2308	Possession of diamorphine	2	-	-	2	-	-	-	-
2312	Possession of other drugs	-	-	-	-	-	-	-	-
2313	Possession of other drugs with intent to supply	-	-	-	-	-	-	-	-
2316	Possession of cannabis with intent to supply	1	2	-	3	3	2	-	5
2320	Possession of cocaine with intent to supply	-	-	-	-	1	-	-	1
2324	Possession of diamorphine with intent to supply	-	-	-	-	-	-	-	-

Source: Supreme Court

Table 1.3.7 cont'd
Unknown Results for Drug-Related Offences by Sex of Offender, 2013 and 2014

JEMS Code	Description	2013				2014			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
2332	Handle cannabis with intent to supply	-	-	-	-	-	-	-	-
2336	Handle cocaine with intent to supply	-	-	-	-	-	-	-	-
2340	Handle diamorphine with intent to supply	-	-	-	-	-	-	-	-
2344	Handle other drugs with intent to supply	-	-	-	-	-	-	-	-
2348	Supply cannabis	-	-	-	-	-	-	-	-
2352	Supply cocaine	-	-	-	-	-	-	-	-
2356	Supply diamorphine	-	-	-	-	-	-	-	-
2357	Supply other drugs	-	-	-	-	-	-	-	-
2364	Import cannabis	-	-	-	-	3	1	-	4
2368	Import cocaine	-	-	-	-	-	-	-	-
2372	Import diamorphine	-	-	-	-	1	-	-	1
2373	Import other drugs	-	-	-	-	-	-	-	-
2380	Conspiracy to import other drugs	-	1	-	1	1	1	-	2
2381	Conspiracy to supply a controlled drug	-	-	-	-	-	-	-	-
2383	Export drug attempt	-	-	-	-	-	-	-	-
2384	Misuse controlled drug	-	-	-	-	-	-	-	-
2388	Possession of drug equipment	2	-	-	2	1	-	-	1
2392	Possession of drug equipment prepare	2	-	-	2	5	-	-	5
2396	Cultivate cannabis	-	-	-	-	-	-	-	-
2400	Permit on premises drug use	-	-	-	-	-	-	-	-
2404	Obstruction	-	-	-	-	-	-	-	-
Total Unknown Results: Drug-Related Offences		**9**	**4**	**-**	**13**	**20**	**5**	**-**	**25**

Source: Supreme Court

Table 1.3.8
Unknown Results for Alcohol-Related Offences by Sex of Offender, 2013 and 2014

JEMS Code	Description	2013				2014			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
3058	Impaired Driving Motor Vehicle	24	7	-	31	45	5	1	51
3059	Impaired Driving (>100 mgs Alcohol)	-	1	-	1	5	3	-	8
3060	Impaired Driving Not Motor Vehicle	-	-	-	-	-	-	-	-
3061	Care and Control of Motor Vehicle Whilst Impaired	3	1	-	4	2	-	-	2
3062	Refuse Breath Test	44	4[r]	1	49[r]	28	4	1	33
3063	Impaired Driving Drug In Body	1	-	-	1	-	-	-	-
3064	Excess Alcohol Motor Vehicle	68[r]	5	3	76[r]	30	3	6	39
3065	Impaired Driving – GBH	1	-	-	1	-	-	-	-
3066	Excess Alcohol Not Motor Vehicle	-	-	-	-	-	-	-	-
3069	Causing Death by Impaired Driving	-	-	-	-	-	-	-	-
3843	Impaired Driving – Power Craft	-	-	-	-	-	-	-	-
4020	Drunk and Incapable	1	-	-	1	-	-	-	-
4022	Drunk in Public Street	-	-	-	-	-	-	-	-
8403	Drunkenness in Aircraft Contrary to Air Navigation	-	-	-	-	-	-	-	-

Source: Supreme Court

Table 1.3.8 cont'd
Unknown Results for Alcohol-Related Offences by Sex of Offender, 2013 and 2014

JEMS Code	Description	2013				2014			
		Male	Female	Not Stated	Total	Male	Female	Not Stated	Total
4500	Liquor Licence Offences	-	-	-	-	-	-	-	-
4556	On Premises Outside Permitted Hours	-	-	-	-	-	-	-	-
4599	Breach of Liquor Licence	-	-	-	-	-	-	-	-
Total Unknown Results: Alcohol-Related Offences		**142[r]**	**18[r]**	**4**	**164[r]**	**110**	**15**	**8**	**133**

Source: Supreme Court

1.4 FINANCIAL INTELLIGENCE

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

Data on financial intelligence showed a decrease (11.3%) in SARs received from 2013 (373) to 2014 (331) (see Table 1.4.1). While quarters two, three, and four in 2014 saw a decline over the same quarters in 2013, the first quarter of 2013, on the other hand, saw an increase of 8.2% over the same quarter in 2014. Activities within banks, for example, HSBC Bank, and money service businesses, for example, Western Union, account for the bulk of the SARs in both 2013 (216 and 102, respectively) and 2014 (234 and 47, respectively). SARS received from banks' report of suspicious activity increased by 8.3% over the two-year period. On the other hand, the number of SARS received from the money service businesses declined considerably by 53.9%, from 102 in 2013 to 47 in 2014. Although relatively few, it is worthy to note that in both 2012 and 2013 there were SARs involving a law firm, trust company, investment providers, and long-term insurers. Further, in 2014, a SAR was received from an accounting firm.

The FIA recorded a total of 64.1% (239 of 373) in 2013 and 61.3% (203 of 331) in 2014 SARs involving the exchange of Bermuda currency to US dollar; 141 and 156 SARs, respectively, involved suspicious cash exchange at financial institutions, and 98 and 47 of them, respectively, were via suspicious wire transfers of money out of Bermuda using Money Service Businesses as their transmitter.[2] Further, the FIA continues to believe that the transactional activity concerning foreign currency exchange is intimately connected with Bermuda's drug trade.[3] This continues to be the foremost trend seen by the FIA over the past few years.

Also in 2014, 107 local and overseas disclosures contained information from 240 SARs compared to 172 disclosures from 322 SARs in 2013, representing a 37.8% decline in disclosures from the 25.5% drop in total SARs disclosed.

In 2013, there was one conviction for money laundering in the Bermuda courts while in 2014 there were three convictions.[4]

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

[2] FIA.

[3] Ibid.

[4] Department of Public Prosecutions.

Table 1.4.1
Suspicious Activity Reports (SARs) by Sector, 2013 and 2014

SECTOR	2013					2014					Annual Percentage Change
	Q1	Q2	Q3	Q4	TOTAL	Q1	Q2	Q3	Q4	TOTAL	
SARs Received											
Banks (includes a Credit Union)	50	59	49	58	216	70	59	54	51	234	8.3
Investment Providers	1	4	1	3	9	-	-	-	1	1	-88.9
Money Service Businesses	28	28	23	23	102	9	14	11	13	47	-53.9
Corporate Service Providers	-	-	-	-	-	-	-	-	-	-	-
Law Firm	-	1	3	3	7	-	-	1	-	1	-85.7
Trust Company	1	1	-	-	2	-	1	-	-	1	-50.0
Local Regulators	-	-	-	-	-	-	-	-	1	1	100.0
Long-Term Insurers	5	3	12	17	37	13	20	4	8	45	21.6
Other (Metal Dealers)	-	-	-	-	-	-	-	-	-	-	-
Accounting Firm	-	-	-	-	-	-	-	-	1	1	100.0
Total SARs Received	85	96	88	104	373	92	94	70	75	331	-11.3
Annual Percentage Change	77.1	-23.2	14.3	-18.8	-1.3	8.2	-2.1	-20.5	-27.9	-11.3	
Total Local and Overseas Disclosures	19	35	55	63	172	31	23	21	32	107	-37.8
Local entities	14	19	36	55	124	27	20	18	30	95	-23.4
Overseas entities	5	16	19	8	48	4	3	3	2	12	-75.0
Total SARs Disclosed	32	56	78	156	322	64	53	51	72	240	-25.5

Source: Financial Intelligence Agency

1.5 FINANCIAL CRIME

Cash is seized by the Financial Crime Unit (FCU) of the Bermuda Police Service as part of Section 50 of the Proceeds of Crime Act (POCA) and Misuse of Drugs Act where persons are convicted by the Department of Public Prosecutions (DPP) for serious financial offences including money laundering. In order to be effective in its operations, the FCU has conducted training for the Joint Intelligence Unit and the Cruise Ship Enforcement Team of HM Customs on Section 50 POCA cash seizures with the aim of enhancing knowledge and understanding in relation to cash seizures, the role of the FCU in the process, and the impact of the POCA powers and its legislative amendments. The BPS FCU also has working relations with the Practitioners Sub-Committee of the National Anti-Money Laundering Committee (NAMLC) and continues to provide assistance to its law enforcement partners, including the United States Department of Justice, in relation to high profile prosecutions.

Cash seizure, under Section 50 of the POCA, relates to powers to seize cash (and/or property) derived from or intended for use in crime. No arrest or conviction is required for the forfeiture of the cash and these proceedings are to the civil not criminal standard of proof. The majority of these types of cases originate when cash is found in the following instances: during a person/baggage search at the Airport, a street search, or a house search where the person concerned cannot account for its derivation. Within 48 hours, the BPS must seek a further detention order from a Magistrate, who authorises its further detention for up to three months. Upon completion of the investigation, and if there is sufficient evidence, a civil forfeiture hearing is held at Court and if the Magistrate is satisfied a Forfeiture Order is signed for the cash to be forfeited to the Confiscation Assets Fund.

Confiscation proceedings take place after criminal conviction in cases primarily involving drug trafficking and/or money laundering. The Judge can order, if requested by the DPP, a hearing in relation to all known assets (for example, houses, cars, jet skis, etc.) held by the convicted person to ascertain if those assets represent his or her proceeds of crime. Following the hearing, the Judge can make a Confiscation Order in relation to the known assets in monetary terms. The onus is then on the person to satisfy that Order or face a term of imprisonment in

default; however, the Order will remain in place until paid and interest is added.

The BPS FCU has reported a total of 8 cash seizures in 2014 compared to a considerably higher number (28) in the previous year (see Table 1.5.1). Despite the fewer number of seizures in 2014 compared to 2013, the total amount of cash seized in 2014 ($623,116) was, in fact, more than the amount seized in 2013 ($423,380). However, forfeitures accounted for the largest proportion of seizures in 2014 versus cash in 2013. Specifically, $87,982 was seized in 2014 compared to $300,475 in 2013; $535,134 was forfeited in 2014 vs. $122,905 in 2013, and there was no confiscation in either of the two years under review.

Table 1.5.1
Cash Seizures, 2013 and 2014

Year/Quarter	Number of Seizures	Section 50 Cash Seizures ($)	Forfeiture ($)	Confiscation ($)	Total ($)
2013	**28**	**300,475.01**	**122,905.00**	**-**	**423,380.01**
Q1	8	134,052.00	32,979.00	-	167,031.00
Q2	7	27,685.01	38,046.00	-	65,731.01
Q3	5	24,303.00	11,525.00	-	35,828.00
Q4	8	114,435.00	40,355.00	-	154,790.00
2014	**8**	**87,982.00**	**535,133.96**		**623,115.96**
Q1	1	13,900.00	469,427.96	-	483,327.96
Q2	4	24,253.00	-	-	24,253.00
Q3	-	-	65,706.00	-	65,706.00
Q4	3	49,829.00	-	-	49,829.00

Source: Financial Crime Unit, Bermuda Police Service

Chapter 2
Imports, Exports, and Licensing

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

2.1 IMPORTS AND EXPORTS

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

The importation of alcohol and tobacco provides an indication of the availability of these products and the environment in which residents are surrounded. In Bermuda, a 33.5% duty is levied on imported cigarettes, while $26.57 is the duty charged on one litre of hard liquor.[5] However, there are varying rates of duty applied to different alcoholic beverages and tobacco products (Appendix III). These rates have been revised and became effective as of April 1, 2013. In addition, there are over 200 establishments licenced to serve or sell alcohol in Bermuda. There is no available data on the number of establishments that sell cigarettes and other tobacco products.

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

Of importance is the quantity and value of alcohol and alcoholic beverages available for domestic consumption (that is, used by persons on the Island whether they are residents or tourists). This usually is comprised of quantities imported in the given year in addition to the amount removed from bonded warehouses valued at the 'free on board' (FOB) basis (not inclusive of handling and freight costs, taxes and duties, and mark-up for profit). In 2013, 6.1 million litres of alcohol and alcoholic beverages were available for local consumption, valued at $25.1 million, and contributed $13.8 million in customs duty (see Table 2.1.1). In contrast, 2014 saw a slight increase in this quantity where 6.5 million litres were available for domestic consumption, valued at $27.2 million, and contributed $14.5 million in customs duty. Beer and wine in containers holding two litres or less accounted for a significant portion of the beverages available for consumption. An additional 2.1 million litres in 2013, valued at $14.2 million, and 2.3 million litres in 2014, valued at $15.8 million, were placed in bonded warehouses upon importation for future consumption (see Table 2.1.2). Wine in containers holding two litres or less and rum and other spirits account for the bulk of alcohol and alcoholic beverages placed in bonded warehouses in both years under review. At the same time, in 2013, 948 thousand litres of alcohol and alcoholic beverages were exported from bonded warehouses, valued at $3.5 million, with $20,709 received in customs duty (see Table 2.1.3). Likewise, in 2014, 923 thousand litres were exported from bonded warehouse, valued at $3.6 million, with $21,864 received in customs duty.

…6.5 million litres were available for domestic consumption, valued at $27.2 million, and contributed $14.5 million in customs duty.

The value of tobacco and tobacco products available for domestic consumption decreased considerably from the $4.1 million recorded in 2013 to $3.0 million in 2014 (see Table 2.1.4), consequently reducing the duty received from $11.4 million to $8.1 million. The major component of tobacco imports is that of cigarettes, with 53 thousand kilograms and 37.1 million units, valued at $2.3 million, being brought to the Island in 2014 or removed from bonded warehouses, contributing $7.9 million towards customs duty. By comparison, in the year 2013, 79 thousand kilograms and 53.5 million units, valued at $3.4 million, were brought to the Island or removed from bonded warehouses, contributing $11.2 million towards customs duty. In both 2013 and 2014, there were quantities of cigarettes that were placed into bonded warehouses and some that were removed for export (see Tables 2.1.5 and 2.1.6).

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

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

Table 2.1.1

Quantity, Value, and Duty of Alcohol and Alcoholic Beverages for Home Consumption (Imports and Removals from Bonded Warehouses), 2013 and 2014

Tariff Code	Description	2013			2014		
		Litreage	Value ($)	Duty ($)	Litreage	Value ($)	Duty ($)
2203.000	Beer	3,755,051.37	6,099,825.06	3,651,546.02	3,970,900.56	7,036,353.91	3,931,191.63
2204.100	Sparkling Wine	89,023.54	1,471,089.51	249,845.45	102,098.53	1,653,043.09	289,459.67
2204.210	Wine in containers holding 2 litres or less	1,198,404.64	10,106,765.37	3,383,611.42	1,284,566.06	11,175,220.20	3,684,983.99
2204.290	Wine in containers greater than 2 litres	84,889.79	1,567,847.63	239,059.63	86,790.55	1,094,136.31	250,579.19
2204.300	Other Grape Must	36.25	694.96	94.71	572.50	2,745.92	1,654.54
2205.100	Vermouth in containers holding 2 litres or less	3,596.10	9,607.04	10,233.62	3,604.40	12,510.58	10,416.73
2205.900	Vermouth in containers holding greater than 2 litres	440.41	4,890.19	1,270.60	23.73	255.12	68.59
2206.000	Other Fermented Beverages	98,259.25	260,600.01	137,932.15	131,834.47	341,214.27	185,886.80
2207.100	Undenatured Ethyl Alcohol	353.46	2,280.24	8,461.94	352.62	1,787.44	8,632.58
2207.200	Denatured Ethyl Alcohol	-	-	-	-	-	-
2208.200	Brandy and Cognac	21,886.24	428,642.74	220,382.11	23,710.88	469,840.56	243,385.32
2208.300	Whiskies	104,451.73	1,377,738.33	1,050,049.81	97,606.13	1,400,974.55	1,000,048.45
2208.400	Rum and Other Spirits Distilled from Sugar Cane	256,697.07	1,262,620.46	2,300,181.99	263,166.82	1,298,101.54	2,282,957.83
2208.500	Gin and Geneva	22,281.85	156,543.59	234,945.86	23,312.40	184,739.84	248,578.50
2208.600	Vodka	151,314.85	1,053,401.24	1,481,344.61	166,391.72	1,147,684.11	1,501,773.58
2208.700	Liqueur & Cordials	59,525.46	619,826.23	423,069.43	63,883.58	641,728.55	428,221.75
2208.900	Other Spirituous Beverages	302,484.46	699,695.08	405,427.96	308,312.87	727,825.97	468,735.79
	TOTAL	**6,148,696.47**	**25,122,067.68**	**13,797,457.31**	**6,527,127.82**	**27,188,161.96**	**14,536,574.94**

Source: HM Customs

Table 2.1.2

Quantity and Value of Bonded Alcohol and Alcoholic Beverages Placed in Bonded Warehouses Upon Arrival**, 2013 and 2014*

Tariff Code	Description	2013		2014	
		Litreage	Value ($)	Litreage	Value ($)
2203.000	Beer	-	-	3,578.40	7,933.80
2204.100	Sparkling Wine	65,538.58	1,043,453.49	80,132.27	1,401,277.75
2204.210	Wine in containers holding 2 litres or less	821,495.71	7,427,249.74	833,484.48	8,114,113.61
2204.290	Wine in containers greater than 2 litres	11,628.00	24,020.24	11,616.00	26,883.53
2204.300	Other Grape Must	-	-	-	-
2205.100	Vermouth in containers holding 2 litres or less	3,792.00	10,469.96	2,106.00	5,626.05
2205.900	Vermouth in containers holding greater than 2 litres	-	-		
2206.000	Other Fermented Beverages	5,826.90	31,277.60	4,171.86	28,208.10
2207.100	Undenatured Ethyl Alcohol	-	-	-	-
2207.200	Denatured Ethyl Alcohol	-	-	-	-
2208.200	Brandy and Cognac	18,183.15	418,551.79	23,926.10	537,892.31
2208.300	Whiskies	82,269.60	1,214,257.93	76,889.10	1,089,788.51
2208.400	Rum and Other Spirits Distilled from Sugar Cane	904,171.90	2,338,858.99	1,092,450.70	2,958,432.01
2208.500	Gin and Geneva	18,282.00	123,051.34	15,972.00	114,105.77
2208.600	Vodka	129,857.55	1,057,695.44	108,828.30	863,043.95
2208.700	Liqueur & Cordials	38,028.50	369,434.24	43,917.85	439,839.93
2208.900	Other Spirituous Beverages	16,948.50	188,724.37	17,202.75	222,571.81
	TOTAL	**2,116,022.39**	**14,247,045.13**	**2,314,275.81**	**15,809,717.13**

Source: HM Customs

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

Table 2.1.3

Quantity, Value, and Duty of Alcohol and Alcoholic Beverages Exported from Bonded Warehouses, 2013 and 2014*

Tariff Code	Description	2013			2014		
		Litreage	Value ($)	Duty ($)	Litreage	Value ($)	Duty ($)
2203.000	Beer	-	-	-	-	-	-
2204.100	Sparkling Wine	741.75	28,844.47	129.21	646.00	27,931.50	126.42
2204.210	Wine in containers holding 2 litres or less	360.00	1,694.32	90.00	-	-	-
2204.290	Wine in containers greater than 2 litres	1,575.00	24,454.19	-	12.00	22.52	3.00
2204.300	Other Grape Must	-	-	-	-	-	-
2205.100	Vermouth in containers holding 2 litres or less	-	-	-	-	-	-
2205.900	Vermouth in containers holding greater than 2 litres	-	-	-	-	-	-
2206.000	Other Fermented Beverages	-	-	-	-	-	-
2207.100	Undenatured Ethyl Alcohol	-	-	-	-	-	-
2207.200	Denatured Ethyl Alcohol	-	-	-	-	-	-
2208.200	Brandy and Cognac	3,426.85	102,763.28	856.93	4,467.05	146,078.71	1,116.96
2208.300	Whiskies	4,597.20	107,467.47	1,149.42	5,503.15	138,723.63	1,375.90
2208.400	Rum and Other Spirits Distilled from Sugar Cane	915,504.83	2,996,698.32	12,964.41	890,053.50	3,058,316.57	13,557.90
2208.500	Gin and Geneva	2,447.00	23,939.10	611.75	2,985.00	29,401.74	746.25
2208.600	Vodka	5,056.00	60,064.73	1,264.09	5,441.50	66,214.41	1,360.46
2208.700	Liqueur & Cordials	6,238.95	56,135.93	1,559.90	5,367.80	51,243.55	1,342.09
2208.900	Other Spirituous Beverages	8,331.50	55,490.17	2,083.05	8,940.85	56,283.11	2,235.28
	TOTAL	**948,279.08**	**3,457,551.98**	**20,708.76**	**923,416.85**	**3,574,215.74**	**21,864.26**

Source: HM Customs

Notes: * There is no correlation between the figures for the goods placed into bond and the figures for goods being removed from bond. Goods being removed from bond for the purposes of export may have arrived in Bermuda at any time in the past.
The duty figures provided reflect the amount of duty collected by HM Customs. These figures are composed of varying rates of duty depending on the Customs Procedure Code (CPC) that was applied when the goods were declared. In certain instances, the applicable rate of duty imposed by a CPC may be either 0.0% or $0.00 per litre, even though the 'full' import duty in the Bermuda Customs Tariff is different.

Table 2.1.4

Quantity, Value, and Duty of Tobacco and Tobacco Products for Home Consumption (Imports and Removals from Bonded Warehouses), 2013 and 2014

Tariff Code	Description	2013			2014		
		Quantity	Value ($)	Duty ($)	Quantity	Value ($)	Duty ($)
2401.100	Tobacco, Not Stemmed/Stripped	-	-	-	22.73 kg	763.38	6.59
2401.200	Tobacco, Partly or Wholly Stemmed/ Stripped	6 kg	4.00	1.74	2 kg	37.96	0.58
2402.100	Cigars, Cheroots, etc. Containing Tobacco	12,160.72 kg	529,682.41	162,271.68	41,200.82 kg	509,849.98	153,318.31
2402.200	Cigarettes Containing Tobacco	78,942.41 kg 53,475,860 u	3,372,542.98	11,201,320.00	52,555.27 kg 37,137,140 u	2,349,569.59	7,864,414.80
2402.900	Other Tobacco Products; or Products of Tobacco Substitutes	61 kg	861.24	288.51	22 kg	77.95	16.06
2403.110	Water Pipe Smoking Tobacco	6,832.49 kg	130,006.48	43,552.19	2,280.35 kg	52,813.52	17,692.54
2403.190	Other Smoking Tobacco	603 kg	11,726.40	3,928.34	355 kg	5,236.38	1,754.19
2403.910	"Homogenised" or "Reconstituted" Tobacco	1 kg	100.00	33.50	-	-	-
2403.990	**Tobacco Extracts and Essences; Other Manufactured Products of Tobacco**	1,151 kg	29,345.78	9,830.84	3,651.16 kg	69,929.19	23,426.28
9803.163	**Smoking Tobacco; Cigars, Cheroots and Cigarillos, Containing Tobacco (Imported by Post or Courier)**	1,157 u	24,909.17	8,344.54	4,117 u	20,380.15	6,827.34
	TOTAL	**99,757.62 kg 53,477,017 u**	**4,099,178.46**	**11,429,571.34**	**104,206.33 kg 37,137,140 u**	**3,008,658.10**	**8,067,456.69**

Source: HM Customs

Table 2.1.5
Quantity and Value of Bonded Tobacco and Tobacco Products Placed in Bonded Warehouses Upon Arrival**, 2013 and 2014*

Tariff Code	Description	2013		2014	
		Quantity	Value ($)	Quantity	Value ($)
2401.100	Tobacco, Not Stemmed/Stripped	-	-	-	-
2401.200	Tobacco, Partly or Wholly Stemmed/Stripped	-	-	-	-
2402.100	Cigars, Cheroots, etc. Containing Tobacco	145.48 kg	46,346.15	36,189.20 kg	76,833.38
2402.200	Cigarettes Containing Tobacco	8,995.46 kg 4,846,000 u	307,352.65	3,041.28 kg 2,400,000 u	147,143.05
2402.900	Other Tobacco Products; or Products of Tobacco Substitutes	-	-	-	-
2403.110	Water Pipe Smoking Tobacco	-	-	-	-
2403.190	Other Smoking Tobacco	-	-	-	-
2403.910	"Homogenised" or "Reconstituted" Tobacco	-	-	-	-
2403.990	Tobacco Extracts and Essences; Other Manufactured Products of Tobacco	-	-	-	-
9803.163	Smoking Tobacco; Cigars, Cheroots and Cigarillos, Containing Tobacco (Imported by Post or Courier)	-	-	-	-
	TOTAL	**9,140.94 kg 4,846,000 u**	**353,698.80**	**39,230.48 kg 2,400,000 u**	**223,976.43**

Source: HM Customs

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

Table 2.1.6
Quantity, Value, and Duty of Tobacco and Tobacco Products Exported from Bonded Warehouses, 2013 and 2014*

Tariff Code	Description	2013		2014	
		Quantity	Value ($)	Quantity	Value ($)
2401.100	Tobacco, Not Stemmed/Stripped	-	-	-	-
2401.200	Tobacco, Partly or Wholly Stemmed/Stripped	-	-	-	-
2402.100	Cigars, Cheroots, etc. Containing Tobacco	13.74 kg	6,085.22	32.51 kg	12,290.16
2402.200	Cigarettes Containing Tobacco	2,389.41 kg 1,837,600 u	137,364.15	2,608.21 kg 2,451,620 u	156,377.46
2402.900	Other Tobacco Products; or Products of Tobacco Substitutes	-	-	-	-
2403.110	Water Pipe Smoking Tobacco	-	-	-	-
2403.190	Other Smoking Tobacco	-	-	-	-
2403.910	"Homogenised" or "Reconstituted" Tobacco	-	-	-	-
2403.990	Tobacco Extracts and Essences; Other Manufactured Products of Tobacco	-	-	-	-
9803.163	Smoking Tobacco; Cigars, Cheroots and Cigarillos, Containing Tobacco (Imported by Post or Courier)	-	-	-	-
	TOTAL	**2,403.15 kg 1,837,600 u**	**143,449.37**	**2,640.72 kg 2,451,620 u**	**168,667.62**

Source: HM Customs

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

2.2 LIQUOR LICENCES

Licensing of Establishments for Sale of Intoxicating Liquor

According to the Liquor Licence Act of 1974, persons or businesses engaged in the sale of intoxicating liquor, whether retail or wholesale, must first be licensed. Otherwise, there may be legal actions in the form of imprisonment or fines instituted by the Liquor Licence Authority.[7] In addition, the sale of liquor by establishments is in respect of the type of licence granted (Class A, Class B, Tour Boat, Nightclub, Restaurant, Hotel, Members' Club, Permit for Association or Organisation).[8] Data is not currently collected on the number of new licences issued. However, the trend over the years has mainly been the renewal of licences by existing establishments rather than new or existing establishments applying for first-time licence. Data on liquor licences granted by the Liquor Licence Authority to the various establishments located across the Island provides a representation of the ease of availability of, and access to, alcohol by residents.

