An Analysis of Cannabis Reform in Bermuda

Final Advisory Document

Prepared by members of the Cannabis Reform Collaborative

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1. Executive Summary

The concept for the Cannabis Reform Collaborative was developed and lead by Stratton Hatfield and Khomeini Talib-Din after they separately approached the Minister of National Security Michael Dunkley to address cannabis reform in Bermuda. After getting approval to begin the process, they reached out to members of the public and asked them to volunteer their time and expertise to consult with the public and study the topic of reform. The CRC was later created in December of 2013 to research and assess current cannabis policy from health, human rights, cultural and economic perspectives in an effort to provide a fair and inclusive overview of solutions for the Government to consider when amending or proposing future legislation. The CRC has been lead by a group of nine core volunteer members, who in partnership with the Ministry of National Security, have spent the past four months consulting with stakeholders and the public to research the topic of cannabis reform as it relates to Bermuda. The following CRC members have played an active role to complete our mandate:

Stratton Hatfield
Lamar Caines
Cordell Reilly
Robyn Swan
Alex Jones
Joleesa Simons
Khomeini Talib-Din
Jules Van Belen
Dr. Ernest Peets
Kyle Bridgewater
Harry Masters

This document is intended to provide information and facts related to cannabis reform that in turn informs sensible recommendations for the Government and people of Bermuda to consider. For the purpose of this paper, the Latin species name of the substance Cannabis, otherwise known as Marijuana, Ganja, Erb, Weed and Pot amongst many other names, will be used.

We need to change our approach to Substance use & abuse

There is strong evidence and a growing conviction globally that the international 'war on drugs' has been an epic failure in terms of its stated objectives to stamp out drug use and eliminate supply: since the 'war of drugs' was implemented, use/demand along with supply has dramatically increased. A 2011 report, produced by The Global Commission on Drug Policy concluded that the international war on drugs has failed to stop organized crime, cost taxpayers billions of dollars and caused thousands of deaths, with no decrease in the number of addicts. In Bermuda, a total of $20.8 million was spent administering our drug plan in 2012. Treatment comprised the bulk of expenditure totaling $12.6 million (60.5%), with enforcement costing $7.4 million (35.3%), and prevention costing $780,000 (3.7%). With an increase of prevention

initiatives and school wide curriculum efforts around substance use Bermuda could observe a decline in substance use and less of a demand for treatment. The public and future of Bermuda must understand any positive or negative consequences related to substance use and abuse while working towards a healthier community.

The CRC recommends

1. Ensure the new master DNDC plan focuses on managing substance use from a health centered approach
2. Age of consent for access and consumption of Cannabis and alcohol should both be twenty-one (21).
3. Treatment continuum should create cannabis specific services to assist those with dependence
4. Companies providing group health insurance must offer insurance coverage to treat alcoholism and drug addiction
5. Government continue to consult with employers, unions, and insurance companies regarding a substantial change in law and policy to protect workers rights.

Cannabis Prohibition isn't working

Individuals prosecuted and incarcerated for non-violent crime related to cannabis are overwhelming the criminal justice system. As a result youths are being lost as useful members of society, relegated to a life path, which includes the challenges that accompany having a criminal record. Based on available data, it is estimated that the rate of Bermudians being criminalized for cannabis convictions is higher than the Bermudian population growth rate during the period of 2006 - 2011. During this time period the Bermuda born population grew by 719 people while 775 Bermudians were convicted for cannabis related offences. Similarly the overall number of people put through the justice system for cannabis related offences in Bermuda is staggering. Between 2003-2008 there were 2,227 cannabis offences (an average of approximately 370/year), and in the period 2011 - 2012, there were 822 cannabis offences (an average of approximately 411/year), averaging to at least 1 cannabis offence per day, and increasing. These figures illustrate the social and economic burden borne by Government in relation to enforcing cannabis laws.

Furthermore, the criminalization of cannabis has been paralleled with disparity along racial lines in terms of enforcement, sentencing, incarceration and related health issues, all of which contribute greatly to the societal challenges of structural racism. Indeed the history of Cannabis prohibition is fraught with nefarious motives linked to the discrimination of non-whites and immigrant populations. As a result, a great number of groups around the globe, variously

comprising lawmakers, enforcement officers and medical practitioners as well as civil rights groups have called to dismantle this dubious history and realign drug policies in the context of human rights and dignity.

The CRC recommends:

1. That the Minister use the statuary powers to proactively enact reform
2. Decriminalize personal possession and personal cultivation immediately
3. Develop a phased approach to cannabis reform and policies that limit potential of Bermudians being denied access to the United States (Stop List)
4. Introduce a less punitive warning system ie: civic penalties, a substance tribunal and harm reduction/education initiatives
5. The Department of National Drug Control be placed under the Ministry of Health and a greater emphasis on demand reduction with a focus on prevention and treatment be the overall focus of drug policy in Bermuda.

Cannabis can be used as a medicinal substance

Cannabis as a medicinal substance is gaining global prominence and there are an overwhelming amount of pre clinical studies supporting the therapeutic potential of cannabis. In Bermuda, patients are requesting special permission from the Minister to use cannabis medicinally to enable them to have it imported with challenges. The community has identified strong interest in the growing medical research and many are seeking more information and access. Based on the amount of diseases and conditions present in Bermuda's population, hundreds of people could benefit from access to medicinal cannabis and research. Significant shifts in international policy and positions taken by a number of countries offer a range of possibilities in terms of legislative and policy reform options for Bermuda, grounded within an international context.

The current emotional, moral and legislated responses to cannabis are largely based on fraudulent motives devised within the last century, by other jurisdictions, with devastating and wide reaching impacts for a historically beneficial and widely used medicinal plant. Specifically, a significant and growing body of research continues to highlight and expand the medical potential of cannabis, but its illegal status deprives access to individuals with often life threatening diseases or chronic ailments, and the dignity to choose for themselves alternative forms of treatment for their own bodies.

The CRC recommends that the Government:

1. Take immediate action to enable access to medical cannabis with a prescription to individuals by way of a regulation under the existing

legislation, until such time as revised legislation is drafted.

2. Provide resources to physicians to effectively prescribe cannabis as a medicine
    1. Research, develop and implement a regulatory model for medicinal cannabis production distribution and use and,
    2. Classify the plant as a prescription substance where those doctors may have the resources and framework to prescribe the substance to patients in need.

We need a long term strategy for substance prevention

Effective health and wellness programs focused on education and treatment initiatives, managed through regulations and which aim to reduce substance use and abuse are vital to a healthy future. The Global Commission on Drug Policy Report of 2011 calls for actions that focus on health and treatment services for drug users. Substance abuse is a health issue which should be addressed without recourse to criminal penalties through the justice system.

The Department for National Drug Control (DNDC) has been functioning under an initial master plan for the period 2007-2011, which included a concerted education and prevention programme. The success of this approach correlates with research and evidence from other countries that a concentrated effort to educate the youth on health matters related to substance abuse is effective, and that youth do make sound choices when given access to good information. The fruits of this effort are borne out in the data contained in the recently released Student Survey 2013 survey, which supports the wider view that indicative prevention is an effective tool. The next master plan being developed by the Department of National Drug Control for the next 5 years must be a new and progressive approach to this social issue, grounded in human rights and dignity for all, with more balanced funding to support efforts to manage and support substance abuse through prevention, education and treatment.

The CRC Recommends

1. Increase resources for prevention and educational initiatives
2. Prevention resources (funding) should be targeted to those who are at high risk for addiction and/or directed towards those who have been identified as persons manifesting symptoms/problems regarding addiction; rather than addressing prevention from a universal point of view.
3. Redirect portions of funds dedicated towards drug interdiction towards prevention and treatment resources

Now is the time

Now more than ever, Bermuda must consider the best way to effectively regulate cannabis so that all sectors of society are given access to sound information to make conscious decisions; and users or abusers are treated as patients rather than convicted criminals. There is a wealth of evidence and experience worldwide on a range of effective strategies and programmes to develop a sustainable cannabis model. Bermuda must implement effective policies and programmes relevant to the problems and challenges in our country. A cannabis model that is localized for Bermuda's population and culture will:

- Drastically reduce government expenses and redirect funds towards demand reduction
- Ensure portions of the population are not criminalized due to cannabis supply & use
- Provide stronger and broader prevention education initiatives
- Supply treatment for people with cannabis dependence
- Empower people to be more knowledgeable about cannabis uses and effects

Bermuda has the opportunity to proactively change the cannabis policies so that they are cost effective, equitable and considerate of human rights. The longer we continue with the current approach, the more people risk losing their livelihoods, access to opportunities or the potential to treat a disease with a natural medicine.

2. Case for Cannabis Reform

Bermuda's Misuse of Drugs Act, discussed in detail in section 5, has remained largely unchanged since 1972. By contrast, many governments, including countries ravaged by violence related to drug crimes are reviewing their approach to substance abuse and illegal drugs. Bermuda's drug related crime is funded primarily through the sale of drugs according to the DNDC. As noted by the DNDC, and as Cannabis is the most widely consumed illegal drug it is likely that it is the cash cow for most gangs. In 2012, 68.8% of drug crimes were related to cannabis, with personal possession of cannabis accounting for 58% of all drug offences. As stated by the Commissioner of Police 92% percent of those charged with personal possession are Bermudians. The impact of a criminal record can have lifelong consequences for an act where the crime is less harmful than the punishment. Regardless of whether these crimes are a youthful misjudgment or a psychological vulnerability of some sort, the result is the same: it severely impacts the future education and employment opportunities, and in some cases pushes people further into an underworld of crime.

The media has increasingly produced very regular reports about both locals and visitors being tried and convicted for actions related to the production, supply and use of cannabis. A comparative review of judgments passed down related to Cannabis cases puts the gravity of these infractions at par with violent crimes involving premeditated harm to others. When viewed in this context, the meting out of justice appears clearly skewed.

Out of a series of meetings, events and focus groups hosted by the CRC, the general consensus of participants was that the review of cannabis laws is extremely timely, some stating that reform is long overdue. A more thorough review of the focus groups and public consultation is in section 3.

Global Drug Policy & Bermuda

Many governments, including Bermuda, adapted and maintained drug policies implemented since 1961 Single Convention on Narcotic Drugs by the United Nations (UN) drug control conventions, whose focus was on law and enforcement operations to stifle and eradicate the supply of illegal drugs. Jurisdictions all over the world are now re- evaluating their previous commitment to these strategies and there is mounting pressure to reform the UN Convention. (See Appendix 3) In the context of Cannabis Reform, The Bermuda Government must consider how reforming current laws, strategies and programmes could make the most effective use of resources and achieve the fundamental objective of drug policy: to maximize human rights, security, health and development.

When addressing a Case for Cannabis Reform, the following areas should be considered:

Social

- The United Nations (UN) system has publicly drawn attention to the breach of fundamental human rights and freedoms in the pursuit of drug control objectives - refer to section 4 - Cannabis Then & Now
- An overwhelming amount of Bermudians are being convicted for cannabis related crimes which is impacting the people, their families and community at large - refer to section 5 - Current Legislative Framework, Policies & Impacts
- The public perception of cannabis is shifting and more people are in support of reformed policies - refer to section 6 - Local Cannabis Culture
- Cannabis Prohibition has had an inequitable racial impact, with blacks bearing a majority of all charges - refer to section 4 - Cannabis Then & Now
- There is a demand for more resources to be applied to overall substance prevention, education and treatment - refer to section 7 - Social & Health Perspectives

Economic

- There are significant and far reaching negative and costly consequences of implementing the current policies (for example, the increased profits of the black market and reach of organized crime and gangs) - refer to section 8 - Economic Considerations
- Reducing the overall scale and impact of the local drug market has proven resource intensive with negative social consequences - refer to section 7 - Social & Health Perspectives
- There is an opportunity to redirect saved resources towards prevention and treatment services to protect the community - refer to section 7 - Social & Health Perspectives
- Vast amounts of locally earned money are leaving the country with respect to the importation of cannabis within the unregulated black market - refer to section 8 - Economic Considerations
- There is the potential for a cannabis industry to thrive as thousands of locals regularly consume cannabis which could increase Government revenue - refer to section 8 - Economic Considerations

Health

- Cannabis has been proven to be less harmful than other legal substances - refer to section 7 - Social & Health Perspectives
- Cannabis is being used to treat many symptoms and diseases around the world - refer to section 9- Cannabis as a Medicinal Substance
- Substance related health problems and sub quality products have created long term health consequences - refer to section 7 - Social & Health Perspectives
- There is a growing global emphasis on addressing addiction from a health approach rather than a criminal justice approach - refer to section 7 - Social & Health Perspectives

Ultimate Aims of Cannabis Reform

It should be inherently desirable to:

- Mitigate the long term consequences of cannabis offences,
- Implement medicinal cannabis access for patients in need,
- Minimize the use of cannabis in the population,
- Raise the age of first use of cannabis to the age when brains are mature,
- Minmize cannabis dependence, and provide support and treatment
- Ensure factual and relevant information about cannabis is public
- Develop regulations around community consensus

3. Community Consultation

The CRC coordinated a variety of consultation efforts to learn more from the public and understand the perception of cannabis reform locally. Over the course of three months, five focus groups, a town hall forum, e-survey, public and government stakeholder solicitation and Facebook group interaction was completed to ensure a wide array of information was collected. The Government of Bermuda empowered the Cannabis Reform Collaborative (CRC) to engage the public and stakeholders to review the positive and negative effects of Cannabis laws and policies in Bermuda. The CRC was required to assess current cannabis policies and legislation in an effort to provide the Government with factual information about the topic of cannabis reform. The aim of the CRC was to provide an inclusive overview, taking into account, and not limited to: health, human rights, spiritual, cultural and economic perspectives.

Below are summaries of the findings from our public outreach:

Focus Groups and the Emerging Themes

The CRC conducted seven focus groups during February and March. Groups consisted of anywhere from six to twelve persons with attempts made to ensure that groups were racially and gender-balanced. The seven groups consisted of the following:

FG 1 - 25 - 35
FG 2 - Bermuda College - 18 - 24
FG 3 - 36 - 45
FG 4 - 55 +
FG 5 - Bermuda College 18 - 24
FG 6 - Persons in Recovery for Drug Abuse
FG 7 - Persons in Recovery for Drug Abuse

In the interests of time, the focus group results were combined and analyzed by key phrases, a minimum of three words and a maximum of six, using the Wordstat 6.1.13 program. The ideal way would have been to analyze the groups separately using underlying themes. This exercise can be done at a later date, if there still remains a demand for the information. While there were some 24 emerging themes, only the salient ones are dealt with below.

Stop and Search (11 mentions)

The top theme emerging was 'stop and search.' The discussion surrounding this theme was that many young men, Blacks in particular, encountered the criminal

justice system through what they deemed were unfair practices. With police using the powers of section 315F of the Criminal Code, they could stop anyone at will, without probable cause . While these searches were intended to assist in reducing crime, they had the unintended effect of criminalizing otherwise law-abiding citizens with grave consequences. The follow verbatim comment sums up the sentiments in this group.

"You've got people whose families are ripped apart with young men being put in jail and you have disparities in sentencing, you have gross disparities in 315F stop and search and people get introduced to the criminal justice system who may be carrying Cannabis on the same proportion; blacks and whites, but 90 percent of the stop and search are on black people, they are getting introduced into the criminal justice system and being held to a different standard and they are being ripped out of families, then have educational opportunities ripped away from them, they are going to jail, they are unable to earn for their families they have that on their record and it is hard for them to get a job."

Amounts of Cannabis (7 mentions)
The main discussion surrounding this theme was that people's lives were being wrecked for relatively small amounts of marijuana, usually just a few grams. One participant put it this way:

"…go down on a Friday or Saturday night to the police station, it was packed full of young black males being processed and most of them being processed for outstanding warrants, could have been nonpayment of car fees; it could be nonpayment of parking tickets; it could be nonpayment of child support; the other frequent one was minor amounts of marijuana. So here are these young people who normally would not have been picked for anything, because there was no probable cause being put into our criminal justice system…"

Alcohol is Legal (7 mentions)
There were a number of comments comparing alcohol to marijuana. For instance, alcohol was once illegal; it was classified as a harmful drug, criminalizing people, and the like. After it became legal, the same discussions around who was going to economically benefit from it, as is currently taking place-surrounding marijuana, ensued.

An example of a comment follows.
"...before alcohol was legal, you had people making it in their backyard and then that created a whole community of lawbreakers. Now that alcohol is legal you don't see that. You see it still in the south a little bit, but you don't see that

anymore, because you can just go to the store and buy it so the fear of taking it out of the hands of the local, let's say the local drug dealers, and putting it–even if you put it–we say big business, whereas you go into a store and buy it, we say oh who is going to make that money…"

Benefits of Cannabis (6 mentions)
Mentions on this theme focused on the fact that most public knowledge about Cannabis was negative due to its illegal status. Respondents pointed out what they saw as the positive benefits of Cannabis and felt that an education campaign was required to reverse negative perceptions.
"I agree and just to a point as far as educating people as far as the benefits of marijuana, I'm just telling you right now, now there is an education to tell you all the bad things about Cannabis and other drugs so unless they change their thought process and start putting up posters...."

Criminal Justice System (5 mentions)
Discussion around this theme was on 315F, race and inequalities in the system that caught Black males disproportionately to White males. Some played these inequalities to their advantage.

"I was hired by a white person who said listen, you know, my son is in trouble; the magistrate is black, the police are black, the prosecutors are black and they also felt that their son was probably going to be made an example out of because the courts did not want to look like they were going to treat him differentially. So as I was focusing on what has happened to the black community I was actually addressing the structural aesthetic effect that our criminal justice system has had on the blacks in reference to what happens to individuals."

Effects of Cannabis (5 mentions)
While advocates of Cannabis extol its perceived benefits, others are concerned about its possible effects. One comment summed up the discussion:
"One of the concerns I have is a bit of research a while back that talked about a pilot's ability to pilot the aircraft and you know that you are not supposed to take alcohol 24 hours before, which is not as easy–I mean it doesn't happen too often chaps and women are drinking and driving the aircraft anyway, but the result–included in that was the use of Cannabis and it seems that the high or the detrimental effects of Cannabis lasts a number of days and with this piece of research, the ability to land the aircraft was seriously curtailed from having smoked multiple days before."

To see an overview of the results collected from the focus groups hosted for

adults persons in recovery of drug abuse reference Appendix 3.

Cannabis Conversation Forum

The CRC hosted a "Cannabis Conversation" on the 25th of February, at Manchester Unity Hall providing the community with a unique opportunity to learn more about and discuss the topic of cannabis reform. One of Bermuda's best spoken word artists and community facilitators, Tiffany Paynter, co hosted the event with Stratton Hatfield and members of the CRC. It was designed and produced in a customized format of World Cafe and the Art of Hosting where attendees were encouraged to come prepared to listen and discuss the questions, Should we reform our cannabis policies? and How do you think cannabis reform will impact our work, our lives and our community?. Four special guests presented from experience in prevention, law enforcement, addictions treatment and medicinal cannabis with local and international perspectives after which smaller groups had the opportunity to discuss and ask questions.

Guests included:

- Judith Burgess the founding Member and Executive Director of PRIDE Bermuda and the Chairperson for the Bermuda Coalition.
- Dr. Chantelle Simmons a Consultant Psychiatrist at Mid Atlantic Wellness Centre for the Acute West (General Adult Psychiatry) and Turning Point (Substance Abuse Treatment Programme services)
- Dr. Jeffrey Hergenrather a Cannabis Consultation Physician and the Vice President / Secretary, American Academy of Cannabinoid Medicine (AACM)
- Jack Cole a retired Detective Lieutenant with the New Jersey State Police for 26 years — 14 in narcotics, who founded Law Enforcement Against Prohibition.

The CRC was fortunate to have an illustrator by the name of Susan Mcleod attend the event and graphically harvest some of the dialogues and presentations. Her attendance helped provide visual insight into the many topics rose during the forum and assistance with compiling the community's feedback.

At the end of the evening, attendees were invited to write on a post it note and explain what type of Cannabis Reform they supported.

Debrief from Cannabis Conversation Vote

Out of the 70 people that decided to participate in our voting exercise at the Community Conversation 77% were in support of cannabis reform stating Yes to reform. Comments included full blown legalization, medical regulation, sensible

regulations, human rights and home growing opportunities. A further 18% were in support of reform only if considerations were factored into the discussion. These "only if" statements were centered around further education initiatives, medicinal uses, increased regulations and more prevention efforts. Only 4% of those in attendance did not support any cannabis reform - one stating "hell no".

e-Survey Analysis

This section will discuss the self-selected, non-equal probability survey. As the quantitative survey was self-selected, the responses only represent those who participated and cannot be used to make inferences about the total population.

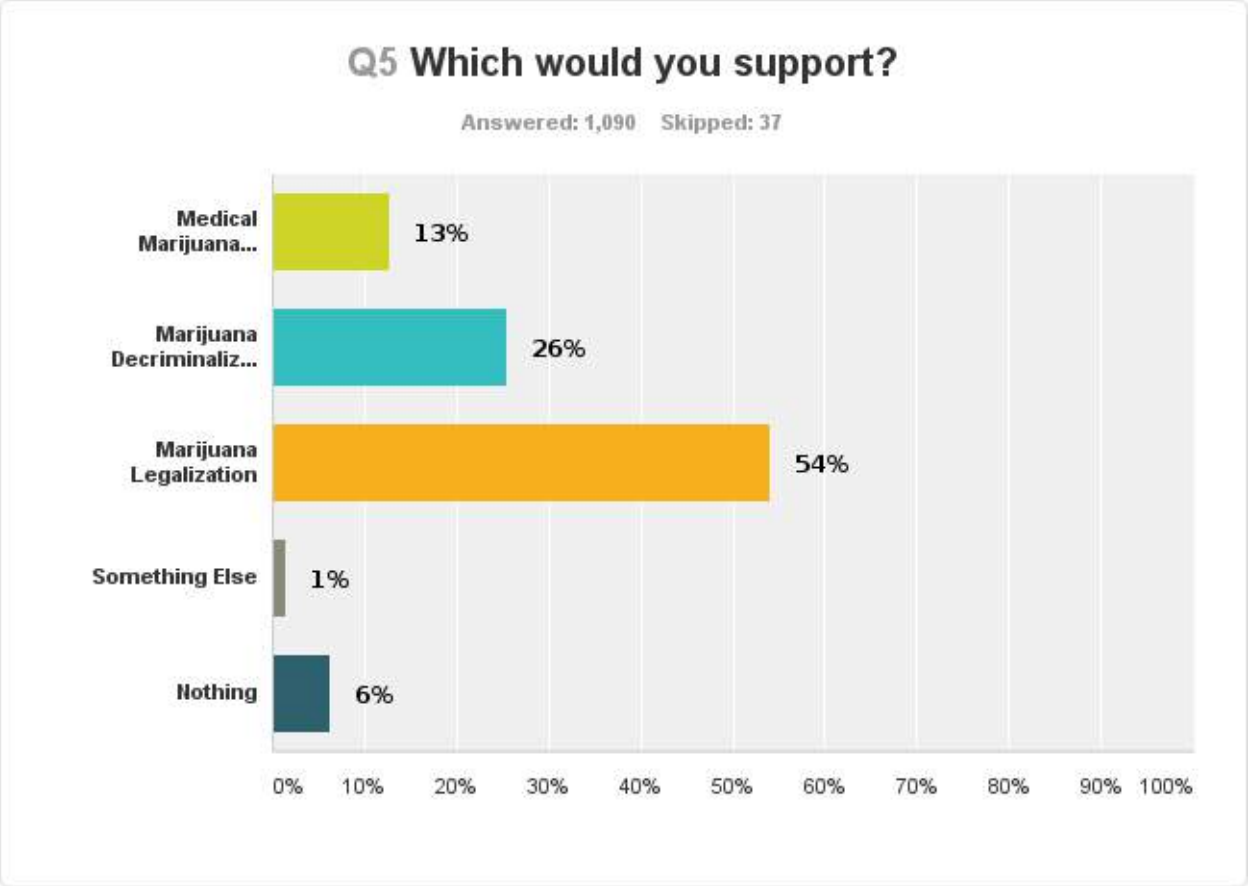
The quantitative survey was put into the public domain through Social Media press outlets and email distributions on March 13, 2014 and was closed on March 30, 2014 when some 1,112 persons had responded. The race demographic was initially omitted but was later added. This omission accounts for the number of non-responses for that question.

Demographics

Some 89% of respondents were Bermudian, 8% were non Bermudian, and the remainder being permanent residents. More than half (59%) of respondents were male while 41% were female. By age, 45% of respondents were between the ages of 18 and 34, while 41% were between 35 and 54, and 14% were aged 55 and over. Out of the 647 respondents who were able to answer the question on race, nearly half (47%) were White while 38% were Black and 14% identified as Other.

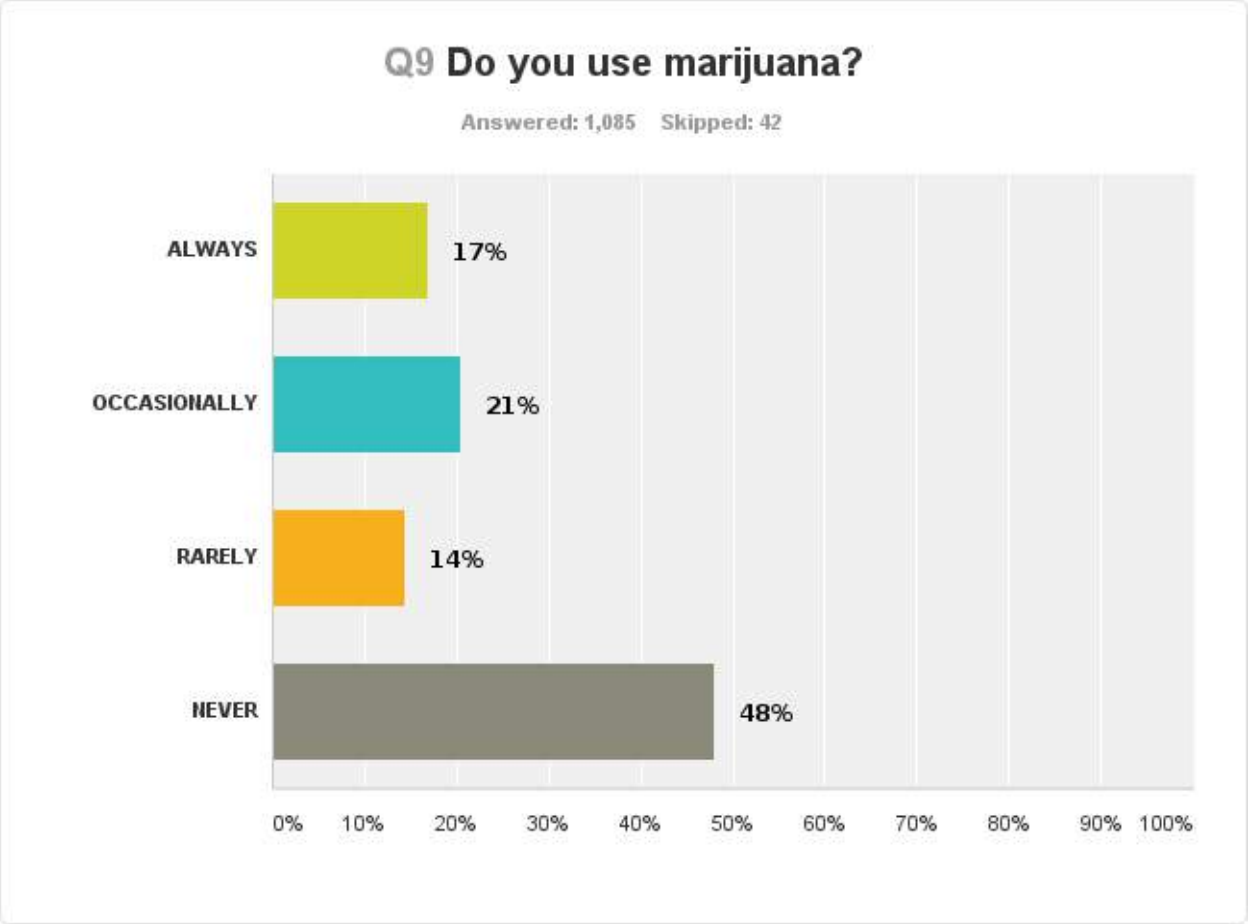
Form of Reform

When respondents were asked what form of reform they preferred, more than half (54%) chose the legalization of marijuana. Just over one-quarter (26%) favored decriminalization, and 13% favored medical Cannabis regulation. Less than 1 in 10 (7%) opted for either nothing else or some other choice. See the graph on the next page.



Use of Marijuana

Nearly half of all respondents (48%) claimed to have never used marijuana, while another 14% claimed to use it rarely. Just over 1 in 5 (21%) claimed occasional use, while just under 1 in 5 (17%) stated that they always used marijuana. What emerges from the two charts is that while just 17% claim to be regular users of marijuana, 93% support some kind of reform. A cross-tabulation by race and gender in particular, would shed light on who is actually pushing for Cannabis reform. Unfortunately the free Survey Monkey account did not allow for such analysis and time constraints do not permit further analysis in a more robust data analysis program. (See graph below on usage.)



Submission Analysis

For several months the CRC, have requested for submissions from the public and a series of innovative recommendations were received.

To our delight many Bermudians rose to the challenge. They produced honest letters of concern, and recognition for an issue that has plagued our island.

The following is a brief summery of the 40 odd submissions received.

Amendments to the legislation appeared to be the recurring theme, while a few stood out with a more radical approach to the issue of cannabis reform. For instance, one submission, dating back to 2009: "An attempt to reduce/eliminate gangs." This writing pulls to view the reality that legalization would "leave our judicial, and police departments to undertake more urgent matters. Resulting in more meaningful arrests, and prosecutions."

Yet another writer, Michel Brangman in his essay, "Cannabis in Bermuda," openly acknowledges, the correlation between gang related crime surrounding cannabis, and the current legislation. "I'm of the opinion that some form of regulation is needed for cannabis market in Bermuda. I would like to see provisions made for local cultivation, service distribution and the removal of the black market status to a legitimate enterprise." He continued to write, "My opinion is that there has not been effective leadership on this issue for decades. We have followed other countries and haven't realized that other countries are changing their laws.

Another submission goes as far to say that, "Today's gangs are a legislative creation. The Al Capone gangs went away when alcohol was legalized. Governments and, corporations, are not our friends. A concerned Bermudian wrote in an un named article, "I personally used to work as both a truck helper and a store clerk for one of Bermuda's largest wine, beer and spirit distributors. When I did so, especially working in the stores, I felt as if I was little more than a little drug dealer." The went on to write about the dangers of alcohol "In comparison to Cannabis whose negative side effects are overblown misstated or outright untruths often passed from mouth to mouth, and generation to generation without critical thought, the delirious effects of alcohol are widely know, and hard if not outright impossible to deny.

Our society has created a culture that has stigmatized Cannabis use. Even for medical uses. One submission entitled. "You asked for submissions for you group here is mine," read "My sister in law succumbed to cancer in Dec 2012, I told my brother to get her some Cannabis to make her feel better. He was afraid to do that because he never used it, and it was illegal.

As our society changes so must the laws. Bermuda has clearly evolved in such a manner that the stigmas attached to certain taboos such as Cannabis must be carefully examined. Another discussion paper from 2009, "Project Restart" by Charles Leon O'Brian explores the concept of regulation. He writes, "The underlining concept of project Re-start is to use a realistic life situation to lesson the impact of the drug industry in Bermuda" it continues to read, "We could and should find a way to get some of the plays to discontinue their unlawful roles in the drug trade, and introduce an option that does not conflict with the ideology and mentality that sets them in that direction."

It should also be noted that one submission has stood out, and may be considered radical. Due to its recommendation of full legalization is supported by a quite unconventional means of usage entitled, "Paradise/ Devils Isle." "An is land where Cannabis is legal to purchase, and consume. The Government will

sanction the island as separate form the main land. No one under the age of 21 is allowed on the island there is a maximum of 4 grams of Cannabis per person. No one is allowed to leave with marijuana."

