BAHAMAS NATIONAL HOUSEHOLD DRUG PREVALENCE SURVEY REPORT

2018

MINISTRY OF HEALTH, THE COMMONWEALTH OF THE BAHAMAS
IN COLLABORATION WITH
THE INTER-AMERICAN DRUG ABUSE CONTROL COMMISSION (CICAD), AND
THE ORGANIZATION OF AMERICAN STATES

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FOREWORD

The Ministry of Health is pleased to share results of the Bahamas National Household Drug Survey, a collaborative work executed in partnership with the Organization of the American States Inter-American Drug Abuse Control Commission (OAS/CICAD); the National Anti-Drug Secretariat, Ministry of National Security; Department of Statistics; and the Bahamas National Drug Council.

Drug use is a concern because of its potential for adverse effects on individuals, families and society at large. As early as the 1960s, alcohol was observed as a major substance of abuse. By the 1970s, it became apparent that other drugs, including marijuana, were also being abused. Cocaine, free-base smoking of cocaine and poly drug use also emerged in the 1970s. It was clear by this time that The Bahamas was truly in the midst of an epidemic.

In response, many initiatives were launched to address drug prevention, treatment and rehabilitation, coupled with other national efforts that included the introduction of supportive legislation. All of these were carried out with the support of local, regional and international partners including the United States Embassy and the OAS/CICAD.

Prior studies conducted in The Bahamas confirmed clinical and social observations of drug use among adolescents as well as adults. With the increased knowledge gained from this survey about the current drug use situation, particularly relative to the most commonly used substances - alcohol, tobacco and marijuana - results may be used to assess existing initiatives and propose effective changes. Such modifications may be made through policies and programmes that will strengthen prevention and control measures to align them with societal realities, and increase understanding about patterns of illicit drug use and emerging trends. Finally, the timely findings will, no doubt, add referential evidence and a relevant perspective to current discussions on the decriminalization of marijuana and its use for medicinal purposes in The Bahamas.

Our vision for a better Bahamas includes having drug-free communities with residents who are well-educated on the dangers of drug use and equipped to navigate the pressures to engage in the use of illicit substances.

My sincere gratitude is expressed to all persons and agencies who made this important work possible.

Dr. The Honourable Duane Sands, M.P.
Minister of Health
Ministry of Health

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EXECUTIVE SUMMARY

The Bahamas began to experience the ravages of drug abuse more than three decades ago. In the 1960s, hospital admissions showed alcohol to be the major substance of abuse. Following this trend between the late 1960s and early 1970s, evidence of other types of drug abuse emerged. In the 1970s, lysergic acid diethylamide (LSD) emerged for a short period, following which, marijuana, methaqualone, phencyclidine were all reported as drugs that were being abused at that time.[1]

Concomitant in the mid-1970s was the growing presence of cocaine hydrochloride and its combined use with other drugs. Later in 1979, freebase smoking of cocaine emerged as a new trend. It was not until almost five years later that early signs of a freebase cocaine epidemic became evident through initial drug abuse cases admitted to hospital that led to increasing annual occurrences.[1]

The adverse effects of drug abuse in The Bahamas have been far-reaching, spiraling into many associated social ills. When the magnitude of the drug abuse problem was realized, The Bahamas Government undertook several responsive actions. Among other initiatives was the appointment of a national task force[2] to assess and address the situation in partnership with local, regional and international organizations, including the American Embassy. The health sector played a major role in the government's response, tackling the areas of drug prevention, treatment and rehabilitation. Other measures taken included the establishment of The Bahamas National Drug Council; formulation of a national drug abuse prevention plan; and the establishment of drug treatment and rehabilitation centres in the public sector and among non-government organizations.

Profiles of drug use from earlier studies showed that among secondary school students there has been increased alcohol use between 2002 and 2011. Marijuana use remained largely unchanged while cigarette use showed a decline.[3] Similar results were found in the Global School Health Survey (2013).[4]

Among adults, alcohol, tobacco, marijuana and cocaine were found to be drugs of choice in the 1991 Community Survey of Drug Use in The Bahamas (n=1,731) that examined substance use among persons 16-59 years.[5] Since that time, a 2012 STEPS Survey examined chronic disease risk factors in The Bahamas (n=1,654) among adults 25-64 years. Results showed that the prevalence of current tobacco smoking was found to be 16.7% (CI 1.2%, 32.2%), and with regard to alcohol consumption, 40.8% (CI 19.0%, 62.6%) for current drinking.[6]

The Bahamas National Household Drug Prevalence Survey provided a valuable opportunity to learn about current trends in alcohol and illicit drug use in The Bahamas. Further, it yielded evidence to support the formulation of policies for further development of the population.

This drug survey was completed with assistance from the Inter-American Drug Abuse Control Commission (CICAD)/Organization of American States (OAS) and through partnerships with local agencies – the National Anti-Drug Secretariat, Ministry of National Security; Department of Statistics; The Bahamas National Drug Council; and the Ministry of Health (MOH). The survey was implemented by the Health Information and Research Unit, Ministry of Health.

SURVEY SCOPE

The survey was performed from February to April 2017 on six islands in The Bahamas: New Providence, Grand Bahama, Abaco, Andros, Eleuthera and Exuma.

Using standardized household survey protocols from the Uniform Data System on Drug Consumption (SIDUC)[7] under CICAD's Inter-American Observatory on Drugs, enumerators conducted face-to-face interviews using pre-programmed computer tablets. With a response rate of 70%, the sample size was 2,533 (52% female, 48% male), with ages of the respondents ranging from 12 to 65 years.

OVERVIEW OF FINDINGS

The results showed that males are more likely than females to use drugs, the most prevalent of which are alcohol, tobacco and marijuana. These are consistent with findings from the 1991 survey. However, cocaine use is relatively low, declining from levels previously reported.

Tobacco

1. *Lifetime, past year and past month prevalence of tobacco smoking was 21%, 9% and 7%, respectively.*

2. *Average age for the initiation of smoking tobacco among males and females was 18 years.*

3. *Current smokers (those who smoked in the past 30 days):*
    a. *Comprised of 11.7% of males and 2.2% of females;*
    b. *Overall, 56% smoked daily (54.2% male, 64.9% female);*
    c. *Forty-one percent (41%) spent $50 or more on cigarettes in the past month;*
    d. *Seventy-two percent (72%) viewed smoking often as a high-risk behaviour, compared to 83% of non-smokers.*

4. *Males and persons who did not complete high school were among those who had the highest smoking prevalence rates.*

Alcohol

1. *Lifetime, past year and past month prevalence of alcohol use was 74%, 55% and 43%, respectively.*

2. *Average age for the initiation of drinking was 18 years (males 17 years, females 18 years).*

3. *Current drinkers (those who drank in the past 30 days):*
    a. *Consisted of 51.5% of males and 34.2% of females;*
    b. *On average they got drunk once in the past month;*
    c. *Nineteen percent (19%) spent $50 or more on alcohol in the past month;*
    d. *Sixty-one percent (61%) viewed drinking often as a high-risk behaviour, compared to 77% of non-drinkers;*
    e. *Binge drinking (5 or more drinks for males, 4 or more for females) was a greater problem among males - 21% binge-drank two to three times in the past two weeks, as compared to females (14%).*

4. *Individuals who completed secondary school had a higher prevalence of drinking (47%), as did those who were employed (50.7%).*

5. *When a further assessment was done using the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT) screening tool that focused on the past year drinkers population,*
    a. *The prevalence of risky drinking among past year drinkers was 11.3%;*
    b. *Among persons who engaged in risky drinking behaviours, those with the highest proportions included young men 12-24 years (23.4%); persons with incomplete secondary school education (22%); and unemployed persons (16.5%).*

Marijuana

1. *Lifetime, past year and past month prevalence of marijuana use was 13%, 3.1% and 2.8%, respectively.*

2. *Average age for the initiation of smoking marijuana was 17 years (males 17 years, females 19 years).*

3. *Current marijuana users (those who used in the past 30 days):*
    a. *Consisted of 5% of males and 1% of females;*
    b. *On average, they smoked an average of 11 joints over most days (17 days) during the past month;*
    c. *Nearly one-half (45%) viewed smoking marijuana often as a high-risk behaviour (compared to 71% of non-marijuana smokers).*
    d. *Among those who ever bought marijuana, nearly 4 in 10 (39%) current and past year users spent $50 or more on the drug in the past month.*

4. *Current users consisting of young males 44 years and younger, persons with incomplete secondary or tertiary education and lower monthly income households earning less than $1,501 all had higher-than-population prevalence rates.*

5. *When behavior in the past year was assessed using the Cannabis Abuse Screening Test (CAST)[i], the prevalence of High Addiction risk was found to be 25% among marijuana smokers. Groups of marijuana smokers particularly at high risk for addiction included males under 44 years (57%, 12-24 years; 41%, 25-44 years), as well as persons with incomplete secondary education (50%) or those unemployed (53%).*

6. *About half of respondents thought it was easy to obtain marijuana: The last time they obtained the drug it was either free or they shared someone else's supply (52%); the most popular place where persons last bought marijuana was outside in a public area (parking lot).*

7. *There was moderate agreement to certain measures regarding marijuana, e.g., placing criminal drug addicts into a court-supervised drug treatment program instead of incarcerating them (62%); cultivating it for scientific research (59%); taking the drug as a form of medicine (56%); allowing*

[ii] Using the tool, all marijuana smokers were asked a series of six questions on their behavior over the past twelve months, including "Have you smoked marijuana before midday?", "Have you had memory problems when you smoked marijuana?", and "Have you had problems because of your use of marijuana (argument, fights, accident, bad result at school, etc.)?"

tourists to use marijuana for medicinal purposes with a permit (47%); and allowing marijuana to be used for religious purposes (25%).

8. *Among all persons, use of marijuana in other forms was also reported, e.g., 7% took it as edibles (pastries, candy, sweets, cooked/uncooked meals) and 3% used it in drinks (teas, juice, etc).*

Cocaine and Crack Cocaine

1. *Lifetime, past year and past month prevalence of cocaine and crack cocaine was very low (less than one percent).*

2. *Average ages for the initiation of cocaine and crack cocaine use were 22 years and 21 years, respectively. All past and current users reported were male.*

3. *Current users:*
    a. *Reported using an average of two (2) grams of cocaine over about 9 days in the past month, and 6 grams of crack cocaine, for an average of 10 days during the same period.*

    b. *Spent $50 to $100 on cocaine, and $20 to $50 on crack in the past month.*

4. *While 19% and 16% of persons had easy access to cocaine and crack cocaine, respectively, most persons (at least 92%) were never offered the drugs.*

5. *At least 91% of all respondents viewed taking cocaine and crack cocaine often as a high risk behavior.*

Other Illicit Drugs

1. *Less than one percent of respondents reported taking prescription drugs (i.e., tranquilizers such as valium; stimulants such as ritalin; analgesics such as codeine; and similar drugs in those categories) without a prescription.*

2. *Equally low levels were also reported on inhalants and ecstasy (less than one percent).*

3. *Low usage was reported for other drugs, e.g.,*
    a. *5% reported ever using beedis (bidis) (8.5% males, 1.5% females), with the average age at first use being 20 years;*

    b. *3% reported grabba (dry tobacco leaf) use (4% males, 1% females), average age being 22 years;*

    c. *2.2% persons used hookah pipes, average age at first use being 21 years;*

    d. *2.2 % also reported ever using lean (sizzurp) (3% males, 1.2% females), average age at first use being 20 years;*

e. *1.9% reported using e-cigarettes (hookah pens/hookah sticks), average age at first use being 20 years.*

4. *Among current users there were low usage rates found for multiple drug use: alcohol and marijuana (2.1%); tobacco and marijuana (1.3%); and alcohol, tobacco and marijuana (1.1%).*

Access to Drugs

1. *Marijuana appeared to be the most accessible drug, as indicated by 48.5% of respondents (55% males, 42.3% females). Other illicit drugs were not so easy to access, as reported for cocaine (19%), crack cocaine (16%), and ecstasy (13%).*

2. *Nine percent (9%) of respondents (13.3% males, 5.7% females) were offered marijuana in the past 30 days while 15% (20% males, 9% females) were offered the drug in the past year - these were mainly young people under age 25 years. A larger proportion (23.8%) was offered the drug more than a year ago.*

3. *Less than two percent (1.3%) of respondents were offered cocaine in the past year, and 7% more than one year ago.*

4. *Crack cocaine was offered to less than two percent of respondents in the past year, and to 4.5% more than a year ago.*

5. *Ecstasy was offered to less than two percent of respondents in the past year.*

Drug Influences and Opportunities for Use

1. *Among respondents, 41.8% reported having two or more friends or relatives who take illicit drugs, and of these, 86% had two or more such relationships.*

2. *Additionally, 35.6% of persons had an opportunity to try an illegal drug, with more males (46.2%) than females (25.7%) reporting this chance.*

Drug Treatment

Only 2% of lifetime drug and alcohol users ever received treatment for their drug use habits. Further, about 2% felt the need to stop their drug use but most did not go for help as they were not ready to stop using drugs.

WORKPLACE POLICIES

1. *Nearly half (48.4%) of respondents who were employed knew of workplace policies concerning alcohol and drug use.*

2. *28.3% knew of programs to help employees with drug problems.*

PERCEPTIONS OF DRUG SITUATION AND GOVERNMENT RESPONSE

1. *Little over two-thirds (70%) of respondents felt that taking drugs had increased in the country and slightly less (65%) expected the drug situation to worsen in coming years.*

2. *Just over a third (38%) saw the drug issue as being among core government concerns. Only a small percentage knew of drug prevention programmes being implemented in their communities.*

IMPLICATIONS OF FINDINGS

Results of the survey highlighted the need to adopt use of evidence-based approaches to strengthen drug prevention, treatment and rehabilitation. Current patterns examined also necessitate the implementation of improved and effective communication strategies to reach target audiences. As alcohol and drug use trends continue to evolve, it must be ensured that the systemic response is both relevant and dynamic to mitigate against the harmful use and availability of these substances in local communities. The eventual successful response of The Bahamas Health System to the cocaine epidemic of the 1970s may well be considered with a view to adapting what may be one of the country's gold standards to reduce current alcohol and marijuana use trends through continued inter-agency collaboration.

Alcohol and marijuana were the most common substances used. The level of alcohol use reported among young males is a concern, as well as risky behaviours such as driving while under the influence and binge drinking. Additionally, vulnerable groups were noted that consisted of persons who had friends or family

who got drunk: These individuals were much more likely to be current alcohol users and risky drinkers themselves and ought to be considered in prevention programmes.

While alcohol is a legal drug and is easy to access (with age restrictions), further education is needed on the consequences of harmful drinking, along with the introduction or strengthening of policies to reduce adverse effects including health disorders, and injuries from violence and road traffic accidents.

Marijuana was the most frequently used and accessible illicit drug, thus presenting opportunities for demand reduction initiatives. There appeared to be an openness toward a policy shift involving softer punitive measures for marijuana addicts who commit crime, as well as other liberal views supportive of cultivation of the drug for scientific research or allowing it to be used for medical and therapeutic purposes. These may be suggestive of a growing acceptance of the substance. Nevertheless, education about associated health risks must be ongoing.

Tobacco use appears to have declined. Among current tobacco smokers, perception of the high health risks associated with smoking often did not appear to coincide with their behavior, suggesting the need for a greater translation of health knowledge into practice, and continued emphasis on education and other prevention measures.

The abuse of prescription drugs does not appear to be a problem. However, increased worldwide concern about prescription drug abuse necessitates ongoing vigilance locally to detect the possible adoption of these practices.

Finally, the results of the Bahamas National Household Drug Prevalence Survey 2017 imply the need to increase awareness of both the harmful use of drugs and existence of available treatment programmes. This may be done using various communication strategies both in the workplace as well as in the wider community.

RECOMMENDATIONS

Some of the key recommendations made as outcomes from a stakeholder engagement policy workshop were as follows in accordance within the scope of the agencies represented:

- ***Drug Prevention***

  Prevention efforts help to mitigate the harmful effects of drug use. During the cocaine epidemic, many lessons were learned which may be applied to reduce marijuana use. In addition, given the reach of the media, there is a need for ongoing partnership to develop and deliver impactful messages to change perceptions about possible health and social consequences of alcohol and drug use. Actions recommended to support drug prevention activities include:

  - *Adopting cocaine prevention strategies that were successful and apply them in initiatives to also reduce marijuana use.*
  - *Engaging a champion for the reduction in alcohol consumption and drug prevention messages.*

- ***Drug Education***

  Survey findings show that the reported age of initiation for alcohol and drugs ranged from 17 years (for marijuana) to 22 years (for cocaine). It is, therefore, important to educate the public at large, and in particular young people, and provide them with information to help build life skills and increase their knowledge about the harmful use of drugs. This requires a multi-sectoral approach. Actions recommended to support drug education include:

  - *Targeting school-age children for alcohol and drug education strategies, commencing at the primary school level.*
  - *Maximizing use of social media platforms to reach the young population.*
  - *Keeping stakeholders up to date on local, regional and international current alcohol and drug use trends.*

- ***Drug Control***

  One of the key strategies for reducing drug use in the population is to reduce the availability of alcohol and drugs. These efforts would be further advanced with other initiatives to deter use of these substances. Approaches recommended include:

- *Enabling law enforcement agencies to develop relevant policies to mitigate drug dealing and drug use activities, particularly in schools and key community locations identified in the survey. In addition, introduce prevention initiatives in those areas.*

- *Introducing alcohol reduction strategies to decrease current high prevalence rates.*

- *Improving and updating drug detection programmes.*

- ***Drug Treatment and Rehabilitation***

  Once drug use has been initiated, there is further risk for drug abuse and addiction. Additional measures recommended to strengthen current intervention systems that provide necessary treatment and rehabilitation include:

  - *Utilizing a biopsychosocial approach in administering treatment to persons with problematic drug use.*

  - *Providing evidence-based treatment to clients, ensuring that it is appropriate for demographic profiles.*

  - *Establishing a hotline for current and potential drug users.*

  - *Implementing a prison drug rehabilitation programme for drug convicts.*

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Finally, last, but not least, we thank God for continuing to bless these fair isles and the populace of our beautiful Bahamaland.

LIST OF ACRONYMS AND DEFINITIONS

AUDIT	Alcohol Use Disorders Identification Test
BNDC	Bahamas National Drug Council
CAST	Cannabis Abuse Screening Test
CI	Confidence Interval (usually 95%)
CICAD	Inter-American Drug Abuse Control Commission
ED	Enumeration District
GSHS	Global School Health Survey
HIRU	Health Information and Research Unit
LSD	Lysergic acid diethylamide (also known as “Acid”)
MDMA	3,4-methylenedioxy-methamphetamine (Ecstasy)
MOH	Ministry of Health
MONS	Ministry of National Security
NADS	National Anti-Drug Secretariat
OAS	Organization of American States
PROP	Proportion
PSU	Primary Sampling Unit
SES	Socioeconomic Status
SIDUC	Inter-American Uniform Drug Use Data System
SVY	Survey Command in STATA statistical software
THC	Tetrahydrocannibol (Active ingredient in marijuana)
USU	Ultimate Sampling Unit

Definitions

Lifetime Prevalence	The proportion of a population who have ever used a drug in a lifetime.

Past Year Prevalence	The proportion of a population who used a drug in the past year preceding the survey.
Past Month Prevalence	The proportion of a population who have used a drug in the past 30 days (or one month) preceding the survey. This is also known as current prevalence.

INTRODUCTION

COUNTRY INFORMATION

The Commonwealth of The Bahamas is an archipelagic nation in the Atlantic Ocean consisting of more than 700 islands and cays, spread out over an area of 80,000 square miles from the southeast of Florida, U.S.A., southeastward to Hispaniola. Around 23 of these islands are inhabited. The capital, Nassau, is located on the island of New Providence.

The population was approximately 352,000 at the 2010 census, with 27% of the population under 15 years, 47% (15 to 44 years), 19% (45 to 64 years), and 6% (65 years and older). The median age was 29 years, and the sex ratio was 94 males to 100 females. Nine out of ten persons in the population (91%) identified themselves as Black, 5% (White), and 2% (mixed race, mostly Black and White). The predominant religion is Christian, consisting primarily of Baptist, Anglican, and Roman Catholic denominations[8]. The projected population for 2017 was 377,000.

The Bahamas achieved independence from Great Britain in 1973, but still considers the Queen of England as the Head of State, represented by a Governor-General. The political tradition follows that of the United Kingdom and the Westminster system, with the Prime Minister as the head of government. While not geographically part of the Caribbean, The Bahamas has similar culture and political governance to other English-speaking Caribbean countries, and is a part of the Caribbean Community (CARICOM). Tourism is the main industry, followed by financial services.

DRUG HISTORY

The geographic layout of The Bahamas has given it a rich history of illegal activities and trafficking, from wrecking in the 17th century; pirating from the 17th to 18th centuries; “rum running” during the American

Prohibition period 1919-1933; to illegal drug trafficking from the 1980s to this day. The Bahamas was, and is still, used as a trans-shipment point for illegal drugs, mainly from Central and South America and parts of the Caribbean, to the United States[9,10,11].

Recreational illegal drug use in The Bahamas had occurred to a negligible degree prior to the 1970s. During the 1970s however, there was an increase in the use of marijuana, accompanied by a rise in drug treatment admissions at the main public mental health facility[10]. In the early 1980s, it appeared that the use of cocaine had especially increased. The epidemic of "freebasing" cocaine became apparent, in which the form of cocaine used, "crack" or "rock", was smoked or inhaled using homemade instruments such as pipes. Similar to earlier marijuana trends, the alarm was sounded with the upsurge in cocaine-related admissions at the main government mental health facility[10]. The escalated use of cocaine and marijuana went hand in hand with the increase in the importation of these drugs as part of the in-transit routes already mentioned [10,11].

Based on more current treatment and survey information, it has been generally accepted that the demand and use of cocaine and crack cocaine has diminished considerably since the 1980s. This was more than likely due to an aggressive government response, including drug education and prevention measures, additional treatment resources, research, and drug interdictions and arrests for illegal smuggling[11]. It appears however, that marijuana has now become the illegal drug of choice.

CURRENT TRENDS

Prevalence Surveys

The last household drug prevalence survey was conducted in 1991[5] on the islands of New Providence and Grand Bahama, representing the majority (84%) of the population. Results showed that alcohol was the most commonly used substance. Among the population 16 to 59 years, in New Providence

(n=1,009) 74%, 39%, and 14% ever used alcohol, tobacco (measured by cigarette smoking), and marijuana respectively; 6% ever used cocaine. Rates were higher for all drugs among males, especially young males 18 to 29 years. Past-month usage levels were 44.3%, 14.2%, and 3.2%, and 1.6%, respectively for all respondents. In Grand Bahama (n=722), equivalent lifetime rates for alcohol, cigarette smoking, marijuana and cocaine were 70%, 35.1%, 13.6% and 5.4%, respectively, while for each drug, the prevalence of use in the past month was 40.3%, 9.4%, 2.1% and 0.9%, respectively.

A STEPS Survey conducted in 2012 examined chronic disease risk factors, including tobacco and alcohol, in The Bahamas (n=1,654) among adults 25-64 years. Results showed that the prevalence of current tobacco smoking was found to be 16.7% (CI 1.2%, 32.2%), and with regard to alcohol consumption, 40.8% (CI 19.0%, 62.6%) for current drinking.[6]

Concerning adolescents, when the last Secondary School Drug Prevalence Survey was conducted in 2011 (n=2,639)[3], 70% of high school students reported that they had ever used alcohol, while 30% of students reporting drinking in the past month (current use). These results showed that the use of alcohol has increased among students as in 2002, 64% and 23% students drank alcohol in their life and past month, respectively.

Cigarette use may have declined in this population, however, as in 2011, the lifetime and current prevalence were 13% and 2%, respectively, whereas in 2002, lifetime use was 20%. Current use, though, remained the same.

Among secondary school students, the prevalence of ever-use of marijuana was 14%, and in the past month, 5%. There was no significant change with marijuana use since 2002.

Inhalants were tried by 10% of students, with 2% reporting use in the past 30 days. Lifetime use for cocaine use remained low, at 1%. Other drugs used by students included tranquilizers (4% lifetime use), stimulants (3%), and ecstasy (1%).

Another secondary school survey, the Global School Health Survey, Bahamas (2013), showed similar findings: around a third of students drank alcohol in the past 30 days, 11% ever used marijuana, and 2% smoked cigarettes in the past month[4]. In the Global Youth Tobacco Survey (2013), also conducted in secondary schools, the prevalence of current tobacco smokers was found to be 10.7%.[12]

Treatment

Treatment information for the year 2016, with most data coming from the Sandilands Rehabilitation Centre, the primary government in-patient mental health treatment centre, showed that the main substance impacting treatment was marijuana, at 46%, with alcohol not far behind, at 37%[13]. Cocaine and crack influenced 9% and 8% of treatment, respectively.

In 2012 at the same facility, mental and behavioural disorders due to marijuana use was the leading cause of drug-related admissions and the second leading cause of all admissions, comprising 15% .[14] Disorders from multiple and other psychoactive substances were third, with 11% of all admissions; alcohol abuse (10%) and the 6th leading cause. Disorders due to cocaine use were the 9th leading cause, making up 3% of all admissions.

Mortality

Mortality directly from drug abuse has always been low in The Bahamas, with deaths stemming mainly from alcohol abuse. In 2014 there were 2,159 deaths, of which 9 (less than 1%) were from mental disorders due to alcohol use. Adding liver diseases due to alcohol use increased the number of alcohol-related deaths to 16 (87.5% males, 12.5% females).[15] No deaths were recorded as related to illicit drug use.

In summary, it appears that alcohol, tobacco, and marijuana are the popular drugs in The Bahamas, while cocaine use has decreased. While secondary school surveys, treatment data, and mortality suggest these trends, a more recent national household drug survey was necessary to complement this information.

BACKGROUND

National epidemiological studies on drug use are useful in providing evidence that can inform drug policy and programming. Through a partnership between the Inter-American Drug Abuse Control Commission (CICAD) and The Bahamas, a national household drug prevalence study was conducted to increase knowledge about the drug situation in The Bahamas.

With the last national drug prevalence study in The Bahamas conducted in 1991, it has become essential to determine the current nature of drug use in the population. This is important so that relevant action can be taken to address the issue in the context of policy development and necessary reorientation of national and non-government organizational programmes toward population needs.

RESEARCH QUESTIONS

1. What is the prevalence of psychoactive substance use among 12-65-year-olds in The Bahamas?

2. What are the patterns of psychoactive substance use among the Bahamian population?

3. Is there an association between psychoactive substance use and socio-demographic factors such as gender, age, occupation, schooling, socioeconomic level and location of residence?

4. Is there an association between psychoactive substance use and exposure to supply, monetary value and resources spent to purchase, risk perception, exposure to drug prevention education and access to treatment?

STUDY OBJECTIVES

The primary aim of The Bahamas National Household Drug Prevalence Survey 2017 was to determine the extent of drug use among persons 12-65 years living in The Bahamas. Specific objectives were to:

1. Determine the prevalence of psychoactive substance use: at least once in lifetime, over the past 12 months and over the past 30 days;

2. Determine the prevalence of psychoactive substance use on the basis of socio-demographic characteristics: gender, age, occupation, schooling, socioeconomic level and location of residence;

3. Detect patterns of use of the various substances;

4. Describe aspects related to the use of substances: exposure to supply and use, monetary value and resources spent to purchase, risk perception, exposure to talks or courses on prevention, among others of interest; and

5. Determine attitudes towards marijuana legislation and its impact on the society.

The study is expected to enhance the Government of The Bahamas' awareness on the extent of drug use in the population, and strengthen drug prevention and treatment efforts in the country.

METHODS

The Bahamas National Household Drug Prevalence Survey 2017 was a cross-sectional study using multi-stage sampling techniques. It was conducted utilizing the Inter-American Drug Abuse Control Commission (CICAD) standardized household methodology, inclusive of the survey design, field protocols, training, software, and the questionnaire.

ETHICS APPROVAL

Administrative approval for the execution of the Bahamas National Household Drug Prevalence Survey was obtained from the Cabinet, Government of The Bahamas. Subsequent ethical approval was granted by the Public Hospitals Authority/University of the West Indies Research Ethics Committee Institutional Review Board, Commonwealth of The Bahamas in April 2017.

FUNDING

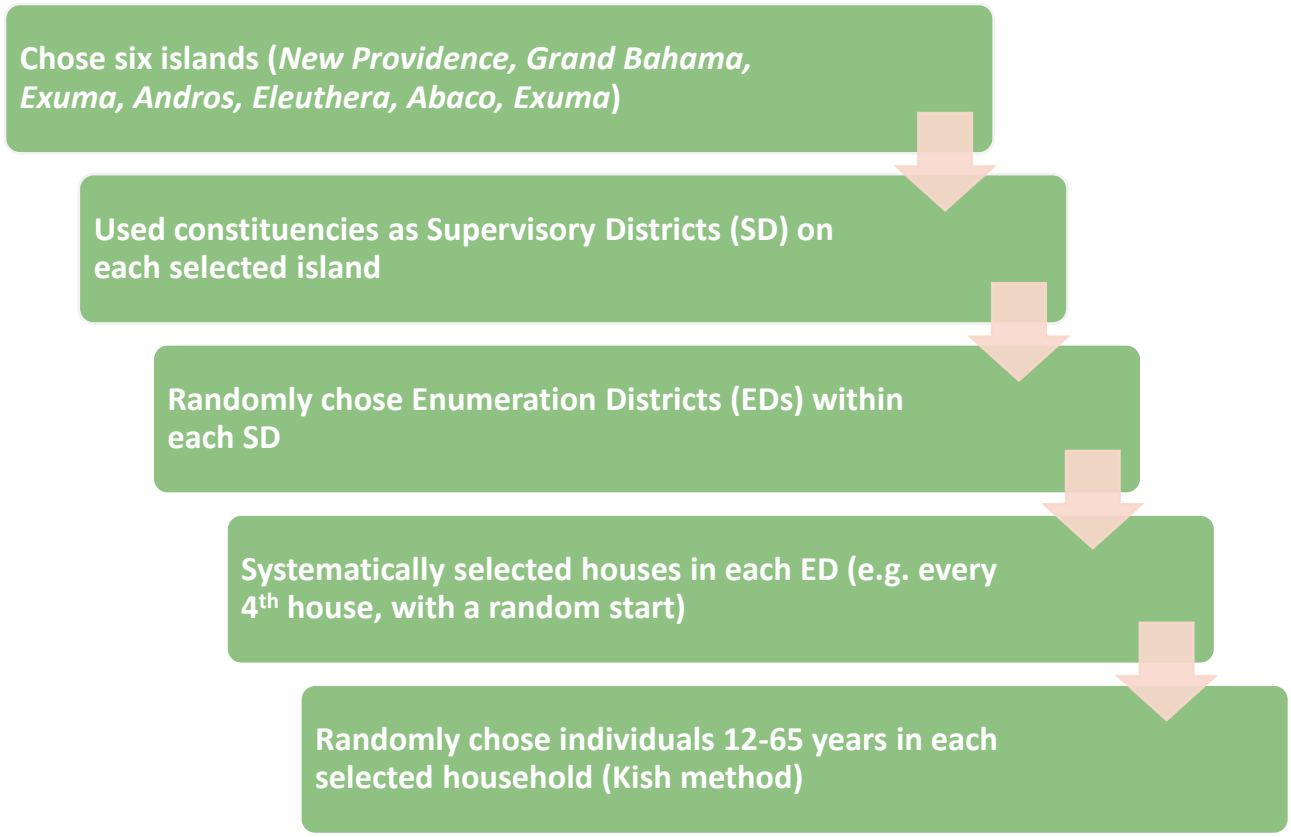
The Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States funded this study through funds donated by the Bureau of International Narcotics and Law Enforcement Affairs (INL) of the United States Department of State. Additionally, the Ministries of Health and National Security provided financial, logistical, administrative, technical and other material support.

METHODS SUMMARY

Using the 2010 Census of Population and Housing[8] as a sampling frame, the six most populous islands in The Bahamas, namely New Providence, Grand Bahama, Andros, Exuma, Abaco, and Eleuthera were included in the survey. Together, these islands comprise 97% of the population.

With few exceptions, within each island, all Enumeration Districts (EDs) were included for each Supervisory District (SD). The SDs are political boundaries known as constituencies, managed by team supervisors. Within each ED, systematic sampling (every n^{th} house with a random start) was used to select households. Eligible individuals within each household were chosen using the Kish[16] selection method which randomly selects members within a household to participate in a survey. Further details are outlined in ***Figure i***.

Figure i: Sampling Steps



INCLUSION/EXCLUSION CRITERIA

Persons between the ages of 12 and 65 years were eligible for inclusion in the survey, as well as those who resided in the selected households for 6 months or longer. Individuals, including temporary residents, not falling into those categories were excluded from the survey.

TIME FRAME

The survey was conducted from February 20, 2017 to April 30, 2017, about 11 weeks.

STUDY POPULATION

The study population consisted of 2,533 respondents ranging in age from 12 to 65 years. Using the Kish method,[16] enumerators randomly selected one individual from each household that was also randomly selected. The islands of New Providence, Grand Bahama, Abaco, Andros, Eleuthera and Exuma were included in the survey.

SURVEY FRAME

The frame for the survey design is based on data from the 2010 Population and Housing Census. The census provides information on the number of households in the country at the ED level, the condition of the dwelling units, as well as basic characteristics of the population such as age, sex, education and economic activity. The ED is the smallest area used in the collection of census data and formed an integral part of the survey design.

Certain areas (mainly Cays) were excluded from the sampling frame. These were EDs 01, 09, 14 and 15 in South Abaco and EDs 01, 02 and 03 in Exuma, as well as Berry Islands and Ragged Island. Additionally, on the island of New Providence, EDs 01, 02 and 03 in St. Thomas, and EDs 01 and 02 in Clifton, were also excluded.

SELECTION OF PARTICIPANTS

Respondents were randomly selected using sampling frames provided by the Department of Statistics. A trained team of 56 interviewers conducted face-to-face interviews using pre-programmed tablets configured with Survey-to-Go software. From each household randomly selected in an ED, one person was

also randomly selected using the Kish method. If this person was not at home, arrangements were made for a return visit. Up to three attempts were to be made to reach an individual selected.

SAMPLE SIZE AND SAMPLING METHODOLOGY

To ensure inclusion of all households, all supervisory districts in the country were included, and within each district, all EDs were included, thus all households in each district were recorded. This ensured that all households in the country had an equal chance of selection in the survey.