In both 2013 and 2014, most licences were issued to establishments in the Central district, followed by the Western and Eastern Districts. There has been a decline of 2.3% in the number of licences issued to establishments between 2013 and 2014. The Liquor Licence Authority also issued occasional liquor licences, which decreased from 338 in 2013 to 327 in 2014 – a 3.3% drop. As in 2013, there were a few instances in 2014 where a licence was issued for an al fresco (outdoors) event. Overall, there has been an annual decline by 2.8% in the total number of licences issued, that is, from 602 being granted in 2013 to 585 in 2014.

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

[8] Ibid. p. 9.

Table 2.2.1
Liquor Licences Issued by District and Type of Licence, 2013 and 2014

Districts and Type of Licence	2013	2014
CENTRAL	165	157
Class 'A'	45	40
Class 'B'	2	3
Tour boat	31	29
Nightclub	2	4
Restaurant	53	49
Hotel	9	9
Members' club	20	20
Permit for association or organisation	1	1
Al fresco	2	2
WESTERN	**53**	**55**
Class 'A'	17	19
Class 'B'	1	1
Restaurant	22	1
Hotel	4	22
Members' club	8	3
Nightclub	-	8
Proprietary club licence	1	1
EASTERN	**46**	**46**
Class 'A'	12	15
Restaurants	18	17
Hotel	6	4
Members' club	7	7
Night club	1	1
Al fresco	1	1
Permit for association or organisation	1	1
Total licences issued to establishments	**264**	**258**
Annual percentage change in total licences issued to establishments	**-0.4**	**-2.3**
Total occasional liquor licences Island-wide	**338**	**327**
Annual percentage change in total occasional liquor licences Island-wide	**-15.1**	**-3.3**
Total licences issued	**602**	**585**
Annual percentage change in total licences issued	**-9.2**	**-2.8**

Source: Liquor Licence Authority, Magistrate's Court

Notes:

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

Chapter 3
Training Intervention ProcedureS (TIPS)

- Sessions
- Participants
- Outcomes

3.1 ALCOHOL SALES, SERVICE TRAINING, AND CERTIFICATION

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

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

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

In 2014, there were seven fewer TIPS training sessions than in 2013 (from 25 to 18), which was accompanied by a corresponding drop in the number of participating establishments and participants (see Table 3.1.1). A total of 247 participants (managers, owners, and supervisors) from 126 licenced establishments were trained (an establishment could have been represented by different participants over the year and hence the number of establishments is not unique) in 2014 compared to 343 participants from 133 licenced establishments in the previous year; averaging 14 participants per session, in both years under review.

Table 3.1.1
Training for Intervention ProcedureS (TIPS) Programme Statistics, 2013 and 2014

Year/Quarter	Number of TIPS Sessions	Number of Participants	Average Number of Participants Per Session	Outcome		Number of Participated Establishments
				Passed	Failed	
2013	**25**	**343[r]**	**14**	**308[r]**	**35[r]**	**133**
Q1	5	72	14	68	4	29
Q2	7	104	15	95	9	38
Q3	6	79	13	64	15	29
Q4	7	88[r]	13	81[r]	7[r]	37
2014	**18**	**247**	**14**	**225**	**22**	**126**
Q1	5	75	15	67	8	42
Q2	5	74	15	68	6	39
Q3	5	64	13	58	6	26
Q4	3	34	11	32	2	19

Source: CADA

Chapter 4
Substance Abuse Treatment and Counselling

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

4.1 BARC STATISTICS

Treatment Assessment and Referral

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

In 2014, a total of 206 referrals were made to BARC compared to 307 in the previous year (see Tables 4.1.1 and 4.1.2). Over the two-year period, the number of new cases referred to BARC (referrals of persons seeking treatment for the first time) declined by 37.9% from 124 cases in 2013 to 77 in 2014 (see Table 4.1.1); while, at the same time, the number of existing or repeat cases (referrals of clients who previously sought assessment for treatment services) decreased by 29.5% from 183 in 2013 to 129 in 2014 (see Table 4.1.2). However, in both years, repeat clients accounted for the greater proportion of all referrals. For instances, 129 (62.6%) of the 206 referrals in 2014 were cases of existing referrals compared to 77 (37.4%), which were cases of new referrals.

In both years under review males represented the majority of the total referrals, by a significant margin, compared to females (see Tables 4.1.1 and 4.1.2). Males were also more likely to reenter the system seeking assessment for treatment services than their female counterparts. In a few instances in 2013, these persons have sought assessment as many as two times within a one-year period; on the other hand, 2014 did not see any client being assessed more than once within that year.

Most of the persons being referred considered themselves black (89.8% or 185 in 2014). Blacks were also more likely be seeking assessment for yet another time(s) compared to whites or persons of other races (see Tables 4.1.1 and 4.1.2).

Overall, while a larger number of all referred persons were between the ages of 17 to 45 years (56.3% or 116 in 2014), persons newly referred to BARC were more likely to be within the younger age group of 17 to 30 compared to the older age groups such as 31 to 45 and 46 to 60, which tended to account for more of the repeat clients (see Tables 4.1.1 and 4.1.2).

Alcohol, cannabis, cocaine, and opiates or heroin remained the primary drugs of choice for which persons were seeking treatment during the past two years (see Tables 4.1.1 and 4.1.2). However, new clients sought treatment mainly for alcohol and cannabis in both 2013 and 2014 compared to existing clients, who primarily sought treatment for opiates and alcohol in 2013 and opiates and cocaine in 2014. Nonetheless, in 2014, there was a decrease in the number of new clients who sought treatment for cocaine and opiates in contrast to alcohol and cannabis in 2013, an increase in those who sought treatment for cannabis, and the number who sought treatment for alcohol remained unchanged. In terms of repeat clients, there was a noticeable increase in the numbers who sought treatment for any of the drugs under consideration. Most of both the new and existing referrals tended to be dependent or have abused one drug. There were also instances where persons reported dependence or abuse of three or more drugs; where reports of more two drugs in use were likely to be seen among repeat clients. A consistent observation over the years is that, collectively, a larger proportion of both the new and existing clients tended to be clinically dependent on their drug(s) of choice versus being abusers (see Table 4.1.3). However, in 2014 this was not the case in that there were slightly more persons who were diagnosed as being clinical abusers (160 clients) of their drug(s) of choice rather than being dependent (157 clients); with new clients more likely to be abusers and repeat clients more likely to be dependent on their drug(s) of choice (see Table 4.1.4). It should be noted that clients might have indicated the use of one or more drug and consequently could be diagnosed as being dependent on one and abusing the other, dependent on all, or abusing all. Hence, the categories of abuse and dependence will exceed the total number of clients but records the drug(s) on which the client is dependent or abusing.

…a larger proportion of both the new and existing clients tended to be clinically dependent on their drug(s) of choice versus being abusers.

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

either outpatient or intensive outpatient care (IOP), and, in some instances, to be followed by residential care.

The Drug Abuse Screening Test (DAST) scores showed that of all clients to whom the assessment was administered in both 2013 and 2014, about one out of every four (or 27%) was classified as having substantial to severe substance (drug) abuse disorders, 54 in 2013 and 47 in 2014 (see Tables 4.1.5 and 4.1.6). Similarly, the Alcohol Dependence Scale scores indicate that of all clients to whom this test was administered, 5.7% (12) in 2013 and 5.4% (9) in 2014 were classified as having substantial to severe alcohol dependence (see Tables 4.1.7 and 4.1.8). The tests were not administered in a number of instances where clients self-reported no use of alcohol or drugs in the days preceding his/her assessment.

Table 4.1.1
Bermuda Assessment and Referral Centre Programme Statistics for New Referrals, 2013 and 2014

	2013	2014
Total New Referrals:	**124**	**77**
Annual Percentage Change	**-12.1**	**-37.9**
Sex:		
Males	102	58
Females	19	19
Not available	3	-
Age (Years):		
16 & Under	1	-
17–30	39	26
31–45	34	25
46–60	36	21
61–75	11	4
76+	-	1
Not stated	-	-
Not available	3	-
Race:		
Black	89	65
White	22	8
Portuguese	5	4
Mixed	3	-
Not stated	2	-
Not available	3	-
Drug of Choice (Dependence Or Abuse):		
Alcohol	46	46
Cannabis	38	44
Cocaine	19	9
Opiates	14	6
Other	-	-
None	23	1
Not stated/No show	17	9
Not available	3	-
One drug	53	34
Two drugs	20	28
Three drugs	8	5
More than three drugs	3	-
Not available	9	3

Source: Bermuda Assessment and Referral Centre

Table 4.1.1 cont'd

Bermuda Assessment and Referral Centre Programme Statistics for New Referrals, 2013 and 2014

	2013	2014
Level of Care:		
Level I – Outpatient	33	27
Level II – IOP	45	32
Level III and IV – Residential (medically monitored/managed intensive inpatient treatment)	13	1
None	13	16
Not stated/No show	17	1
Not available	3	-
Referred From:		
Magistrates Court	28	21
Self-referral	25	14
Turning Point	17	6
Court Services (including DTC, Probation Team, Parole Officer)	16	9
Family Services	8	7
Other/Other community	6	1
Corrections	6	1
EAP	5	6
MWI	2	1
Focus	2	-
Supreme Court	1	2
Financial Assistance	1	3
Parole Board	1	-
Private practice	1	4
Family Court	-	2
Caron	-	-
BYCS/CLSS	-	-
Not stated/No show	2	-
Not available	3	-
Referred To:		
Turning Point	66	50
BYCS/CLSS	11	3
Men's Treatment	7	2
Harbour Light	3	-
WTC	2	1
Other	1	2
Family Centre	-	-
None	12	16
Not stated/No show	19	3
Not available	3	-

Source: Bermuda Assessment and Referral Centre

Table 4.1.2
Bermuda Assessment and Referral Centre Programme Statistics for Existing Referrals, 2013 and 2014

	2013	2014
Total New Referrals:	**183**	**129**
Annual Percentage Change	**22.8**	**-29.5**
Sex:		
Males	153	103
Females	30	26
Age (Years):		
16 & Under	-	-
17–30	27	18
31–45	77	47
46–60	69	62
61–75	7	2
76+	-	-
Not stated	3	-
Race:		
Black	165	120
White	15	7
Portuguese	-	2
Mixed	1	-
Not stated	2	-
Drug of Choice (Dependence Or Abuse):		
Opiates	51	73
Alcohol	17	64
Cannabis	24	56
Cocaine	35	50
Other	-	1
None	22	1
Not stated/No show	34	-
One drug	53	39
Two drugs	41	62
Three drugs	33	27
Level of Care:		
Level I – Outpatient	25	22
Level II – IOP	54	50
Level III and IV – Residential (medically monitored/managed intensive inpatient treatment)	54	42
None	10	4
Not stated/No show	40	11
Referred From:		
Self-referral	55	49
Court Services (including DTC, Probation Team, Parole Officer)	41	22
Magistrates Court	24	19
Turning Point	22	15
Corrections	10	5
Family Court	6	1
Supreme Court	5	2
Focus	3	1

Source: Bermuda Assessment and Referral Centre

Table 4.1.2 cont'd
Bermuda Assessment and Referral Centre Programme Statistics for Existing Referrals, 2013 and 2014

	2013	2014
Referred From:		
Family Services	3	5
Financial Assistance	3	3
Other/Other community	2	6
MWI	2	-
EAP	1	-
Not stated/No show	6	1
Level of Care:		
Turning Point	100	95
Men's Treatment	17	6
WTC	10	7
Residential (including RLH)	9	10
BYCS/CLSS	3	-
Harbour Light	2	1
Other	1	1
Focus	-	1
None	7	4
Not stated/No show	1	4

Source: Bermuda Assessment and Referral Centre

Table 4.1.3
Clinical Diagnosis (Abuse or Dependence) of New and Existing Clients' Drug Use by Drug(s) of Choice, 2013

Drug of Choice	Abuse		Dependence		Deferred Diagnosis	
	New Clients	Existing Clients	New Clients	Existing Clients	New Clients	Existing Clients
Alcohol	18	28	28	35	-	-
Cannabis	24	37	14	15	-	-
Cocaine	10	23	9	26	-	-
Heroin	-	5	14	65	-	-
Methadone	-	-	-	-	-	-
TOTAL	**52**	**93**	**65**	**141**	**-**	**-**

Source: Bermuda Assessment and Referral Centre

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

Table 4.1.4
Clinical Diagnosis (Abuse or Dependence) of New and Existing Clients' Drug Use by Drug(s) of Choice, 2014

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

Source: Bermuda Assessment and Referral Centre

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

Table 4.1.5
DAST Results (Number of Clients by Level of Severity of Drug Abuse) of New Clients from the Bermuda Assessment and Referral Centre Programme, 2013 and 2014

		Number of Clients	
	Level of Severity (DAST Score)	2013	2014
Substance Abuse or Dependence	None (0)	2	4
	Low (1–5)	47	30
	Intermediate (6–10)	19	14
	Substantial (11–15)	6	5
	Severe (16–20)	1	-

Source: Bermuda Assessment and Referral Centre

Note: The DAST was not administered to 46 clients in 2013 and 24 clients in 2014. Test scores were unavailable for three clients in 2013. Clients from various referral sources, at times, do not follow-through with the request for treatment.

Table 4.1.6
ADS Results (Number of Clients by Level of Severity of Alcohol Dependence) of New Clients from the Bermuda Assessment and Referral Centre Programme, 2013 and 2014

		Number of Clients	
	Level of Severity (ADS Score)	2013	2014
Substance Abuse or Dependence	None (0)	23	22
	Low (1–13)	55	37
	Intermediate (14–21)	8	8
	Substantial (22–30)	4	2
	Severe (31–47)	-	-

Source: Bermuda Assessment and Referral Centre

Note: The ADS was not administered to 31 clients in 2013 and 8 clients in 2014. Test scores were unavailable for three clients in 2013. Clients from various referral sources, at times, do not follow-through with the request for treatment.

Table 4.1.7
DAST Results (Number of Clients by Level of Severity of Drug Abuse) of Existing Clients from the Bermuda Assessment and Referral Centre Programme, 2013 and 2014

		Number of Clients	
	Level of Severity (DAST Score)	2013	2014
Substance Abuse or Dependence	None (0)	5	4
	Low (1–5)	27	36
	Intermediate (6–10)	46	40
	Substantial (11–15)	42	39
	Severe (16–20)	5	3

Source: Bermuda Assessment and Referral Centre

Note: The DAST was not administered to 58 clients in 2013 and seven clients in 2014.

Table 4.1.8
ADS Results (Number of Clients by Level of Severity of Alcohol Dependence) of Existing Clients from the Bermuda Assessment and Referral Centre Programme, 2013 and 2014

		Number of Clients	
	Level of Severity (ADS Score)	2013	2014
Substance Abuse or Dependence	None (0)	33	31
	Low (1–13)	68	55
	Intermediate (14–21)	13	5
	Substantial (22–30)	6	5
	Severe (31–47)	2	2

Source: Bermuda Assessment and Referral Centre

Note: The ADS was not administered to 61 clients in 2013 and 31 clients in 2014.

4.2 COUNSELLING AND LIFE SKILLS SERVICES STATISTICS

Youth Counselling

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

In comparing 2014 to 2013, there has been an increase in the results observed for all the areas monitored with the exception of the number of referrals and assessments, which decreased from 124 to 87 and 96 to 23 in 2014, respectively (see Table 4.2.1). However, the decrease in the number of assessments recorded is as a result of a change in process implemented by the Department. CLSS has seen 126 clients in 2014, which increased from 84 clients seen in 2013. Clients are usually referred for either behavioural or substance use reasons. According to CLSS, in 2014, about 93% of the referrals were for drug-related reasons. At the same time, there has been a considerable increase in the number of family conferences, moving from 70 in 2013 to 190 in 2014. CLSS also offers substance education groups that are short-termed, ranging from eight to 10 sessions, which uses evidence-based curriculums tailored to the needs of its clients. There were a total of 15 group participants in 2014.

Table 4.2.1
Counselling and Life Skills Services Statistics, 2013 and 2014

Year	2013	2014
Number of referrals	124	87
Number of clients seen	84	126
Number of consultations	-	126
Number of readmissions	2	-
Number of assessments	96	23*
Number of family conferences	70	190
Number of discharges	45	66
Number of group participants	-	15

Source: CLSS

Note: * The Department of Child and Family Services has implemented a centralised intake and assessment process for all its services; therefore, the number of assessments has decreased for CLSS.

4.3 DRUG TREATMENT COURT STATISTICS

Drug Treatment Court

The Drug Treatment Court (DTC) programme is an intense, comprehensive, case management programme for offenders with substance abuse issues, and not strictly a substance abuse treatment programme.

The last year saw an increase in the number of new referrals to the programme, climbing from 20 cases being referred in 2013 to 32 in 2014 (see Table 4.3.1). Of the new referrals, the programme admitted 10 persons in 2013 and almost doubled its intake with 19 admissions in 2014. There was a corresponding increase in the number persons who completed Phase IV of the programme in 2014 (nine) than in 2013 (six).

It should be noted that as of 2014, the DTC programme was revised to make completion of Phase V (a year-long programme consisting of monitoring and support) mandatory for all participants (prior to 2014, finishing Phase IV was deemed as a programme completion and remaining in Phase V was voluntary; and in 2013, one person elected to continue to this Phase). Hence, the nine persons who completed Phase IV in 2014 will not be included programme completions in 2014 until they would have completed the now mandatory Phase V; only one person finished this Phase in 2014. As such, since the DTC programme's inception in 2001, there has now been a total of 32 programme completions with the one other person completing (Phase V) in 2014.

Table 4.3.1
Drug Treatment Court (DTC) Statistics, 2013 and 2014

	2013	2014
New referrals	20	32
Programme admissions	**10**	**19**
Successful completion Phase IV	**6**	**9**
Successful completion Phase V	**1**	**1**

Source: Drug Treatment Court

Notes:

1. Referrals are the number of persons that were sent to the programme for consideration. Admissions are the number of persons who were accepted into the programme. Some persons are referred by another Magistrate but may be found ineligible or unsuitable for the programme so they are not admitted.
2. After receiving their Phase IV certificates, seven participants elected to remain in the programme to complete the year-long Phase V, which consists of monitoring and support. Of these, six did not complete Phase 5, and one remained in Phase 5 at the end of 2014.
3. The reasons persons were referred to the DTC programme but not admitted include:
   a) Two offenders were referred to the Mental Health Treatment Court Programme.
   b) One offender's index offence was not sufficient to warrant the rigorous nature of the programme.
   c) One person was sentenced to Probation and reviewed in DTC.
   d) Four persons were deemed eligible but not suitable as their criminality superseded their substance abuse as determined during the assessment phase.
   e) Three persons opted to receive other sentences rather than participate in the DTC programme.
   f) Two persons remained in observation at the end of 2014.
4. In 2013, seven persons did not complete the programme. All were sentenced to periods of incarceration, with one individual having that sentence suspended. In 2014, four persons did not complete the programme. One was released outright due to legal matters, one was sentenced to time served following a period of remand, and two were incarcerated.
5. Persons may apply to the programme multiple times. In 2013, three offenders re-entered the programme having previously completed it. In 2014, one previous participant was allowed to re-enter the programme.
6. In 2014, the DTC Programme was revised, making Phase 5 mandatory for all participants. The last of the voluntary participants were in Phases 4 and 5 at the end of 2014.

4.4 MEN'S TREATMENT STATISTICS

Drug Abuse among Men in Treatment

Men who were screened include all men who were admitted for services in addition to those who were still receiving treatment in the years under review. A total of 21 and 17 men were screened for drugs in 2013 and 2014, respectively. Drug screening is done randomly, on suspicion of drug use, for clients going on outings or requiring day passes, for work detail, and also for Drug and Mental Health Court.

Men's Treatment (MT) collected a total of 322 urine samples of its clients to test for drug use during 2014; increasing from 289 in 2013 (see Table 4.4.1). This corresponds to 3,864 drug screens in 2014 since each tests consists of 12 substances compared to 1,445 screens in 2013, when each test consisted of five substances. However, only a small proportion of total drug screens yielded positive results. Although there were more drug screens in 2014, the proportion of positive drug screens declined from 2.4% (or 35) in 2013 to 0.1% (or 2) in 2014. The positive results observed in 2013 were due to a methadone client being in treatment and in 2014 the positive results were for benzodiazepines and opiates. At the same time, in both years, alcohol and heroin, and to a lesser extent crack, cocaine, and marijuana, were the primary drugs used by men prior to treatment (see Table 4.4.2).

Poly drug use was prevalent in both years with drugs in highest combination in 2014 being heroin with THC (marijuana) and crack. Other two- and three-drug combinations included alcohol, heroin, and marijuana, alcohol and marijuana, heroin and marijuana, heroin and alcohol, among others (see Table 4.4.3).

Poly drug use was prevalent in both years with drugs in highest combination in 2014 being heroin with THC (marijuana) and crack.

Table 4.4.1
Drug Screening Results among Men in Treatment, 2013 and 2014

Year	Total Samples	Total Screens	Number of Positive Screens					% Positive Screens
			Cocaine	Opiates	THC	Methadone	Total	
2013	289	1,445	-	-	-	35	35	2.4
2014	322	3,864	-	1	1	-	2	0.1

Source: Women's Treatment Centre

Notes: In 2014, a drug urinalysis sample was screened for 12 substances (amphetamines, barbiturates, buprenorphine, benzodiazepines, cocaine, methadone, methamphetamines, opiates, oxycodone, phencyclidine, propoxyphene, and marijuana), whereas in 2013 it was screened for five substances (THC, cocaine, opiates, methadone, and ecstasy), and may detect positive results for one or more substances for any given specimen or sample. Potentially adulterated screens are reported as positive.

Table 4.4.2
Primary Drug Used by Men Prior to Treatment, 2013 and 2014

Drug	Number of Men	
	2013	2014
Alcohol	9	4
Marijuana	-	1
Crack	2	2
Cocaine	2	-
Heroin	8	10
Methadone	-	-
TOTAL CLIENTS	**21**	**17**

Source: Men's Treatment

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

Table 4.4.3
Number of Cases of Poly-Drug Use among Clients at Men's Treatment, 2013 and 2014

Combinations	Number of Clients	
	2013	2014
Three-Drug Combination:		
Heroin, Crack, THC	-	8
Alcohol, Heroin, THC	-	2
Alcohol, Crack, THC	-	1
Two-Drug Combination:		
Alcohol, THC	3	2
Alcohol, Cocaine	2	-
Alcohol, Crack	1	-
Crack, THC	-	1
Heroin, Cocaine	2	-
Heroin, Crack	1	-
Heroin, Alcohol	3	-
Heroin, THC	3	-
TOTAL	**15**	**14**

Source: Men's Treatment

4.5 TURNING POINT SUBSTANCE ABUSE PROGRAMME STATISTICS

Drug Abuse among Turning Point Clients

Turning Point Substance Abuse Treatment Programme received a total of 6,920 specimens in 2014, an increase from the 6,297 specimens in 2013 (see Table 4.5.1). Of these specimens in 2014, 37.8% (2,578) tested positive for illicit drugs compared to 35.5% (2,222) in 2013. The number of positive specimens excludes those specimens that were tested positive for prescribed medications such as opiates, benzodiazepines, and methadone. In both years, a significant number of tested specimens were provided by male clients (5,622 in 2013 and 6,195 in 2014) compared to females (639 in 2013 and 624 in 2014). The majority of positive specimens tested positive for only one drug (63.5% in 2013 and 60.7% in 2014) while the remainder tested positive for poly drug use of two or more drugs inclusive of prescription medication. In both years the drug most often found in positive screens was opiates (heroin) (62.0% in 2013 and 63.1% in 2014), cocaine (46.0% in 2013 and 49.8% in 2014), and THC (marijuana) (20.8% in 2013 and 26.5% in 2014) (see Table 4.5.3). Noticeably, positive screens for opiates, cocaine, and marijuana increased from 2013 but those for benzodiazepines dropped year over year.

Over the two-year period under review, the total number of methadone clients dropped from an average of 120 clients in 2013 to 113 in 2014 (see Table 4.5.4). Similarly, inpatient detoxes also declined from 99 clients in 2013 to 79 in 2014; while, at the same time, outpatient detoxes remained low with four clients in 2013 and only one in 2014.