Still others continue to draw attention to the fact that the consequences of a criminal system reach deeper then law. Bearing a harsh social consequence. In the submission, by Paul Giraud named, "He who Feels it knows it." "Locking up otherwise law abiding citizens for ganja alongside murderers, rapists, thieves, and hard drug addicts etc, has got to be one of societies most grievous crimes against humanity since the trans Atlantic slave trade. In fact, more black men are now in the US jails than there were slaves taken form Africa.

Spirituality was also taken into consideration as one submission openly explored the ideals of psychoactive potential of the plant. "The legalization of cannabis is a net benefit to society to allow the public to gain added perspective which leads to greater tolerance for difference by its very nature of expanding consciousness."

One individual who is a champion to the cause of cannabis reform in Bermuda is Alan Gordon submitted a detailed submission entitled "Bermuda Cannabis Policy Reform" We encourage the general public to read the entire document on Slide Share.com. It gives a full view of the current legislation and how it has negatively impacted our society. It provides realistic alternatives to the current legislation.

Alan Gordon has promoted his ideals threw various media sources, and his "Gunja Fever," is catching. His efforts have inspired others to educate themselves, and open their minds to the possibilities of cannabis reform. Several submissions have acknowledged his influence. One letter read, "I signed Alan Gordon's petition, and went to add my urgent plea for medical marijuana."

Even when it seemed that the need to change current laws are met with what appeared to be a landslide of support. Some Bermudians remain apprehensive, and articulated a genuine concern for the potential consequences of changes in legislation. In the submission, "Marijuana-Amend the Legislation" one concerned writer explained, "In respective of the outcome of effects of Cannabis on its users, Bermuda can not afford to lose positive contribution of any of its citizens to negative outcomes of substance abuse. It is well known academic achievement suffers, and social impairment can be obvious when an individual is under the influence of drugs."
The two long, strong and loud recurring themes of the submissions have been amendments to the current legislation, and medical marijuana. It has been

comforting to know that so many Bermudians are ready to see the issue of Cannabis addressed publicly. A lot of time, energy, research, and detail was put into each submission. This demonstrates the passion, and importance the community has placed on this issue.

Public & Stakeholder Solicitation (refer to Appendix 3)

- Bermuda Police Service
- Attorney General's Chambers
- Department for National Drug Control
- Workforce Development
- Bermuda Industrial Union
- Human Rights Commission
- Department of Family & Child Services
- Department of Corrections
- Department of Court Services
- Department of Health
- Department of Public Prosecutions
- PRIDE Bermuda
- Family Centre
- Dr. Andrea Barthwell - Former Deputy Director of National Drug Control Policy (USA)
- Dr. Chantelle Simmons - MAWI
- Jack Cole of Law Enforcement Against Prohibition
- US Consulate General
- People of Faith

The CRC also attended and participated in the following forums:

- CAN – Cannabis Awareness Network Event – an event which invited experts via Skype to discuss medical cannabis
- PLP Open Mic

Limits to Resources & Consultation

Due to time constraints and availability, many organizations that were contacted for comment and input were unable to submit formal responses. The nature of a volunteer committee lead by members of the public has impacted our ability to reach out to all relevant parties.

The CRC recommends:

1. **That Government continue to consult with the public and stakeholders about cannabis reform**
2. **Help the community understand what cannabis is and what reform means**

4. Cannabis – Then & Now

Culturally

Cannabis Sativa has been growing on the planet for thousands of years, as examined and recorded during countless archaeological expeditions conducted all over the world. Its value as a medicinal herb and a raw material with a wide range of fiber applications has been recognized by many cultures for millennia. Early references to cannabis come from India in the Atharva Veda from the second millennium BC and from tablets from the Royal Library of Ashurbanipal, an Assyrian King, who lived around 650 BC[1]. Although it is unclear when cannabis was first introduced to Europe; an urn containing cannabis leaves and seeds, unearthed near Berlin, is believed to date from 500 BC.[1] Cannabis has played a significant role in the religions and cultures of Africa, the Middle East, India, and China.

Medically

A Chinese treatise on pharmacology attributed to the Emperor Shen Nung and alleged to date from 2737 B.C. contains probably the earliest reference to cannabis and its potential as a medicine.[1] It was used in ancient Indian Culture before 2000 B.C.

At the turn of the twentieth century, the Indian Hemp Drugs Commission, which had been summoned in the 1890s to investigate the use of cannabis in India, concluded that the plant was so much an integral part of the culture and religion of that country that to curtail its usage would certainly lead to unhappiness, resentment, and suffering.[1] After thousands of years of use the U.S. passed the first federal law against cannabis, The Cannabis Tax Act in 1937, many well known pharmaceutical firms produced medicines that contained Cannabis and the substance was legally available in the United States until Cannabis was removed from the American pharmacopoeia in 1942[2] . Within less than 100 years turned from a cultural staple to societal pariah by direction of the United States and UN Conventions.

In 1970 the USA enacted The Controlled Substances Act and placed all illicit

1 http://www.ukcia.org/culture/history/
[2] 20 Legal Medical Cannabis States and DC
[2]http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881

and prescription drugs into five "schedules" (categories). The DEA website states:

> Drugs, substances, and certain chemicals used to make drugs are classified into five (5) distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential. The abuse rate is a determinate factor in the scheduling of the drug; for example, Schedule I drugs are considered the most dangerous class of drugs with a high potential for abuse and potentially severe psychological and/or physical dependence.[3]

The original intent was that Cannabis would initially be placed in Schedule I temporarily, while the National Commission on Marihuana and Drug Abuse (sometimes referred to as the Schafer Report) was completed. Notwithstanding the conclusions reached in this report, that

> "society should seek to discourage use, while concentrating its attention on the prevention and treatment of heavy and very heavy use. The Commission feels that the criminalization of possession of marihuana for personal is socially self-defeating as a means of achieving this objective"[4],

Cannabis remains on Schedule 1, alongside other far more dangerous and addictive substances. Bermuda followed this trend with the implementation of the Misuse of Drugs Act 1972, consigning cannabis to the same regulations as far more dangerous drugs. This position subsequently tainted the ability to research the medicinal and practical qualities of cannabis. The underlying science related to medicinal cannabis in recent research is investigated further in section 9.

Legally

The present system of worldwide drug control is based upon three international United Nation conventions. These are the 1961 Single Convention on Narcotic Drugs, as amended by the 1972 Protocol, the 1971 Convention on Psychotropic Substances and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. In 1968, under the provisions of the Single Convention,

[3] http://www.justice.gov/dea/druginfo/ds.shtml
[4] http://www.druglibrary.org/schaffer/library/studies/nc/ncrec1_17.htm *National Commission on Marihuana and Drug Abuse*, 1972, Raymond Philip Schafer et al., commissioned by President Nixon

the International Narcotics Control Board (INCB) was created as the 'independent and quasi-judicial monitoring body' for its implementation. The mandate of the INCB was subsequently strengthened, within clearly defined limits, under the 1972 protocol and extended to also monitor compliance of the 1971 Convention and to oversee the precursor control system established under the 1988 Convention.

Bermuda is bound by the Misuse of Drugs Act since 1972. Its implementation came in response to UN agreements, particularly the 1961 UN Convention on Narcotic Drugs. With its companion conventions the 1971 Convention on Psychotropic Substances and the 1988 Convention on Illicit Trafficking, these international instruments have guided global drug policy, and are the subject of continued discussion. These Conventions do provide some latitude in the control of various substances, particularly if for the use of medical or scientific purposes. However, the requirements imposed are subject to a varying degree of interpretation by disparate parties and various jurisdictions around the world.

100 years of Cannabis History Internationally

1906
Pure Food and Drugs Act Requires Labelling of Medicine, Including Cannabis

1915
Jan. 1915 - President Wilson Signs Harrison Act, the Model for Future Drug Regulation Legislation

1915-1927 - 10 States Pass Marijuana Prohibition Laws

1925
Feb. 19, 1925 - League of Nations Sign Multilateral Treaty Restricting Cannabis Use to Scientific and Medical

1928
1928 - Cannabis Added to the UK's "Dangerous Drugs Act"

1930s
1930s – Decrease of the well-known herb and useful plant name of Cannabis and an increase in the negative campaign name for the same herb with the word "Marijuana" in the US.

By Contrast 1930s - American Pharmaceutical Firms Sell Extracts of Cannabis as Medicines

1930
1930 - Harry J. Anslinger Appointed Commissioner of the Federal Bureau of Narcotics

1933
1933 - William Randolph Hearst an up and coming newspaper tycoon, owner of thousands of hectares of timber to be used in making paper Plays Role in Denouncing Marijuana, its hemp products a stiff competition to selling tree paper.

1936
1936 - Bureau of Narcotics Urges Federal Action to Control Marijuana

1936
1936 – New Medications Opium and otherwise derived Supplant Marijuana as Treatment for Pain
1936 - Reefer Madness Originally a small town church production, the rights were purchased by parties with particular interests and the film was adapted further to become the marketing tool for spin as the Film Cautions Against Marijuana
By Contrast on May 4, 1937 - American Medical Association Opposes the Proposed Marihuana Tax Act and Supports Research on Medical Cannabis

1937
Oct. 1937 - "Marihuana Tax Act" Enacted
Oct. 2, 1937 - First Marijuana Seller Convicted under US Federal Law Is Arrested

1938
1938 - Canada Prohibits Cannabis Cultivation

1942
1942 - Marijuana Removed from US Pharmacopeia

1944
LaGuardia Report Concludes Marijuana Less Dangerous Than Commonly Thought - The 1944 report, titled "The Marihuana Problem in the City of New York," but commonly referred to as the "LaGuardia Report," concludes that many claims about the dangers of marijuana are exaggerated or untrue.

1951

1951 - Boggs Act Establishes Minimum Prison Sentences for Simple Possession

1952

The Immigration Nationality Act (INA) was enacted. The US "Stop List" began its formation

1956

1956 - Inclusion of Marijuana in Narcotics Control Act Leads to Stricter Penalties for Marijuana Possession

1961

1961 - UN Convention Provides Basis for Prohibition of Marijuana

1964

1964 - THC, Main Psychoactive Component of Cannabis, First Identified and Synthesized

1968

Nov. 1, 1968 - UK Wootton Report Finds that "the long term consumption of cannabis in moderate doses has no harmful effects... Cannabis is less dangerous than the opiates, amphetamines and barbiturates, and also less dangerous than alcohol..."

Apr. 8, 1968 - President Johnson Creates Bureau of Narcotics and Dangerous Drugs (BNDD)

1970

1970 - Controlled Substances Act Classifies Marijuana as a Drug with "No Accepted Medical Use"

1970 - NORML (National Organization for the Reform of Marijuana Laws) Founded

1971

1971 - UN Convention on Psychotropic Substances

1971 - UK Introduces Drug Classification System & Misuse of Drugs Act

June 17, 1971 - President Nixon Declares "War on Drugs"

1972

1972 - Bermuda GVT Enacts Misuse of Drugs Act Cannabis made Illegal

1973
1973 - Drug Enforcement Agency (DEA) Established

1974
1974 - NIDA Established, Placed in Charge of Contracts to Grow Marijuana for Research Purposes

1976
Marijuana Decriminalized in the Netherlands

1978
1978 - Federal Government IND Compassionate Use Program Supplies Patients with Marijuana

1981
1981 - Legal Medical Marijuana Patients Form Organization to Help Others Obtain Access

1985
May 1985 - Marinol Approved by FDA

1986
1986 - Anti-Drug Abuse Act Increases Penalties for Marijuana Possession and Dealing

1990
1990 - Scientists Discover Cannabinoid Receptors

1991
Nov. 5, 1991 - First Medical Marijuana Initiative Passed in San Francisco

1992
1992 - Scientists Discover First Endocannabinoid

1996
Nov. 5, 1996 - California Becomes First State to Legalize Medical Marijuana

Human Rights & Racial Injustice

In order to understand possible outcomes of any moves to reform cannabis laws, it is necessary to examine the historical construction of Bermuda, specifically the social construction of two Bermuda's. In this section of the paper, a brief history of the racial development of Bermuda will be provided, along with the rationale behind the legalization of drugs laws in the United States, and their outcomes for people of color, in particular males; the manifestation of Bermuda's development today, and the reason why the focus cannot simply be on the drug when considering reform.

The Social Construction of Two Bermudas

It only took just a few years after English settlers arrived in 1612 to embark on a course of constructing two Bermuda's - one beneficial to Whites, the other denigrating to Blacks. In 1616, the first people of color were brought to the island to dive for non-existent pearls; they were indentured servants and not slaves in the normal sense. But by 1623, the first of a string of Acts were passed by the fledgling colony. This first Act prevented Blacks from engaging in business without the permission of their White masters. In 1663, perhaps in response to the growing Black population and the need to keep the White race 'pure,' miscegenation was prohibited. In 1704, the settlers past the 'insolence of Negros' Act which carried the punishment of castration for Blacks. In England, where the final authority for decision-making was held, the law was repealed a year later on the grounds that it was too "inhumane."

The construction of such laws continued for centuries. In 1833, the Black population was 4,898 compared to 4,297 Whites. Of the Black population, however, 74% were slaves. This was significant because in 1834, when Britain freed all slaves in its colonies, including Bermuda, there existed the potential for political power to switch from the landed gentry to former slaves. To ensure that that would not happen, the settlers passed an Act to 'fix the qualifications of jurors, voters, and the electors of candidates for certain offices and positions of trust' to a level thought to be unreachable by newly-freed slaves.

The early settlers also raised the property qualification for voting from £40 to £100, and the fee to run for the House of Parliament from £200 to £400. This would not have been onerous for the settlers as the owners of the 3,612 slaves would have received various amounts of money from the £20 million pounds paid out to slave owners, 40% of the British Government's budget, to compensate for their 'loss.' There were some 1,116 claims by Bermudian slave owners who would have received varying amounts depending on the value placed on their slaves. For instance John Tucker, who owned 22 slaves, received £284 9S 4D. However Catherine Tucker, who owned 8 slaves, received £89 16S

10D.[1] Based on these payouts, it is likely that the total figure paid to Bermuda's slave owners exceeded £40,000. Slaves received nothing. Due to their professions, some free Blacks became wealthy[2] and were able to purchase land, such as Pilot Darrell, whose descendants still live on the property he purchased today. However, it would take nearly 50 years, in 1883, for the first Black man to be elected to Bermuda's parliament.

By the late 1800's, the foundation for the two Bermudas had been firmly made and the structure was now complete. In the early 1920s, the peaceful village of Tucker's town, mostly but not entirely inhabited by Blacks, was earmarked for development as a tourist resort. The land was taken away by the equivalent of a Special Development Order. In dispute was the purchase price . For instance a Royal Gazette story at that time indicated that one property owner was offered £350 for their property but they were asking £5000 for it. Descendants of the former property owners contend to this day that their ancestors did not receive fair market price for their land, which would be worth in the $100s of millions today.

While the structure for the two Bermudas had been built , it was not without its attacks. In 1959 a theatre boycott was arranged by young, newly-graduated college students . At that time, theatres were mostly frequented by young Blacks, who had to sit on the lower floors while Whites set in the balconies. The students, who had pursued their degrees in Canada, were not used to the stark racism they found in Bermuda and decided to do something about it. While this successful boycott led to the formal makers of segregation being removed, the structure remained in place which paved the way for future social unrest.

In 1967, after a racial dispute occurred after Whites were admitted to an event ahead of Blacks who were standing in line, riots ensued. A Royal Commission was set up by Sir Hugh Wooding to look into the underlying causes of the riots and to make recommendations to prevent such activity in the future. In his conclusion Sir Wooding wrote the following.

"… the roots of the civil disorders lie deep in the history of Bermuda's society. The society was typically white plantation in character and the history, in the years before the forties, was of accepted white supremacy with all the concomitant evils of segregation."
Sir Wooding went on to state that Black men and women should be placed in authoritative positions in the government and throughout industry in Bermuda, and that the island needed to introduce income tax and not rely on import duties which "bears unfairly on the less wealthy."

There was more social unrest in the late 70s after two Black men were convicted of murdering the Governor and his ADC, and the Police Commissioner. Another Commission was convened to look into the root causes of these disturbances. British peer, Lord Pitt who was of African descent, was the lead investigator. While some of the findings of the Pitt Report were not dissimilar to those found in the Wooding Report, Lord Pitt not only recognised the two Bermudas, particular the wealth gap, but sought to do something about it. He highlighted the need to share Bermuda's wealth among all people, and recommended that "... in the long run it will prove essential to regulate the transmission of inherited wealth."

It is perhaps not surprising that Lord Pitt focused on 'inherited wealth' since the historical development of Bermuda had created a wealth imbalance. He understood clearly the possible negative outcomes, particularly to persons of African descent, that could accrue to them in their future, as a result of the imbalance, and attempted to head them off. His recommendation was not implemented.

Also in the 70s, primary schools that had become segregated voluntarily were forced to merge by Government policy. The prevailing view was that by bringing children together at an early age, and having them growing up together, the two Bermudas would eventually be dismantled. While seemingly sound in theory, social designers overlooked the intransigence of White parents who exercised their right to remove their children from the newly-desegregated schools, resulting in 'White flight' and the resegregation of schools, a situation which remains prevalent more than four decades later.

The Rationale for Drug Laws

The 70s was significant for another major reason - the introduction of the Misuse of Drugs Act in the United Kingdom (in 1971 and coming into full effect in 1973), and an Act of a similar title being introduced in Bermuda. The rationale for the UK Act, and most likely for the Bermuda Act, was as follows.

> It shall be the duty of the Advisory Council to keep under review the situation in the United Kingdom with respect to drugs which are being or appear to them likely to be misused and of which the misuse is having or appears to them capable of having harmful effects sufficient to constitute a social problem…for educating the public (and in particular the young) in the dangers of misusing such drugs, and for giving publicity to those dangers...

It appears, from cursory glance, that the Bermuda Act followed closely the UK Act, and named specific drugs that were to be regulated, including cannabis.

In the United States, the rationale for controlling drugs, particularly marijuana, were clearly based on racism. The name which surfaces, when one delves into the history of drug control in the United States, is Harry J. Anslinger. In 1930, Anslinger was the Director of a new department, that of the Federal Bureau of Narcotics. Anslinger's position gave him the power to regulate drugs, such as marijuana. Then legal, Cannabis had been used for centuries as a medicinal herb, rope and for a number of other positive means. However, Anslinger used a racial and violence theme to draw attention to a drug which he felt could have negative effects on American by those who would be considered 'others.' The following comments attributed to him underlie his intent.

> *"There are 100,000 total Cannabis smokers in the US, and most are Negroes, Hispanics, Filipinos and entertainers. Their satanic music, jazz, and swing, result from Cannabis use. This Cannabis causes White women to seek sexual relations with Negroes, entertainers and others."*
>
> *"...the primary reason to outlaw Cannabis is its effect on the degenerate races."*
>
> *"Cannabis is an addictive drug which produces in its users insanity, criminality and death."*
>
> *"Reefer makes darkies think they're as good as White men."*
>
> *"Cannabis is the most violence-causing drug in the history of mankind."*[3]

While today such remarks would be looked at with suspicion, they drew wide acceptance in the United States of the 1930s. The similarity for the laws in the UK and Bermuda are obvious and, to some extent, so too are the drug laws in the United states - to protect the public from harm. In the United States, however, the harm was not so much perceived to come from the use of the drug, but in the degenerate actions of the races who used them. While the UK and Bermuda laws do not appear to be borne out of racism, the application of those laws continued to give credence to the notion of 'two Bermudas.'

Current Manifestations of the Two Bermudas

If there are two Bermudas, then there must be tangible evidence of same. In the 2012 Labour force survey, for example, while unemployment was recorded at 8%, unemployment for Blacks was 11% while for Whites it was 4%. These differences are historically similar. In that same study, personal income for Blacks

stood at $55,000, while for Whites it was $73,000. These results are also historically similar. Incarceration rates among Blacks have consistently been around 90% of the prison population and for Whites and Others, around 10%. Blacks however make up just 54% of the population.

With regard to stop and searches by the Police Service, there is evidence of racial profiling. At the prime of stop and searches in 2011, some 17,000 were made, although that has dropped considerably in the last couple of years. Of those stopped and searched 90% were male and 85% were Black. Nearly two-thirds, were males between the ages of 18 and 36. Given the Black male population in that age group, it was possible to search everyone of them four times in 2011. At a public forum hosted by the Centre for Justice in 2012, some Black males admitted to being searched multiple times.
Psychologists and noted author Amos Wilson views such tactics as a way to introduce Blacks into the criminal justice system, beginning their journey toward societal isolation. Richley Mann, author of Unequal Justice: A Question of Color, stated the point more succinctly when he wrote:

> At the root of the possible consequences of economic inequality and crime is the conflict perspective, which perceives the dominant, powerful (white) groups in society as attempting to control culturally dissimilar groups (in this case, nonwhites) who are seen by the dominant group as a threat to the political and social order benefiting them. Domination of nonwhites is achieved through agents of social control such as police… (FN)

If some accept the notion of two Bermudas, they might quickly point out that real inequality lies in education, that the disparities in educational attainment accounts for the other deficits among Blacks. And on the surface that notion appears to be true. In 2000, for instance, 23% of White Bermudians had a college degree, compared to just 11% of Black Bermudians. Of course the creation of two Bermudas could also account for the discrepancy but for now, the argument will stand. In 2009, Columbia professor Dr. Ronald Mincy, was hired by the Government to look into income disparities of Black males and their counterparts. His findings debunked the lack of education theory. What he found contributed most to the income discrepancies was industry, or where a person 'chose' to work, at more than 50%. Race accounted for nearly 30% and education just 14%. Considering that if one had full control of where they worked, and educational disparities were eliminated, a person's race would still be a factor in their economic outcomes. Mincy's findings were backed up by the 2006 Study on Literacy in Bermuda, published by the Statistics Department.

The OECD-sponsored study found that there were no appreciable differences by races of born Bermudians when it came to functionality in society.

Cannabis Legalization: Part of the Problem, or the Solution?

So, it could be rightfully asked, what does the construction of two Bermudas have to do with the review of cannabis laws. Perhaps much, if we see this exercise as a way to deconstruct the two Bermudas. Much of the data presented in this paper, and indeed in this section, will have focused on how laws in Bermuda, particularly drug laws, disproportionately affect young Black males, while usage of drugs is more equal among the races. If we look at the example of the United States in particular, where some states have legalised cannabis while others are considering it, there is concern that while legalisation of cannabis would eliminate the criminality of the drug, it would do precious little to eliminate the racial divide that the so-called war on drugs helped to create. Michelle Alexander, author of the New Jim Crow: Mass incarceration in the age of colorblindness, made this point in a recent interview with the Huffington Post:

> "When I see images of people using Cannabis and images of people who are now trying to run legitimate Cannabis businesses, they're almost all white," she said, noting she supports legalizing pot…After 40 years of impoverished black men getting prison time for selling weed, white men are planning to get rich doing the same things," she added. "So that's why I think we have to start talking about reparations for the war on drugs. How do we repair the harms caused?"[4]

Alexander, in her book, stated that Ronald Reagan's so-called war on drugs starting in the 80s, at a time when drug use was actually on the decline, resulted, in just three decades, the United States' prison population quadrupling to 2.4 million. The single factor contributing most to this increase was arrests for drugs, the majority of which was for the possession of Cannabis and not for trafficking.

Psychologist and noted author, Dr. Amos Wilson, provided the following rationale for the results described by Alexander:

> The alleged criminality of Black males will be used to justify the oppression of the African American Community and quite possibly its genocide and annihilation. [5]

To cement his views, Dr. Wilson added:

> In the eyes of White America, an exaggeratedly large segment of Black America is criminally suspect. This is especially true relative to the Black male. In the fevered mind of White America, he is cosmically guilty. His guilt is existential. For him to be alive is to suspected, to be stereotypically accused, convicted and condemned for criminal conspiracy and intent. On the streets, in the subways, elevators, in the "wrong" neighborhood... [6]

That our criminal justice outcomes mirror those in the United States gives rise to the belief that those same attitudes may exist in colonialist Bermuda, in spite of the fact that it has a majority Black population. Indeed, among the top twenty-five countries that imprison high proportions of their population, a number of them, including Bermuda in the 11th position, were, or are, colonies. The United States tops the list. [7]

In the United States there is a concern that even the legalization of Cannabis will not have the perceived benefits of eliminating racial disparities in the criminal justice system. In the book Cannabis by Katherine Tate et al, the authors stated:

> ... that the case against legal cannabis starts with the position that legalization won't end racism in the criminal justice system, ...will not end the nightmare that Blacks and Latinos face daily in the American criminal justice system. Racism will still mean that racial disparities in prosecution and sentencing will continue... police will continue to stop and frisk minorities more than Whites…

The authors went on to state that the legalization of Cannabis cannot be made into a civil rights issue, but that it would be better served by placing energies into challenging the racism in the legal system. And like gambling casinos on Indian 'homelands', which were supposed to economically enhance their lot, the authors also poured cold water on the "politics of self-sufficiency." They stated that:

> It plays into the neo-liberal agenda that supports market forces as a better way to achieve better outcomes for disadvantaged minorities. It feeds fantastical beliefs that minorities on their own, without government assistance, can improve their grim economic job prospects and economically disadvantaged schools, and close down the opportunistic businesses that tend to spring up in their segregated communities.

Medical doctor and American, Andrea Barthwell, who met with with the CRC, felt that Whites were misrepresenting the debate for their own gain. She made

a statement that "Whites were using the issue to get access to Cannabis for themselves". Ronald Walters, author of The Price of Racial Reconciliation, had a clear message for those who legitimately wanted to assist Blacks:

"Racial advocates need to sustain efforts toward group reparations for Blacks who have been tragic victims of America's laws and policies."

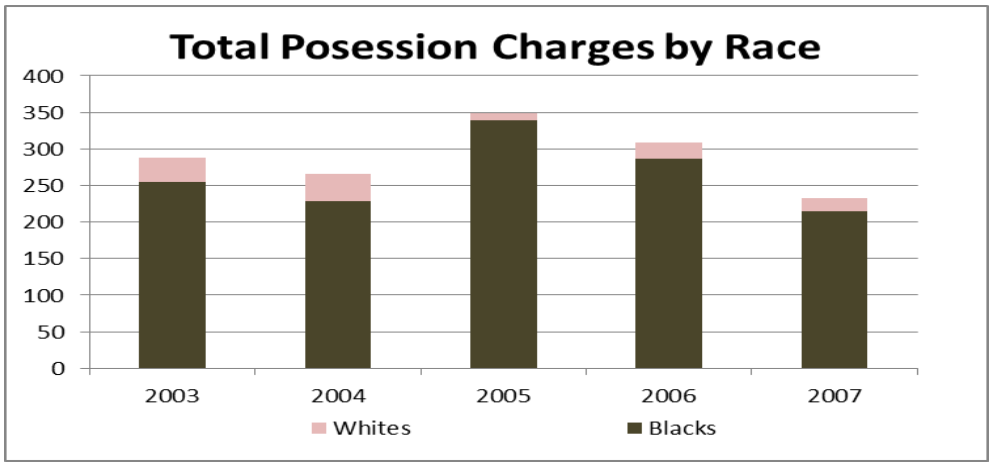
There may be those quick to point out that much of what has been quoted above has nothing to do with Bermuda since it is based on what is happening in America. However, at the PLP forum on drug reform, which members of the CRC attended, in the question and answer period that followed, lawyer Eugene Johnston made the comment that if we focused solely on the drug, we would be missing the point. He elaborates:

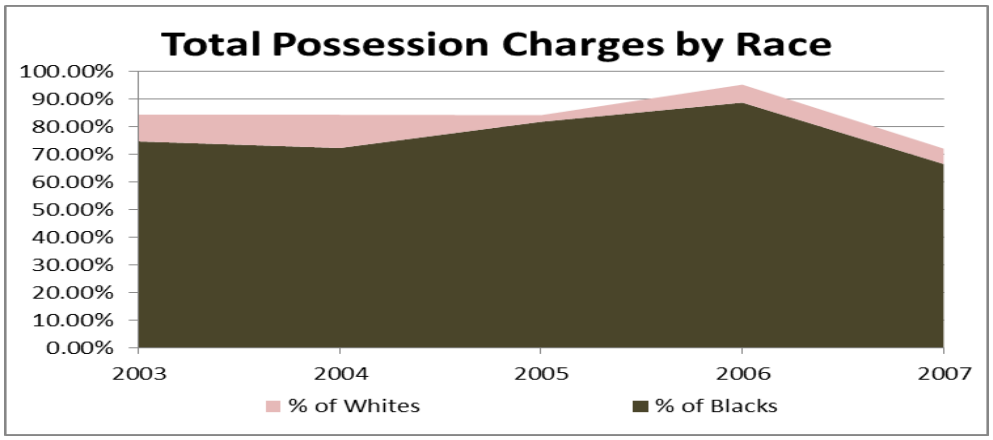
> The debate is really not about marijuana, cannabis, because that is just one of the means by which they trap certain segments of the community. So if you legalize cannabis, it doesn't mean that they would not find another mechanism to criminalize the Black community, in fact they will. And not only that, it doesn't mean that the Black community wouldn't have to find another elicit means of surviving in a society which is inherently off balanced. So if you focus on the drug, rather than the social issues that surround the legalization debate, than you miss the point entirely because you think it is only about medical use or you think its about only what you can do with this drug, or whether the drug is harmful. It's not really important to the debate whether the drug is harmful. What's important is that it's going to lead to an escalating series of societal demands on dire segments of the community, and we don't know where this is going to pan out.

If cannabis laws are to be reformed, with the end goal of regulated legalization, then serious thought ought to be given to repairing the harms of the past and leveling the economic playing field. One plausible way to do this is to grant free cannabis cultivating and trading licenses, for a period of up to five years, solely to those persons who currently have a drug conviction. This recommendation, if adopted will turn on its head the notion that:

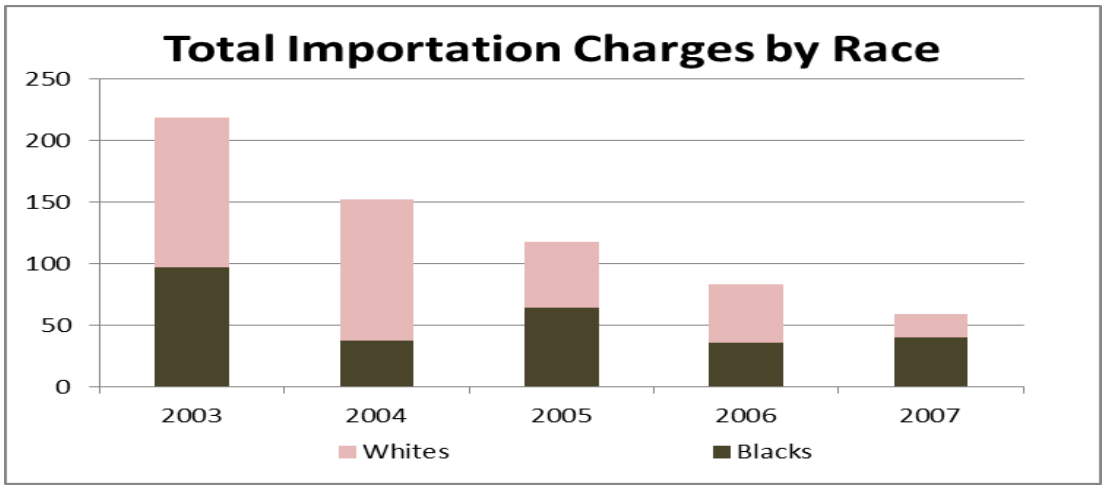
"Legalization demands today appear especially elitist, and literally so, because legalization may really only benefit America's (Bermuda's) economic and social elites. In fact, medical Cannabis profoundly illustrates the way laws protect wealth and 'Whiteness' over poor Black and Latino communities."[8]

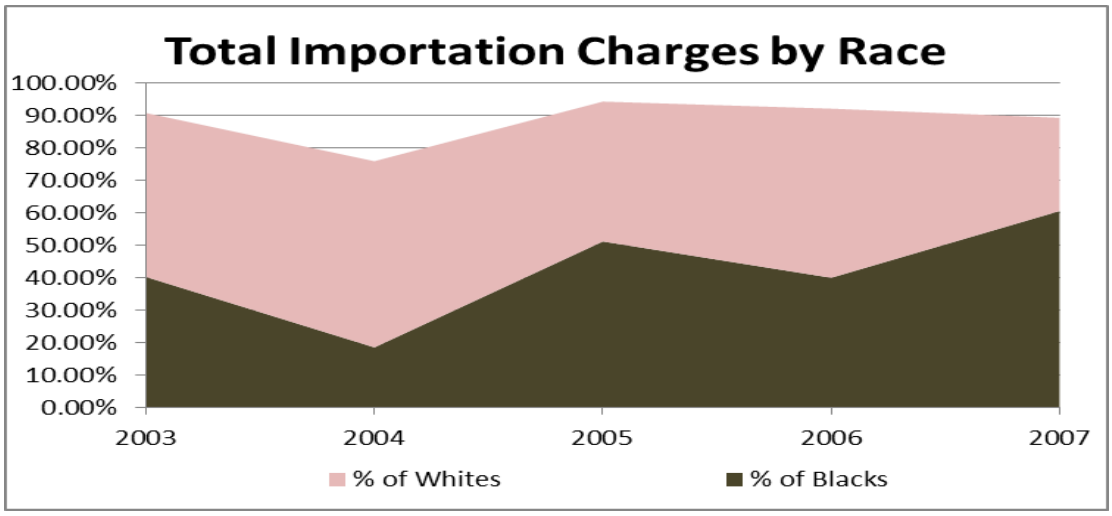
The idea of there being two Bermuda's is obvious when researching the racial disparity in those charged with drug crimes, more specifically Cannabis. Blacks are by far more likely to feel the negative impacts of the cannabis prohibition, disproportionate to the size of the population. According to the 2010 census blacks made up 54% of the population however blacks by far make up majority of all cannabis offences. The following graphs show a racial breakdown of cannabis possession crimes from 2003 – 2007. This data was sourced from the DNDC.