Sample Size Calculation

The sample size *(n)* was calculated using the formula:

$$n = Z^2 (P(1-P)/e^2)$$

where values used are shown below:

Level of Confidence Measure (Z):	*1.96*
Margin of Error (e):	*0.05*
Baseline levels of the indicators (P):	*0.50*
Number of strata	*6*
Design Effect	*1.5*
Projected response rate	*0.91*

The islands were first grouped by size - Group 1 being New Providence, Group 2 (Grand Bahama), Group 3 (Abaco), Group 4 (Andros), Group 5 (Eleuthera including Harbour Island), and Group 6 (Exuma) (***Appendix 3***).

It was agreed that because of cost constraints and other difficulties associated with data collection, particularly in the Family Islands, large workable cluster sizes ranging from 20 to 25 households would be more effective in reducing the number of primary sampling units or EDs to be visited. Additionally, it was also necessary to keep the cluster sizes as close as possible to reduce the sampling error.

SAMPLING PROCESS

A two-stage design was used, with the selection of the primary sampling units (PSUs) being the first stage. The PSUs (EDs) were selected with probability proportional to size, that is, the number of households in the ED at the time of the census. The design also took into account the need to make statements about the groups and also about the larger islands among the first three groups. This means that the sampling fraction varied from group to group.

The second stage was the selection of a cluster of households, the ultimate sampling unit (USU) from the selected EDs. The proportion of persons 12 years old and over with 4 years of high school education and higher was used to arrange the EDs within supervisory districts in each of the islands. The EDs were arranged in descending order of these proportions and were assigned based on their size or the number of households in the ED.

Selection of EDs

Before selecting the households for the sample, EDs were systematically selected within each group. This was done by accumulating the number of clusters in the EDs with the cumulated number being placed next to the ED (see ***Appendix 3***). A random number was selected between 1 and the inverse of the sampling fraction of the group. The inverse of the sampling fraction was the sampling interval. The sampling interval was added to the randomly selected number and the process was repeated until the number of clusters for the group was reached but not exceeded.

For example, in the case of Group 1, the random number selected was 27. With an interval of 60, this meant that clusters 27, 87 etc. were selected. The EDs within which these clusters fell became a selected ED (***Appendix 3***).

Selection of Households

The second stage of the design was the selection of the USU or households to be interviewed. For the selection of households within EDs, the procedure is the same as that for selection of EDs, with the interval being the number of clusters assigned to the ED. The final selection of the EDs for the survey can be found in ***Appendix 3***.

The number of households expected to be interviewed in the survey was 3,598.

Sampling Errors

The sampling design for the Bahamas National Household Drug Prevalence Survey is a self-weighting design. This means that the probability of the selection of a household is the same for all households in the population, which in effect means a fixed sampling interval for all strata. The sampling fraction was different for each strata (group) (see ***Appendix 3*** for further details).

Data Collection and Instrument

A standardized (Inter-American Uniform Drug Use Data System (SIDUC) questionnaire used by CICAD was incorporated in computer tablets loaded with the Survey to Go software. The questionnaire consisted of 17 main sections (see ***Appendix 4***):

1. Demographics – including Age, Sex, Religion, Race, Household Income, Marital Status, Employment Status, Occupation and Education;
2. Perceived risk level of selected drugs;
3. Tobacco use, and additional details, including age of first use, drug use frequency, spending, etc;
4. Alcohol use and additional details;
5. Perceived ease of access to selected drugs;
6. Lifetime use ("ever used') for selected (mostly illicit) drugs, including prescription drugs without a prescription, marijuana, cocaine, heroin; with age at first use for each selected drug;

7. Tranquilizers use and additional details;
8. Stimulants use and details;
9. Inhalants use and details;
10. Cocaine use and details;
11. Crack cocaine use and details;
12. Marijuana use and details;
13. Problems from drug and alcohol use;
14. Treatment;
15. Adverse neighbourhood activities;
16. Perceptions on government response;
17. Opinions on proposed marijuana policies;

Each question was read by the interviewer to each selected individual in a private area, and the response was entered into the electronic database by the interviewer. Question order and skip patterns were built into the software.

DATA ANALYSIS

As responses were entered directly into the software, further data entry was not needed. Because data was collected using multi-stage sampling, data analysis that takes this design into account was incorporated, including weighting, software commands, and error estimation. These are different from the usual analyses in which a survey is done using simple random sampling.

Weighting

Weighting, primarily using expansion weights to reflect the population, was done in several steps:

The first step was to calculate a sample weight. The sample weight was the inverse of the probability for each household to be selected using the population for each SD as a basis. This was then multiplied by the

inverse of the probability for each individual within each household to be selected, which was essentially the household size. For example, if the population of households for SD 1 was 5,000, and 100 were selected to be interviewed, the probability is 100/5,000, resulting in 0.02, or 2/100. The inverse of 2/100 is 100/2, resulting in 50. This was then multiplied by the eligible household size, which was a part of the questionnaire, to equal a final sample weight. Therefore, if the household size was 4, the sample weight was 50*4 = 200.

The second step was to calculate a non-response weight, which was determined by considering the inverse of the probability that each assigned household was actually interviewed for each SD. For example, if 100 houses were assigned, but only 50 were interviewed, then the response probability is 50/100. The inverse is 100/50, resulting in a non-response weight of 2.

The third step was the population weight. The population weight is the application of the proportion of five year age-sex groupings according to population projections to the age and sex proportions of the survey. For example, if 5% of the population were males ages 45 to 50 years, and the sample reflected that only 2.5% were collected, all males 45 to 50 years were multiplied by 2 to match the population.

The three weights were then multiplied step by step after the application of each weight (as opposed to all at once), to result in a final weight applied to each individual response.

Analysis

Data analysis reflected the survey design. Microsoft Excel was used to calculate some of the weights, and SPSS was used to calculate final weights and recoding of some question responses. All further analyses for the sample design were done using Stata (Version 10). This entailed declaring the Strata (the six islands), the PSUs (the EDs), and the weight (the final weight as already described). Error estimation was done using Taylor series linearization. The following commands were then used:

SVY: PROP - for proportion estimates for each variable (individual questions)

SVY: TAB – for cross-table estimates to compare two categorical variables for group differences and potential associations (e.g. marijuana use by sex)

SVY: MEAN – to derive means for questions such as age, number of beverages drank in last month, etc.

95% confidence intervals (CIs) are included for each analysis. Where CIs are not displayed, this indicates that a stratum had only one sampling unit due to small sample sizes for some groups, and therefore a CI could not be calculated by Stata.

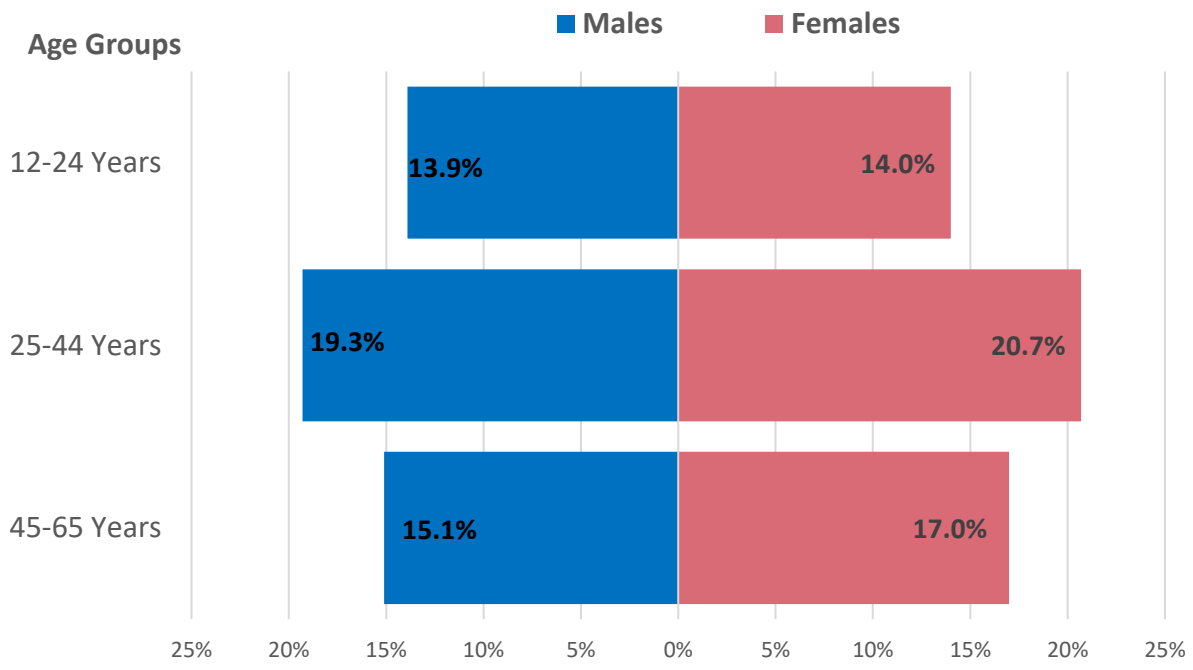
RESULTS

DEMOGRAPHICS

General

The total sample size was 2,533, a response rate of 70%. Approximately 52% of respondents were female ***(Table 1)***. Among age groups, 28% were 12-24 years, 40% (25-44 years), and 32% (45-65 years old) ***(Table 1)***. The mean age was 36 years (95% CI 35, 37), with a range of 12 to 65 years. ***Figure 1*** shows age and sex proportions, with similar distributions for each age group by sex. There were slightly more females (17.0%) than males (15.1%) in the 45-65 year age group.

***Figure 1*. Age and Sex Proportions of Sample**



Source: Bahamas National Household Drug Prevalence Survey, 2017

When asked about ethnic origin, the overwhelming majority (94.0% [95% CI 91.1%, 96.8%]) described themselves as Black or African, while 3.2% (CI 0.8%, 5.6%) were White. Nine out of ten respondents (89.6%

[CI 86.8%, 92.5%]) were born in The Bahamas. Of the remaining 10.4%, most were born in Haiti and Jamaica (3.5% and 2.4%, respectively). Further, 1.1% was born in the United States, and persons from Canada and the Philippines had equal proportions at 0.6% (not shown). Persons who were not born in The Bahamas have lived in the country for an average of 16.5 years.

Table 1. General Demographics

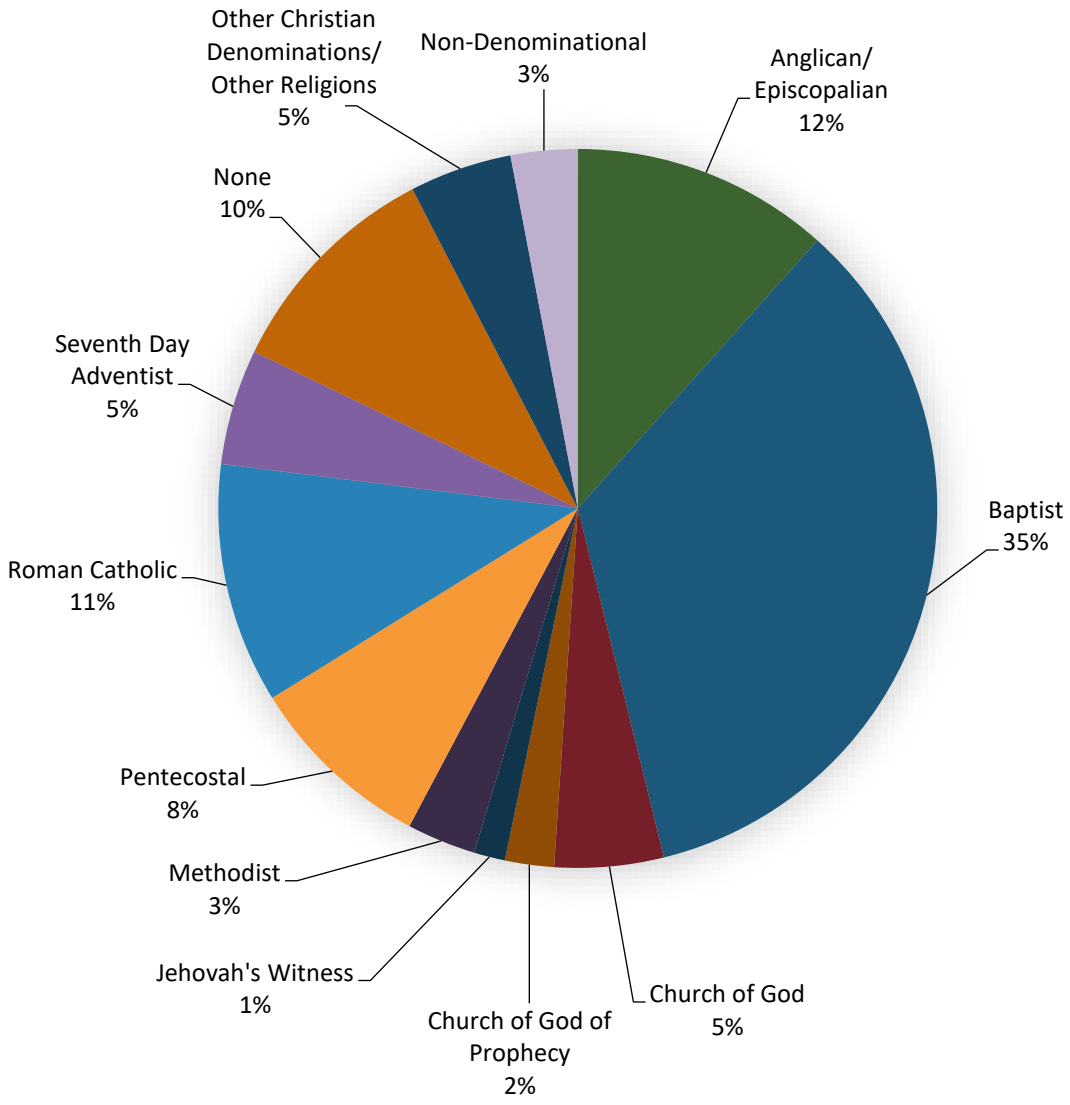
Demographics		Percent* *(95% CI)*
Sex	Male	48.3 *(45.9, 50.7)*
	Female	51.7 *(49.3, 54.1)*
Age (Years)	12-24	27.9 *(24.6, 31.1)*
	25-44	40.1 *(37.2, 42.9)*
	45-65	32.1 *(28.8, 35.4)*
Marital Status	Single, never married	56.6 *(53.4, 59.7)*
	Married	30.6 *(27.6, 33.7)*
	Divorced	2.6 *(1.9, 3.3)*
	Separated	3.5 *(2.5, 4.6)*
	Living Together/Common Law	5.3 *(3.9, 6.8)*
	Widow/Widower	1.3 *(0.9, 1.7)*

Source: Bahamas National Household Drug Prevalence Survey, 2017

With regard to marital status, more than half (57%) were single, never married, and 31% were married; around 3% were separated or divorced (***Table 1***).

As for religion, Christianity was the most predominant religion respondents practiced, with most (34.5%) identifying as Baptist. Other major denominations included Anglican (11.6%), Roman Catholic (10.8%), and Pentecostal (8.4%) (***Figure 2***).

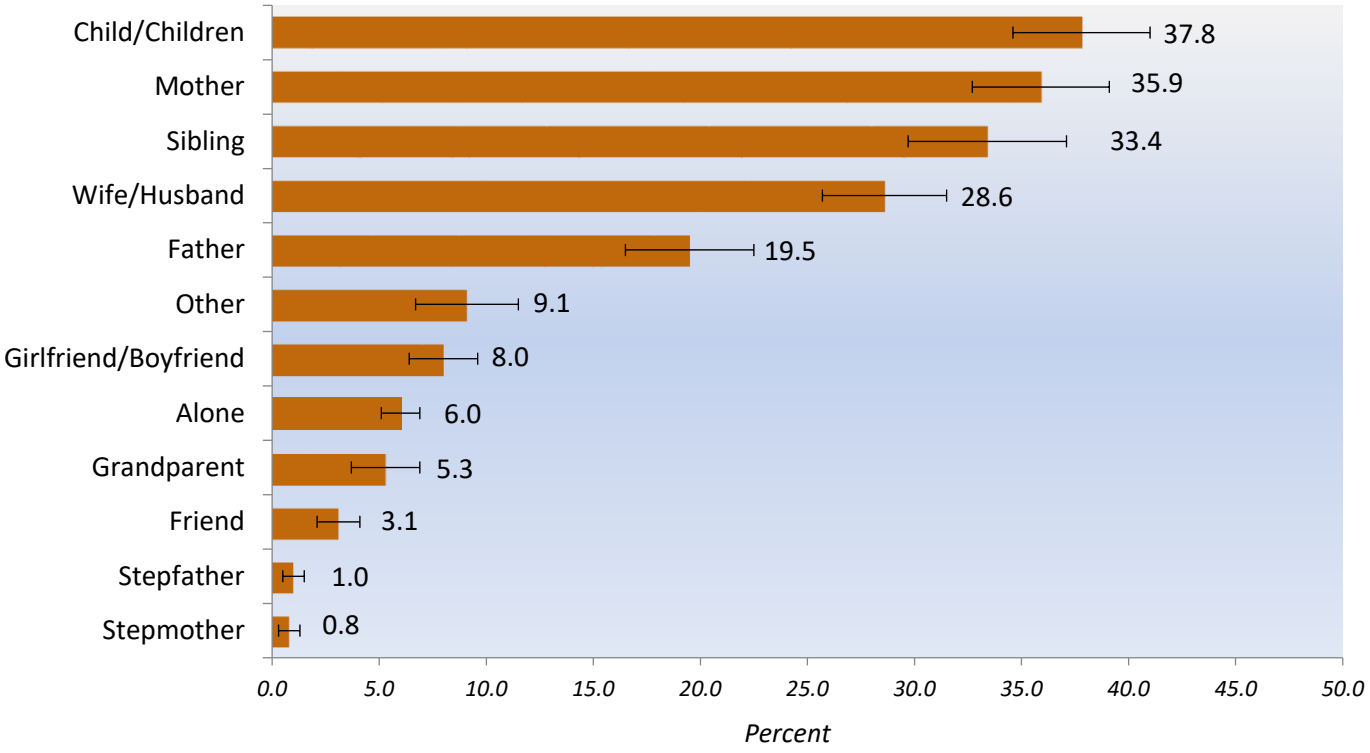
Figure 2. Religion/Christian Denomination



Source: Bahamas National Household Drug Prevalence Survey, 2017

When respondents were asked with whom they live, 37.8% reported living with their children; 35.9%, their mother; 33.4%, their sibling; and 28.6%, their spouse (***Figure 3***).

Figure 3. Persons Living with Respondent



Source: Bahamas National Household Drug Prevalence Survey, 2017

Socioeconomic Status

Examining levels of socioeconomic status (SES) revealed that of the total surveyed, most persons (53.6%) had a secondary education as their highest achieved; 17.7% completed tertiary education, and 3.6% had vocational (technical trade, e.g., carpentry) training; 9.5% completed primary school, which included students who were in secondary school during the survey. Another 9.2% did not complete secondary school, that is, dropped out while in high school (***Table 2***).

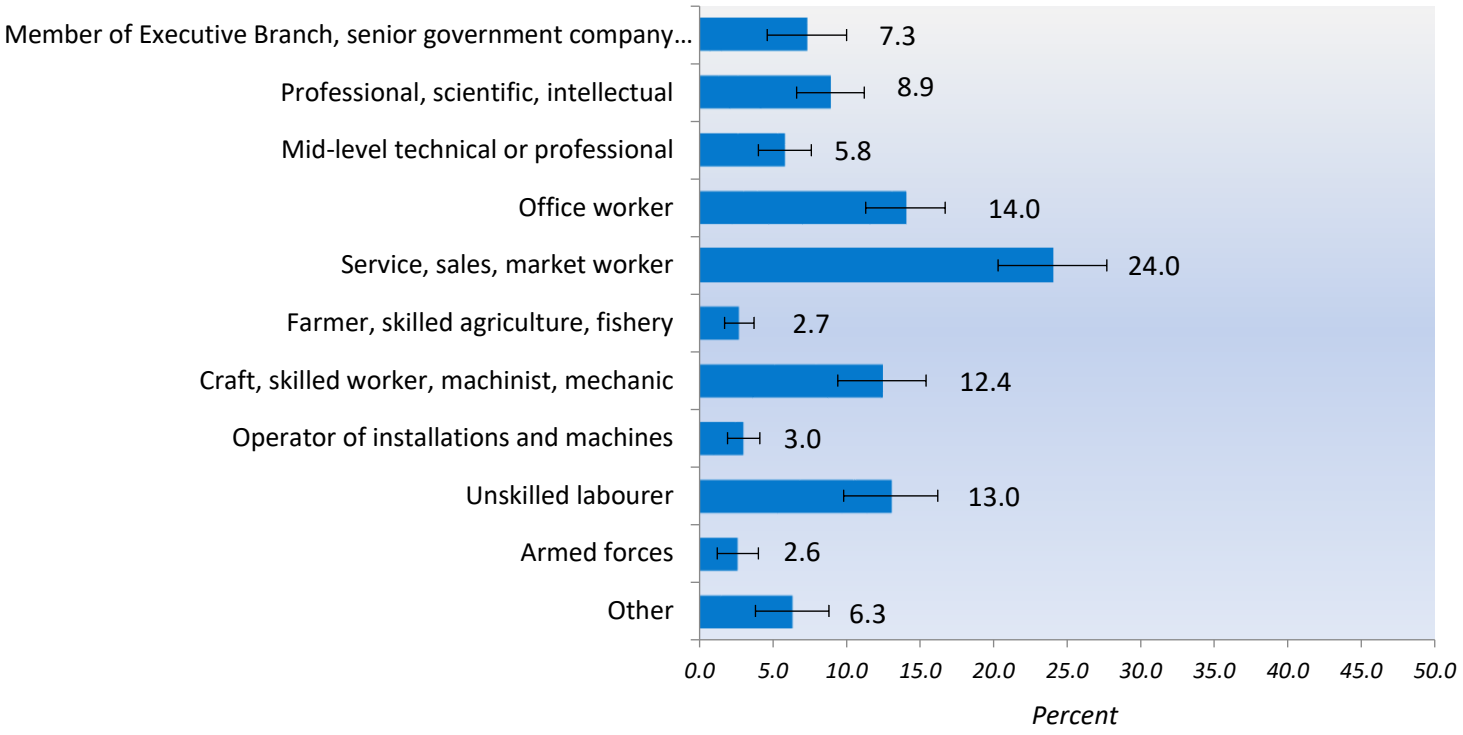
Table 2. **Socioeconomic Status**

SES Demographics		Percent *(95% CI)*
Education	Never Attended/Incomplete Primary	0.9 *(0.5, 1.4)*
	Complete Primary	9.5 *(7.5, 11.5)*
	Incomplete Secondary	9.2 *(7.2, 11.2)*
	Complete Secondary	53.6 *(50.1, 57.0)*
	Incomplete University/Tertiary	5.3 *(3.9, 6.8)*
	Complete University/Tertiary	17.7 *(14.3, 21.0)*
	Vocational	3.6 *(2.3, 4.9)*
Employment	Working/Self-employed	62.4 *(58.6, 66.2)*
	Working and Studying	3.4 *(1.9, 4.9)*
	Unemployed	14.7 *(12.3, 17.1)*
	Not working, student	13.6 *(11.1, 16.1)*
	Not working (Retired; of independent means)	3.7 *(2.7, 4.8)*
	Not working (Housewife, other)	2.2 *(1.4, 3.1)*

Source: Bahamas National Household Drug Prevalence Survey, 2017

Almost two out of three (62.4%) persons were employed, and 14.7% unemployed (***Table 2***). When grouped into occupational categories, a quarter (24.0%) worked as service, sales or market workers (***Figure 4***). Seven percent (7.3%) worked in the highest level (member of executive branch, legislative bodies, and senior government, while 13.0% worked as unskilled labourers, the lowest economic branch. Employed persons worked a mean of 38.9 hours a week.

Figure 4. Occupation Groupings

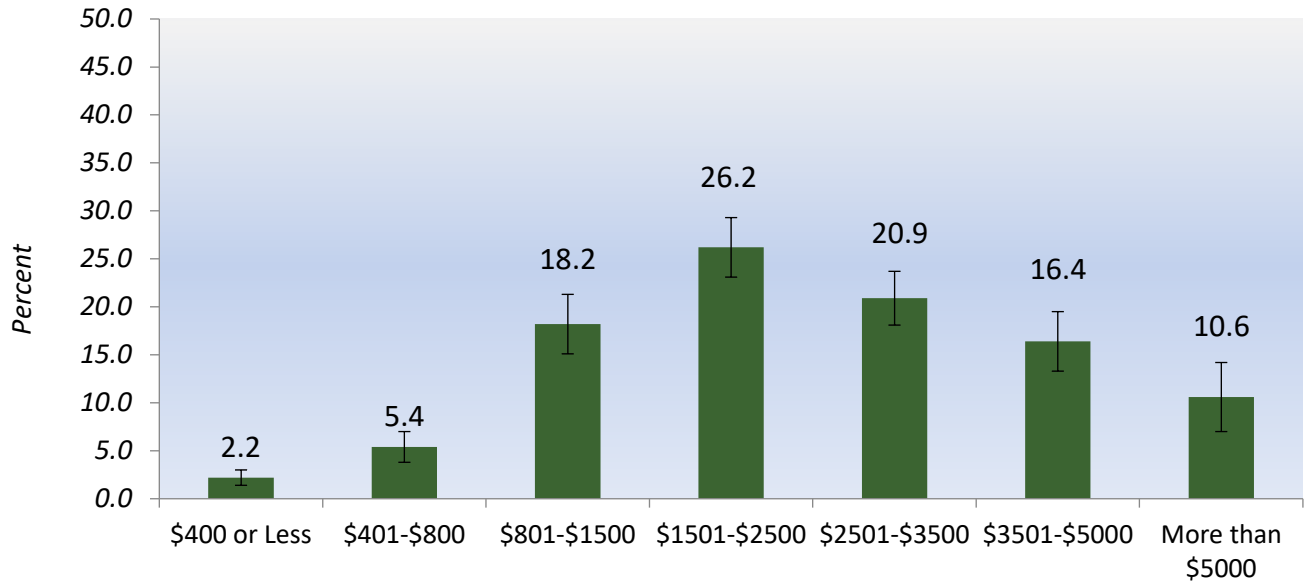


Source: Bahamas National Household Drug Prevalence Survey, 2017

Figure 5 shows monthly household income proportions: the most frequently occurring income for 26.3% of households ranged between $1,501 and $2,500 a month. Around one in ten (10.6%) reported a monthly income of more than $5,000.

Forty percent (40.3%) of respondents were heads of their households (CI 37.4%, 43.2%). Looking at all households (including respondents), most (61.3%) heads of households were male (*not shown*). As for the highest level of education attained by household heads, it was similar to that of all respondents in that 58.1% (CI 53.9%, 62.3%) completed high school; 16.2% (CI 12.7%, 19.8%) completed college or university; and 2.7% (CI 1.6%, 3.7%) had vocational training.

Figure 5. Monthly Household Income



Source: Bahamas National Household Drug Prevalence Survey, 2017

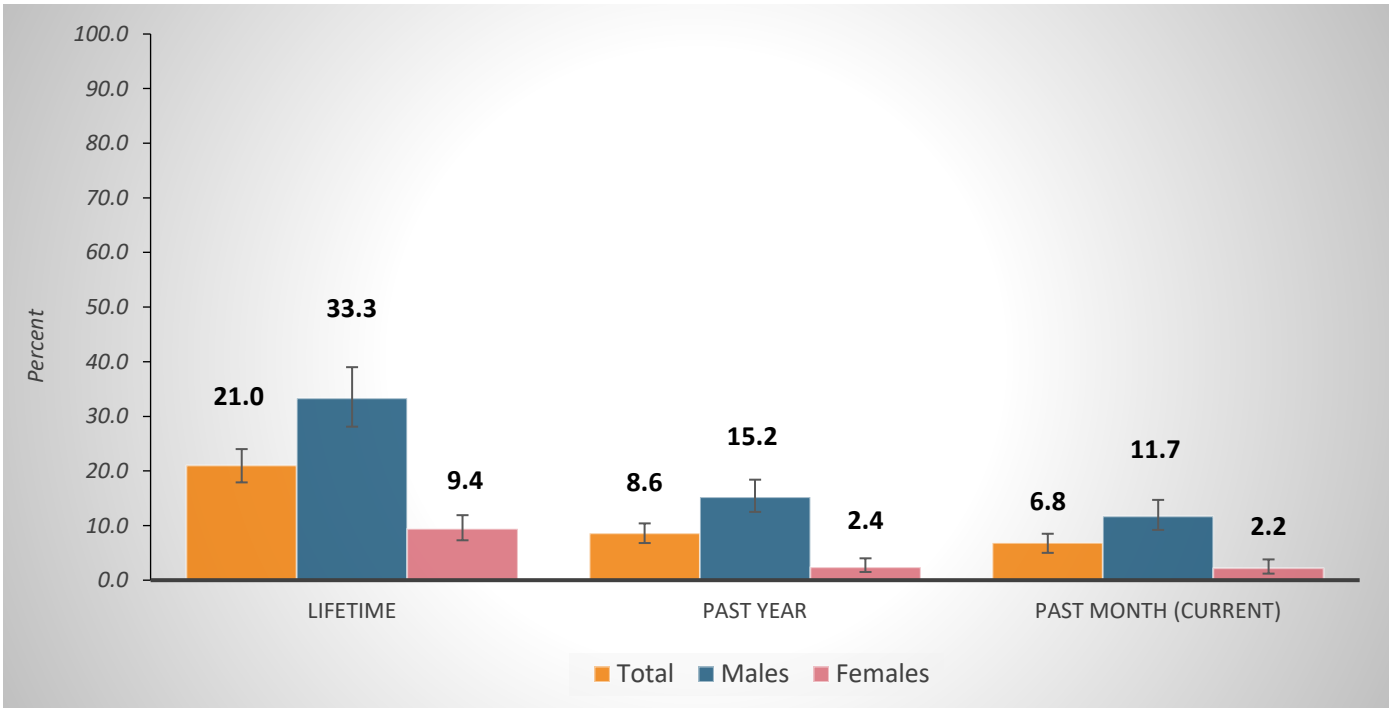
TOBACCO

Overall Prevalence

Persons were asked whether they smoked tobacco, including cigarettes with or without a filter, cigars, pipes or similar items. For alcohol, tobacco and all other drugs examined, categories of use were: Ever use (lifetime); use in the past year (past year users); and use in the past month (current users).

One out of five respondents (21.0%), comprising of a third of males (33.3%) and 9.4% of females were lifetime smokers (see ***Figure 6)***. Lifetime smokers were then asked when they last smoked: 8.6% (of the ***total*** population) smoked in the past year, (15.2% males, 2.4% females), and 6.8% in the past month (11.7% males, 2.2% females). Note that lifetime smokers include past year smokers, and past year smokers include current smokers.

Figure 6. Lifetime, Past Year, and Past Month Prevalence of Tobacco Use by Sex



Source: Bahamas National Household Drug Prevalence Survey, 2017

When all respondents were asked about the ***first time*** they smoked (including those who never smoked, 79%), 17.1% (CI 14.6%, 19.7%) smoked more than a year ago, 1.3% (CI 0.4%, 2.1%) smoked more than a

month but less than a year ago, and 2.5% (CI 0.9%, 4.2%) first smoked in the past month. The mean age respondents smoked for the first time was 17.9 years (CI 17.3, 18.6, range 7 to 55 years). There was no significant difference in age at first smoking by sex. The mean age for a current smoker was 35.8 years (CI 32.6, 39.0 years).

Of current smokers, that is, those who smoked in the past month, more than half (56.1% [CI 46.0%, 56.1%]) smoked on a daily basis. A larger proportion of female smokers (64.9% [CI 41.1%, 83.1%]) than male smokers (54.2% [CI 44.7%, 63.4%]) smoked daily. A little more than a third, (35.7% [CI 26.7%, 44.8%]) smoked less than daily; of this group, 28.7% smoked daily in the past (CI 20.4%, 37.0%). Additionally, of past month smokers who reported that they do not currently smoke (6.1% [CI 2.4%, 9.8%]), 7.9% of this group smoked daily in the past.

Spending

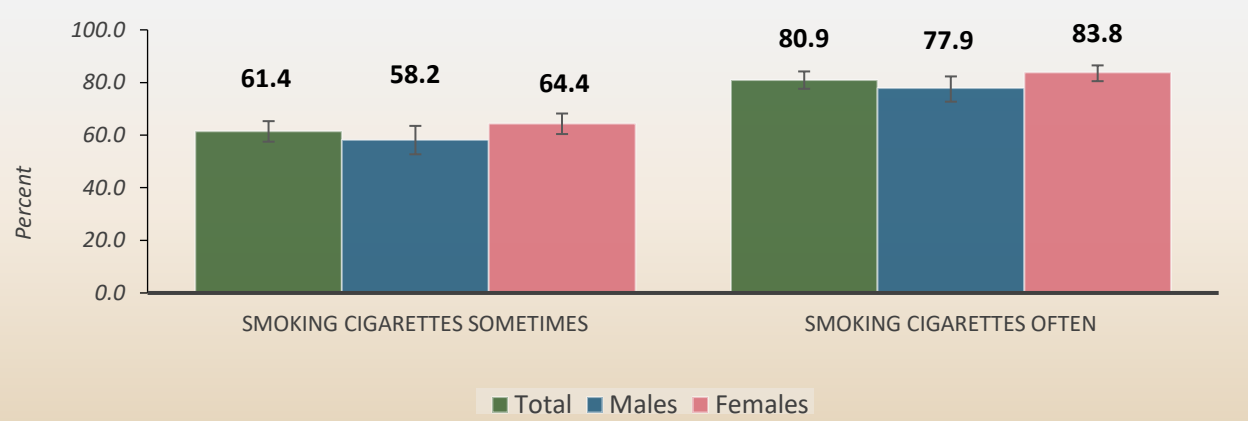
Respondents who smoked were asked how much they spent on cigarettes in the past month. Most responded spending little to no money: 65.2% (CI 57.5%, 73.0%) responded they didn't spend any, and 11.7% (CI 6.6%, 16.8%) spent $20 or less. At the higher end, 9.7% (CI 5.2%, 14.2%) spent between $50 and $100, and 4.3% (CI 1.7%, 6.9%) spent $100 or more.

Examining current smokers, however, (around 7% of respondents), 29.1% of this group spent $50 to $100 (CI 20.9%, 39.0%), while 12.1% (CI 6.5%, 21.4%) spent $100 or more. Continuing, looking at current smokers who smoked daily, 45.0% spent $50 to $100 (CI 33%, 58%), and 17.5% (CI 8.8%, 31.9%) spent $100 or more (figure not shown).