Table 4.5.1
Proportion of Positive Drug Screens and Poly Drug Use by Turning Point Clients, 2013 and 2014

		2013	2014
Total specimens requested		**6,297**	**6,920**
	from females	653	647
	from males	5,644	6,273
Total specimens provided		**6,261**	**6,819**
	by females	639	624
	by males	5,622	6,195
Total positive specimens for illicit drugs*		**2,222**	**2,578**
% Positive specimens of total specimens provided		**35.5**	**37.8**
Positive Specimens for Drugs+			
	for one drug	1,412	1,565
Poly Drug Use	for two drugs	755	878
	for three drugs	126	209
	for more than three drugs	40	46

Source: Turning Point Substance Abuse Programme

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

Table 4.5.2
Positive Screens as a Proportion of Total Specimens Provided by Year and Type of Drug Detected at Turning Point, 2013 and 2014

Drug	2013	2014
Methadone	6,157 (98.3%)	6,616 (97.0%)
Opiates	1,377 (22.0%)	1,628 (23.9%)
Cocaine	1,022 (16.3%)	1,284 (18.8%)
Marijuana	462 (7.4%)	683 (10.0%)
Benzodiazepines	106 (1.7%)	27 (0.4%)
Alcohol	103 (1.6%)	101 (1.5%)
Oxycontin	9 (0.1%)	23 (0.3%)
Other	174 (2.8%)	168 (2.5%)

Source: Turning Point Substance Abuse Programme

Table 4.5.3
Positive Screens as a Proportion of Total Positive Specimens by Year and Type of Drug Detected at Turning Point, 2013 and 2014

Drug	2013	2014
Opiates	1,377 (62.0%)	1,628 (63.1%)
Cocaine	1,022 (46.0%)	1,284 (49.8%)
Marijuana	462 (20.8%)	683 (26.5%)
Benzodiazepines	106 (4.8%)	27 (1.0%)
Alcohol	103 (4.6%)	101 (3.9%)
Oxycontin	9 (0.4%)	23 (0.9%)
Other	174 (7.8%)	168 (6.5%)

Source: Turning Point Substance Abuse Programme

Table 4.5.4
Number of Methadone Clients, Inpatient, and Outpatient Detoxifications at Turning Point, 2013 and 2014

Year	Methadone Clients*	Inpatient Detoxes	Outpatient Detoxes
2013	120	99	4
2014	113	79	1

Source: Turning Point Substance Abuse Programme

Note: *Average

4.6 RIGHT LIVING HOUSE STATISTICS

Mandatory Drug Treatment

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

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

During both 2013 and 2014, the RLH had a maximum of 18 residents in care; however, in 2014, the average number of residents over the 12 months dropped to 15 when compared to 18 in 2013 (see Tables 4.6.1 and 4.6.2). There were at most eight persons who were placed on the waiting list for admissions in 2014 versus three persons in 2013. Persons from the wait list did not get into the

residential programme immediately, although it was not full to capacity, mainly because of the relocation of the residence due to the hurricane in 2014. In addition, some of these waitlisted persons would have had to first complete any outstanding requirement at the Westgate Correctional Facility, for example, a class such as anger management or the GED programme, before acceptance in the RLH residential treatment programme. Aftercare, a programme component, saw at most nine clients in both 2013 and 2014. Drug screens were conducted over the two years at various intervals including: at random, after outings and day passes, after work detail, and on suspicion. In total, 279 screening tests were conducted in 2013 versus 256 in 2014, with no positive substance abuse test result recorded in 2013 but one in 2014.

Table 4.6.1
Right Living House Programme Statistics, 2013

Programme Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2012
Number of Residents	18	18	18	18	18	18	18	18	18	18	18	17	18*
Total Programme Admissions	1	1	1	2	-	4	1	1	1	-	2	-**	14
Number of Discharges	1	-	3	-	3	1	1	1	1	-	1	1	13
Number of Substance Abuse Tests	24	23	29	34	15	15	28	29	23	17	20	22	279
Random Tests	16	23	12	-	-	-	14	-	6	-	-	-	71
Tests for Outings & Day Passes	8	-	17	16	15	15	14	29	16	17	20	22	189
Work Detail	-	-	-	18	-	-	-	-	-	-	-	-	18
Suspicious Tests	-	-	-	-	-	-	-	-	1	-	-	-	1
Number of Positive Substance Abuse Test	-	-	-	-	-	-	-	-	-	-	-	-	-
Wait Listed for Admission	1	1	1	1	1	2	3	3	3	3	3	3	2*
Residents in Aftercare	7	6	5	7	7	8	8	9	9	9	9	9	8*

Source: Right Living House

Note: *Average
**Admission delayed due to holiday procedures.

Table 4.6.2
Right Living House Programme Statistics, 2014

Programme Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2013
Number of Residents	18	18	18	18	17	14	13	12	11	13	12	15	15*
Total Programme Admissions	2	1	-	-	-	-	1	-	2	-	3	[2]	11
Number of Discharges	-	1	-	1	3	1	2	1	-	1	-	2	12
Number of Substance Abuse Tests	36	19	24	36	29	24	22	12	7	12	19	16	256
Random Tests	17	-	4	7	2	5	8	4	-	5	12	-	64
Tests for Outings & Day Passes	19	19	20	29	25	16	6	8	7	7	7	16	179
Work Detail	-	-	-	-	2	2	8	-	-	-	-	-	12
Suspicious Tests	-	-	-	-	-	1	-	-	-	-	-	-	1
Number of Positive Substance Abuse Test	-	-	-	-	-	-	-	-	-	-	-	1	1
Wait Listed for Admission	3	4	4	4	2	4	3	3	8	8	6	4	4*
Residents in Aftercare	9	9	8	8	6	6	8	8	7	7	7	7	8*

Source: Right Living House

Note: *Average

4.7 SALVATION ARMY TREATMENT PROGRAMMES

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

Over the last two financial years (April to March), the Harbour Light programme was able to maintain full capacity of 12 clients during the last quarter of 2013/2014. In the other quarters during the two fiscal years under review, there were eight to 11 clients at any given time (see Table 4.7.1). On average, two to four clients were admitted in each quarter while, at the same time, one to two clients completed the programme. The programme randomly conducts drug tests with its clients and only one of the tests administered to clients in the fourth quarter of the 2014/2015 year proved to be positive for an illicit substance.

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

Table 4.7.2 shows the performance of this programme. Over the last two years the number of clients ranged from as low as 29 clients in the second quarter of 2013/2014 to as many as 40 clients in the first quarter of that same year. The year 2014/2015 started with 30 clients participating in the programme and ended with 38 clients in the fourth quarter. As many as five new referrals were made in the fourth quarter of 2014/2015 but in some quarters there was only one referral. During the past two years no evening group sessions were conducted because of the cut in grant funding. However, a number of clients did receive crisis intervention and quite a few families also received relapse prevention education; although fewer in the last fiscal year. The programme's success can be judged by the fact that a number of clients successfully reintegrated with their families and into the community. For instance, in any given quarter, six to 14 clients successfully reintegrated. At the same time five to six clients were in stable committed relationships. Another success measure of the programme is that of financial stability. A number of clients have either opened or reactivated bank accounts, have secured savings in a bank, and made regular payments towards outstanding bills. Most importantly of all is the number of clients who abstained from substance abuse and the data shows that a significant number of clients did in fact abstain from drug use, averaging over 30 clients in any given quarter over the last two years under review.

Table 4.7.1
Salvation Army Harbour Light Residential Treatment Programme Performance, 2013/2014 and 2014/2015

Programme Indicators	FY 2013/2014				FY 2014/2015			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Intakes/Screenings/Assessments	6	7	2	4	2	6	6	4
Enrollment	4	2	2	2	2	2	2	3
Completions	-[r]	1	-	2	2	1	-	2
Total Clients	11	11	11	12	10	9	8	11
Random Drug Tests	22	22	22	22	10	-	-	11
Positive Drug Tests	-	-	-	-	-	-	-	1

Source: Salvation Army

Table 4.7.2
Salvation Army Community Life Skills Recovery Programme Performance, 2013/2014 and 2014/2015

Programme Indicators	FY 2013/2014r				FY 2014/2015			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total number of clients who participated in the programme	40	29	31	32	30	31	32	38
Number of new clients referred	3	1	2	2	2	3	2	5
Number of intakes/screenings/assessments	3	1	2	2	2	3	2	5
Number of evening groups	-	-	-	-	-	-	-	-
Clients who received crisis intervention	11	11	11	21	4	10	8	13
Families who received relapse prevention	13	3	2	2	2	1	2	4
Clients who reintegrated with families, employment, education, community	10	7	7	7	14	8	6	11
Clients who were in stable committed relationships	5	5	5	5	5	5	6	5
Clients who obtained financial stability (financial planning and banking)	8	8	7	7	7	6	6	11
Clients who opened and reactivated bank accounts	-	-	2	2	-	2	-	-
Clients with secured savings in bank accounts	8	8	7	7	7	7	7	7
Clients who made regular payments towards outstanding bills	2	2	3	3	3	3	3	3
Clients who abstained from substance abuse	33	33	31	32	28	28	26	35

Source: Salvation Army

4.8 FOCUS COUNSELLING SERVICES SUPPORTIVE RESIDENCY PROGRAMME

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

Table 4.8.1 shows the performance of the programme over the last two fiscal years. During this time, the programme operated four houses with 20- to 22-bed capacity. There were about 15 to 19 clients who were accommodated by this programme in any given quarter. At the same time, there were about two to four persons who were in pre-treatment during the first three quarters of the 2013/2014 financial years; but no others have been reported to be in pre-treatment since that time. In addition, there were about 13 to 17 after-care sessions conducted in any given three-month period offering services to between 10 and 17 clients. Random drug tests of clients show a few positive results especially for cocaine and alcohol and to a lesser extent for opiates. None of the clients tested positive for either THC or MDMA over the two year period under review.

Table 4.8.1
Focus Counselling Services Supportive Residence Programme Performance, 2012/2013 and 2013/2014

Programme Indicators	FY 2013/2014r				FY 2014/2015			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Houses	4	4	4	4	4	4	4	4
Number of Beds	20	20	22	22	22	22	22	22
Number of Clients/Occupancy	17	18	19	17	19	19	17	15
Number of Drug Tests	46	54	38	45	38	22	36	21
MDMA	-	-	-	-	-	-	-	-
THC	-	-	-	-	-	-	-	-
Opiates	3	-	1	-	2	2	1	1
Cocaine	-	1	2	2	3	-	5	2
Alcohol	4	1	4	2	2	1	3	2
Number of Pre-Treatment Clients	4	3	2	…	…	…	…	…
Number of After-Care sessions	13	13	14	13	17	13	13	13
Average Number of Participants in After-Care	13	13	16	15	13	10	17	14

Source: Focus Counselling Services

4.9 CLIENTS IN TREATMENT

Tables 4.9.1 and 4.9.2 show the number of 'unique' individuals admitted to treatment during 2014 and altogether the numbers of different persons who received treatment during that year, respectively. This is the first year these indicators are being monitored. They provide an indication of access to and availability of treatment services in Bermuda for persons with substance abuse and dependence problems. Further, it can serve as an indication as to whether or not persons assessed and referred by BARC are actually engaged in the recommended level of care. These numbers do not include any person who sought treatment or were in treatment more than once in the given year. It should be noted, however, that there were in fact a few repeat clients to the treatment services.

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

The number of new clients admitted to treatment in 2014 was 236 (203 men and 33 women) and number of persons who were in treatment, which includes any person(s) still in treatment from a previous year, together with the newly admitted persons, amounted to 497 (438 men and 59 women) during this same period (see Tables 4.9.1 and 4.9.2). As is quite noticeable, the number of males in treatment far outweigh their female counterparts. This does not mean that there are no females who need treatment; it simply means that fewer women are accessing the treatment services provided for any given reason. It is, however, known that women face certain distinctive barriers to treatment than do men. At the same time, treatment facilities also conduct intake and assessment of other persons seeking services but who may not meet the criteria for admission into a programme and, for those who do meet the criteria, but cannot be accommodated because of the facility's capacity, are placed on waiting lists. These numbers are not accounted for on the tables below. In terms of capacity and utilisation of the treatment services, the majority, of almost two-thirds, was seen by the Turning Point Substance Abuse Programme for mainly inpatient detoxification or methadone maintenance. Approximately three out of every 10 persons who were in treatment received residential care.

…the number of males in treatment far outweigh their female counterparts. … Approximately three out of every 10 persons who were in treatment received residential care.

Table 4.9.1
Number of New Treatment Admissions, 2014

Treatment Agency	Male	Female	Total
WTC	-	10	10
MT	17	-	17
Turning Point (Methadone, Inpatient, Outpatient/Detox)	134	20	154
Salvation Army Harbour Light*	16	-	16
Salvation Army Life Skills	9	3	12
Focus	16	-	16
RLH	11	-	11
TOTAL	**203**	**33**	**236**

Source: Treatment Agencies

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

Table 4.9.2
Number of Persons in Treatment, 2014

Treatment Agency	Male	Female	Total
WTC	-	12	12
MT	27	-	27
Turning Point (Methadone, Inpatient, Outpatient/Detox)	304	44	348
Salvation Army Harbour Light*	18	-	18
Salvation Army Life Skills	36	3	39
Focus	26	-	26
RLH	27	-	27
TOTAL	**438**	**59**	**497**

Source: Treatment Agencies

Chapter 5
Drug Screening Surveillance

- Illicit and Anti-Doping Tests
- Drug Screening Among Criminal Offenders
  - » Westgate Correctional Facility
  - » Prison Farm
  - » Co-Ed Facility

5.1 BERMUDA SPORT ANTI-DOPING AUTHORITY STATISTICS

Anti-Doping and Illicit Drug Use in Sports

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

It is important to note that BSADA offers two programmes – World Anti-Doping Agency (WADA) Programme and the Illicit Drug Programme.

The year 2014 saw a slight decline (from 648 in 2013 to 638) in the number of illicit drug tests administered by BSADA (see Table 5.1.1). These tests were mainly for the sports of football, track and field, and basketball. Four positive test results for THC (marijuana) were observed in 2014 compared to only one in the previous year. On the other hand, the number of anti-doping tests (of both urine and blood) increased from 49 in 2013 to 68 in 2014. Most of the tests were administered for competition purposes especially for athletics and cycling. However, no test in either year screened positive for performance enhancing drugs.

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

Table 5.1.1
Drug Testing Results at BSADA, 2013 and 2014

Year	Illicit Tests			Anti-Doping Tests	
	Number of Tests	Number of Positive		Number of Tests	Positive
		THC	Cocaine		
2013	648	1	-	49	-
2014	638	4	-	68	-

Source: BSADA

5.2 DEPARTMENT OF CORRECTIONS STATISTICS: WESTGATE CORRECTIONAL FACILITY

Drug Use among Criminal Offenders

Monthly provision of urinalysis screening results from the Westgate Correctional Facility [9] has yielded data allowing for comparison of patterns of use amongst offenders with stratified analysis according to type of drug used and whether or not persons were first-time or repeat offenders.

In 2014, 95.9% of reception inmates were screened for illicit drugs (see Table 5.2.1), 4.1% refused to participate in screening (7.5% refused in 2013), and 3.7% were released prior to specimen collection (6.0% in 2013). However, drug screening of offenders on reception increased in 2014 by 3.1% from the previous year, which saw 92.5% of specimens screened. By extension, the overall proportion of positive screens for illicit drugs increased 57.7% in 2013 to 68.1% in 2014 (see Table 5.2.2). Screening results indicated that marijuana, cocaine, and opiates, in sequential order, remained the most prevalent drugs amongst this population (see Tables 5.2.3 and 5.2.5). In 2014, a decrease by 0.6% in poly drug use, at the time of reception, was observed over the previous year (see Table 5.2.5). Random urine results provided evidence of mostly THC (marijuana) and opiate use (one positive screen) among offenders serving a sentence at Westgate Correctional Facility (see Table 5.2.4).

Of the reception inmates, the number of first-time offenders decreased from 63 (22.4%) in 2013 to 45 (20.5%) in 2014 (see Table 5.2.6). The proportion of repeat offenders received into Westgate decreased by 1.9% over the last year moving from 77.6% in 2013 to 79.5% in 2014. The urinalysis screens revealed that most repeat offenders used THC, cocaine, or opiates versus first-

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

time offenders who use mostly marijuana and a few using cocaine (see Table 5.2.7). The highest prevalence-of-use was recorded for marijuana, followed by opiates (heroin) and cocaine. When it came to poly drug use, the same number of first-timers tested positive in both 2013 and 2014. However, there were significantly more repeat offenders that were multiple substance users, at least at the time of reception (see Table 5.2.8).

…there were significantly more repeat offenders that were multiple substance users, at least at the time of reception.

Table 5.2.1
Screening Results at Reception by Number and Proportion of Inmates, 2013 and 2014

Year	Reception Inmates	Screened	Refused	Released
2013	281	260 (92.5)[r]	21 (7.5)	17 (6.0)
2014	219	210 (95.9)	9 (4.1)	8 (3.7)

Source: Westgate Correctional Facility

Table 5.2.2
Percentage of Positive Illicit Drug Screens among Prison Reception Inmates, 2013 and 2014

Year	Number of Positive Illicit Drug Screens	Percentage of Total Screens
2013	150	57.7[r]
2014	143	68.1

Source: Westgate Correctional Facility

Table 5.2.3
Drug Prevalence (Urinalysis) at Reception by Number and Proportion of Screened Offenders, 2013 and 2014

Year	Marijuana	Cocaine	Opiates	Methadone	Poly Drug Use
2013[r]	140 (53.8)	40 (15.4)	18 (6.9)	..[*]	40 (15.4)
2014	124 (59.0%)	34 (16.2)	14 (6.7)	3 (1.4)	31 (14.8)

Source: Westgate Correctional Facility

Note: Drug prevalence is derived from the number of positive results in each category compared to the overall number of offenders who were screened.

Table 5.2.4
Random Positive Urine Screens by Substance and Number and Proportion of Inmates, 2013 and 2014

	2013	2014
Overall Positive	12 (4.3)	13 (5.9)
Marijuana	12 (4.3)	12 (5.5)
Opiates	-	1(0.5)
Cocaine	-	-

Source: Westgate Correctional Facility

Table 5.2.5
Drug Prevalence at Reception by Number and Proportion of Positive Illicit Drug Screens, 2013 and 2014

Year	Marijuana	Opiates	Cocaine	Methadone	Poly Drug Use
2013	140 (93.3)	18 (12.0)	40 (26.7)	..[*]	40 (26.7)[r]
2014	124 (86.7)	34 (23.8)	14 (9.8)	3 (2.1)	31 (21.7)

Source: Westgate Correctional Facility

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

Table 5.2.6
Number and Proportion of First-Time and Repeat Offenders by Year, 2013 and 2014

Year	Category of Offenders		
	Reception inmates	First time offenders	Repeat offenders
2013	281	63 (22.4)	218 (77.6)[r]
2014	219	45 (20.5)	174 (79.5)

Source: Westgate Correctional Facility

Table 5.2.7
Any Illicit Drug Prevalence (Urinalysis) by Number and Proportion of First-Time and Repeat Offenders, 2013 and 2014

Year	Offender	Marijuana	Cocaine	Opiates
2013	Repeat offender	125 (57.3)	41 (18.8)	18 (8.3)
	First-time offender	15 (23.8)	-	-
2014	Repeat offender	100 (57.4)	11(6.3)	34 (19.5)
	First-time offender	24(53.3)	3(6.7)	-

Source: Westgate Correctional Facility

Table 5.2.8
Number of First-Time and Repeater Offenders with Poly Drug Use, 2013 and 2014

Year	First-Time Offender	Repeat Offender
2013	4	36
2014	4	27

Source: Westgate Correctional Facility

5.3 DEPARTMENT OF CORRECTIONS STATISTICS: PRISON FARM

Drug Use among Criminal Offenders

The Prison Farm is a correctional facility in Bermuda that houses adult males in a minimum security setting, with capacity for 111 inmates. During 2014, the Prison Farm collected 370 urine specimens from 371 requested compared to 358 collected from 362 requested in 2013 (see Tables 5.3.1 and 5.3.2). These specimens are collected at intervals for various types of drug tests such as randomly conducted drug tests, tests done for day or work release, and those done if drugs are suspected to be in use. Of those specimens provided in 2014, 4.3% (16) were found to be positive for an illicit substance. Specifically, 10 of the 16 positive specimens tested positive for THC, while five tested positive for opiates and one tested positive for cocaine.

Table 5.3.1
Drug Screening Results for Persons at the Prison Farm, 2013

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens		
			Total	THC	Opiates
Random	201	199	13	13	–
Day pass	40	40	–	–	–
Pre-parole	5	5	1	–	1
Suspicion	13	11	2	1	1
Spiritual pass	17	17	1	1	–
Work release	86	86	7	6	1
Total	**362**	**358**	**24**	**21**	**3**

Source: Department of Corrections

Table 5.3.2
Drug Screening Results for Persons at the Prison Farm, 2013

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

Source: Department of Corrections

5.4 DEPARTMENT OF CORRECTIONS STATISTICS: CO-ED FACILITY

Drug Use among Criminal Offenders

The Co-Ed is a correctional facility in Bermuda that houses females and juvenile offenders in a minimum security setting. During 2014, the Co-Ed facility collected 58 urine specimens from 58 requested compared to 88 requests and specimens received in 2013 (see Tables 5.4.1 and 5.4.2). These specimens are collected at intervals for various types of drug tests such as randomly conducted drug tests, tests done for day or work release, and those done if drugs are suspected to be in use. Of those specimens provided in 2014, 17.2% (10) were found to be positive for an illicit substance. Specifically, six of the 10 positive specimens tested positive for THC while three tested positive for opiates, and one tested positive for cocaine (see Table 5.4.2). In comparison, THC was present in all of the 22 specimens tested to be positive in 2013 (see Table 5.4.1).

Table 5.4.1
Drug Screening Results for Persons at the Co-Ed Facility, 2013

Type of Test	Specimens Requested	Specimens Provided	Number of Positive Specimens		
			Total	THC	Opiates
Random	61	61	8	8	-
Day Release	6	6	1	1	-
Parole	3	3	-		-
Suspicion	14	14	13	13	-
Work Detail	-	-	-	-	-
School Pass	-	-	-	-	-
Work Release	**4**	**4**	**-**	**-**	**-**
Total	**88**	**88**	**22**	**22**	**-**

Source: Department of Corrections

Table 5.4.2
Drug Screening Results for Persons at the Co-Ed Facility, 2014

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

Source: Department of Corrections

Chapter 6
Impaired Driving

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

6.1 BLOOD ALCOHOL CONCENTRATION

Blood Alcohol Levels of Motorists

The proportion of alcohol to blood in the body is expressed as the blood alcohol concentration (BAC). In the field of traffic safety, BAC is expressed as the percentage of alcohol in decilitres of blood, for example, 0.08 percent (that is, 0.08 grams per decilitre or 80 mg/100 dl). Research has documented that the risk of a motor vehicle crash increases as BAC increases and that the more demanding the driving task, the greater the impairment caused by low doses of alcohol. Compared with drivers who have not consumed alcohol, the risk of a single-vehicle fatal crash for drivers with BAC between 0.02 and 0.04 percent is estimated to be 1.4 times higher; for those with BAC between 0.05 and 0.09 percent, 11.1 times higher; for drivers with BAC between 0.10 and 0.14 percent, 48 times higher; and for those with BAC at or above 0.15 percent, the risk is estimated to be 380 times higher.[10]

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

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

In 2014, there has been a considerable decline in the number of persons who were stopped to undertake a breathalyser test, when compared to 2013. This trend is consistent with the gradual decline observed over the last few years. Specifically, in 2014, 131 persons were stopped to undertake a breathalyser test compared to 227 in the previous year (see Table 6.1.1). However, not all of the persons who were stopped agreed to undertake a breathalyser test; in fact, quite a number of them refused to do so, since breathalyser testing is not mandatory, not even when there has been an accident.

…quite a number of them refused to do so, since breathalyser testing is not mandatory, not even when there has been an accident.

A larger number of males (172 in 2013 and 88 in 2014) provided a sample for testing compared to females (15 in 2013 and 10 in 2014); however, in general, more males were stopped than females. In general, most persons failed the breathalyser test, irrespective of whether they were male or female. For instance, of those who provided a breathalyser sample, 131 out of 187 and 79 out of 98 failed in 2013 and 2014, respectively (with 34 in 2013 and 17 in 2014 passing the breathalyser test).

Overall, the mean BAC reading for all samples provided increased from 151 mg/dl in 2013 to 156 mg/dl in 2014 (see Table 6.1.2). At the same time, the mean BAC reading for individuals who failed the breathalyser test also increased from 179 mg/dl in 2013 to 181 mg/dl in 2014. In instances where there were accidents, the average BAC was significantly above the legal limit. In 2013, the mean failed BAC where there were accidents was recorded at 182 mg/dl and somewhat lower at 168 mg/dl in 2014. There were also instances where accidents occurred and the average BAC was under the legal limit – 45 mg/dl in 2013 and 27 mg/dl in 2014. As a reminder, the alcohol limit in Bermuda is less than 80 mg/dl. Breathalyser readings, nonetheless, ranged from 0 to 365 mg/dl in 2013 and 0 to 316 mg/dl in 2014 equivalent to as much as over four times the legal limit. On average, the majority of persons who failed the breathalyser test were two to three times above the legal limit in both 2013 and 2014 (see Table 6.1.3). Only 18% (34) of those who were tested in 2013 were within the legal limit compared to 16% 16) in 2014. In both 2013 and 2014, there were a few instances where accidents occurred and the corresponding breathalyser readings were as much as three to four times above the legal limit.

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

Table 6.1.1
Impaired Driving Incidences by Sex and Breathalyser Results, 2013 and 2014

Year	Number of Persons Stopped	Gave Sample					Male		Female	
		Total	Male	Female	Failed	Passed	Failed	Passed	Failed	Passed
2013	**227**	**187[r]**	**172[r]**	**15**	**131**	**34**	**118**	**33**	**13**	**1**
Q1	79	61	56[1]	5	44	11	39	11	5	-
Q2	50	42[r]	39[2r]	3	26	9	23	9	3	-
Q3	47	42	39[3r]	3[4]	30	7	28	7	2	-
Q4	51	42[r]	38[2r]	4	31	7	28	6	3	1
2014	**131**	**98**	**88[5]**	**10[5]**	**79**	**17**	**70**	**17**	**9**	**-**
Q1	22	14	10	4[5]	10	3	7	3	3	-
Q2	29	23	22[5]	1	19	3	18	3	1	-
Q3	42	35	34	1	28	7	27	7	1	-
Q4	38	26	22	4	22	4	18	4	4	-

Source: Bermuda Police Service

Notes:

[1] One blood sample for which there was no result, four incomplete, and one invalid result.
[2] Four incomplete.
[3] Two blood samples for which there were no results, one incomplete, and one interference.
[4] One invalid result.
[5] One incomplete.