The two Bermuda's has manifested itself in drug crime as blacks are more likely targeted through profiling and structural racism. The two graphs show the extent to which profiling has had a more pronounced impact within the black community. The follow graph shows data on importation by race.





These graphs show that at the importation level there is a more equitable distribution of offences through the races. This is proof that the demand for cannabis is non-discriminatory, while racial profiling is evident in charges. Blacks bear the brunt of most possession charges while whites are far less likely to be charged with a cannabis offence.

The CRC Recommends:

1. **Providing factual education around cannabis history and its uses**
2. **Ending racial profiling within the criminal justice system**
3. **Expunge all convictions related to cannabis only**
4. **If cannabis is legalized, ensure equal opportunities to enter the industry**

5. Current Legislative Framework, Policies & Impacts

Interpretation of The Misuse of Drugs Act 1972 Act

The following is a brief survey of the Misuse of Drugs Act 1972 and other associated legislation and legal concepts.

The Misuse of Drugs Act 1972 ("the Act") legislates general prohibitions [1] on the importation, exportation, production, supply, possession and misuse ("the proscribed activities") of "controlled drugs" as defined in Schedule 2 to the Act, subject to any regulations made by the Minister under section 12 of the Act.

The Schedule provides an exhaustive list of the compounds and substances to which the general prohibition applies. This list includes both "recreational drugs", being those drugs usually associated with substance abuse (such as Cannabis, Cocaine and Heroin), and "clinical drugs", being those substances usually made available by a medical practitioner by prescription.

The general prohibitions imposed are subject to regulations made by the Minister responsible for Drug Prevention, currently the Minister of National Security, under section 12 of the Act. Section 12 provides wide powers of regulation, enabling the Minister to exclude certain controlled drugs from the prohibitions set out under sections 4, 5 and 6 of the Act, and to make "such other provision as he thinks fit for the purpose of making it lawful for persons to do things which under [sections 4(1), 5(1) or 6(1)] it would otherwise be unlawful for them to do."[2]

Section 12 of the Act also provides specific powers to the Minister to make regulations authorizing the lawful doing of the proscribed activities under and in accordance with the terms of a license issued by the Minister, and in compliance with any conditions he may attach to that license, or in compliance with other prescribed conditions. The Minister is required to exercise this power so as to secure protection for medical practitioners [3] and pharmacists to prescribe, administer, manufacture, compound, supply or possess a controlled drug for the purposes of acting in their professional capacities.

The one exception to that requirement is where the Minister is of the opinion that it is in the public interest to declare that the production, supply or possession of a particular controlled drug is wholly unlawful, or unlawful for the purposes of research or other special purpose, or to require a medical practitioner or pharmacist to hold a license to deal with that particular drug. In such cases, the

Minister may issue an order applying such restrictions to the drug.

Sections 14 to 24 of the Act give the Minister other powers to regulate how controlled drugs are dealt with. These include:

- **Power to make regulations that appear to him necessary and expedient for preventing the misuse [4] of controlled drugs**
- **Power to regulate the importation of controlled drugs**
- **Power to require precautions be taken for the safe custody of controlled drugs**
- **Power to require the documentation of transactions involving controlled drugs**
- **Power to require copies of documents relating to transactions be furnished to the Minister or other prescribed authority**
- **Power to inspect any precautions taken or records kept pursuant to regulations**
- **Power to regulate the packaging and labeling of controlled drugs**
- **Power to regulate the transport, and method for destruction or disposal of drugs no longer required**
- **Power to regulate for prescriptions of controlled drugs, their supply and reporting obligations of those dispensing the controlled drug**
- **Power to limit the ability of a physician to administer, supply etc controlled drugs to an addict**
- **Power to give directions to the owner of premises where controlled drugs are to be kept to take special precautions in relation to specified drugs**
- **Power to prohibit practitioners or pharmacists with criminal convictions from dealing with controlled drugs**
- **Power to require a medical practitioner or pharmacists to give information to him relating to the amount and frequency of supply of specified controlled drugs by that practitioner or pharmacist**
- **Power to make regulations to establish treatment and rehab centers on the island**

ANNEX

Offence	Maximum Penalty on Summary Conviction	Maximum Penalty for Conviction on Indictment
Importation, Production, Supply, Possession w/ intent to Supply, Handling w/ intent to supply, Misuse of Controlled Drug, Possession of Drug Equipment, Acts Preparatory to Importation or Supply, Cultivation, Occupier Permitting Prohibited Activity, Contravention by practioner/pharmacist of Ministerial Direction under section 16(6) or 17(3)	10 years imprisonment or $500,000 fine or 3x Street Value of Controlled Drug, whichever is greater, or both such fine and imprisonment	Life imprisonment or $1 Million Fine or 3x Street Value of Controlled Drug, whichever is greater, or both such fine and imprisonment
Simple Possession	12 months or $1,000 fine or both	1st Offence: 5 years or a fine or both; 2nd + Offence: 10 years or a fine or both.
Failure to adhere to Ministerial Direction on Safe Custody of Controlled Drug	12 months or $1,000 fine or both	2 years or a fine, or both such imprisonment and fine
Contravention of Regulations, terms of a License and other miscellaneous offences	12 months or $1,000 fine or both	2 years or a fine, or both such imprisonment and fine
Giving of false	Fine of $250	n/a

information by practioner/pharmacist; Failure to Comply with request for handwriting or fingernail analysis		

[1] Under sections 4(1), 5(1) and 6(1) of the Act.
[2] Section 12(1) of the Act.
[3] Term includes Doctors, Dentists and Vets.
[4] Per section 2(2), references in the Act to "misusing" a drug are references to using it otherwise than as authorized by or under the act by "taking, i.e. by a human being smoking, inhaling, ingesting or injecting the drug, or any other form of self-administration, whether or not involving the assistance of another.
[5] Except offences under section 20(3) and 36(2), which are summary only offences.
[6] Relevant offences are Importation, Exportation, Production, Supply, Possession, Possession with intent to Supply, Handling with intent to Supply, Misuse of controlled drugs, Possessing Equipment in connection with the misuse of a controlled drug, acts preparatory to importation or supply and cultivation of cannabis.
[7] Increased Penalty Zones are set out in Schedule 4 to the Act.
[8] 'Benefit' may be given a wide interpretation.

Summary of Legality around Cannabis

Prepared by Richard Horseman - Barrister & Attorney - Wakefield Quinn

The basic criteria for issuing a warning or caution for personal possession of cannabis has been said to be generally that the amount must be under 4 grams, the defendant is a first time offender and the offender accepts his responsibility and culpability for the offence. The policy seems to be implemented on a haphazard basis as many individuals are still attending court for simple possession of small amounts of cannabis has witnessed by the author of this summary.

It is currently illegal to possess cannabis with intent to supply it and/or supply it. Normally, these charges are reserved for cases where there is a commercial intent to supply cannabis to other for profit. Literally speaking, the passing of a Cannabis cigarette or spliff to another person is supply, however, this is rarely charged as such. Under the Misuse of Drugs Act, if you possess more than 20 grams of cannabis, it is deemed to be intent to supply unless you prove otherwise.

Where an individual is convicted for possessing cannabis with intent to supply, a sentence of imprisonment is almost always imposed. Much will depend upon the amount of cannabis the individual is caught with. For instance, in the days of "Operation Clean Sweep", individuals were sentenced to two years imprisonment for supplying small amounts of cannabis i.e. a gram to three grams of product. Where a defendant is convicted of possessing amounts ranging from one to five pounds, sentences of imprisonment would range from one to five years imprisonment.

Possession with intent to supply of amounts exceeding 10 lbs usually result in sentences of 5 to 7 years. Amounts in the range of 50 lbs usually result in sentences in the range of 8 to 10 years.

Importation of cannabis is defined as causing to be brought into Bermuda. Typically, there are two types of charges of importation that are dealt with by the courts. Importation of small amounts of cannabis are usually dealt with in Magistrates' Court and do not normally involve a custodial sentence. Importation on a commercial basis though invariably results in a custodial sentence. Sentences fall in the same range as charges of possession with intent to supply cannabis.

Importation charges of approximately one pound of cannabis/resin have recently resulted in sentences of one-year imprisonment. A sentence of three years of approximately one pound of cannabis resin was reduced by the Supreme Court to one year imprisonment. Importation of large amounts of cannabis i.e. fifty pounds, will usually result in a sentence of approximately least ten years.

Penalties are dependent upon the weight of the product. There are also other factors that will be taken into account including any mitigating factors such as whether a defendant pleads guilty and whether or not he has any previous convictions. The severity of the sentence primarily turns on the weight of the amount of drug involved. See the references above to ranges of sentences.

Penalties for personal use also depend upon the amount as well as the record of the defender. If a particular defendant has numerous convictions, the court will treat them differently than a first-time defender. The courts have recently started implementing sentences of conditional discharges. A conditional discharge means that there is no conviction recorded on the basis that the defendant does not get himself into any further mischief within a specified period of time, namely, one year.

Production of cannabis is by cultivation. At the moment, sentences relating to cultivation depend on whether the individual is cultivating for personal use or for commercial use. People have been arrested and convicted several times for cultivating a couple of plants and they did not receive sentences of imprisonment, the distinction being whether the cultivation was being cultivated for commercial purposes.

Bermuda Police Service (BPS) Input

According to the Commissioner of Police, intelligence and research suggests that Cannabis is used socially among gangs and their members. There have been a number of overseas arrests of gang members for the importation of drugs via boats and couriers. In addition, certain gangs are involved in street dealing from certain areas throughout the island. The BPS only started to collate data around drugs crimes in 2008 and they currently provide data to the DNDC for record keeping. Not every drug arrest will lead to house search. As such, at the lowest level the arrest and process of a person to receive a caution could be done within two to four hours. Individual circumstances will affect that timing: for example, where the arrest involves a juvenile and there is a delay in waiting for an appropriate adult to arrive. Where a house search is included, another two to six hours could be added. The BPS workload is large and diverse and it is difficult to quantify any real effect of reduction in time across the board if cannabis policies were to change. Clearly, there would be a reduction in the amount of hours spent on the investigation and prosecution of the specific category of drug offence, but this would not represent a significant portion of the overall BPS daily workload. Police Commissioner Michael DeSilva stated:

> "There have been 194 cautions for drug possession to local persons and 1 for importation (cruise ship or airport related to an overseas visitor) since December 21st 2010. The original caution authority given to the police by the DPP in 2010 was rescinded in 2012. Cautions now require prior approval from the DPP before they are administered."

Based on this quote, it can be stated that the policy was effective in reducing the number of individuals that were charged with a cannabis offense. Lower court costs and lower criminality rate were also benefits that were realized through a warning system of this kind.

Department of Public Prosecutions (DPP) Input

The following information was provided by the DPP.

The criteria for issuing a caution for personal possession is outlined in The Formal

Policy on Cautioning Adults, which is a published, document entitled "Director of Public Prosecutions Guidance Issued in Preparation for Section 36 of the Police and Criminal Evidence Act 2006"

> "6. Cautions
>
> (a) Where the police consider that there is sufficient evidence to charge a person for an offence which may be cautioned under the Formal Policy for Cautioning Adults and the police determine it is in the public interest to caution rather than charge, they may issue that caution without referring the matter to the Director.
> (b) Whether or not the police choose to issue a caution under the Formal Policy for Cautioning Adults in any case, notwithstanding that all of the mitigating criteria set out as examples of the types of factors that might be considered by them may be satisfied, is a matter that remains solely within the discretion of the police."

With respect to the possession of small quantities of cannabis for personal use the advice of the Department of Public Prosecutions is often sought before a Caution is issued. The factors that are considered include: (a) whether the drug was possessed in an increased penalty zone; (b) the antecedent character of the possessor; (c) whether there are factors that may signal earning proceeds from the drug or other criminal activity; (d) whether the quantity is very small (less than three (3) grams; (e) whether the time taken to analyze the cannabis would cause suffering to the possessor; (f) whether there was a full and early admission of culpability on the part of the possessor. The overriding concerns of the interest of justice and the public interest are factored into the decision making process.

It is also to be noted that the 'increased penalty zone' mentioned above are areas that are specially protected and will incur an increase in the penalties in a manner specifically delineated in section 27A and 27B of the Misuse of Drugs Act. A list of the increased penalty zones is found in Schedule 4 of the same Act.

The Criminal Code gives further guidance to the Court in determining the exact sentence to be applied for each offence:

Purpose
53 The fundamental purpose of sentencing is to promote respect for the law and to maintain a just, peaceful and safe society by imposing just sanctions that have one or more of the following objectives—

(a) to protect the community;
(b) to reinforce community-held values by denouncing unlawful conduct;
(c) to deter the offender and other persons from committing offences;
(d) to separate offenders from society, where necessary;
(e) to assist in rehabilitating offenders;
(f) to provide reparation for harm done to victims;
(g) to promote a sense of responsibility in offenders by acknowledgement of the harm done to victims and to the community.

Fundamental principle

54 A sentence must be proportionate to the gravity of the offence and the degree of responsibility of the offender.

Imprisonment to be imposed only after consideration of alternatives

55 (1) A court shall apply the principle that a sentence of imprisonment should only be imposed after consideration of all sanctions other than imprisonment that are authorized by law.

The Criminal Code goes on (in section 55(2) to list several factors that the Court ought to consider in determining the appropriate sentence.

It should be noted that judges and magistrates case law of sentences previously imposed in matters of a similar nature with a view to maintaining some consistency.

The total amount of cannabis is one factor that the Court considers. As the amount is only one factor considered, it is not an arithmetically calculable difference relative to the amount.

An example of the way the Court reasons out the considerations for sentencing can be found in Vincent Hewey v Lyndon Raynor (Police Sergeant) [2012] Bda LR 66:

> "17. For instance, Crown counsel referred to the Royal Gazette report of the Magistrates' Court case of Scraders who imported over 100g of cannabis concealed in soda bottles and swallowed in pellet form. Although the quantity of drugs involved was less than that involved in the present case, the Learned Acting Magistrate imposed a 3 year prison term for "a very calculated" offence. On the [other] hand, counsel also

> referred the Court to a Royal Gazette report of the case of Dyer , a breach of trust case where the offender was a security officer responsible for searching planes, who received an 18 months sentence of imprisonment from the Learned Senior Magistrate for handling 948.7g of cannabis which he removed from a plane concealed on his body. The quantity was half that involved in the present case and the offence was not importation, but the responsibility of the offender would seem to be clearly far greater than the culpability of the Appellant in the present case.
>
> 18. Ms Christopher relied essentially on what section 54 of the Criminal Code itself describes as the "fundamental principle of sentencing" , namely: "A sentence must be proportionate to the gravity of the offence and the degree of responsibility of the offender" . She submitted that the fact that the Learned Magistrate had accepted that the Appellant, despite completing the offence of importation, had genuinely abandoned the drugs at the airport was a factor which greatly diminished both the gravity of the offence and the responsibility of the offender. Even if a partially suspended sentence was inappropriate, then a shorter custodial term ought to have been imposed. I find this submission compelling.
>
> 19. The offence of importation of controlled drugs falls into a category of offence where the gravity of the offence and the responsibility of the offender may vary markedly even though the full offence is completed depending upon whether either: (a) but for the intervention of the authorities or some other intervening agency beyond the control of the offender, the purpose of the criminal enterprise would have been fulfilled; or (b) the offender himself, of his own volition, abandons the enterprise. With offences of violence, the completion of the offence necessarily means inflicting the full extent of the harm that the penalties for the relevant offence are intended to sanction. With other offences, the gravity of the offence in term of harm caused may vary markedly depending on events occurring after the completion of the offence. By way of example, the gravity of an offence of stealing would be far less if the thief had a crisis of conscience after committing the offence and abandoned the stolen property in a place where it was likely to be found by the owner." (a copy of the full judgment of the Court is attached)

It is a process of balancing the myriad considerations that may be unique to each offence and each offender.

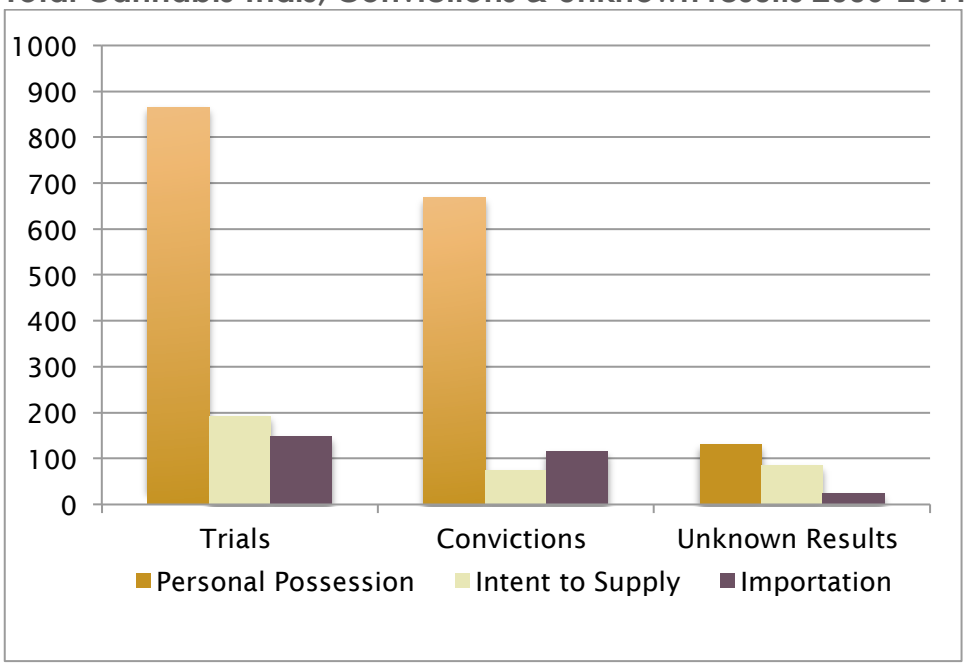
There is an overriding principle that the sentence should be proportionate and not excessive in all the circumstances. The aim is to allow the Court the latitude to arrive at the best and fairest sentence in each particular case.

According to the DPP, the sentencing in Bermuda seems to be in line with the general sentencing in other commonwealth jurisdictions such as Australia and Canada.

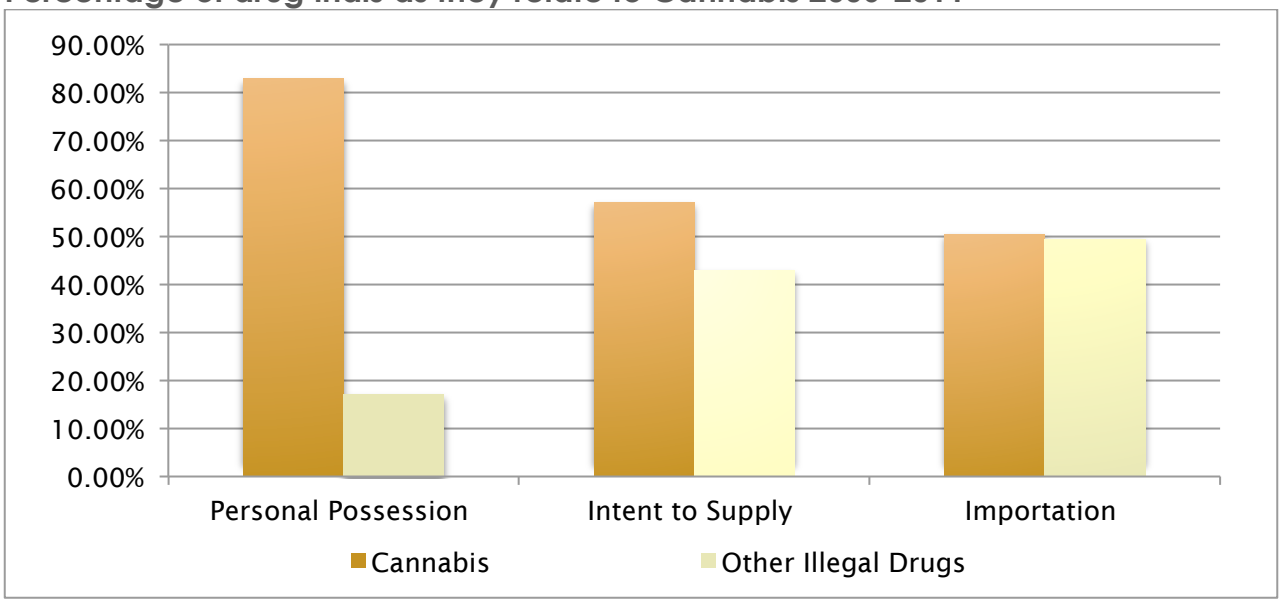
The Department of Public Prosecutions, unfortunately, does not keep statistics in the way that would assist with specific quantification for any reduction in processing time from reformed cannabis policies. Cannabis cases are not a very large portion of what the DPP deals with however they do not currently collate data around court cases or prison years served for cannabis offences. The Department of Public Prosecutions is beginning a process of digitization that should make these statistics available in the future.

Cannabis Crime Statistics

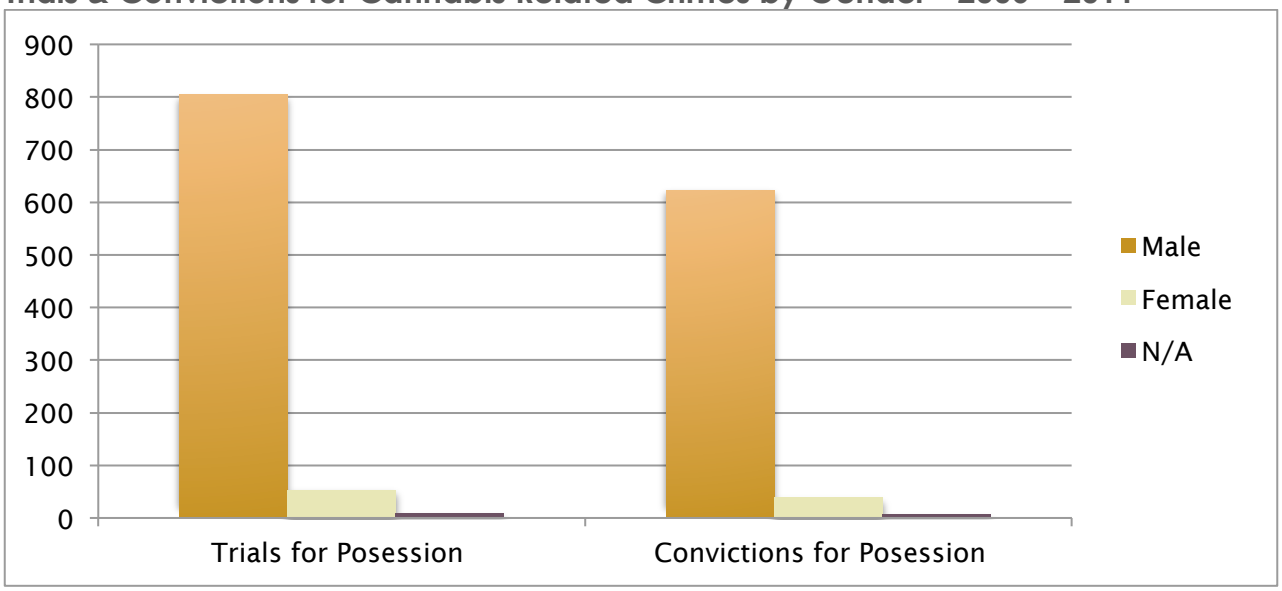
Total Cannabis Trials, Convictions & Unknown results 2006-2011



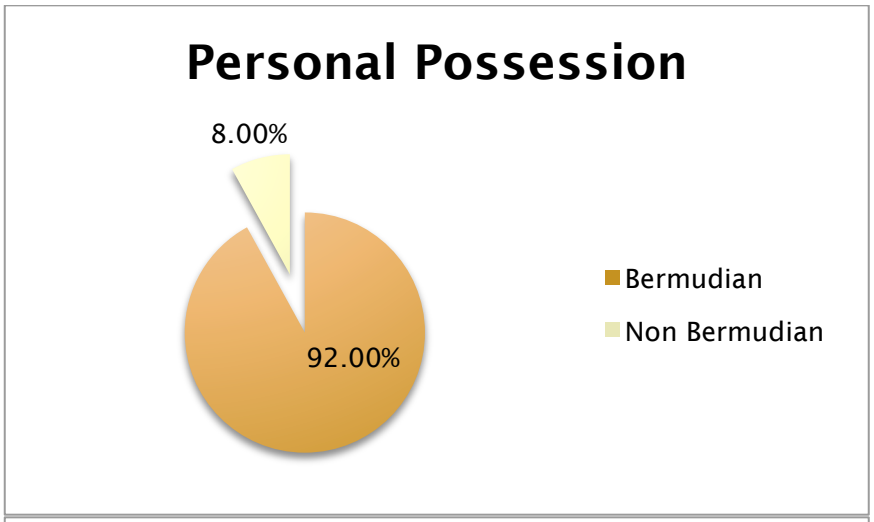
Percentage of drug trials as they relate to Cannabis 2006-2011

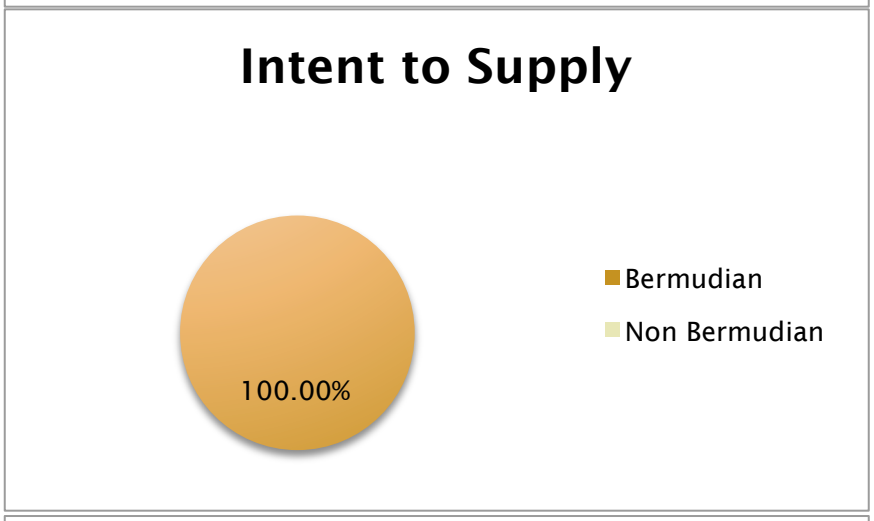


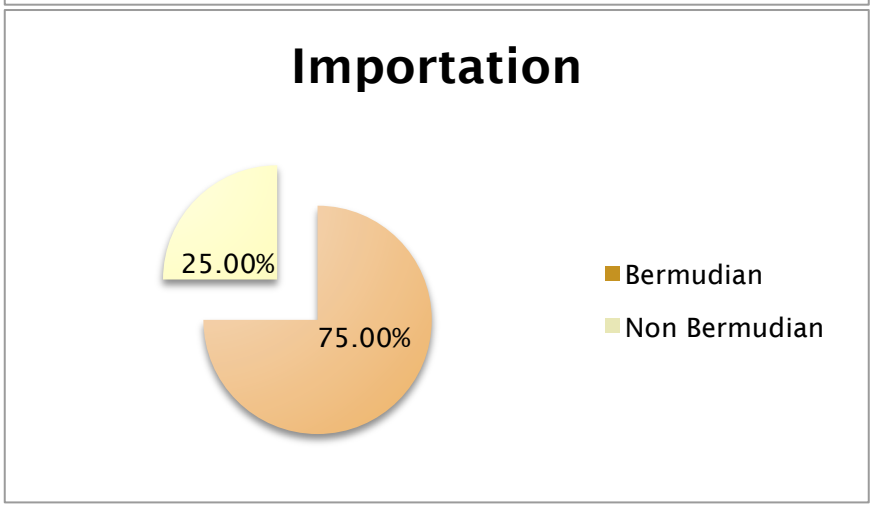
Trials & Convictions for Cannabis Related Crimes by Gender - 2006 – 2011



Percentage of Bermudians versus Non Bermudians who are caught and/or charged for the following with respect to Cannabis:







During the time period of 2009 - 2010 reliable data around cannabis crime was unavailable and therefore omitted from this report.

During the years 2011 - 2012 cannabis made up 69.2% and 68.8% of total offences respectively. Possession of cannabis increased from 81.5% of all cannabis offences in 2011 to 84.1%. Though overall cannabis offences declined by 42.3% their contribution to overall offences remained relatively flat. Drug offences were down across the board from 813 in 2011 to 458 in 2012, a 43.7% decrease.