Perceived Risk

When all respondents were asked how risky they thought it may be to smoke cigarettes sometimes, 61.4% thought that the risk was high (***Figure 7***). As for smoking cigarettes often, 80.9% thought this practice carried a high risk. ***Figure 7*** below shows that females were slightly more likely to respond that cigarette smoking is risky.

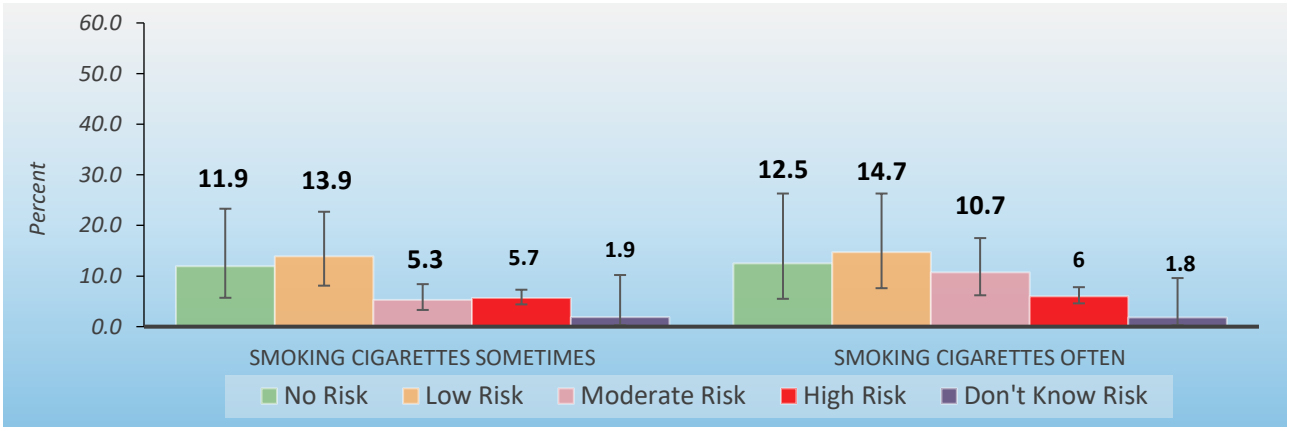
Figure 7. Perceived Smoking as "High" Risk by Sex



Source: Bahamas National Household Drug Prevalence Survey, 2017

The level of perceived risk for tobacco smoking was examined among by the prevalence of tobacco smoking (***Figure 8***). Most current tobacco smokers were among those who responded that smoking cigarettes sometimes or often had either no risk (11.9%, 12.5% respectively), or low risk (13.9%, 14.7% respectively). Alternatively, those who thought smoking cigarettes carried a moderate or high risk had much lower prevalence of current smokers. Those who did not know the risk appeared to be non-smokers. Conversely, examining those who currently smoke tobacco, most of this group responded that smoking often had a high risk (72.0% [CI 60.9%, 80.9%]). This proportion was lower, however, than among those who do not smoke at all (82.5% [CI 79.1%, 85.4%]). (Figure not shown.)

Figure 8. Current Tobacco Smoking by Level of Risk Perception



Source: Bahamas National Household Drug Prevalence Survey, 2017

Current Tobacco Smoking by Age and Sex Groups, Socioeconomic Status (SES), and Constituency

Differences in current smokers by age groups and sex, socioeconomic status (education, income, and employment), and constituency were examined (***Table 3***). While there was a clear difference in smoking proportions by sex (see ***Figure 6***), there were not many differences in age for each sex (***Table 3***). Nonetheless, males 25-44 years were the group with the highest percentage of current smokers (13.1%), compared to the other age-sex groupings and the total population of current smokers (6.8%).

As for education, there were two groups that showed especially high rates of smokers: those with incomplete secondary schooling (12.5%), and vocational schooling (11.3%) (***Table 3***). Persons who had completed primary (1.4%) and tertiary education (3.7%) appeared least likely to be current smokers.

Looking at employment, some differences emerged: students, whether they were working (3.3%), or not (2.5%), showed low rates of smoking. Other employment groups had similar proportions, both to each other and to the general population. Unemployed persons had the highest percentage of smokers (8.3%) (***Table 3***).

Significant smoking differences by household income were not apparent. Nonetheless, persons whose households made more than $5,000 a month had the lowest rate (4.9%) (***Table 3***).

Looking at smoking by constituency, the top three were Montague, with almost a quarter (24.5%), of its residents reporting smoking in the last month. Carmichael (14.8%), and Bain and Grants Town (13.6%) had the second and third highest rates respectively (***Table 3***).

Table 3. **Current Tobacco Smoking Age and Sex Groups, SES, and Constituency***

Variables			Percent Current Smokers	*95% CI*
Age and Sex Groups	12-24 Years	Males	11.0	*6.3, 18.5*
		Females	1.7	*0.6, 4.5*
	25-44 Years	Males	13.1	*9.7, 17.4*
		Females	3.0	*1.2, 7.1*
	45-65 Years	Males	10.3	*7.9, 13.3*
		Females	1.5	*0.7, 3.2*
Education	Never Attended/Incomplete Primary		0.0	n.a.
	Complete Primary		1.4	*0.4, 4.1*
	Incomplete Secondary		12.5	*6.8, 21.6*
	Complete Secondary		7.4	*5.8, 9.4*
	Incomplete University/Tertiary		7.8	*3.5, 16.8*
	Complete University/Tertiary		3.7	*1.9, 7.2*
	Vocational		11.3	*5.4, 22.1*
Employment	Working/Self-employed		7.4	*5.8, 9.4*
	Working and Studying		3.3	*1.1, 9.8*
	Unemployed		8.3	*5.2, 13.1*
	Not working, student		2.5	*0.9, 6.8*
	Not working (Retired; of independent means)		7.4	*3.4, 15.4*
	Not working (Housewife, other)		6.5	*2.3, 17.1*
Monthly Household Income	$400 or Less		5.8	*1.8, 17.1*
	$401-$800		6.4	*3.2, 12.5*
	$801-$1500		9.4	*5.8, 14.7*
	$1501-$2500		7.8	*4.2, 14.1*
	$2501-$3500		5.2	*3.1, 8.5*
	$3501-$5000		6.8	*4.2, 10.9*
	More than $5000		4.9	*2.2, 10.6*
Constituency*	Montague		24.5	*10.3, 48.1*
	Carmichael		14.8	*5.9, 32.2*
	Bain and Grants Town		13.6	*11.2, 16.4*

* The top three constituencies with the largest proportions of current (past month) tobacco smokers.

Source: Bahamas National Household Drug Prevalence Survey, 2017

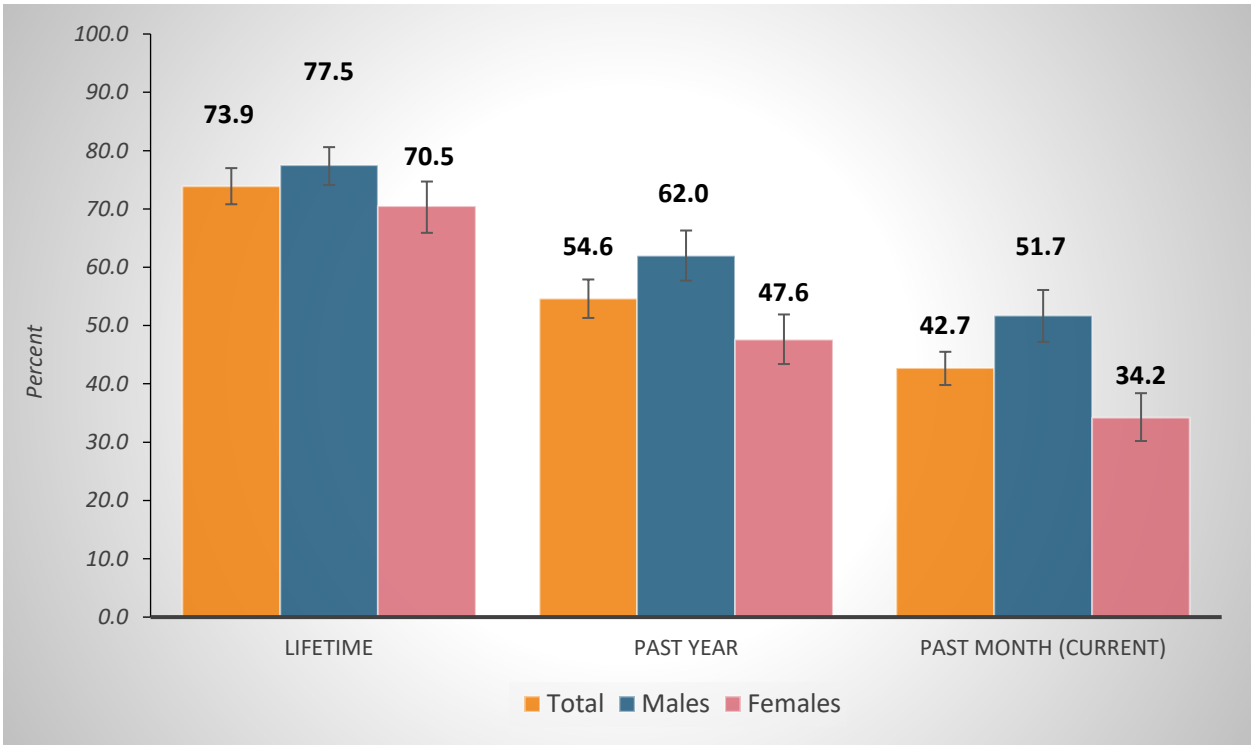
ALCOHOL

Overall Prevalence

Survey participants were asked about their alcohol consumption and related behaviour. Ever use (lifetime); use in the past year (past year users); and use in the past month (current users).

The lifetime prevalence was 73.9% (77.5% males, 70.5% females) (***Figure 9***). Fifty-five percent (54.6%; 62% males, 47.6% females), and 42.7% (51.7% males, 34.2% females) of respondents drank in the past year and past month respectively (***Figure 9***). There was a higher proportion of males for all consumption levels.

Figure 9. Lifetime, Annual and Monthly Prevalence of Alcohol Consumption by Sex



Source: Bahamas National Household Drug Prevalence Survey, 2017

The mean age of first drink was 17.6 years (CI 17.3, 17.9 years; 16.9 years males, 18.3 years females). Ages ranged from 5 to 51 years. Looking at incidence, most ***drinking*** respondents reported having their first drink more than a year ago (80.9% [CI 75.7%, 86.2%]); 12.4% of persons had their first drink during the past 30 days (CI 8.2%, 16.6%), while 6.7% (CI 4.9%, 8.4%) had their first drink more than a month ago but within the past year. Summarizing, past year incidence was 19.1% for alcohol consumers, however, for the ***total*** population it was 14.1%.

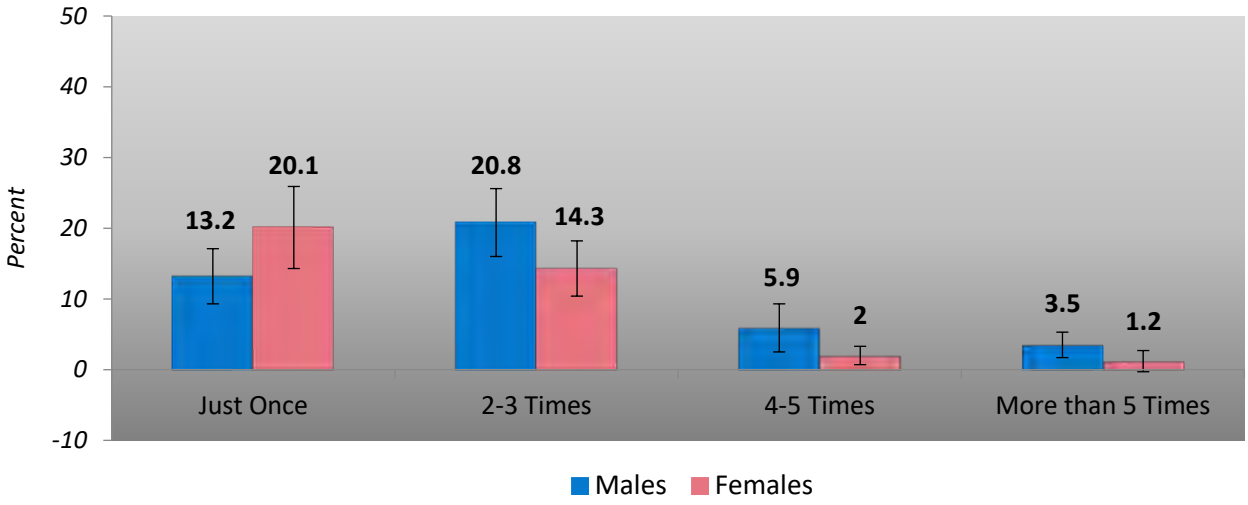
Current Alcohol Drinkers Behaviour

The average age of a current alcohol drinker was 36.3 years (CI 35.3, 37.3 years). When persons who drank in the past month were asked how many days they had gotten drunk in the past month, the average was about one day (0.84 [CI 0.59, 1.1 days]).

Binge Drinking

To measure binge drinking, current drinkers were asked if they had drunk, on a single occasion in the past two weeks, 5 or more drinks for males, or 4 or more drinks for females (see ***Figure 10***). Most persons (55.2% males [CI 49.4%, 61.1%]; 61.5% females [CI 54.9%, 68.0%]) responded that they had never had the defined number of drinks in one sitting (***not shown***). Of those who binge drank, however, one out of five males (20.8%) did this two to three times, while a similar proportion of females (20.1%) binge drank just once in the past two weeks (***Figure 10***).

Figure 10. Binge Drinking (Males 5 or More Drinks/Females 4 or More in One Sitting) in the Past Two Weeks

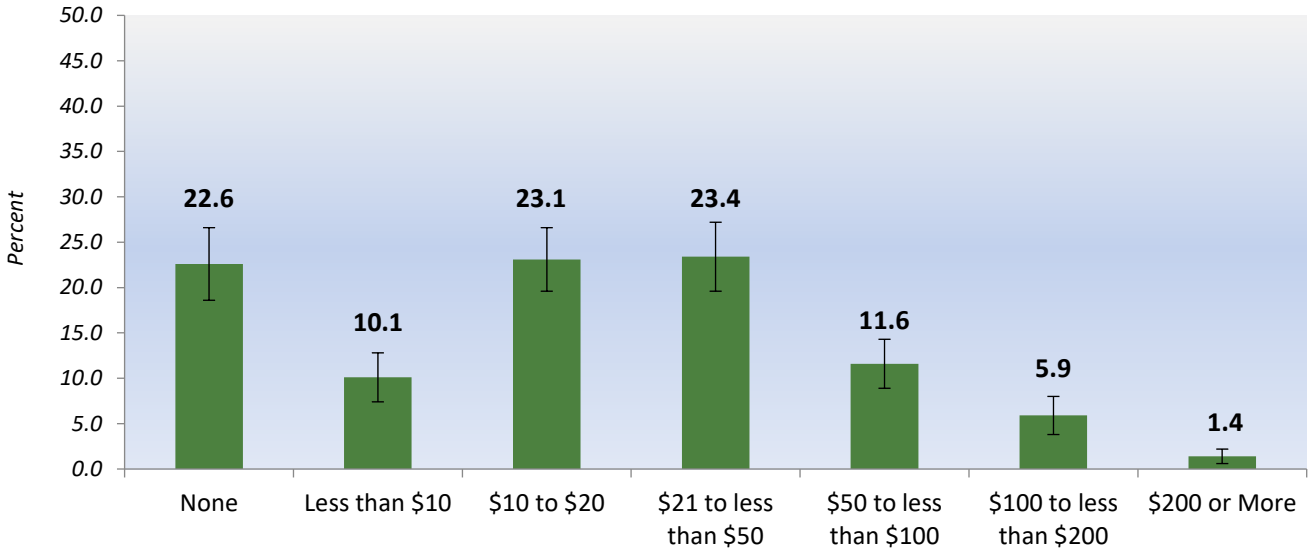


Source: Bahamas National Household Drug Prevalence Survey, 2017

Spending

Current drinkers were asked to estimate the amount of money spent on alcohol in the past month. Almost a quarter (22.6%) did not spend any money; 10.1% reported having spent less than $10, while comparable proportions spent between $10 to $20, and $20 to $50 (23.1% and 23.4%, respectively) (***Figure 11***). Those who spent more than $50 on alcohol in the past month amounted to approximately one out of five (18.9%) current alcohol consumers. Males reported spending higher amounts than females.

Figure 11. Alcohol Spending in Past Month by Current Drinkers



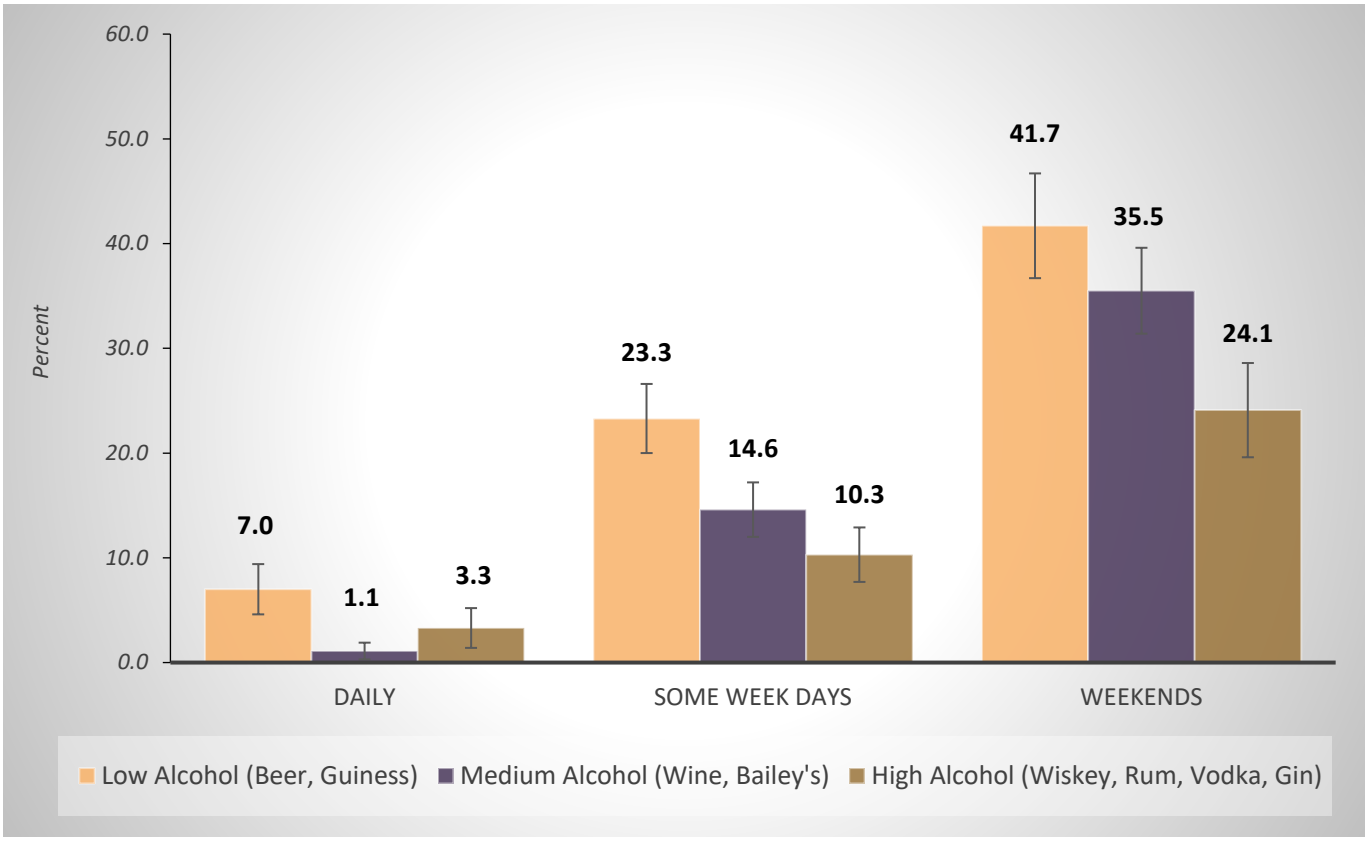
Source: Bahamas National Household Drug Prevalence Survey, 2017

Beverage Type and Frequency

Current drinkers were asked what types of alcoholic beverages they drink, defined by low to high alcoholic content, and with what frequency. Except for low alcohol content drinks (for example beer and Guinness), the most popular response in terms of frequency for each type was "Not at All", with 28.1% for low alcohol (CI 23.6%, 32.5%), 48.7% (CI 44.7%, 52.7%) for beverages with medium alcohol content such as wine and Bailey's, and 62.3% (CI 56.5%, 68.1%) for high alcohol content drinks like rum, vodka, and gin (figure not shown).

Figure 12 shows alcoholic beverages and the frequency of use (daily, some week days or weekends) among those who do drink. The most popular time for consumption of all beverage types was the weekend, with 41.7%, 35.5%, and 24.1% of current drinkers consuming low, medium and high alcohol content drinks, respectively. Low alcohol content drinks were the most popular for all frequencies.

Figure 12. Alcoholic Beverage Type and Consumption Frequency Among Current Drinkers

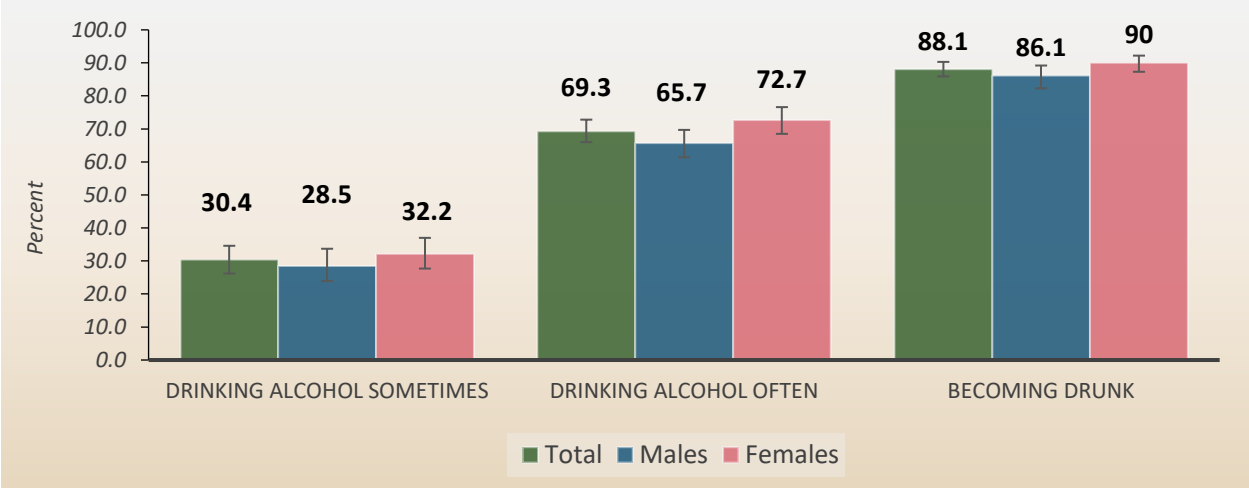


Source: Bahamas National Household Drug Prevalence Survey, 2017

Perceived Risk

When all respondents were asked about the risk of drinking alcohol sometimes, with response options ranging from no risk to high risk, 30.4% thought the risk was high (***Figure 13***). As for drinking alcoholic beverages often, and getting drunk, 69.3% and 88% respectively thought this carried a high risk. While females were slightly more likely to think alcohol drinking is risky, the difference compared to males is not notable.

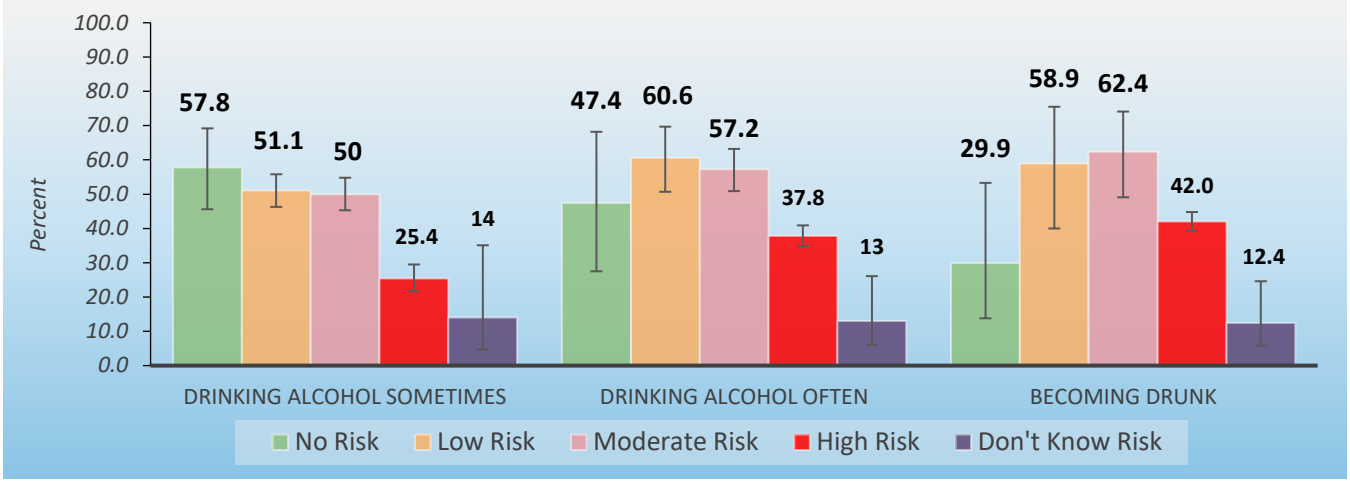
Figure 13. Perceived Alcohol Consumption as "High" Risk by Sex



Source: Bahamas National Household Drug Prevalence Survey, 2017

Risk perception was further examined by current alcohol consumption. Looking at ***Figure 14***, it appeared that persons who responded that any form of drinking is high risk were the least likely to be current alcohol consumers. For example, when asked about the risk of drinking alcohol often, 47.4% of the no risk, 60.6% of the low risk, 57.2% of the moderate risk, and 37.8% of the high risk perception groups reported drinking in the past month. However, only those who did not know the risk of drinking had lower prevalence rates. Continuing, among current alcohol users, while most, 61.4% (CI 56.5%, 66.1%) thought drinking often is risky, this proportion was lower than that found among those who did not drink at all (76.8% [CI 72.1%, 80.9%]) (figure not shown).

Figure 14. Current Alcohol Consumption by Level of Risk Perception



Source: Bahamas National Household Drug Prevalence Survey, 2017

Current Alcohol Consumption by Age and Sex Groups, SES, and Constituency

Current alcohol consumption was examined by age group for both sexes, SES variables, and the three constituencies with the highest prevalence (***Table 4***). Older males showed slightly higher prevalence (59.2% and 52.9% of the 25-44 and 45-65 age groups, respectively) than their younger counterparts (40.0%). Older females, however, had a lower current alcohol prevalence at 28.9% when compared to younger females (31.9% 12-24 years, 40.1% 25-44 years).

An overall pattern shows that persons with higher education, who at least completed secondary school, had higher current consumption rates (***Table 4***). Those with vocational training showed the highest prevalence at 62.3%.

The employment group with the highest prevalence was working/self-employed persons. Half (50.7%) of these persons were current alcohol drinkers (***Table 4***). Students who did not work had the lowest rates at 13.5%.

For the most part, the higher the income, the higher the past month alcohol consumption (range 36.0% to 49.7%), but the differences were not significant (***Table 4***).

The three constituencies with the highest prevalence rates were North Eleuthera, Carmichael, and Fox Hill, each with more than 60% current drinking proportions (***Table 4***), markedly higher than the population rate of 42.7%.

Table 4. **Current Alcohol Consumption by Age and Sex Groups, SES, and Constituency***

Variables			Percent Current Alcohol Drinkers	*95% CI*
Age and Sex Groups	12-24 Years	Males	40.0	*32.4, 48.2*
		Females	31.9	*24.7, 40.2*
	25-44 Years	Males	59.2	*53.2, 64.9*
		Females	40.1	*34.2, 46.3*
	45-65 Years	Males	52.9	*46.7, 59.0*
		Females	28.9	*23.7, 34.7*
Education	Never Attended/Incomplete Primary		14.6	*4.4, 39.0*
	Complete Primary		13.7	*8.6, 21.2*
	Incomplete Secondary		34.4	*27.1, 42.6*
	Complete Secondary		47.0	*43.4, 50.6*
	Incomplete University/Tertiary		51.8	*39.7, 63.8*
	Complete University/Tertiary		44.2	*38.1, 50.4*
	Vocational		62.3	*49.3, 73.7*
Employment	Working/Self-employed		50.7	*46.9, 54.5*
	Working and Studying		41.2	*31.1, 52.2*
	Unemployed		41.3	*34.1, 48.8*
	Not working, student		13.5	*7.5, 23.0*
	Not working (Retired; of independent means)		31.2	*20.4, 44.5*
	Not working (Housewife, other)		26.3	*12.5, 47.2*
Monthly Household Income	$400 or Less		36.0	*22.7, 51.8*
	$401-$800		37.0	*27.7, 47.3*
	$801-$1500		38.4	*32.5, 44.6*
	$1501-$2500		46.3	*40.6, 52.2*
	$2501-$3500		43.0	*36.7, 49.5*
	$3501-$5000		49.0	*42.5, 55.5*
	More than $5000		49.7	*36.5, 62.9*
Constituency	North Eleuthera		66.7	*53.3, 77.9*
	Carmichael		66.3	*39.8, 85.4*
	Fox Hill		60.4	*50.8, 69.3*

***** The top three constituencies with the largest proportions of current (past month) alcohol drinkers.

Source: Bahamas National Household Drug Prevalence Survey, 2017

Risky Alcohol Consumption by Age and Sex Groups, SES and Constituency

The World Health Organization's (WHO) Alcohol Use Disorders Identification Test (AUDIT)[17] screening tool was incorporated in the questionnaire. Past year drinkers were asked ten questions, including regular and binge drinking frequency, injuries from alcohol consumption, and friends, relatives, or doctors' concerns about the respondents' drinking. Responses were subsequently added to form a score with four categories: "Low-risk," "Risky/hazardous level," "High-Risk/harmful level," and "High risk." Because of the relatively low proportions for each risk group in this survey, all risky levels other than Low-risk were combined in this report to form a two-level variable: those with Low-risk, and those with any Risky drinking.

The overall Risk group prevalence for the past year drinkers population was 11.3% (5.9% of the ***total*** population). ***Table 5*** shows a breakdown of Risky drinking by the usual variables of age and sex, SES, and constituency. Young males 12-24 years had the highest risky drinking prevalence of 23.4% among the age and sex groups. Persons with incomplete secondary education, that is, high school drop outs (not students currently in high school), also had high rates, with more than one out of five (22%) with risky drinking habits. Among employment levels, unemployed persons had the highest risky drinking proportions at 16.5%. Persons working and studying also had comparatively high rates (14.2%).

Examining risky drinking by household income, there does not appear to be a clear pattern. Persons from households making $401 to $800 a month had the highest prevalence of risky drinking at 16.9%, with respondents from households earning $3,501 to $5,000 being a close second at 15.0% (***Table 5***).

The Englerston constituency had the highest prevalence of risky drinking at 30.8%, followed by Carmichael (25.8%), and Fox Hill (25.6%) (***Table 5***).

Table 5. **Past Year Alcohol Consumption showing Risky Drinking using the Alcohol Use Disorders Identification Test (AUDIT) by Age and Sex Groups, SES, and Constituency***

Variables			Percent Past Year Alcohol Drinkers with Risky Drinking	*95% CI*
Age and Sex Groups	12-24 Years	Males	23.4	*13.6, 37.2*
		Females	8.0	*3.7, 16.4*
	25-44 Years	Males	14.9	*9.8, 21.9*
		Females	6.3	*3.6, 10.7*
	45-65 Years	Males	12.4	*8.3, 18.3*
		Females	1.4	*0.4, 5.5*
Education	Never Attended/Incomplete Primary		10.5	*1.3, 51.8*
	Complete Primary		11.3	*4.3, 26.8*
	Incomplete Secondary		22.0	*11.8, 37.3*
	Complete Secondary		11.8	*8.5, 16.2*
	Incomplete University/Tertiary		16.1	*7.8, 30.1*
	Complete University/Tertiary		6.0	*3.3, 10.8*
	Vocational		7.5	*2.7, 19.1*
Employment	Working/Self-employed		10.7	*8.4, 13.6*
	Working and Studying		14.2	*5.0, 34.5*
	Unemployed		16.5	*9.4, 27.3*
	Not working, student		8.6	*2.8, 24.0*
	Not working (Retired; of independent means)		7.5	*3.4, 15.9*
	Not working (Housewife, other)		7.1	*1.4, 28.7*
Monthly Household Income	$400 or Less		6.3	*2.1, 17.1*
	$401-$800		16.9	*7.9, 32.5*
	$801-$1500		10.0	*5.7, 16.9*
	$1501-$2500		11.0	*7.0, 16.7*
	$2501-$3500		4.9	*2.7, 8.9*
	$3501-$5000		15.0	*9.4, 23.1*
	More than $5000		12.5	*5.4, 26.6*
Constituency	Englerston		30.8	*24.5, 37.9*
	Carmichael		25.8	*16.2, 38.5*
	Fox Hill		25.6	*10.3, 50.7*

***** The top three constituencies with the largest proportions of Risky AUDIT Scores of past year alcohol drinkers.

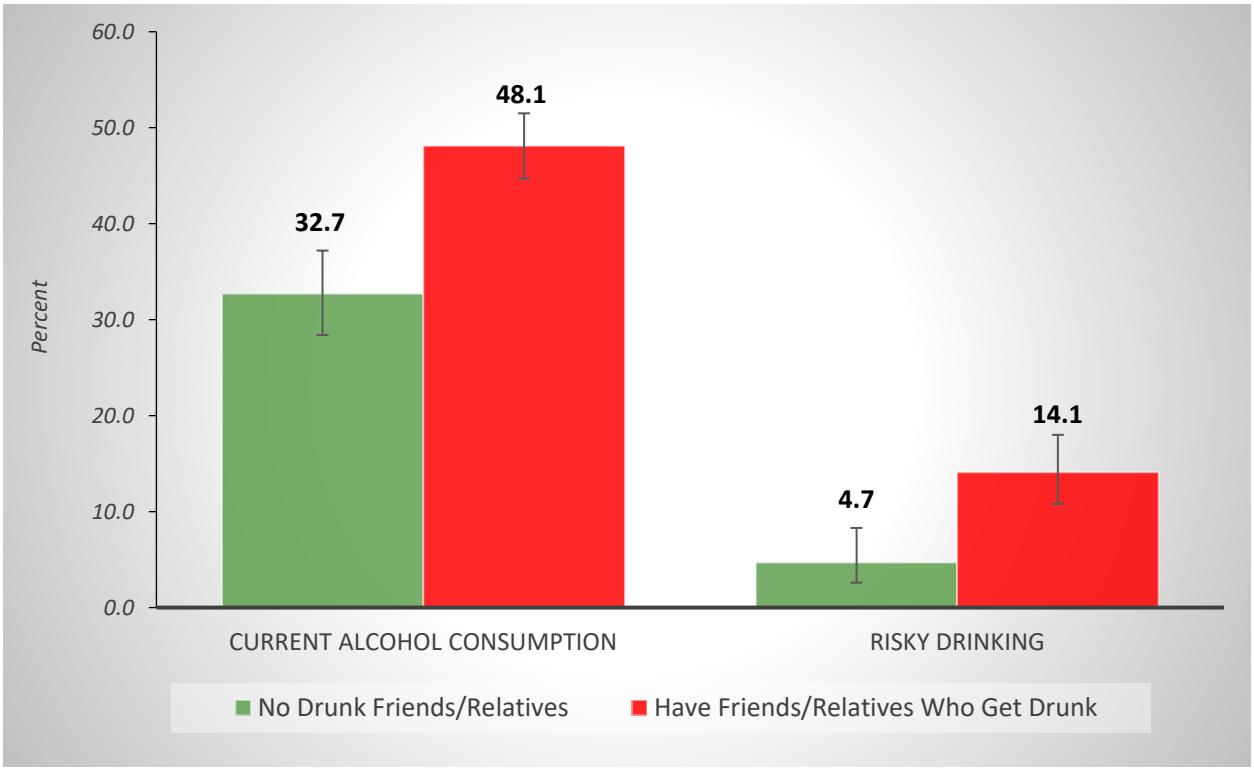
Source: Bahamas National Household Drug Prevalence Survey, 2017

Drinking by Friends and Family

All persons were asked whether they had friends or relatives who got drunk. Almost two out of three (64.9% [CI 61.4%, 68.4%]) answered "Yes", with most of this group, 85.1% (CI 82.4%, 87.7%), having two or more such friends or family members. If looking at total prevalence, this represents 55.2% of ***the total population*** having two or more friends or family who got drunk.