Table 6.1.2
Breathalyser Readings for Impaired Driving Incidences, 2013 and 2014

	2013					2014				
	Q1	Q2	Q3	Q4	Year	Q1	Q2	Q3	Q4	Year
Mean Reading: All Breathalyser Samples	145	152	158*	152	**151***	120	156*	155	175	**156***
Mean Reading: Failed Breathalyser Samples	174	188	179	180	**179**	148	167	190	195	**181**
Mean Reading: Failed Breathalyser Samples of Males	174	190	177	176	**178**	144	165	191	193	**180**
Mean Reading: Failed Breathalyser Samples of Females	172	176r	217	214	**189**	156	204	167	209	**186**
Mean Reading: Accident with Failed Breathalyser Samples	183	201	162	180	**182**	120	150	176	201	**168**
Mean Reading: Accident with Passed Breathalyser Samples	58	37	54	42	**45**	9	-*	37	-	**27***
Range of Reading: Failed Breathalyser Samples	83-318	81-365	97-326	85-276	**81-365**	81-225	86-280	86-293	104-316	**81-316**
Range of Reading: Passed Breathalyser Samples	0-58	0-78	14-78	0-68	**0-78**	7-70	35-68	0-73	45-75	**0-75**

Source: Bermuda Police Service

Notes:

Readings in mg/dl.
[*] Reading was not recorded for one passed breathalyser test and therefore not included in the average.
[1] In Q1 2013, there were 20 accidents of which 14 had a failed BAC level, one passed, one blood sample for which there was no result, one incomplete, and three refusals of the breathalyser test. In Q1 2014, there were 10 accidents of which three had a failed BAC level, one passed, one incomplete, and five refusals of the breathalyser test.
[2] In Q2 2013, there were 15 accidents of which nine had a failed BAC level, three passed, two refusals of the breathalyser test, and one for which no information was provided. In Q2 2014, there were 10 accidents of which eight had a failed BAC level, one passed, and one has an incomplete reading.
[3] In Q3 2013, there were 16 accidents of which eight had a failed BAC level, three passed, two were blood samples for which there were no results, one was incomplete, and two refusals of the breathalyser test. In Q3 2014, there were 12 accidents of which nine had a failed BAC level, two passed, and one refusal of the breathalyser test.
[4] In Q4 2013, there were 14 accidents of which eight had a failed BAC level, four passed, one for which no information was provided, and one refusal of the breathalyser test. In Q4 2014, there were nine accidents of which seven had a failed BAC level and two refusals of the breathalyser test.

Table 6.1.3
Number of Breathalyser Sample Readings by Limit, 2013 and 2014

Year	Within Limit	1-2 Times Above Limit	2-3 Times Above Limit	3-4 Times Above Limit	4+ Times Above Limit
2013	**34**	**53**	**60**	**15**	**3**
Q1	11	19	19	6	-
Q2	9	10	12	2	2
Q3	7*	14	11	4	1
Q4	7	10	18	3	-

Source: Bermuda Police Service

Table 6.1.3 cont'd
Number of Breathalyser Sample Readings by Limit, 2013 and 2014

Year	Within Limit	1-2 Times Above Limit	2-3 Times Above Limit	3-4 Times Above Limit	4+ Times Above Limit
Male	33*r	50	52	13	3
Female	1r	3	8	2	-
Accident+	11	16	19	3	1
2014	16	27	40	12	-
Q1^	3	6	4	-	-
Q2^	2*	8	8	3	-
Q3	7	8	16	4	-
Q4	4	5	12	5	-
Male	16	25	34	11	-
Female	-	2	6	1	-
Accident++	3	12	13	2	-

Source: Bermuda Police Service

Notes:
* Reading was not recorded for one passed test.
^ One reading was incomplete.
+ There were 15 other accidents in 2013 for which a result was not available (refused, incomplete, blood sample).
++ There were 11 other accidents in 2014 for which a result was not available (refused, incomplete, unrecorded result).

6.2 DUI EDUCATIONAL PROGRAMME STATISTICS

Counselling and Treatment for DUI Offenders

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

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

Over the last two years, a number of inquiries have been made into this programme – 59 in 2013 and 37 in 2014 (see Table 6.2.1). However, of these inquiries, only 41 and 31 persons participated in the programme in 2013 and 2014, respectively. Most of the participants in either year were males (see Table 6.2.2). In 2013 most of the participants were 22 to 25 or 36 to 40 years as compared to 2013 where most were 31 to 35, 41 to 45, or over 50 years (see Table 6.2.2). Participants of the programme are assessed for chemical dependency and addictive behaviours using the Triage Assessment for Addictive Disorders (TAAD). The results of the TAAD showed that more persons in 2013 were assessed as abusers or misusers (using the DSM IV criteria) of alcohol compared to the programme participants in 2014 where the majority of persons were considered to be in the early dependence stage, a component of severe diagnosis (using the DSM V criteria) (see Table 6.2.3). Specifically, in 2013, 32% (13) of the participants misused alcohol, 41% (17) abused alcohol, and 17% (7) were in the early dependence stage. In comparison, 16% (5) of the participants in 2014 were diagnosed as mild, another 16% (5) as moderate, and 39% (12) were judged to be in the early dependence stage. All of the persons who attended the programme completed it at which time they are given a certificate which indicates that he/she has completed all aspects of the Level 1 DUI Programme.

Table 6.2.1
DUI Education Classes' Inquiries and Participants, 2013 and 2014

	2013	2014
Number of inquiries	59	37
Number of participants	41	31

Source: Bermuda Professional Counselling Services

Table 6.2.2
DUI Programme Participants' Statistics, 2013 and 2014

Year	Sex		Age							
	Male	Female	17 – 21	22 – 25	26 – 30	31 – 35	36 – 40	41 – 45	46 – 50	50+
2013	40	1	3	7	6	5	7	4	5	4
2014	25	6	-	4	1	7	5	7	-	7

Source: Bermuda Professional Counselling Services

Note: In both years all participants have completed the programme.

Table 6.2.3
TTriage Assessment for Addictive Disorders Results by Number of Participants, 2013 and 2014

TAAD Scores*		2013*	2014
No Diagnosis		-	6
Mild		13	5
Moderate		17	5
Severe	Early Dependence	7	12
	Mid to Late Dependence	4	3
TOTAL		**41**	**31**

Source: Bermuda Professional Counselling Services

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

Chapter 7
Health

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

7.1 DRUG-RELATED INFECTIOUS DISEASES

One of the more serious health consequences of the use of illicit drugs, and in particular of drug injection, is the transmission of HIV and other infectious diseases, notably hepatitis B and C. They may have the largest economic impact on health care systems of all consequences of drug use, even in countries where HIV prevalence in intravenous drug users (IDUs) is low. The relationship between intravenous drug use and the transmission of infection is well established. Reducing intravenous drug use and the sharing of injecting equipment has therefore become a primary goal of public health interventions in this area. Studies also point to a relationship between drug use and high-risk sexual activity; this suggests a growing importance in linking drug use interventions with public health strategies aimed at sexual health.[11]

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

Prevalence of drug-related infectious diseases was non-existent in 2013. However, in 2014, there were reported cases of drug-related hepatitis B and C, as evident by the one of eight and four of eight reported cases, respectively. Reports on these cases indicate a history or current use of injection drugs. No case of HIV or AIDS, related to drug use, was recorded in either of 2013 or 2014 (see Table 7.1.1).

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

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

Table 7.1.1
Drug-Related Infectious Diseases, 2013 and 2014

Infection	2013		2014	
	Number of Cases	Number of ATOD-Related Cases	Number of Cases	Number of ATOD-Related Cases
HIV	7	-	7	-
AIDS	3	-	1	-
Hepatitis B*	1	-	8	1
Hepatitis C**	19	…	8	4
Chlamydia	321	…	312	…
Gonorrhoea	40	…	25	…
Herpes	76	…	72	…
Syphilis	11	…	7	…

Source: Epidemiology & Surveillance

Notes: * Hepatitis B is a vaccine-preventable disease in Bermuda and is in Bermuda's immunisation schedule; therefore, the vast majority of hepatitis B cases is imported from countries where hepatitis B is endemic and is not related to local drug-use.
** Almost all (>90%) of Hepatitis C cases are local and related to injection drug use.

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

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

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

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

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

King Edward Memorial VII Hospital reported a small number of inpatient cases for which drugs were the primary diagnosis during 2013 (7) and 2014 (2) (see Tables 7.2.1 and 7.2.2). Similarly, inpatient cases in which poisoning and toxic effects were the primary diagnosis, more than doubled from 14 cases in 2013 to 30 cases in 2014 (see Tables 7.2.3 and 7.2.4). Regarding secondary diagnosis cases, 1,126 cases were reported for inpatient drug-related cases in 2013 compared to 1,225 cases in 2014 (see Tables 7.2.5 and 7.2.6). Secondary diagnoses of greatest occurrence were for conditions such as tobacco use disorder, chronic alcohol dependence, and cannabis abuse; a similar trend as in previous years. Secondary diagnoses for inpatient drug-related cases over the combined years of 2013 and 2014 were more prevalent to males (1,619) than females (552). In 2013, there were 10 cases of secondary diagnosis of inpatient cases of poisoning and toxic effects of substances, while in 2014 there were 16 cases (see Tables 7.2.7 and 7.2.8).

Table 7.2.1
Primary Diagnoses of Inpatient Drug-Related Cases, 2013*

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other
Acute Alcoholic Intoxication – Continuous	5	1	-	-	-	-	4	2	2	4	-
Opioid Type Dependence – Continuous	1	-	-	-	-	-	1	-	1	-	-
Alcohol Abuse – Unspecified	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**6**	**1**	**-**	**-**	**-**	**-**	**5**	**2**	**3**	**4**	**-**

Source: King Edward VII Memorial Hospital

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

Table 7.2.2
Primary Diagnoses of Inpatient Drug-Related Cases, 2014*

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other
Acute Alcoholic Intoxication – Continuous	-	-	-	-	-	-	-	-	-	-	-
Opioid Type Dependence – Continuous	-	1	-	-	1	-	-	-	1	-	-
Alcohol Abuse – Unspecified	1	-	-	-	1	-	-	-	1	-	-
TOTAL	**1**	**1**	**-**	**-**	**2**	**-**	**-**	**-**	**2**	**-**	**-**

Source: King Edward VII Memorial Hospital

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

Table 7.2.3
Primary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2013

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other
Poisoning – Insulin & Antidiabetic Agents	1	-	-	-	-	-	-	1	1	-	-
Poisoning – Propionic Acid Derivatives	-	2	2	-	-	-	-	-	2	-	-
Poisoning – Anticonvulsants	-	1	-	-	1	-	-	-	1	-	-
Poisoning – Aromatic Analgesics Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Propionic Acid Derivatives	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Other Antirheumatics	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Central Nervous System Muscle Depressants	-	1	-	-	-	1	-	-	1	-	-
Poisoning – Phenothiazine Tranquillisers	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Antipsychotic Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Benzodiazepine-Based Tranquilisers	1	2	-	-	-	-	-	3	1	2	-
Poisoning – Hallucinogens	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Selective Serotonin Reuptake Inhibitors	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Antidepressant Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Central Nervous System Stimulants - Crack	-	2	-	-	-	-	1	1	2	-	-
Poisoning – Cocaine	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Parasympathomimetic	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Cardiotonics Glycosides	1	-	1	-	-	-	-	-	-	1	-
Poisoning – Gastrointestinal Agents Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Uric Acid Metabolism Drugs	-	1	-	-	1	-	-	-	1	-	-

Table 7.2.3 cont'd
Primary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2013

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18–25 Yrs	26–35 Yrs	36–45 Yrs	46–60 Yrs	61+ Yrs	Black	White	Other
Poisoning – Antitussives	1	-	-	1	-	-	-	-	1	-	-
Toxic Effect – Ethyl Alcohol	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Carbon Monoxide	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Berry/Plant Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Pesticides Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Caustic Unspecified	-	1	-	-	-	-	-	-	-	1	-
TOTAL	**4**	**10**	**4**	**1**	**2**	**1**	**1**	**5**	**10**	**4**	**-**

Source: King Edward VII Memorial Hospital

Table 7.2.4
Primary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2014

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other
Poisoning – Insulin & Antidiabetic Agents	1	2	-	-	-	-	2	1	2	-	-
Poisoning – Propionic Acid Derivatives	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Anticonvulsants	1	-	-	-	-	-	-	1	-	1	-
Poisoning – Arommatic Analgesics Not Elsewhere Classified	2	3	2	-	1	-	2	-	2	3	-
Poisoning – Propionic Acid Derivatives	-	1	1	-	-	-	-	-	1	-	-
Poisoning – Other Antirheumatics	1	-	-	-	-	-	1	-	-	1	-
Poisoning – Central Nervous System Muscle Depressants	2	-	-	-	-	1	-	1	1	1	-
Poisoning – Phenothiazine Tranquillisers	1	-	-	-	-	-	1	-	1	-	-
Poisoning – Antipsychotic Not Elsewhere Classified	1	-	-	-	-	-	-	1	1	-	-
Poisoning – Benzodiazepine-Based Tranquilisers	1	1	-	-	-	-	1	1	-	2	-
Poisoning – Hallucinogens	-	1	1	-	-	-	-	-	1	-	-
Poisoning – Selective Serotonin Reuptake Inhibitors	-	1	1	-	-	-	-	-	1	-	-
Poisoning – Antidepressant Not Elsewhere Classified	-	3	-	-	1	-	2	-	1	1	1
Poisoning – Central Nervous System Stimulants - Crack	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Cocaine	-	1	-	-	-	-	-	1	1	-	-
Poisoning – Parasympathomimetic	-	1	-	-	-	-	-	1	1	-	-
Poisoning – Cardiotonics Glycosides	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Gastrointestinal Agents Not Elsewhere Classified	1	-	1	-	-	-	-	-	1	-	-
Poisoning – Uric Acid Metabolism Drugs	-	-	-	-	-	-	-	-	-	-	-
Poisoning – Antitussives	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect – Ethyl Alcohol	-	1	-	-	-	-	-	1	1	-	-
Toxic Effect – Carbon Monoxide	1	1	-	-	-	-	-	2	2	-	-
Toxic Effect – Berry/Plant Not Elsewhere Classified	1	-	1	-	-	-	-	-	-	1	-
Toxic Effect – Pesticides Not Elsewhere Classified	1	-	-	-	-	-	1	-	1	-	-
Toxic Effect – Caustic Unspecified											
TOTAL	**14**	**16**	**7**	**-**	**2**	**1**	**10**	**10**	**18**	**11**	**1**

Source: King Edward VII Memorial Hospital

Table 7.2.5
Secondary Diagnoses of Inpatient Drug-Related[*] Cases, 2013

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other[+]
Acute Alcoholic Intoxication - Continuous	7	2	-	-	1	-	5	3	6	3	-
Acute Alcoholic Dependence	23	4	-	2	-	3	12	10	19	8	-
Chronic Alcohol Dependence - Continuous	145	26	1	5	17	25	58	65	107	60	-
Chronic Alcohol Dependence - In Remission	2	-	-	-	-	-	1	1	2	-	-
Opioid Type Dependence - Unspecified	6	2	-	-	-	1	6	1	6	2	-
Opioid Dependence - Continuous	20	2	-	-	-	1	6	1	6	2	-
Opioid Type Dependence - In Remission	3	2	-	-	-	-	5	-	4	1	-
Cocaine Dependence - Unspecified	1	-	-	-	-	-	1	-	1	-	-
Cocaine Dependence - Continuous	11	4	-	-	-	5	10	-	14	1	-
Cocaine Dependence - In Remission	-	1	-	-	-	-	1	-	1	-	-
Cannabis Dependence - Unspecified	2	1	-	1	1	-	1	-	3	-	-
Cannabis Dependence - Continuous	4	-	-	-	-	1	3	-	4	-	-
Other Specified Drug Dependence - Unspecified	-	1	-	-	-	-	1	-	-	1	-
Opioid/Other Dependence - Continuous	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Dependence - Continuous	1	-	-	-	-	1	-	-	1	-	-
Alcohol Abuse - Unspecified	26	7	-	3	7	5	13	5	25	7	1
Alcohol Abuse - Continuous	18	3	-	4	7	3	5	2	16	4	1
Alcohol Abuse - Episodic	1	-	-	-	1	-	-	-	1	-	-
Alcohol Abuse - In Remission	2	2	-	-	-	1	1	2	3	1	-
Tobacco Use Disorder	376	186	1	28	80	91	223	139	403	145	14
Cannabis Abuse - Unspecified	30	11	-	7	18	6	7	3	37	4	-
Cannabis Abuse - Continuous	99	23	1	25	30	30	32	4	110	11	1
Cannabis Abuse - Episodic	18	8	-	4	8	3	8	3	21	5	-
Cannabis Abuse - In Remission	1	1	-	-	-	1	1	-	2	-	-
Opioid Abuse - Unspecified	2	-	-	-	-	1	1	-	2	-	-
Opioid Abuse - Continuous	2	-	-	-	-	1	1	-	2	-	-
Opioid Abuse - Episodic	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse - In Remission	3	-	-	-	-	-	1	2	3	-	-
Cocaine Abuse	11	2	-	1	1	2	8	2	12	2	-
Cocaine Abuse - Continuous	5	5	-	-	1	2	5	2	9	1	-
Cocaine Abuse - In Remission	3	5	-	-	-	1	5	2	8	-	-
Amphetamine Abuse	-	-	-	-	-	-	-	-	-	-	-
Amphetamine or Related Acting Sympathomimetic Abuse – Episodic	-	1	1	-	-	-	-	-	1	-	-
Other, Mixed, or Unspecified Drug Abuse - Unspecified	2	1	-	-	-	-	3	-	3	-	-
Other, Mixed, or Unspecified Drug Abuse - Continuous	-	1	-	-	-	-	-	1	-	1	-
Other, Mixed, or Unspecified Drug Abuse - In Remission	-	1	-	-	-	-	-	1	-	1	-
TOTAL	**824**	**302**	**4**	**80**	**173**	**188**	**430**	**251**	**846**	**259**	**21**

Source: King Edward VII Memorial Hospital

Notes:

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

Table 7.2.6
Secondary Diagnoses of Inpatient Drug-Related[*] Cases, 2014

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other[+]
Acute Alcoholic Intoxication - Continuous	4	1	-	-	-	-	3	2	2	3	-
Acute Alcoholic Dependence	12	-	-	-	1	-	2	-	10	2	-
Chronic Alcohol Dependence - Continuous	148	29	-	4	28	25	65	55	118	56	3
Chronic Alcohol Dependence - In Remission	8	-	-	-	-	1	3	4	3	5	-
Opioid Type Dependence - Unspecified	2	3	-	-	2	-	2	1	4	1	-
Opioid Dependence - Continuous	19	3	-	-	2	4	14	2	18	4	-
Opioid Type Dependence - In Remission	7	-	-	-	-	2	4	1	7	-	-
Cocaine Dependence - Unspecified	-	-	-	-	-	-	-	-	-	-	-
Cocaine Dependence - Continuous	13	4	-	-	1	4	9	3	17	-	-
Cocaine Dependence - In Remission	1	1	-	-	-	-	2	-	2	-	-
Cannabis Dependence - Unspecified	-	-	-	-	-	-	-	-	-	-	-
Cannabis Dependence - Continuous	1	1	-	-	1	-	-	1	2	-	-
Other Specified Drug Dependence - Unspecified	-	-	-	-	-	-	-	-	-	-	-
Opioid/Other Dependence - Continuous	1	-	-	-	-	1	-	-	1	-	-
Unspecified Drug Dependence - Continuous	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse - Unspecified	18	2	-	4	3	3	7	3	14	6	-
Alcohol Abuse - Continuous	28	2	1	1	8	4	13	3	17	10	3
Alcohol Abuse - Episodic	1	-	-	-	-	-	-	1	1	-	-
Alcohol Abuse - In Remission	3	1	-	-	-	-	3	1	2	2	-
Tobacco Use Disorder	368	152	1	18	55	68	194	184	385	123	12
Cannabis Abuse - Unspecified	18	6	-	6	6	2	8	2	21	3	-
Cannabis Abuse - Continuous	96	25	2	20	22	31	35	11	108	13	-
Cannabis Abuse - Episodic	11	8	-	5	4	2	5	3	15	4	-
Cannabis Abuse - In Remission	7	2	-	-	-	-	6	3	7	2	-
Opioid Abuse - Unspecified	3	1	-	1	-	-	3	-	3	1	-
Opioid Abuse - Continuous	2	-	-	-	-	-	2	-	2	-	-
Opioid Abuse - In Remission	4	-	-	-	-	-	2	2	4	-	-
Cocaine Abuse	5	1	-	-	-	-	5	1	6	-	-
Cocaine Abuse - Continuous	4	2	-	-	-	-	5	1	5	1	-
Cocaine Abuse - Episodic	1	1	-	-	-	-	2	-	2	-	-
Cocaine Abuse - In Remission	8	3	-	-	-	-	8	3	10	1	-
Amphetamine Abuse - Continuous	-	1	-	-	1	-	-	-	1	-	-
Amphetamine or Related Acting Sympathomimetic Abuse - Episodic	-	-	-	-	-	-	-	-	-	-	-
Other, Mixed, or Unspecified Drug Abuse - Unspecified	1	1	-	1	-	-	-	1	2	-	-
Other, Mixed, or Unspecified Drug Abuse - Continuous	1	-	-	-	-	1	-	-	1	-	-
Other, Mixed, or Unspecified Drug Abuse - In Remission	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**795**	**250**	**4**	**60**	**134**	**148**	**402**	**297**	**790**	**237**	**18**

Source: King Edward VII Memorial Hospital

Notes:

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

Table 7.2.7
Secondary Diagnoses of Inpatient Cases of Poisoning and Toxic Effects of Substances, 2013

Secondary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other*
Poisoning - Antineoplatic & Immunosuppresive Drugs	-	1	-	-	1	-	-	-	1	-	-
Poisoning - Anticoagulants	1	-	-	-	-	-	-	1	1	-	-
Poisoning - Salicylates	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticonvulsants Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Heroin	-	1	-	-	-	1	-	-	1	-	-
Poisoning - Methadone	1	-	-	-	1	-	-	-	1	-	-
Poisoning - Propionic Acid Derivatives	-	1	-	-	-	1	-	-	1	-	-
Poisoning - Other Antirheumatics	-	1	-	-	1	-	-	-	1	-	-
Poisoning - Unspecified Sedative or Hypnotics	-	1	-	-	-	-	-	1	-	1	-
Poisoning - Central Nervous System Muscle Depressants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressants	-	1	-	-	-	-	1	-	-	1	-
Poisoning - Antidepressants Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Benzodiazepine-Based Tranquilisers	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Psychotropic Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Diuretics Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Electrollytic, Caloric, and Water-Balanced Agents	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cocaine	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Ethyl Alcohol	-	1	-	-	-	1	-	-	1	-	-
Toxic Effect - Alcohol Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Benzene	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Venom	-	1	-	-	-	-	1	-	1	-	-
TOTAL	**2**	**8**	**-**	**-**	**3**	**3**	**2**	**2**	**8**	**2**	**-**

Source: King Edward VII Memorial Hospital

Table 7.2.8
Secondary Diagnoses of Inpatient Drug-Related® Cases, 2014

Secondary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other*
Poisoning - Antineoplatic & Immunosuppresive Drugs	-	1	-	-	-	-	1	-	-	1	-
Poisoning - Anticoagulants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Salicylates	-	1	1	-	-	-	-	-	1	-	-
Poisoning - Anticonvulsants Not Elsewhere Classified	-	1	-	-	-	-	1	-	-	1	-
Poisoning - Heroin	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Methadone	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Propionic Acid Derivatives	-	1	-	-	1	-	-	-	-	-	1
Poisoning - Other Antirheumatics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Unspecified Sedative or Hypnotics	-	1	-	-	-	-	1	-	-	1	-
Poisoning - Central Nervous System Muscle Depressants	-	1	1	-	-	-	-	-	1	-	-
Poisoning - Antidepressants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressants Not Elsewhere Classified	-	1	-	-	-	1	-	-	-	1	-
Poisoning - Benzodiazepine-Based Tranquilisers	-	2	-	-	-	1	1	-	-	2	-
Poisoning - Psychotropic Not Elsewhere Classified	-	1	-	-	-	1	-	-	-	1	-
Poisoning - Diuretics Not Elsewhere Classified	1	-	-	-	-	-	-	1	-	1	-
Poisoning - Electrollytic, Caloric, and Water-Balanced Agents	1	-	-	-	-	-	1	-	-	1	-

Source: King Edward VII Memorial Hospital

Table 7.2.8 cont'd
Secondary Diagnoses of Inpatient Drug-Related Cases, 2013*

Secondary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other+
Poisoning - Cocaine	1	-	-	-	-	-	1	-	1	-	-
Toxic Effect - Ethyl Alcohol	1	-	-	-	-	1	-	-	1	-	-
Toxic Effect - Alcohol Not Elsewhere Classified	1	-	-	-	-	-	1	-	-	1	-
Toxic Effect - Benzene	1	-	-	-	-	-	1	-	1	-	-
Toxic Effect - Venom	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**6**	**10**	**2**	**-**	**1**	**4**	**8**	**1**	**5**	**10**	**1**

Source: King Edward VII Memorial Hospital

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

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

The emergency room saw 97 cases in 2013 in which the primary diagnosis was related to drugs and 125 cases in 2014 (see Tables 7.3.1 and 7.3.2). The main primary diagnosis was for alcohol abuse. Emergency room cases in which poisoning and toxic effects were the primary diagnosis and saw 148 cases in 2013 compared to 157 cases in 2014 (see Tables 7.3.3 and 7.3.4). In 2013, there was an overall total of 329 cases reported to the emergency room for which there was a drug-related secondary diagnosis compared to 454 cases in 2014 (see Tables 7.3.5 and 7.3.6); with significantly more cases of males than females. The secondary diagnoses for the majority of drug-related cases in both years were due to tobacco use disorder, alcohol abuse, and acute alcoholic dependence. When it came to secondary diagnosis of emergency room cases of poisoning and toxic effects of substances, 19 cases presented in 2013 and slightly more cases (26) were seen in 2014 (see Tables 7.3.7 and 7.3.8); with more incidents occurring to females versus males.