A Brief Overview of the Department of National Drug Control

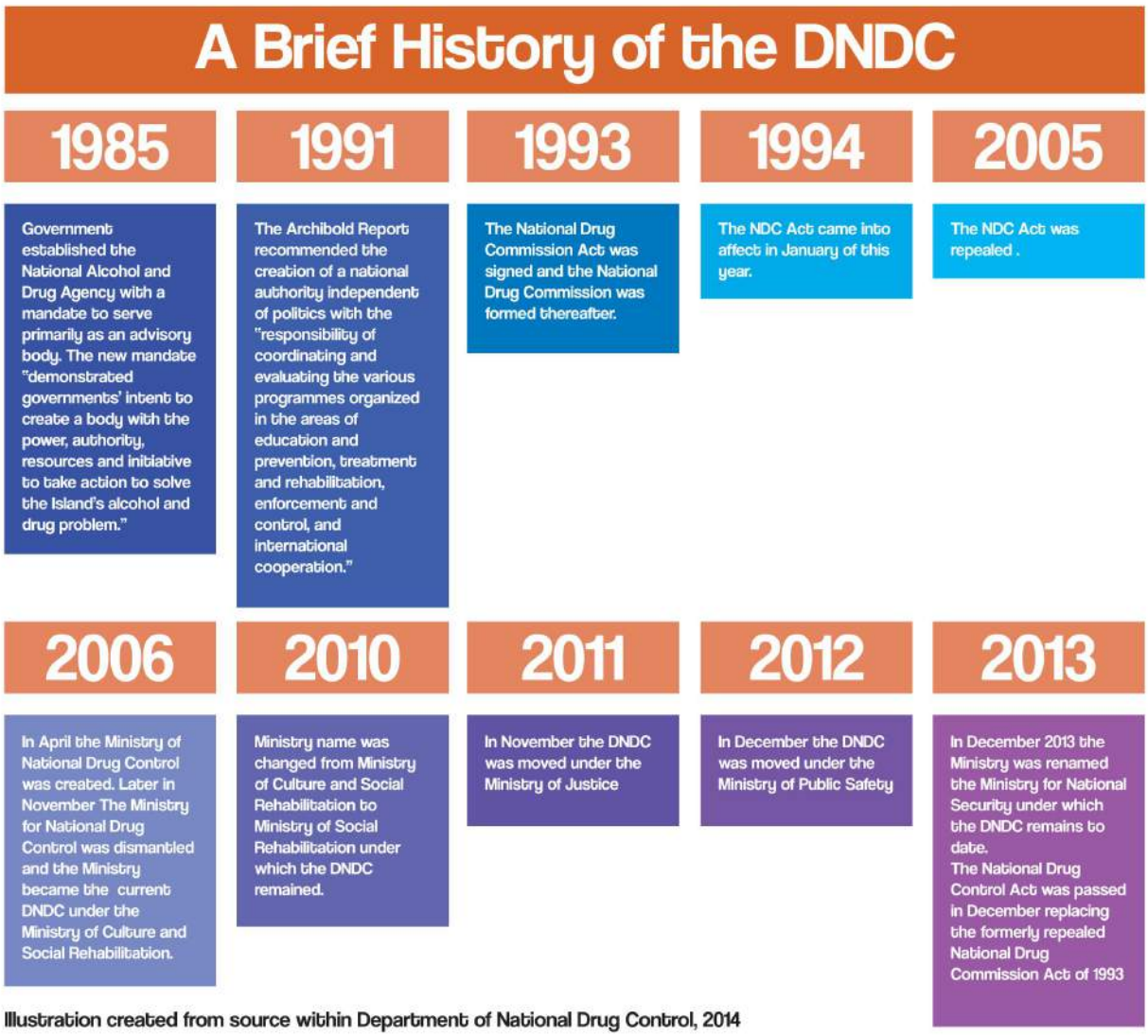


Illustration created from source within Department of National Drug Control, 2014

Current DNDC Framework:

The National Drug Control Policy and Master Plan 2007 -2011 is the document which the government uses as guidance to administer its drug prevention plan. In 2011 there was an evaluation of the master plan and in 2012 a needs assessment and consultation initiative took place to develop a new plan. In 2013 a the new master plan was drafted and submitted to the Ministry of National Security, it has yet to be made public. As an illegal drug cannabis prevention is treated as any other drug outlawed by the Misuse of drugs act. The methods which are utilized to achieve the objectives of the national plan are demand, harm and supply reduction. Section 7; Social and Health Perspectives, speaks to the effectiveness of harm reduction in the context of international finding. This portion of the report will focus on demand and supply reduction efforts.

Below is a list of the goals of the national plan according to the DNDC web site:

Goals of the National Drug Control Master Plan

1. Strengthen and sustain national level mechanisms to coordinate, manage and evaluate the implementation of the national initiatives for drug control.
2. Prevent young people from becoming substance users/abusers of alcohol tobacco and other drugs.
3. Decrease alcohol and other drug problems in at-risk groups.
4. Minimize the health and social impact of drug dependency on the affected society through the provision of treatment and rehabilitation services that is of high quality, accessible and affordable.
5. Reduce the availability of illicit drugs, and reduce the increasing threats of drug trafficking and drug-related crime.
6. Ensure a strong and comprehensive legislative and institutional framework for implementation of the national strategies.

Demand reduction is the method which includes prevention education, treatment and rehabilitation as highlighted in Chapter 7. Current prevention efforts are focused on school aged children and to some extent older youths. There is very little prevention efforts provided to the greater community. As a result, parents are not well equipped with factual health based and historical information. According to the Bermuda Assessment & Referral Centre (BARC) there were 141 referrals for drug abuse in 2012; 41 were for marijuana. A total of 118 of the referrals resulted in some form of in-patient program; 83.7% of referrals. Cannabis dependence rarely require residential programs meaning the proportion of the treatment budget allocated toward Cannabis must be minimal.

Supply reduction utilizes the interception and seizure of drugs as a method of reducing their supply and by extension overall use. Due to the bulky nature of cannabis compared to other drugs it is much more readily detected. Also because it is the most widely consumed illegal drug, a greater supply is needed to meet local demand.

UN Treaties

Countless other jurisdictions are faced with a complex range of drug related problems and many are exploring the development of nationally appropriate policies that shift away from the prohibition-oriented approach. In so doing, countries must consider the UN based global drug control framework of which as a British Overseas Territory, Bermuda is a part of. The following information outlines the international legal drug control obligations, what maneuverability our Government has to change any drug laws and the clear limits that cannot be crossed without violating these treaties. This information has been sourced from a paper The Limits of Latitude - The UN drug control conventions - by Dave Bewley-Taylor and Martin Jelsma - Transitional Institute

KEY POINTS

1. Decriminalization of possession, purchase and cultivation for personal use operates reasonably comfortably inside the confines of the UN drug control conventions
2. Harm reduction services, including drug consumption rooms, can operate lawfully under the drug control treaty system. There is greater scope to provide healthcare or social support instead of punishment for people caught up in minor offences related to personal use or socio-economic necessity
3. All controlled drugs can be used for medical purposes, including heroin prescription and 'medical marijuana'; what constitutes medical use is left to the discretion of the parties
4. The INCB often increases tensions around interpretations instead of resolving them, though the Board should be guided 'by a spirit of cooperation rather than by a narrow view of the letter of the law'
5. There are limits of latitude; a legal regulated market for non-medical use of cannabis or any other scheduled drug is not permissible within the treaty framework
6. Legal tensions exist with other international legal obligations such as those stemming from human rights or indigenous rights
7. Growing doubts and inherent inconsistencies and ambiguities provide legitimate ground for demanding more space for experimentation with alternative control models than the current systems allows

An Explanation of the "USA Stop List"

US Consulate General Robert Settje provided the following information in a meeting with members from the Cannabis Reform Collaborative on March 26th 2014.

Bermudians are entitled to enter the USA for up to 90 days without applying for a visa waiver; the only other jurisdiction with this agreement is Canada. Other nationalities have to apply for specific visas to visit the USA and some people can wait for months to obtain them.

Those Bermudians who have been found inadmissible to the United States under U.S. Immigration and Nationality Act are on the so-called "US Stop list" and must obtain a visa and a waiver of that inadmissibility to enter the US. Waivers may be granted for up to five years, depending on the nature of the inadmissibility, the time that has passed since the behavior leading to the inadmissibility, the applicant's need to travel, and other factors as deemed relevant by the Consular Officer accepting the visa/waiver application. As a general rule, once one is found inadmissible to the U.S., he/she will have to apply for a waiver to visit the US for the rest of his/her life.

Bermuda is one of a few jurisdictions that have local US Customs and Border Protection preclearance, which began in its current form in 1974. This service eliminates the need for immigration and customs clearance once people land in the US. The existence of CBP preclearance in Bermuda is based on tradition and history. None of the usual justifications for a preclearance facility – interdicting crime and terrorism, facilitating travel to multiple U.S. destinations with no CBP presence, or providing special services to U.S. government personnel – has existed since the U.S. bases closed in 1995.

The Immigration Nationality Act (INA) was enacted in 1952. The Act governs primarily immigration and citizenship in the US and is federal law rather than state law.
Section 212(a) of the INA lists the circumstances under which persons may be found inadmissible to the U.S. and, thus, find themselves on the "Stop List". There are several grounds – criminal and non-criminal – under which one may be deemed inadmissible to the U.S. However, for purposes of this paper, we will address the "Stop List" from the perspective of drug-related criminal activity and/or substance abuse / dependence.

The "US Stop List" is not unique to Bermuda. When it comes to the attention of the United States government that an individual may be inadmissible to the

United States, a government official will enter his/her name into a worldwide database. If/when that person applies for a visa or seeks to enter the United States, a U.S. consular officer or immigration official will determine whether he/she is in fact inadmissible and, if so, will deny him/her entry into the United States. If a waiver is available for the inadmissibility in question, the consular officer or immigration official will so inform the subject. In some jurisdictions, U.S. consular offices collect and maintain names for the "list" by communicating with law enforcement, following local media, etc. The Consulate General in Bermuda DOES NOT receive information from the the Bermuda Police Service about those who may have inadmissibilities, nor does it routinely follow the local media for the purpose of finding names to add to the "Stop List," although the media are occasionally the source of names. A majority significant number of people whose names are on the "stop list" have admitted to the underlying behavior, often to CBP at the airport.

If a Bermudian is:

- Convicted of drug crime or multiple drug crimes; or
- Addicted to or has drug dependence; or
- A US consular officer has reason to believe, based on credible evidence, that the Bermudian is somehow involved in drug trafficking; or
- Under certain circumstances, admits to any of the above

Then he/she is considered inadmissible to the US and, therefore, on the "Stop List, "unless he/she applies for and is granted a visa and a waiver by the US Government.

Under the INA, a "conviction" is:

1. A formal judgment of guilt entered by a court; OR
2. If no formal judgment, a finding of guilty by a judge or a jury; OR
3. A plea of guilty or nolo contendere (no contest)
4. PLUS, with regard to (1), (2), and (3) above, the imposition of some form of punishment, penalty, or restraint of liberty by a judge;
5. OR
6. A formal admission to a consular officer made when certain procedural safeguards are in place of facts sufficient to warrant a finding of guilt.

Convictions include cases where:

1. The sentence is suspended, reduced, mitigated, or commuted or otherwise relieved in whole or in part of the penalty imposed or where probation or parole are imposed.
2. Most expungements
3. Foreign pardons

A conviction will always remain a conviction under the INA – even if Bermuda changes its laws – unless the USA changes its laws, which at this point is unlikely. A conviction is still a conviction even if someone is pardoned by local courts.

A "conviction" is not a "conviction" if:

1. Obtained in absentia
2. A prosecutor does not prosecute the case (nolle prosequi);
3. The court vacates its own conviction;
4. It is overturned on appeal;
5. The convicted person receives a full and unconditional pardon from a U.S. court.

Keep in mind that even if there is no conviction, one may still be found inadmissible:

as a drug trafficker, based on the facts of the particular case; OR
as one who abuses or is dependent upon a controlled substance.

Waiver Application Process

Once the Consular Officer reviews the application, he/she decides whether to recommend to the Admissibility Review Office (ARO) – a CBP office in the United States – that a waiver be granted. If he/she makes no waiver recommendation, the matter ends there, although the applicant can re-apply at any time. If the consular officer recommends a waiver, ARO will review the case and decide whether to grant or deny. Recently, the Consulate's Consular Officer has been recommending waivers in in 94% of cases, and ARO has been granting waivers in 98% of those. Waivers can be and are granted not only in drug cases but for more serious crimes, including assault, murder, robbery and sex crimes. In the past, waiver application processing took a week to ten days. Due to increased demand worldwide, it now takes five-six months. The Consulate General will expedite waiver applications in emergency cases, e.g., situations involving health, life/death, etc.

Family members of drug traffickers who have received a benefit from the drug trafficker anytime in the past five years are also inadmissible to the US.

Bermudians on the "stop list" may seek a waiver to visit the US for any reason, including medical reasons.

The only way a Bermudian can determine if he/she is on the stop list is by seeking admission to the U.S. at the CBP Preclearance facility at the airport or by applying for a visa at the U.S. Consulate General.

The Consulate General does not have records of the total number of Bermudians on the "stop list," but in 2013 it processed 250 waiver requests, which is about the average for recent years. Most of those waiver requests are for renewals of old requests.

Regarding any Cannabis Reform in Bermuda

The INA will still remain federal law and until the US drug laws change cannabis will remain classified as a Schedule 1 drug.

A change in the law of Bermuda will have no effect on past findings of inadmissibility under the INA. If convictions related to cannabis crimes are expunged or repealed in Bermuda, or if those previously convicted are pardoned in Bermuda, those persons will still be inadmissible under US law, will remain on the "stop list," and will need a visa and waiver to enter the US.

If distribution of cannabis is regulated and or legislated in Bermuda, distributors might still be considered "traffickers" under the INA and could be deemed inadmissible to the US.

If cannabis is legally available for medical or recreational purposes, users might still be considered abusers of or dependent on a controlled substance under the INA and could be deemed inadmissible to the US laws and may be deemed abusers or substance dependents by the US Consular or Immigration Officers.

Noted as somewhat of a potential knee jerk reaction from the USA, Cannabis Reform in Bermuda could possibly provide justification for the US pre clearance to remain in place to protect the US from drug trafficking and traffickers.

To sign a memorandum of understanding (MOU) with the US regarding cannabis reform, Bermuda, as an independent overseas territory of the UK, would need permission from the UK government. Whether the UK would permit such an MOU is unknown. Whether the US would be interested in signing such an MOU is unlikely, given that US federal law still treats cannabis in all its forms as an illegal controlled substances, despite legalization/decriminalization in various states.

The CRC Recommends

1. **That the Minister use the statutory powers to proactively enact reform without taking the topic to the House of Assembly**
2. **Decriminalize personal possession and personal cultivation immediately**
3. **Develop a phased approach to cannabis reform and policies that limit potential of Bermudians being denied access to the United States (Stop List) and conduct further discussions with the US Consulate.**
4. **Introduce a less punitive warning system i.e.: civic penalties and harm reduction/education initiatives**
5. **The Department of National Drug Control be placed under the Ministry of Health and a greater emphasis on demand reduction with a focus on prevention and treatment be the overall focus of drug policy in Bermuda.**
6. **Confirmation of any obligations and level of autonomy with respect to policy reform, as a British Overseas Territory**

6. Local Cannabis Culture

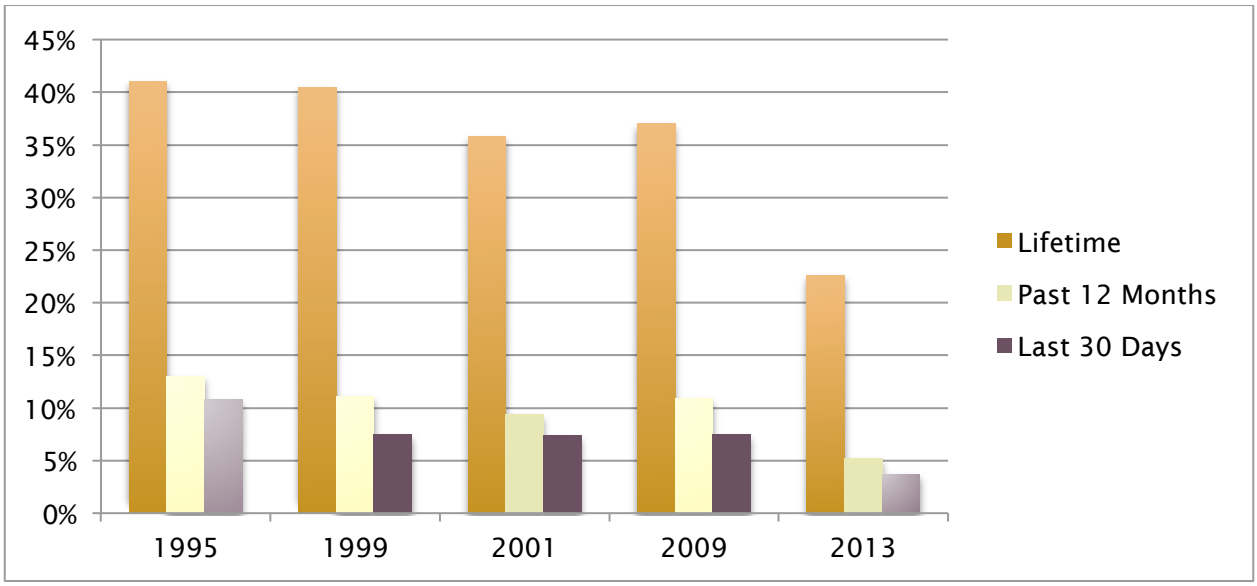
Perception shifts - political & public

In the 2013 Throne Speech, the OBA Government announced plans to review and reform the current cannabis policies and subsequently the PLP presented a draft amendment to the 1972 Misuse of Drugs Act to permit personal possession of cannabis in 2014. This in combination with the public's attitude towards reform reflects a shift as reported in the 2013 Household National Drug Survey, where 48.6% of those surveyed are in favor of Cannabis for personal use. Out of 1,088 respondents in a CRC e survey, 54.04% identified being in support of the legalization of cannabis while 25.46% were in support of decriminalization of cannabis and another 12.78% were in support of medical cannabis.

By comparison, it should be noted that there also sectors of the community that believe that the current approach to cannabis policy is effective in reducing usage and the dangers that accompany abuse.

According to the 2013 Household National Drug Survey conducted by the DNDC, 22% of the surveyed population reported that they use cannabis. As reported by the DNDC, Lifetime use of cannabis has decreased since 1995 from 41% to 22% in 2013. Many contributions to the CRC have stated that use of cannabis is far higher than an estimated 22% of the population. Through an e-survey conducted by the CRC, 48% out of 1,080 respondents identified that they never use cannabis.

Bermuda Cannabis Use Rates (Reported) (DNDC 1995 - 2013)



Survey of Students on Knowledge and Attitudes of Drugs and Health 2012
P5, P6 & M1 - Reasons for Drug Use

The top two statements with positive responses were "people use drugs because their friends use drugs" at 38.2% and "people use drugs because their parents use drugs" at 23.7%, while a smaller proportion of students felt that "using drugs make you look cool" (1.3%).

National School Survey 2011
School students in Bermuda in grades M2 through S4 report a Lifetime cannabis use rate of 21.2% and current use rate of 8.1%.[5]

2013 College Students' Drug Use: Report of the Behavioral Study of Attitudes toward and Consumption of Alcohol, Tobacco, and Other Drugs among College Students in Bermuda

Reported Cannabis Use
Lifetime = 46.1% 12 Months = 34.2% 30 Days = 24.7%

Use Scenarios

Cultural Events

Cannabis is a significant part of Bermuda culture and is regularly traded, shared, and sold at local social events such as football games, Cup Match, and county cricket games. Despite being illegal it is common to smell the aroma of cannabis at many Bermudian events while listening to the sounds of reggae and dancehall.

Cruise Ship Seizures

Currently, despite being seen as a friendly tourist destination, there are repeated reports of cannabis searches on visiting cruise ships resulting in time resources and costs to implement searches, prosecution and court costs as well as co-ordination with the US authorities etc.

Bermuda Cannabis Facts

Costs

The price of Cannabis hasn't changed much over the past decade and the street value per gram has mainly remained at $50 per gram. Larger amounts can be purchased for less including quarter ounces (7 grams) for $150 and ounces for $600.

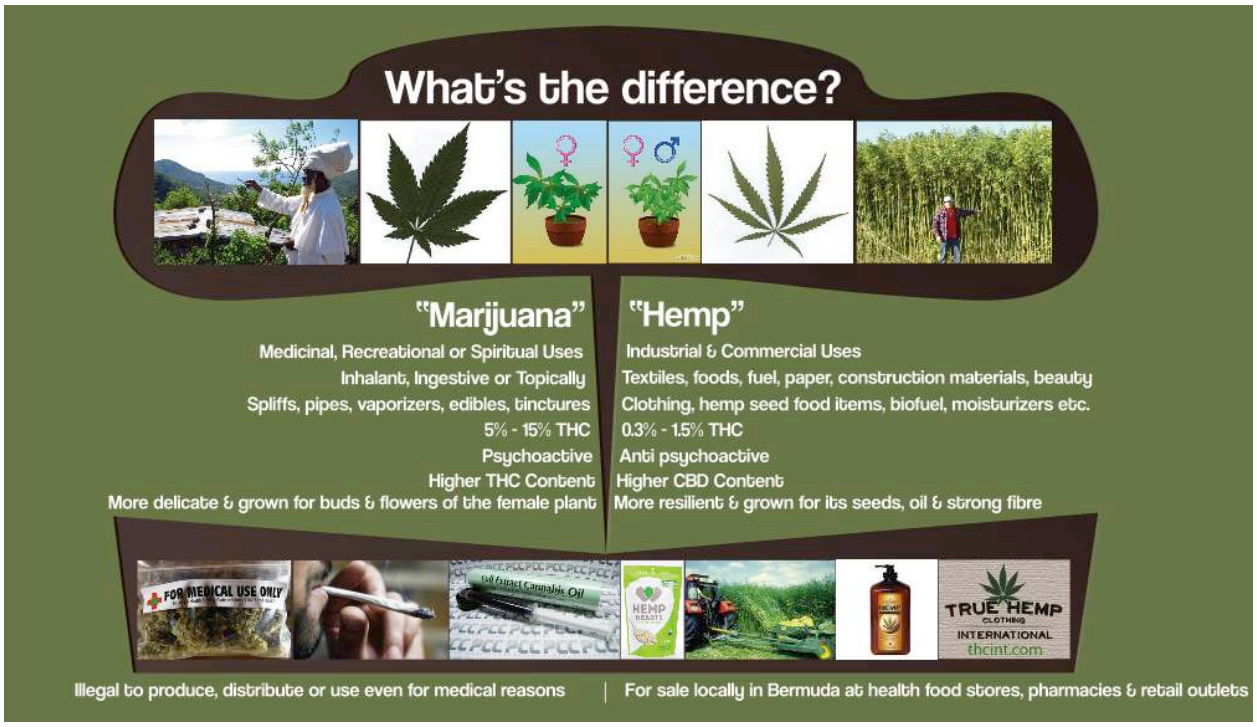
[5] DNDC - National School Survey 2011

Quality
The quality of cannabis is variable depending on the source. Some locals identify that the product can be contaminated when smuggled into Bermuda and has been subject to mold growth. There are sources for locally grown cannabis that provide better quality for a higher price.

Outlets to purchase
Places to purchase cannabis vary based due to easy access and the high returns many people purchase cannabis with the intent to supply persons within their networks. Cannabis dealing has been noted as a full time occupation or a way to supplement income or habits.

Rizla Stats
According to reports from Pitt & Co - who has the largest market share of rolling papers and distributes well known brand Rizla - in 2013 there were over 6.5 Million individual rolling papers imported into the island. Of that figure, it is estimated that roughly 50%, say 3.6 million would have been used for "roll your own" tobacco products leaving the remaining 2.9 million individual rolling papers for additional uses. Many would attest that Rizla is the common choice for rolling cannabis spliffs and if we were to say a quarter of the 2.9 million were used for cannabis that would illustrate that over 725,000 papers were used for cannabis spliffs. Spliffs are generally rolled from 1, 2 or 3 papers. Assuming a conservative 10% of wastage, leaves approximately 650,000 papers used, resulting in a minimum of 250,000 spliffs for that period.

"Hemp" vs "Marijuana"
Cannabis Sativa has been referenced in many ways over the years however there is a significant difference in the terms of Hemp and Marijuana. Hemp has a lower THC content, is used industrially and available locally while "Marijuana" can have a higher THC content, is used recreationally and medicinally and currently illegal. The term hemp was used to refer to actual uses of the plants fibers whereas the term Marijuana has been used to describe the illegal substance. Below is a chart that explains the difference between the two terms:



The CRC recommends:

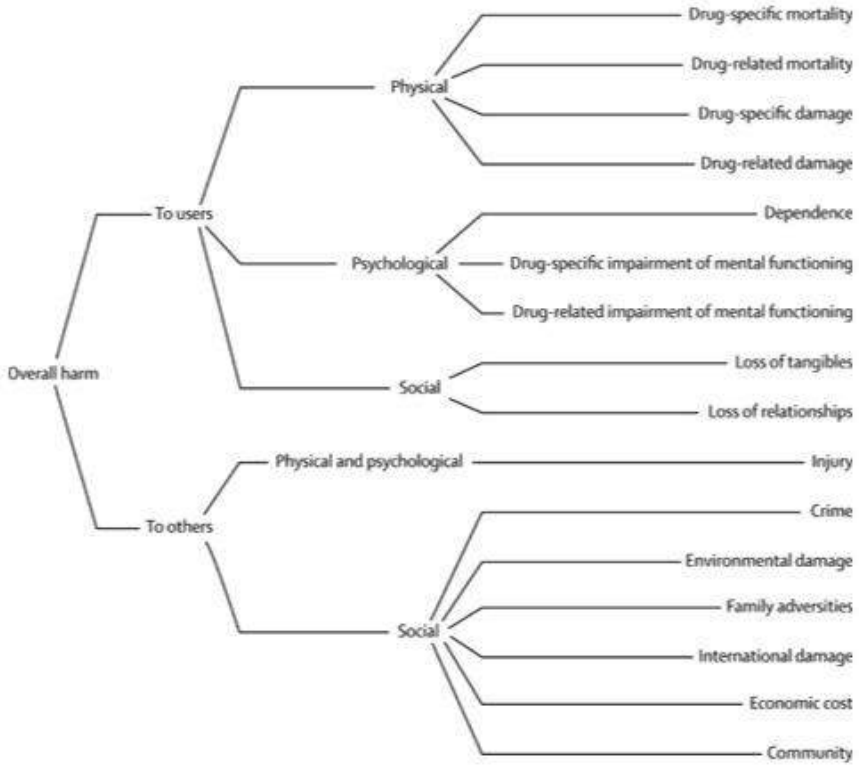
1. **Increase education resources around Cannabis.**
2. **Improve quality of cannabis education to ensure that it is more objective and fact based.**
3. **Implement more effective data collection to understand effects of courts, police and prison forces.**

7. Social & Health Perspectives

The importance of aligned and integrated policies and programmes in drug policy reform cannot be underestimated and themes included in this chapter are based on a common desire for social and health wellness. These are fundamental considerations for policy reform in Bermuda and they form the basis of a wide range of topics explored in this chapter.

COMPARATIVE ANALYSIS OF HEALTH RISKS CANNABIS, TOBACCO AND ALCOHOL

In reviewing the validity of revising the legal status of cannabis, it is useful to assess the health risks and consider them in the context of other widely used social drugs. A study in the Lancet, a British medical journal, looked at the harmfulness of different substances to users and society. As reported, members identified 16 harm criteria" as noted in the chart to the right: [6]



Drugs were assessed based on a score of 1-100 and the study found that alcohol was by-far the most harmful drug overall, and alcohol and tobacco each presented a greater harm to users than every drug except heroin, methamphetamine, and crack cocaine.

The authors explain that one of the limitations of this study is that drug harms are functions of their availability and legal status in the UK, and so other cultures' control systems could yield different rankings. These measures for harm to others and users include damage to health, drug dependency, economic costs and

[6] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61462-6/fulltext

crime. Note that alcohol (despite being legal more often than the other drugs) is by far the most harmful; not only is it the most damaging to societies, it is also the fourth most dangerous for the user. Most of the drugs were rated significantly less harmful than alcohol, with most of the harm befalling the user.

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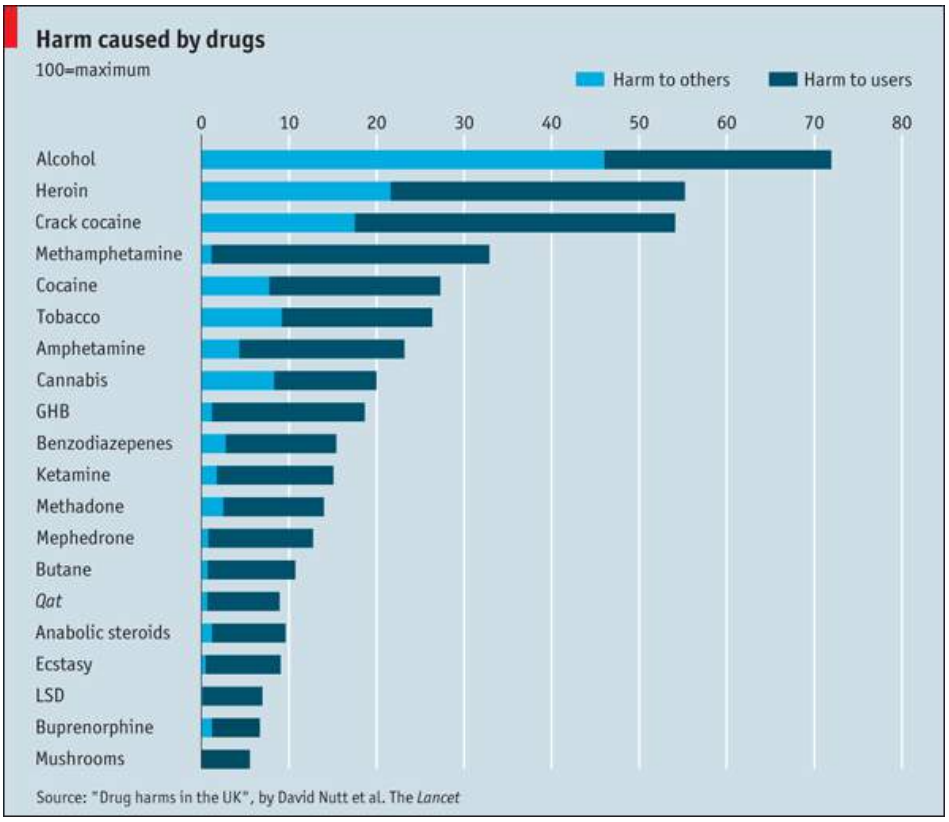
The Global Status Report on Alcohol and Health[9], outlined the overwhelming nature of the problem: "Alcohol consumption is the world's third largest risk factor for disease and disability; in middle-income countries, it is the greatest risk. Alcohol is a causal factor in 60 types of diseases and injuries and a component cause in 200 others. Almost 4% of all deaths worldwide are attributed to alcohol, greater than deaths caused by HIV/AIDS, violence or tuberculosis. Alcohol is also associated with many serious social issues, including violence, child neglect and abuse, and absenteeism in the workplace.



Tobacco while, far less harmful in terms of impacts on society (other than Health costs), is highly addictive and widely recognized as a considerable health risk to users.