Having friends and/or relatives who get drunk appeared to make respondents more likely to be current alcohol drinkers, as well as risky drinkers (***Figure 15***). Almost half (48.1%) of persons with relatives and friends who got drunk, compared to 32.7% of persons who did not have such friends/relatives, were current alcohol consumers.

Figure 15. Current Alcohol Consumption and Risky Drinking* by Having Friends/Relatives who Get Drunk



** Classified based upon AUDIT scores*.

Source: Bahamas National Household Drug Prevalence Survey, 2017

As for risky drinking (results from the AUDIT score), 14.1% of those reporting drunk friends/relatives of past year alcohol consumers showed risky habits, compared to 4.7% of those with no friends/relatives who got drunk (a three-fold difference).

Drinking and Driving

Persons who have drunk alcoholic beverages were asked if they have driven a vehicle while under the influence of alcohol. Of those who have ever drunk alcohol, and driven a vehicle in the past year, 20.9% (CI 17.4%, 24.4%) drove in the past year while under the influence. This represents 12.4% of the ***total*** population.

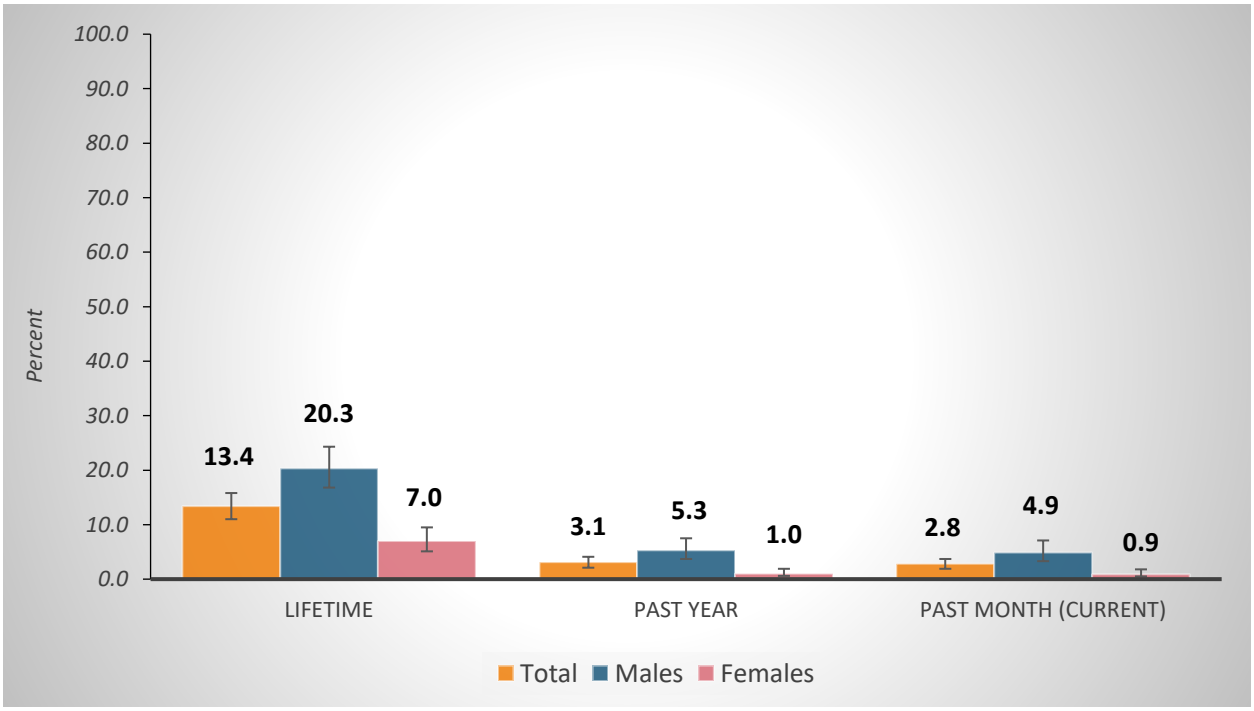
MARIJUANA

Overall Prevalence

Thirteen percent (13.4%) of persons have ever smoked marijuana, defined as lifetime smokers, (20.3% males, 7.0% females), and 3.1% smoked in the past year (5.3% males, 1.0% females). Those who smoked in the past month (current smokers) had similar proportions (2.8%) to past year smokers (***Figure 16***).

When lifetime marijuana users were asked when was the first time they smoked marijuana, most, 88.0% (6.3% of ***all*** persons [CI 4.5%, 8.0%]), started smoking more than a year ago. One out of ten (10.4%) lifetime marijuana smokers first smoked in the past year, representing less than 1% of the ***total*** population. The mean age of respondents' first marijuana smoke is 17.2 years (range 5 to 43 years). By sex, the mean age was 16.5 years for males, and 19.0 years for females. The average age of a current marijuana smoker is 31.5 years (CI 27.6, 35.3 years).

Figure 16. Lifetime, Annual and Monthly Prevalence of Marijuana Use by Sex



Source: Bahamas National Household Drug Prevalence Survey, 2017

Marijuana Smokers' Behaviour

Past year marijuana users were asked how often they smoked in the past year (***Figure 17***): The largest proportions smoked daily/almost daily (39.7%), with half (50.0%) consisting of female smokers, and 37.5% of males; while (26.8%) smoked weekly (27.7% males, 22.3% females).

Figure 17. Frequency of Marijuana Smoking in Past Twelve Months by Sex*

* The sample size of marijuana users was too small for 95% confidence intervals.

Source: Bahamas National Household Drug Prevalence Survey, 2017

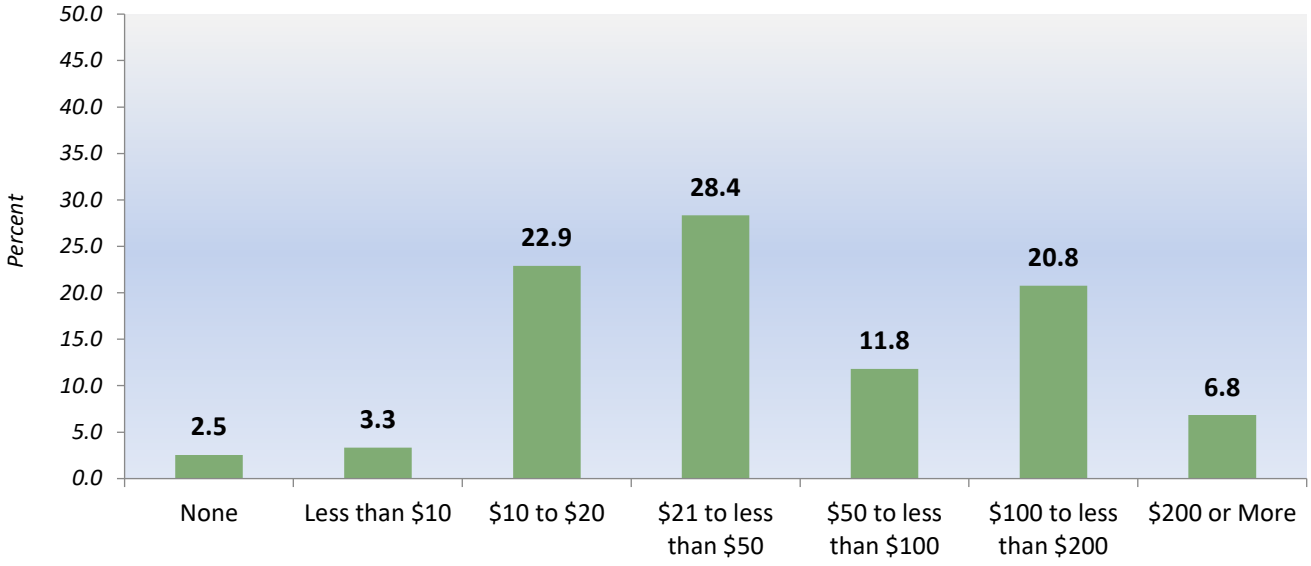
Current marijuana smokers smoked an average of 16.9 days in the past month (range 1 to 30 days), and smoked a monthly average of 11.3 joints (range 0 to 80 joints).

Spending

Of the 79.4% of all marijuana smokers who reported that they had ever bought marijuana, 80% last bought the drug within the past month. ***Figure 18*** conveys the estimated amount of money spent by this group

who bought in the past month: most spent in excess of $20: 28.4% spent between $20 and $50; 11.8% spent $50 to $100, while more than a quarter (27.6%) spent $100 or more.

Figure 18. Marijuana Spending in Past Month by Past Year/Month Users*



* The sample size of marijuana users was too small for 95% confidence intervals.

Source: Bahamas National Household Drug Prevalence Survey, 2017

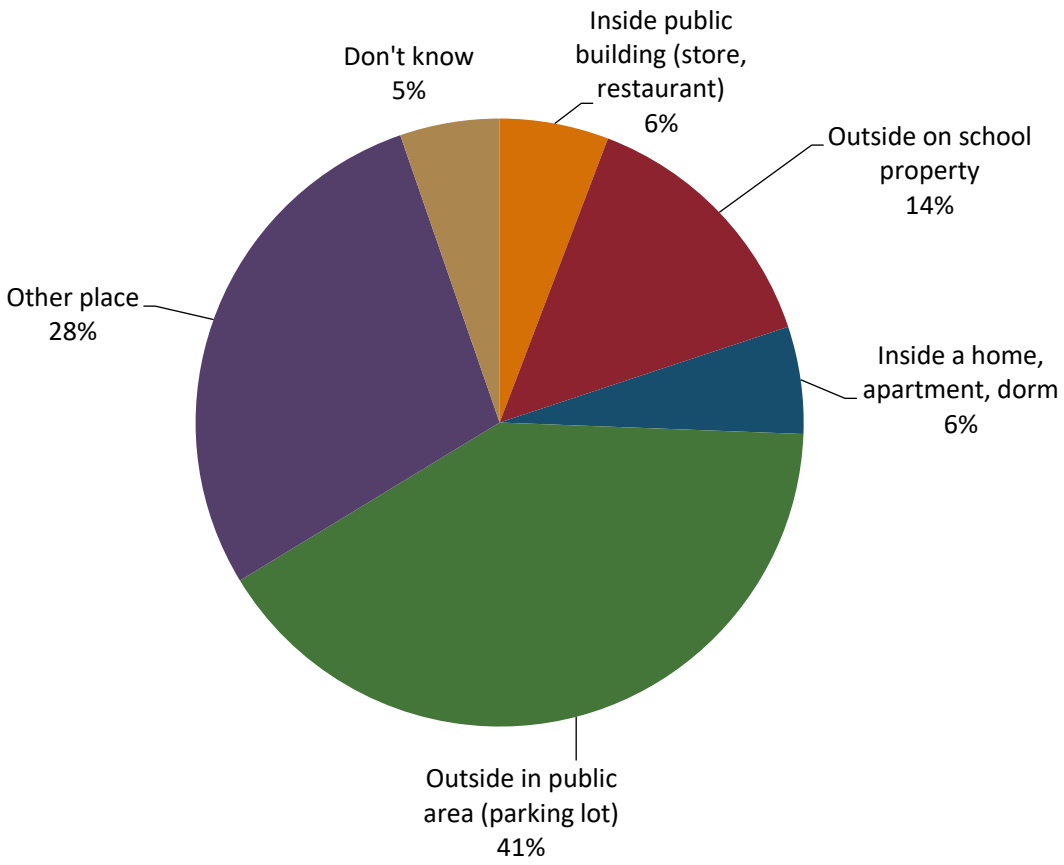
When asked how much marijuana was bought in terms of weight, most (47.2%) used the number of grams as a measure, and with the majority buying small amounts. Thirty-seven percent (36.6%) indicated buying 1 gram, 17.0%, two grams, and 10.0%, three grams. The range of grams bought was 1 to 27. Some (13%), however, used ounces, with most (63.4%) buying one to two ounces.

All (lifetime, yearly, and monthly) users indicated that a joint cost an average of $7 (range $2 to $20).

Marijuana Sales and Exchanges

Regarding where persons were when they last bought their marijuana, "outside in a public area (parking lot)" was the most popular response (40.7%) by far. ***Figure 19*** below shows proportions of other places, such as "Outside on school property" (14.1%), and "Inside a home, apartment, or dorm" (5.7%).

Figure 19. Places Where Marijuana Was Last Bought*



* The sample size of marijuana users was too small for 95% confidence intervals.

Source: Bahamas National Household Drug Prevalence Survey, 2017

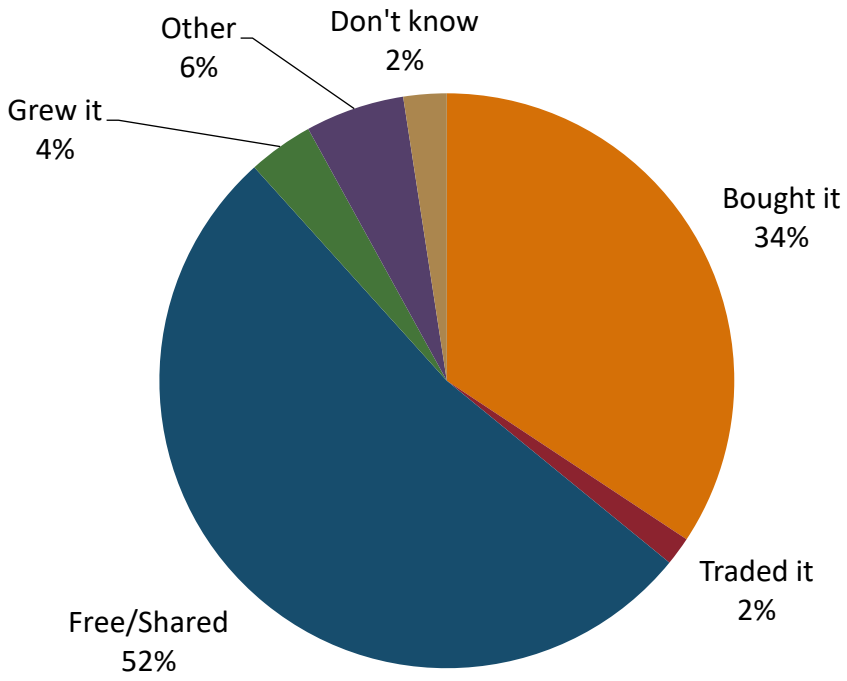
Other drugs reported to be sold along with marijuana at these places include alcohol, tobacco and Bidis.

Most persons who buy marijuana get it from "the same dealer" (53.5%), or "look for it at the same venue

every time" (29.9%), or a "new venue every time" (7.8%). A very small percent (4.4%) go to a new dealer (figure not shown).

All marijuana users were then asked how they got the marijuana they last used. More than half (52.4%) responded that they got it for free or shared with someone else. Around a third (34.3%) bought it, and 4% grew it themselves (***Figure 20***).

Figure 20. Method of Obtaining Marijuana (Last Time)



* The sample size of marijuana users was too small for 95% confidence intervals.

Source: Bahamas National Household Drug Prevalence Survey, 2017

When all users were asked to estimate the potency of the marijuana they most recently used, i.e., the amount of Tetrahydrocannibol (THC) it contained, most thought it was "medium" strength (27.2%), "strong" (25.1%), or "very strong" (20.4%). A sizeable amount however (17.4%) did not know the strength.

Most marijuana users, who got their marijuana for free, last obtained it from a friend (63.6%). Eleven percent (10.6%) got it from a relative, 4.1% from someone they had just met/did not know well, while 18.0% never got it for free. Other open-ended responses include growing it themselves, finding it, getting it from a prison officer, or a social grouping. Users got their last free joint primarily outside in a public area (27.8%), inside a home, apartment or dorm (21.3%), or some other place (33.5%).

Driving While Under the Influence

Almost nine percent (8.5%) of marijuana smokers who drove a vehicle in the past year did so while under the influence of marijuana (around 5% of the total population).

Current Marijuana Use by Age and Sex Groups, SES, and Constituency

Current marijuana smokers were looked at by age and sex groups, SES, and constituency (***Table 6***). Males under 45 years had the highest proportions of current marijuana smokers. Seven percent (7.3%) of males 12 to 24 years, and 5.9% of 25 to 44 year old males were current smokers. Females of all ages showed low rates (range 0.7% to 1.1%).

Among educational groups, persons with incomplete secondary school to incomplete university/tertiary education had similar prevalence (4.0%, 3.4%, 4.8% respectively). Persons with incomplete primary or no education (0%), and those who completed university (0.8%) had the lowest rates (***Table 6***).

Regarding smoking marijuana, there appeared to be no differences in working status, with around 3% for most categories (***Table 6***). Students (1.7%), non-working persons such as housewives or other (0%) had the lowest proportions.

Persons from households making less than $1,501 a month were more likely to report being current marijuana smokers (4.9% to 6.6%) (***Table 6***).

The constituency of Bain and Grants Town had almost four times the national prevalence of current marijuana smokers, with a proportion of 11% (***Table 6***). Rates for Fort Charlotte (7.9%) and St. Cecelia's (6.7%) were not far behind.

Table 6. **Current Marijuana Smokers by Age and Sex Groups, SES, and Constituency***

Variables			Percent Current Marijuana Smokers	*95% CI*
Age and Sex Groups	12-24 Years	Males	7.3	*3.8, 1.6*
		Females	0.7	*0.2, 2.7*
	25-44 Years	Males	5.9	*3.7, 9.2*
		Females	1.1	*0.4, 3.4*
	45-65 Years	Males	1.4	*0.7, 2.8*
		Females	0.9	*0.3, 2.4*
Education	Never Attended/Incomplete Primary		0	*n.a.*
	Complete Primary		1.9	*0.5, 6.4*
	Incomplete Secondary		4.0	*2.0, 7.7*
	Complete Secondary		3.4	*2.2, 5.3*
	Incomplete University/Tertiary		4.8	*1.9, 11.8*
	Complete University/Tertiary		0.8	*0.3, 2.2*
	Vocational		2.4	*0.5, 10.0*
Employment	Working/Self-employed		3.1	*2.0, 4.9*
	Working and Studying		3.1	*0.9, 10.6*
	Unemployed		3.1	*1.6, 6.1*
	Not working, student		1.7	*0.6, 4.9*
	Not working (Retired; of independent means)		2.3	*0.6, 8.3*
	Not working (Housewife, other)		0	*n.a.*
Monthly Household Income	$400 or Less		6.6	*2.3, 17.6*
	$401-$800		4.9	*1.9, 11.8*
	$801-$1500		5.5	*2.6, 11.4*
	$1501-$2500		1.8	*0.9, 3.4*
	$2501-$3500		3.3	*1.6, 6.7*
	$3501-$5000		1.2	*0.4, 3.7*
	More than $5000		1.5	*0.3, 6.7*
Constituency	Bain and Grants Town		11.0	*5.2, 21.9*
	Fort Charlotte		7.9	*2.7, 21.2*
	St. Cecelia		6.7	*1.6, 24.8*

* The top three constituencies with the largest proportions of current (past month) marijuana smokers.

Source: Bahamas National Household Drug Prevalence Survey, 2017

Marijuana Addiction Risk

To measure marijuana addiction risk, the Cannabis Abuse Screening Test (CAST)[18] was added to the questionnaire. Using the tool, all marijuana smokers were asked a series of six questions on their behavior over the past twelve months, including "Have you smoked marijuana before midday?", "Have you had memory problems when you smoked marijuana?", and "Have you had problems because of your use of marijuana (argument, fights, accident, bad result at school, etc.)?". The responses ranged from "Never" (0 points) to "Very Often" (4 points). Points were then totaled to a score, which is subsequently categorized into three types of addiction: No addiction risk, Low addiction risk, and High addiction risk. Proportions for Low addiction risk were 16.0%, and High addiction risk, 25.3%, representing 1.1% and 1.8% of the ***entire*** population respectively.

Table 7 shows the prevalence of those at risk for high addiction for the age and sex groups, SES, and constituency. Young males 12 to 24 years (56.9%) and 25 to 44 years (41.3%) showed higher rates of high addiction risk. Among females, high addiction risk seemed to be present only for those 45 to 65 years (25.6%).

As for education, those with complete primary education reported a high addiction risk of 23.8%, comparable to those who completed secondary school or had incomplete university education (27.5% and 24.2%, respectively). Respondents with incomplete secondary education had the highest risk, however, at 50.2% (***Table 7***). Those with tertiary education showed no addiction risk, while those with vocational training had a risk of 17.2%.

Persons who were working and studying had the highest proportion of high addiction risk at 55.4%. Unemployed persons also showed high risk rates, with 32.5%. A quarter of working persons (24.2%) had a high risk for marijuana addiction, while full time students had a 16% prevalence. Retired and other non-working persons both showed zero high risk (***Table 7***).

For the most part, as income rose, the prevalence of addiction risk decreased (***Table 7***). Over half (52.8%) of those from homes making $400 or less showed marijuana addiction risk, which generally decreased to 13.5% of respondents from households with an income of $5,000 or more.

The Montague, Fort Charlotte, and Sea Breeze areas had the greatest prevalence of high risk (77.9%, 77.4%, 73.2%, respectively; ***Table 7***).

Table 7. **Marijuana Users showing High Addiction Risk using the Cannabis Abuse Screening Test (CAST) by Age and Sex Groups, SES, and Constituency***

Variables			Percent Marijuana Smokers with High Addiction Risk	*95% CI***
Age and Sex Groups	12-24 Years	Males	56.9	
		Females	0	
	25-44 Years	Males	41.3	
		Females	6.5	
	45-65 Years	Males	4.7	
		Females	25.6	
Education	Never Attended/Incomplete Primary		0	
	Complete Primary		23.8	
	Incomplete Secondary		50.2	
	Complete Secondary		27.5	
	Incomplete University/Tertiary		24.2	
	Complete University/Tertiary		0	
	Vocational		17.2	
Employment	Working/Self-employed		24.2	
	Working and Studying		55.4	
	Unemployed		32.5	
	Not working, student		16.0	
	Not working (Retired; of independent means)		0	
	Not working (Housewife, other)		0	
Monthly Household Income	$400 or Less		52.8	
	$401-$800		23.8	
	$801-$1500		31.4	
	$1501-$2500		24.9	
	$2501-$3500		20.8	
	$3501-$5000		10.1	
	More than $5000		13.5	
Constituency	Montague		77.9	
	Fort Charlotte		77.4	
	Sea Breeze		73.2	

* The top three constituencies with the largest proportions of High Addiction Risk CAST Scores of marijuana smokers.

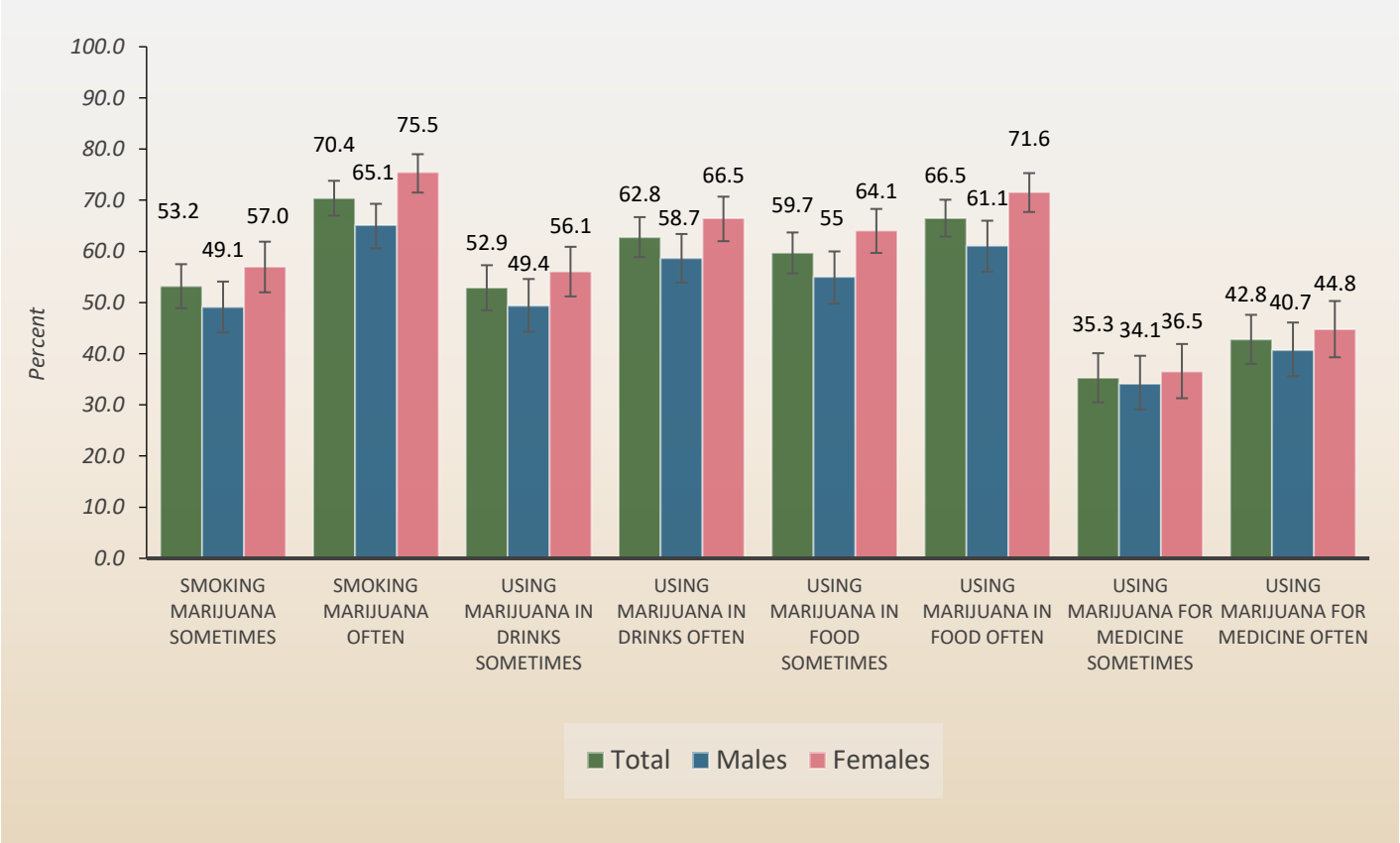
** The sample size was too small for confidence intervals.

Source: Bahamas National Household Drug Prevalence Survey, 2017

Perceived Risk

More than half (53.2%) of all respondents thought smoking marijuana sometimes is a high risk, with proportionally more females (57.0%) than males (49.1%) reporting this view. (***Figure 21***) A greater proportion (70.4%) thought smoking marijuana often poses a high risk (65.1% males, 75.5% females).

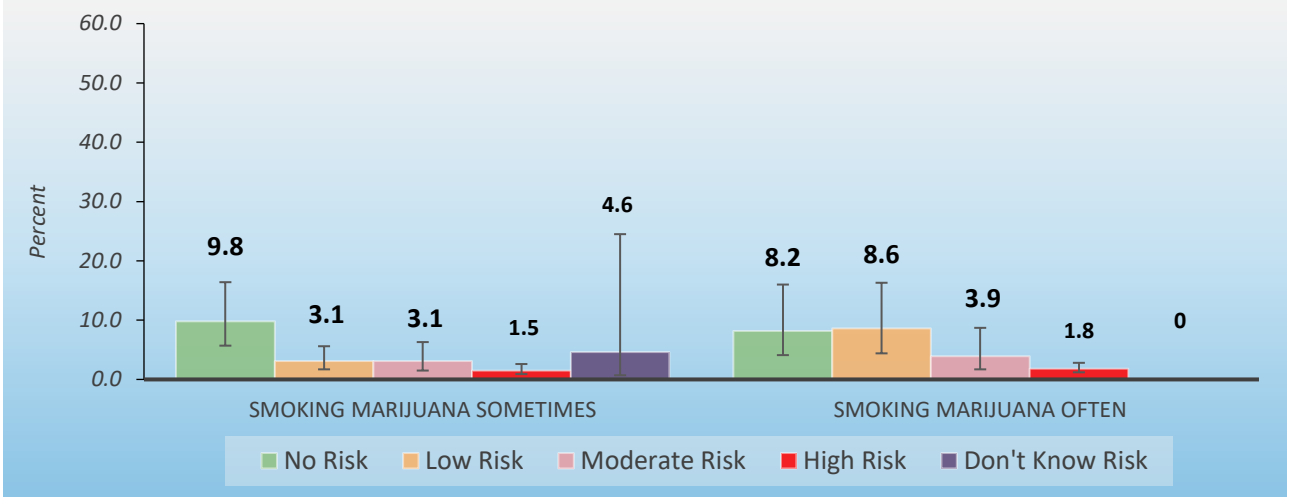
Figure 21. Perception of "High" Risk in Various Forms of Marijuana Use, by Sex



Source: Bahamas National Household Drug Prevalence Survey, 2017

Figure 22 below shows the proportion of current marijuana smokers at each level of perceived risk of marijuana smoking. The general pattern reveals that the higher the perceived risk, the lower the proportion of marijuana smokers. Almost one out of ten no-risk perception groups were comprised of current marijuana smokers who viewed "smoking marijuana sometimes," (9.8%) or "smoking marijuana often" (8.2%) as low risk. This was high compared to those who thought smoking marijuana is high risk, which is around 2% for both the smoking sometimes and often groups.

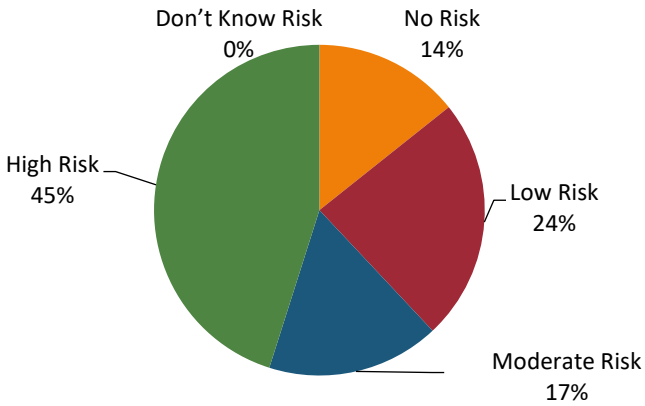
Figure 22. Current Marijuana Smoking by Level of Risk Perception



Source: Bahamas National Household Drug Prevalence Survey, 2017

When current marijuana smokers were examined as a single group to gauge their perceived risk of smoking marijuana, differences for smoking marijuana sometimes were similar, ranging from 25.9% (CI 15.1%, 40.8%) responding that it was no risk, to 28.6% (CI 17.9%, 42.4%) replying that it was high risk (figure not shown). However, when it came to smoking marijuana often, differences were clearer: 45% of current smokers answered that often smoking marijuana carried a high risk. (**Figure 23)** This was significantly lower, however, than found among those who do not smoke at all, 71% (CI 67.8%, 74.5%) (figure not shown).

Figure 23. Perceived Risk of Smoking Marijuana Often Among Current Marijuana Smokers



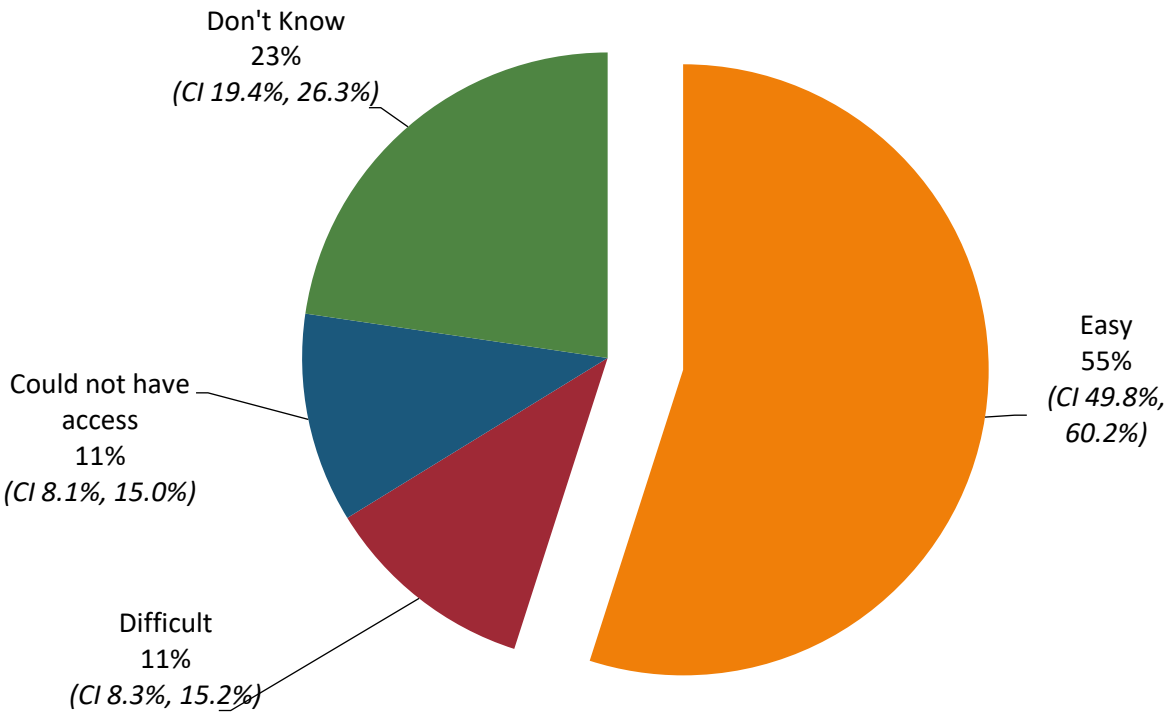
Source: Bahamas National Household Drug Prevalence Survey, 2017

Access

When asked how easy would it be to have access to marijuana, almost half (48.5%) of survey respondents replied that it would be "easy" (CI 43.9%, 53.0%). A higher proportion of males (55.0% [CI 49.8%, 60.2%]) (***Figure 24***) than females (42.3% [CI 36.6%, 48.2%]) answered as such. There were no notable differences by age among males or females.