Table 7.3.1
Primary Diagnoses of Emergency Room (ER) Drug-Related Cases, 2013*

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other+
Acute Alcoholic Intoxication	3	1	-	1	-	1	1	1	1	2	1
Acute Alcoholic Intoxication – Continuous	2	-	-	-	-	-	1	1	1	1	-
Acute Alcoholic Dependence	1	-	-	-	-	-	-	1	-	1	-
Other & Unspecified Alcohol Dependence	2	-	-	-	-	-	-	2	-	2	-
Opioid Type Dependence	3	-	-	-	-	-	3	-	3	-	-
Opioid Dependence – Continuous	1	-	-	-	-	1	-	-	-	1	-
Other Specified Drug Dependence – Unspecified Use	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Dependence – Unspecified Use	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse	52	28	11	17	15	10	17	10	42	32	6
Alcohol Abuse – Continuous Drinking Behaviour	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse – Episodic	1	-	-	-	-	-	1	-	1	-	-
Cannabis Abuse – Unspecified Use	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse – Unspecified Use	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse	2	-	-	-	-	2	-	-	2	-	-
Other, Mixed, or Unspecified Drug Abuse	-	1	-	-	-	-	1	-	-	1	-
Other, Mixed, or Unspecified Drug Abuse – Continuous Use	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**67**	**30**	**11**	**18**	**15**	**14**	**24**	**15**	**50**	**40**	**7**

Source: King Edward VII Memorial Hospital

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

Table 7.3.2
Primary Diagnoses of Emergency Room Drug-Related Cases, 2014*

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other+
Acute Alcoholic Intoxication	6	-	-	1	-	-	3	2	5	1	-
Acute Alcoholic Intoxication – Continuous	3	-	-	-	-	-	1	2	1	2	-
Acute Alcoholic Dependence	-	-	-	-	-	-	-	-	-	-	-
Other & Unspecified Alcohol Dependence	-	-	-	-	-	-	-	-	-	-	-
Opioid Type Dependence	1	-	-	-	-	-	-	1	-	1	-
Opioid Dependence – Continuous	4	-	-	-	-	3	-	1	2	2	-
Other Specified Drug Dependence – Unspecified Use	1	-	-	-	-	1	-	-	1	-	-
Unspecified Drug Dependence – Unspecified Use	1	-	-	-	-	-	1	-	1	-	-
Alcohol Abuse	61	31	7	22	21	12	19	11	59	28	5
Alcohol Abuse – Continuous Drinking Behaviour	2	-	-	-	-	-	1	1	2	-	-
Alcohol Abuse – Episodic	-	-	-	-	-	-	-	-	-	-	-
Cannabis Abuse – Unspecified Use	1	2	-	3	-	-	-	-	2	1	-
Opioid Abuse – Unspecified Use	5	-	-	-	-	3	2	-	4	1	-
Cocaine Abuse	2	-	-	-	-	1	-	1	2	-	-
Other, Mixed, or Unspecified Drug Abuse	2	2	-	-	1	2	-	1	2	2	-
Other, Mixed, or Unspecified Drug Abuse – Continuous Use	1	-	-	1	-	-	-	-	1	-	-
TOTAL	**90**	**35**	**7**	**27**	**22**	**22**	**28**	**19**	**83**	**37**	**5**

Source: King Edward VII Memorial Hospital

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

Table 7.3.3
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2013

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other+
Poisoning - Penicillins	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Specified Antibiotics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Sulfonamides	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anti-Infectives	-	2	-	-	-	1	-	1	2	-	-
Poisoning - Ovarian Hormone	1	-	1	-	-	-	-	-	1	-	-
Poison - Insulin & Antidiabetic Agents	1	1	-	-	-	1	1	-	1	1	-
Poisoning - Thyroid Derivatives	-	1	1	-	-	-	-	-	-	1	-
Poisoning - Antiallergic & Antiemeticm Drugs	1	1	-	1	-	1	-	-	1	1	-
Poisoning - Vitamins	2	-	2	-	-	-	-	-	2	-	-
Poisoning - Opium	1	-	-	-	-	-	1	-	1	-	-
Poisoning - Codeine, Meperidine, Morphine	2	1	-	-	-	1	2	-	3	-	-
Poisoning - Aromatic Analgesics	3	2	3	1	-	-	-	1	4	1	-
Poisoning - Propionic Acid Derivatives	1	4	3	-	-	-	2	-	3	1	1
Poisoning - Other Anti-Rheumatics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Hydantoin Derivatives	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticonvulsants	-	1	-	-	1	-	-	-	1	-	-
Poisoning - Other Sedative or Hypnotics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Central Nervous System Muscle Depressants	-	1	-	-	-	1	-	-	1	-	-
Poisoning - Selective Serotonin Reuptake Inhibitors	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Antidepressant	2	1	1	-	-	1	-	1	3	-	-

Table 7.3.3 cont'd
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2013

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other*
Poisoning - Butyrophenome-Based Tranquilisers	-	1	-	-	-		1	-	-	1	-
Poisoning - Antipsychotic, Neuroleptic, & Major Tranquilisers	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Benzodiazepine-Based Tranquilisers	1	3	-	-	1	1	-	2	1	3	-
Poisoning - Hallucinogens	-	1	-	-	1	-	-	-	1	-	-
Poisoning - Sympatholytics (Antiadrenergics)	1	-	-	-	-	-	-	1	1	-	-
Poisoning - Cardiac Rhythm Regulators	-	1	-	-	1	-	-	-	-	1	-
Poisoning - Cardiotonics Glycosides	1	-	1	-	-	-	-	-	-	1	-
Poisoning - Antilipemic & Antiarteriosclerotic Drugs	-	1	1	-	-	-	-	-	1	-	-
Poisoning - Coronary Vasodilators	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidiarrheal Drugs	-	1	1	-	-	-	-	-	-	1	-
Poisoning - Gastrointestinal Agents	-	1	-	-	-	-	1	-	1	-	-
Poisoning - Purine Derivative Diuretics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Saluretics	1	-	-	-	-	1	-	-	1	-	-
Poisoning - Uric Acid Metabolism Drugs	1	1	1	-	1	-	-	-	1	1	-
Poisoning - Skeletal Muscle Relaxants	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Expectorants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anti-Asthmatics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Local Anti-Infective & Anti-Inflammatory Drugs	-	1	-	-	-	-	-	1	-	-	1
Poisoning - Antipruritics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Emollients, Demulcents & Protectants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Keratolytics, Keratoplastics, Other Hair Treatment Drugs and Preparations	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anti-Infectives and Other Drugs and Preparations for Ear, Nose, and Throat	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Agents Affecting Skin& Mucous Membrane	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Other Specified Drugs or Medicinal Substances	-	1	1	-	-	-	-	-	1	-	-
Poisoning - Unspecified Drugs or Medicinal Substances	2	1	1	2	-	-	-	-	2	1	-
Toxic Effect - Isopropyl Alcohol	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Unspecified Alcohol	3	1	1	-	1	1	1	-	4	-	-
Toxic Effect – Non-Petroleum-Based Solvents	1	-	-	-	-	-	-	1	1	-	-
Toxic Effect - Caustic Alkalis	-	1	-	1	-	-	-	-	1	-	-
Toxic Effect - Caustic Unspecified	1	2	2	-	-	-	1	-	2	1	-
Toxic Effect - Carbon Monoxide	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Other Specified Gases, Fumes, or Vapours	2	1	-	-	-	-	2	1	2	1	-
Toxic Effect - Unspecified Gas, Fumes, or Vapour	-	1	-	-	-	-	1	-	1	-	-
Toxic Effect - Fish & Shellfish	-	1	-	-	1	-	-	-	-	1	-
Toxic Effect - Berries and Other Plants Eaten as Food	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Other Pesticides, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Venom	41	32	18	9	11	11	18	6	39	33	1
Toxic Effect - Soap & Detergent	3	-	3	-	-	-	-	-	3	-	-
Toxic Effect - Other Substances	1	1	1	-	1	-	-	0	-	2	-
Toxic Effect - Unspecified Substances	3	2	3	-	-	-	-	2	4	1	-
TOTAL	**78**	**70**	**47**	**14**	**19**	**21**	**30**	**17**	**93**	**52**	**3**

Source: King Edward VII Memorial Hospital

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

Table 7.3.4
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2014

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other*
Poisoning - Penicillins	-	1	1	-	-	-	-	1	1	-	-
Poisoning - Other Specified Antibiotics	-	1	-	-	-	1	-	-	-	-	1
Poisoning - Sulfonamides	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Anti-Infectives	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Ovarian Hormone	-	1	1	-	-	-	-	-	1	-	-
Poison - Insulin & Antidiabetic Agents	-	4	-	-	-	-	1	3	3	1	-
Poisoning - Thyroid Derivatives	-	1	-	1	-	-	-	-	1	-	-
Poisoning - Antiallergic & Antiemeticm Drugs	-	1	-	-	1	-	-	-	1	-	-
Poisoning - Vitamins	2	-	2	-	-	-	-	-	2	-	-
Poisoning - Opium	1	-	-	-	-	-	1	-	1	-	-
Poisoning - Codeine, Meperidine, Morphine	-	1	-	-	-	-	1	-	-	1	-
Poisoning - Aromatic Analgesics	4	3	3	-	3	-	1	-	3	3	1
Poisoning - Propionic Acid Derivatives	1	2	2	-	-	1	-	-	1	1	1
Poisoning - Other Anti-Rheumatics	1	-	-	-	-	-	1	-	-	1	-
Poisoning - Hydantoin Derivatives	2	1	-	-	-	2	-	1	3	-	-
Poisoning - Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Sedative or Hypnotics	-	1	1	-	-	-	-	-	-	1	-
Poisoning - Central Nervous System Muscle Depressants	1	-	-	-	-	1	-	-	-	1	-
Poisoning - Selective Serotonin Reuptake Inhibitors	1	1	2	-	-	-	-	-	2	-	-
Poisoning - Other Antidepressant	1	3	2	-	-	-	2	-	2	2	-
Poisoning - Butyrophenome-Based Tranquilisers	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antipsychotic, Neuroleptic, & Major Tranquilisers	-	2	-	-	-	1	-	1	1	-	-
Poisoning - Benzodiazepine-Based Tranquilisers	1	3	-	-	-	-	2	2	1	3	-
Poisoning - Hallucinogens	-	3	-	-	2	1	-	-	3	-	-
Poisoning - Sympatholytics (Antiadrenergics)	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cardiac Rhythm Regulators	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Cardiotonics Glycosides	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antilipemic & Antiarteriosclerotic Drugs	1	-	-	-	-	-	-	1	1	-	-
Poisoning - Coronary Vasodilators	-	1	-	-	-	-	-	1	1	-	-
Poisoning - Antidiarrheal Drugs	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Gastrointestinal Agents	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Purine Derivative Diuretics	1	-	-	-	-	-	-	1	1	-	-
Poisoning - Saluretics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Uric Acid Metabolism Drugs	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Skeletal Muscle Relaxants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Expectorants	-	1	1	-	-	-	-	-	1	-	-
Poisoning - Anti-Asthmatics	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Local Anti-Infective & Anti-Inflammatory Drugs	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Antipruritics	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Emollients, Demulcents & Protectants	2	-	2	-	-	-	-	-	2	-	-
Poisoning - Keratolytics, Keratoplastics, Other Hair Treatment Drugs and Preparations	-	2	1	-	-	1	-	-	2	-	-
Poisoning - Anti-Infectives and Other Drugs and Preparations for Ear, Nose, and Throat	2	-	2	-	-	-	-	-	2	-	-
Poisoning - Other Agents Affecting Skin & Mucous Membrane	-	-	-	-	-	-	-	-	-	-	-

Table 7.3.4 cont'd
Primary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2014

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other*
Poisoning - Other Specified Drugs or Medicinal Substances	1	-	1	-	1	-	1	1	4	-	-
Poisoning - Unspecified Drugs or Medicinal Substances	2	2	1	-	-	-	1	2	4	-	-
Toxic Effect - Isopropyl Alcohol	1	-	-	-	1	-	-	-	1	-	-
Toxic Effect - Unspecified Alcohol	-	2	-	-	1	-	1	-	-	2	-
Toxic Effect - Non-Petroleum-Based Solvents	1	1	1	-	-	-	1	-	2	-	-
Toxic Effect - Caustic Alkalis	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Caustic Unspecified	-	5	1	-	-	-	1	3	5	-	-
Toxic Effect - Carbon Monoxide	3	1	-	-	-	1	1	2	4	-	-
Toxic Effect - Other Specified Gases, Fumes, or Vapours	-	1	-	-	-	-	-	1	1	-	-
Toxic Effect - Unspecified Gas, Fumes, or Vapour	-	4	-	-	2	1	1	-	3	1	-
Toxic Effect - Fish & Shellfish	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Berries and Other Plants Eaten as Food	1	1	2	-	-	-	-	-	-	2	-
Toxic Effect - Other Pesticides, Not Elsewhere Classified	-	1	-	-	-	1	-	-	-	-	1
Toxic Effect - Venom	32	28	14	3	9	9	16	9	37	20	3
Toxic Effect - Soap & Detergent	-	1	1	-	-	-	-	-	1	-	-
Toxic Effect - Other Substances	2	2	2	-	2	-	-	-	2	1	-
Toxic Effect - Unspecified Substances	1	2	1	-	1	1	-	-	2	-	1
TOTAL	**70**	**87**	**49**	**4**	**23**	**21**	**32**	**28**	**107**	**41**	**9**

Source: King Edward VII Memorial Hospital

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

Table 7.3.5
Secondary Diagnoses of Emergency Room Drug-Related® Cases, 2013

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other*
Acute Alcoholic Intoxication	10	2	-	2	1	1	5	3	5	7	-
Acute Alcoholic Intoxication - Continuous	2	-	-	-	-	1	1	-	2	-	-
Acute Alcoholic Dependence	53	12	-	1	4	8	29	23	44	20	1
Chronic Alcohol Dependence - Continuous	5	1	-	1	-	2	-	3	3	2	1
Chronic Alcohol Dependence - Episodic	-	1	-	1	-	-	-	-	1	-	-
Chronic Alcohol Dependence - In Remission	1	1	-	-	-	-	1	1	1	1	-
Opioid Type Dependence - Unspecified	25	3	-	-	1	8	19	-	24	4	-
Opioid Dependence - Continuous	6	1	-	-	1	3	3	-	6	1	-
Sedative, Hypnotic or Anxiolytic Dependence	-	1	-	-	-	-	-	1	1	-	-
Cocaine Dependence - Unspecified	2	-	-	-	-	-	2	-	2	-	-
Cocaine Dependence - Continuous	-	-	-	-	-	-	-	-	-	-	-
Cannabis Dependence	-	-	-	-	-	-	-	-	-	-	-
Combinations of Opioid Type Drug With Any Other - Continuous	1	-	-	-	-	-	1	-	1	-	-
Unspecified Drug Depend - Not Otherwise Specified	3	-	-	-	-	-	3	-	3	-	-
Unspecified Drug Dependence - Continuous Use	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse - Unspecified	70	12	1	11	18	14	22	16	59	21	2
Alcohol Abuse - Continuous	-	-	-	-	-	-	-	-	-	-	-
Alcohol Abuse - In Remission	-	-	-	-	-	-	-	-	-	-	-
Tobacco Use Disorder	59	17	1	3	4	14	29	25	52	22	2

Table 7.3.5 cont'd
Secondary Diagnoses of Emergency Room Drug-Related Cases, 2013*

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other+
Cannabis Abuse - Unspecified	5	1	-	2	1	1	1	1	6	-	-
Cannabis Abuse - Continuous	1	-	-	-	-	-	1	-	1	-	-
Sedative, Hypnotic or Anxiolytic Abuse	1	-	-	-	-	-	1	-	1	-	-
Opioid Abuse - Unspecified	1	7	-	-	-	3	5	-	7	1	-
Opioid Abuse - Continuous	1	-	-	-	-	-	1	-	1	-	-
Opioid Abuse - In Remission	1	2	-	-	1	-	2	-	2	1	-
Cocaine Abuse	2	1	-	-	1	1	-	1	3	-	-
Cocaine Abuse - Continuous	1	-	-	-	-	1	-	-	1	-	-
Cocaine Abuse - In Remission	2	2	-	-	1	-	3	-	3	1	-
Other, Mixed, or Unspecified Drug Abuse	11	2	1	-	1	3	7	1	12	1	-
Other, Mixed, or Unspecified Drug Abuse - Continuous Use	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**263**	**66**	**3**	**21**	**34**	**60**	**136**	**75**	**241**	**82**	**6**

Source: King Edward VII Memorial Hospital

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

Table 7.3.6
Secondary Diagnoses of Emergency Room Drug-Related Cases, 2014*

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other+
Acute Alcoholic Intoxication	7	-	-	-	1	-	2	4	5	2	-
Acute Alcoholic Intoxication - Continuous	-	-	-	-	-	-	-	-	-	-	-
Acute Alcoholic Dependence	28	6	-	3	5	2	12	12	23	11	-
Chronic Alcohol Dependence - Continuous	6	1	-	-	-	-	4	3	5	2	-
Chronic Alcohol Dependence - Episodic	-	-	-	-	-	-	-	-	-	-	-
Chronic Alcohol Dependence - In Remission	-	-	-	-	-	-	-	-	-	-	-
Opioid Type Dependence - Unspecified	22	2	-	-	-	7	14	3	17	7	-
Opioid Dependence - Continuous	-	-	-	-	-	-	-	-	-	-	-
Sedative, Hypnotic or Anxiolytic Dependence	-	-	-	-	-	-	-	-	-	-	-
Cocaine Dependence - Unspecified	-	1	-	-	-	-	1	-	-	1	-
Cocaine Dependence – Continuous Use	1	-	-	-	-	-	-	1	1	-	-
Cannabis Dependence	1	1	-	-	1	-	1	-	2	-	-
Combinations of Opioid Type Drug With Any Other - Continuous	-	-	-	-	-	-	-	-	-	-	-
Unspecified Drug Depend - Not Otherwise Specified	2	-	-	-	-	1	1	-	1	1	-
Unspecified Drug Dependence - Continuous Use	1	-	-	-	-	1	-	-	1	-	-
Alcohol Abuse - Unspecified	90	35	1	15	26	8	54	21	87	33	5
Alcohol Abuse - Continuous	1	1	-	-	2	-	-	-	1	1	-
Alcohol Abuse - In Remission	1	-	-	-	-	-	-	1	1	-	-
Tobacco Use Disorder	106	50	-	7	24	30	60	35	100	45	11
Cannabis Abuse - Unspecified	16	10	1	5	12	5	3	-	22	3	1
Cannabis Abuse - Continuous	2	-	-	1	-	1	-	-	1	1	-
Sedative, Hypnotic or Anxiolytic Abuse	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse - Unspecified	22	3	-	-	-	6	15	4	15	10	-
Opioid Abuse - Continuous	2	-	-	-	-	1	1	-	2	-	-
Opioid Abuse - In Remission	1	1	-	-	-	-	2	-	2	-	-

Table 7.3.6 cont'd
Secondary Diagnoses of Emergency Room Drug-Related Cases, 2014*

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other+
Cocaine Abuse	11	2	-	-	-	1	10	2	13	-	-
Cocaine Abuse - Continuous	-	-	-	-	-	-	-	-	-	-	-
Cocaine Abuse - In Remission	-	1	-	-	-	-	1	-	1	-	-
Other, Mixed, or Unspecified Drug Abuse	13	6	2	2	2	4	5	4	8	10	1
Other, Mixed, or Unspecified Drug Abuse - Continuous Use	-	1	1	-	-	-	-	-	1	-	-
TOTAL	**333**	**121**	**5**	**33**	**73**	**67**	**186**	**90**	**309**	**127**	**18**

Source: King Edward VII Memorial Hospital

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

Table 7.3.7
Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2013

Secondary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other+
Poisoning - Antiviral Drugs	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antiallergic and Antiemetic Drugs	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antineoplastic & Immunosuppressive Drugs	-	1	-	-	1	-	-	-	1	-	-
Poisoning - Anticoagulants	1	-	-	-	-	-	1	-	1	-	-
Poisoning - Opium (Alkaloids), Unspecified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Aromatic Analgesics, Not Elsewhere Classified	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Propionic Acid Derivatives	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Antirheumatics	-	1	-	-	1	-	-	-	1	-	-
Poisoning - Other and Unspecified Anticonvulsants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Glutethimide Group	-	1	-	-	-	-	-	1	1	-	-
Poisoning - Antidepressant	-	1	-	-	-	-	1	-	-	1	-
Poisoning - Phenothiazine-Based Tranquilisers	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anti-psychotic, Neuroleptics & Major Tranquilisers	-	1	-	-	-	1	-	-	1	-	-
Poisoning - Benzodiazepine-Based Tranquilisers	1	-	-	-	-	-	-	-	-	-	-
Poisoning - Other and Unspecified Agents Primarily Affecting the Cardiovascular System	-	-	-	-	-	-	-	-	-	-	-
Poisoning- Antipruritics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Emollients, Demulcents, and Protectants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Specified Drugs or Medicinal Substances	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other Specified Drugs or Medicinal Substances	1	-	-	-	-	-	-	1	-	1	-
Poisoning - Unspecified Drug or Medicinal Substance	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Ethyl Alcohol	-	-	-	-	-	-	-	-	-	-	-
Toxic Effects - Unspecified Alcohol	-	1	-	-	-	-	-	1	-	1	-
Toxic Effect - Acids	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Caustic Agents	1	-	-	1	-	-	-	-	1	-	-
Toxic Effect - Other Specified Gases, Fumes, or Vapours	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Unspecified Gas, Fume, or Vaopur	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Venom	2	6	1	-	2	2	3	-	7	1	-
Toxic Effect - Asbestos	-	-	-	-	-	-	-	-	-	-	-

Table 7.3.7 cont'd
Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2013

Secondary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other*
Toxic Effect - Latex	1	-	-	-	-	-	1	-	1	-	-
Toxic Effect - Unspecified Substance, Chiefly Nonmedical Source	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**7**	**12**	**1**	**1**	**4**	**3**	**4**	**6**	**15**	**4**	**-**

Source: King Edward VII Memorial Hospital

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

Table 7.3.8
Secondary Diagnoses of Emergency Room Cases of Poisoning and Toxic Effects of Substances, 2014

Secondary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other*
Poisoning - Antiviral Drugs	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Antiallergic and Antiemetic Drugs	1	-	-	-	1	-	-	-	-	-	1
Poisoning - Antineoplastic & Immunosuppressive Drugs	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anticoagulants	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Opium (Alkaloids), Unspecified	1	-	-	-	-	-	-	1	-	1	-
Poisoning - Aromatic Analgesics, Not Elsewhere Classified	1	1	-	-	-	-	1	1	1	1	-
Poisoning - Propionic Acid Derivatives	1	-	-	-	-	-	1	-	-	1	-
Poisoning - Other Antirheumatics	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Other and Unspecified Anticonvulsants	-	1	-	-	-	-	1	-	-	1	-
Poisoning - Glutethimide Group	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Antidepressant	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Anti-psychotic, Neuroleptics & Major Tranquilisers	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Benzodiazepine-Based Tranquilisers	-	2	-	-	-	-	2	-	-	2	-
Poisoning - Sympathomimetics	1	-	-	-	1	-	-	-	-	-	1
Poisoning - Other and Unspecified Agents Primarily Affecting the Cardiovascular System	-	1	-	-	-	-	-	1	1	-	-
Poisoning- Antipruritics	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Emollients, Demulcents, and Protectants	1	-	1	-	-	-	-	-	1	-	-
Poisoning - Other Specified Drugs or Medicinal Substances	-	-	-	-	-	-	-	-	-	-	-
Poisoning - Unspecified Drug or Medicinal Substance	1	1	-	-	-	-	1	1	2	-	-
Toxic Effect - Ethyl Alcohol	1	-	-	-	-	-	1	-	1	-	-
Toxic Effects - Unspecified Alcohol	1	-	-	-	1	-	-	-	-	1	-
Toxic Effect - Acids	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Caustic Agents	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Other Specified Gases, Fumes, or Vapours	-	1	1	-	-	-	-	-	1	-	-
Toxic Effect - Unspecified Gas, Fume, or Vaopur	-	1	-	-	-	-	-	1	1	-	-
Toxic Effect - Venom	3	2	-	2	-	1	2	-	3	2	-
Toxic Effect - Asbestos	1	-	-	-	-	-	-	1	1	-	-
Toxic Effect - Latex	-	-	-	-	-	-	-	-	-	-	-
Toxic Effect - Unspecified Substance, Chiefly Nonmedical Source	1	-	-	-	-	-	-	1	-	1	-
TOTAL	**16**	**10**	**4**	**2**	**3**	**1**	**10**	**6**	**15**	**9**	**2**

Source: King Edward VII Memorial Hospital

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

The Mid-Atlantic Wellness Institute (MWI) is the only inpatient medical facility providing detoxification services for opiate and alcohol dependence. In 2014 there were 86 cases with a primary diagnosis that was drug-related within the MWI compared to 106 in 2013 (see Tables 7.4.1 and 7.4.2). Males accounted for the majority of these cases, with the primary diagnosis being opioid dependence, alcohol dependence, and acute alcohol intoxication. In terms of the secondary diagnoses, a total of 134 cases were reported in 2013 compared to 178 cases in 2014 (see Tables 7.4.3 and 7.4.4), with significantly more males versus females diagnosed with cannabis dependence, a tobacco use disorder, cocaine dependence, acute alcohol intoxication, amongst other secondary diagnoses. While there were no reported case of poisoning and toxic effects of substances in 2013, there were, however, four reported cases of poisoning in 2014 related to benzodiazepines, analgesics, a medical agent, or unspecified substance.