[7] "Scoring drugs", The Economist, data from "Drug harms in the UK: a multi-criteria decision analysis", by David Nutt, Leslie King and Lawrence Phillips, on behalf of the Independent Scientific Committee on Drugs. November 5, 2011

[8] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61462-6/fulltext

[9] http://www.who.int/substance_abuse/publications/global_alcohol_report/msbgsruprofiles.pdf?ua=1

[9]

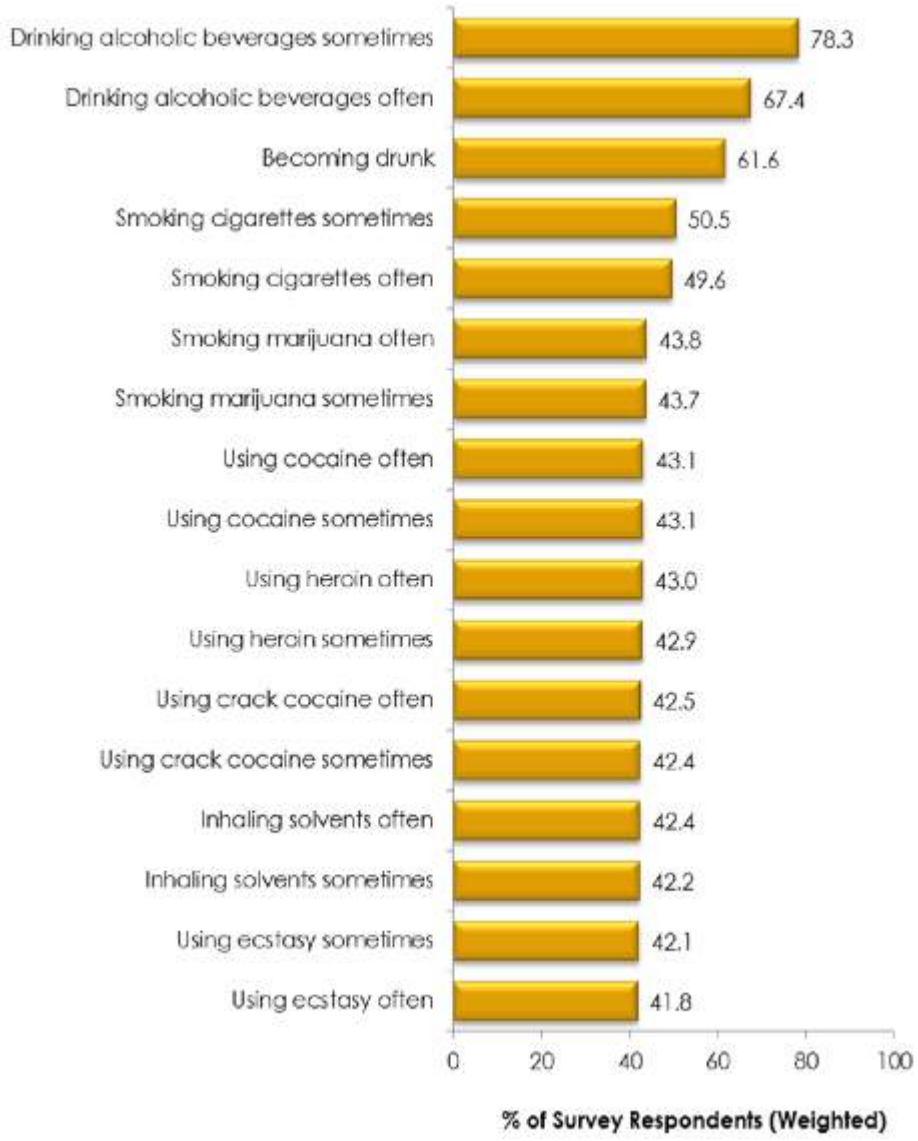
Yet, in spite of this, comparatively speaking, the potential harm associated with alcohol and tobacco use are eclipsed by the societal focus on cannabis as a result of its illegal status , which is entirely inconsistent with its relatively low health risks.

In their 2009 report studying Cannabis, Tobacco and Alcohol Use in Canada by Gerald Thomas, Chris Davis noted that health-related costs per user are eight times higher for drinkers of alcoholic beverages than they are for those who use cannabis, and are more than 40 times higher for tobacco smokers. Although they acknowledge that a lot of the variance in harms, risks and social costs of alcohol, cannabis and tobacco has to do with how the substances are handled legally, and that this for example will explain the low enforcement costs of Alcohol and tobacco relative to cannabis, they conclude that the health costs per user of tobacco and alcohol are much higher than for cannabis.[10]

These reported findings are further supported by the intuitive responses garnered by the DNDC in their recent survey of a random sampling of 1200 Bermuda Households where "drinking alcohol beverages sometimes" was perceived by 78.3% of the respondents to be the highest ranked behavior with "some level of risk" [11]

Remarkably, the level of risk assigned to cannabis use in Bermuda is fairly level with the risks associated with harder drugs with vastly higher health risks. This points to a greater need for clearer information to be disseminated in the community with increased education efforts.

[10] ibid.
[11] Report of the 2013 National Household Survey Final, p 25



Substance Danger & Dependence Potential

The chart below identifies that the psychoactive compounds within a cannabis plant high in THC are far less lethal than other legal substances such as Morphine, Nicotine and Alcohol. It also illustrates that the dependence potential of cannabis is moderate to low and on par with that of caffeine (available island wide and in no regulated manner). Such information should be actively considered when reviewing cannabis policies and comparing the plant to other legal substances and their impact.

Data source: Gable, R. S. (2006). Acute toxicity of drugs versus regulatory status. In J. M. Fish (Ed.),Drugs and Society: U.S. Public Policy, pp.149-162, Lanham, MD: Rowman & Littlefield Publishers. April 2, 2010

Dependence Potential	**Very high**	**Heroine**		
	High	**Nicotine**	**Morphine**	
	Moderate / High	**Cocaine**		
	Moderate	**Alcohol**		
	Moderate / Low	**Cannabis**	**Caffenine**	**MDMA**
	Low	**Ketamine**		
	Very low	**LSD**		

The Department for National Drug Control (DNDC) - *Demand Reduction Efforts*

Good prevention efforts first start with a proper assessment of the problem. Most would agree that an appropriate prevention model will be designed to address a potential problem. In this regard, Bermuda's prevention efforts regarding cannabis are found in the overall national strategy regarding all illicit drug use. In general terms, local prevention efforts are designed to:

1. Delay early onset of first use
2. Provide information regarding the harmful effects of illicit drug us
3. Prevent and discourage the sale and distribution of controlled substances

While these efforts follow a standard prevention model, a more progressive approach would be designed to:

1. Delay early onset of cannabis use
2. Decrease potential engagement in the Criminal Justice system and its related cost to the user and the Government
3. Decrease potential negative immigration consequences for casual/recreational cannabis use

In this regard, prevention strategies that are addiction specific should be guided by three guiding principles:[12]

- Addiction is a complex disease. No single factor can predict who will become addicted to drugs. Addiction is influenced by a tangle of factors involving genes, environment, and age of first use.
- Addiction is a developmental disease. It usually begins in adolescence or even childhood when the brain continues to undergo changes. The prefrontal cortex (located just behind the forehead) governs judgment and decision-making functions and is the last part of the brain to develop; therefore delaying the first use of illicit substances beyond the developmental years is advised.
- Prevention and early intervention work best. The developmental years might also present opportunities for resiliency and for receptivity to intervention that can alter the course of addiction.

Regarding a prevention model around cannabis reform, guiding principles should include:

- Public consultation Legislative or regulatory changes should be based on public input and be guided by sound science.
- Public safety. Law and policies must take into consideration public safety and balance the linkage between personal liberties and public safety.
- Sustainability. Potential changes should be guided by the "big picture." In doing so, any regulatory framework should take into consideration global trends, and explore public and private sector innovation and investment regarding new industries and revenue streams.

According to the DNDC, in terms of substance abuse prevention regarding direct service delivery (i.e. drug prevention education and community level information, awareness and interventions) These services are carried out by a few dedicated non-profit agencies which include: PRIDE, the Centre for Alcohol and Drug Abuse Prevention (CADA) and to a lesser extent, the Bermuda Council for Drug-free Sports (BCDS) which also is a recipient of a grants from the DNDC.[13]

In addition to the aforementioned, there are other agencies that promote pro-social /anti-drug life styles; such as Clubs, Brigades and Youth Groups. To some degree these agencies engage in non-formal activities that aid in prevention work to prevent or delay the onset of drug use. However, these agencies have

12 [1] http://www.drugabuse.gov/publications/topics-in-brief/drug-abuse-prevention

13 [2] National Drug Control Policies & Master Plan 2007-2011 pg. 44

very little training regarding addiction and are usually ill-equipped to offer specific interventions regarding addiction related issues. As such, Bermuda's prevention services are primarily offered by PRIDE, CADA and the BCDS who are solely tasked with prevention related services.

According to National Drug Control Policies & Master Plan 2007-2011, our national prevention goals include:[14]

1. Educate the public about substance abuse and promote social norms that discourage illegal and inappropriate use of alcohol, tobacco, and other drugs.
2. Target youth with clear messages that no use of alcohol, tobacco or other drugs is acceptable.
3. Support the development of community coalitions to promote, plan, and coordinate prevention activities that address specific community needs.
4. Involve families, schools, and community support in prevention efforts.
5. Motivate and prepare teachers, health professionals, clergy, community leaders, business leaders and all levels of workers, and other citizens to serve as positive role models by creating a greater sense of awareness of the harmful consequences of drug use at the community level through public education.
6. Use media and other technology to promote prevention through clear, consistent drug-free messages.
7. Provide research-based prevention programmes to foster positive, healthy lifestyles among youth, equipping them to resist the use of alcohol, tobacco, and other drugs.
8. Create employment settings where all employees adhere to a programme of policies and activities designed to provide a safe workplace.

Local Prevention efforts in Bermuda

According to the DNDC, substance prevention programs were initiated in Bermuda during the decade of the 1980's, under the auspices of the National Alcohol and Drug Agency. During this time there was an emergence of programmes such as Toughlove, Council on Alcohol and Drug Abuse, (CADA) Parent Resource Institute for Drug Education (PRIDE), Youth to Youth and in collaboration with the faith community.

14 [3] National Drug Control Policies & Master Plan 2007-2011 pg. 13

The current substance prevention initiatives administered by the DNDC are based on six specific strategies for the prevention of substance abuse:

1. Information Dissemination
2. Education
3. Alternatives
4. Problem identification & referral
5. Community-based process
6. Environmental

When it comes to developing programmes there is a seven-step process:

1. Community Readiness
2. Needs Assessment
3. Prioritizing
4. Resource Assessment
5. Targeting Efforts
6. Best Practices
7. Evaluation

Works in prevention have been formulated with assistance from the Substance Abuse & Mental Health Services Administration (SAMHSA) and the United Nations. According to the DNDC, programmes are localized as best as possible and through trial and error. Entities such as the Institute of Medicine, American Medical Society, National Institute on Health, and United Nations are used to collect information around substances. It is important to note that cannabis is not particularly targeted in prevention as all substances of abuse are considered collectively. In the past, the DNDC has focused on prevention around "gateway drugs" which included alcohol and cannabis in particular. The "gateway theory is discussed further in this section.

According to the DNDC, the goal for prevention is "to have substance abuse prevention education implemented into the school curriculum at all school levels.".

Programmes are incorporated into all schools across the island including public and private but some have more programmes than others - but not every school. Until the teachers are trained to deliver the courses - there will be no consistent prevention programmes incorporated into the entire school system curriculum.

Lower primary age school children have programmes in the public primary schools at levels 1 & 2. A coordinator goes to all the primary schools to support

teachers who have been trained to deliver the DNDC's Als Pals: Kids Making Healthy Choices Programme. This is a programme for children ages 3-8 years. This early childhood programme is also utilized in some private pre-schools on the island. The DNDC has also implemented a substance abuse prevention afterschool middle school after school programme at the five public middles schools on the island. PRIDE is working with Whitney Institute to implement a curriculum based programme.

PRIDE has been working with the senior schools. There are some gaps in the prevention system, however, the DNDC and their partners are working together to develop effective more programs.

Programmes in the school system begin as early as preschool and most schools include substance prevention as part of their health curriculum. Substance abuse prevention programming is also included in afterschool activities and in programmes scheduled during the lunch hour. The DNDC provides substance abuse education for all school age children and their parents. Different substances are addressed depending on the age of the students, but most programmes focus on alcohol, tobacco, cannabis and prescription drugs. These drugs are most prevalent in youth culture and therefore should continue to be an area of focus for the DNDC.

The DNDC is responsible for training the educators and evaluating the implemented programming. Training for professionals is provided at least twice a year and either teachers or prevention specialists administer programmes in the schools. Programs that are implemented and supported by the DNDC address student social emotional learning, i.e. student self-management, self awareness, social awareness, relationship skills and more important responsible decision-making. Comparable to other jurisdictions, programmes are culturally sensitive and evidence based in addition to focusing on what puts students at risk drugs and other anti-social behaviours.

There are standards set by the National Institute on Health which are adhered to by the DNDC and its partners including CADA & PRIDE School Programs
Prevention programs can be designed to intervene as early as preschool to address risk factors for drug abuse, such as aggressive behavior, poor social skills, and academic difficulties.

Prevention programs for elementary school children should target improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout. Education should focus on the following skills:

- self-control;
- emotional awareness;
- communication;
- social problem-solving; and
- academic support, especially in reading.

Prevention programs for middle or junior high and high school students should increase academic and social competence with the following skills (Botvin et al.1995; Scheier et al. 1999):

- study habits and academic support;
- communication;
- peer relationships;
- self-efficacy and assertiveness;
- drug resistance skills;
- reinforcement of antidrug attitudes; and
- strengthening of personal commitments against drug abuse.

Teachers provide students with the myths and the facts around substances including cannabis. The DNDC defines Cannabis like all other substances of abuse, "as a psychoactive drug, which alters the way you may act and think." In addition, because cannabis is illegal and stated as an addictive substance, students are provided facts about the harms that are associated with tobacco alcohol and cannabis and other substances. The DNDC does not discuss any of the medicinal elements of the cannabis plant in their curriculum.

Prevention agencies including CADA & PRIDE provide quarterly reports on programming to the DNDC and in addition student surveys are completed in the schools. The last two surveys have shown a decline in drug use but which is an indication that prevention is working - as identified in section 6.

The DNDC states, "There is always room for improvement and all prevention programmes in Bermuda utilize tested effective modalities. The unfortunate aspect is that there are few internationally certified prevention professionals." "Trying to include drug prevention education, as part of the school's curriculum" is also another stated challenge of the DNDC.

Ministry of Education

According to the Acting Commissioner of Education, Lou Matthews, the Ministry of Education (MOED) has a decentralized approach to Substance Prevention and programs are typically initiated from the school sites and in partnership with the DNDC. There is no current national strategy regarding substance prevention directly within the Ministry of Education curriculums. The current approach has been to work with the DNDC who has hired part-time persons to monitor use of the programmes in school. The MOED provides feedback to the DNDC regarding its system initiatives and survey. Usage rates of substances are monitored in the annual student surveys conducted by the DNDC. Students do use or come to school having used cannabis and this is dealt with directly by schools and school principals. Students may be suspended under the Education Act for drug violations and these violations are reported to both parents and schools. If amounts are substantial and the activity of distribution and selling is involved, BPS are involved most typically by way of the Community Action officer. All ages are reported to BPS but statistics are not kept on cases related to cannabis use or sales in the schools. The cases are treated as individual cases under the Education Act. There are a host of student services including drug testing, referrals to external agencies, internal interventions or meetings with parents for example.

Addiction & Treatment

According the American Society of Addiction medicine, drug addiction is defined as:

"Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death."[1]

According to new criteria in the Diagnostic Statistical Manual 5 (DSM-5), there is major shift. A diagnosis of substance abuse previously required only one symptom to be present as indicated by the patient. The DSM-5 now requires two to three symptoms from a list of 11 potential symptoms. The purpose of the change is to create a distinction between abuse and dependence. Previously,

the diagnosis of dependence caused much confusion. Most people link dependence with "addiction" when in fact dependence can be a normal body response to a substance.[2]

The DSM 5 criterion for "abuse" allows the assessor to make a diagnosis when two or more symptoms are present. Two or three symptoms indicate a mild substance use disorder, four or five symptoms indicate a moderate substance use disorder, and six or more symptoms indicate a severe substance use disorder.[3] Below is a list of presenting symptoms:

1. Taking the substance in larger amounts or for longer than the you meant to
2. Wanting to cut down or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home or school, because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational or recreational activities because of substance use
8. Using substances again and again, even when it puts the you in danger
9. Continuing to use, even when the you know you have a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the effect you want (tolerance)
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

As it relates to cannabis reform, there are two major changes to the new DSM-5 criteria for substance use disorder that should be noted:[4]

- "Recurrent legal problems" criterion for substance abuse has been deleted from DSM-5
- A new criterion has been added: craving or a strong desire or urge to use a substance.

According to the Bermuda DNDC, Cannabis is the local "drug of choice."[5] Cannabis is also the most widely used illicit substance in the United States and Europe.[6] As such, drug testing and the enforcement of anti-drug laws have negatively affected recreational users of cannabis. Despite a disproportionate number of arrests for Cannabis related offences, positive tests for Cannabis use

amongst court mandated clients under the supervision of the Department of Court Services only represent 18% of all services users; which may indicate low incidences of dependency. According to the Bermuda Assessment and Referral Center (BARC), "there has been a decrease in the number of individuals who test positive for cannabis alone."[7] Similarly, persons accessing treatment services specifically for Cannabis is almost statistically irrelevant, notwithstanding, "there is a gap in services for persons seeking treatment for cannabis treatment alone."[8]

Treatment for drug dependency in Bermuda fall into two main categories – inpatient or outpatient services. Currently there are only two agencies, which provide residential services for males (Harbor Light / Men's Treatment Center), with a third companion program (Recovery Support Service, a 90 day residential) opening soon which will be operated by Focus Counseling Service. Turning Point, which is run by the Bermuda Hospital's Board, is the only entity offering outpatient treatment, inpatient detoxification, and methadone maintenance. Presently there isn't a cannabis specific program available on the island. Typically persons with cannabis specific issues are referred to outpatient services and/or participate in drug education courses. These courses are designed to provide the participant with information regarding the harmful effects of drugs, and equip them with coping strategies, relapse prevention skills, and assist the participant in connecting to a support network.

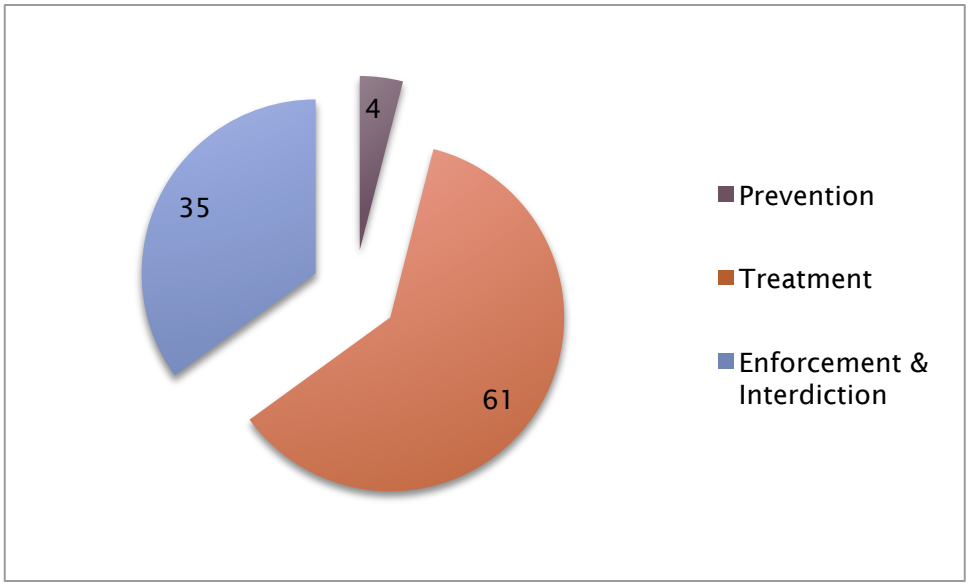
Substance abuse treatment falls into two main categories—detoxification and rehabilitation. Detoxification refers to short-term medical treatment provided to manage withdrawal symptoms. This kind of treatment is usually offered in an inpatient setting. Rehabilitation is multifaceted, with treatment programs and types varying in length, settings, and focus. For many addicts, sobriety is achieved after many treatment episodes. Currently, insurance benefits for individuals seeking drug treatment is only possible for persons deemed "indigent" under the Standard Hospital Benefit (SBH), persons with private insurance are not eligible for insurance benefits regarding addiction related treatment. If insurance benefits exist beyond SBH, they vary by insurers, and are not regulated.[1]

In the United States, major health insurers have yet to provide insurance coverage for medical marijuana. Insurers are unwilling to change their policies/positions due to the fact that the U.S. Food and Drug Administration has not given its seal of approval to medical marijuana, because Cannabis remains illegal (controlled substance) by federal law.[2] As such, local insurers will be reluctant to discuss insurance policy changes if Cannabis remains illegal (controlled substance).

[1] http://www.asam.org/for-the-public/definition-of-addiction
[2] http://www.dsm5.org/Documents/Substance%20Use%20Disorder%20Fact%20Sheet.pdf
[3] http://addictions.about.com/od/aboutaddiction/a/Dsm-5-Criteria-For-Substance-Use-Disorders.htm
[4] http://pro.psychcentral.com/2013/dsm-5-changes-addiction-substance-related-disorders-alcoholism/004370.html
[5] National Drug Control Policies & Master Plan 2007-2011 pg. 50
[6] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2797098/
[7] Department of Court Services March 20, 2014 submission to the CRC
[8] Department of Court Services March 20, 2014 submission to the CRC

Demand for more Prevention

As identified by the DNDC, of the drug control expenditure, demand reduction activities received the larger proportion of the allocated resources in the 2012/13 fiscal year when compared to the allotment given to supply reduction. On the demand reduction side, there is a marked disparity in focus and allotment of resources between treatment and prevention, with treatment receiving the greater proportion. The majority of the supply reduction budget is allocated to the Bermuda Police Service for its drugs and intelligence division.



It is evident from the chart above that Bermuda does not spend enough money on prevention with the result that we have to pay much more for treatment in the long term. The lack of consistent and relevant prevention programs available for users of illicit drugs and cannabis has enabled drug abuse and perpetuated the cycles of addiction.

Studies show that long term planning of prevention strategies and providing sustained funding will reduce substance use rates and the demand for treatment in the future. The National Institute on Drug Abuse (NIDA) in the US reports that "For every dollar spent on drug abuse prevention, communities can

save US$ 4-5 in cost for drug abuse treatment and counseling." A shift of focus from criminalizing and punishing substance users to promoting human rights, public health and socio-economic development will bring better results and be more consistent with other areas of social and health policy. This philosophy should be at the core of future substance use and prevention campaigns.

The Bermudian Drug Treatment Court is having tremendous success and this approach is demonstrating the value of focusing on treatment as opposed to criminalization and how it is an effective solution to managing substance use and addiction in Bermuda. However the core long-term focus should be towards education intervention and prevention efforts.

The Gateway Theory and Transition to dependence

The "gateway pattern", was coined in the early 80's, based on community epidemiological research, concentrated in North America and Oceania, to describe a progression of use following a common sequence of drug use initiation that begins with tobacco and alcohol use, followed by cannabis and then other illicit drugs, where use of an earlier drug in this sequence predicts progression to use of later ones (e.g. cannabis and other drugs)[15].

More recently however, it has been posited that it is unclear whether the normative sequence of drug use initiation, beginning with tobacco and alcohol, progressing to cannabis and then other illicit drugs, is "due to causal effects of specific earlier drug use promoting progression, or to influences of other variables such as drug availability and attitudes"[16]. In a study conducted in 2010, researchers "compared patterns and order of initiation of alcohol, tobacco, cannabis, and other illicit drug use across 17 countries with a wide range of drug use prevalence" [17]. Their findings were that,

> The present study provided suggestive evidence to suggest that drug use initiation is not constant across contexts and cultures. Although cannabis is most often the first illicit drug used, and its use is typically preceded by tobacco and alcohol use, the variability seen across

[15] Evaluating the drug use "gateway" theory using cross-national data: Consistency and associations of the order of initiation of drug use among participants in the WHO World Mental Health Surveys Louisa Degenhardt, Lisa Dierker, [...], and Ronald C. Kessler, Drug Alcohol Depend, April 1 2010, 108 (1-2) p84-97.

[15] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835832/#!po=31.2500
[16] ibid
[17] ibid

> countries, which is related to the background prevalence of such drug use, provides evidence to suggest that this sequence is not immutable. Violations of this sequence are not associated with the development of dependence; rather, it seems to be the age of onset and degree of exposure to any drugs that are more important predictors.

Another consideration in the gateway perspective is the issue of proximity. The separation of Cannabis from other illegal substances on the black market by way of openness and easier access was found to be a useful and successful tactic employed by the Dutch. Dutch policy also demonstrates that it is possible to separate markets for Cannabis and other drugs, minimizing any "gateway" effect that might be caused by Cannabis dealers introducing users to other substances. "We argue that coffee shops and tolerance of cannabis played an important role in pacifying the heroin epidemic and keeping young people away from that," says Grund. And there's evidence for that. In a 1999 report, the Institute of Medicine reviewed the data and concluded that there was little support for the idea that marijuana, which is often the first drug used by heroin and cocaine addicts, specifically leads users to others drugs.

The lead author of the Open Society report, Jean Paul Grund, senior research associate at the Addiction Research Center in Utrecht, says that the Dutch also have fewer problem drug users than is typical in Europe and that heroin use has dramatically declined over the last several decades, with fewer young people starting to take the drug. "The average age of people using heroin is now 50 years," he says.[18]

The Developing Brain & Substance Use

In considering effective cannabis policy in relation to Bermuda's youth, it is important to gain a perspective on the issues and ensure they are being addressed from a youth centric perspective. Medical justification of any proposed legal age for cannabis use should be evaluated based on current scientific research related to the developing brain.

As Sheryl Feinstein, author of Inside the Teenage Brain: Parenting a Work in Progress (Rowman and Littlefield, 2009.), explains, the developing teenage brain relies more on the limbic system (the emotional seat of the brain) than the more rational prefrontal cortex, decision-making can be overly influenced by emotions in the heat of the moment[19]. In an article 10 Facts Every Parent Should

[18] http://www.opensocietyfoundations.org/sites/default/files/Coffee%20Shops%20and%20Compromise-final.pdf

[19] http://www.livescience.com/13850-10-facts-parent-teen-brain.html

Know about Their Teen's Brain[20], the author reports of brain imaging studies showing that after infancy, a second burst of neuronal sprouting happens right before puberty, peaking at about age 11 for girls and 12 for boys. This structural reorganization is thought to continue until the age of 25, and smaller changes continue throughout life. As the brain develops, it becomes more interconnected and gains processing power and adolescents start to have the computational and decision-making skills of an adult if given time and access to information[21]

In a study by Dan I. Lubman, et al., Substance use and the adolescent brain: A toxic combination? regarding developmental changes taking place in the adolescent brain the following was stated:

> Early onset substance use has consistently been associated with increased risk for a range of adverse outcomes in late adolescence and early adulthood. However, the mechanisms that underlie this relationship are not fully understood. Recent advances in developmental neuro-science, together with emerging literature on early onset substance use, suggest that the adolescent brain may be more vulnerable to the effects of addictive substances because of the extensive neuromaturational processes that are occurring during this period. Such findings are suggestive of disrupted developmental trajectories in early onset users, although there is growing evidence that high-risk youths have premorbid neurobiological vulnerabilities.[22]

While any interference with the extensive brain development processes occurring in this age group are likely to be viewed as a risk, these risks are not unique to Cannabis, and present in other legally available products such as alcohol, cigarettes and inhalants. The comparative health risks of these substances are explored in other parts of this paper. However, many studies including those cited above point to a predisposition to substance abuse disorder, a factor also noted in another recent study that found that Cannabis use appears to magnify risks in youths predisposed to mental illness. Cannabis use, addiction risk and functional impairment in youth seeking treatment for primary mood or anxiety concerns, published in 2013 by Osuch E, Vingilis E, et al., determined:

> there is evidence that the co-occurrence of cannabis use (and other substance use) with mental illnesses predicts poorer

[20] ibid

[22] http://jop.sagepub.com/content/21/8/792.short

> outcomes, including suicide"[23]. Their study looked at (i) rates of cannabis use and substance use disorder risk, and (ii) predictors for cannabis use among youth seeking help for mood and/or anxiety concerns in a sample population prescreened to exclude primary substance use disorders; and (iii) to determine if there was an association between cannabis use and functional impairment in this sample. Results of this study showed that approximately half of the participants were at moderate to high risk for a substance use disorder, and just over 4% appeared to have a primary substance use disorder. They also suggested an association between cannabis use and gender (male), age of first cannabis use, recent cigarette use, and functional impairment. These results support the need for substance use treatment programs to optimize care wherever youth with primary mood and/or anxiety concerns are seen.[24]

Taking the commonalities of the above references, it is clear that any shift in policy needs to be accompanied by a robust programme of education and support which is youth centric and recognizes the specific developmental vulnerabilities of this group. Indicated prevention focuses its attention on the needs of the target group, which point to the importance of vigilance and access to information for this age group.

Studies on Cannabis induced chronic Psychosis

A significant and prevalent concern in the medical community is the alleged link between heavy cannabis use and chronic psychosis. In their 1972 report, The Effects of Long Term Cannabis Use[25], The National Commission on Marihuana and Drug Abuse asserted that "the alleged connection between mental illness and cannabis derives from Africa, the Middle East and India" where for "many years medical care and especially psychiatric care were given low priority"[26] This report cites a vast range of studies on cannabis induced chronic psychosis from around the world, and is worth review by anyone with a deep interest in this topic [APPENDIX 5] It summarizes conclusions reached and notes that many early studies reported a link between mental illness patients in institutions and cannabis use, and conversely other studies demonstrated a low link, creating a confused picture on cannabis induced chronic psychosis.

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[23] http://www.hubmed.org/display.cgi?uids=23839811 Cannabis use, addiction risk and functional impairment in youth seeking treatment for primary mood or anxiety concerns, 2103 Osuch E, Vingilis E, Ross E, Forster C, Summerhurst C Int J Adolesc Med Health. 2013; 25(3): 309-14

[24] ibid

[25] http://www.druglibrary.org/schaffer/library/studies/nc/nc1g_7.htm The Report of the National Commission on Marihuana and Drug Abuse: Effects of Long-Term Cannabis Use 1972.

[26] ibid., The Report of the National Commission on Marihuana and Drug Abuse: Effects of Long-Term Cannabis Use,

This report also cites the widely publicized study by Kolansky and Moore (1971) of cases of individuals ages 13-to-24, which claimed profound adverse psychological effects from smoking marihuana two or more times a week. It is somewhat interesting to note the context in which the Kolansky Moore study was conducted: a period of intense persecution and criminalization of cannabis, largely with a racial bias, during the Nixon era. The following is the assessment by the National commission on Cannabis and Drug Abuse, of the Kolansky and Moore study:

> Of 38 individuals reported, all had decompensated personalities, eight had psychoses (four attempted suicide) and 13, according to the authors became sexually promiscuous due to marihuana. These clinical impressions were, all based on, at most, a few interviews with the, individuals who were referred to these psychiatrists for consultation for problems (including one-third by legal authorities after arrest for possession of marihuana). Thus, it is impossible, to state unequivocally, as the authors do, that since marihuana use and psychiatric problems occurred at the same time the former is causative of the latter.[27]

The review by the National commission reports that unfortunately, the authors of the Kolansky Moore study made sweeping generalizations to all young adolescent marihuana users from this biased and non-representative sample. No attempt was made to interview other young cannabis users who have not been referred for psychiatric help, and the high prevalence of promiscuity and psychopathology in comparable adolescent populations was totally disregarded[28]. In addition, case histories of previous mental health were obtained introspectively from the patient, their families or the referral source.

The report by the National Commission concluded that:

> Some reports describing a prolonged psychotic course after an initial acute episode cannot rule out the role of pre-existing psychopathology. At the present time evidence that cannabis is a sufficient or contributory cause of chronic psychosis is weak and rests primarily on temporal association[29].

A review article titled Causal association between cannabis and psychosis: examination of the evidence, published in the British Journal of Psychiatry in

2004[30], acknowledges that cannabis use "can lead to acute transient psychotic episodes in some individuals (D'Souza et al, 2004)"[31], it observes that "most studies were unable to establish whether prodromal manifestations of schizophrenia preceded cannabis use, leaving the possibility that cannabis use may be a consequence of emerging schizophrenia rather than a cause of it"[32]. It further observes "despite steadily increasing rates of cannabis use over past decades, the incidence of schizophrenia in the population has remained stable"[33]. And taken altogether, the report finds that the causal relationship is tenuous and likely only part of a complex picture:

> On an individual level, cannabis use confers an overall twofold increase in the relative risk for later schizophrenia. At the population level, elimination of cannabis use would reduce the incidence of schizophrenia by approximately 8%, assuming a causal relationship. Cannabis use appears to be neither a sufficient nor a necessary cause for psychosis. It is a component cause, part of a complex constellation of factors leading to psychosis[34].

Is there a link between cannabis & violent crime?