Most (61.6%) persons have never been offered marijuana to buy or to use (CI 57.8, 65.3). About a quarter (23.8%; CI 20.9, 26.8) had been offered more than a year ago, while one out of ten (9.4% [CI 7.5%, 11.3%]) were offered in the past 30 days. Focusing on this last group, significantly more males (13.3% [CI 10.8%, 16.3%]) than females (5.7% [CI 3.9%, 8.1%]) were offered marijuana in the past month (not shown), especially young males under 45 years (***Table 8***).

Figure 24. Perceived Ease of Access to Marijuana, Males Only



Source: Bahamas National Household Drug Prevalence Survey, 2017

Marijuana as Medicine

Many persons have taken marijuana in ways other than smoking or to mainly get high, particularly for medicinal purposes. The perceived risk of using marijuana in drinks and food was like that of smoking it (***Figure 21***). Taking it for medicine, however, did not appear to seem particularly risky to persons interviewed (35.3% sometimes, 42.8% often) (***Figure 21***).

All respondents were asked if they took marijuana in other forms, with responses shown below:

- Drinks (teas, juice, etc.) – 2.7% *(CI 1.8%, 3.6%)*
- Edibles (pastries, candy, sweets, cooked/uncooked meals) – 6.9% *(CI 5.1%, 8.7%)*
- Concentrates (Oils, shatter, budder wax, etc.) – 1.2% *(CI 0.4%, 2.0%)*
- Other means – 2.2% *(CI 1.2%, 3.2%)*

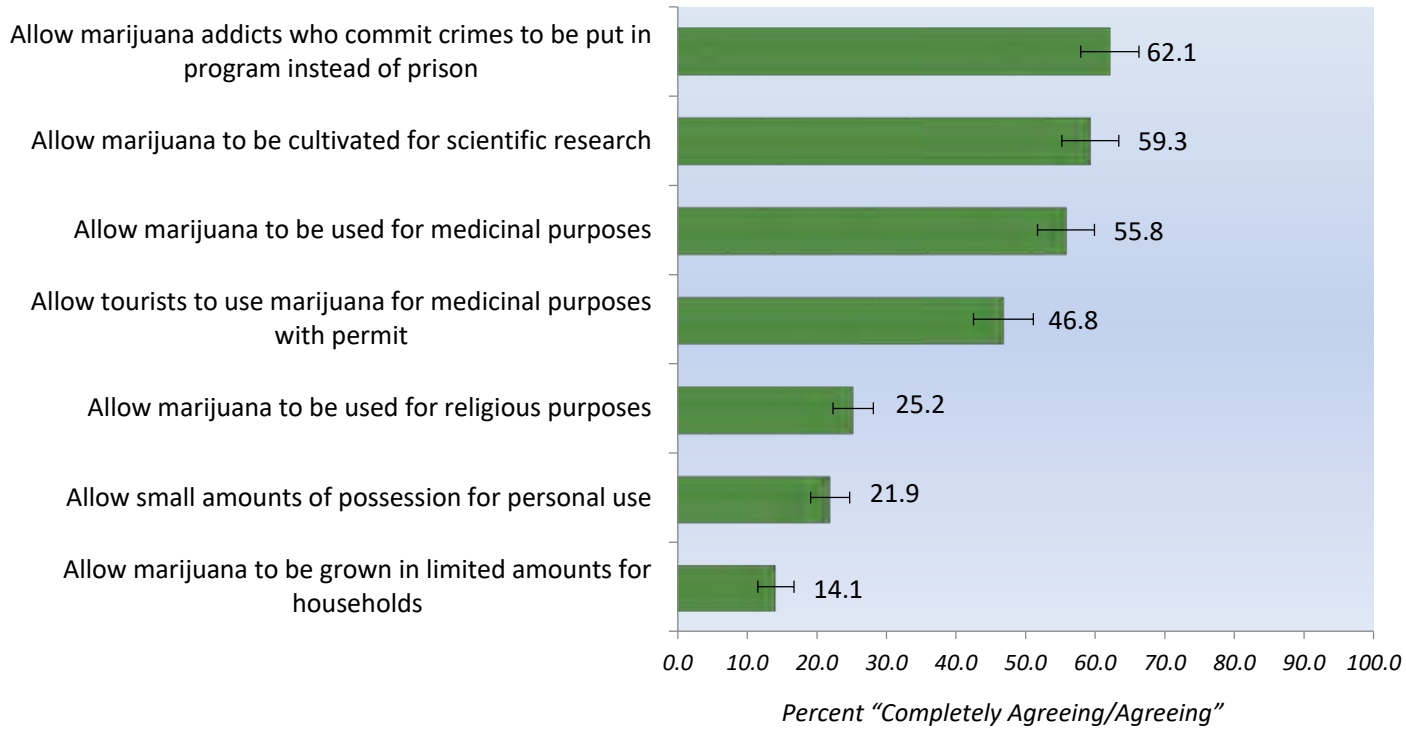
Continuing, 2.0% (CI 1.2%, 2.8%) of all persons have used marijuana for a medical condition, including:

- Attention deficit hyperactivity disorder
- Anxiety
- Asthma
- Breathing problems
- Back problems
- Car accident
- Cataracts
- Depression
- Diabetes
- Flu
- Joint pains
- General sickness
- Glaucoma
- Gun shot
- Headaches
- Sinus
- Heart condition
- Multiple sclerosis
- Ovaries condition
- Sciatica
- Sleeping
- Stress
- Stroke

Marijuana Policies

All persons were asked to what extent they agreed with marijuana policies such as allowing marijuana to be used for medicinal purposes, and allowing the plant to be grown in limited amounts by individual households. Combining those who "completely agree" and "agree", the most popular view appeared to be to allow marijuana addicts who commit crimes such as theft, to be put into a court-supervised drug treatment program instead of prison, with 62.1% agreeing/completely agreeing (see ***Figure 25***). Allowing marijuana to be cultivated for scientific research (59.3%), and for medicinal purposes (55.8%) also received favourable responses. Persons did not agree with allowing marijuana for more personal use, such as possession of small amounts (21.9%), or growing for individual household use (14.1%).

Figure 25. Opinions on Marijuana Policies



Source: Bahamas National Household Drug Prevalence Survey, 2017

COCAINE

Overall Prevalence

The population prevalence of persons who ever used cocaine was 1.2% (CI 0.4%, 1.9%). This consisted of 1.9% males (CI 1.1%, 3.5%) and 0.5% females (CI 0.2%, 1.4%). Past year and current prevalence was 0.05% (CI -0.02%, 0.1%). All past year and current users were male (0.1% of males [CI 0.02%, 0.5%).

The mean age of first use is 21.7 years (CI 19.4, 24.1 years; range 16 to 43 years), and the average age of a current user is 48.5 years (CI 37.8, 59.2 years).

All users first used cocaine more than one year ago.

Cocaine Use Behaviour

Of past year cocaine users, 30.5% used cocaine once in the past year, while the remaining 69.5% used cocaine weekly. As for the past thirty days, users consumed cocaine an average of 9.4 days. Further, they used an average of 2.4 grams a month. Most (69.5%) current users spent between $50 and $100 on cocaine in the past month.

Perceived Risk

The majority of persons viewed cocaine as a dangerous drug, with 87.0% (CI 84.2%, 89.8%) responding that using cocaine sometimes, and 92.0% (CI 90.1%, 93.8%) taking it often, is high risk (not shown).

Access

Almost one out of five (19.2% [CI 16.5%, 21.9%) persons had “easy” access to cocaine with no notable sex difference. Continuing, when respondents were asked if anyone had offered them cocaine, most

(91.6% [CI 90.1%, 93.1%]) were never offered, while 7.1% were offered more than a year ago (CI 5.8%, 8.4%) (not shown).

CRACK COCAINE

Overall Prevalence

The population prevalence of persons who ever used crack cocaine was 0.7% (CI 0.07%, 1.4%). This was comprised of 1.0% males (CI 0.4%, 2.3%) and 0.5% females (CI 0.1%, 1.7%). Past year and current prevalence was 0.08% (CI -0.03%, 0.2%) and 0.03% (CI -0.03%, 0.1%), respectively. All past year and current crack cocaine users were male (0.07% of males [CI 0.01%, 0.5%).

The mean age of first use is 21.2 years (range 12 to 33 years), and the average age of a current user was 54 years. All users first used crack more than a year ago.

Crack Cocaine Use Behaviour

Of past year cocaine users, 42.0% used crack cocaine weekly in the past year, while the remaining 58.0% used crack less than monthly. As for the past 30 days, users used crack for an average of 10.0 days, and an average of 6.0 grams a month. Current users spent between $20 and $50 on crack in the past month.

Perceived Risk

Like cocaine, most persons perceive crack cocaine as a dangerous drug, with 88.2% (CI 85.4%, 90.9%) replying that using crack cocaine sometimes, and 91.0% (CI 88.8%, 93.3%) using it often, is high risk.

Access

Almost sixteen percent (15.8% [CI 13.3%, 18.3%]) of persons had “easy” access to crack cocaine. Sex differences were comparable. When respondents were asked if anyone had offered them cocaine, 4.5%

reported they were offered the drug more than a year ago (CI 3.4%, 5.7%). Most (94.7% [CI 93.3%, 96.0%) persons, however, were never offered crack cocaine.

OTHER ILLICIT DRUGS

Persons were asked if they had ever used drugs from a list presented, most of which were illicit. Those that will be further discussed, while they have relatively low proportions of lifetime users when compared to marijuana for example, are of national interest, either from earlier drug studies, or high enough to warrant attention as apparently new drugs. It should first be noted that 82.3% (CI 79.3%, 85.3%) of the population reported that they have never taken any illegal drug, including marijuana, cocaine and crack cocaine.

Prescription Drugs

Tranquilizers

Tranquilizers include prescription drugs such as Valium, Rohypnol, and Librium. Taking these however without a prescription is illegal. Less than one percent (0.4% [CI -0.2%, 1.0%]) of persons have taken these drugs illicitly. The average age of first use was 17.4 years.

Stimulants

Stimulants include the prescription drugs Ritalin, Preludin or Adepsin, Adderall, and others. Less than 1% (0.4% [CI -0.2%, 0.9%) took these without a prescription, with an average age of first use of 19.3 years.

Analgesics/Pain-Killers

Codeine, Hydrocodone, Vicodin, Methadone, and Morphine are all examples of prescription-only pain-killers. Less than one percent (0.6% [CI -0.03%, 1.3%]), however, have taken these without a prescription. The average age of first use for analgesics was 18.3 years.

EMERGING DRUGS

Inhalants

Inhalants including glue, paint, varnish, gasoline, and other substances, are inhaled to get high. Less than one percent (0.3% [CI -0.3%, 0.9%]) of the population reported ever using these substances. The average age of first use was 10 years.

Ecstasy

3,4-methylenedioxy-methamphetamine (MDMA), more commonly known as ecstasy, or Molly, was tried by 0.3% of the population, with an average age of first use of 23.9 years.

Persons were asked how easy it was for them to have access to ecstasy. Around thirteen percent (12.8% [CI 10.4%, 15.1%]) though it was "easy" for them. A higher percentage of males (15.6% [CI 12.8%, 18.9%]) than females (10.1% [CI 7.7%, 13.1%]) replied thusly. When further asked if they were ever offered ecstasy, 6.5% had ever been offered, with 5.5% (CI 4.2%, 6.8%) being offered more than a year ago.

Grabba

Grabba, a dried tobacco leaf that is usually smoked, was used by 2.6% (CI 1.4%, 3.8%) of the population. There were sex differences: 3.8% of males (CI 2.4%, 6.2%) compared to 1.4% of females (0.5%, 3.6%). The average age of first use was 22.1 years (CI 20.0, 24.1 years).

Beedi/Bidi

Beedis, small thin cigarettes or mini cigars, were ever used by 5.0% of the population (CI 3.3%, 6.5%). Significantly more males (8.5% [CI 6.3%, 11.4%]) than females (1.5% [CI 0.8%, 3.1%]) have used beedis. The average age of first use was 20.5 years (18.4, 22.6 years).

E-Cigarettes

E-Cigarettes, otherwise known as hookah pens, or hookah sticks, were used by 1.9% (CI 1.1%, 2.6%) of the population (2.5% males [CI 1.6%, 3.9%]; 1.3% females [CI 0.7%, 2.5%]). The average age of first use was 19.9 years (CI 18.5, 21.3 years).

Hookah Pipes

Hookah pipes (Tobacco water pipes), have been used by 2.2% of persons (CI 1.2%, 3.3%). The average age of first use was 21.0 years.

Lean

Lean is codeine-containing prescription cough medication mixed with soda, also known as “sizzurp”, to get high. Lifetime users had a prevalence of 2.2% (CI 1.1%, 3.4%). This consisted of 3.3% males (CI 2.0%, 5.6%) and 1.2% females (CI 0.4%, 3.4%). The average age of first use for Lean was 19.8 years.

MULTIPLE DRUG USE

Estimates were derived as to the proportion of the population that use multiple drugs, particularly marijuana, with both legal and illegal drugs. It is estimated that 2.1% of persons are current users of both alcohol and marijuana, and 1.3% are current users of tobacco and marijuana. One percent (1.1%) are current users of alcohol, tobacco, and marijuana. Continuing, less than one percent (0.07%) are users of both marijuana (current), and beedi (lifetime). None of the marijuana users were concurrent users of cocaine, crack, Grabba, or Lean.

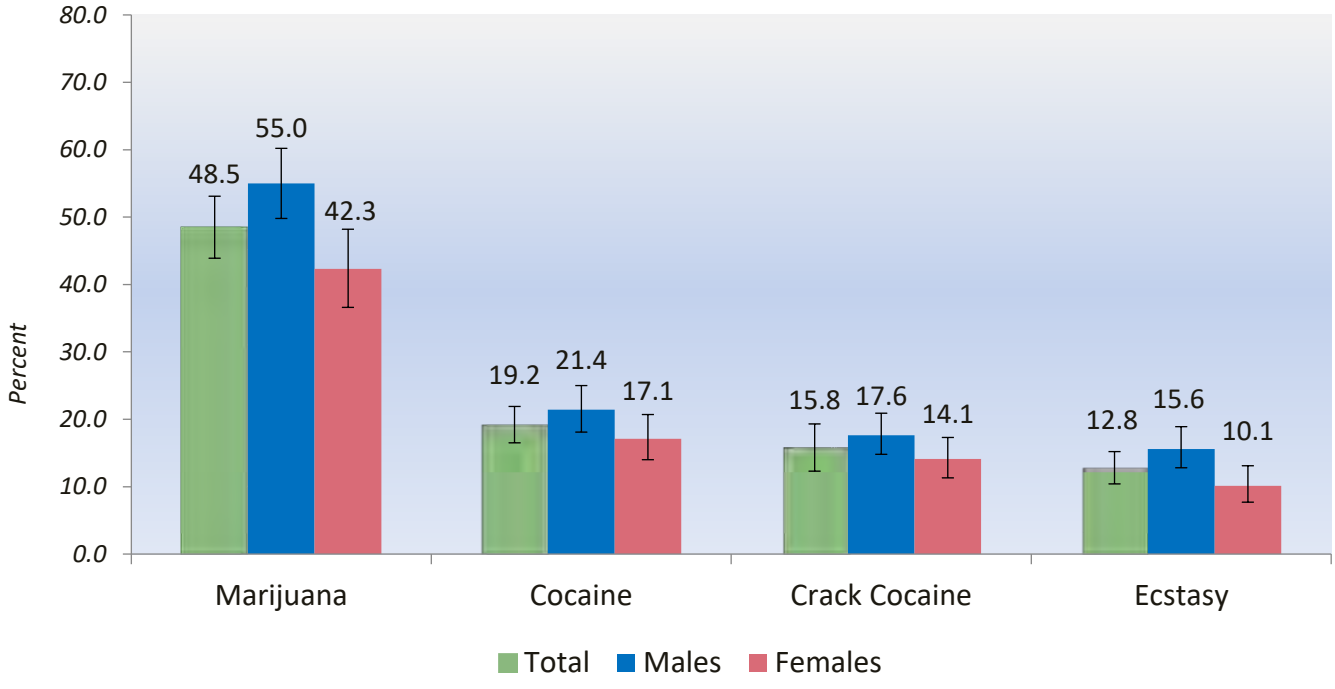
ACCESS

Ease of Access

All persons were asked how easy it would be for them to have access to selected drugs, namely marijuana, cocaine, ecstasy, and crack cocaine. The choices ranged from "Could not have access to", "Difficult", "Easy", and "Don't know". Shown in ***Figure 26*** below are those who thought that access was easy.

Marijuana appeared to be by far the most accessible illicit drug (48.5%), particularly for more males (55.0%) than females (42.3%). One out of five persons thought cocaine access was easy (19.2%), followed by crack cocaine (15.8%), and ecstasy (12.8%).

Figure 26. Perceived "Easy" Access of Selected Drugs



Source: Bahamas National Household Drug Prevalence Survey, 2017

Drug Offerings

Interviewees were further asked about the last time they were offered illicit drugs - during the past month, past year, more than a year, or never been offered. Combining those offered within the past month and past year, proportions were low for cocaine (1.3% [CI 0.7%, 1.9%), crack cocaine (0.8% [CI 0.4%, 1.3%]), and ecstasy (1.0% [CI 0.6%, 1.4%]).

A sizeable proportion, however, were offered marijuana (14.6% [CI 12.4%, 16.9%]) within the past year, again with proportionally more males (20.3% [CI 16.9%, 24.2%]) than females (9.3% [CI 7.1%, 12.1%]). Below (***Table 8***) further shows the extent of marijuana offerings by age/sex groups.

Young males (32.3% [CI 25.1, 40.5]) and females (19.8% [CI 14.3, 26.7]) 12 to 24 years appeared the most likely to have been offered marijuana. Further, one out of five males (21.6% [CI 16.7, 27.6]) 25 to 44 years were also offered marijuana in the past year.

Table 8. **Percent Offered Marijuana Drugs within the Past Year by Age and Sex Groups**

Drug	Age and Sex Groupings		Percent Offered Marijuana Within the Past Year	*95% CI*
Marijuana	12-24 Years	Males	32.3	*25.1, 40.5*
		Females	19.8	*14.3, 26.7*
	25-44 Years	Males	21.6	*16.7, 27.6*
		Females	7.8	*5.0, 12.0*
	45-65 Years	Males	7.6	*5.4, 10.5*
		Females	2.6	*1.4, 4.7*

Source: Bahamas National Household Drug Prevalence Survey, 2017

Drug Use by Friends and Family

All interviewees were asked if any of their friends or family take illegal drugs such as marijuana or cocaine. Forty one percent (41.8% [CI 37.8%, 45.7%]) had such friends or relatives, and of these, 86% had two or more (CI 82.8%, 89.1%). This represents 35.9% (CI 31.9%, 39.9%) of the total population who know two or more friends/relatives who take illegal drugs.

Further, of those who have friends or relatives who take drugs, 5.6% (CI 3.9%, 8.0%) of this group are current users of marijuana, compared to less than 1% (CI 0.5%, 1.5%) of those with no family members who take illegal drugs.

Chance and Curiosity to Try Illegal Drugs

More than a third (35.6% [CI 31.9%, 39.3%]) of persons have had a chance to try an illicit drug, as reported by significantly more males (46.2% [CI 41.0%, 51.5%]) than females (25.7% [CI 21.2%, 30.7%). The majority, 80.4% (CI 76.9%, 83.9%), had this opportunity more than once.

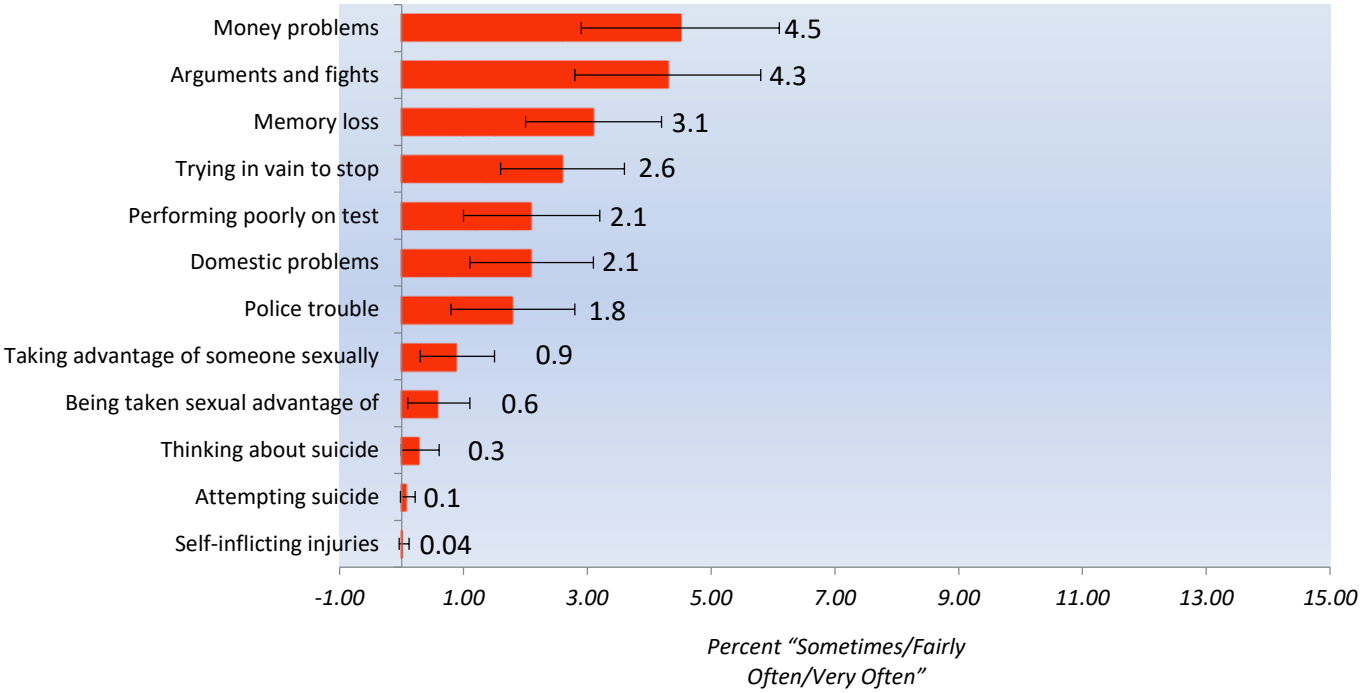
Of those who never had a chance to try a drug, 4.1% were “maybe” curious (CI 2.5%, 5.7%), and 5.9% were definitely curious (CI 4.2%, 7.5%). Two percent (2.2% [CI 1.0%, 3.4%) responded that if they had the chance, they would try an illegal drug.

PROBLEMS FROM DRUG USE

Lifetime users of all drugs, including alcohol, were asked if they experienced or lived certain situations over the past twelve months because of drug or alcohol use. Some circumstances include getting in trouble with the police, memory loss, self-inflicting injuries, or taking sexual advantage of someone. Because of the small proportions of those who reported problems, those who replied "sometimes" "fairly often" to "often" were combined. The results are shown in ***Figure 22*** below.

Having serious money problems (4.5%), and getting involved in intense arguments and fights (4.3%) were the most common drug problems. Having memory loss, trying in vain to stop drinking and/or taking drugs, performing poorly on a test, domestic problems, and getting in trouble with police happened to 2% to 3% of alcohol and drug users (***Figure 27***). The prevalence of sexual abuse, self-inflicting injuries and suicidal thoughts or attempts were all below one percent.

Figure 27. Users Experiencing Selected Consequences of Drug and Alcohol Use



Source: Bahamas National Household Drug Prevalence Survey, 2017

TREATMENT

Lifetime drug and alcohol users were asked if treatment was ever received for drug and alcohol use. Approximately two percent (1.5% [CI 0.7%, 2.3%) replied affirmatively. Of this group, more than a third `(36.7%) received treatment in the past year, representing 0.5% of the total population. Of this past year group, 9.5% received treatment only for alcohol, 70% only for drugs, and 20.5% for both alcohol and drugs. Continuing, 71.3% were admitted in a rehabilitation centre or therapeutic community, 22.8%, in an outpatient health or rehabilitation centre, and 5.9%, got help in another situation. Persons spent a mean of 3.3 months (range 0 to 24 months) in the last treatment episode.

Another 1.5% (CI 0.7%, 2.4%) were not treated, but felt the need for help or treatment to reduce or stop drinking alcohol or taking drugs. When asked why they did not get the treatment needed, among the list provided in the questionnaire, responses were:

- Not ready to stop using, 36.0%
- Could not afford treatment, 11.3%
- No transportation, too far away, 11.2%
- Could not find type of treatment wanted, 4.8%
- Don't know where to get treatment, 23.6%
- Treatment might cause neighbours to have negative opinion of me, 5.6%
- Treatment might have negative effect on job, 10.7%.

There was no indication that treatment was not covered on their health care plan, or that there was no space in the treatment program. Other responses to open-ended questions on reasons for not seeking treatment were: "can't find a good job", "don't want anyone to force me to stop", and "power of prayer".

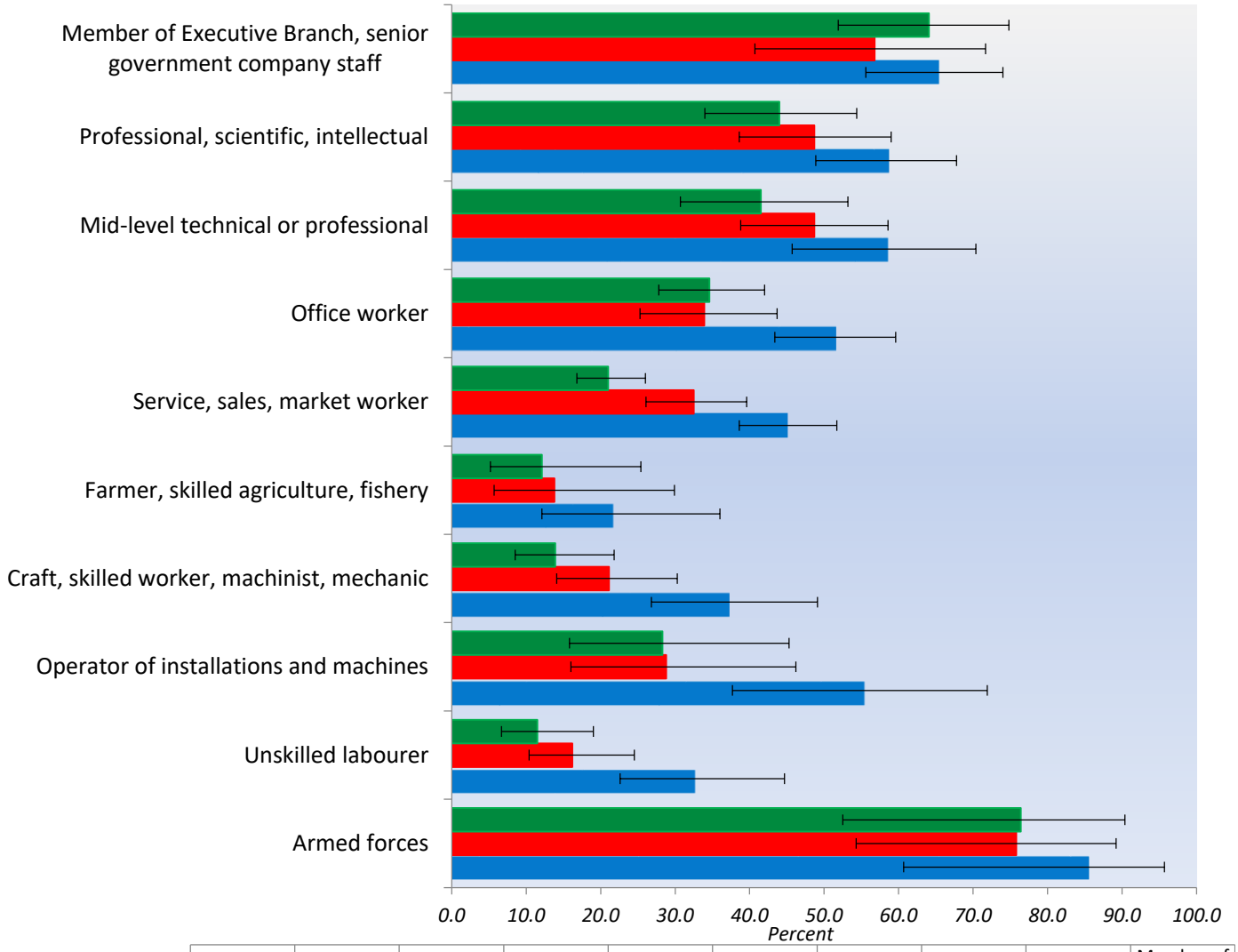
WORKPLACE ALCOHOL AND DRUG POLICIES

Working interviewees were asked if they knew of any workplace policies regarding the use of alcohol and drugs. The first question asked if the respondents had any knowledge of special regulations controlling the use of alcohol and drugs among employees. A little under half (48.4% [CI 44.2%, 52.6%]) knew of such policies. When asked if they received from their current job any kind of information about drug and alcohol prevention and use, a third (33.3% [CI 29.3%, 37.4%]) got such information. Further, when asked about their knowledge of programs to help an employee who has a drug problem involving the use of alcohol or drugs, 28.3% (CI 24.7, 32.0) replied affirmatively.

The three types of workplace policies are shown by occupational groupings (***Figure 28***). It appears that members of the armed forces had more favourable responses for all three types: 85.5% of workers' jobs had special regulations controlling drug and alcohol use, 75.8% had information, and 76.4% were aware of programs that help employees with drug or alcohol problems.

Somewhat comparable with the armed forces responses were those from highest occupational branch of senior executives and government officials (65.4%, 56.8%, 64.1%, respectively). In fact, a general pattern emerges: as one goes down the occupational ladder, the less the reporting of the knowledge of the existence of drug and alcohol workplace policies.

Figure 28. Drug and Alcohol Workplace Policies by Branch of Occupation

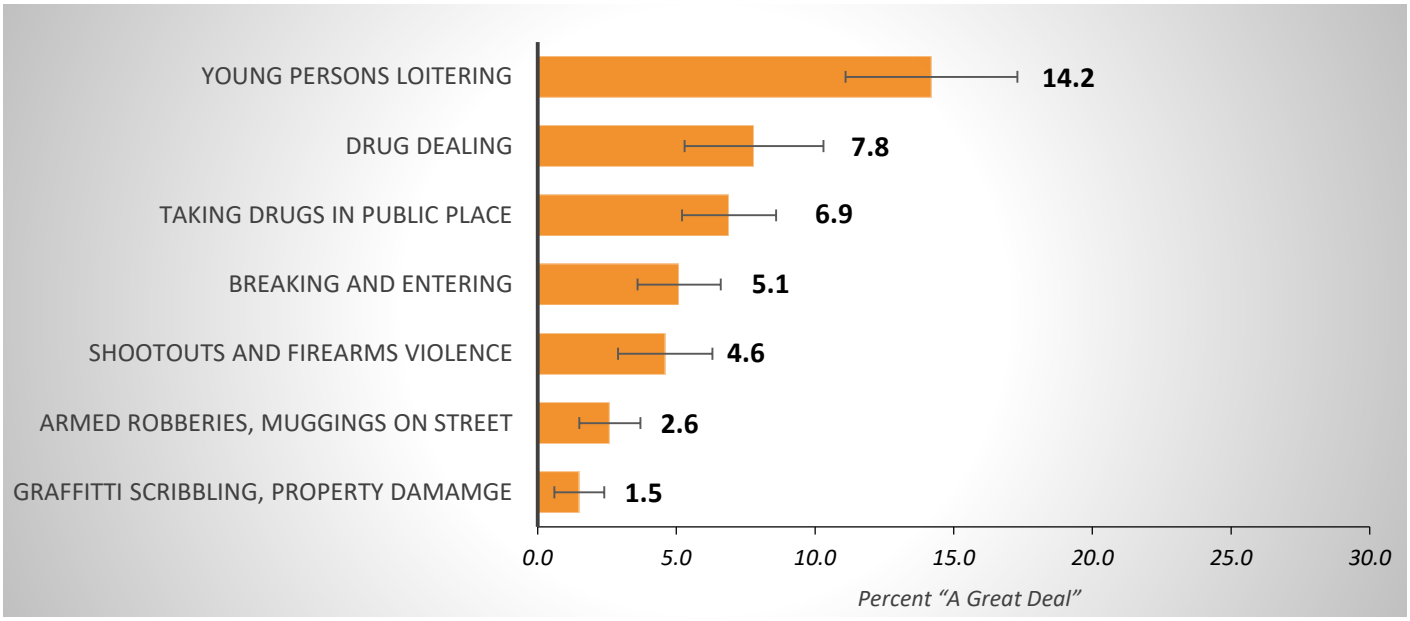


	Armed forces	Unskilled labourer	Operator of installations and machines	Craft, skilled worker, machinist, mechanic	Farmer, skilled agriculture, fishery	Service, sales, market worker	Office worker	Mid-level technical or professional	Professional, scientific, intellectual	Member of Executive Branch, senior government company staff
Program	76.4	11.5	28.3	13.9	12.1	21	34.6	41.5	44	64.1
Information	75.8	16.2	28.8	21.1	13.8	32.5	33.9	48.7	48.7	56.8
Special Regulations	85.5	32.7	55.4	37.3	21.7	45.0	51.6	58.6	58.7	65.4

Source: Bahamas National Household Drug Prevalence Survey, 2017

Persons were asked if undesirable activities such as drug dealing; loitering by young persons; or armed robberies and muggings taking place on the street occurred in their neighbourhoods, and to what extent. Choices ranged from "None", "Little", "Some", to "A great deal". Overall, the proportion of persons who indicated these actions happen "a great deal" was low, with responses ranging from 14.2% (young persons loitering), to 1.5% for graffiti and vandalism (***Figure 29***).