Table 7.4.1
Primary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2013*

Secondary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other+
Acute Alcohol Intoxication – Continuous	13	2	-	-	1	2	10	2	5	9	1
Alcohol Dependence – Not Specified	18	8	-	-	-	9	10	7	16	9	1
Other Alcohol Dependence – Episodic	1	-	-	-	-	-	1	-	-	1	-
Opioid Dependence – Continuous	36	6	-	-	8	14	20	-	34	8	-
Cocaine Dependence – Continuous	-	2	-	-	-	1	1	-	2	-	-
Cannabis Dependence – Continuous	-	1	-	-	1	-	-	-	1	-	-
Other Specified Drug Dependence – Continuous	1	-	-	-	-	-	1	-	-	1	-
Opioid/Other Dependence – Continuous	10	5	-	-	1	9	5	-	10	5	-
Combination of Opioid Drugs with Others	1	-	-	-	1	-	-	-	1	-	-
Tobacco Use Disorder	1	-	-	-	-	-	-	1	-	1	-
Opioid Abuse – Continuous	-	1	-	-	-	-	1	-	-	1	-
TOTAL	**81**	**25**	**-**	**-**	**12**	**35**	**49**	**10**	**69**	**35**	**2**

Source: King Edward VII Memorial Hospital

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

Table 7.4.2
Primary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2014*

Secondary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other
Acute Alcohol Intoxication – Continuous	18	3	-	-	1	5	10	5	12	9	-
Alcohol Dependence – Not Specified	7	-	-	-	1	3	2	1	6	1	-
Other Alcohol Dependence – Episodic	1	-	-	-	-	1	-	-	-	1	-
Opioid Dependence – Continuous	33	6	-	-	3	15	20	1	34	5	-
Cocaine Dependence – Continuous	1	2	-	-	-	2	1	-	1	2	-
Cannabis Dependence – Continuous	-	1	-	-	1	-	-	-	1	-	-
Other Specified Drug Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-
Opioid/Other Dependence – Continuous	9	4	-	-	1	3	8	1	12	1	-
Combination of Opioid Drugs with Others	-	-	-	-	-	-	-	-	-	-	-
Tobacco Use Disorder	-	1	-	1	-	-	-	-	1	-	-
Opioid Abuse – Continuous	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**69**	**17**	**-**	**1**	**7**	**2**	**41**	**8**	**67**	**19**	**-**

Source: King Edward VII Memorial Hospital

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

Table 7.4.3
Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2013*

Secondary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other+
Acute Alcohol Intoxication – Continuous	15	7	-	2	2	6	12	-	16	6	-
Acute Alcohol Intoxication – In Remission	1	-	-	-	-	-	-	1	-	1	-
Alcohol Dependence – Not Specified	8	2	-	1	1	2	5	1	5	5	-
Opioid Dependence – Continuous	6	4	-	-	1	3	5	1	9	1	-
Cocaine Dependence – Continuous	12	5	-	-	5	5	7	-	14	3	-
Cannabis Dependence – Continuous	20	4	-	4	4	11	5	-	20	4	9
Other Specified Drug Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-
Other Specified Drug Dependence – Episodic	-	-	-	-	-	-	-	-	-	-	-
Amphetamine Dependence	-	1	-	-	-	-	1	-	1	-	-
Hallucinogen Dependence	1	-	-	-	1	-	-	-	1	-	-
Opioid/Other Dependence – Continuous	9	1	-	-	4	4	2	-	8	2	-
Combined Opioid Type Drugs	-	-	-	-	-	-	-	-	-	-	-
Combination of Drug Dependence – Excluding Opioids	2	-	-	-	-	1	1	-	2	-	-
Unspecified Drug Dependence	1	-	-	1	-	-	-	-	1	-	-
Drug Dependence Not Otherwise Specified – Continuous	1	-	-	-	-	1	-	-	1	-	-
Alcohol Abuse-Continuous	-	2	-	-	-	1	-	-	1	-	-
Tobacco Use Disorder	14	7	-	-	-	12	9	-	11	10	-
Cannabis Abuse – Continuous	6	-	-	1	2	1	2	-	5	-	1
Sedative, Hypnotic Abuse	-	1	-	-	-	-	1	-	-	1	-
Opioid Abuse – Continuous	1	-	-	-	-	1	-	-	-	1	-
Cocaine Abuse – Continuous	-	1	-	-	-	-	1	-	-	1	-
Drug Dependence – Unspecified	-	2	1	-	-	-	1	-	-	2	-
TOTAL	**97**	**37**	**1**	**9**	**21**	**47**	**53**	**3**	**94**	**39**	**1**

Source: King Edward VII Memorial Hospital

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

Table 7.4.4
Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2014*

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other+
Acute Alcohol Intoxication – Continuous	19	7	1	-	3	9	12	1	20	5	1
Acute Alcohol Intoxication – In Remission	-	-	-	-	-	-	-	-	-	-	-
Alcohol Dependence – Not Specified	3	2	-	1	1	1	1	1	3	2	-
Opioid Dependence – Continuous	4	2	-	-	1	2	1	2	2	4	-
Cocaine Dependence – Continuous	21	8	-	1	3	11	14	-	26	3	-
Cannabis Dependence – Continuous	26	2	1	4	5	13	5	-	26	2	-
Other Specified Drug Dependence – Continuous	2	-	-	-	-	-	2	-	2	-	-
Other Specified Drug Dependence – Episodic	1	-	-	-	-	-	1	-	1	-	-
Amphetamine Dependence	-	-	-	-	-	-	-	-	-	-	-
Hallucinogen Dependence	-	-	-	-	-	-	-	-	-	-	-
Opioid/Other Dependence – Continuous	-	-	-	-	-	-	-	-	-	-	-
Combined Opioid Type Drugs	19	5	-	-	4	5	15	-	20	3	1
Combination of Drug Dependence – Excluding Opioids	7	3	-	1	1	2	6	-	9	1	-
Unspecified Drug Dependence	-	1	-	-	-	1	-	-	1	-	-

Table 7.4.4 cont'd
Secondary Diagnoses of Mid-Atlantic Wellness Institute Drug-Related Cases, 2014*

Primary Diagnosis	Sex		Age Group						Race		
	Male	Female	<18 Yrs	18-25 Yrs	26-35 Yrs	36-45 Yrs	46-60 Yrs	61+ Yrs	Black	White	Other+
Drug Dependence Not Otherwise Specified – Continuous	1	-	-	-	-	1	-	-	1	-	-
Alcohol Abuse – Continuous	4	-	-	-	1	2	1	-	4	-	-
Tobacco Use Disorder	26	7	-	1	3	9	17	3	27	6	-
Cannabis Abuse – Continuous	4	-	-	-	1	2	1	-	4	-	-
Sedative, Hypnotic Abuse	-	-	-	-	-	-	-	-	-	-	-
Opioid Abuse – Continuous	1	-	-	-	-	-	-	1	1	-	-
Cocaine Abuse – Continuous	-	1	-	-	1	-	-	-	-	-	1
Drug Dependence – Unspecified	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**138**	**40**	**2**	**9**	**26**	**57**	**76**	**8**	**149**	**26**	**3**

Source: King Edward VII Memorial Hospital

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

7.5 MORTALITY: SUSPICIOUS DEATHS

Toxicology Screening Results

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

The challenge with drug-related deaths is that the causes of death recorded by physicians certifying the deaths in certain cases are usually linked to causes other than substance or drug use overdose. For instance, a person may be involved in a fatal road traffic accident. In this case, the physician records or codes the death as "transport accident" using the ICD-10.[13] In this instance, it was the transport accident that led directly to the death. This is, therefore, the underlying cause of death, otherwise known as the primary or proximate cause of death. In other words, it is the disease or injury that initiated all other causes or conditions and started the train of morbid events leading directly to death, or the circumstances or violence that produced the fatal injury. However, any antecedent or intermediate causes of death must also be observed and recorded. As such, a death record usually provides an arrangement of the causal or etiological relationship of the medical conditions that finally led to the death; in the end, yielding the underlying cause of death. For example, the transport accident may have been caused by excess alcohol or drug overdose. In instances where there may be an intermediate cause, physicians must determine if these suspicious deaths are related to substance use and then send these cases to the Central Government Laboratory for toxicology screening.

The toxicology screening is performed by the Government Analyst to determine the presence or absence of drugs. In 2014, 36 cases were screened compared to 30 in 2013 (see Table 7.5.1). Most of the cases forwarded for screening were for males, all 30 in 2013 and 27 cases in 2014. In addition, the majority of the cases screened were of older persons, especially persons over 46 years.

Ethanol in excess of the legal limit and drugs (illegal or psychoactive medicines above therapeutic range), were detected in many of the cases screened in each year under review. For instance, in 2013, 70.0% of the cases (21 of 30) screened positive for excess ethanol or illegal or non-prescribed drugs compared to 72.2% (26 of 36) in 2014. Drugs, for example, THC, cocaine, codeine, morphine, and others, as well as drugs in combination with others, were more often detected than excess alcohol. In other instances, ethanol was detected, but the quantity was below the legal limit or no substance at all was detected. There were no instances where the underlying cause of death was recorded as drug-induced deaths (acute episode

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

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

of poisoning or toxicity to drugs, for example, accidental overdose or intentional self-harm, or drug dependence) though the Department of Health has indicated that drug use likely contributed to the underlying cause of death in four instances of those cases screened in 2013; with no indication of this being the case for any death screened in 2014.

Nonetheless, the Epidemiology and Surveillance Unit can confirm that there were a couple of deaths in 2014 that were alcohol-related; with mental and behavioural disorders due to use of alcohol and alcoholic liver disease being the cause of death. There were no deaths in either year that was drug-induced. On the other hand, in both years under review, there were a number of deaths in Bermuda that were classified as tobacco-related, 184 in 2013 and 206 in 2014; with malignant neoplasm of trachea, bronchus, and lung, major cardiovascular diseases, and chronic lower respiratory diseases being recorded as the causes of death.

…of all cases where excess alcohol or drugs were detected, the cause of death was recorded as transport accident or some diseases of the circulatory system.

At the same time, there were a few road traffic fatalities in both years for which alcohol and or drugs were present (and in excess of the legal limit in the case of alcohol), six cases in 2013 and nine in 2014 (see Table 7.5.1).

In general, of all cases where excess alcohol or drugs were detected, the cause of death was recorded as transport accident or some diseases of the circulatory system (see Table 7.5.1). However, there were also instances of deaths, which were caused as a result of other external causes such as assault, drowning, mental and behavioural disorders, and diseases of the respiratory or digestive system, where excess alcohol or drugs were detected. Epidemiological research has indicated that alcohol use increases the risk for many chronic health consequences (e.g., diseases) and acute consequences (e.g., traffic crashes).[14] However, conclusions on causality of death due to excess alcohol or drug use cannot be inferred but the data suggests that there may be some relationship between substance use and cause of death, especially, among those categorised as external causes. As a consequence, considerable care should be exercised when interpreting statistics on drug-induced deaths.

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

Table 7.5.1
Toxicology Screens, Substances Detected, and Causes of Death, 2013 and 2014

	2013	2014
Total Number of Deaths (All Causes)	471	469
Proportion of Deaths with Toxicology Screens (%)	6.4	7.7
Total Number of Toxicology Screens	30	36
By Sex:		
Males	30	27
Females	-	9
By Age Group:		
< 18 Years	2	-
18 – 25 Years	4	4
26 – 35 Years	4	3
36 – 45 Years	2	2
46 – 60 Years	13	13
60+ Years	4	14
Not Stated	1	-
Substances Detected in Toxicology Screens (Number of Cases)		
Ethanol[1] (>80 mg)	10	10
Drugs[2]	16	22
Ethanol and Drugs	5	6
None/<80 mg Ethanol/Drugs in Therapeutic Range	9	10
Causes of Death (ICD-10)[3] (Persons with Detected Substances)	**22[r]**	**26**
Malignant Neoplasm	-	-
Mental and Behavioural Disorders	-	1
Endocrine, Nutritional, and Metabolic Diseases	-	1
Diseases of the Blood	1	-
Diseases of the Circulatory System	5[r]	7
Diseases of the Respiratory System	1	1
Diseases of the Circulatory and Respiratory Systems	1	-
Diseases of the Digestive System	1	-
Diseases of the Skin and Subcutaneous Tissue	-	-
External Causes of Morbidity and Mortality	-	-
Transport Accident	6	9
Other External Causes of Accidental Injury	1[r]	-
Assault	5	2
Intentional Self-Harm	1	1
Accidental Drowning and Submersion	-	2
Hanging, Strangulation, and Suffocation – Undetermined Intent	-	1
III Defined and Unknown Causes of Death Not Elsewhere Classified	-	-
Pending	-	1

Source: Central Government Laboratory and Epidemiology and Surveillance

Notes:
[1] Whether in blood, vitreous, or urine.
[2] Drugs whether in blood, vitreous, urine, or liver and include: 6-MAM, amitriptyline, benzoylecgonine, BZE, cocaine, codeine, diphenhydramine, hydrocodone, ibuprofen, midazolam, morphine, paracetamol, THC, THC-OH, THC-COOH, or a combination.
[3] Internationally accepted classification of deaths according to the World Health Organisation (WHO) http://apps.who.int/classifications/icd10/browse/2010/en

7.6 PRENATAL DRUG USE

Drug Use among Pregnant Women

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

Many pregnant women sometimes use medications without prior consideration to the adverse effects of these substances on their unborn children. Pregnant women who use drugs during their pregnancy pass the drugs along to the baby through the placenta. Women who smoke marijuana while they are pregnant are more likely to have low birth-weight, premature babies. These conditions can both lead to developmental delays and respiratory problems. Another obstacle these babies face is withdrawal symptoms for almost a week after birth. The most common long-term effect on these infants is that they may have a shorter attention span than a child not exposed to the drug. These problems are more prevalent in women who smoke more than six times per week.[15] At birth, the baby may experience drug withdrawal, depending on the amount of drug the mother used and when the drug was last consumed. The American Academy of Pediatric explains that if a week or more elapses between the mother's last use of the drug and delivery of the baby, the risk that the baby will develop drug withdrawal is, however, low. Drugs such as heroin, oxycodone, cocaine, alcohol, marijuana and even inhalants such as glue, gasoline, and paint thinner can all cause newborns to experience drug withdrawal.[16]

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

According to data reported by the Maternal Health Clinic in Bermuda (see Table 7.6.1), which only represents a proportion of pregnant women receiving pre-natal care, about four in 10 pregnant women in both 2013 (39.1%) and 2014 (41.9%) used one or more than one illicit drug over their gestational cycle. In 2013, the nine positive tests were confirmed for marijuana whereas, in 2014, 11 of the 13 positive tests were confirmed for marijuana while two were confirmed for cocaine. Most of the women have used these drugs during their second trimester (six in 2013 and 10 in 2014); though there was one reported case each in 2013 and 2014 of a pregnant woman using marijuana in her third trimester.

In 2013, the nine positive tests were confirmed for marijuana whereas, in 2014, 11 of the 13 positive tests were confirmed for marijuana while two were confirmed for cocaine. Most of the women have used these drugs during their second trimester…

Further, according to the 2015 Survey of Pregnant Women, conducted by the DNDC, 14.3% (n=34) of pregnant women indicated episodes of binge drinking, which is 5 or more drinks at once in the past two weeks; and three-quarters of them were either in their second or third trimester (see Table 7.6.2). Additionally, 10.1% (n=24) of those women surveyed indicated the use of marijuana in the 12 months prior to the survey, while 2.5% (n=6) indicated use in the 30-day period prior to the survey (see Table 7.6.3). At the same time, 8.4% of the respondents indicated tobacco use in the past year, while 2.5% indicated using tobacco in the past month.

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

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

Table 7.6.1
Drug Screening for Marijuana among Pregnant Women Attending the Maternal Health Clinic, 2013 and 2014

	Number of Pregnant Women	
	2013	2014
Total Number of Tests	23	31*
Total Number of Positive Tests	9	13
Positive Tests by Gestation		
First Trimester	2	2
Second Trimester	6	10
Third Trimester	1	1

Source: Maternal Health Clinic

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

Table 7.6.2
Reported Binge Drinking by Number of Pregnant Women and Gestation Period, 2015

(n = 238)

BINGE DRINKING	TRIMESTER		
	1ST	2ND	3RD
Yes	8	14	12
No	12	11	36

Source: DNDC's 2015 Survey of Pregnant Women

Table 7.6.3
Annual and Current Tobacco Use by Number of Pregnant Women, Age Group, Gestation, and Parity, 2015

(n = 238)

	ANNUAL USE (PAST YEAR)		CURRENT USE (PAST 30 DAYS)	
	YES	NO	YES	NO
Overall	**20**	**215**	**6**	**227**
Age Group				
15-19	1	4	-	5
20-24	1	15	-	15
25-29	7	47	1	53
30-34	7	87	3	90
35-39	1	48	-	49
40+	3	11	2	12
Trimester				
1st	4	31	3	31
2nd	8	83	1	90
3rd	8	97	2	102
First Pregnancy				
Yes	8	86	2	91
No	12	126	4	133

Source: DNDC's 2015 Survey of Pregnant Women

Table 7.6.4
Lifetime and Current Marijuana Use by Number of Pregnant Women, 2015

(n = 238)

SMOKING MARIJUANA	PAST YEAR	PAST 30 DAYS
Yes	24	6
No	206	227

Source: DNDC's 2015 Survey of Pregnant Women

Chapter 8
Drug Prevention Programmes

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

8.1 BOTVIN'S LIFESKILLS TRAINING PROGRAMME

Botvin's LifeSkills Training (LST) is a research-validated substance abuse prevention programme proven to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviours.[17] It is recognised as a model or exemplary programme and has been adopted for use in Bermuda in the past few years by drug prevention partners Pride Bermuda and CADA. The LST programme runs in selected classrooms at the primary, middle, and high school levels during the school year either at scheduled class times or times dedicated for this curriculum. This comprehensive programme provides adolescents and young teens with the confidence and skills necessary to successfully handle challenging situations. Rather than merely teaching information about the dangers of drug abuse, Botvin's LST consists of three major components – drug resistance skills, personal self-management skills, and general social skills – that cover the critical domains found to promote drug use. These skills help to promote healthy alternatives to risky behaviour through activities designed to: teach students the necessary skills to resist social (peer) pressures to smoke, drink, and use drugs; help students to develop greater self-esteem and self-confidence; enable students to effectively cope with anxiety; increase their knowledge of the immediate consequences of substance abuse; and enhance cognitive and behavioural competency to reduce and prevent a variety of health risk behaviours.

Although LST programme data has been compiled by Pride and CADA as part of its programme performance monitoring, this is the second time such data is being reported in the BerDIN Annual Report. The data in Table 8.1.1 shows that for the school year 2013/2014, Pride has implemented the LST programme only in classrooms at the primary level due to insufficient grant funding. Specifically, LST was in 20 classrooms in nine primary schools. In the 2014/2015 school year, the LST was implemented at one additional primary school but one less classroom than in the previous academic year, that is, bringing programme coverage to 19 classrooms in 10 schools. In addition, the programme was offered to two classes in one high school in the form of a teen summer camp during 2014 that is recorded as part of the school year 2014/2015 data. While there were a few students who dropped out of the programme at the primary school levels during the school years, a total of 319 and 272 students completed the programme at the primary level during 2013/2014 and 2014/2015, respectively; with an additional 25 students completing the programme at the high-school level. Across all participating classrooms in primary schools, students were engaged for 175 sessions in 2013/2014 and 168 in 2014/2015, averaging approximately 45 minutes, and covered all three levels of the primary curriculum, which is equivalent to each class completing the assigned eight modules in each school year under review. The average pre-test score for the students at the primary level was 57.7% versus 70.2% at the post test in 2013/2014 and 57.6% versus 71.2% in 2014/2015; this is equivalent to an average gain score (difference between post test and pre-test scores) of more than 10.0%. The seven-module curriculum was completed by 25 students in the two classrooms at the high-school level over 20 sessions. The average pre-test score was 73.6% in 2014/2015 compared to 76.1% at the post test – a gain score of 2.5%, on average. The programme was not delivered to at the high-school level in the previous academic year; thereby precluding comparisons to be made.

CADA, on the other hand, implemented the LST in only the middle- and high-school levels in both school years under review. In both years, two classes in one middle school received the 14-module Level 1 middle-school programme, with 36 and 35 students completing the curriculum over 34 and 31 sessions, respectively (see Table 8.1.2). There was a 100% completion rate of all the modules in both classes in both years. In 2013/2014 the average gain score at this level was 14.2% with an average pre-test score of 62.6% versus 76.8% at the post test; and in 2014/2015 the gain score dropped to 9.1% with an average pre-test score of 67.6% compared to 76.7% at the post test. At the high-school level, three classes in two high schools and two classes in one high school received the programme over 27 and 17 sessions with a total of 49 and 32 students, respectively, in 2013/2014 and 2014/2015. There was a 100.0% completion rate of the seven-module curriculum. The programme showed improvement in the last two academic years at this level in terms of the gain score. Specifically, in the 2013/2014 school year at the high-school level the average post test score (78.7%) was 5.7% higher than the average pre-test score (73.0%). Similarly, the 2014/2015 school year recorded a slightly lower, but positive, gain score of 3.4% with average pre-test score of 77.6% increasing to an average post test score of 81.0%.

The programme showed improvement in the last two academic years at this level in terms of the gain score.

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

Table 8.1.1
Pride Bermuda's LifeSkills Programme Statistics, 2013/2014 and 2014/2015

Programme Indicators	School Year					
	2013/2014			2014/2015		
	Primary	Middle	High	Primary	Middle	High
Number of Schools Participated	9	..	..	10	-	1
Number of Classes Participated	20	..	..	19	-	2
Number of Students Engaged	323	..	..	274	-	25
Number of Students Dropped Out	4	..	..	2	-	-
Number of Students Retained	319	..	..	272	-	25
Number of Sessions	175	..	..	168	-	20
Number of Modules Completed	156	..	..	148	-	14
Total Number of Modules	160	..	..	152	-	14
Proportion of Curriculum Completed	97.5%	..	..	97.4%	-	100.0%
Average Pre-Test Score	57.7%	..	..	57.6%	-	73.6%
Average Post Test Score	70.2%	..	..	71.2%	-	76.1%

Source: PRIDE Bermuda

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

Table 8.1.2
CADA's LifeSkills Programme Statistics, 2013/2014 and 2014/2015

Programme Indicators	School Year					
	2013/2014			2014/2015		
	Primary	Middle	High	Primary	Middle	High
Number of Schools Participated	..	1	2	-	1	1
Number of Classes Participated	..	2	3	-	2	2
Number of Students Engaged	..	36	49	-	35	32
Number of Students Dropped Out	..	1	-	-	-	-
Number of Students Retained	..	36	49	-	35	32
Number of Sessions	..	34	27	-	31	17
Number of Modules Completed	..	28	21	-	28	14
Total Number of Modules	..	28	21	-	28	14
Proportion of Curriculum Completed	..	100.0%	100.0%	-	100.0%	100.0%
Average Pre-Test Score	..	62.6%	73.0%	-	67.6%	77.6%
Average Post Test Score	..	76.8%	78.7%	-	76.7%	81.0%

Source: PRIDE Bermuda

8.2 PROMOTING ALTERNATIVE THINKING STRATEGIES PROGRAMME

The Promoting Alternative THinking Strategies (PATHS) curriculum is a model social and emotional learning programme that was designed to help children develop self-control, positive self-esteem, emotional awareness, and interpersonal problem-solving skills; and it has been recognised for its effectiveness. An evaluation tool is used to assess the PATHS lessons to see how well these lessons were received by students. Students are evaluated at two different time points: at the beginning of the school year (pre-curriculum) with a pre-test and then again at the end of the school year (post curriculum) with a post test to monitor the progress that they have made during the school year. Both the pre- and post tests contain questions covering three key behavioural areas (aggression/disruptive behaviour, concentration or attention, and social and emotional competence) with a total of 30 (Primary 2 level) and 31 (Primary 1 level) individual behaviours on which students are evaluated using a numerical raring scale of 0

to 5 (never or almost never, rarely, sometime, often, very often, and almost always).

This programme is coordinated by Pride Bermuda and in the last two academic years the curriculum was delivered to one primary school in Bermuda. The data on Table 8.2.1 shows that two Primary 1 classes participated initially in the 2013/2014, with another two Primary 1 classes in 2014/2015. The programme was also extended to the Primary 2 level in the 2014/2015 school year, which meant that students who received the curriculum in 2013/2014 at the Primary 1 level, now continued onto the next level of the curriculum in Primary 2. The curriculum was delivered two times each week with each session being approximately 30 minutes in length. A total of 33 students were engaged for the entire programme in 2013/2014 at the Primary 1 level and 35 students each at the Primary 1 and 2 levels in 2014/2015 (average class size was approximately 16 to 17 students). The students at the Primary 1 level completed 27 of 45 modules in 2013/2014 (60.0% curriculum completion) and 44 in 2014/2015 (97.8% curriculum completion). The Primary 2 curriculum contains 50 modules and the students completed 26 modules (52% curriculum completion).

In terms of behavioural maturity the average change results (difference between the post test and pre-test scores) showed that about half or more of the students showed improvement in the three key behavioural areas with the largest proportion of students showing improvement in social and emotional competence (73.3% of Primary 1 students and 61.3% of Primary 2 students in 2014/2015). At the same time there was a fraction of the students who showed no change, on average, in any of the behaviours assessed or whose behaviours actually became worse (negative change). For instance, 30.0% of the Primary 1 students and 29.0% of the Primary 2 students showed a negative average change on aggression/disruptive behaviours, which include elements such as fights, handling disagreements negatively, and getting angry when provoked, among other; indicating that for these students, their behaviours on this component worsened. Likewise, there were 10.0% of the Primary 1 students whose behaviour on concentration/attention remained unchanged and the same for 25.8% of the Primary 2 students. Nonetheless, overall, all of the Primary 1 students improved in at least one of the behavioural items and there was improvement on as many as 22 of the 31 items for this level. At the Primary 2 level, 28 of the 31 students showed improvement on at least one of the behavioural items (three students showed no improvement on all of the items) and there was improvement on as many as 28 of the 30 items for this level.