There is widespread concern in the community about violent crime and gang related violence which is widely attributed to the black market in drugs. This perceived relationship has led to a resistance to any sort of loosening of restrictions related to the supply, distribution and use of illegal substances, and possibly a related concern that any such change will be seen to condoning violence and could lead to increased crime. Numerous studies have been carried out on the relationship between cannabis and violent crime. One 2010 study out of Norway Cannabis and crime: findings from a longitudinal study, Pedersen W, and Skardhamar T., found "robust associations between cannabis use and later registered criminal charges, both in adolescence and in young adulthood"[35]. However, when these associations were adjusted for a range of confounding factors, such as family socioeconomic background, parental support and monitoring, educational achievement and career, previous criminal charges, conduct problems and history of cohabitation and marriage"... and when "all types of drug-specific charges" were eliminated from the models, the researchers "no longer observed any significant association with

[30] http://bjp.rcpsych.org/content/184/2/110.full
[31] ibid.
[32] ibid.
[33] ibid.
[34] ibid.
[35] http://www.ncbi.nlm.nih.gov/pubmed?cmd=Search&doptcmdl=Citation&defaultField=Title%20Word&term=Pedersen%5Bauthor%5D%20AND%20Cannabis%20and%20crime%3A%20Findings%20from%20a%20longitudinal%20study. *Cannabis and crime: findings from a longitudinal study. Pedersen et al.*,

cannabis use (and criminality)" and that therefore "the association seems to rest on the fact that use, possession and distribution of drugs such as cannabis is illegal"[36]. These findings point to the strong possibility that legalizing cannabis would actually reduce criminality.

In a similar very recent study, The Effect of Medical Cannabis Laws on Crime: Evidence from State Panel Data, 1990 – 2006 by Robert G. Morris, et al.[37], published March, 2014, the authors reviewed an extensive range of references on the supposed link between cannabis and violent crime (as a result, the entire report has been included in Appendix 7), and investigate the effect of Medical Cannabis Legalization (MML) and whether it supported a causal link to an increase in violent crime. The study's findings were that

> Results did not indicate a crime exacerbating effect of MML on any of the Part I offenses. Alternatively, state MML may be correlated with a reduction in homicide and assault rates, net of other covariates. [38]

The researchers go on to conclude that:

> These findings run counter to arguments suggesting the legalization of Cannabis for medical purposes poses a danger to public health in terms of exposure to violent crime and property crimes[39]

It should also be noted however, that in jurisdictions where cannabis legislation is only relaxed with respect to medical uses, in an overall context of illegality, challenges have sometimes been faced, with respect to theft, and for these cases, one study, Evaluating Medical Cannabis Dispensary Policies: Spatial Methods for the Study of Environmentally-Based Interventions recommends increased security in the immediate vicinity of dispensaries to reduce chances of theft[40].

Recent data released from Denver Colorado Police Department shows a slight decrease in the past year: violent crime in January and February fell by 2.4

[36] ibid

[37] http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0092816 *The Effect of Medical Cannabis Laws on Crime: Evidence from State Panel Data, 1990-2006*, Robert G. Morris, et al, March 26, 2014

[39] ibid

[40] http://link.springer.com/article/10.1007/s10464-012-9542-6 *Evaluating Medical CannabisDispensary Policies: Spatial Methods for the Study of Environmentally-Based Interventions*, Bridget Freisthler, et al.

percent compared to the first two months of 2013.[41]

Impairment & Detection

Like other psychoactive substances including many prescription drugs, cannabis can alter an individual's ability to perform certain tasks. Although some studies have found that it enhances certain functions, with respect to the operation of equipment and driving, it has been shown to impair performance on driving simulator tasks and on open and closed driving courses for up to approximately 3 hours. According to the National Highway Traffic Safety Administration's (NHTSA) Drug and Human Performance Fact Sheets, the performance effects of Cannabis are

> Decreased car handling performance, increased reaction times, impaired time and distance estimation, inability to maintain headway, lateral travel, subjective sleepiness, motor incoordination, and impaired sustained vigilance have all been reported. Some drivers may actually be able to improve performance for brief periods by overcompensating for self-perceived impairment. The greater the demands placed on the driver, however, the more critical the likely impairment. Cannabis may particularly impair monotonous and prolonged driving. Decision times to evaluate situations and determine appropriate responses increase. Mixing alcohol and Cannabis may dramatically produce effects greater than either drug on its own[42].

Since Public Safety is an important consideration of any society, effective methods for detecting impairment in drivers is an important tool for law enforcement.

The horizontal gaze nystagmus (HGN) test is one of three field sobriety tests that comprise the standardized field sobriety test (SFST) battery along with walk-and-turn test and the one-leg-stand test. Scientific evidence establishes that the horizontal gaze nystagmus[43] test is a reliable roadside measure of a person's impairment due to alcohol or certain other drugs[44]

However, the NHTSA Fact Sheets determine that with Cannabis,

> Horizontal gaze nystagmus not present; vertical gaze nystagmus not present; lack of convergence present; pupil size normal to dilated;

[41] http://www.denvergov.org/police/PoliceDepartment/CrimeInformation/CrimeStatisticsMaps/tabid/441370/Default.aspx
[42] http://www.nhtsa.gov/people/injury/research/job185drugs/cannabis.htm

[44] http://www.nhtsa.gov/people/injury/research/job185drugs/cannabis.htm

> reaction to light normal to slow; pulse rate elevated; blood pressure elevated; body temperature normal to elevated. Other characteristic indicators may include odor of Cannabis in car or on subject's breath, Cannabis debris in mouth, green coating of tongue, bloodshot eyes, body and eyelid tremors, relaxed inhibitions, incomplete thought process, and poor performance on field sobriety tests[45]

A number of recent studies have confirmed that the Dräger Drug Test® 5000 "appears to be a promising tool for detecting THC in oral fluid as far as correct THC detection is concerned"[46], although further development is required to overcome some concerns that relate to the time required to complete the test (8.5 minutes).

Cannabis policy shifts & usage rates

One of the concerns expressed by some sectors of the community is that decriminalization and/or legalization will lead to an increase in use. Like the "gateway" theory, this has been the topic of study for a number of years, with varied conclusion. One American report, Effects of State Medical Cannabis Laws on Adolescent Cannabis Use, published in October 2012, by Sarah D. Lynne-Landsman, PhD, et al. reviewed data from the period 2003-2011 to investigate whether a pattern of increased use in adolescents could be discerned in states where medical Cannabis a has been legalized compared to states where it has not. The findings of this study were that

> In 40 planned comparisons of adolescents exposed and not exposed to MMLs across states and over time, only 2 significant effects were found, an outcome expected according to chance alone. Further examination of the (no significant) estimates revealed no discernible pattern suggesting an effect on either self-reported prevalence or frequency of Cannabis use.
>
> Our results suggest that, in the states assessed here, MMLs have not measurably affected adolescent Cannabis use in the first few years after their enactment. Longer-term results, after MMLs are more fully implemented, might be different.[47]

[45] ibid.

[46] http://link.springer.com/article/10.1007%2Fs00213-012-2732-y *A placebo-controlled study to assess Standardized Field Sobriety Tests performance during alcohol and cannabis intoxication in heavy cannabis users and accuracy of point of collection testing devices for detecting THC in oral fluid*, October 2012, W. M. Bosker, et al.

[47] http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2012.301117, *Effects of State Medical Cannabis Laws on Adolescent Cannabis Use*, 14 October 2012, Sarah D. Lynne-Landsman, et al.

Another study, however, published in March 2014, Does Liberalizing Cannabis Laws Increase Cannabis Use?, the authors found that any potential of increased use would be concentrated in the youth in the first five years after policy reform.[48]

Other studies in Portugal, the Netherlands and other countries, have found that decriminalization does not lead to increased use and, in fact, may contribute to a reduction in crime.

Cannabis in the Workplace

As noted above there is considerable concern in the community that any changes in legislation will signal an acceptance and lead to wide spread and irresponsible use of cannabis. This extends to a concern about the impacts for employers and use in the workplace. It should be noted however that many employers already have drug free policies in place, and in addition, impairment related to alcohol, a legally available substance, is also not currently tolerated in most workplaces however drug tests rarely screen for alcohol use. Employers would be therefore free to continue to enforce these workplace policies in the face of any policy reforms related to cannabis.

These sentiments provided by the Department of Workforce Development are reflective of the employers opinions as cannabis is currently classified as illegal. Any shift in policy will accompany a shift in perspective of how the substance is viewed in the workplace. It could be argued that employers will use drug testing as a tool to exclude Bermudian candidates from an employment pool and secure authorization to initiate or renew a work permit. Additionally, most training and apprenticeship programmes will require participants to submit the results of drug testing in order to be eligible. There is an inherent risk of excluding a section of our population from securing gainful employment if cannabis policies are reformed. Regardless of the legality of the substance, employers are united that it is not desirable to have candidates/employees who use cannabis particularly where machinery and labor intensive work are key components of the company. Most employers are reluctant to hire candidates with a conviction. Employers will generally disclose their drug testing policy in their employment advertising. Businesses that require employees to operate machinery, trade industries and many service industries will require drug testing. Candidates who test positive for cannabis use are generally immediately disqualified for training/assessment opportunities and are excluded from employment pools by employers. Although the Department of Workforce

[48] http://www.sciencedirect.com/science/article/pii/S0167629614000356 *Does liberalizing cannabis laws increase cannabis use?, March .1014*, Jenny Williams et al.

[48]

Development does discover evidence of cannabis use through client interviews and testing we do not have the data to comment on the extent of usage. The impacts primarily include exclusion from employment opportunities and the inability to participate in training and/or assessment programmes.

Regarding cannabis reform, any legislative shift or change in policy may have ramifications with respect to employment legislation and contracts. As such, any change will require thorough consideration. In this regard, two serious issues would need to be carefully thought through:

(1) Could a potential employee be turned down for a job as a result of testing positive for Cannabis if it was decriminalized? What if it was legalized? What time limits would be appropriate? (Note: Cannabis is detectable up to six (6) weeks by urinalysis, depending use).

(2) Currently, insurance benefits are not available for treatment services where illicit substances are the concern.

The CRC Recommends

1. **Increase resources for prevention and educational initiatives**
2. **Indicative Prevention - resources (funding) should be targeted to those who are at high risk for addiction and/or directed towards those who have been identified as persons manifesting symptoms/problems regarding addiction; rather than addressing prevention from a universal point of view.**
3. **Ensure the new master DNDC plan focuses on managing substance use from a health centered approach**
4. **Age of consent for access and consumption of Cannabis and alcohol should both be twenty-one (21).**
5. **Treatment continuum should create cannabis specific services to assist those with dependence**
6. **Companies providing group health insurance must offer insurance coverage to treat alcoholism and drug addiction**
7. **Government consult with employers, unions, and insurance companies regarding a substantial change in law and policy to protect workers rights.**

[1] Bermuda Health Council April 9, 2014 submission to the CRC
[2] http://www.insurancequotes.com/health/health-insurance-medical-marijuana

8. Economic Profile

Economic Impacts of Cannabis Prohibition

The widespread use of cannabis in Bermuda has created a relatively large black market. This portion of the report will give an overview of the economics of cannabis.

Size of Cannabis Market

To calculate the total amount of current users the National Household survey conducted by the DNDC is used. Applicable to the total adult population according to the survey 22.5% of total adults have tried cannabis, 5.2% have used in the past year and 3.7% have used in the past month. The 2013 numbers have shown a considerable decrease from 2009 where lifetime use was 37%, annual use 11% and current use of 7%. By using data from the 2010 census we can approximate the total number of user.

	2009 %	2009 #	2013 %	2013 #	% change
Current use	7%	3025	*4%	1,599	-47%
Annual use	11%	4,754	5%	2,247	-52%
Lifetime use	37%	15,991	23%	9,767	-38%

*Data on frequency of use totals 4.5% of total respondents as compared to the stated 3.7% current use rate
* *The 2010 Census records an adult population at 43,219

Current police prices estimate the retail price of cannabis as $50 per gram while ounces can be purchased at $600. The household survey breaks frequency of use into the following categories; daily, weekly, monthly and annuals. By estimating consumption in each usage category and using stated police prices it is possible to quantity of the value of the cannabis trade. The estimated in weekly consumption are as follow:

	2009 #	2013 #	Weekly use
Daily users	1,187	605	7 grams

Weekly users	999	562	2 grams
Monthly users	1,291	345	.25 gram
Annual users	1,234	432	.02 grams

**Totals will not reconcile with previous table as the frequency of use total is higher.*

Assuming daily and weekly users utilize the wholesale price of cannabis $600 per ounce or $150 per 7 grams and monthly and annual users purchase at $50 per gram the weekly market is:

	2009 pounds	2009 $	2013 pounds	2013 $
Daily use	18	$178,070	9	$90,759
Weekly use	4	$42,794	2	$24,075
Monthly use	.7	$14,572	.2	$3,903
Annual use	.05	$4,751	.02	$1,663

Daily and weekly users are 60% of all users and 95% of all sales. This shows the extent to which there is a consistent demand for cannabis as most users use regularly. The graph below shows total consumption and dollar value daily, weekly and annually.

	2009 pounds	2009 $	2013 pounds	2013 $
Daily	3.3	$34,218	1.7	$17,200
Weekly	23	$240,190	12	$120,402
Annually	1,221	$12,489,888	625	$6,260,930

To put this in perspective if every joint rolled contained .5 grams there would have been 567,250 spliffs smoked per year or 1,554 per day. This data only reflects retail level sales and consumption. Including the trade between importers, wholesalers and retail sellers would give a better perspective of the amount of overall cannabis sales in Bermuda.

Indirect economic benefits

The use of cannabis requires rolling papers, lighters or usually other smoking paraphernalia. With 567,250 joints smoked annually and some rolling papers coming in packs of 32 selling for $1.50 in local retail stores, the annual market for rolling papers $26,587. The indirect economic contribution of the cannabis trade is quite large and some of the industries that benefit financially from cannabis prohibition include:

- Banks
- Couriers, freight and shipping
- Convenience and grocery stores
- Lawyers

Like many goods consumed in Bermuda cannabis is imported through courier/mail, air or ship providing a contribution to the economic output of these services. Banks benefit at various stages of the money laundering process through fees from foreign exchange, wires and services charges to name a few. Grocery and convenience stores benefit from the paraphernalia purchased for either the consumption or sale of the drug. Lawyers receive offers of representation in charges related to the drug. It would be difficult to identify all businesses that benefit from the cannabis trade but the indirect benefit of a multi-million dollar industry must be substantial.

Implications of the black market

A black market is an underground economy where goods and services are sold illegally. The illegal status of cannabis creates an artificially high price for the good. At stated prices of $600 per ounce Bermuda prices are $333 more than the Canadian price of $267 (United Nations). This artificially high price can diminish the broader economic contribution of users; the more money spent on cannabis the fewer funds available to spend elsewhere.

The margins on selling cannabis in Bermuda are quite large making the trade very lucrative. A pound which cost $4,275 in Canada can be sold in Bermuda for $9,600 if sold in ounces or $22,400 when sold in $50 grams. It is the artificially high selling price that would encourage entrepreneurial individuals to invest in the cannabis trade as compared to legal industry where returns on capital would be much less. The capital that is being deployed in the cannabis trade with the hope of high returns could potentially be deployed to stimulate economic activities in other industries if it weren't for the black markets higher prices.

Outflow of Funds

The majority of all cannabis consumed in Bermuda is imported. This creates a

large outflow of funds from Bermuda to supplier countries as payment for the drugs. As a result, Cannabis like many imported goods, offers a diminished benefit to the local economy and by extension funds available to stimulate economic activity. In 2013 based on the average wholesale price per pound from Canada, United Kingdom and US, Bermuda sent an estimated $2.6 million abroad to pay for cannabis.

According to Berdin of the 322 pounds of drugs seized in 2012 316 pounds were cannabis, 98.5%. Of the cannabis seized in 2012 99.6%; was intercepted at the ports. This shows a shift in policy as 2011 showed a more equitable distribution with 42.2% of seizures occurring in the street. The amount of cannabis seized at ports increased from 239 pounds to 315 a 31.6% increase. Due to the laws of supply and demand it is difficult to conclude whether this increase is driven by more efficient interdiction methods by law enforcement or an increase of cannabis being trafficked due to higher street prices in the lucrative cannabis trade.

Unlike some other important goods, cost effective local production of cannabis appears to be viable. At the current stated police prices of $50 per gram or $600 per ounce there is significant potential to grow cannabis locally at a competitive price. This would drive down and possibly eliminate competition from importation, without compromising supply and quality, creating a self-sustaining closed loop and entirely local market, where all related funds remain on island.

Fiscal Impact

The impact of cannabis prohibition on government finances is most obvious in supply reduction efforts. With Cannabis offences representing 68.8% of all offences in 2012 and a total budget of $7.4 million allocated to supply reduction, approximately $5.1 million could be applicable to reducing cannabis supply. The supply reduction costs are split between the police service and an inter-agency border control unit.

There were 1,205 persons tried for Cannabis related offences from 2006 – 2011; on average 200 per year. This contributed to total cannabis law enforcement cost related to the courts and prosecutors office. Based on an estimate to the order of $10,000 per trial total and 1205 trials, costs over this time period were roughly $2million annually. More money is spent incarcerating people convicted of cannabis offences. 190 persons were convicted for cannabis crimes and likely received jail time. We have not been able to properly quantify this figure but assuming each of the 190 offenders serves one year at a cost of $80,000 per prisoner this translates to $2.5m. spent annually on incarceration from 2006 -

2011. The enforcement of cannabis laws is quite costly considering it requires the Police/Interdiction efforts, Courts, Prosecutions, and Corrections. Taking the above sums together, it is safe to estimate that supply reduction efforts related to cannabis cost the government in the range of $9.5m.

Furthermore, the illegal status of Cannabis deprives the government of the tax revenues it would have received if cannabis were legal. If legalized cannabis could be could be charged a sin tax, like tobacco and alcohol. There is also the lost revenue for licensing, permits, payroll tax and any other taxes applicable to the trade. If there were a 15% sales tax on the $6.2 million market that would translate to income of $932,696. The current prohibition of cannabis leave the government to spend money enforcing the laws while it is deprived of the possible income had the cannabis trade been legal.

The illegal status of cannabis creates a black market economy with upwards of 3,000 users and roughly estimated revenue of $6 million annually. Many businesses benefit directly and indirectly from the trade, though substantial the overall economic impact is difficult to quantify. The black market creates artificially high prices and encourages those with the risk appetite to invest in the trade as compared to legitimate businesses. Over $2 million must leave Bermuda annually to pay for the cannabis consumed here; funds that could potentially remain on island to stimulate economic activity. The government must spend money to enforce the prohibition while it loses potential income due to the prohibition; a double loss financially.

Health Insurance

The scope of this document limits the discussion on Health Insurance, but it is nevertheless worth highlighting. Although the therapeutic properties of Cannabis are largely undisputed (ref section on Medical Cannabis), and there is increasing research and a body of evidence of its efficacy in the treatment of a broad spectrum of terminal and chronic illnesses as well as anxiety, it is still classified as Schedule 1 under Federal law in the US. Over the years, and as early 1972, there have been numerous attempts to lobby the US Government to reclassify Cannabis and remove it from Schedule I, the most tightly restricted category reserved for drugs with no currently accepted medical use. Most recently, the medical cannabis advocacy group Americans for Safe Access filed an appeal in January 2012 with the D.C. Circuit, which was heard on October 16, 2012. However, the Drug Enforcement Administration denied the request to reclassify the drug, following an evaluation by the Department of Health and Human Services. As a result of this federal designation, the FDA does not plan to approve the drug, which means that insurance companies have chosen to steer clear of covering its cost to consumers.

Land Use

Land use in Bermuda is guided by the Development and Planning Act 1974 and the Bermuda Plan 2008, and to some extent should also be informed by the sustainability paper and the Infrastructure papers. Agricultural uses are protected in Bermuda under Agricultural zoning. Land resources in Bermuda are an increasingly scarce commodity, and as a result tension exists between development and the preservation of open spaces. When the value of land is most commonly defined by its direct potential to be converted into disposable income, then any limits or restrictions placed on it are interpreted as an obstacle or limitation. Agricultural Reserve is no exception. Currently there are no restrictions how much of any one crop is grown, and plantings are partially driven by market forces as well as a level of co-ordination within the farming community. If Food Security is indeed a National priority as noted in the Throne Speech, then balance will need to continue to be an important feature in terms of commodity crops.

With respect to Cannabis, illegal cultivation is currently taking place in low travelled conservation areas including conservation zones such as Woodland Reserve, with resulting damage to these areas. In a legalized state, clandestine cultivation may still persist if regulations are too restrictive, however cultivation would also likely expand to Residential (home grown) and Agricultural Zonings (commercial cultivation), and possibly other development zones such as mixed use or industrial zones. However, although indoor growing is a possibility and does indeed offer security and conformity benefits, costs in Bermuda are likely to be too prohibitive to make this an intensive option. Therefore, presuming a majority of cultivation would be outdoors and focusing on commercial efforts, within Agricultural zoning, a concern exists that undue pressure may be exerted on land use, diverting focus away from food crops. However, recognizing the potential of cannabis as a cash crop, a sustainable model including an element of regulation which limits plantation sizes, might offer an opportunity to farmers to subsidize income, and provide rotation without compromising current food crops.

Security and theft of food crops has increasingly become a problem in Bermuda, as fewer people understand how to grow their own food, and economic pressures mount. Theft and security of cannabis crops is no exception and observations from other countries with varying approaches is noted in Chapter 7, Social and Health Perspectives. An emerging pattern seems to be that higher restrictions and regulation lead to more clandestine activity and theft, and a heightened need for security. The UK Home Office document entitled Security guidance for all existing or prospective Home Office

Controlled Drug Licensees and/or Precursor Chemical Licensees or Registrants.[49] highlights the challenges associated with a highly regulated framework.

Notwithstanding the above, considering the sums currently leaving the country in support of the current black market, a sustainable economic model must include local cultivation. This would need to be balanced with environmental considerations also noted above, and taken together, suggest that an appropriate legislative framework would need to include a level of regulation to ensure that cultivation is restricted to small scale operations, and that adequate measures are put in place to encourage diversity.

Economics of legal Cannabis Market Structure

Porter's 5 Forces

Porter's 5 Forces is a framework for industry analysis to derive the competitive intensity of a market and thus the degree of a tendency toward a fragmented market of small businesses vs. a market with low competition dominated by a few large businesses. Cannabis markets tend to inherently be fragmented markets with many small players and generally fungible products grouped by quality.

- Threat of new entrants: Cannabis is relatively easy to grow and sell. It does not require large amounts of capital to begin growing it in terms of land or equipment. There are unlikely to be large cost advantages from large operations vs. smaller greenhouse growers. Brand differentiation does not exist presently and there are no brands or customer loyalty to a brand.
- Threat of substitute product or service –
- Bargaining power of customers (buyers) -
- Bargaining power of suppliers (retailers) - With a small fragmented market of producers and easy entrance of new producers the retailers will easily be able to switch to new producers and thus have substantial bargaining power.
- Intensity of competitive rivalry - Without the ability to advertise to create a brand, highly transparent pricing, and many small firms the rivalry is likely to be intense with competition focusing on price and quality. The end result is likely to be low price, high quality, and low profits just sufficient to keep a balance between supply and demand.

Regulation

The government should not be in the Cannabis business. It should not grow, sell, or otherwise take on a role in the supply chain other than as a regulator.

[49] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/271565/SecurityGuidanceBusinessesOrganisationsJan14.pdf

Regulation should focus on creating a light but effective regulatory authority in keeping with Bermuda's overall regulatory philosophy. Regulation should focus on minimizing the harms from Cannabis such as youth use, smuggling, the black market, etc. The regulatory authority should be tasked with regulating the Cannabis industry with the aim of minimizing the social harm from abuse, as well as allowing changes to policy to flexibly meet needs.

Regulation should not create substantial barriers to entry that limit participation in the market to those with substantial capital.

The overall goals of a Cannabis regulation policy should be to:

- Reduce harm from abuse.
- Reduce access to minors - measured as the percentage of the underage population who have used, median age of first use, and frequency of use.
- Prevent negative impacts of dependence.
- Remove the life impact of criminal convictions.
- Maximize tax revenue to the government.

It should not:

- Control quality. Quality control can be handled by the market and branding. In a small market any low-quality offerings will quickly develop a reputation and lose their market share.

The effectiveness of regulations should be measured according to the following goals:

- Low use among people during their most vulnerable years (under 25)
- Avoid legal issues with Britain, the United States, and other countries.
- Lower use among the general population
- Reduce harm from dependence.

Building a Legal Supply Chain

- Limited personal use cultivation.
    - ~6 plants per household (?)
    - Personal use cannot be sold. Make it an offence to sell without a license.
    - Severe penalties for providing personal use Cannabis to those underage.
- Tiered licenses for commercial growers.
    - Low entry point for entrepreneurs.
    - Pathway to legitimacy for current local black-market cultivators.

Use the BEDC to help train people who have been in the black market to enter the legitimate market.
    - Licenses required to sell or to grow more than 6 plants (personal use limitation).
        - Annual renewal.
        - Different price points based on the number of plants authorized to grow.
    - License fees should be set so that they pay for the regulatory authority's expenses.
    - Licenses should be cheap to small growers and more expensive for larger growers. The exact price will need to be worked out. To protect smaller growers from the domination of the business by large suppliers.
- Licensed retailers
    - Require retailers to buy from commercial growers.
    - Require retailers to only sell to those of-age. A simple mandatory ID check may be sufficient. The onus should be on the retailer to ensure that buyers are of age.
    - Violation of these should result in a prosecution and a revocation of a license to sell.
    - Retailers responsible for paying sales tax
    - A violation of not paying tax, buying from an unlicensed grower, or other violations should be severely penalised.
- Licensed on-premises consumption
    - Ensure that neighbors are not impacted by the smell.
    - Indoor smoking if there is an appropriate ventilation system.
- After-Market
    - Once sold by a legal retailer the responsibility falls on the buyer to ensure that Cannabis does not end up in the hands of minors. Severe penalties for those who provide Cannabis to people under-age. This may also become a model we may wish to adopt for alcohol.

Cost of Production & Land Use

- Yields vary greatly depending on:
    - Grower skill
    - Strain of plant
    - Type of growing (outdoor, indoor, hydroponic, etc.)
- Normal indoor production of smokable Cannabis per plant is 5oz but yields can vary from 1 ounce per plant to a pound per plant.

Taxation

Colorado levies a 12.9% sales tax on recreational Cannabis and a 2.9% tax on medicinal marijuana. For 2014 the state is expecting that taxes will bring in $98m which will be spent on substance abuse treatment ($40.4m), youth Cannabis prevention ($45.5m), and other public health initiatives ($12.4m).

Colorado also levies a 15% excise tax. The state revenue projections expected are higher than those given to voters in the 2012 projections.

A simple sales tax is the easiest to administer.

If Bermuda has a Cannabis market of ~$100m at the retail level then if use and prices remain the same then a similar tax would yield ~$15m from sales taxes alone. If Bermuda's market allows for a higher rate of tax to keep the price around the US black market retail

Tax should be set such that there is no financial incentive to export Cannabis into the United States or any other country.

Given the need to prevent the creation of an incentive to export Cannabis to the US,

Limits Around Research

We were unable to secure an average age, the racial makeup or percentage of re-offenders in the numbers given by the BPS concerning the 2013 Cannabis drug enforcement policies. In addition and due to time constraints and resources, we were unable to collect more data around this important topic.

The CRC Recommends:

1. **Save money by substantially reducing supply reduction costs associated with cannabis**
2. **Redirect money saved towards prevention and treatment resources**
3. **Empower those currently in the illegal cannabis trade to have first access to entrepreneurial opportunities in a legal trade**
4. **Promote local production to mitigate the amount of funds that leave the island to pay for cannabis.**
5. **Provide another source of taxation - increase revenue streams**

9. Cannabis as a Medicinal Substance

The scope of this document does not permit an in depth review of the potential of Cannabis as a medicinal substance. However, considering the increased prominence of this topic, and in the overwhelming evidence surrounding the therapeutic potential of this plant, an overview is warranted. For those interested, a list of some of the more recent global studies are provided in Appendix 9

Current Position of Ministry of Health

Research into the issue and policy options for medicinal Cannabis are in their preliminary stages at the Ministry. There are numerous international authorities, professional consensus bodies and individual experts by which information is drawn. The Public Health opinion seems to be well-informed and shows consensus on the question of the medical uses for Cannabis and the processes needed to advance the options in this regard. However, the health and social impacts of decriminalization and legalization are less clear and opinion more varied. Accordingly, the Ministry relies heavily on the experience of addiction professionals and on the Department of National Drug Control (NDC) for research input and expert, evidence-based opinion.

Underlying principles/concepts:

There a three fundamental concepts or principles that inform the public health perspective in this brief.

First, a scientific process is required to reveal evidence which supports or discredits a health recommendation. Therefore for Cannabis, to be classed as a medicine, it should require the same rigorous testing through clinical trials and marketing authorization as any other medication.

Secondly, that drugs that pose a risk of harm require regulation, that is proportionate to their risk. Cannabis poses a risk to the health and well being of individuals. The research has indicated that Cannabis contains cannabinoids with psychoactive properties that can result in addiction and pose a risk of harm. To be clear the risk of addiction is less than other controlled and uncontrolled drugs[i] Lifetime dependence risk: 9% for Cannabis; 32% for nicotine; 23% for heroin; 17% for cocaine; 15% for alcohol (Bostwick, 2012)
; however it is still deemed a risk. This risk is concentrated in individuals initiating use during their early teens. Specifically there is evidence of persistent effects for youth using during puberty in addition to possible addiction. These effects include negative impacts on cognitive, behavioral and social development of this population.

Finally both these positions do not preclude recognition of the special circumstances of persons with terminal or debilitating medical conditions who have not responded to conventional medical treatment. This acknowledgment thus must also be considered in policy decision in conjunction with the first two points.

The Ministry of Health is currently continuing its research and investigation of the potential impact of Cannabis reform on the community. According to the Chief Medical Officer, there are plans to advise the Minister who will make the decisions regarding policy recommendations moving forward.

The illegal classification of cannabis as a controlled substance has led local physicians to not prescribe cannabis as a medicine and subsequently prescribe manufactured synthetic drugs imported from abroad. Advocates of Medical Cannabis are widespread though and many studies from various jurisdictions have been and are being carried out around the medical properties and research of the endocannabinoid system. (ref Appendix 9.)