Figure 29. Respondents Experiencing Negative Activities in Their Community

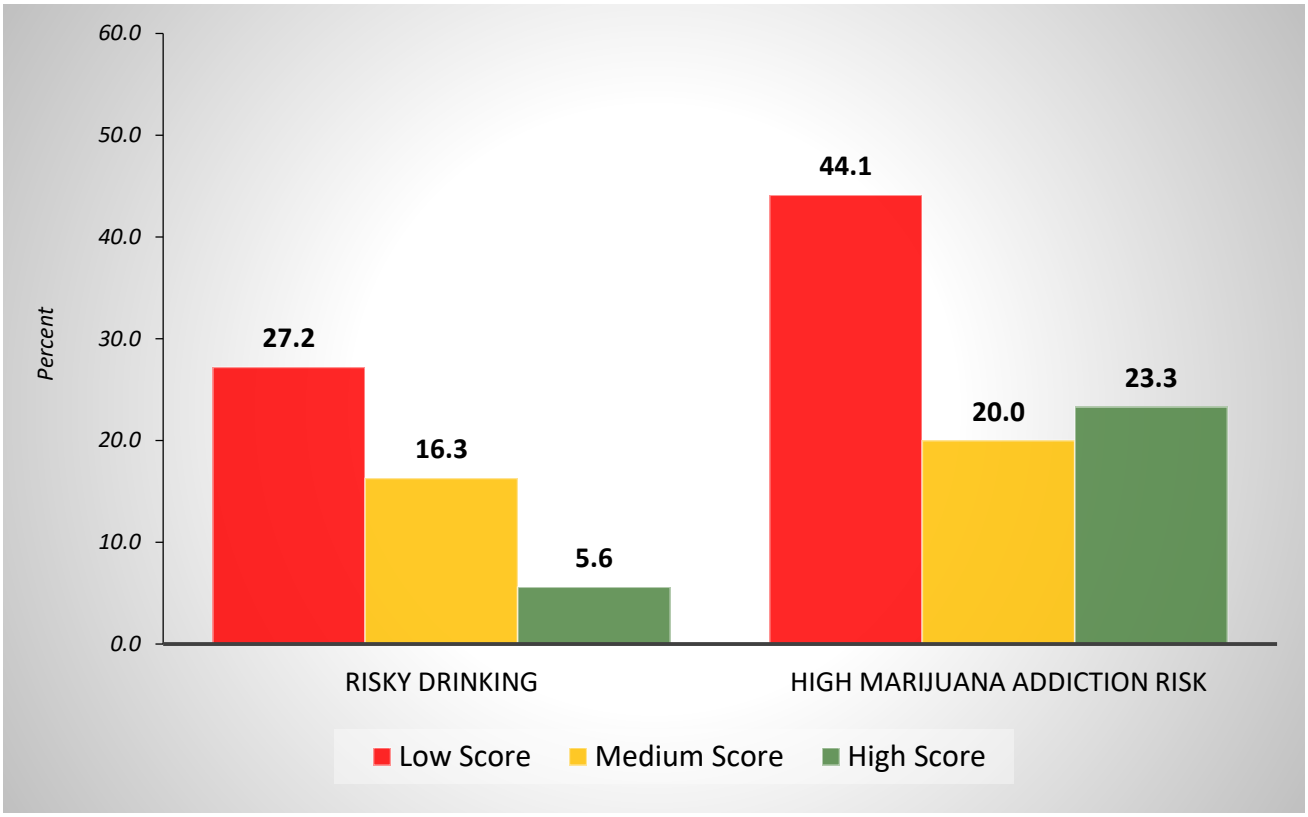


Source: Bahamas National Household Drug Prevalence Survey, 2017

To see if these neighbourhood activities were linked with risky alcohol and marijuana use, a neighbourhood "score" was derived by adding the codes linked to each response, with the highest code, 4, being "none", and the lowest, 1 "a great deal". The higher the score, the less these activities took place. Scores, therefore, ranged from 7 to 28 as there were seven items. These scores were then categorized into three groups: 7-16 = **1, Low** (9.7% [CI 6.5%, 12.9%]); 17-26= **2, Medium** (49.7% [44.6%, 54.8%]); and 27-28= **3, High** (40.6% [CI 34.8%, 46.4%]).

Categories already discussed for risky drinking and marijuana addiction risk from the AUDIT and CAST tools, respectively, were grouped by the neighbourhood scores. The results are shown in ***Figure 30*** below.

Figure 30. Risky Drinking and High Marijuana Addiction Risk by Level of Negative Neighbourhood Activities (Based on Neighbourhood Score)



Source: Bahamas National Household Drug Prevalence Survey, 2017

It appears that the lower the neighbourhood score, meaning a high level of adverse activities, the more likely respondents were either risky drinkers, or at high risk for marijuana addiction. Twenty-seven percent (27.2% [CI 15.8%, 42.7%]) of persons from low scoring neighbourhoods, 16.3% (CI 11.7%, 22.2%) from medium, and 5.6% (CI 3.5%, 8.9%) from neighbourhoods with high scores were risky drinkers. Similarly, 44.1%, 20.0%, and 23.3% from low to high scoring neighbourhoods, respectively, had a high

risk for marijuana addiction. Note, however, that high-scoring neighbourhoods carried a slightly higher risk for marijuana addiction than those with medium scores.

PERCEPTIONS OF DRUG SITUATION AND GOVERNMENT RESPONSE

Interviewees were asked a series of questions as to their opinion on the drug situation in the country, and the government's response. When asked if they believed over the past few years, that taking drugs in the country had increased, remained the same, or declined, 70.4% (CI 67.4%, 73.4%) believed it increased, 10.7% (CI 8.8%, 12.5%) thought it remained the same, while 6.3% (4.8%, 7.8%) thought it declined. Thirteen percent (12.7% [CI 10.2%, 15.1%]) did not know.

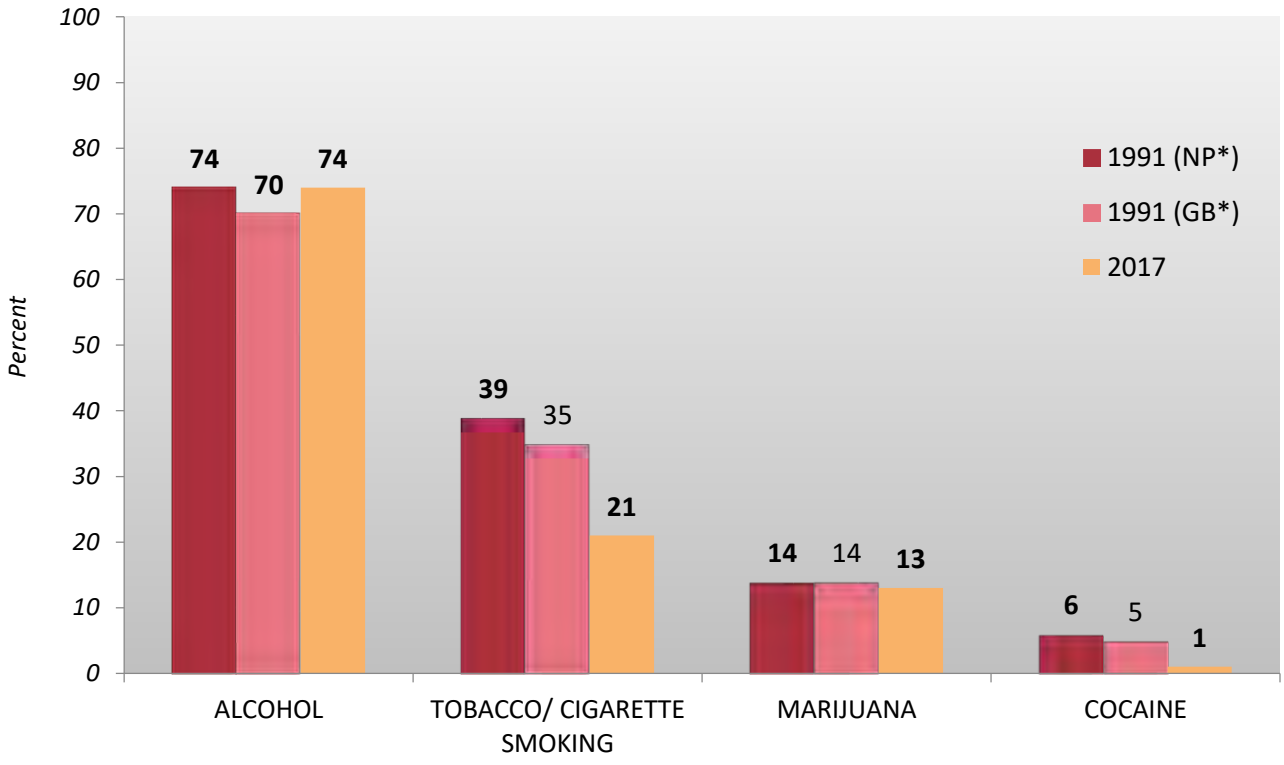
The majority (64.9% [CI 62.0%, 67.8%]) believed that the drug situation was going to get worse "in the coming years", 13.3% (CI 11.3%, 15.3%) thought it was going to remain the same, and 7.7% (CI 6.1%, 9.4%) responded that the drug problem was going to decline. Again, a sizeable proportion, 14.1% (CI 11.5%, 16.7%) did not know.

A little more than a third, 37.6% (CI 34.0%, 41.2%) thought that the drug issue was among the core concerns of the government. When asked if they knew of any drug prevention programs that were being implemented in their community, 3.4% (CI 2.3%, 4.5%) replied affirmatively. Twelve percent (11.7% [CI 9.5%, 14.0%]) knew the name of The Bahamas national drug control agency, and 9.1% (CI 7.3%, 11.0%) knew the name of the national drug prevention agency.

SUMMARY OF RESULTS

- The three most popular drugs in The Bahamas remain alcohol (74% lifetime prevalence), tobacco (21%), and marijuana (13%).
- Lifetime use of cocaine and crack cocaine in the population were both around one percent (1%).
- When lifetime prevalence is compared to the Drug Prevalence Survey in 1991 (26 years ago), alcohol and marijuana prevalence has largely remained the same. That of tobacco (measured by cigarette smoking in the 1991 survey) and cocaine, however, appears to have decreased, from more than 30% to 21% for tobacco/cigarette smoking, and from around 6% to 1% for cocaine (***Figure 31***).

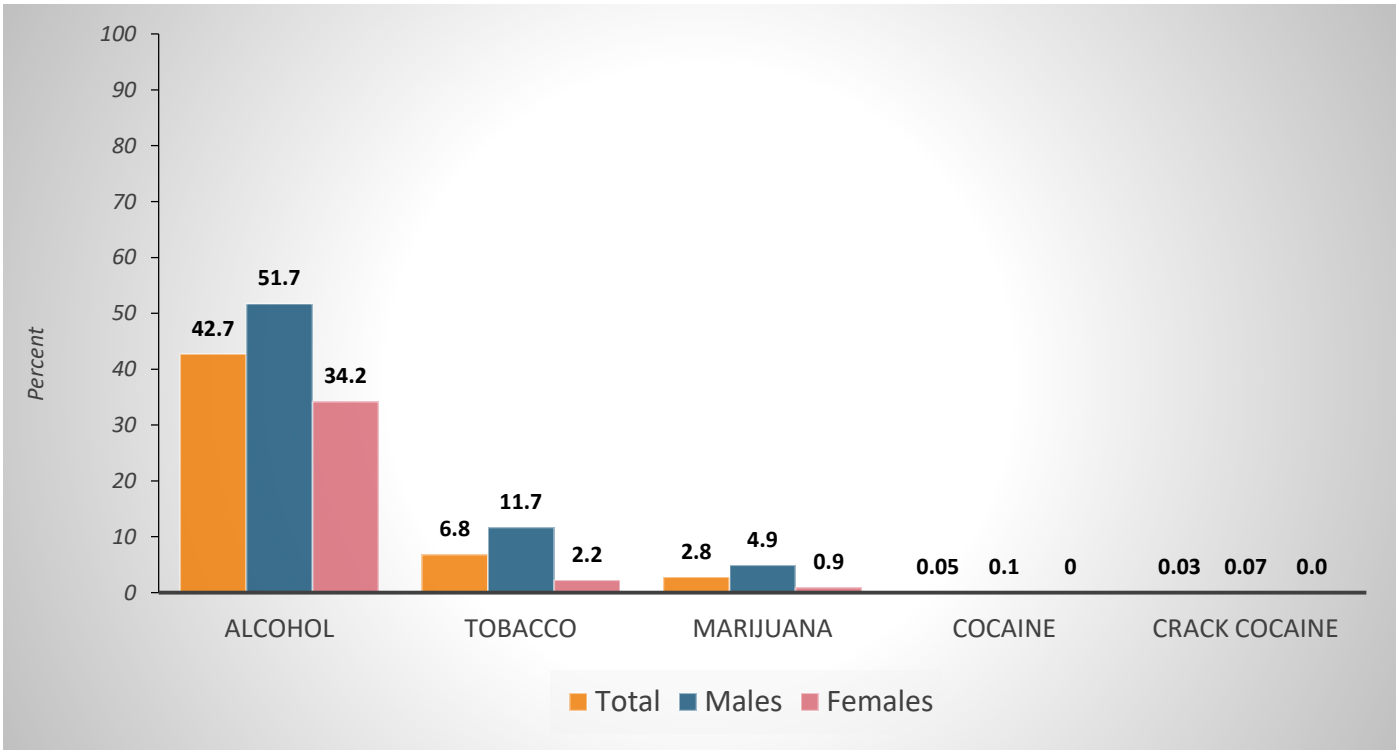
Figure 31. Percent of Selected Drugs Ever Used – Comparison with 1991 Prevalence Survey



NP – New Providence; GB – Grand Bahama.
Source: Bahamas National Household Drug Prevalence Survey, 2017; Community Survey of Drug Use in The Bahamas, 1991

- Current prevalence for alcohol was 43%, tobacco, 7%, marijuana, 3%, and cocaine and crack, less than 1% (***Figure 32***).
- For all drugs, males were more likely to report use (see ***Table 9***).
- Most persons first started using alcohol, tobacco and marijuana at age 17 to 18 years.
- While most drug users responded that using various drugs often was a high risk, proportions were still significantly lower than among those who did not use drugs at all.

Figure 32. Past Month (Current) Population Prevalence of Selected Drug Use, Ages 12 to 65 Years, By Sex, Bahamas 2017



Source: Bahamas National Household Drug Prevalence Survey, 2017

- Marijuana seems to be the most accessible illegal drug, especially for younger persons under 44 years.

- Not surprisingly, persons who had friends or family who got drunk or used illegal drugs were more likely to be current users themselves. In addition, they seemed also more likely to be drinkers with risky behavior habits, or at a high risk for marijuana addiction.
- The same can be said for persons who resided in areas with a high number of harmful and illegal activities.
- A small percent of alcohol and drug users reported specific problems stemming from their alcohol and drug use. Money problems (5%), getting into arguments and fights (4%), and memory loss (3%) were the most popular.
- Eleven percent (11%) of past year drinkers (6% of the total population) were considered risky consumers.
- More than one out of five marijuana smokers (22%) seem to be at a high risk for addiction (2% of the total population).
- Other mostly illegal drugs ever used included prescription drugs (without a prescription) such as tranquilizers, stimulants, and analgesics (all less than 1% lifetime use); inhalants (less than 1%); Ecstasy (less than 1%); Grabba (3% lifetime use); Beedi (5%); E-cigarettes (2%); Hookah Pipes (2%), and “Lean” (2%).
- The method of drug use by injection was virtually nil.
- Only 2% of drug and alcohol users ever received treatment. Most who felt they needed but did not get were not ready to stop using (36%), or did not know where to get treatment (24%).
- The knowledge of any workplace policy, regulations, general information, and special programs to help employees with drug and alcohol use is low (28% to 48%). Persons who work in the armed forces, however, showed the highest prevalence of such knowledge and information (76% to 86%). Policy knowledge among farmers, fishermen and agriculture, however, appeared to be especially low.

- Two out of three persons thought that the drug situation was going to get worse in The Bahamas. Further, many did not know the name of the national drug control or prevention agencies.

Table 9. **Percent Current Use of Alcohol, Tobacco, and Marijuana by Age and Sex Groups**

Drug	Age and Sex Groupings		Percent Currently Using
Alcohol	12-24 Years	Males	40
		Females	32
	25-44 Years	Males	59
		Females	40
	45-65 Years	Males	53
		Females	29
Tobacco	12-24 Years	Males	11
		Females	2
	25-44 Years	Males	13
		Females	3
	45-65 Years	Males	10
		Females	2
Marijuana	12-24 Years	Males	7
		Females	1
	25-44 Years	Males	6
		Females	1
	45-65 Years	Males	1
		Females	1

TOBACCO

- The lifetime, past year, and past month prevalence of tobacco smoking was 21%, 9%, and 7%, respectively.
- Males reported much higher rates than females; male use was 33%, 15%, and 12%, for lifetime, past year, and current use, while female rates were 9%, 2%, and 2% respectively.
- The mean age of first smoke was 18 years (18 years both sexes).
- The average age of a current tobacco smoker is 36 years.
- There were no notable differences among males or females by age when it came to current tobacco consumption (***Table 9***).
- Past year incidence for first smoke was 4% of the total population. Most smokers it appears are long time users.
- Most current smokers, 56%, smoked on a daily basis. Almost two out of three female smokers (65%) smoke daily, compared to around half (54%) of males.
- Fourteen percent (14%) of all tobacco smokers, 41% of current smokers, and 63% of current daily smokers spent $50 or more in the past month on cigarettes.
- Sixty one percent (61%) and 81% of all interviewees thought that smoking sometimes or often, respectively, carried a high risk.
- Those who thought cigarette smoking was a high risk behaviour were among the least likely to report being smokers.
- Among current tobacco smokers, many (72%) perceived smoking often carried a high risk, still significantly lower, however, than those among who do not smoke at all (83%).
- The following groups showed higher current smoking prevalence rates than their counterparts:
    - Males of all ages;

- Persons whose highest educational level was incomplete secondary (13%), and vocational training (11%); and
- The Montague (25%), Carmichael (15%), and Bain and Grants Town (14%) constituencies.

ALCOHOL

- The lifetime, past year, and past month prevalence of alcohol was 74%, 55%, and 43% respectively.
- Male use was 78%, 62%, and 52%, for lifetime, past year, and current use, respectively, while rates for females were 71%, 48%, and 34%, respectively.
- Mean age of first drink is 18 years (17 years males, 18 years females).
- The average age of a current drinker is 36 years.
- Males older than 24 years (59% 25 to 44 years, 53% 45-65 years), and females 25 to 44 years (40%) were the most likely to report current alcohol consumption (***Table 9***).
- Past year incidence (when had first drink) was 19% for consumers and 14% for the total population.
- Persons got drunk an average of one day during the past month.
- One out of five (21%) current drinking males, and 14% of their female counterparts binge drank 2 to 3 times in the past two weeks.
- Nineteen percent of current drinkers spent $50 or more in the past month on alcohol.
- Most current alcohol consumers drink low alcoholic content beverages during the weekend.
- Around a third (30%) thought drinking sometimes was high risk; 69% responded drinking alcohol often, and 88% thought getting drunk carried a high risk. Females were more slightly more likely to respond that drinking carried a high risk.
- Persons who thought any form of drinking was a high risk were among those least likely to be current alcohol consumers.

- Most (61%) current alcohol drinkers perceive drinking often is a high risk, but this is still lower than those who do not drink at all (77%).
- Males who had vocational training comprised the highest proportion of current users (62%) among the occupational groups. Generally, as educational levels rose, so did current alcohol prevalence.
- Overall, working persons had higher consumption rates ranging from 41% to 51% when compared to non-working persons (14% to 31%).
- As income rose, current alcohol use also rose slightly, from 36% to 50%.
- North Eleuthera (67%), Carmichael (66%), and the Fox Hill (60%) constituencies had the highest prevalence of current alcohol consumers.
- Risky drinking was measured using the AUDIT test. Overall prevalence among past years drinkers was 11%; this is 6% of the total population. The following groups showed high prevalence rates:
    - Young males 12 to 24 years who had the highest proportion of risky drinking at 23%;
    - Persons with incomplete secondary school education (22%);
    - The unemployed (17%); and
    - The Englerston, Carmichael, and Fox Hill constituencies.
- Persons who had friends or family who got drunk were significantly more likely to be current alcohol users and risky drinkers themselves.
- Of those who ever drank alcohol, 21% drove in the past year whole under the influence. This is 12% of the total population.

MARIJUANA

- The lifetime, past year, and current prevalence of marijuana was 13%, 3%, and 3% respectively.
- Males were more likely to report use, at 20% (7% females) for lifetime, 5% (1% females) for past year, and 5% (1% females) for current use.

- One out of ten (10%) marijuana smokers first started smoking in the past year, which represents less than 1% of the total population. Most marijuana users however appear to be long-term smokers, with 88% first starting more than a year ago.
- Marijuana smokers first started smoking at the mean age of 17 years (17 years males, 19 years females).
- The average age of a current smoker is 32 years.
- Males 44 years and under had the highest prevalence rates (6%-7%; ***Table 9***).
- Most (40%) past year marijuana smokers smoked daily/ almost daily in the past year.
- Half (50%) of females, and 38% of males smoked daily in the past year.
- Current marijuana smokers smoked an average of 17 days in the past month, a mean of 11 joints.
- Thirty-nine percent (39%) of smokers spent $50 or more on marijuana in the past month.
- A joint cost an average of $7.
- Most (41%) marijuana smokers last bought their joint outside in a public area.
- Most, however, got their marijuana for free (52%).
- Forty-six percent (46%) indicated their last joint was strong or very strong.
- Nearly one out of ten (9%) marijuana smokers drove a vehicle in the past year while under the influence of marijuana (around 5% of the total population).
- Young males 44 years and younger (6% to 7%); persons with incomplete secondary (4%) and incomplete tertiary education (5%); and lower income levels with monthly household incomes of less than $1,501 (5% to 7%) had higher-than-population current use prevalence rates .
- The Bain and Grants Town (11%), Fort Charlotte (8%), and St. Cecelia (7%) constituencies had the three highest area rates for current marijuana use.
- When using the CAST tool to measure addiction risk, the overall prevalence for a High Addiction Risk was 25.3% among smokers; this is approximately 2% of the entire population.

- Groups of marijuana smokers especially at high risk for addiction include:
    - Young males under 44 years, comprising 57% of males 12 to 24 years, and 41% of males 25 to 44 years.
    - Older females 45 to 65 years (26%).
    - Persons with incomplete secondary education (50%).
    - Persons working and studying (55%) and the unemployed (33%).
    - Persons from households making $400 or less a month (53%).
    - The Montague, Fort Charlotte, and Sea Breeze constituencies (all greater than 70%).
- A little more than half of respondents (53%), and 70% perceive that smoking marijuana sometimes or often, respectively, carried a high risk.
- There were similar perceptions for using marijuana in other ways such as drinks and food. Using marijuana as medicine, however, carried a lower perceived high risk, at 35% for sometimes using it as medicine, and 43% using marijuana as medicine often.
- For the most part, the higher the risk perception of marijuana smoking, the lower the proportion of current marijuana smokers.
- Among current marijuana smokers, many (45%) responded that smoking marijuana often carried a high risk. This is lower however than those who do not smoke at all at 71%.
- Around half of respondents think marijuana access is easy.
- Young males under 45 years appear especially vulnerable to be offered marijuana. The same can be said for females under 25 years.
- Many persons use marijuana alternatively in drinks, food, and for self-medicating.
- Persons appear open to some marijuana policies, particularly:
    - Allowing marijuana addicts who commit crimes to attend a special program instead of being sent to prison (62%)

- Allowing marijuana to be cultivated for scientific research (59%)
- Allowing marijuana to be used for medicinal purposes (56%).

COCAINE AND CRACK COCAINE

- Cocaine use appears to have declined, from 6% ever using in 1991, to 1% in 2017.
- Current use for cocaine and crack cocaine was very low, at less than 1%.
- Nine out of ten persons saw the drugs as dangerous when used sometimes or often.
- Between 16% and 19% of persons thought access to cocaine and crack cocaine was easy. Five percent to 7% were last offered these drugs more than a year ago.

OTHER DRUGS

- Less than 1% of the population have ever taken prescription drugs illegally (without a prescription) such as tranquilizers, stimulants, and pain-killers.
- Less than one percent have ever used inhalants and ecstasy to get high.
- New drugs never measured before in The Bahamas included Grabba, with 3% ever using; Beedis, ever used by 5% of the population; e-cigarettes, 2%; hookah pipes, 2%; and "Lean", with 2% ever trying this drug. For many of these drugs, it appeared that they are popular among young persons under 44 years (see ***Appendix 2***).
- Prevalence of multiple current drug use, namely marijuana with alcohol, was 2%. One percent currently used tobacco, marijuana, and alcohol.

DISCUSSION AND CONCLUSION

Results of The Bahamas National Household Drug Prevalence Survey 2017 provide a much-needed profile of drug use patterns; drug treatment; exposure to drug supply, pricing and spending; risk perception; and perspectives on drug use in the country, all while offering insight into the social landscape surrounding the local drug use culture, as well as emerging drugs. Stakeholders may use the findings and recommendations to develop policies that would positively impact the health and wellbeing of the population.

Tobacco

As a disease risk factor, tobacco smoking is a global health concern. Therefore, the prevalence of current use of 7% in the general population requires public health attention. It is encouraging to note that the findings suggest a decrease in lifetime use of tobacco/cigarette smoking and cocaine since 1991 when the last national household drug survey (inclusive of adolescents) was conducted, at that time, on the two major islands of New Providence and Grand Bahama where over 80% of the population reside. The 2012 STEPS survey showed the prevalence of current tobacco smoking among adults 25-64 years to be 16.7% (CI 1.2%, 32.2%)[6] while in a later survey among secondary school students, the prevalence was 10.7%[12] .

Among current tobacco smokers, perception of the high risk of smoking often did not appear to coincide with their behaviour. As regards educational level, the highest proportion of current smokers had incomplete secondary (12.5%), or vocational schooling (11.3%), while persons who completed primary or tertiary education seemed least likely to be current smokers. These findings suggests the need for a greater translation of health knowledge into practice, and continued emphasis on education. On average, 41% of current smokers spent at least $50 on cigarettes in the past month.

There are targeted efforts by the World Health Organization (WHO) to prevent and reduce tobacco use and, in the process, closely monitor priority indicators showing progress with drug use and treatment. The Sustainable Development Goals (SDG) are the key means by which countries, including The Bahamas, will report.

Another measure taken by the WHO was the development and subsequent adoption of the Framework Convention on Tobacco Control by the World Health Assembly in 2003. The Bahamas signed on to the Treaty in 2009 and a Tobacco Bill that will support the prevention of tobacco use is currently under review.

Alcohol

The level of alcohol use does not appear to have changed significantly since the last household drug survey was conducted in 1991. Despite existing regulations and warnings issued on its harmful use, alcohol, a risk factor for non-communicable diseases, still remains a popular substance used among adults as demonstrated in the current survey, as well as adolescents, as seen from results of the Secondary School Drug Survey[3]. Further, the prevalence of current drinking among adults 25-64 years was found to be 40.8% (CI 19.0%, 62.6%) in the 2012 STEPS Survey.[6]

Alcohol is a legal substance (with age restrictions) and is fairly easy to access. The average age of initiation is 17 years for young males and 18 years for females, therefore, prevention messages targeting persons in this age range and younger would be well placed. The average age of current drinkers was 36 years and users were predominantly male.

On average, 21% of current drinkers spent at least $50 on alcohol in the past month. The risk of impaired driving was observed in the finding that one in eight (12.4%) lifetime drinkers who drove a vehicle in the past year reported the high risk behaviour of driving while under the influence of alcohol.

Regarding risk perception, most (61%) current drinkers thought drinking often is a high risk behavior but this did not appear to impact use.

High prevalence of risky drinking as measured by the AUDIT test[17] was found most often among young males 12-24 years (23%); persons who did not complete their secondary education (22%); and the unemployed (17%). Further research would help to understand factors related to risky drinking among these groups.

Based on these findings, there is a clear need for further education on the consequences of harmful drinking, along with the introduction or strengthening of policies to reduce these adverse events. Negative effects include health disorders, and injuries from violence or road traffic accidents. Such outcomes can also place an extra burden on health care facilities which must respond by e.g., providing emergency care to persons in acute states. In a 2008 study on the role of drug and alcohol use in hospital Emergency Department (ED) visits, results showed that alcohol was used more than any other psychotropic substance (10.7% for alcohol versus 4.9% for marijuana) during the 6-hour period prior to admittance to the ED. Further, in the study, alcohol and/or drug use were more prevalent among the eight (8) patients who arrived at the hospital's ED in an unconscious state (57.1%) than among those who were conscious on arrival (5.8%). [19]

Marijuana

As with alcohol, the prevalence of lifetime use of marijuana, another illicit drug, appeared to be relatively unchanged at 13% (with males being chief users), when compared to 14% found overall in the 1991 survey. The prevalence of smoking marijuana in this current survey was 3%. A high percentage of marijuana smokers (70%) perceived the risk of smoking marijuana to be high, however, this view did not appear to influence their behaviour.

Notably in the current survey, marijuana was found to be the most accessible illegal drug, as a fairly high frequency of users (41%) got it in a public area (parking lot) or even at no cost (52%), the latter suggesting an excess supply. Respondents estimated the price of a marijuana joint at $7, and on average 39% of smokers spent at least $50 on marijuana in the past month.

As with alcohol, raising the concern for driving safety was the finding that one in twelve (8.5%) lifetime marijuana smokers who drove a vehicle in the past year reported doing so while under the influence of marijuana.

Interestingly, there was openness to a policy shift toward softer punitive measures where, for example, marijuana addicts who commit crime would not be incarcerated but instead be required to attend a court-supervised drug treatment programme (62%). Other views expressed were supportive of allowing the drug to be cultivated for scientific research (59%); or allowing it to be used for medical and therapeutic purposes (56%). A moderate proportion of persons were in support of growing the drug in limited proportions for personal use (21%) or, to a lesser extent, by individual households (14%). These views coincide with similar positions favoured in other jurisdictions. Therefore, the findings brought to light are important as local policy makers join the conversational thread surrounding considerations about marijuana reform including decriminalization and medicinal use of marijuana.

Cocaine and Crack Cocaine

The response to the cocaine epidemic in the 1970s and 1980s was highly effective through close collaboration between government sectors, particularly the Ministry of Health, and Law Enforcement and legal entities; non-government agencies; and the United States Government. All of these combined efforts were effective in bringing about a sustained reduction in the supply and demand of the drug. Further, even though some persons in the survey thought it was easy to access cocaine, most perceived

the drug to be dangerous – a view that could act as a deterrent from regular use. The current prevalence is less than one percent.

Other Drugs

Survey findings showed that use of inhalants, ecstasy, and illegal use of prescription drugs were all at low levels - less than 1%. Among other drugs, use of beedis (bidis) was most popular at 5%, followed by Grabba, e-cigarettes, hookah pipes and "Lean," each 2%. Despite their relatively low prevalence, there must be vigilance in ongoing monitoring of these substances due to their potential for adverse effects on the health of the population.

Use of polydrugs could have severe side effects. Among current users in the survey, low usage rates were observed for multiple drug use such as alcohol and marijuana (2.1%); tobacco and marijuana (1.3%); and alcohol, tobacco and marijuana (1.1%).

Treatment

With regard to exposure to drug prevention and access to treatment services, results revealed that among lifetime users of alcohol and drugs, only a small proportion (2%) received treatment for alcohol or drug use. In this grouping, the main reasons given for not receiving treatment or counselling for their drug use indicated that those users could not afford or find the type of treatment wanted; had no transportation; or did not know where to get treatment. Another reason given was that they were not ready to stop using those drugs. To a lesser extent there were concerns about the views of neighbours and possible effects on their jobs. Further, regarding knowledge about helpful resources available, results showed that just under one-half of employed respondents were aware of drug use regulations on their jobs, and even less got information about alcohol or drug prevention in their work settings.

These explanations reflect opportunities for introducing additional prevention strategies. Key approaches would be increased substance abuse education and community awareness about treatment services currently available at government and non-government agencies. In addition, those measures may be supported by the implementation of workplace programmes and policies, along with the provision of information to employees about drug or alcohol use.

Conclusion

In conclusion, there must be vigorous alcohol and drug prevention efforts to bring about positive changes in both attitudes and practices related to use of those substances. While maintaining low prevalence rates for tobacco smoking and cocaine use, efforts must be intensified to reduce and prevent alcohol and marijuana use. This is particularly important because of their potential for adverse consequences on the individual, the family and society at large. In addition, it is essential that the availability of rehabilitation services be well aligned with the need for treatment by those who are affected by drug use. Further, there must be ongoing public education and monitoring of current drug use trends and emerging issues, both locally and abroad.

Clearly, all of this cannot be done without strong, sustainable programmes. These systems must be developed through continued, close collaboration with stakeholders and community partners who work together to mitigate the harmful effects of drug use in the population.

RECOMMENDATIONS

During the month of July 2017, a meeting was held to share highlights of the survey findings. Immediately following the event, a workshop provided key stakeholders with an opportunity to discuss implications of the results and make recommendations for policy formulations. Outputs from those discussions are shown below as derived from the group, which was representative of key agencies involved in drug education, prevention, treatment and rehabilitation.

1. Implications of the Findings

Survey results highlighted the need to adopt use of evidence-based approaches to strengthen drug prevention, treatment and rehabilitation. There must be emphasis on effective communication strategies to reach target audiences and at-risk populations. As drug use trends continue to evolve, there is a need to ensure that the systemic response is both relevant and dynamic to mitigate against the harmful use of drugs in our communities, with particular attention to those drug hot-spots identified through research findings and existing data sources. The Bahamas Health System's successful response to the cocaine epidemic may well be worth a review to adapt what may be one of the country's gold standards to curb current marijuana use trends through close inter-agency collaboration.

In summary, specific implications of the results were to:

- Strengthen community policing, education and adverting.
- Use research findings along with existing data sources to locate drug "hot spots", i.e., areas of drug-related activities.