In terms of behavioural maturity the average change results (difference between the post test and pre-test scores) showed that about half or more of the students showed improvement in the three key behavioural areas with the largest proportion of students showing improvement in social and emotional competence.

Table 8.2.1
Pride Bermuda's PATHS Programme Statistics, 2013/2014 and 2014/2015

Programme Indicators	2013/2014*	2014/2015	
	Primary 1	Primary 1	Primary 2
Number of Schools (Elliott Primary)	1	1	1
Number of Classes Participated	2	2	2
Number of Students Engaged	33	35	35
Number of Students Dropped Out	-	-	-
Number of Students Retained	33	35	35
Number of Sessions	54	88	59
Number of Modules Completed	54	88	52
Total Number of Modules	90	90	100
Proportion of Curriculum Completed	60.0%	97.8%	52.0%
Evaluation of Behaviours		(n = 30)+	(n = 31)+
Improvement (% of students)			
Aggression/Disruptive Behaviours	..	46.7%	61.3%
Concentration/Attention	..	70.0%	51.6%
Social and Emotional Competence	..	73.3%	61.3%
Negative Change (% of students)			
Aggression/Disruptive Behaviours	..	30.0%	29.0%
Concentration/Attention	..	20.0%	22.6%
Social and Emotional Competence	..	16.7%	19.4%

Table 8.2.1 cont'd
Pride Bermuda's PATHS Programme Statistics, 2013/2014 and 2014/2015

Programme Indicators	2013/2014*	2014/2015	
	Primary 1	Primary 1	Primary 2
No Change (% of students)			
Aggression/Disruptive Behaviours	..	23.3%	9.7%
Concentration/Attention	..	10.0%	25.8%
Social and Emotional Competence	..	10.0%	19.4%

Source: PRIDE Bermuda

Note:
* This first cohort started a pilot of the PATHS programme, which ran from February to June 2014. Only a sample of the students (10) were evaluated; hence, the results of the evaluation of behaviours are not included for 2013/2014. All of these students were again tested as Primary 2 students in 2014/2015.
+ Although 35 students received the programme not all were pretested; hence the numbers for which the evaluation of behaviours are presented do not match the number of students engaged.

Chapter 9
Certified Professionals

- Occupation
- Type of Certification

9.1 CERTIFIED TREATMENT AND PREVENTION PROFESSIONALS

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

Certification of treatment and prevention professionals occurs every two years ending in May, at which time persons must be recertified. Statistics from the BACB showed that seven professionals were added to the fields of drug treatment and prevention since the last report. Specifically, in 2013 there were 42 certified persons in substance abuse treatment and prevention occupations, compared to 49 professionals in 2014; most of whom are alcohol or drug counsellors followed by clinical supervisors and prevention specialists (see Table 9.1.1). This means that most persons are holders of the ICADC (International Certified Alcohol and Drug Counselor) certification, a few of whom may also be CCS (Certified Clinical Supervisor) certified (see Table 9.1.2). It should be noted that there are also private and other practitioners who have not yet been certified by the BACB.

Table 9.1.1
Certified Treatment and Prevention Professionals by Occupation, 2013 and 2014

Occupation	2013	2014
Treatment		
Alcohol/Drug Counsellors	27	32
Associate Counsellors	2	3
Clinical Supervisors	8	8
Prevention		
Prevention Specialists	5	6
Associate Prevention Professional	-	-
Total	**42**	**49**

Source: Bermuda Addiction Certification Board

Table 9.1.2
Certified Treatment and Prevention Professionals by Type of Certification, 2013 and 2014

Field of Certification	2013	2014
Treatment		
ICADC	27	32
CCS	8	8
ACAD	2	3
Prevention		
CPS	5	6
APP	-	-
Total	**42**	**49**

Source: Bermuda Addiction Certification Board

Chapter 10
Survey Data

- Public Perceptions
- Drug Prevalence
  - » Homeless Population
  - » Criminal Offenders
- Treatment Demand

10.1 PUBLIC PERCEPTIONS

Concerns relating to crime, drug prevalence, and health have been common issues for Bermuda's residents in recent years. The DNDC utilised the second quarter 2015 Omnibus Survey, a sample survey of 400 residents, to evaluate the community's perceptions of these issues.

Concerns relating to crime have been a common issue for Bermuda residents over the past number of years. In order to assess feelings of personal safety, residents were asked how safe they felt in their own neighbourhood. The degree of feeling safe has remained relatively stable since 2012. The results showed that almost all residents (98%, up from 95%) felt either extremely (36%, up from 30%) or mostly (62%, down from 65%) safe in their neighbourhoods (see Table 10.1.1). Fewer residents reported feeling unsafe, to any extent, in their own neighbourhoods (1%, down from 5%). It is important to note, however, that no one reported feeling extremely unsafe in their neighbourhoods. Of note, those residents with lower household incomes are more likely to report feeling extremely safe in their neighbourhood when compared to those who have higher household incomes. Across the Island, residents of Hamilton/St. George's/Smiths are most likely, and residents of Pembroke/Devonshire are least likely, to indicate they feel extremely safe in their respective neighbourhoods.

In addition, residents were asked about their current feeling of safety in their neighbourhoods compared to those from six months ago. The majority of Bermuda residents indicated that they felt as safe (81%, up from 77%) as they were half a year ago; although slightly fewer felt safer (10%, down from 15%). Consistent with the previous years' results, far fewer resident felt that their neighbourhoods had become less safe (7%, up from 6%). These results suggest a steadiness in how residents view their safety has been maintained over the years.

Residents were asked which types of crime they knew to have occurred in their neighbourhood in the past year. Consistent with previous years' findings, theft remains the most commonly noted crime, as four out of every 10 residents (39%, down from 45%) were aware of cars or personal property being stolen, while a similar number (36%, down from 44%) were aware of breaking and entering to steal personal property (see Table 10.1.2). Drug-related or violent crime was recalled in relatively few neighbourhoods with two out of every 10 residents being aware of people openly selling or using drugs (21%, up from 19%); a similar number indicate having heard of gun crimes (18%, up from 14%). Moreover, one out of every 10 residents (8%, unchanged) indicated that an assault had occurred in their neighbourhood in the past year, while the same number knew of a murder that happened in their neighbourhood within the past 12 months (8%, up from 6%).

Some differences were evident between parishes and demographics. Across parishes, residents of Sandys/Southampton were most likely, while residents of Hamilton/St. George's/Smiths were least likely, to mention breaking and entering. Meanwhile, residents of Sandys/Southampton and Pembroke/Devonshire were more likely than residents of other parishes to recall higher levels of drug-related and gun crime as well as murder in their neighbourhoods. Moreover, recall of breaking and entering was higher among residents with higher levels of household income, and recall of theft was higher among residents with household incomes of at least $75K. Finally, White residents were more likely to report being aware of theft (56% vs. 37%) and breaking and entering (54% vs. 35%) happening in their neighbourhoods compared to black residents.

Across the population, those between 18 and 34 years are more likely than their older counterparts to recall theft in their neighbourhood, while higher income earners and white residents were more likely to recall breaking and entering crime. Drug crime was more commonly recalled by those in the lowest income category and black residents, while men were more likely than women to recall gun crimes in their neighbourhood.

Drug crime was more commonly recalled by those in the lowest income category and black residents, while men were more likely than women to recall gun crimes in their neighbourhood.

In order to measure perceptions of overall physical and mental well-being, respondents were asked how they would rate their own health. Almost all the residents (95%, down from 97%) considered themselves to be healthy. More specifically, more than one-half said their health was good (50%, down from 55%), while over four out of every 10 residents described their health as being very good (44%, up from 42%). Meanwhile, a small but increasing proportion of the population, (5%, up from 2%), indicated their health is poor, while no resident gave an answer of very poor.

Table 10.1.1

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

(n = 400)

	Bermuda Overall %	Parish				Gender		Household Income			Age			Race		Bermudian?	
		Sndy/ Sthp	War/ Paget	Pem/ Devon	Ham/ Sm/Sg	Male	Female	<$75K	$75K-$150K	>150K	18-34	35-54	55+	Black	White	Yes	No
Extremely Safe	36	39	34	25	45	37	35	43	37	28	49	34	35	36	35	35	49
Mostly Safe	62	48	65	73	54	61	63	54	62	70	51	65	62	62	64	63	51
Mostly Unsafe	1	2	1	1	-	2	-	3	1	-	-	1	1	2	-	1	-
Extremely Unsafe	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Don't Know/No Answer	1	1	1	-	1	1	1	1	-	2	-	-	2	-	1	1	-
Weighted Sample Size (#)	**400**	**101**	**90**	**95**	**110**	**190**	**210**	**131**	**125**	**111**	**51**	**219**	**131**	**215**	**127**	**365**	**35**
Unweighted Sample Size (#)	**400**	**88**	**97**	**98**	**113**	**150**	**250**	**134**	**120**	**107**	**23**	**138**	**239**	**165**	**192**	**364**	**35**
% Exremely/Mostly Safe	98	97	98	99	99	98	99	97	99	98	100	99	97	98	99	98	100
% Mostly/Extremely Unsafe	1	2	1	1	-	2	-	3	1	-	-	1	1	2	-	1	-

Source: DNDC's Commissioned Questions in 2nd Quarter 2015 Bermuda Omnibus Survey©

Table 10.1.2

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

People openly selling or using drugs?

(n = 400)

	Bermuda Overall %	Parish				Gender		Household Income			Age			Race		Bermudian?	
		Sndy/ Sthp	War/ Paget	Pem/ Devon	Ham/ Sm/Sg	Male	Female	<$75K	$75K-$150K	>150K	18-34	35-54	55+	Black	White	Yes	No
Yes	21	31	13	27	12	23	18	31	16	15	26	23	16	26	10	22	11
No	77	67	84	70	86	76	78	66	82	83	71	76	81	72	88	76	84
Don't Know	2	2	3	3	2	1	3	3	2	2	3	1	3	3	2	2	5
Weighted Sample Size (#)	**400**	**101**	**90**	**95**	**110**	**190**	**210**	**131**	**125**	**111**	**51**	**219**	**131**	**215**	**127**	**365**	**35**
Unweighted Sample Size (#)	**400**	**88**	**97**	**98**	**113**	**150**	**250**	**134**	**120**	**107**	**23**	**138**	**239**	**165**	**192**	**364**	**35**

A theft (auto or personal property) having occurred?

	Bermuda Overall %	Parish				Gender		Household Income			Age			Race		Bermudian?	
		Sndy/ Sthp	War/ Paget	Pem/ Devon	Ham/ Sm/Sg	Male	Female	<$75K	$75K-$150K	>150K	18-34	35-54	55+	Black	White	Yes	No
Yes	39	42	46	34	35	10	37	37	40	42	50	39	34	38	41	40	28
No	60	57	54	65	63	58	62	61	59	57	50	60	63	61	57	59	72
Don't Know	1	1	-	1	2	1	1	2	-	1	-	-	3	1	2	1	-
Weighted Sample Size (#)	400	101	90	95	110	190	210	131	125	111	51	219	131	215	127	365	35
Unweighted Sample Size (#)	400	88	97	98	113	150	250	134	120	107	23	138	239	165	192	364	35

Breaking and entering to steal personal property?

	Bermuda Overall %	Parish				Gender		Household Income			Age			Race		Bermudian?	
		Sndy/ Sthp	War/ Paget	Pem/ Devon	Ham/ Sm/Sg	Male	Female	<$75K	$75K-$150K	>150K	18-34	35-54	55+	Black	White	Yes	No
Yes	36	45	34	39	25	31	39	29	41	40	34	36	36	30	42	36	27
No	63	55	64	60	74	68	59	71	57	60	66	63	63	69	57	63	73
Don't Know	1	-	2	1	1	-	2	-	2	1	-	1	1	1	1	1	-
Weighted Sample Size (#)	**400**	**101**	**90**	**95**	**110**	**190**	**210**	**131**	**125**	**111**	**51**	**219**	**131**	**215**	**127**	**365**	**35**
Unweighted Sample Size (#)	**400**	**88**	**97**	**98**	**113**	**150**	**250**	**134**	**120**	**107**	**23**	**138**	**239**	**165**	**192**	**364**	**35**

Crimes committed with guns?

	Bermuda Overall %	Parish				Gender		Household Income			Age			Race		Bermudian?	
		Sndy/ Sthp	War/ Paget	Pem/ Devon	Ham/ Sm/Sg	Male	Female	<$75K	$75K-$150K	>150K	18-34	35-54	55+	Black	White	Yes	No
Yes	18	27	10	28	7	22	13	23	16	16	14	22	11	19	10	18	12
No	81	71	90	70	92	77	85	76	83	83	82	77	87	80	88	81	83
Don't Know	1	2	-	2	2	1	2	2	1	1	3	1	1	1	2	1	5
Weighted Sample Size (#)	**400**	**101**	**90**	**95**	**110**	**190**	**210**	**131**	**125**	**111**	**51**	**219**	**131**	**215**	**127**	**365**	**35**
Unweighted Sample Size (#)	**400**	**88**	**97**	**98**	**113**	**150**	**250**	**134**	**120**	**107**	**23**	**138**	**239**	**165**	**192**	**364**	**35**

Source: DNDC's Commissioned Questions in 2nd Quarter 2015 Bermuda Omnibus Survey©

10.2 DRUG PREVALENCE: HOMELESS POPULATION

A total of 165 homeless persons participated in the survey during the one-month period of enumeration. Males accounted for the larger proportion of the respondents, with slightly over nine homeless males (92.7%) for every homeless female respondent (7.3%).

The highest level of prevalence-of-use was evident for two legal substances (cigarettes and alcohol), where 75.2% and 65.5% of the homeless persons reported that they currently use these substances, respectively (see Table 10.2.1). This means that three out of every four homeless persons presently smoked cigarettes and about two out of every three consumed alcohol. The results showed that 37.0% of homeless persons reported current use of marijuana, with 12.7% and 11.5% who said they used crack and cocaine, respectively, in the present period. There were also a few persons who reported current use of heroin, inhalants, non-medical dosage of prescription drugs, or some other drug like ecstasy, LSD, speed, or hemp. It should be noted, however, that these are not unique persons, in that a homeless person who reported use of one substance could have also reported the use of other substance(s). At the same time, the majority of homeless persons reported that they have never used heroin (67.3%), inhalants (85.5%), or non-medical dosage of prescription drugs (80.0%), in their lifetime. On the other hand, fewer participants reported that they never used substances such as cigarettes (5.5%), alcohol (7.3%), marijuana (15.2%), crack (43.6%), or cocaine (46.7%). In other words, cigarettes and alcohol, and to a slightly lesser extent, marijuana, are the substances of choice among the homeless population in Bermuda.

…37.0% of homeless persons reported current use of marijuana, with 12.7% and 11.5% who said they used crack and cocaine.

The frequency with which the homeless persons drink (those who reported current use of alcohol) was assessed by asking them to report the average number of days in a week that they consumed alcohol (see Table 10.2.2). The majority, about three out of every 10 homeless persons (28.5% or n = 47), reported that they drink every day of the week, that is, all seven days. There was an additional 10.3% (n = 17) who drank for more than half of the week, that is on four to six days. In contrast, fewer respondents drank on just one day (7.9%), two days (9.7%), or three days (9.1%) of the week. The average number of days that the participants consumed alcohol is 4.6 out of seven days. From the results, it is evident that drinking alcohol is a common practice among the homeless population.

The level of alcohol consumption was gauged by asking the respondents who said they drink alcohol to report on the number of (standard) drinks they consumed on a 'typical drinking day'. The number of drinks ranged from one drink to as many as 30 drinks in a day, with an average of 4.7 drinks per day. Most of the respondents (22.4% or n = 37) drank in excess of five or more drinks per day, while only 5.5% (n = 9) consumed one drink per day. There were others who consumed two (12.7%), three (10.9%), or as many as four (13.9%) drinks per day.

In an effort to assess the effects of substance use, specifically the consumption of alcohol, the homeless persons who indicated that they consumed alcohol, whether in the past or currently, were asked to report on three situations: if they felt guilt or remorse after drinking; if they had to be reminded about things they said or did while drinking that they could not remember; or if they failed to do what was normally expected of them because of their drinking. In the first situation, about one out of every five homeless person (21.8%) indicated that they felt guilt or remorse after drinking (see Table 10.2.3). Secondly, slightly over one-third of the respondents (35.2%) said that they had to be reminded by a friend or family member about things they said or did while under the influence of alcohol. Additionally, about one-quarter or one out of every four respondents (26.7%) reported that they failed to meet normal expectations because of their drinking. The extent of the homeless persons' alcohol use was further assessed by asking respondents whether they 'sometimes take a

drink when they first get up'. There were 17.6% (n = 29) of the respondents who affirmed this behaviour.

Further, the homeless survey participants were questioned on the number of times they were treated for alcohol or drug abuse. The majority of the respondents indicated that they never received any type treatment for substance abuse (see Table 10.2.4). On the other hand, there were 7.9% and 8.5% of the respondents who said that they were treated one time for alcohol abuse and drug abuse, respectively. These persons, however, may not be unique in that the same persons who received treatment for alcohol abuse may have also received treatment for drug abuse. An additional 8.5% and 10.9%, respectively, reported to have received treatment two to four times in their lifetime for alcohol or drug abuse. There were a few persons who received treatment in excess of five times in their lifetime.

Table 10.2.1
Prevalence of Substance Use, 2015

Substances	Never Used		Used In The Past		Use Now		Not Stated	
	n	%	n	%	n	%	n	%
Cigarettes	9	5.5	32	19.4	124	75.2	7	4.2
Alcohol	12	7.3	38	23.0	108	65.5	7	4.2
Marijuana	25	15.2	71	43.0	61	37.0	8	4.8
Crack	72	43.6	59	35.8	21	12.7	13	7.8
Cocaine	77	46.7	58	35.2	19	11.5	11	6.6
Heroin	111	67.3	34	20.6	10	6.1	10	6.0
Inhalant	141	85.5	8	4.8	1	0.6	15	9.1
Prescription Drugs	132	80.0	9	5.5	1	0.6	23	13.9
Other Drugs	138	83.6	4	2.4	1	0.6	22	13.3

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

Table 10.2.2
Frequency and Level of Alcohol Use, 2015

Number of Drinks Per Day	Number of Days Per Week							n	%
	1	2	3	4	5	6	7		
1	5	2	-	1	1	-	-	9	5.5
2	5	6	2	2	-	-	6	21	12.7
3	2	5	6	2	-	-	3	18	10.9
4	-	1	5	4	2	2	9	23	13.9
5+	1	2	2	2	-	1	29	37	22.4
n	13	16	15	11	3	3	47	108	65.5
%	7.9	9.7	9.1	6.7	1.8	1.8	28.5		

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

Table 10.2.3
Problem Alcohol Use, 2015

	Yes		No		Refused/Don't Know	
	n	%	n	%	n	%
Feeling of guilt or remorse after drinking	36	21.8	107	64.8	3	1.8
Reminded about things you said or did while you were drinking	58	35.2	88	53.3	-	-
Failed to do what was normally expected of you because of drinking	44	26.7	101	61.2	1	0.6
Sometimes take a drink when you first get up	29	17.6	117	70.9	-	-

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

Table 10.2.4
Treatment for Alcohol or Drug Problem, 2015

Number of Times	Treated For Alcohol Abuse		Treated For Drug Abuse	
	n	%	n	%
0	127	77.0	117	70.9
1	13	7.9	14	8.5
2-4	14	8.5	18	10.9
5+	3	1.8	6	3.6
Not Stated	8	4.8	10	6.1
Total	**165**	**100.0**	**165**	**100.0**

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

10.3 DRUG PREVALENCE: CRIMINAL OFFENDERS

The Drug Abuse Monitoring Survey is part of the Drug Abuse Monitoring Programme (DAMP). The survey tracks patterns of self-reported drug use by criminal offenders and results of urinalysis upon reception at the Westgate Correctional Facility and the Co-Ed prison facility. The urinalysis tests for five illicit substances (THC, opiates, methadone, amphetamines, and ecstasy). The results of this survey are useful in monitoring drug use in the offender population in Bermuda.

The offender population in 2014-2015 that participated in the survey is characteristically 89.9% male; 81.4% black, 69.1% single offenders; 60.6% with dependents; 44.1% raised by single parents; 38.3% with at most a high school education; 38.8% with part-time or odd jobs; and 55.9% being 35 years or younger. Overall, 98.9% of the 188 respondents (n = 186) have reported use of at least one drug in their lifetime, and three in five (56.9%) were poly substance users. There were no repeat offenders who participated in the survey.

Overall, 98.9% of the 188 respondents (n = 186) have reported use of at least one drug in their lifetime, and three in five (56.9%) were poly substance users.

Highest lifetime consumption was observed for alcohol (95.7%), marijuana (92.0%), and cigarettes/tobacco (91.0%) (see Table 10.3.1). Likewise, in the 30 days prior to the survey, respondents indicated the highest consumption for alcohol (73.4%), cigarettes/tobacco (69.1%), and marijuana (61.7%). The self-reported use of marijuana was supported by the drug screening results, which confirmed the predominant use of THC (60.1%), the active chemical in marijuana, followed by cocaine (14.9%), and opiates (7.4%) (see Table 10.3.2). The age of initiation of drug use ranges from a low of 14.4 years for marijuana to a high of 31.0 years for methadone. Alcohol and cigarette/tobacco use began around 14.8 and 15.2 years, respectively, and the use of heroin and cocaine began after 23 years, on average. Of the 188 surveyed inmates, 69 (36.7%) were non-poly drug users, in that they used only one or no substance, including alcohol. In contrast, 107 offenders (56.9%) were poly substance users, of which 80 used a combination of only two drugs, while 27 used combinations of three or more of these drugs.

Respondents were asked specific questions to determine whether or not drugs and/or alcohol were in any way connected to their current or previous offence(s). About three out of every 10 offenders reported that drugs were connected to their current (28.9%) and past (27.4%) offence(s) (see Table 10.3.3). On the other hand, about one-quarter or one in four persons felt that alcohol was connected to their current (24.1%) and one in five to their past (18.3%) offence(s). In other words, drugs were more connected to both past and current offence(s) than alcohol. When asked about the ways in which drugs and alcohol were connected to the offence(s), 17.6% indicated that the offence was because of personal use or possession of drugs. Likewise, 16.5% of the respondents indicated that the offence(s) was committed while under the influence of drugs and 15.4% of them indicated that the offence was committed to support their drug habit by providing money to buy drugs. The connection to the offence(s) being committed while under the influence of alcohol compares less favourably than the offence being committed while under the influence of drugs. The results showed that alcohol played a significant role in respondents offending in that there were slightly over one-quarter (26.1%) or one in four respondents who reported that the offence(s) was committed while under the influence of alcohol.

About three out of every 10 offenders reported that drugs were connected to their current (28.9%) and past (27.4%) offence(s).

In order to assess the drug market, respondents were also asked to indicate if they bought any illegal drugs, for "*yourself*" or "others" over the past 12 months. Interestingly, about half of the respondents (50.5%) of survey respondents said they had, while 43.1% reported buying illegal drugs for themselves or others during the past 30 days prior to being arrested (see Table 10.3.4). When asked if they had sold illegal drugs to make money in the past 12 months, 13.8%

or 26 people indicated they had sold drugs. On the other hand, when it came to selling illegal drugs during the past 30 days, prior to being arrested, 10.6% (n = 20), admitted they had sold drugs.

Table 10.3.5 presents the distribution of the DAST scores for the 188 offenders who participated in the survey (see Table 10.3.6 for the results on the DAST items). About one in 10 (9.6%) offenders reported no substance abuse problems, while a small proportion (4.8%) was assessed as having severe substance abuse problems. Overall, 43.1% of reception offenders were classified as having "intermediate to severe" drug abuse problems prior to their current arrests and incarceration, with 22.3% classified as "intermediate" and 16.0% as "substantial". This, therefore, means that slightly less than half of the reception population, or about two out of every five, requires some type of assistance or intervention for substance abuse problems.