Current Medical Cannabis Requests

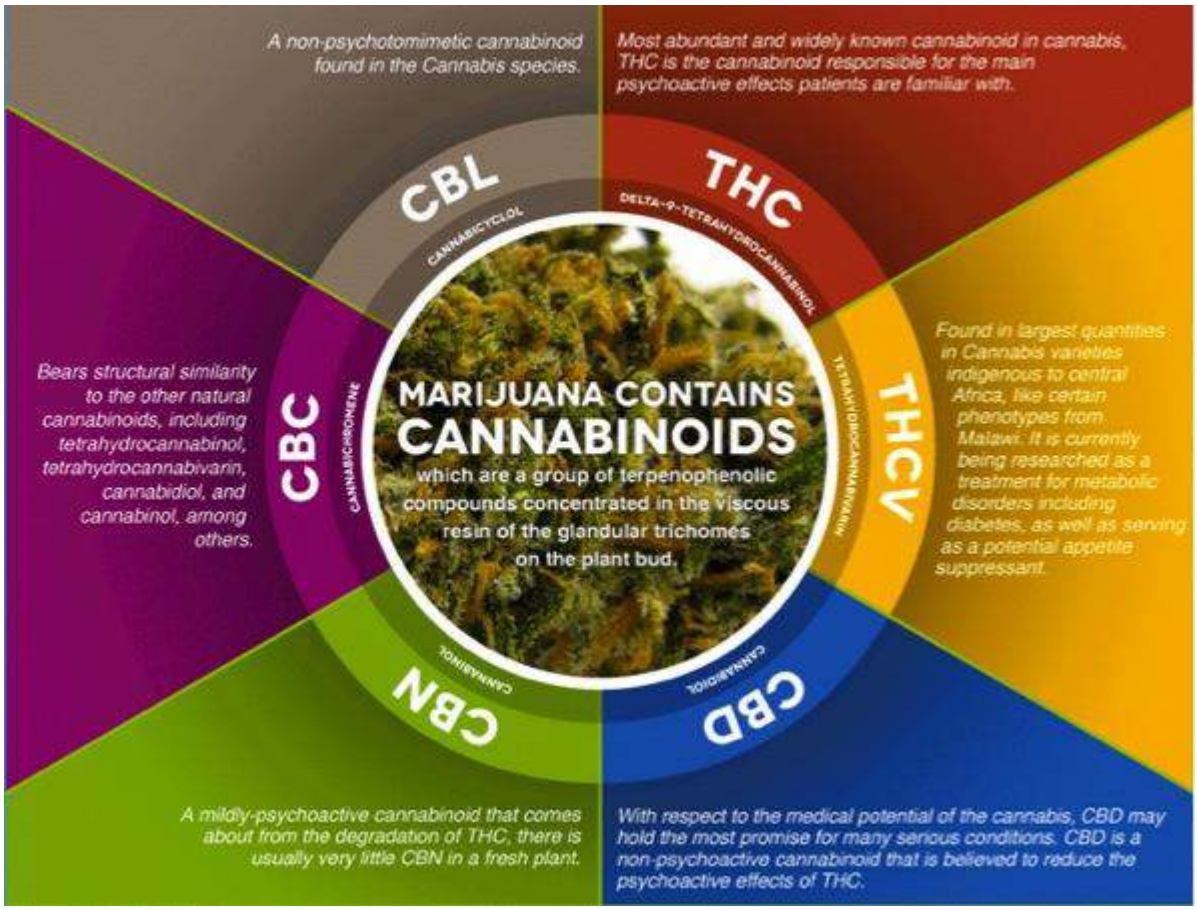
To date, the ministry has received a small amount of applications for access to medical cannabis directed towards approval from the Minister of National Security as per the Misuse of Drugs Act. The process to apply for approval from the Ministry is not publicized and many people are unaware of how to apply and get approval. Refer to Chapter 5 for more details.

Plant physiology

The ASA notes that "the therapeutic benefits of cannabis are derived from the interactions of cannabinoids and the human body's own endocannabinoid system, first identified in 1988. The endocannabinoid system (ECS) is a sophisticated group of neuromodulators, their receptors, and signaling pathways involved in regulating a variety of physiological processes including movement, mood, memory, appetite, and pain"[50]. In spite of severe restrictions imposed on research in the United States in the past as a result of federal prohibition on cannabis, recent discoveries have increased interest among scientists in the more than 100 different cannabinoids so far identified in the cannabis plant[51]

[50] http://www.safeaccessnow.org/medical_cannabis_research_what_does_the_evidence_say.
[51] http://www.safeaccessnow.org/medical_cannabis_research_what_does_the_evidence_say.

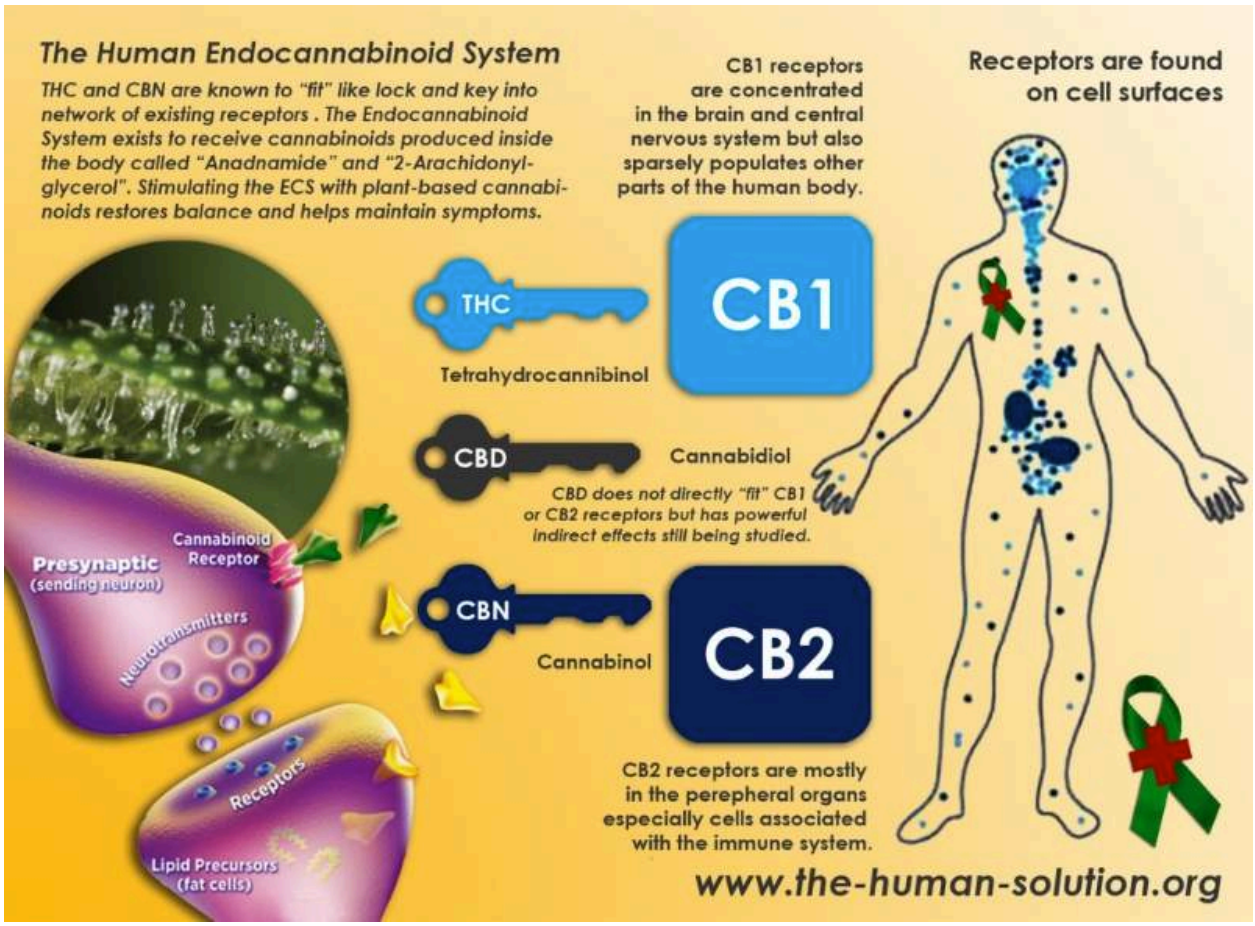
Of these, THC is most commonly known - as it produces psychoactive effects - however a growing amount of research is taking place around CBD compounds. The ASA reports that "to date, more than 15,000 modern peer-reviewed scientific articles on the chemistry and pharmacology of cannabis and cannabinoids have been published, as well as more than 2,000 articles on the body's natural endocannabinoids"[52]



Cannabinoids have a remarkable safety record, particularly when compared to other therapeutically active substances. Most significantly, the consumption of cannabis, regardless of quantity or potency, cannot induce a fatal overdose, and the side effects are short lived.[53]

[52] http://www.safeaccessnow.org/medical_cannabis_research_what_does_the_evidence_say.
[53] http://medireview.com/2013/04/the-safety-profile-of-medical-cannabis/

The Human Endocannabinoid System



Treatment using Cannabis as a Medicinal Substance

Many recent studies have found that medicinal cannabis offers a very broad spectrum of therapeutic benefits as a result of its various chemical attributes. However, without a doubt perhaps the most significant focus of attention has been on its reputed effects in cancer treatment. Proponents of cannabis in the treatment of Cancer report that unlike FDA approved artificial extracts, the efficacy of Cannabis in its natural form is in the compounds working in unison, where multiple mechanisms work together to combat cancer and treat other chronic conditions. The collective functions can be summarised as:

Anitproliferative effect - prevents cancer cells from reproducing
Antiangiogenic properties - prevents the formation of new blood vessels needed by the tumor to grow
Antimetastatic Effect - prevents cancer from spreading to other organs
Apoptotic - speeds suicide of Cancer cells

These effects derive from the interaction between the cannabinoids and the body's own endocannabinoid system, which compliment the widely accepted palliative uses of this plant. In fact cannabis is so widely accepted for its palliative uses to overcome the negative side effects of chemotherapy, in management of nausea, pain and stress, as well as an appetite stimulant, that Marinol, a synthetic version of a naturally occurring compound known as delta-9-THC (the only legal cannabinoid), which used to stimulate appetite and suppress nausea,has been approved by the FDA and is legally available.

Current research shows that cannabis is beneficial in the treatment of many other medical conditions, and is a vast topic on its own. For further details and references, the reader is recommended to review the medical research link on the ASA website[54] and a selection of research papers referenced in Appendix 9. For the purposes of this paper, below is a brief summary of ailments which studies have shown to be treatable by cannabis:

HIV/AIDS

HIV/AIDS Cannabis can reduce the nausea, vomiting, and loss of appetite caused by the ailment itself and by various AIDS medications. Observational research has found that by relieving these side effects, medical Cannabis increases the ability of patients to stay on life-extending treatment. "Cannabis Use in HIV for Pain and Other Medical Symptoms"[55]

HEPATITIS C.

As with AIDS, Cannabis can relieve the nausea and vomiting caused by treatments for hepatitis C. In a study published in the September 2006 European Journal of Gastroenterology & Hepatology, patients using Cannabis were better able to complete their medication regimens, leading to a 300% improvement in treatment success. "Cannabis use improves retention and virological outcomes in patients treated for hepatitis"[56]

GLAUCOMA

Glaucoma is the leading cause of blindness and damages vision by increasing eye pressure over time. Cannabis can reduce intraocular pressure, alleviating the pain, slowing and sometimes stopping damage to the eyes.[57]

[54] ibid
[55] http://www.jpsmjournal.com/article/S0885-3924(05)00063-1/abstract
[56] http://journals.lww.com/eurojgh/pages/articleviewer.aspx?year=2006&issue=10000&article=00005&type=abstract
[57] Cannabis in Medical Practice: Mary Lynn Mathre, Ed.

MULTIPLE SCLEROSIS

Cannabis can limit the muscle pain and spasticity caused by the disease, as well as relieving tremor and unsteadiness of gait. (Multiple sclerosis is the leading cause of neurological disability among young and middle-aged adults in the United States.)[58]

EPILEPSY

Cannabis strains high in CBD compounds have been proven to reduce and eliminate epileptic seizures in hundreds of cases around the world.[59] A notable case is of a young girl with epilepsy who had a specific CBD rich cannabis strain named after her: Charlottes Web.

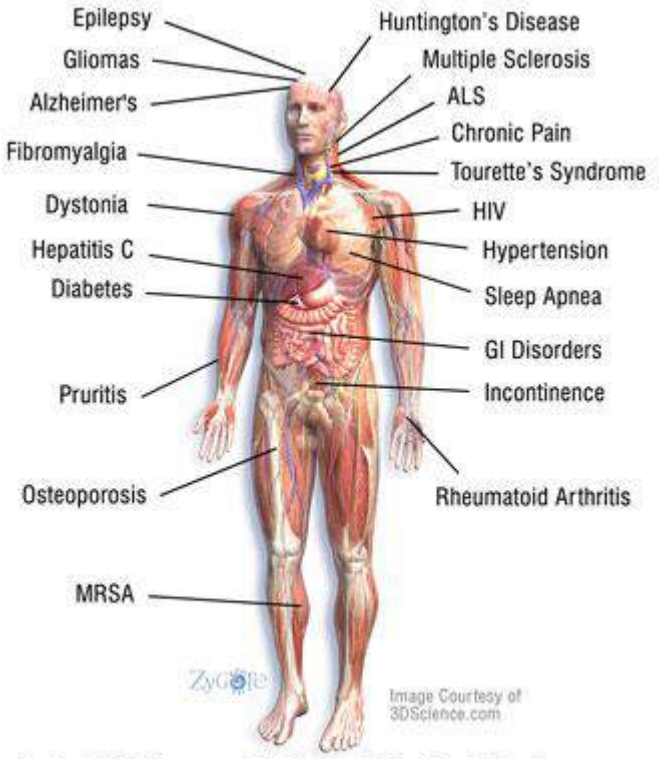
CHRONIC PAIN

Cannabis can alleviate chronic, often debilitating pain caused by myriad disorders and injuries. Since 2007, three published clinical trials have found that Cannabis effectively relieves neuropathic pain (pain cause by nerve injury), a particularly hard to treat type of pain that afflicts millions suffering from diabetes, HIV/AIDS, multiple sclerosis, and other illnesses.[60]

Many studies also report that cannabis is useful for treating arthritis, migraine, menstrual cramps, alcohol and opiate addiction, and depression and other debilitating mood disorders.

The only cannabis derived prescription medicines currently approved at the US Federal level for medical use is Marinol, a synthetic form of tetrahydrocannabinol (THC), the most active component of Cannabis. It was developed as an antiemetic (an agent that reduces nausea used in chemotherapy treatments), which can be taken orally in capsule form.[61] European countries and Canada have approved Sativex which is a whole plant medicinal cannabis extract indicated for the relief of multiple sclerosis (MS) symptoms and the treatment of severe neuropathic-related cancer pain.[62]

[58] Cannabisand Multiple Sclerosis http://www.doctordeluca.com/Library/Med/MedMJ/MjAndMs04.htm
[59] http://www.epilepsy.com/article/2014/2/epilepsy-foundation-calls-increased-medical-marijuana-access-and-research
[60] http://www.medpagetoday.com/Neurology/PainManagement/21939
[61] http://www.marinol.com/
[62] http://www.sativex.co.uk/patients-and-carers/sativex/what-is-sativex



Potential Therapeutic Uses of Medical Marijuana

Ways of using Cannabis Medicinally

There are numerous way in which cannabis can be used that include smoking, ingesting and topical application:

(i) Smoking
(ii) Vaporizer
(iii) Oils- topical application or ingestion
(iv) Ingesting - via juicing or edibles

Smoking

Although there is an embedded concern about the harm of smoking to the lungs, research has shown harm caused by smoking cannabis is curiously minimal especially when compared to tobacco. (Ref Appendix 9 for more information). Smoking is also seen by some as the least effective method of treatment for more serious ailments as a result of the relatively low doses of medical compounds absorbed by this method. However these low doses are

beneficial in the treatment of chronic symptoms and smoking is therefore used for pain management, nausea and vomiting, discomfort associated with chemotherapy, appetite stimulation, management of muscle pain and spasticity caused by diseases such a muscular sclerosis, as well as relieving tremor and unsteadiness of gait.

Vaporizer

A vaporizer is a machine that is used to 'vaporize' herbal substances and produce a vapor which is then inhaled. There are several types of vaporizers, the most common 3 used with Cannabis are whip-style, bag-style and portable-style vaporizers. Vaporizers do not produce smoke, therefore you do not inhale carcinogens with this method. What is meant by 'vaporizing' is essentially heating - without burning - the substance and running air through it to extract the cannabinoids in the form of vapor.

Oils

Oils are made by concentrating the resin from the buds of the female plant. This allows concentrated doses of the medical compounds to be absorbed, and is therefore especially effectively in the treatment of serious illnesses such as cancer. Oils are applied topically (such as in cases of skin cancer), or dissolved under the tongue. According to Rick Simpson, a well known and respected grassroots expert on medical cannabis:

> One pound of very dry high quality cannabis hemp bud material will usually produce 55 to 60 grams of high grade oil. This amount of oil will usually cure most serious cancers unless the patient has been badly damaged by chemo and radiation. In such cases the patient can often still be saved, but they will have to ingest much more oil to undo the damage the chemo and radiation has left behind. The average patient can ingest a full 60 gram cancer treatment in about 90 days. But if they have been damaged by chemo and radiation often much more oil will

need to be taken, over a longer period of time. Sometimes such patients will require 120 to 180 grams to undo the damage from all the chemo and radiation[63]

For more information and research on the efficacy of cannabis oil refer to Appendix 9.

Ingesting

Cannabis foods, more informally known as edibles, are food products made with cannabis in herbal or resin form as an ingredient. They are consumed as an alternate delivery means to harness the effects of cannabinoids without smoking or vaporizing cannabis or hashish. Instead, the cannabinoids are put into cake, cookie, brownie, or other foods, and are consumed for recreational or medicinal purposes.

INTERNATIONAL POLICY RELATED TO CANNABIS AS A MEDICAL SUBSTANCE

There is a shifting perspective and approach to medical cannabis globally, as acceptance of its therapeutic benefits gains momentum and strength. Even now, the political approach to cannabis continues to be severely clouded by the taboo perception and image of cannabis as an illegal substance, which limits access to funding and focus for much needed research. Nevertheless in countries and states where shifting perspectives are taking hold, with the possible exception of the Netherlands, medical cannabis is invariably the step taken.

Israel

One country which is achieving trailblazing status in the area of research and development is Israel. The Israeli government still classifies cannabis as illegal, and it remains a crime to use the plant recreationally and without a license from an approved physician. The nationwide program in Israel has won growing support from government officials, inciting relatively little controversy among Israeli citizens, public officials, and religious leaders.

[63]http://phoenixtears.ca/make-the-medicine/http://phoenixtears.ca/dosage-information/http://phoenixtears.ca/natures-answer-for-cancer-2/http://phoenixtears.ca/buy-phoenixtears-the-rick-simpson-story/

In 1995, the Israeli Parliament Drug Committee formed a subcommittee to examine the legal status of cannabis, which recommended that the government continue to categorize cannabis as illegal, but also that it allow and regulate access to medicinal cannabis for severely sick patients. Cannabis for medical use has been permitted in Israel for cancer patients and those with pain-related illnesses such as Parkinson's, multiple sclerosis, Crohn's Disease, other chronic pain and post-traumatic stress disorders. Patients can smoke the drug, ingest it in liquid form, or apply it to the skin as a balm. The numbers of patients authorized to use Cannabis in Israel in 2012 was over 10,000 a number that has swelled dramatically, up from serving just a few hundred patients in 2005. The medical cannabis industry is expanding as well, fueled by Israel's strong research sector in medicine and technology - and notably, by government encouragement. According to reports, Israel has a US$ 40 million dollar medical cannabis industry.

Ultimately, and notwithstanding its awareness of the US position and the UN Convention Treaties, Israel was able to take comfort and establish its own path based on the wide range of interpretation of the Convention taken by countries other than the US[64]. Although Israel has earned the reputation as a world leader in medical marijuana, its pioneering status has been accompanied by unsurprising teething problems. According to the Jerusalem Post, Israel is struggling to find an effective way to balance supply in a country where it is otherwise illegal. "Approximately 15 tons of medicinal cannabis are stolen each year, police records show"[65], and police want the fields more tightly controlled.

Canada

Possession of any amount of Cannabis is illegal in all provinces. Minor possession of 30g or less can result in a lower level (summary offence) and a criminal record. Strangely many people are under a misconception that the substance is 'legal' and/or 'decriminalized' for small amounts. Currently under the Marihuana for Medical Purposes Regulations, interested parties must apply to Health Canada to become a licensed producer. Licensed producers can be authorized to possess, sell provide, ship, deliver, transport, destroy, produce, export and/or import marihuana for medical purposes under the Marihuana for Medical Purposes Regulations. Medical patients can get a 'Personal-use Production license'. There are no apparent restrictions on the variety of products permitted under the Marihuana for medical Purposes Regulations for medical producers. There are no THC/potency limits and no information about strength of the product for illicit or medical use. Price for recreational use is determined

[64] http://www.jewishjournal.com/cover_story/article/green_gold_israel_sets_a_new_standard_for_legal_medical_marijuana_reasearch

[65] http://www.jpost.com/Health-and-Science/Israel-is-world-leader-in-medical-marijuana-use

by the illicit market. Price for medical use is determined by the licensed vendor and the Regulations identified by Health Canada. There are no THC/potency limits and no information about strength of the product for illicit or medical use. Medical sales are not currently taxed either as medical Cannabis 'zero-rated' (tax free).There has been some recently reported discrepancies around the federal government plans to overhaul the production of medical cannabis in 2013, arguing the current system had grown out of control and was rife with problems ranging from unsafe grow-ops to infiltration by criminals but on March 24, 2014 a Federal Court judge ruled anyone already licensed to grow the drug may continue to do so.[66]

California

Possession of up to and including 28.5 grams of cannabis is an infraction punishable by a fine of $100 in California. Medical cannabis users and/or their primary caregivers may possess up to 8 ounces of dried cannabis, and have up to 8 mature plants (or 12 immature plants). Patients can also possess more if recommended by a physician. Medical cannabis producers are licensed by government agency and laws vary by county or municipality. All other production is considered a felony under state law. Medical cannabis preparation is regulated within the state-licensed dispensaries and many products are currently available for sale. State-licensed medical cannabis facilities are responsible for the contents of their products. Prices for medicinal cannabis are regulated by market forces. Medicinal cannabis can be sold to anyone of the age 18 or older. Younger patients require parental consent. Only medicinal cannabis patients are permitted to purchase cannabis, and limits are set for purchase. Medicinal cannabis vendors are required to adhere to licensing condition and are subject to penalties for license violations, such as fines or loss of license. Taxes for medicinal purchase of cannabis based on government laws. Home growing permitted for medicinal users, allowing up to 8 mature plants (a flowering plant), or 12 immature plants (plants that are not flowering).[67]

Washington State

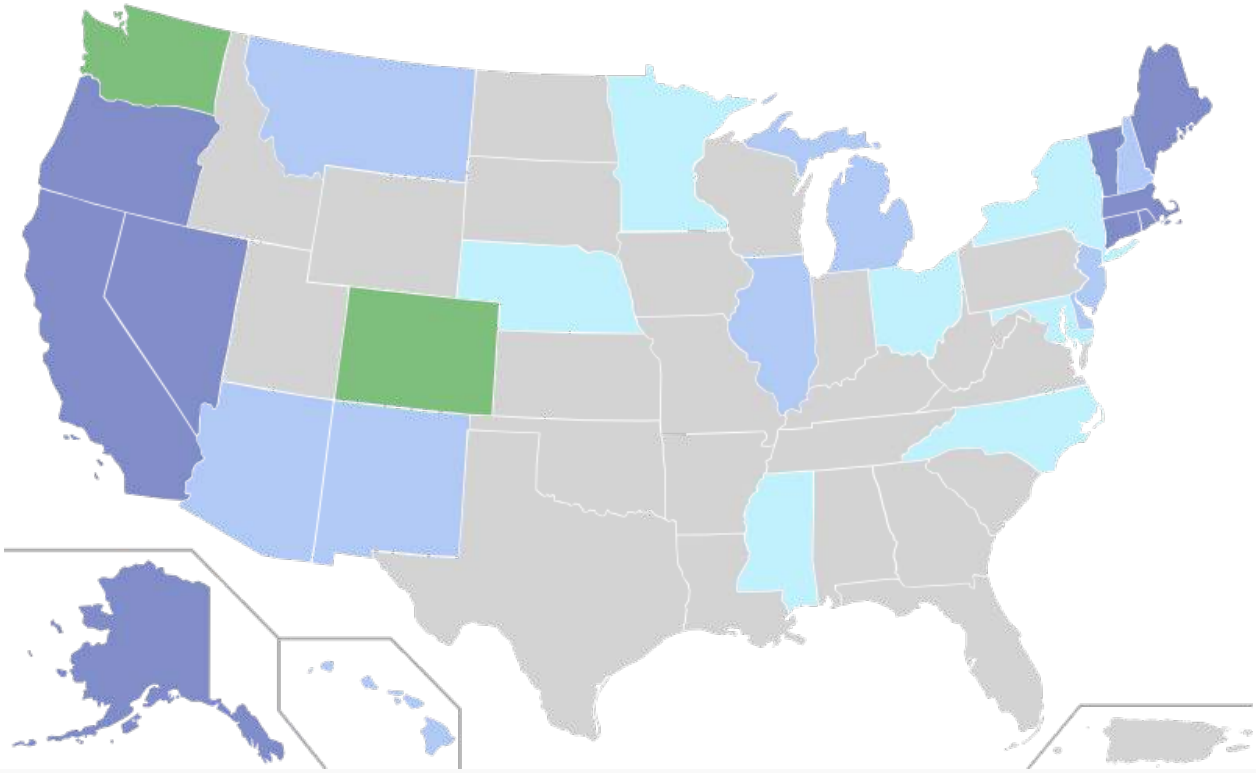
Regulated private companies are licensed to produce and supply cannabis. Adults can possess up to one-ounce of cannabis (and/or up to 16 ounces of cannabis-infused product in solid form, and 72 ounces of cannabis-infused product in liquid form) for their own personal use in private and are not subject to criminal or civil penalties. Cannabis recreational use is legal however the public consumption of cannabis is subject to a civil violation and fine. Patients

[66] http://www.hc-sc.gc.ca/dhp-mps/marihuana/index-eng.php
[67] http://www.cdph.ca.gov/programs/MMP/Pages/default.aspx

(or their primary caregivers) may legally possess or cultivate no more than a 60-day supply of cannabis. The designated provider may be the primary caregiver for only one patient at any one time. The law does not establish a state-run patient registry. WA Department of Health Rules define the 60 Day Supply limit as up to 15 plants and 24 ounces of dried medicine. Production licenses are granted by the State Liquor Control Board to individuals or companies that pass background checks and meet specified security and quality control criteria. Producers must submit samples of cannabis for regular safety and potency testing by an independent laboratory. Producers may hold no more than three production and/or processor licenses. The state-wide area dedicated to cannabis production must not exceed 2 million sq ft. The retail price is essentially determined by the market and taxes. Both residents and non-residents of Washington may purchase up to 1 ounce of cannabis per transaction. There are penalties for breaches of licensing conditions, such as sales to minors and no formal training of vendors is required. Stores cannot be set up within 1,000 ft of schools or other areas where children are likely to gather. Retailers may own no more than 3 outlets and each one must be in a different county. Cannabis is subject to a 25% excise tax at three stages in the supply chain – when it is sold by the grower to the processor, when it is sold by the processor to the retailer, and when it is sold by the retailer to the consumer. On top of this, cannabis is taxed at the standard state sales tax rate of 8.75%. Advertising is forbidden from promoting over-consumption and storefront window displays of cannabis products are also banned.[68]

68

http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/MedicalMarijuanaCannabis.aspx



Map of the US showing US cannabis laws.
State with legalized cannabis.
State with both medical and decriminalization laws.
State with legal medical cannabis.
State with decriminalized cannabis possession laws.*
State with total cannabis prohibition

In Bermuda, unless regulations are changed, people currently suffering from any of the conditions mentioned above, for whom the legal medical options have proven unsafe or ineffective, have three options:

1. Apply for a permit directly from the Minister with advise from a physician
2. Continue to suffer without effective treatment;
3. Leave Bermuda to live elsewhere where treatment is possible (assuming they are well enough to travel); or
4. Remain in Bermuda and source cannabis Illegally and risk suffering consequences directly related to its illegality, such as:

- an insufficient supply due to the prohibition-inflated price or scarcity;
- Substandard quality - impure, contaminated, or chemically adulterated Cannabis;
- arrests, fines, court costs, property forfeiture, incarceration, probation, and criminal records.

Government must recognize the emerging scientific research related to the medicinal qualities of the plant and begin to view cannabis as a medicinal substance that the population can use to treat dozens of symptoms and diseases.

The CRC Recommends:

1. Take immediate action to enable access to medical cannabis with a prescription to individuals by way of a regulation under the existing legislation, until such time as revised legislation is drafted.

2. Provide resources to physicians to effectively prescribe cannabis as a medicine

1. Research, develop and implement a regulatory model for medicinal cannabis production distribution and use and,

2. Classify the plant as a prescription substance where that doctors may have the resources and framework to prescribe the substance to patients in need.

10. Foreign Shifts in Cannabis Policy

The outright prohibition of cannabis, in addition to other drugs, has been a focal point in cannabis policy for many years. Proponents of prohibition argue that criminalizing drug users will ultimately lead to lower use, addiction rates, and associated crimes. Countries around the world implemented various prohibitionist policies, in particular throughout the early to mid 20th Century. Though international support for the prohibition of cannabis was widespread, the last 40 years has seen a shift in this stance, with countries around the world adopting more liberal policies. Citing inadequacies in the prohibitionist model, many states have adopted alternative models to address cannabis use, ranging from decriminalization, to the legalization of medicinal cannabis, to—more recently—the legalization of cannabis for recreational purposes. There is a changing tide in cannabis policy, with countries adopting specific policies that they feel better fit the needs of their people. Bermuda too can be a leader in this change to adopt a more appropriate model targeting cannabis use on the Island.

The early 20th century saw countries taking a stance of strict drug prohibition and control. International support for the prohibition of the production, use and supply of cannabis was formalized under treaties such as the United Nations Single Convention on Narcotic Drugs of 1961 (UN Convention). This treaty requires the strict control of cannabis production, to the same extent that drugs such as opium are to be controlled (1, p. 14). It specifies cannabis as a Schedule I drug, similar to many other, more harmful drugs, thus promoting a sense of harm associated with the drug.

Recent years have seen a significant shift in attitudes towards the UN Convention, causing countries to change their approaches to drug policy, including cannabis reform. Research from a number of research institutes such as LSE IDEAS have argues that human rights must be more sufficiently addressed in drug policy (2). The UN High Commissioner for Human Rights, Navanethem Pillay, makes a similar case, stating that those who use drugs often "suffer discrimination, are forced to accept treatment, [are] marginalized and often harmed by approaches which over-emphasize criminalization and punishment while under emphasizing harm reduction and respect for human rights" (3).

Beyond human rights issues, literature has pointed towards the inefficiencies of strict prohibitionist models. Research has shown that drug use is not distributed evenly, and is not simply affected by drug policy. Countries with stringent user-level drug policies do not have lower levels of use than countries with more liberal models (4). Increased recognition of the ineffectiveness of prohibition as

a strategy to combat abuse, and the need to ensure that human rights are enshrined as an underlying and fundamental principle to any reform, have led numerous countries to review and reform their internal legislation and policies with respect to substance abuse, including cannabis.

Not long after the UN Single Convention on Narcotic Drugs, countries began to enact significant liberal drug reforms. As early as the 1970s, several European countries began to decriminalize the use of cannabis, in addition to other drugs. Spain was a leader in this regard, following a 1974 ruling that the possession and use of cannabis for personal purposes was not a criminal offense. In 1992 the government in Spain created administrative penalties for public use and possession of up to five days' worth of cannabis supply, equating to 200g of cannabis or 25g of cannabis resin (5). This legislation has even allowed what have become known as 'cannabis clubs' that members can join to partake in the use of cannabis personally.

The Netherlands was another early adopter of liberal cannabis policy, however with a much different approach. While changes to their drug policy in 1976 continued to criminalize drug possession, it also created guidelines for prosecution that stipulates cannabis possession and supply be of the lowest priority to law enforcement—thus creating a decriminalization model (6). Such legislation currently permits possession of up to 5g of cannabis or the equivalent of one dose of hard drugs without threat of any penalty, civil or criminal. Regarding hard drugs, the policy has proven a success, with lower rates of addiction as well as usage. Studies however have shown that cannabis use has risen at times, but this is likely attributable for the commercialization of cannabis through 'coffee shops,' rather than decriminalization policies (8).

Early shifts were not seen merely in Europe, but other parts of the world as well. Paraguay was another early adopter of cannabis reform, and their use rates remain low to this day. In 1988 Paraguay enacted Law N° 1.340, removing all criminal and administrative sanctions for the possession of up to 10g of cannabis or 2g of cocaine (9). In addition, courts can determine if an offender is in need of drug treatment. After almost three decades of such policies, though, Paraguay has not witnessed the massive increase in drug use that may be expected to accompany liberalized policies. As of 2011, Paraguay was tied for the lowest consumption of cocaine, and the fourth lowest consumption of cannabis (10).