- Use improved and up-to-date communication strategies with impactful public service announcements. This would enable greater effectiveness in reaching vulnerable populations and thereby achieve a reduction in marijuana and other drug use.

- Modify and adopt strategies successful with cocaine reduction to similarly impact and reduce marijuana use.

- Engage in evidence-based approaches to address drug prevention, as well as treatment and rehabilitation. Prevention strategies must be considered that include evaluation and assessment of ongoing programs, and treatment methods that are comprehensive with a bio-psychosocial approach.

- Explore factors preventing young clients from seeking treatment and development strategies for early identification of persons with drug use problems.

- Modernize and expand current drug prevention and treatment programmes.

- Network and improve collaboration with all other related agencies.

2. Recommendations by Agencies Responsible for: a) Drug Prevention; b) Drug Control; c) Drug Education; d) Drug Treatment; and e) Rehabilitation

Close collaboration between relevant agencies is a key means of addressing the complexities arising from drug supply and demand issues, some of which can be seen in the survey findings. The need for a multi-faceted response to combat these dynamics was recognized. Therefore, the stakeholder policy workshop was arranged to allow for the free exchange of ideas that would culminate in the most impactful approaches to strengthen drug prevention, drug control, and drug treatment and rehabilitation. Some of the recommendations listed below are new while others presented would refine

existing measures, keeping them abreast of current trends in the response to the drug use situation in The Bahamas.

a) Drug Prevention

- Given the positive effects of a reduction in cocaine use, repurpose the cocaine stigma and apply the same prevention strategies to reduce marijuana use and thereby take advantage of the benefits to be gained.

- Effects of marijuana are not always seen as negative. Consequently, messaging for marijuana prevention must be highly visual, keeping in mind user demographics - particularly young males - and perception of drugs.

- "Combat messaging on medicinal uses of marijuana."

- For ongoing monitoring of drug use, advocate for mandatory budgetary allocations at the local level so that household drug prevalence studies can be carried out every four years in order to monitor the drug situation on a more consistent basis. Additionally, create self-administered drug survey opportunities for the wider population as well as vulnerable groups (e.g., males 12-24 years with risky drinking behaviour), using a variety of digital and social media platforms.

- Increase training and intelligence in drug prevention agencies.

- A social-media approach to drug prevention may be taken that is age-appropriate with high impact using e.g., Facebook, Twitter, Messenger, Instagram, etc.

- Messages may also be integrated using a revised, multi-sectoral communications plan with effective public service announcements.

- Make use of audience vetting prior to release of messages to ensure that messages are effective (e.g., utilize audience in schools and drug treatment institutions).

- Post prevention messages in key locations such as areas known for drug dealing and drug use, particularly around schools and key community locations.

- Seek the commitment of an influential spokesperson or "champion" to deliver public messages for greater impact.

- Strengthen after-school and community activities for young people to reduce boredom and unsupervised time which may lead to drug exposure.

- Ensure that prevention strategies developed are reflective of the Family Island context, bearing in mind separate approaches may be needed.

b) Drug Control

- It is recommended that available data be used to identify drug "hot spots".

- Enable law enforcement agencies to develop relevant policies that would mitigate drug dealing and drug use activities, particularly in schools and key community locations identified in the survey. More aggressive prevention and intervention strategies should be launched in those places, taking into account community dynamics, types of drugs used, and gender and age groupings of target populations.

- Monitor the internet and share information with stakeholders regarding current local, regional and international drug use trends.

- Introduce alcohol reduction strategies to decrease the high prevalence rates of alcohol consumption in all categories (lifetime, past year and past month) by 5% by 2022.

- Improve and update drug detection programmes.

c) Drug Education

- Revise and/or expand drug education in schools.

- Using computer tablets or other media, begin drug education at the primary school level to afford persons the age-appropriate knowledge they need to make better decisions regarding risks of substance use.

- Use social media platforms to target younger audiences.

- Establish scheduled visits by the National Anti-Drug Secretariat to schools as part of the Ministry of Education's school curriculum.

d) Drug Treatment

- Provide evidence-based treatment to clients, making it appropriate for demographic profiles.
- Establish a hotline for potential and current drug users.
- Utilize a biopsychosocial approach in the treatment of persons with problematic drug use.
- Institute more training on the Family Islands to increase knowledge, and develop supportive follow-up groups.

e) Rehabilitation

- As there are no programmes in Her Majesty's Prison for persons convicted of drug use, there must be provisions made for rehabilitation of this population.

- Improve drug rehabilitation and Non-Government Organization programmes through:
    - Staff training in specific areas
    - Provision of resources to maintain current programmes
    - Licensing and routinely inspecting programmes to ensure effectiveness

- Establish and utilize social reintegration programmes.
- Conduct programme evaluations in accordance with international standards of care.
- Establish more outreach programs in response to rehabilitation.

3. Policies and Interventions: Sector-Specific Main Factors

Previous surveys have shown patterns of drug use, mainly for alcohol and marijuana, among school students. It is important to have focused efforts on them as a group, as well as the general population to ensure that agency programmes are adequately resourced and strategically aligned to meet emerging needs. Emphasis must also be placed on effective advertising; ongoing public education; and training of health professionals. Other important dimensions include the development of workplace substance abuse policies; strengthening linkages with the criminal justice system; and funding. Specific agency recommendations follow:

Ministry of Education

- Establish and advertise after-school programs in New Providence and the Family Islands that would encourage parents to enroll students.

- A comprehensive review of approaches to mitigate against the use of drugs by the youth should be undertaken. This may include incorporating anti-drug messaging, programmes, and information sessions into school curricula.
- Provide resources and referrals for students, teachers and other workers to get help for drug addiction problems.

Ministry of Health

- Provide relevant, accurate, and timely information to the public, guided by a communications plan.

- Assist with training staff of other agencies to understand the clinical side of drug use and abuse.

- Enforce a public health approach to treatment, noting that a public health issue is not a criminal issue.

Other Agency Recommendations

- Post targeted advertisements in communities, particularly in those identified with high drug-related activity. Further, increase visibility of signage that would discourage the use of legal and illegal drugs. Messages should point the way to treatment programmes and promote the availability and means of accessing help.

- Survey findings indicate that only a moderate proportion of respondents had knowledge of existing programmes, regulations or general information on drug use in their workplaces. It is,

therefore, recommended that there be advocacy for the update or formulation of a Substance Use Workplace Policy in both the public and private sectors.

- Re-establish ties with the criminal justice system, with particular focus on reacceptance of clients. Additionally, increase interaction with the court system and seek ways to reinstitute alternative sentencing programs.
- Establish drug prevention initiatives for young people, including the re-introduction of peer-counselling programmes.
- Increase resources and funding for evidence-based drug prevention, treatment and rehabilitation programmes that have demonstrated sustained success.
- Implement a ticketing system for drug use.
- Design and implement a Prison Treatment Programme.
- Approve and implement the National Drug Prevention Policy.
- Approve and implement a National Drug Court.
- Shift the government's focus from drug control (i.e. Customs seizures) to drug prevention (i.e., employment opportunities and education).
- Establish community centres in collaboration with churches and civil organizations. Health or drug prevention/counselling staff can be utilized (either through deployment or call services) to resources these centres.
- Establish a comprehensive programme approach, e.g., sport groups (soccer, basketball and rugby), and performing arts programmes to respond to the problem of drug use.

4. Potential Barriers in the Implementation of Recommendations

Despite well-laid out plans, even the best initiatives can be upset by factors presenting roadblocks to steady advancement. However, with well-integrated strategies, it is expected that the impact of the hurdles as outlined below will have minimal negating effect upon the prevention of drug use in The Bahamas:

- Limited resources (human and financial).
- Bureaucracy, including political and administrative inaction.
- Lack of buy-in by law-makers and other persons in the community.
- Unregulated private treatment and rehabilitative service facilities.
- Geographic makeup of The Bahamas.
- Existing culture.
- Lack of understanding of the impact of recommendations upon benefits and costs.

REFERENCES

1. Allen D.F. (1987) Introduction. In: Allen D.F. (eds) The Cocaine Crisis. Springer, Boston, MA.

2. Jekel J.F., Allen D.F., Podlewski H., Clarke N., Dean-Patterson S., Cartwright P. (1987) Epidemic Freebase Cocaine Abuse: A Case Study from The Bahamas. In: Allen D.F. (eds) The Cocaine Crisis. Springer, Boston, MA.

3. Fountain, Terrance. *Bahamas Secondary School Drug Prevalence Survey 2012.* Ministry of National Security, The Bahamas, 2012.

4. *Global School Health Survey, The Bahamas*. Pan American Health Organization (PAHO), 2013.

5. *Community Survey of Drug Use in The Bahamas*. Ministry of Health, The Bahamas, 1991.

6. Bahamas STEPS Survey of Risk Factors for Chronic Diseases Fact Sheet, 2012. www.bahamas.gov.bs/healthstat.

7. "Organization of American States," 2018. [Online]. Available: http://www.cicad.oas.org/Main/Template.asp?File=/oid/protocols_eng.asp (accessed June 6, 2018).

8. Dorsett, Kelsie, and Coralee Mackey, editors. *2010 Census of Population and Housing, Commonwealth of The Bahamas*. Department of Statistics, 2012, pp. 1–10. www.bahamas.gov.bs/wps/wcm/connect/a6761484-9fa0-421d-a745-34c706049a88/Microsoft+Word+-+2010+CENSUS+FIRST+RELEASE+REPORT.pdf?MOD=AJPERES.

9. Neville, Michael, and Nelson Clark. “Drug Abuse in The Bahamas.” *Journal of Substance Abuse Treatment*, vol. 2, no. 3, 1985, pp. 195–197, www.sciencedirect.com/science/article/pii/0740547285900534.

10. *The Commonwealth of The Bahamas National Anti-Drug Strategy 2017-2021*. Ministry of National Security, 2017, /!ut/p/b1/vZLLkqIwFEC_pT-AJjwCuIyIPISEpwgbC0QREEFBRL5-dGoWXVPV3ZvpSVapOsmpOrl0TG_o-JwMRZ70RXNOTq9zLGw5oFoI8ZKlQiAAPbBNZIsaKy3hE4g-BwgPvrsf0hsz4vCi0e-K7h5ad098V7nYYHdAD6FOT_3OEffKtUikwRtGjGeWUeIal5aTbu8gYMKzRiincPC4TuzGrzT9mgzC6Ah8sexk5CRHY0NVVeL1ylEPuW7LT_xhFXinR2mcd5fqgmY8lFTtvIstouX5LVv0cnpJCdUL4rXXh02QDaE7AWp_ufUaMLo72uIxbsCgwkOiDY8Ivb396QA-WejbDgYdF2n9ft_V7-CdnQEoMRInsCKQWEivywjOr51-XyjeUFVsWMmTa4PTMZ9Ned9GHgGN1aaH7bxTiL6Opn2bquZ9Ot5WZWiPs9kGZ4zP2rHxqCiuGmqxxv3uqpjlFdxYLCOsr7u9C6bWabCXU2f5eu0KeWcgadKLVNaiOEpxIepC3oxZyNhbckkrqYLzYn18rGB5K1PPPIx1hpQllzSGEarMktKAqe1wzs-W7UBMChRhmSkJJPe9apgJWA7ByFNFPxgZtihtm1NjAYX0ORLxV7XIiv0GeE3db-CL74iegPjhBX8NgM4A5HqMAyQX0j69AfzWKx-tPlWTW07O5PkK5_nOBABjWeImwP6SeBlh_IXOAX9tdMERW6AlnY8eGGt2tnaDOZL3xQaqfwsJ68-eQpkRVgEEnsr-tFCFRHo2En0bQRYA-b8LmZ8SqsRy5FdSf_5KymkaEkxOAvz_Fgr_XIi1pt7TbR0MJhw8nUo-bPT2C4-V79k!/dl4/d5/L2dBISEvZ0FBIS9nQSEh/.

11. *Global Youth Tobacco Survey, The Bahamas*. Pan American Health Organization (PAHO), 2013.

12. Clarke, Pernell. "Treatment Presentation, The Bahamas, July 2017 Final." 20th July, 2017.

13. "Morbidity SRC 2008-2012 Various Statistics." Ministry of Health, The Bahamas, http://www.bahamas.gov.bs/wps/wcm/connect/7fde33d9-2a22-49e8-9ed7-5ef591fcd8e8/Morbidity+SRC+2008-2012+%28Various+Statistics%29.pdf?MOD=AJPERES.

14. "Mortality Due to Drug Abuse and Mental Disorders, 1996-2014." Ministry of Health, The Bahamas, http://www.bahamas.gov.bs/wps/wcm/connect/08a15991-56e4-4d3d-82a9-c86d5d15ac21/Alcohol+%26+Mental+Health+Alcohol+Deaths+Chart2.pdf?MOD=AJPERES.

15. http://www.statisticshowto.com/kish-grid/

16. http://www.drugabuse.gov/nidamed-medical-health-professionals.

17. Spilka, Stanislas, et al. “Detection of Problem Cannabis Use: The Cannabis Abuse Screening Test (CAST).” *Observatoire Francais Des Drogues Et Des Toxicomanies*, no. 2013-2, 3 Sept. 2013, pp. 1–9.

18. Fountain, Terrance. *Role of Drug and Alcohol Use in Emergency Department Visits in The Bahamas.* Bahamas National Drug Council, The Bahamas, 2008.

Appendices

APPENDIX 1

Survey Field Team

Field Supervisor*:* *Mrs. Cypreanna Winters*

Team Supervisor

New Providence
Lekiecha Bain
Angelique Davis
Erica Francis
Tia Rolle
Nanika Brathwaite

Family Islands
Nerissa Gibson

Grand Bahama
Tonya Butler

Enumerators

Abaco
Sharon Coakley
Eugina Neely
Kendra Sands-Smith

Andros
Rosalie Long
Sheena Murphy-Roberts

Eleuthera
Kayla Davis
Latiesha Mia Williams

Exuma
Joan Bethel
Lynda Russell

Grand Bahama
Stacy Bowe
Vivian Brathwaite
Eddene Cox
Pamela Culmer
Omese Higgs
Andrea Kelly
Meoshe Munroe
Shannon Roberts

New Providence
Kayla Armbrister
Sandra Bridgewater
Jasmine Brown-Davis
J'Arrell Cartwright
Mimose Dorcely
Raquel Edwards
Davanta Ferguson
Dornell Ferguson
Naomi Ferguson
Amorette Patrice Fernander
Georgina Gabrielle
Christianna Gibson
Cynric Gibson
Vanrea Heastie
Merrilen Hepburn
Davia Isaacs
Carla Johnson
Kendesha Kemp
Algeria Lewis
Trevaj Lightbourne
Katrinka Mackey
Latoya Major
Shantell McPhee
Martha Missick
Ezekiel Munnings
Daliesha Murray
Devern Nairn
Marian Pinder
Arlene Poitier
Melissa Rahming
Dorette Rolle
Johann Rolle
Tia Rolle
Glathonya Sands
Telsine Sands
Wellington Smith
Alfreda Strachan
Stefanel Taylor
Anthony Williams
Shanell Williams

APPENDIX 2

Lifetime ("Ever Used") Percent of All Drugs, 2017

Drug	*% Ever Used*
Alcohol	73.9
Tobacco	21.0
Tranquilizers (Valium)	0.4
Amphetamine-type Stimulants (e.g. Ritalin. Adderal)	0.4
Analgesics (Painkillers, Codeine, Vicodin, Morphine, etc.)	0.6
Inhalants (e.g. glue, paint, varnish, deodorants to get high)	0.3
Marijuana	13.4
Hashish	0.5
Cocaine	1.2
Crack	0.7
Heroin	0.3
Poppers (e.g. Rush, Jolt)	0
Hallucinogens (e.g. LSD, PCP)	0.006
MDMA (Ecstasy, Molly)	0.3
Amphetamines and Methamphetamines (Crystal, Meth, Speed)	0
GHB (G, Blue Nitro, Cherry Meth, Liquid Ecstasy)	0
Ketamine (K or Special K, Vitamin K)	0.1
Grabba (Dried tobacco leaf)	2.6
Beedi (Bidi)	4.9
E-Cigarettes (Hookah pens, Hookah sticks)	1.9
Hookah pipes (Tobacco water pipes)	2.2
Seasoned Spliff (lace, marijuana mixed with cocaine)	0.04
Synthetic Marijuana	0.1
Marijuana blunt laced with ecstasy	0.1
Bells of Death (boiled and smoked)	0.1
Lean (Sizzurp, cough medication mixed with soda)	2.2

Source: National Household Drug Prevalence Survey, 2017

Lifetime Prevalence (% Ever Used) of Selected Drugs, by Age and Sex, Bahamas 2017

Drug	12-24 Years		25-44 Years		45-65 Years	
	Males	Females	Males	Females	Males	Females
Alcohol	59.9	60.9	85.1	76.3	83.9	71.3
Tobacco	27.7	4.6	34.4	11.5	37.1	10.8
Marijuana	18.7	6.2	22.0	9.9	19.4	4.0
Cocaine	0.3	0	0.7	0.8	5.1	0.4
Crack Cocaine	0	0	0.4	0.8	2.6	0.5
Inhalants	0	0	0.04	0.6	1.2	0
Tranquilizers	0.1	0	0.3	0.8	1.2	0
Stimulants	0	0	0	0.6	1.5	0
Analgesics	1.3	0	0.2	1.0	1.2	0.04
Grabba	7.4	0.8	3.8	2.6	0.6	0.3
Beady/Bidi	12.0	1.4	11.1	2.5	1.9	0.6
E-Cigarettes	5.1	2.6	2.2	1.3	0.4	0.2
Hookah Pipes	3.4	1.3	5.4	1.8	0.7	0.2
Lean	8.3	0.3	2.1	2.8	0.3	0

Source: National Household Drug Prevalence Survey, 2017

Proportion (%) of Perceived Risk of Use of Selected Drugs

Drug Use Behaviour	No Risk	Low Risk	Moderate Risk	High Risk	I Don't Know the Risk
Smoking cigarettes (not including beedis) sometimes	5.3	11.3	18.8	61.4	3.3
Smoking cigarettes (not including beedis) often	2.8	3.5	9.3	80.9	3.5
Smoking e-cigarettes (hookah pens/stick) sometimes	6.8	13.0	12.8	45.1	22.3
Smoking e-cigarettes (hookah pens/stick) often	4.4	9.4	11.4	51.7	23.1
Smoking hookah pipes (tobacco water pipes) sometimes	5.5	8.8	13.9	52.3	19.6
Smoking hookah pipes (tobacco water pipes) often	3.3	6.5	11.0	59.3	19.9
Drinking alcoholic beverages sometimes	8.4	29.4	29.4	30.4	2.4
Drinking alcoholic beverages often	2.0	6.0	20.2	69.3	2.5
Becoming drunk	1.4	2.4	5.7	88.1	2.4
Taking unprescribed tranquilizers/stimulants sometimes	1.7	3.5	9.2	74.6	11.0
Taking unprescribed tranquilizers/stimulants often	1.6	2.0	4.1	81.1	11.2
Using inhalants/solvents (glue, paint) to get high sometimes	1.8	3.4	6.6	78.1	10.1
Using inhalants/solvents (glue, paint) to get high often	1.7	2.1	4.4	82.3	9.5
Smoking marijuana sometimes	7.5	16.5	17.6	53.2	5.1
Smoking marijuana often	5.0	7.8	12.3	70.4	4.5
Using marijuana in drinks (teas, juice) sometimes	6.9	15.3	14.4	52.9	10.6
Using marijuana in drinks (teas, juice) often	5.5	8.7	12.5	62.8	10.5
Using marijuana in food (pastries, candy, etc.) sometimes	5.8	13.5	12.9	59.7	8.1
Using marijuana in food (pastries, candy, etc.) often	5.0	8.4	11.9	66.5	8.1
Using marijuana for medicine sometimes	15.7	26.2	14.0	35.3	8.7
Using marijuana for medicine often	13.1	18.4	16.8	42.8	8.8
Using cocaine sometimes	1.7	1.7	5.1	87.0	4.5
Using cocaine often	1.7	1.0	1.0	92.0	4.4
Taking ecstasy sometimes	1.7	1.7	4.9	81.1	10.6
Taking ecstasy often	1.7	1.1	2.0	84.6	10.7
Using crack cocaine sometimes	1.7	1.5	3.2	88.2	5.5
Using crack cocaine often	1.7	0.5	1.4	91.0	5.4
Smoking beedis sometimes	6.3	10.9	14.5	59.2	9.1
Smoking beedis often	4.6	6.2	13.0	66.9	9.3
Smoking cigars sometimes	6.6	15.2	21.1	50.7	6.4
Smoking cigars often	4.7	8.6	17.7	62.3	6.6

Source: National Household Drug Prevalence Survey, 2017

APPENDIX 3

Distribution of Islands Selected

Island	Sample Size
1. New Providence	1,800
2. Grand Bahama	395
3. Abaco	120
4. Andros	60
5. Eleuthera/Habour Island	90
6. Exuma	60
Total, All Bahamas	**2,525**

Example of Selection Process of EDs

	ED NO	% 12+ Pop. with 4+ years High School	No. of H/holds	No. of Clusters Assigned	Cumulated Clusters	E.D.'s Selected R.S=27
NEW PROVIDENCE						
Yamacraw	11601	100.0	88	4	4	
	12001	97.7	53	3	7	
	11501	95.7	124	6	13	
	11901	94.3	61	3	16	
	10701	92.5	147	7	23	
	11201	92.2	111	6	29	#
	10901	89.0	145	7	36	
	10801	88.2	103	5	41	
	11001	88.0	160	8	49	
	11201	86.7	75	4	53	
	10201	86.4	118	6	59	
	11101	85.7	106	5	64	
	11701	84.0	115	6	70	
	11401	82.1	103	5	75	
	11801	80.6	72	4	79	
	10301	79.1	113	6	85	
	11401	78.8	91	5	90	#

Selection and Number of Households Assigned for EDs by Island

Island	Supervisory District	Enumeration District Number	Number of Households Assigned
NEW PROVIDENCE			
	Yamacraw	1401	22
		2001	27
		1201	22
		2501	23
	Elizabeth	1201	22
		3001	35
		3201	38
	St. Anne's	801	24
		2501	31
	Fox Hill	401	37
		2601	36
		1301	36
	Montagu	3501	25
		1701	33
		2701	25
	Sea Breeze	2601	26
		1401	22
		2501	30
		801	38

Island	Supervisory District	Enumeration District Number	Number of Households Assigned
NEW PROVIDENCE			
	Marathon	0801	26
		2401	23
NEW PROVIDENCE			
	St. Thomas Moore	2401	23
		3401	21
		1701	25
		0101	24
	Farm Road & Centerville	1701	22
		0601	22
		0501	30
	Englerston	2301	19
		1201	23
		1401	23
		2901	23
	Garden Hills	2901	20
		0801	24
		2801	24
	Kennedy	1301	25
		0601	38

Island	Supervisory District	Enumeration District Number	Number of Households Assigned
NEW PROVIDENCE	South Beach	2201	27
		0601	28
		1601	37
	Bain and Grants Town	2301	22
		1901	35
	St. Cecelia	1001	32
		1501	24
		2201	38
NEW PROVIDENCE	Golden Gates	1501	36
		1201	35
	Bamboo Town	1601	35
		1401	30
	Pinewood	0801	29
		1501	27
	Blue Hills	3001	38
		2701	36
		1301	22
	Carmichael	1901	44
		1101	43
	Golden Isles	2401	29

Island	Supervisory District	Enumeration District Number	Number of Households Assigned
NEW PROVIDENCE	Golden Isles cont'd	4101	30
		0101	28
		2001	30
	Fort Charlotte	801	28
		2001	37
		2201	34
	Mount Moriah	701	29
		1901	31
	Clifton	3001	28
		0601	32
	Killarney	1901	34
		2401	44
	Killarney	2801	36
		1001	34
GRAND BAHAMA	West End	601	26
		1301	29
	Eight Mile Rock	1501	27
		701	31
		1801	32
	Pineridge	1001	21

Island	Supervisory District	Enumeration District Number	Number of Households Assigned
GRAND BAHAMA		301	43
	Lucaya	301	25
		501	25
		1501	22
		2001	26
	Marco City	2001	36
		1401	33
	High Rock	601	17
		2301	24
		2401	39
			80
ABACO	North Abaco	201	13
		702	14
		1901	14
		2701	11
	South Abaco	901	12
		1401	20
		2201	13
		2401	11
		2601	22
		1901	20
	North Andros		

Island	Supervisory District	Enumeration District Number	Number of Households Assigned
ANDROS	Nicholls Town	401	14
	Kemps Bay	1001	17
	San Andros	0801/02	15
	South Andros		
	Kemps Bay	601	18
	Burnt Rock/Pinders	1001/2	13
	Congo Town	0201/0202	13
EXUMA	Barraterre	102	11
	Rolleville	401	16
	Steventon/Hart	0601/02	28
	Moss Town/Hermitage	1401/02	23
	George Town	1801	12
NORTH ELEUTHERA	Bluff	201/02	22
	Lower Bogue	301	21
	Church Street	1901	22
	Nesbitt Street	2101	16
	Bay Street	2001	21
	Gregory Town	2401/2501	18

Estimation Procedures

Estimator of Total

The estimator of a given total Y for a given subpopulation A is:

$$Y_A = \sum_h \sum_i \sum_{j \in A} w'_{hij} y_{hij}$$

where

Y_A = the estimated total for variable Y in subpopulation A

h = the substratum within the estimation domain: 1 - 4

i = the sample PSU, 1 - n_h

j = the unit of analysis or element, 1 - A

A = a subset of elements possessing a given attribute, that is, belonging to a given subpopulation A, for example, persons in a given age group

y_{hij} = the observed value of the variable 'y' for the j-th element of the i-th sample PSU in substratum h; and

w'_{hij} = the final (adjusted) sampling weight for the element; includes all the stages of selection

Estimator of Variance for Total

Under the ultimate clusters approach, the variance of an estimator of total for a given subpopulation A, within any domain of estimation is estimated by:

$$v(Y_A) = \sum \frac{n_h}{n_h - 1} \left[\sum Y_{Ahi} - \frac{Y_A}{n_h} \right]^2$$

where:

Y_{Ahi} = $\sum_{j \in A} w'_{hij} y_{hij}$

Y_{Ah} = $\sum_i \sum_{j \in A} w'_{hij} y_{hij}$

Other notation as previously defined.

Estimation for a Proportion (p)

For a proportion for example the proportion of households with a given characteristic (poverty)

$$\mathbf{P_h = \sum w_h p_h}$$

Where

p_h = proportion of household with the given characteristics i.e. in stratum # (group) h

w_h = $F^*_h n_h / \sum F^*_h n_h$

f_h = the sampling fraction for stratum (group) h

F_h = $1/ f_h$

F^*_h = F_h adjusted for non-response

= F_h x no.of household selected /No of households interviewed

n_h = number of elements (households)

Variance of a proportion

$$\underline{\text{Var}(P_h) = \sum w_h^2 (1-f_h).P_h (1-p_h)}$$
$$(n_h - 1)$$

APPENDIX 4

Questionnaire

NTER-AMERICAN DRUG ABUSE CONTROL COMMISSION (CICAD)
INTER-AMERICAN OBSERVATORY ON DRUGS (OID)

Ministry of Health

INTER-AMERICAN UNIFORM DRUG USE DATA SYSTEM
(SIDUC)

The information provided in this questionnaire is strictly confidential and will only be used to develop general statistics.

HOUSEHOLD SURVEY

Standardized Questionnaire - 2017

1. GEOGRAPHIC IDENTIFICATION

Island	Supervisory District	ED #	Household number	Letter for drawing lots

2. TABLE FOR DRAWING LOTS

(a) In the table below, enter the names of all household members, starting with the eldest.

(b) In the Order No. column, number sequentially the individuals in the 12-65 year age range and who is a usual resident of this household for six months or more.

First Name or Initial	Age	Order No.	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
			1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2	2
			1	1	1	1	1	1	2	2	2	2	2	2	3	3	3	3	3	3
			1	1	1	2	2	1	2	2	2	3	3	3	4	3	3	4	4	4
			1	1	1	2	2	3	2	2	3	3	4	4	3	4	4	5	5	5
			1	2	1	2	2	2	3	3	3	4	4	4	5	5	5	6	5	6
			1	1	2	1	2	3	4	3	4	4	5	4	5	6	7	6	7	7
			1	1	2	2	3	4	4	3	4	5	6	5	5	6	7	7	8	8
			1	1	2	2	3	3	4	4	5	5	6	6	7	7	8	8	9	9
			1	1	2	2	3	3	4	5	4	6	7	6	8	8	9	9	10	10
			1	2	3	4	2	4	5	5	6	6	7	7	8	10	8	9	10	11
			1	2	3	4	2	4	5	6	5	7	8	7	9	10	9	11	10	12

1. COUNTRY	2. Island	3. QUESTIONNAIRE NUMBER

4. Sex

☐ 1. Male ☐ 2. Female

5. How old are you? _____Years (12-65 years old only)

6a. What is the highest **educational level** that you have achieved?

Level achieved:		
	1. Never attended school	
	2. Incomplete Primary	
	3. Complete Primary	
	4. Incomplete Secondary	
	5. Complete Secondary	
	6. Incomplete University/Tertiary	
	7. Complete University/Tertiary	
	8. Vocational (**Specify in 6b below**)	
	9. Don't know	
	0. No response	

6b. Please specify the type of vocational education_____

7. What is your ethnicity?

1. African Origin/Black		10. Garifuna	
2. Indigenous People		11. Maya(Ketchi, Mopan,Yucatec)	
3. East Indian		12. Mennonite	
4. Chinese		13. Mestizo/Spanish	
5. Portuguese		14. Javanese	
6. White		15. Maroon	
7. Mixed		16. Don't know	
8. Syrian/Lebanese/Arab		17. Other, specify	
9. Creole			

7a. Where were you born?

1. Bahamas **(Skip to #8)**
2. Abroad

7b. In which Country were you born?

_____
(Name of Country)

7c. How long have you lived in The Bahamas? _____ (Years)

8. What religion or belief do you identify with?

	1. Anglican/Episcopalian		15. Moravian
	2. Assemblies of God		16. New Testament Church of God
	3. Baha'i		17. Pentecostal
	4. Baptist		18. Presbyterian
	5. Brethren		19. Rastafarian
	6. Church of God		20. Revivalist
	7. Church of God of Prophecy		21. Roman Catholic
	8. Greek Orthodox		22. Seventh Day Adventist
	9. Hinduism		23. United Church
	10. Islam		24. None
	11. Jehovah's Witnesses		25. Other, Specify_____
	12. Judaism		0. Not Stated
	13. Lutheran		
	14. Methodist		

9. With whom do you live? (Tick all that apply)

1. Father		0. No Response
2. Mother		9b. Please specify other _____
3. Brother/ sister		
4. Girlfriend/Boyfriend		
5. Alone		
6. Child/Children		
7. Stepfather		
8. Stepmother		
9. Wife/Husband		
10. Friend		
11. Grandparent		
12. Other		

10a. What is your work status now?

☐ 1. Working/Self-employed
☐ 2. Working and studying
☐ 3. Unemployed (skip to #14)
☐ 4. Not working, student (skip to #14)
☐ 5. Housewife (skip to #14)
☐ 6. Not working (retired; of independent means)(skip to #14)
☐ 7. Not working (other, specify) (skip to #14)

Please specify "Not working other" _____

0b. Approximately how many hours per week do you work? _____ hours

11. Please describe your job (main job if respondent has more than one) :

- ☐ 1. Member of executive branch, legislative bodies, or senior government or company staff
- ☐ 2. Professional, scientific, or intellectual
- ☐ 3. Mid-level technical or professional
- ☐ 4. Office worker
- ☐ 5. Service, sales, or market worker
- ☐ 6. Farmer or skilled agricultural or fishery worker
- ☐ 7. Craft or skilled worker, machinist, specialized mechanic, or other type of tradesman
- ☐ 8. Operator of installations and machines or erector of installations and machines
- ☐ 9. Unskilled worker
- ☐ 10. Member of armed forces
- ☐ 11. Other, describe occupation

_____

12a. Could you tell me if, at your current job, there are any special regulations controlling the use of alcohol or drugs among employees?

INTERVIEWER: IF THE PERSON HAS MORE THAN ONE JOB, THEN ANSWER THE QUESTIONS FOR THE SAME MAIN JOB FOR WHICH HE ANSWERED QUESTION 11.

	1. Yes
	2. No
	3. Don't know
	0. No response

12b. At your current job, have you received any kind of information about drug or alcohol prevention and use?

	1. Yes
	2. No
	3. Don't know
	0. No response

13. And at your current job, is there any kind of program to help an employee who has a problem involving the use of alcohol or drugs?

	1. Yes
	2. No
	3. Don't know
	0. No response

14. Marital status

	1. Single, never married
	2. Married
	3. Divorced
	4. Separated
	5. Living together/Common law
	6. Widow/widower
	0. No response

15a. Are you the head of household?

☐ 1. Yes (Skip to #17) ☐ 2. No

15b. The head of this household is:

☐ 1. Male ☐ 2. Female ☐ 3. Don't know

16a. What is the highest level of education that the head of household has achieved?

Level achieved:		
	1. Never attended school	
	2. Incomplete Primary	
	3. Complete Primary	
	4. Incomplete Secondary	
	5. Complete Secondary	
	6. Incomplete University/Tertiary	
	7. Complete University/Tertiary	
	8. Vocational (**Specify in 16b below**)	
	9. Don't know	
	0. No response	

16b. Please specify the type of vocational education

17. In approximate terms and considering a normal month, where would you rank your household's total monthly income? If the person is underage, try to obtain this information from an adult.