Table 10.3.1
Lifetime and Current Prevalence of Substance Use by Proportion of Respondents, 2014/2015

Substance	Lifetime Use (%) *(n = 188)*	Average Age of First Use (Years)	Current Use (%) *(n = 188)*	Average Number of Days Used in Last 30 Days
Cigarettes/Tobacco	91.0	15.2	69.1	23.1
Alcohol	95.7	14.8	73.4	14.3
Marijuana	92.0	14.4	61.7	18.5
Crack Cocaine	27.7	24.0	14.9	14.1
Cocaine Powder	22.3	23.3	3.7	8.6
Heroin	20.7	23.6	7.4	20.1
Ecstasy	20.7	22.3	1.1	1.0
LSD	3.7	18.8	-	-
Methamphetamine	0.5	17.0	-	-
Valium/Benzodiazepine	1.6	22.5	-	-
Methadone	4.8	31.0	0.5	30.0
Other Street Drugs	4.8	25.9	0.5	3.0

Source: DNDC's 2014/2015 Drug Abuse Monitoring Survey

Table 10.3.2
Comparison of Self-Reported Current Users of Substances and Positive Urine Tests, 2014/2015 **(n = 188)**

Substance	Current Use		Positive Unit Test		Current Use and Positive Urine Test	
	n	%	n	%	n	%
Marijuana	116	61.7	113	60.1	95	50.5
Cocaine	7	3.7	28	14.9	5	2.7
Opiate	14	7.4*	14	7.4	10	5.3
Methadone	1	0.5	2	1.1	1	0.5

Source: DNDC's 2014/2015 Drug Abuse Monitoring Survey

Table 10.3.3
Drug and Alcohol Connection with Offence, 2014/2015 **(n = 188)**

DRUG CONNECTION TO OFFENCE(S)	% RESPONDENTS
Drug connection to current offence(s) (Yes)	28.9
Drug connection to previous offence(s) (Yes)	27.4
WAYS DRUGS WERE CONNECTED TO OFFENCE(S)	**% RESPONDENTS**
Offence committed while under the influence of drugs	16.5
Offence committed to support drug habit (for money to buy drugs)	15.4
Through being involved with the drug trade	7.4
Personal use of drugs (possession)	17.6
Other	0.5
No answer	3.2

Table 10.3.3 cont'd
Drug and Alcohol Connection with Offence, 2014/2015 **(n = 188)**

ALCOHOL CONNECTION TO OFFENCE(S)	% RESPONDENTS
Alcohol connection to current offence(s) (Yes)	24.1
Alcohol connection to previous offence(s) (Yes)	18.3
WAYS ALCOHOL WAS CONNECTED TO OFFENCE(S)	**% RESPONDENTS**
Offence committed while under the influence of alcohol	26.1
Offence committed to support alcohol habit (for money to buy alcohol)	0.5
Drunk driving	3.2
Other	0.5
No answer	3.2

Source: DNDC's 2014/2015 Drug Abuse Monitoring Survey

Table 10.3.4
Drug Market: Supply and Demand, 2014/2015 **(n = 188)**

QUESTIONS	% RESPONDENTS
During the **past 12 months** did you **buy** any illegal drugs, either for yourself or for others? (Yes)	50.5
During the **past 30 days** before your arrest did you **buy** any illegal drugs, either for yourself or for others? (Yes)	43.1
During the **past 12 months** did you **sell** any illegal drugs to anyone to make money? (Yes)	13.8
During the **past 30 days** before your arrest did you **sell** any illegal drugs to anyone to make money? (Yes)	10.6

Source: DNDC's 2014/2015 Drug Abuse Monitoring Survey

Table 10.3.5
Proportion of Respondents by Level of Severity of Substance Abuse – DAST Results, 2014/2015 **(n = 188)**

	LEVEL OF SEVERITY	% RESPONDENTS
Substance Abuse or Dependence	None (0)	9.6
	Low (1-5)	46.8
	Intermediate (6-10)	22.3
	Substantial (11-15)	16.0
	Severe (16-20)	4.8

Source: DNDC's 2014/2015 Drug Abuse Monitoring Survey

Table 10.3.6
"Yes" Responses to the DAST by Proportion of Respondents, 2014/2015

QUESTION	OVERALL (YES) *(n = 188)*	
	n	%
Have you used drugs other than those required for medical reasons?	156	83.0
Have you abused prescription drugs?	18	9.6
Do you abuse more than one drug at a time?	60	31.9
Can you get through the week without using drugs (other than those required for medical reasons)?	160	85.1
Are you always able to stop using drugs when you want to?	148	78.7
Do you abuse drugs on a continuous basis?	59	31.4
Do you try to limit your drug use to certain situations?	100	53.2
Have you had "blackouts" or "flashbacks" as a result of drug use?	35	18.6
Do you ever feel bad about your drug abuse?	76	40.4
Does your spouse (or parents) ever complain about your involvement with drugs?	91	48.4

Table 10.3.6 cont'd
"Yes" Responses to the DAST by Proportion of Respondents, 2014/2015

QUESTION	OVERALL (YES) *(n = 188)*	
	n	%
Do your friends or relatives know or suspect you abuse drugs?	108	57.4
Has drug abuse ever created problems between you and your spouse?	63	33.5
Has any family member ever sought help for problems related to your drug use?	45	23.9
Have you ever lost friends because of your use of drugs?	51	27.1
Have you ever neglected your family or missed work because of your use of drugs?	56	29.8
Have you ever been in trouble at work because of drug abuse?	32	17.0
Have you ever lost a job because of drug abuse?	31	16.5
Have you gotten into fights when under the influence of drugs?	74	39.4
Have you ever been arrested because of unusual behaviour while under the influence of drugs?	49	26.1
Have you ever been arrested for driving while under the influence of drugs	34	18.1
Have you engaged in illegal activities to obtain drugs?	47	25.0
Have you ever been arrested for possession of illegal drugs	65	34.6
Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	40	21.3
Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, etc.)?	16	8.5
Have you ever gone to anyone for help for a drug problem?	66	35.1
Have you ever been in hospital for medical problems related to your drug use	24	12.8
Have you ever been involved in a treatment program specifically related to drug use?	63	33.5
Have you been treated as an outpatient for problems related to drug abuse?	38	20.2

Source: DNDC's 2014/2015 Drug Abuse Monitoring Survey

10.4 TREATMENT DEMAND

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

The last publication of data from the Treatment Demand Indicators Survey, in the 2013 Annual Report of the BerDIN, included 100 records up to June 2013. However, this section of the report contains data on clients who sought treatment from January 2013 to August 2015; therefore, note there is an overlap in the reporting period. There were 87 persons who have sought substance abuse treatment over this period by these treatment facilities (see Table 10.4.1). A total of 65 males and 22 females have required the services of inpatient (including residential), outpatient, and in-prison (residential) treatment. The demand for treatment services, as indicated by the dates of assessment, was highest in 2013 with 39 clients, which then fell in 2014 to 20 clients, than increased again in 2015 to 18 clients up to mid-year. Most persons were clients of Right Living House at the Prison Farm; although it is known that most persons receive treatment at the Turning Point Substance Abuse Treatment programme; but data from this facility has not been consistently submitted to the DNDC. Persons requiring treatment services ranged from 23 years to 64 years with more than half of these clients being 45 years or older and less than one-fifth under 35 years.

Persons who sought treatment were more likely to self-refer (41.4%) or, in other instances, sought treatment because of a court order or to complete probation or parole (27.6%). The majority of clients (60.9%) who sought treatment during this period have received treatment sometime in the past, from as early as 2003 to more recent as earlier in 2015. However, only 10.3% of persons who sought treatment have been receiving substitution treatment such as methadone. In terms of the primary drug of impact for which persons sought treatment (see Table 10.4.2), slightly over one-third (35.6%) of the persons sought treatment for heroin use, while fewer than one-fifth sought treatment for use of crack (19.5%) or alcohol (17.2%). Persons also sought treatment for cannabis, cocaine, opiates in general (including methadone). Most of the persons (59.8%) have reported daily use of drugs whereas 24.1% indicated that they have not used any drugs in the past month prior to

The age of first use of the identified primary drug ranged from seven years to 46 years, with an average age of onset being 21.3 years.

seeking treatment (see Table 10.4.3). Smoking or inhaling (49.4%) was reported as the main method of administering the drugs followed by sniffing (19.5%) (see Table 10.4.4).

The age of first use of the identified primary drug ranged from seven years to 46 years, with an average age of onset being 21.3 years. However, slightly less than one-third (28.7%) of the persons who sought treatment indicated that they first used their primary drug between the ages of 13 to 17 years, while about one in 10 (9.2%) used drugs before becoming a teenager (see Table 10.4.5). Apart from the main drug of choice, some persons also reported the use of a secondary drug, for which the age of initiation ranged from an average of 14 years for cannabis to 55 years for methadone (see Table 10.4.6).

The drug market is still operational in Bermuda as reflected by the demand for and availability or supply of drugs. A significant proportion of the persons who sought treatment reported that their primary drug was "always available" (73.6%) or "mostly available" (16.1%) and more than two-thirds (69%) indicated that they purchased their drugs from a regular supplier (see Table 10.4.7). At the same time, about half of the persons (49.4%) stated that they made money or obtained drugs by selling illegal drugs or being involved in the manufacture or transportation of drugs. Persons also specified the way(s) in which the various drugs are usually packaged for sale (see Table 10.4.8), utilising paper, plastic, or foil in which drugs are wrapped or twisted, and quantities can be sold for any dollar value in demand; but some common denominations are $10, $20, $50, and $100. Reported prices paid for drugs still seemed volatile and, hence, were not included in this publication until they can be reliably validated, possibly from other sources or treatment agencies.

Table 10.4.1
Demographic Characteristics of Clients Seeking Treatment, 2013 to 2015

Characteristic	Number of Persons
Total	**87**
Sex	
Males	65
Females	22
Facility	
Men's Treatment	19
Women's Treatment	15
Turning Point	9
Right Living House	27
Salvation Army Harbour Light	17
Type of Treatment Facility	
Inpatient	53
Outpatient	7
Treatment in Prison	27
Source of Referral	
Self-Referred	36
Family/Friends	6
Other Drug-Treatment Centre	8
Social Service	3
Court/Probation/Parole	24
Other	8
Not Stated	2

Source: DNDC's 2014/2015 Drug Abuse Monitoring Survey

Table 10.4.1 cont'd
Demographic Characteristics of Clients Seeking Treatment, 2013 to 2015

Characteristic	Number of Persons
Living Status (With Whom)	
Alone	17
With Parents	19
Alone with Child	4
Alone with Partner	5
With Partner and Child/Children	7
With Friends	2
Other	31
Not Known & Not Stated	2
Living Status (Where)	
Stable Accommodation	48
Unstable Accommodation	19
Institution (Prison/Clinic)	17
Not Known & Not Stated	3
Nationality	
National of Bermuda	86
National of Another Country	-
Not Known & Not Stated	1
Labour Status	
Regular Employment	23
Economically Inactive	3
Pupil/Student	1
Unemployed	53
Other	6
Not Stated	1
Highest Education Level Completed	
Never Went to School/Never Completed Primary School	1
Primary Level of Education	15
Secondary level of Education	40
Higher Level of Education	30
Not Known & Not Stated	1

Source: DNDC's 2014/2015 Drug Abuse Monitoring Survey

Table 10.4.2
Primary Drug of Impact of Clients Seeking Treatment, 2013 to 2015

Primary Drug of Impact	Number of Persons
Heroin	31
Crack (only)	17
Cocaine (only)	7
Alcohol	15
Cannabis	8
Opiates (Heroin, Methadone, Other Opiates)	2
Cocaine (including Crack)	4
Stimulants	1
Not Stated	2

Source: DNDC's Treatment Demand Indicators Survey

Table 10.4.3
Frequency of Drug Use, 2013 to 2015

Frequency	Number of Persons
Used daily	52
Not used in past month	21
Used 2-6 days per week or less	7
Used once per week or less	4
Not known	2
Not stated	1

Source: DNDC's Treatment Demand Indicators Survey

Table 10.4.4
Primary Route of Drug Administration, 2013 to 2015

Primary Route	Number of Persons
Smoke/Inhale	43
Sniff	17
Drink	13
Inject	2
Other	1
Not Stated	1

Source: DNDC's Treatment Demand Indicators Survey

Table 10.4.5
Age of First Use of Primary Drug, 2013 to 2015

Age	Number of Persons
Less than 13 years	8
13 – 17 Years	25
18 – 20 Years	13
21 – 24 Years	12
25 – 29 Years	11
30 – 34 Years	8
35 – 39 Years	4
40+ Years	3
Not Stated	3

Source: DNDC's Treatment Demand Indicators Survey

Table 10.4.6
Average Age of Initiation by Type of (Secondary) Drug, 2013 to 2015

Drug	Average Age of Initiation
Cannabis	13.6
Alcohol	14.1
Opiates (Total)	19.0
Heroin	28.1
Methadone	55.0

Source: DNDC's Treatment Demand Indicators Survey

Table 10.4.6 cont'd
Average Age of Initiation by Type of (Secondary) Drug, 2013 to 2015

Drug	Average Age of Initiation
Other Opiates	-
Cocaine (Total)	25.5
Cocaine	25.1
Crack	23.9
Stimulants (Total)	-
Amphetamine	-
MDMA and Other Derivatives	25.5

Source: DNDC's Treatment Demand Indicators Survey

Table 10.4.7
Drug Market (Availability, Supplier, and Proceeds), 2013 to 2015

Availability of Primary Drug	Number of Persons
Always Available	64
Mostly Available	14
Sometimes Available	2
Never Available	6
Not Stated	1
Purchased from Regular Supplier	
Yes	60
No	24
Not Stated	3
Made Money or Obtained Drugs by Selling Illegal Drugs or Being Involved in Manufacture or Transportation of Drugs	
Yes	43
No	41
Not Stated	3

Source: DNDC's Treatment Demand Indicators Survey

Table 10.4.8
Drug Market (Packaging of Drugs), 2013 to 2015

Cannabis	Cocaine
$20	$20 - $50 wraps
$50 to $150	$50 to $100
Brown paper/twist	$50 packets
Plastic bag	Brown paper/twist
Not Stated	Plastic twist
	Not packaged
Crack	**Heroin**
$20 and up	$2.50, $4.50, $20, $50
$50, $100	$20 in plastic
Brown paper/twist or clear plastic	$20 in foil wrap
Plastic bag	$10 to $100
Foil wrap	$50 bags/packages
Wax paper twist	For any amount of money
Rocks	Foil wrap
Paper	Plastic twist/wrap
In hand	Plastic bag
Opiates	**Alcohol**
Foil wrap	Bottle
Plastic bag	Can

Source: DNDC's Treatment Demand Indicators Survey

Chapter 11
Financing Drug Control

- Drug Treatment and Prevention Expenditure
- Enforcement and Interdiction Expenditure

11.1 DRUG CONTROL EXPENDITURE

In total, the government expended in excess of $15 million on drug control in Bermuda in each of the last two fiscal years.

The majority of Bermuda's demand reduction programmes and activities are funded and overseen by the DNDC. A few treatment and prevention programmes are directly funded through the Department, while other initiatives are supported through an annual grant provision to community-based partners and stakeholders.

In total, the government expended in excess of $15 million on drug control in Bermuda in each of the last two fiscal years. Of the drug control expenditure, demand reduction activities received the larger proportion of the allocated resources in both years under review when compared to the allotment given to supply reduction; $10.0 million and $9.6 million versus $5.7 million and $5.8 million, in FY 2013/2014 and FY 2014/2015, respectively (see Tables 11.1.1 and 11.1.2). On the demand reduction side, disparity in allotment continued to exist between treatment and prevention, with treatment receiving the greater proportion, especially due to the operations of a fairly new residential facility. However, funding for treatment services declined by 4.1% from FY 2013/2014 to FY 2014/2015; funding for prevention services, at the same time, also decreased slightly by 0.9% (see Table 11.1.1). In both fiscal years under review, the majority of the supply reduction budget was allocated to HM Customs' interdiction efforts and a smaller proportion to the Bermuda Police Service for its drugs and intelligence division (see Table 11.1.2). Government expenditure on supply reduction, which entails enforcement, interdiction, and intelligence, saw a negligible increase of 0.2% year over year – moving from a $5.7 million in FY 2013/2014 to $5.8 million in FY 2014/2015.

Sufficient evidence exist that point to the fact that Bermuda continues to witness a constant presence of illicit drug use and drug-related criminal activities such as violence and illicit trafficking. In response to this growing threat, the Government of Bermuda has initiated and continued to operationalise a complementary battery of measures to combat the problem, on both the demand and supply reduction sides. With the technical support from the Department for National Drug Control and through the implementation of the National Drug Control Master Plan and Action Plan for 2013-2017, Government will continue to make a commitment to, and have a strategy for, the adequate funding of substance abuse prevention and drug addiction treatment and rehabilitation.

Table 11.1.1
Government Expenditure on Drug Treatment and Prevention, 2013/2014 and 2014/2015

	2013/2014 ACTUAL ($000)	2014/2015 REVISED ($000)
TREATMENT	**9,306**	**8,927**
% Change	**-25.8**	**-4.1**
DNDC (MT*, WTC, Treatment Unit)	2,454	2,015
Grantees		
Salvation Army	100	100
FOCUS Counselling Services	185	185
Other (BACB)	**100**	**100**
Other Agencies		
BARC	834	1,004
BYCS	967	1,095
Drug Court	311	406
Mandatory Drug Treatment (RLH)	1,481	1,488
Turning Point Substance Abuse Programme+	2,384	2,384
Capital Project++	490	150

Table 11.1.1 cont'd
Government Expenditure on Drug Treatment and Prevention, 2013/2014 and 2014/2015

	2013/2014 ACTUAL ($000)	2014/2015 REVISED ($000)
PREVENTION	**690**	**684**
% Change	**3.6**	**-0.9**
DNDC (Prevention Unit & Community Education)	407	401
Grantees		
PRIDE	183	183
CADA	100	100
TOTAL DEMAND REDUCTION	**9,996**	**9,611**
% Change	**-24.3**	**-3.9**

Source: Government of Bermuda Budget

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

Table 11.1.2
Government Expenditure on Enforcement and Interdiction, 2013/2014 and 2014/2015

	2012/2013 ACTUAL ($000)	2013/2014 REVISED ($000)
ENFORCEMENT AND INTERDICTION		
Police – Enforcement (Drugs, Financial Crime, and Intelligence Divisions)	1,312	1,578
Customs – Interdiction	4,429	4,176
Border Control – Interdiction	5,741	5,754
TOTAL SUPPLY REDUCTION	**399.2**	**0.2**
% Change	**89.0**	**283.2**

Source: Government of Bermuda Budget

LOOKING AHEAD

This fifth Report of the Bermuda Drug Information Network demonstrates that drug control remains constant in Bermuda. This is evidenced from the analysis presented in the foregoing chapters showing that substance misuse and abuse are still valid today. While the BerDIN information is comprehensive, there remains incomplete information in terms of problem drug use, drug use prevention programmes, and the economic cost of drug use to the Bermudian society.

Prevention of drug use is one of the key provisions of Bermuda's drug policy. Aimed at protecting the health of people from harm caused by the non-medical use of controlled substances while ensuring availability of those substances for medical and scientific purposes, drug use prevention encompasses any activity focused on preventing or delaying the initiation of drug use and the potential transition to problem drug use. There are effective and feasible interventions and policies in place and available for drug prevention. However, the gaps in both evidence and effectiveness research point to the fact that more evaluation of impact is needed. Additionally, researching those groups with heightened vulnerability remains a challenge, while the question of how to adapt interventions to the local context has yet to be answered.

In absence of data on patterns of drug use, data on drug users in treatment is taken as a proxy. Treatment demand differs by substance of choice, with most people who access treatment for drug use being repeat clients. The proportion of existing clients seeking assessment for substance use treatment and whose substance of choice is opiates, cocaine, or marijuana was significantly higher in 2014 than in 2013; indicating that there remains a high demand for treatment.

An apparent major benefit of drug treatment, aside from the recovery of the client and the subsequent health and social implications, is the element of cost; as research studies indicate that spending on treatment is cost-effective. It has been shown that drug treatment is less expensive than either incarceration or a complete lack of treatment. Drug treatment is cost-effective in reducing drug use along with its associated health and social costs and it is also less expensive than the alternatives, such as not treating addicts or simply incarcerating dependent users. While the figures presented in this publication represent an estimate of the costs of treating substance users in Bermuda, it is a good proxy for the purposes of this report. Better and more accurate information that speaks to the cost of treatment and the economic cost contributed by illegal drug activity will provide more precise information.

While there appear to be small changes in reported figures, the overall message is positive – that the drug control system is working. Crime is down with the exception of property crime and people have reported feeling safe in their communities. As reflected in the treatment admission numbers, demand remains high for substance abuse treatment services although access issues continue and limited funding threatens the provision of a continuum of care. These factors have led to a renewed emphasis on the continued provision of tested and effective prevention and treatment strategies that demonstrate sound outcomes.

The Bermuda Drug Information Network has indeed come a long way since 2010. The system continues to evolve despite challenges that could hinder the provision of information. The DNDC technical staff have provided several hours of support to agencies requiring capacity building. These challenges have not deterred the Department's resolve to identify and report on key indicators that inform the drug situation in Bermuda. We remain steadfast, now more than ever, to the provision of reliable, accurate, and up-to-date information.

…renewed emphasis on the continued provision of tested and effective prevention and treatment strategies that demonstrate sound outcomes.

SUMMARY OF SOURCES AND DATA

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

+ New data source/report item.

IMPLICATIONS OF THE PRESENT DRUG SITUATION

Public Health, Programme, Policy, and Legislative Implications

New Indicators

DATA	IMPORTANCE OF THE INDICATORS	PUBLIC HEALTH/ PROGRAMME IMPLICATIONS	POLICY AND LEGISLATIVE IMPLICATIONS
Clients in Treatment	An indicator of treatment demand used to demonstrate the need for increases in services.	Ability to adequately address the rehabilitation needs of persons abusing and dependent on alcohol and drugs.	Waiting list policy. Implementation of alternative services that address the needs of the community, such as outpatient type services.
Classification of Drug Abuse and Dependence (DSM-IV)	Indicates harmful use for alcohol and drugs for the past 30 days. It assesses frequency and severity of symptoms.	Designed to provide an indication of recent severity of substance abuse and dependence on alcohol and specifically by drug type. Offers unique advantages as a measure of treatment outcome that may be more sensitive to changes in clinical status than outcome measures routinely used, such as self-report substance use, urinalysis results, or diagnostic status. The Substance Dependence Severity Scale (SDSS) can be used as a baseline and follow up measure in alcoholism and drug abuse treatment studies and other studies requiring quantification.	Improved access to substance abuse treatment services and diversification of services.
Drug Screening Results – Co-Ed Correctional Facility	Can distinguish alcohol and drug users from nonusers, make initial treatment recommendations, make case management decisions, and provide information for a continuum of services.	Assessment may occur at any stage in a person's movement through the criminal justice system. Coordination of assessment strategies and the sharing of information is vital to ensure that the incarcerated receive the continuum of services needed.	Assessment information must be integrated, evaluated, and used appropriately in decision making regarding individual inmates, such as drug resistance classes and counselling.
PATHS Programme Indicators	The PATHS curriculum is a comprehensive programme for promoting emotional and social competencies and reducing aggression and behaviour problems in elementary school-aged children while simultaneously enhancing the educational process in the classroom.	Systematic, developmentally-based lessons, materials, and instructions are provided to facilitate emotional litreacy, self-control, social competence, positive peer relations, and interpersonal problem-solving skills. Key objectives in promoting these developmental skills are to prevent and to reduce behavioural and emotional problems.	The implementation of this curriculum throughout primary schools as a means to reduce aggression and behaviour problems.
Homeless Population Substance Use	Substance abuse is much more common among homeless people than in the general population. Therefore, obtaining an accurate prevalence rate for this cohort is necessary to providing treatment and support services.	Substance abuse is both a cause and a result of homelessness, both issues need to be addressed simultaneously. In addition to housing, supported housing programmes offer services such as mental health treatment, physical health care, education and employment opportunities, peer support, and daily living, and money management skills training. Successful supported housing programmes include outreach and engagement workers, a variety of flexible treatment options to choose from, and services to help people reintegrate into their communities.	Additional services for homeless population directed at preventing and treating substance abuse.

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

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

Notes:

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

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

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

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

DEFINITIONS OF TERMS AND CONCEPTS

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

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

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

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

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

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

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

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

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

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

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

DRUG ABUSE: The use of a chemical substance for purposes other than medical or scientific, including use without prescription, in excessive dose levels, or over an unjustified period of time in such a fashion that it impacts on or impairs

an individual in a physical, psychological, behavioural, or social manner.

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

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

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

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

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

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

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

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

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

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

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

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

PREVALENCE: The terms prevalence refers to the proportion of a population who has used a drug over a particular time period. Prevalence is measured by asking respondents to recall their use of drugs. Typically, the three most widely used recall periods are: lifetime (ever used a drug), last year (used a drug in the last 12 months), and last month (used a drug in the last 30 days).

PREVENTION: A proactive process that attempts to prevent the onset of substance use or limit the development of problems associated with using psychoactive substances. Prevention efforts may focus on the individual or their

surroundings and seeks to promote positive change. It typically focuses on minors — children and teens.

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

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

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

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

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

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

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

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

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

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

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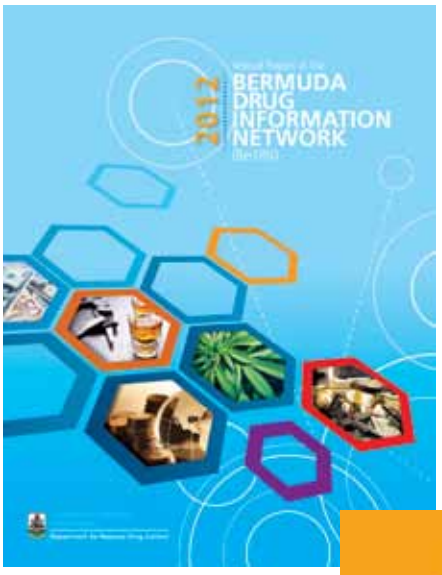

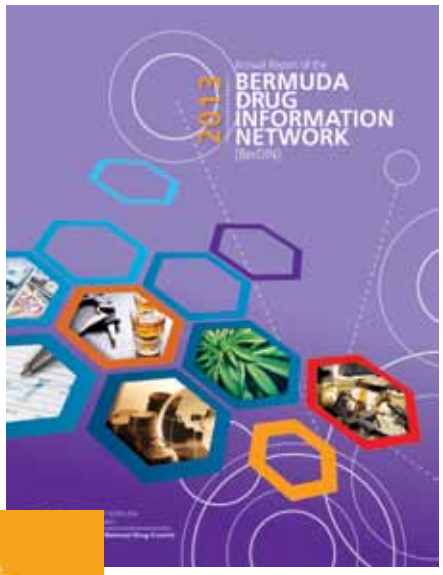

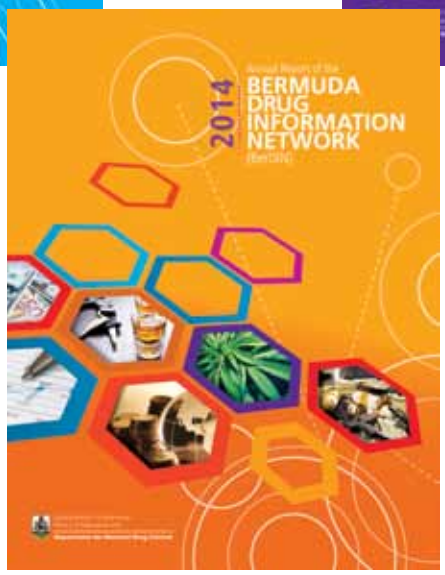

Deconstructing the Drug Problem in Bermuda 2010
A Pictorial Presentation of the Present Drug Situation

Illegal Drugs Fact Sheet 2010

Annual BAC Levels 2010

Drug Screening Results for Turning Point 2010

Drug Users as Offenders Drug Using Offenders 2005 – 2008

Bermuda Police Service Arrest Data for the Period 2003 – 2007