	17a IF JAMAICA	17b IF THE BAHAMAS	17c IF GUYANA
	1. Less than JAD$25,000	1. Less than BSD$200	1. Less than GYD$40,000
	2. Between JAD$25,000 and 50,000	2. Between BSD$200 and 400	2. Between GYD$40,001 and 80,000
	3. Between JAD$50,001 and 70,000	3. Between BSD$401 and 600	3. Between GYD$80,001 and 120,000
	4. Between JAD$70,001 and 100,000	4. Between BSD$601 and 800	4. Between GYD$120,001 and 160,000
	5. Between JAD$100,001 and 120,000	5. Between BSD$801 and 1,000	5. Between GYD$160,001 and 200,000
	6. Between JAD$120,001 and 180,000	6. Between BSD$1,001 and 1,500	6. Between GYD$200,001 and 300,000
	7. Between JAD$180,001 and 240,000	7. Between BSD$1,501 and 2,000	7. Between GYD$300,001 and 400,000
	8. Between JAD$2400,001 and 300,000	8. Between BSD$2,000 and 2,500	8. Between GYD$400,001 and 500,000
	9. Between JAD$300,001 and 356,000	9. Between BSD$2,501 and 3,000	9. Between GYD$500,001 and 600,000
	10. Between JAD$356,001 and 415,000	10. Between BSD$3,001 and 3,500	10. Between GYD$600,001 and 700,000
	11. Between JAD$415,001 and 475,000	11. Between BSD$3,501 and 4,000	11. Between GYD$700,001 and 800,000
	12. Between JAD$475,001 and 590,000	12. Between BSD$4,001 and 5,000	12. Between GYD$800,001 and 1,000,000
	13. More than JAD$590,000	13. More than BSD$5,000	13. More than GYD$1,000,000
	14. Don't know	14. Don't know	14. Don't know
	0. No response	0. No response	0. No response

18. In your opinion, please indicate the risk level of:	No risk	Low risk	Moderate risk	High risk	I don't know the risk
1. Smoking cigarettes (not including beedi/bidis) sometimes	1	2	3	4	5
2. Smoking cigarettes (not including beedi/bidis) often	1	2	3	4	5
3. Smoking e-cigarettes (hookah pens/hookah sticks) sometimes	1	2	3	4	5
4. Smoking e-cigarettes (hookah pens/hookah sticks) often	1	2	3	4	5
5. Smoking hookah pipes (tobacco water pipes) sometimes	1	2	3	4	5
6. Smoking hookah pipes (tobacco water pipes) often	1	2	3	4	5
7. Drinking alcoholic beverages (not communion wine) sometimes	1	2	3	4	5
8. Drinking alcoholic beverages (not communion wine) often	1	2	3	4	5
9. Becoming drunk	1	2	3	4	5
10. Taking unprescribed tranquilizers/stimulants sometimes	1	2	3	4	5
11. Taking unprescribed tranquilizers/stimulants often	1	2	3	4	5
12. Using inhalants/solvents to get high sometimes (glue, paint, varnish, deodorants, gasoline)	1	2	3	4	5
13. Using inhalants solvents to get high often (glue, paint, varnish, deodorants, gasoline)	1	2	3	4	5
14. Smoking marijuana sometimes	1	2	3	4	5
15. Smoking marijuana often	1	2	3	4	5
16. Using marijuana in drinks sometimes (teas, juice etc.)	1	2	3	4	5
17. Using marijuana in drinks often	1	2	3	4	5
18. Using marijuana in food sometimes (pastries, candy/sweets, cooked/uncooked meals)	1	2	3	4	5
19. Using marijuana in food often	1	2	3	4	5
20. Using marijuana for medicine sometimes	1	2	3	4	5
21. Using marijuana for medicine often	1	2	3	4	5
22. Using cocaine sometimes	1	2	3	4	5
23. Using cocaine often	1	2	3	4	5
24. Taking ecstasy sometimes	1	2	3	4	5
25. Taking ecstasy often	1	2	3	4	5
26. Using crack cocaine sometimes	1	2	3	4	5
27. Using crack cocaine often	1	2	3	4	5
28. Smoking beedis (bidis) sometimes	1	2	3	4	5
29. Smoking beedis (bidis) often	1	2	3	4	5
30. Smoking cigars sometimes	1	2	3	4	5
31. Smoking cigars often	1	2	3	4	5

Tobacco: For all questions consider cigarettes with or without a filter, cigars, pipes or similar items.

19a. When was the first time that you smoked tobacco?

	0. Never (skip to #20a)
	1. In the past 30 days
	2. More than 1 month ago, but less than 1 year ago
	3. More than 1 year ago

19b. At what age did you smoke tobacco for the first time?

	Years old

19c. When was the last time that you smoked tobacco?

	1. In the last month	
	2. More than 1 month ago, but less than 1 year ago	(Skip to 19e)
	3. More than 1 year ago	(Skip to 19e)
	4. Don't know	
	0. No response	

19d. Do you currently smoke tobacco on a daily basis, less than daily, or not at all?

	1. Daily	(skip to #19g)
	2. Less than daily	
	3. Not at all	(Skip to 19f)
	4. Don't know	(skip to #19g)
	0. No response	(skip to #19g)

19e. Have you smoked tobacco daily in the past?

	1.Yes	(skip to #19g)
	2.No	(skip to #19g)
	3. Don't know	(skip to #19g)
	0. No response	(skip to #19g)

19f. In the past, have you smoked tobacco on a daily basis, less than daily, or not at all?

Interviewer: If the respondent has done both 'Daily' and 'Less than daily' in the past, check 'daily'.

	1. Daily
	2. Less than daily
	3. Not at all
	4. Don't know
	0. No response

19g. Over the past month, how much money did you spend on cigarettes?

	19g1 IF JAMAICA	19g2 IF THE BAHAMAS	19g3 IF GUYANA
	1. None	1. None	1. None
	2. Less than JAD$1,000	2. Less than BSD$10	2. Less than GYD$2,000
	3. Between JAD$1,000 and 2,000	3. Between BSD$10 and 20	3. Between GYD$2,000 and 4,000
	4. More than JAD$2,000 but less than 5,000	4. More than BSD$20 but less than 50	4. More than GYD$4,000 but less than 10,000
	5. More than JAD$5,000 but less than 10,000	5. More than BSD$50 but less than 100	5. More than GYD$10,000 but less than 20,000
	6. More than JAD$10,000 but less than 20,000	6. More than BSD$100 but less than 200	6. More than GYD$20,000 but less than 40,000
	7. More than JAD$20,000	7. BSD$200 or more	7. More than GYD$40,000
	8. Don't know	8. Don't know	8. Don't know
	0. No response	0. No response	0. No response

Alcohol:

20a. Have you ever drank alcoholic beverages?	20b. How old were you when you drank for the first time?
☐ 1. Yes ☐ 2. No (skip to #23)	☐ Years old
20c. When was the first time you drank alcoholic beverages?	20d. Have you drank alcoholic beverages in the past 12 months?
☐ 1. During the past 30 days ☐ 2. More than 1 month ago, less than 1 year ago ☐ 3. More than a year ago	☐ 1. Yes ☐ 2. No (skip to #23)
20e. Have you drank alcoholic beverages in the past 30 days?	20f. Approximately how many days have you gotten drunk in the past month?
☐ 1. Yes ☐ 2. No (skip to #22)	☐ Days

20g. Males: Over the past 2 weeks, how many times have you taken 5 drinks or more on a single occasion/outing?

	1. Not once
	2. Just once
	3. 2 to 3 times
	4. Between 4 and 5 times
	5. More than 5 times
	6. Don't know
	0. No response

20h. Females: Over the past 2 weeks, how many times have you taken 4 drinks or more on a single occasion/outing?

	1. Not once
	2. Just once
	3. 2 to 3 times
	4. Between 4 and 5 times
	5. More than 5 times
	6. Don't know
	0. No response

20i. Over the past month, how much money did you spend on alcoholic beverages?

	IF JAMAICA	IF THE BAHAMAS	IF GUYANA
	1. None	1. None	1. None
	2. Less than JAD$1,000	2. Less than BSD$10	2. Less than GYD$2,000
	3. Between JAD$1,000 and 2,000	3. Between BSD$10 and 20	3. Between GYD$2,000 and 4,000
	4. More than JAD$2,000 but less than 5,000	4. More than BSD$20 but less than 50	4. More than GYD$4,000 but less than 10,000
	5. More than JAD$5,000 but less than 10,000	5. More than BSD$50 but less than 100	5. More than GYD$10,000 but less than 20,000
	6. More than JAD$10,000 but less than 20,000	6. More than BSD$100 but less than 200	6. More than GYD$20,000 but less than 40,000
	7. More than JAD$20,000	7. BSD$200 or more	7. More than GYD$40,000
	8. Don't know	8. Don't know	8. Don't know
	0. No response	0. No response	0. No response

21. In the past 30 days, what type of alcoholic beverage did you drink, and with what frequency?
INDICATE WITH (√) WHAT CORRESPONDS FOR EACH ALCOHOLIC BEVERAGE

	1. Daily	2. Some week days	3. Weekends	4. Not at all
1) Low alcohol content (Beer, Guinness, Smirnoff Ice)				
2) Medium alcohol content (Wine, Bailey's, etc)				
3) High alcohol content (Whiskey, Rum, Vodka, Gin)				

22. During the past 12 months:

22.1. How often do you have a drink containing alcohol? (If never, skip to #22.9)	0 Never	1 Monthly or less	2 2 to 4 times a month	3 2 to 3 times a week	4 4 or more times a week
22.2. How many drinks containing alcohol do you have on a typical day when you are drinking? USE THE SCALE BELOW TO ESTIMATE THE NUMBER OF DRINKS	0 1 or 2	1 3 or 4	2 5 or 6	3 7, 8 or 9	4 10 or more

1 drink	1 drink and a half	6 drinks	18 drinks
- One bottle or individual can of beer (333 cc.) - One glass of wine (140 cc.). -One shot of hard liquor (40 cc.) (pisco, rum, vodka, whisky) either alone or mixed with another	Half liter of beer	One bottle of wine (750 cc.)	One bottle of hard liquor (750 cc.)
	3 drinks	8 drinks	
	One liter of beer	One case of wine (1 liter)	

22.3. How often do you have 6 or more drinks on one occasion?	0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily
22.4. How often during the past year have you found that you were not able to stop drinking once you started?	0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily
22.5. How often during the last year have you found that you failed to do what was normally expected from you because of drinking?	0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily
22.6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily
22.7. How often during the past year have you had a feeling of guilt or remorse after drinking?	0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily
22.8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily
22.9. Have you or someone else been injured as a result of your drinking?	0 No		2 Yes, but not in the last year		4 Yes, during the last year
22.10. Has a relative, friend or a doctor or another health worker been concerned about your drinking or suggested that you cut down?	0 No		2 Yes, but not in the last year		4 Yes, during the last year

23. How easy would it be for you to have access to the following drugs? **INDICATE WITH (√) WHAT CORRESPONDS FOR** EACH DRUG	1 Easy	2 Difficult	3 Could not have access to	4 Do**n't** know
1. Marijuana				
2. Cocaine				
3. Ecstasy				
4. Crack cocaine				

24a. Do you have friends or family members who get drunk? ☐ 1. Yes ☐ 2. No (skip to #25a) 24b. How many friends or family members get drunk? ☐ 1. None ☐ 2. One ☐ 3. Two or more	25a. Do you have friends or family members who take illegal drugs such as marijuana or cocaine? ☐ 1. Yes ☐ 2. No (skip to #26a) 25b. How many friends or family members take illegal drugs such as marijuana or cocaine? ☐ 1. None ☐ 2. One ☐ 3. Two or more
26a. Have you ever had a chance to try an illegal drug? ☐ 1. Yes ☐ 2. No (skip to #27) 26b. How many times have you had a chance to try an illegal drug? ☐ 1. One (skip to #29) ☐ 2. Two or more (skip to #29)	
27. Have you ever been curious to try an illegal drug? ☐ 1. No ☐ 2. Maybe ☐ 3. Yes	28. If you had the chance, would you try an illegal drug? ☐ 1. No ☐ 2. Maybe ☐ 3. Yes

29. When was the last time that you were offered any of these drugs, either to buy or to use? **INDICATE WITH (√)** WHAT CORRESPONDS FOR EACH DRUG	Drug	1 During the last 30 days	2 More than a month ago, but less than a year ago	3 More than a year ago	0 I have never been offered
	1. Marijuana				
	2. Cocaine				
	3. Ecstasy				
	4.Crack cocaine				

30. Have you ever used any of these substances? INDICATE WITH (✓) WHAT CORRESPONDS FOR EACH SUBSTANCE			31. How old were you when you tried for the first time?
	NO	YES	
a. Tranquilizers such as Alprazolam, Diazepam (Valium), Flunitrazepam (Rohypnol), Chlordiazepoxide (Librium) or similar without a prescription.			→ Years old
b. Amphetamine-type stimulants such as Methylphenidate (Ritalin), Phenmetrazine (Preludin or Adepsin), Amphetamines (Adderall), Dextroamphetamine (Dexedrine, DextroStat), Pemoline (Cylert) or similar without a prescription.			→ Years old
c. Analgesics such as Codeine, Hydrocodone, Vicodin, Methadone, Morphine, Pethidine, Tramal or similar without a prescription.			→ Years old
d. Inhalants to get high such as glue, paint, varnish, deodorants, gasoline, benzene or similar.			→ Years old
e. Marijuana (weed, ganja, sensi, herb, joint, chronic, high-grade, krypt, killer, fire)			→ Years old
f. Hashish			→ Years old
g. Cocaine (coke, flake, snow, dust, eight ball)			→ Years old
h. Crack			→ Years old
i. Heroin			→ Years old
j. Poppers (nitrites) such as Rush, Jolt, Locker Room, Leather Man, etc.			→ Years old
k. Hallucinogens such as LSD, PCP and Psilocybin			→ Years old
l. MDMA (Ecstasy, Molly, Adam, X-TC)			→ Years old
m. Amphetamines and methamphetamines (Ice, pep pills, Crystal, Meth, Speed)			→ Years old
n. GHB (G, Blue Nitro, Cherry Meth, Poor man's heroin, Liquid ecstasy)			→ Years old
o. Ketamine (K or Special K, Vitamin K)			→ Years old
p. Grabba (dried tobacco leaf)			→ Years old
q. Beedi (bidi)			→ Years old
r. e-cigarettes (hookah pens/hookah sticks)			→ Years old
s. Hookah pipes (tobacco water pipes)			→ Years old
t. Seasoned spliff (lace, marijuana mixed with cocaine)			→ Years old
u. Synthetic marijuana (fake weed)			→ Years old
v. Marijuana blunt laced with ecstasy			→ Years old

w. Bells of Death (boiled and smoked)			→ Years old
x. Lean (cough medication mixed with soda, sizzurp)			→ Years old
y. Other drugs: specify (_____)			→ Years old
None of the above			

SKIP to Q 53 IF THE ANSWERS TO QUESTIONS 30 A – 30 Y **ARE ALL "NO"**

Tranquilizers (without a prescription): ONLY IF RESPONDED 'YES' TO QUESTION 30.a

32a. When was the <u>first time</u> you tried Tranquilizers such as Alprazolam, Diazepam (Valium), Flunitrazepam (Rohypnol), Chlordiazepoxide (Librium) or similar without a prescription ? ☐ 0. Never (skip to #33a) ☐ 1. In the past 30 days ☐ 2. More than 1 month ago, but less than 1 year ago ☐ 3. More than 1 year ago	32b. Have you used tranquilizers in the <u>past 12 months</u> without a prescription? ☐ 1. Yes ☐ 2. No (skip to #33a)
32c. How often in the past 12 months have you used tranquilizers without a prescription? ☐ 1. Only once ☐ 2. Less than monthly ☐ 3. Monthly ☐ 4. Weekly ☐ 5. Daily or almost daily	32d. Have you used tranquilizers in the <u>past 30 days</u> without a prescription? ☐ 1. Yes ☐ 2. No (skip to #33a)
32e. Just focus on the past 30 days. How many days have you used tranquilizers over the past 30 days without a prescription? Number of days (from 0 to 30)	32f. How many tranquilizer pills or capsules do you use a month without a prescription? capsules
32g. Based on what you know, how much does a tranquilizer pill or capsule without a prescription cost? In national currency	

32h. Over the past month, how much money did you spend on tranquilizers without prescriptions?

	32h1 IF JAMAICA	32h2 IF THE BAHAMAS	32h3 IF GUYANA
	1. None	1. None	1. None
	2. Less than JAD$1,000	2. Less than BSD$10	2. Less than GYD$2,000
	3. Between JAD$1,000 and 2,000	3. Between BSD$10 and 20	3. Between GYD$2,000 and 4,000
	4. More than JAD$2,000 but less than 5,000	4. More than BSD$20 but less than 50	4. More than GYD$4,000 but less than 10,000
	5. More than JAD$5,000 but less than 10,000	5. More than BSD$50 but less than 100	5. More than GYD$10,000 but less than 20,000
	6. More than JAD$10,000 but less than 20,000	6. More than BSD$100 but less than 200	6. More than GYD$20,000 but less than 40,000
	7. More than JAD$20,000	7. BSD$200 or more	7. More than GYD$40,000
	8. Don't know	8. Don't know	8. Don't know
	0. No response	0. No response	0. No response

Stimulants (without a prescription): ONLY IF RESPONDED 'YES' TO QUESTION 30.b

33a. When was the first time you tried Amphetamine-type stimulants such as Methylphenidate (Ritalin), Phenmetrazine (Preludin or Adepsin), Amphetamines (Adderall), Dextroamphetamine (Dexedrine, DextroStat), Pemoline (Cylert) or similar without a prescription? ☐ 0. Never (skip to #34a) ☐ 1. In the past 30 days ☐ 2. More than 1 month ago, but less than 1 year ago ☐ 3. More than 1 year ago	33b. Have you used stimulants in the past 12 months without a prescription? ☐ 1. Yes ☐ 2. No (skip to #34a)
33c. How often in the past 12 months have you used stimulants without a prescription? ☐ 1. Only once ☐ 2. Less than monthly ☐ 3. Monthly ☐ 4. Weekly ☐ 5. Daily or almost daily	33d. Have you used stimulants in the past 30 days without a prescription? ☐ 1. Yes ☐ 2. No (skip to #34a)
33e. Just focus on the past 30 days. How many days have you used stimulants over the past 30 days without a prescription? Number of days (from 0 to 30)	33f. How many stimulants (pills or capsules) do you use a month without a prescription? Number of stimulants (pills or capsules)
33g. Based on what you know, how much does a stimulant without a prescription cost? In national currency	

33h. Over the past month, how much money did you spend on stimulants without prescriptions?

	33h1 IF JAMAICA	33h2 IF THE BAHAMAS	33h3 IF GUYANA
	1. None	1. None	1. None
	2. Less than JAD$1,000	2. Less than BSD$10	2. Less than GYD$2,000
	3. Between JAD$1,000 and 2,000	3. Between BSD$10 and 20	3. Between GYD$2,000 and 4,000
	4. More than JAD$2,000 but less than 5,000	4. More than BSD$20 but less than 50	4. More than GYD$4,000 but less than 10,000
	5. More than JAD$5,000 but less than 10,000	5. More than BSD$50 but less than 100	5. More than GYD$10,000 but less than 20,000
	6. More than JAD$10,000 but less than 20,000	6. More than BSD$100 but less than 200	6. More than GYD$20,000 but less than 40,000
	7. More than JAD$20,000	7. BSD$200 or more	7. More than GYD$40,000
	8. Don't know	8. Don't know	8. Don't know
	0. No response	0. No response	0. No response

Inhalants: ONLY IF RESPONDED 'YES' TO QUESTION 30.d

34a. When was the first time you tried inhalants to get high? (e.g. glue, paint, varnish, deodorants, gasoline, benzene) ☐ 0. Never (skip to #35a) ☐ 1. In the past 30 days ☐ 2. More than 1 month ago, but less than 1 year ago ☐ 3. More than 1 year ago	34b. Have you used inhalants in the past 12 months to get high? ☐ 1. Yes ☐ 2. No (skip to #35a)
34c. How often in the past 12 months have you used inhalants to get high? ☐ 1. Only once ☐ 2. Less than monthly ☐ 3. Monthly ☐ 4. Weekly ☐ 5. Daily or almost daily	34d. Have you used inhalants in the past 30 days to get high? ☐ 1. Yes ☐ 2. No
34e Which inhalants did you use most often in the past 30 days? (Tick all that apply) ☐ 1. Glue ☐ 2. Paint ☐ 3. Deoderants ☐ 4. Gasoline ☐ 5. Other, Specify	

Cocaine: ONLY IF RESPONDED 'YES' TO QUESTION 30.g

35a. When was the first time you tried cocaine?	35b. Have you used cocaine in the past 12 months?
☐ 0. Never (skip to #36a) ☐ 1. In the past 30 days ☐ 2. More than 1 month ago, but less than 1 year ago ☐ 3. More than 1 year ago	☐ 1. Yes ☐ 2. No (skip to #36a)
35c. How often in the past 12 months have you used cocaine?	35d. Have you used cocaine in the past 30 days?
☐ 1. Only once ☐ 2. Less than monthly ☐ 3. Monthly ☐ 4. Weekly ☐ 5. Daily or almost daily	☐ 1. Yes ☐ 2. No (skip to #36a)
35e. Just focus on the past 30 days. How many days have you used cocaine over the past 30 days? Number of days (from 0 to 30)	35f. How many grams of cocaine do you use a month? Number of grams
35g. Based on what you know, how much does a gram of cocaine cost? In national currency	

35h. Over the past month, how much money did you spend on cocaine?

	35h1 IF JAMAICA	35h2 IF THE BAHAMAS	35h3 IF GUYANA
	1. None	1. None	1. None
	2. Less than JAD$1,000	2. Less than BSD$10	2. Less than GYD$2,000
	3. Between JAD$1,000 and 2,000	3. Between BSD$10 and 20	3. Between GYD$2,000 and 4,000
	4. More than JAD$2,000 but less than 5,000	4. More than BSD$20 but less than 50	4. More than GYD$4,000 but less than 10,000
	5. More than JAD$5,000 but less than 10,000	5. More than BSD$50 but less than 100	5. More than GYD$10,000 but less than 20,000
	6. More than JAD$10,000 but less than 20,000	6. More than BSD$100 but less than 200	6. More than GYD$20,000 but less than 40,000
	7. More than JAD$20,000	7. BSD$200 or more	7. More than GYD$40,000
	8. Don't know	8. Don't know	8. Don't know
	0. No response	0. No response	0. No response

Crack: ONLY IF RESPONDED 'YES' TO QUESTION 30.h

36a. When was the first time you tried crack?	36b. Have you used crack in the past 12 months?
☐ 0. Never (skip to #37) ☐ 1. In the past 30 days ☐ 2. More than 1 month ago, but less than 1 year ago ☐ 3. More than 1 year ago	☐ 1. Yes ☐ 2. No (skip to #37)
36c. How often in the past 12 months have you used crack?	36d. Have you used crack in the past 30 days?
☐ 1. Only once ☐ 2. Less than monthly ☐ 3. Monthly ☐ 4. Weekly ☐ 5. Daily or almost daily	☐ 1. Yes ☐ 2. No (skip to #37)
36e. Just focus on the past 30 days. How many days have you used crack over the past 30 days? Number of days (from 0 to 30)	36f. How many grams of crack do you use a month? Number of grams
36g. Based on what you know, how much does a gram of crack cost? In national currency	

36h. Over the past month, how much money did you spend on crack?

	36h1 IF JAMAICA	36h2 IF THE BAHAMAS	36h3 IF GUYANA
	1. None	1. None	1. None
	2. Less than JAD$1,000	2. Less than BSD$10	2. Less than GYD$2,000

	3. Between JAD$1,000 and 2,000	3. Between BSD$10 and 20	3. Between GYD$2,000 and 4,000
	4. More than JAD$2,000 but less than 5,000	4. More than BSD$20 but less than 50	4. More than GYD$4,000 but less than 10,000
	5. More than JAD$5,000 but less than 10,000	5. More than BSD$50 but less than 100	5. More than GYD$10,000 but less than 20,000
	6. More than JAD$10,000 but less than 20,000	6. More than BSD$100 but less than 200	6. More than GYD$20,000 but less than 40,000
	7. More than JAD$20,000	7. BSD$200 or more	7. More than GYD$40,000
	8. Don't know	8. Don't know	8. Don't know
	0. No response	0. No response	0. No response

37. Have you injected any of the following substances once in your lifetime? (only if you **answered "yes" to Q30b, 30c, 30g, 30i)**

	1. Cocaine
	2. Amphetamines/Methamphetamines
	3. Heroin
	4. Morphine, pethidine or similar
	5. Other drugs: specify.....
	0. No, I have never injected myself (Skip to #39a)

38. When was the last time you injected any of these substances?

		Over the past 30 days	More than one month ago, but less than one year ago	More than one year ago
	1. Cocaine			
	2.Amphetamines / Methamphetamines			
	3. Heroin			
	4. Morphine, Pethidine or similar			
	5. Other drugs, specify.....			

Marijuana: ONLY IF RESPONDED 'YES' TO QUESTION 30.e

39a. When was the first time you smoked Marijuana?
☐ 0. Never (skip to #53)
☐ 1. . In the past 30 days
☐ 2. More than 1 month ago, but less than 1 year ago
☐ 3. More than 1 year ago

39b. Have you smoked marijuana in the past 12 months?
☐ 1. Yes
☐ 2. No (skip to #47)

39c. How often in the past 12 months have you smoked marijuana?
☐ 1. Only once
☐ 2. Less than monthly
☐ 3. Monthly
☐ 4. Weekly
☐ 5. Daily or almost daily

39d. Have you smoked marijuana in the past 30 days?
☐ 1. Yes
☐ 2. No (skip to #39f)

39e. Just focus on the past 30 days. How many days have you smoked marijuana over the past 30 days?

	Number of days (from 0 to 30)

39f. Just focus on the past 30 days. How many marijuana joints did you smoke over the past 30 days?

	Number of marijuana joints

40. Have you ever bought marijuana?
☐ 1. Yes
☐ 2. No (skip to #47)

41. How long has it been since you last bought any marijuana?

	1. Within past 30 days
	2. More than 30 days but within 12 months (skip to #47)
	3. More than 12 months ago (skip to #47)
	4. Don't know (skip to # 47)
	0.No response

42. Over the past month, how much money did you spend on marijuana?

	IF JAMAICA	IF THE BAHAMAS	IF GUYANA
	1. None	1. None	1. None

	2. Less than JAD$1,000	2. Less than BSD$10	2. Less than GYD$2,000
	3. Between JAD$1,000 and 2,000	3. Between BSD$10 and 20	3. Between GYD$2,000 and 4,000
	4. More than JAD$2,000 but less than 5,000	4. More than BSD$20 but less than 50	4. More than GYD$4,000 but less than 10,000
	5. More than JAD$5,000 but less than 10,000	5. More than BSD$50 but less than 100	5. More than GYD$10,000 but less than 20,000
	6. More than JAD$10,000 but less than 20,000	6. More than BSD$100 but less than 200	6. More than GYD$20,000 but less than 40,000
	7. More than JAD$20,000	7. BSD$200 or more	7. More than GYD$40,000
	8. Don't know	8. Don't know	8. Don't know
	0. No response	0. No response	0. No response

43. Approximately how much marijuana did you buy the last time you bought it?

☐ 1. Grams _____
☐ 2. Ounces _____
☐ 3. Pounds _____
☐ 4. Don't know
☐ 5. Other, specify_____
☐ 0. No response

44. The last time you bought marijuana, where were you when you bought it?

	1. Inside a public building (store, restaurant)
	2. Inside a school building
	3. Outside on school property
	4. Inside a home, apartment or dorm
	5.Outside in a public area (parking lot)
	6. Some other place
	7. Don't know
	0. No response

45. At the place where you buy marijuana, which other drugs can you get regardless of whether you bought these other drugs or not? (Tick all that apply)

	1. Alcohol
	2. Tobacco
	3. Cocaine
	4. Ecstasy
	5. Hallucinogens
	6. Amphetamines/methamphetamines
	7. None
	8. Other, specify_____
	9. Don't know
	0. No response

46. Who usually provides the marijuana that you buy?

☐ 1. The same dealer (3 times or more)
☐ 2. A new dealer each time
☐ 3. I look for it at the same venue every time
☐ 4. I look for it in a new venue every time
☐ 5. I don't buy marijuana
☐ 6. Other, specify_____
☐ 0. No response

47. Think about the last time you used marijuana. How did you get this marijuana?

	1. You bought it
	2. You traded something else for it
	3. You got it for free or shared someone else's
	4. You grew it yourself
	5. Other, specify_____
	6. Don't know
	0. No response

48. If you had to guess about the potency (amount of THC) that was in the marijuana you most recently used, would you say that it was?

☐ 1. Very strong
☐ 2. Strong
☐ 3. Medium strength
☐ 4. Low strength
☐ 5. Don't know
☐ 0. No response

49. The last time you got marijuana for free, who did you get it from?

	1. A friend
	2. A relative or family member
	3. Someone I had just met or didn't know well
	4. Other, specify_____
	5. Don't know
	5. Never got it for free (Skip to Q51)
	0. No response

50. The last time you got marijuana for free, where were you when you got it?

51. Based on what you know, how much does a marijuana joint cost?

	$ In national currency

	1. Inside a public building (store, restaurant)		
	2. Inside a school building		
	3. Outside on school property		
	4. Inside a home, apartment or dorm		
	5.Outside in a public area (parking lot)		
	6. Some other place		
	7. Don't know		
	0. No response		

52.	Over the PAST 12 MONTHS:	0. Never	1. Rarely	2. Some times	3. Fairly often	4. Very often
	a. Have you smoked marijuana before midday?					
	b. Have you smoked marijuana when you were alone?					
	c. Have you had memory problems when you smoked marijuana?					
	d. Have friends or members of your family told you that you ought to reduce your marijuana use?					
	e. Have you tried to reduce or stop your marijuana use without succeeding?					
	f. Have you stopped or interrupted social, work or leisure activities because of marijuana smoking?					
	g. Have you had problems because of your use of marijuana (argument, fight, accident, bad result at school)?					

53. (Do not ask this question if the responses to Q20A. & Q30A to Q30Y are all NO. Skip to Q54) Over the PAST 12 MONTHS, how often have you experienced or lived the following situations because of alcohol or illicit drug use?	0. Never	1. Rarely	2. Sometimes	3. Fairly often	4. Very often
a) Performing poorly on an important test or project					
b) Getting into trouble with the police					
c) Getting involved in an intense argument or fight					
d) Memory loss					
e) Having domestic problems					
f) Being taken advantage of sexually or having someone take liberties with you					
g) Taking sexual advantage of someone or taking liberties with another person					
h) Trying in vain to stop drinking or taking illicit drugs					
i) Self-inflicting injuries					
j) Thinking seriously about committing suicide					
k) Attempted suicide					
l) Had serious money problems					

54. Have you ever used marijuana in any of the following forms? (Tick all that apply)	55a. Have you ever used marijuana for a medical condition?
☐ 1. Drinks (tea, juice etc.)	
☐ 2. Edibles (pastries, candy/sweets, cooked/uncooked meals)	☐ 1. Yes

☐ 3. Concentrates (Oils, shatter, budder wax etc.) ☐ 4. Other, specify _____ ☐ 5. I have never used marijuana in any form ☐ 0. No response	☐ 2. No (Skip to #56) ☐ 0. No response (Skip to #56) 55b. If yes, specify medical condition_____

56. (Do not ask this question if the responses to Q20A, & Q30A to Q30Y are all NO. Skip to Q66)
Have you driven a vehicle in the past 12 months?
☐1. Yes
☐2. No (skip to #59)

During the past 12 months (Do not ask this question if the responses to Q20A, & Q30A to Q30Y are all NO. Skip to Q66)		1. YES	2. NO	0. no response
57.	Have you driven a vehicle while you were under the influence of alcohol?			
58	Have you driven a vehicle while you were under the influence of illegal drugs?			
58b	Have you driven a vehicle while you were under the influence of marijuana?			

Treatment

(Do not ask this question if the responses to Q20A, & Q30A to Q30Y are all NO. Skip to Q66)

59. Have you ever in your lifetime received treatment for alcohol or drugs?

	1. Yes
	2. No (Skip to #64)
	0. No response

60. And, over the past 12 months, have you received treatment for alcohol or drugs?

	1. Yes
	2. No (Skip to #64)
	0. No response

61. When you were treated in the past 12 months, was it only for alcohol, only for drugs or for both alcohol and drugs?

	1. Only for alcohol
	2. Only for drugs
	3. For both alcohol and drugs
	4. Don't know
	0. No response

62. With respect to the last time you were being treated for alcohol or drugs.

	1. Were you admitted in a rehabilitation center or a therapeutic community?
	2. Were you going to an outpatient health or rehabilitation center?
	3. Were you going to the office of a private practitioner?
	4. Were you going to a self-help group such as Alcoholics Anonymous (AA).
	5. Another situation, specify_____

63. How long did you spend on this last treatment episode for drugs or alcohol?

Months

64. Over the past 12 months, have you felt the need for help or treatment of some kind to reduce or stop drinking alcohol or taking any drug?

	1. Yes
	2. No (Skip to #66)

65. Which of these statements explain why you did not get the treatment or counselling you needed for your use of alcohol or other drugs? (tick all that apply)

	1. I could not afford the treatment
	2. Treatment not covered on health care plan
	3. No transportation, too far away
	4. I could not find the type of treatment that I wanted
	5. I am not ready to stop using
	6. There was no space in the treatment program
	7. I don't know where to get treatment
	8. Treatment might cause neighbours to have a negative opinion on me
	9. Treatment might have a negative effect on my job
	10. Other, specify_____

66. As far as you know, how much of the activities listed below are in your neighborhood?	A great deal	Some	Little	None	Not known / no answer
a) Drug dealing/trafficking					
b) Breaking and entering homes					
c) Scribbling graffiti on the walls, damaging cables or things of that kind					
d) Taking drugs in public place such as the street or squares, or on the block.					
e) Armed robbery or mugging in the street					
f) Young people standing around or loitering at street corners or on the block.					
g) Shootouts and violence with firearms					

67. Do you believe that, over the past few years, taking drugs in the country has increased, remained the same or declined?

	1. Increased
	2. Remained the same
	3. Declined
	4. Don't know
	0. No response

68. Do you believe that, in coming years, the drug problem is going to get worse, remain the same or decline?

	1. It's going to get worse
	2. It's going to remain the same
	3. It's going to Decline
	4. Don't know
	0. No response

69. Do you believe that the drug issue is among the core concerns of the government?

	1. Yes
	2. No
	3. Don't know
	0. No response

70. Do you know of any drug prevention program being implemented in your neighborhood or community?

	1. Yes
	2. No
	3. Don't know
	0. No response

71a. Do you know the name of the national drug control agency?		71b. Do you know the name of the **country's** national drug prevention agency?	
	1. Yes		1. Yes
	2. No		2. No
	3. Don't know		3. Don't know
	0. No response		0. No response

72. Focusing now on just marijuana, how much do you agree with the following measures?	Completely agree	Agree	Disagree	Completely disagree	Not known / no answer
a) Allow marijuana to be used for medical and therapeutic purposes					
b) Allow marijuana to be used for religious purposes (e.g. Rastafarians)					
c) Allow marijuana to be grown in limited amounts by individual households					
d) Allow possession of marijuana in limited amounts, for personal use					
d) Allow persons who are addicted to marijuana and other substances, who commit crimes such as theft, to be put into a court supervised drug treatment program instead of prison					
e) Allow tourists to use marijuana for medical or therapeutic purposes, with a permit					
d) Allow marijuana to be cultivated for scientific research					