Portugal is an exceptional example, centering their drug policy around a model of public health. Faced with one of the biggest drug problems in the region, the Government of Portugal decriminalized up to a ten days' supply of an average

dose of drugs (11). If caught with an amount under the prescribed limit, offenders are issued a citation to meet with a 'dissuasion commission' (CDT) comprised of an attorney, a psychiatrist, and a social worker. With a broad range of sanctions at their disposal including mandatory treatment, suspension of drivers license, and even fines, the Commission assesses the appropriate measure, with a health-centered approach in mind. Though some research has shown a small increase in lifetime drug use among adults since decriminalization, there is also significant evidence to show decreases in the prevalence of vulnerable groups such as the youth and problematic drug users (13). In addition, Portugal has made significant strides in the criminal justice arena. Between 1999 and 2008, Portugal has reduced the percentage of those incarcerated for drug offences by almost half (14), both reducing costs and allowing law enforcement to focus on other, more serious drug offenses such as large-scale trafficking.

Since those early adopters, many other countries have taken similar approaches, and several others—some which may be more similar to Bermuda—are currently looking to decriminalize cannabis. Belgium, Colombia, the Czech Republic, Germany, and Mexico—in addition to several other countries, and various states within the USA and Australia—have all enacted their own form of cannabis decriminalization (12) based on their individual situations. Each one of these can serve as examples from which to draw in creating new policies.

Closer to Bermuda, there are similar jurisdictions which are currently looking at ways which they can decriminalize the use of cannabis. Belize—a small Central American country and member of CARICOM—has the highest cannabis use rate within Central America and recently has seen increases in violence and gangs associated with drug violence (15). As recent as July 2012, the Government of Belize established a committee to assess the feasibility of decriminalizing cannabis, citing the observation that current policy fills the courts and jails with small-time drug offenders representing only a marginal portion of society. Jamaica too is looking to decriminalize the use of cannabis. A previous commission there had advocated for the decriminalization of the drug, due to the fact that cannabis is ingrained in their culture, and that drug charges serve as a serious impediment to those affected. However Government did not act, in the face of potential foreign relations issues, including possible economic sanctions (16). It seems now though that the Government of Jamaica is leaning towards decriminalization, with various members of the Government claiming that such reform will be achieved by the end of this year (17).

Beyond decriminalization, jurisdictions have even gone so far as to outright

legalize cannabis for recreational use. Individual states within the United States of America have been leaders in cannabis reform, despite the stance of prohibition still promoted by the federal government. With the enactment of Amendment 64, Colorado became one of two states to be the first to legalize cannabis within its borders. The primary drivers for adopting such legislation are the efficient use of law enforcement resources, the enhancing of public revenue, and the freedom of individuals (18). From its onset, Colorado citizens aged 21 and over were allowed to grow up to six cannabis plants at a time, with no more than three of those being mature at any one time. Beyond personal cultivation, cannabis is now regulated in a similar fashion to alcohol. Entrepreneurs can open up cannabis cultivation facilities and retail outlets that require licenses and are regulated by the state government. Unlike alcohol though, there is a maximum to the amount of cannabis that can be purchased—a total of one ounce—and transported (18).

It was not until later in 2013 though that Cannabis was formally made legal on a national scale. On December 23, 2013 President José Mujica of Uruguay signed into law legislation that created a strictly regulated market for legal cannabis—making Uruguay the first country in the world to legalize the cultivation, distribution and sale of cannabis. Reasons for a move to legalization include attempts to stem violence created in black market activities, as well as increasing revenue for the Government—through taxes of the supposed $750 million cannabis market. Simply, their traditional drug policy was just not working (19). Unlike Colorado, Uruguay is seeking to maintain greater control over the sale of cannabis, with the government itself becoming the sole seller of cannabis. Residents will be permitted to purchase up to 40g of cannabis from the government per month, and crow up to six crops (for a total of 480g per year) for non-commercial uses (20). Nonresidents will not have access to cannabis sales. Unlike Colorado, Uruguay is presenting a very formalized system, and more importantly a radically different and nonviolent alternative to the war on drugs.

Cannabis policy has come along way since the early 1990s. After decades of increasing control of all drugs, including cannabis, policy has liberalized since in many jurisdictions. The assumptions that proved the basis for prohibition were no longer relevant to societies within different national boundaries. For decades there has been a massive trend of decriminalizing the use of cannabis for personal use and more recently, the full on legalization of cannabis for recreational use. Though the latter is still in its infancy, decriminalization has proven to not cause many of the social ills that many people originally feared. It is time that Bermuda address its current cannabis policies. Bermuda faces many of the social ills connected to the prohibition of cannabis, as did many of the

countries mentioned. It is time to accept that traditional prohibition has not served to eradicate drug use, both problematic and otherwise. Bermuda today has a chance to be a leader in this global trend of liberalizing cannabis policy, reaping the many benefits that a shift away from prohibition has to offer.

The CRC Recommends:

1. **Bermuda should become a global leader in cannabis policy by implementing an efficient regulations model.**

1) http://www.unodc.org/pdf/convention_1961_en.pdf
2) October 2012, Governing Global Drug Wars- Special Report
3) http://reformdrugpolicy.com/beckley-main-content/war-on-drugs/human-rights/#sthash.38SzNmRf.dpuf
4) Global View of Alcohol, Tobacco, Cannabis, and Cocaine Use: Findings from the WHO World Mental Health Survey written in 2008
5) EMCDDA. THRESHOLD QUANTITIES FOR DRUG OFFENCES. LISBON: EMCDDA, 2010 (HTTP://WWW.EMCDDA.EUROPA.EU/HTML.CFM/INDEX99321EN.HTML, ACCESSED 14 MAY 2012).
6) SEE STEVENS A. DRUGS, CRIME AND PUBLIC HEALTH: THE POLITICAL ECONOMY OF DRUG POLICY. ABINGDON: ROUTLEDGE, 2010: PP.120–122.
7) 120. GRAY JP. THE HOPELESSNESS OF DRUG PROHIBITION. 13 CHAPMAN LAW REVIEW 2010;521:545.
8) 116. KILMER B. DO CANNABIS POSSESSION LAWS INFLUENCE CANNABIS USE?. CANNABIS 2002 REPORT: A JOINT INTERNATIONAL EFFORT AT THE INITIATIVE OF THE MINISTERS OF PUBLIC HEALTH OF BELGIUM, FRANCE, GERMANY, THE NETHERLANDS, SWITZERLAND: TECHNICAL REPORT OF THE SCIENTIFIC CONFERENCE. BRUSSELS: BELGIAN MINISTRY OF PUBLIC HEALTH, 2002: P.105.
9) http://www.druglawreform.info/en/country-information/paraguay/item/206-paraguay
10) http://www.unodc.org/documents/data-and-analysis/WDR2011/World_Drug_Report_2011_ebook.pdf
11) 132. EMCDDA. THRESHOLD QUANTITIES FOR DRUG OFFENCES. LISBON: EMCDDA, 2010 (HTTP://WWW.EMCDDA.EUROPA.EU/HTML.CFM/INDEX99321EN.HTML, ACCESSED 14 MAY 2012) – THIS AMOUNTS IN PRACTICE TO UP TO 5 GRAMS OF CANNABIS RESIN OR 25 GRAMS OF HERBAL CANNABIS, 1 GRAM OF ECSTASY, 1 GRAM OF HEROIN, AND 2 GRAMS OF COCAINE.
12) http://www.release.org.uk/sites/release.org.uk/files/pdf/publications/Release_Quiet_Revolution_2013.pdf
13) http://www.release.org.uk/sites/release.org.uk/files/pdf/publications/Release_Quiet_Revolution_2013.pdf
14) HUGHES CE, STEVENS A. WHAT CAN WE LEARN FROM THE PORTUGUESE DECRIMINALIZATION OF ILLICIT DRUGS? BRITISH JOURNAL OF CRIMINOLOGY 2010;50:1008.
15) http://www.huffingtonpost.com/ethan-nadelmann/belize-to-consider-decrim_b_1684055.html
16) http://www.jamaicaobserver.com/westernnews/Decriminalise-it_14967441
17) http://www.jamaicaobserver.com/news/Ganja-green-light-this-year
18) http://www.fcgov.com/mmj/pdf/amendment64.pdf
19) http://world.time.com/2012/06/26/uruguay-wants-to-legalize-marijuana-sales-should-the-rest-of-the-world-follow/#ixzz1z0z02xqa
20) http://www.nytimes.com/2013/12/25/world/americas/uruguay-marijuana-becomes-legal.html?_r=2& http://www.drugpolicy.org/sites/default/files/3371_DPA_NYAM_Report_FINAL_for_WEB%20April%2019%202013.pdf

11. Final Cannabis Policy Analysis

Policy Option Analysis

Countries around the world have taken vastly different approaches to drug reform within their borders. Each of these changes has impacted the respective jurisdictions in a number of arenas—public health, social justice, the economy, and criminal justice, among others. There are a number of options that the Government of Bermuda can pursue, each with its own advantages and disadvantages. Four such options are discussed below. Since drug policy is quite intricate, a number of considerations are listed with each option that can be used in assessing an adequate policy approach.

1) Maintain the Current Policies

Through analysis it may be decided that the best course of action is to take no action at all. This would entail no changes in legislation or procedural matters regarding the use, possession, sale, and distribution of cannabis in Bermuda. The Government in this case would choose to continue prosecuting people for cannabis related offenses, continuing the impact that such prohibitionist policies have on society.

It may be appealing to maintain the status quo for a number of reasons. Politically, failing to reform drug policy will continue to satisfy those voters who support prohibition. There are a number of people on the Island who support this traditional approach. Maintaining the status quo also eliminates a significant amount of risk for the Government. Liberalization of drug policy may affect the way in which Bermuda is perceived internationally, affecting sectors such as tourism, international business, as well as foreign relations. There are also risks as to what impact liberalizing cannabis policy may have on society. Changes in drug policy could potentially affect the availability of cannabis and usage rates.

Maintaining the status quo also entails a number of disadvantages, stemming from the current inadequacies of drug policy. In deciding to continue to enforce prohibitionist policies, Government will continue to allow the social justices that currently exist due to the current policies. Drug users will continue to face prosecution and often a life plagued by discrimination. Further, certain populations will continue to be unfairly prosecuted over others. There are also issues surrounding the current sourcing of cannabis through the illicit market. Maintaining the status quo will continue to support an illicit drug trade without any regulations and safety controls. Money used to purchase cannabis often fuels other criminal and gang activity, instead of being recalculated into the

economy and taxed for the Government. There is a significant population in Bermuda that is in support of some sort of reform, so it may be disadvantageous to not change existing cannabis laws and policy.

Considerations:

- There are no considerations, as no changes are made under this option

2) Decriminalization of Cannabis

The decriminalization of cannabis could involve the removal of criminal penalties for those found using cannabis or those found in possession of cannabis for personal use. The same policy could potentially be extended to the cultivation of cannabis for personal use. In place, administrative penalties may be administered such as drug education, rehabilitation, community service, or even fines. Alternatively, no penalties could be administered for those falling within the prescribed limits. Though models may vary significantly, criminal penalties typically remain in place for the possession of larger quantities, the sale of cannabis, and the cultivation of cannabis for commercial purposes.

There are a number of significant strengths to the policy of decriminalization. The primary benefit of shifting to a decriminalization model is that a sizeable portion of society will no longer be criminalized. Avoiding criminal offenses will have a positive impact on the lives of these people, as they will have a better chance to obtain employment or schooling abroad. This may ultimately have a positive effect on society as a result. Another significant benefit of decriminalization is the lower cost associated with enforcing current cannabis laws. Less money is likely to be spent on the criminal justice system, allowing these resources to be used more effectively elsewhere. Decriminalization, politically, has the benefit of being more palatable that other forms of reform. A large portion of the population is in support of reducing the harms that are done through current policies, so enacting decriminalization reform could be quite a popular decision.

Despite the strengths of decriminalization of cannabis for personal use, there are a number of weaknesses. While this policy prevents the unjust discrimination of cannabis end users, it fails to address issues associated with the illegal supply chain. Cannabis purchases will continue to feed the black market and fuel gang violence. Users will still be exposed to varying qualities of cannabis and potential health hazards, as well as inflated costs resulting from the risks of the black market. Failing to address the cultivation and distribution of cannabis deprives legal access to a sizeable market whose demand looks to continue in the future in addition to potential Government revenue.

Considerations:

Quantity threshold: a maximum-quantity threshold may be established to differentiate between personal possession and intent to supply. A policy of no defined threshold allows for more flexibility but can be abused by police, allowing for discrimination. Maximum thresholds must be meaningful to reflect the true amount suitable for personal possession.
Form of response: a wide range of responses exists to address cannabis offenses. Administrative penalties can be enforced, including fines, community service, or the suspension of driver's licenses. The goal, though, is to set just sanctions so as to not unnecessarily impact someone's life. Treatment is another form of response, and could be beneficial if a person is truly in need. Forced treatment for those who do not need it however may be counterproductive. Finally, there may be no response. In this case, details may be retained for information purposes, but the offender faces no discrimination.
Recurring offenses: offenders could be given a period of time (eg. 6 months), after which their offense is expunged, assuming no further offenses are recorded. However if the offender re-commits an offense, the penalties could increase.
Roles of judiciary versus police: the decision regarding the appropriate penalty could be made at the scene of the offense by police, or in a court of law.
Implementation challenges: all parties involved in implementing the desired policy must work in tandem. This means that law enforcement; the judiciary and social services must all work towards the ultimate goals of the policy.
Social and cultural structure: decriminalization policies should reflect the societal needs of Bermuda to ensure that it fits the needs of its citizens.
Record keeping: accurate recording of statistics regarding offenses both before and after implementation of decriminalization is necessary to gauge the effectiveness of the policy.
Retroactive abolishment of prior drug convictions for possession of cannabis: though there is no system currently in existence to do so, it could be very beneficial to expunge prior convictions for possession of cannabis. Such a policy could have a significant positive impact on the lives of those people.
Age limits: a different approach could be taken for minors found in possession of cannabis. For example, education programs could be more beneficial for this demographic.

3) Legalization of Medical Cannabis

Medical cannabis is another form of reform that can be pursued by the Bermuda Government. The justification behind medical cannabis centers on both health and human rights issues. An increasing body of evidence has shown

that cannabis can be used as an effective treatment for a number of ailments, ranging from cancer to epilepsy to glaucoma, and many others. Current policies deny access to cannabis for treatment of such conditions; so medical cannabis policies aim to fix this injustice by giving patients the medicine they need.

Under such policies criminal penalties are removed for the production, possession, delivery, or administration of cannabis—or paraphernalia use to administer that cannabis—as necessary for the exclusive benefit to treat the debilitating conditions of patients. Patients must suffer from one of the conditions stipulated by the Department of Health, and also must be approved by a licensed physician. Patients can specify a Primary Caregiver to aid them in obtaining and administering their medicinal cannabis. Limits can be set to state the maximum amount of cannabis or cannabis oil that a patient or caregiver is allowed to possess. Cultivation of cannabis for medicinal use by the patient or caregiver may also be allowed.

There are some obvious benefits of enacting policies that allow the use of medical cannabis. First and foremost, patients suffering from a number of debilitating health conditions will have access to the relief and treatment that medical cannabis can provide. These vulnerable populations deserve the right to have legal access to such medications. Currently, if the aforementioned persons desire to obtain cannabis for medical purposes, they must seek it from the illicit market. This exposes them to undue physical dangers as well as health hazards. Legalizing and regulating the use and distribution of medical cannabis would alleviate this issue. There are economic benefits for the Government to enacting medical cannabis policies. Revenue could be collected through fees associated with a cannabis patient registry, and additional revenue could be collected through taxes associated with retail stores.

The drawbacks of allowing medical cannabis need also be considered. As mentioned before, there are still ethical considerations surrounding the use of cannabis, and some members of the public may not support such policy. In addition, though there is much evidence that shows the medical benefits of cannabis use, there is indeed a significant amount of public debate surrounding the issue. A main area of concern is the potential for abuse within the system. Members of the public who do not suffer from the specified list of conditions may try to gain access to cannabis through the medical system. Lastly, there is a potential that distributors of medical cannabis could face issues with foreign travel, as anyone involved in the sale of cannabis could be considered a drug trafficker under other nations' laws such as the U.S. Immigration and Nationality Act.

Considerations:
Maximum allowable quantities: a limit must be set to the amount of cannabis, cannabis oil, or other cannabis product that a patient or caregiver is allowed to possess. In addition, if cultivation is required, restrictions must be made regarding a maximum number of plants grown. Limits should be in line with appropriate dose and use requirements for medical cannabis patients.
Patient Registry and Record keeping: an adequate patient registry must be established to support such a policy. The Department of Health and law enforcement would have to collaborate extensively to ensure proper records are kept regarding patients and instances of possession.
Sale of medical cannabis: beyond cultivation on the part of patients and caregiver, another option for distribution is that of retail stores. If retail stores are permitted, then regulations must govern such measures of hours of operation, sourcing, and quality testing, among others.
Sourcing of medical cannabis: if retail outlets are permitted, then a method of sourcing cannabis for those outlets must be identified. One such method would be to allow for local production. Another option would be to find a source from which to import cannabis.
Age Restrictions: it must be decided whether there are specific restrictions placed on people under a certain age using medical cannabis. If so, an appropriate age must be decided upon, under which parental consent is mandatory.

4) Legalization of Cannabis for Recreational Use

The final policy option that is to be explored here is the legalization of cannabis for recreational purposes. Legalization would include the removal of all penalties—criminal as well as civil—for the use, possession, production, and supply of cannabis per Government regulations. There are a wide range of possible ways to implement such a policy, ranging from the removal of all restrictions, to a highly regulated market with specific restrictions on the use, manufacture, and supply of cannabis.

Such a drastic shift in policy towards cannabis can have a number of positive impacts for both society and the economy. As with decriminalization policy, legalization of recreational cannabis use ends criminal penalties for use and possession, avoiding the costs to individual freedom as well as the financial costs associated with prohibition (such as law enforcement and incarceration). Legalization ends the oppositional relationship between cannabis users and law enforcement, making it easier for police to cooperate with otherwise law-abiding cannabis users.

Creating a legal market also ends the black market for cannabis, estimated to be worth between $20 million and $100 million a year. Such a shift thereby ends clandestine funding for the underground economy and instead creates a legal market for cannabis. Such a market has the potential to generate tax revenue for the Government as well as preventing capital from leaving the island through purchase for the illicit trade. Regulating a legal market has additional benefits, such as making it easier to keep cannabis out of the hands of minors, and ensuring that cannabis products are safe and fit for human consumption.

Despite these benefits, there are also drawbacks to legalization. There may be pushback from the more traditional sectors of the population, and there are unforeseen implications for interactions with foreign governments. As with the legalization of medical cannabis, distributors of cannabis may be viewed as traffickers to other countries and could face travel restrictions such as being placed on the U.S. "stop list." Lastly, there is the potential that legalization could lead to increased cannabis use within the population. This increase though, is more likely to be attributable to efforts to promote products in retail outlets, rather than the policy of legalization itself.

Considerations:

Maximum allowable quantities: limits may be set as to the quantity of cannabis a user can purchase or possess at any given time. These quantities must be determined in accordance with the goals of the legalization policy.

Producers: regulations must address who may produce cannabis. Cannabis may be produced by the Government only, or private commercial cannabis producers licensed by Government. Regulations may also dictate which types of products can be produced for sale to the public.

Vendors: regulations must be established to govern who may sell cannabis, and under what conditions they must adhere to. Penalties can be ascribed to those that do not comply with regulations.

Outlets: regulations may govern how many outlets are permitted, in what location, and what products are permitted for sale at such outlets.

Marketing: controls can be put in place so producers and vendors must abide by certain marketing restrictions, in line with the policy's goals.

Home growing: regulations can be put in place to allow adults to cultivate their own cannabis plants, under certain restrictions. Allowances could also be made for cultivators to participate in informal cannabis clubs, permitting the informal trade of cannabis.

Age Restrictions: as with alcohol sales, regulations must govern the age at which people can legally purchase and use cannabis for recreational purposes.

12. Final Recommendation Analysis

The existing policy framework in Bermuda and its place within an international context has been presented and offers a range of possibilities in terms of cannabis reform options. Unlike other larger jurisdictions, the compact nature of our framework is unencumbered by levels of government and only ensure it negotiates any legal obligations as a UK dependent territory, and adequately addresses potential impacts on international relations.

As indicated in Chapter 7, there is strong evidence to suggest that age of first use may be a strong indicator with respect to a heightened likelihood of irresponsible use and that specific attention should be given to vulnerable youths. The DNDC 2013 survey supports evidence from other countries that a concentrated effort to educate the youth on health matters related to substance abuse is effective, and that youth do make sound choices when given access to good information. Indicative prevention, which focuses on a target audience has been shown to be an effective method of education and prevention. Research has shown and evidence has been presented in this paper that substance abuse is often predicated by a preexisting genetic vulnerability or tendency towards it. This is a health issue, which should be addressed via the correct channels that are based on science and health, not the criminal justice system.

Any reform must adequately address the negative outcome of the criminal prosecution of small amounts of marijuana, as well other negative environmental factors created by illicit drug sales (i.e. price, quality and availability of marijuana). In this regard, consideration should be given to legislative reform in efforts of creating legal framework/industry for Cannabis similar to alcohol.

The culture of Bermuda is a vitally important consideration in shaping policy reform. Too often we as a country look to approaches taken by other jurisdictions on a range of issues without carefully adjusting for our unique conditions. The following is a list of overall recommendations from our report and a summary of each chapter recommendation.

1. Legislation based on Human rights and dignity

Legislation should uphold the basic tenets of human rights and dignity above all. Cannabis legislation is founded on and carries a tainted legacy of racial discrimination which is insupportable. Notwithstanding this, substance abuse is a nonviolent dependency, which can potentially affect the health of individuals and have wider consequences on other vulnerable members of the community. Depriving those already challenged with addiction of civil liberties deals with the consequences and fails to address the causes.

Those with medical conditions should have jurisdiction over their own bodies and the right to choose approaches for the treatment of their ailments, and right of access to those treatments - see Recommendation 6 below.

Data shows that Cannabis offences represent a large proportion of all offences in Bermuda, and that although use is widespread and indiscriminate along racial lines, significant racial disparity is indicated in terms of prosecution and incarceration. The social and economic impacts of this reality must be addressed through policy and legislated reform.

Bermuda should take steps to follow the lead taken by other countries to acknowledge that substance abuse is a health issue not a criminal act, and legislation, policy and associated departments and agencies must be aligned with this approach.

2 - A compassionate approach to Addiction

Substance abuse affects vulnerable members of the community and is the direct result of irresponsible use or a preexisting genetic predisposition. Irresponsible use has been shown to be effectively addressed with proper access to factual information based on health related choices, devoid of moral judgment. Similarly, support for individuals predisposed to substance addiction is better served by an environment of compassion and understanding.

Bermuda is subject to a variety of substance use and abuse. This social issue should be addressed in a holistic manner where the community are informed of benefits and consequences to make informed decisions. Many substances are classified as "drugs" which places them into a negative light while neglecting to address that many of these substances - legal and illegal - are addictive. Addiction is a disease and something that can be treated, yet we are not viewing all substances with this outlook of treatment. All substances should be considered as potentially addictive including processed white sugar, processed food, caffeine. Bermuda should strive to create a culture of responsible substance use where people are aware of addictive substances and what impacts they might have on health and wellness.

3 - Regulation for Public Health & Safety

The illegal status of cannabis enables unregulated and often violent black markets to thrive at the expense of the health and safety of the wider community, with wide ranging social and economic consequences. As a result many jurisdictions are reviewing their approach to drug policy. A wide body of research is showing that cannabis policy reform does NOT negatively impact Public Health and Safety.

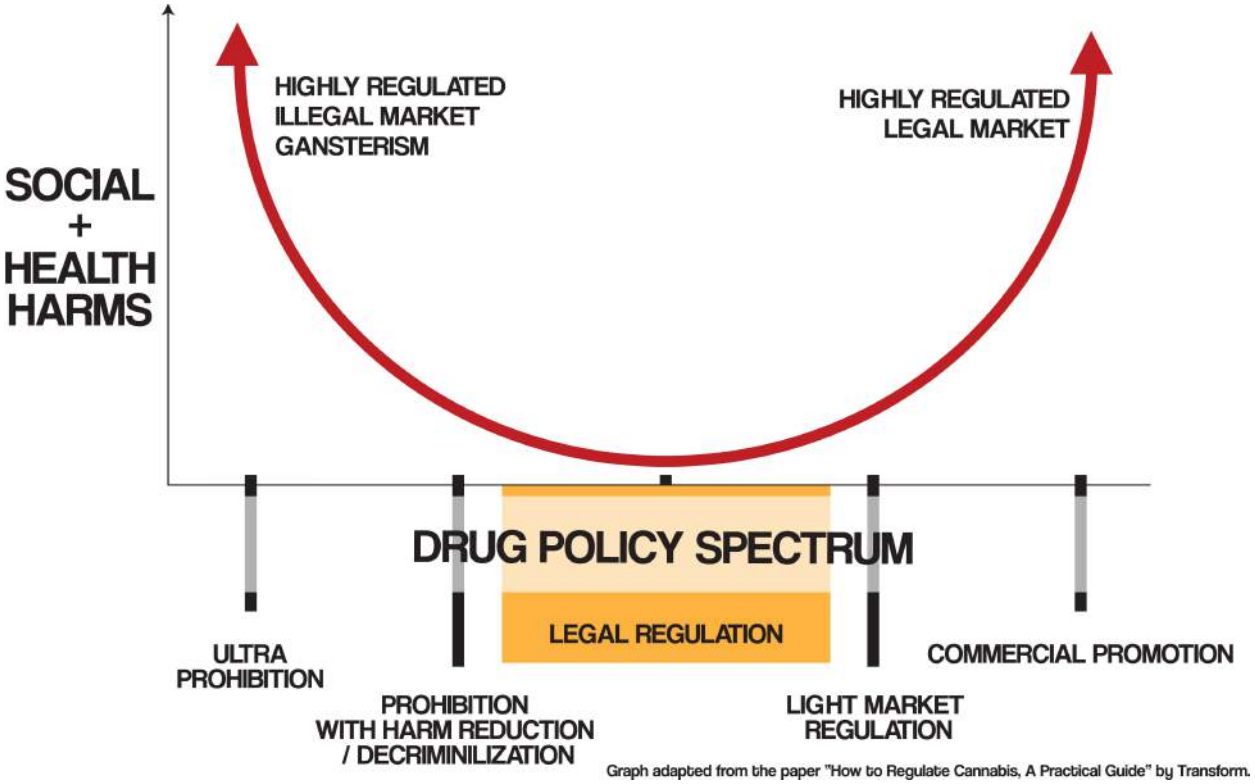
A well considered strategy for Public safety should be uppermost in considering the welfare of a healthy community. Although Bermuda is generally still seen as a safe country, a high percentage of violent crime in Bermuda relates to gang violence

and the unregulated black market. The government is urged to consider and acknowledge the vast and growing number of countries reviewing drug policies, and the success of countries who have already changed their approach and experienced a reduction in drug related violent crime. The current regime is failing to eliminate the black market and instead creates an environment in which it can thrive. Reducing opportunities for the black market to flourish can be achieved by proactively managing and regulating cannabis supply and demand through legislation.

4 - A locally appropriate regulatory model

A review of the range of positions taken by a number of countries around the world provides useful retrospective information on the impacts of various legislative measures, from fully illegal, to medical access only, decriminalization, to full legalization with a range of regulatory frameworks.

The following illustration is a graph adapted from the document "*How to Regulate Cannabis, A Practical Guide*" by Transform. It represents the range of options available in considering drug policy reform and predicted outcomes based on the history of prohibition models. It suggests that the key question for reform is: "what kind of regulation model will most effectively achieve the policy aims of any given jurisdiction" i.e.: Bermuda.



Graph adapted from the paper "How to Regulate Cannabis, A Practical Guide" by Transform.

It should be noted that in both the cases of Israel and Canada, significant challenges are arising as a result of medical cannabis within in an illegal framework. These include theft and security challenges.

5 - A Phased Approach

Although a number of longitudinal studies have been conducted in other jurisdictions on whether there are unintended impacts of Policy Reform, the recent historical attitude to cannabis has resulted in a residual fear in some sectors of the community . A phased approach employs the precautionary principle so that the community can be part of the reform process.

A phased approach to Cannabis Reform offers the benefits of assessing, establishing and implementing long term plans that focuses on more efficient prevention initiatives, effective treatment programs that are supported by the Ministry of Health and sensible society guided regulations that our community understands.

Medical access should be a top priority in this phased approach - see Recommendation 6 below.

Decriminalisation should be prioritised to address the negative social and economic implications of incarcerating cannabis related activity, and to enable a shift in Government expenditure from enforcement to education and prevention see Recommendation 1 above.

Full legalisation is shown to be supported by over 50% of the population according to the CRC survey and should be seriously considered as the final step in this phased approach to enable regulation of the market and avoid unintended consequences resulting from other reform approaches, as witnessed in other jurisdictions see also Recommendation 7 below.

6 - Enable immediate Access for Medical Cannabis

The current emotional, moral and legislated responses to cannabis are largely based on fraudulent motives devised within the last century, by other jurisdictions, with devastating and wide reaching impacts for a historically beneficial and widely used medicinal plant. Specifically, a significant and growing body of research continues to highlight and expand the medical potential of cannabis, but its illegal status deprives access to individuals with often life threatening diseases or chronic ailments, and the dignity and right to have autonomy over their own bodies, and the ability to choose for themselves alternative forms of treatment.

The powers of the Minister under the current legislation extend to regulations which may be written without change to the legislation, to enable access for medical

purposes. Regulations should be immediately prepared to allow access to medical cannabis, in conformance with Recommendation 1 above.

7 - Future potential market

Policy reform should consider short medium and long term potential in the context of a sustainable model. The potential exists for a truly local market in terms of supply and demand, which could potentially oust the black market through an economically sustainable framework.

A viable economy is the 3rd pillar of a sustainable community along with environmental and social considerations. Economic impacts of the do nothing approach have been noted in Section 08, and are shown to be a drain on the local economy, with reduced benefits and undesirable and unintended consequences. The government must take into consideration the potential to redirect a negative situation into a revenue generating market with benefits for a local economy, and explore what this might look like.

8 - Increase emphasis on prevention initiatives

Research has shown that addiction and mental illness manifest in individuals with a preexisting genetic disposition or tendency to these conditions, and that awareness and support is vital for those displaying signs of these tendencies. Age of first use is a concern as it relates to possible and as yet unproven impacts on the developing brain. Indicative prevention has been found to be an effective way to target and specifically address relevant issues for vulnerable populations, and raise age of first use.

With an increase of prevention initiatives; school wide curriculum around substance use and education programme for the wider community, Bermuda will continue to see a decrease in substance use and abuse. The public and future of Bermuda need to be provided with a balanced approach to understand any positive or negative consequences related to substance use and abuse while working towards a healthier community.

The following is a summary of recommendations outlined in chapters throughout this report:

Chapter 3 - Community Consultation

1. That the Government continue to consult with the public and stakeholders about cannabis reform
2. That the Government and NGOs collaborate in helping the community understand what cannabis is and what reform means

Chapter 4 - Cannabis then & now

1. Provide factual education around cannabis history and its uses
2. End racial profiling within the criminal justice system
3. Expunge all convictions related to cannabis only
4. If cannabis is legalized, ensure equal opportunities to enter the industry

Chapter 5 - Current Legislative Framework, Policies & Impacts

1. The Minister use the statuary powers to proactively and immediately enable reform in the case of Medical access without taking this to the House of Assembly
2. Decriminalize of personal possession and personal cultivation immediately
3. Confirm any obligations and level of autonomy with respect to policy reform, as an British Overseas Territory
4. Develop a phased approach to cannabis reform and policies that limit potential of Bermudians being denied access to the United States (Stop List) and conduct further discussions with the US consulate
5. Introduce a less punitive warning system ie: civic penalties and harm reduction/education initiatives
6. The Department of National Drug Control be placed under the Ministry of Health and a greater emphasis on demand reduction with a focus on prevention and treatment be the overall focus of drug policy in Bermuda.

Chapter 6 - Cannabis Culture

1. Increase education resources around Cannabis
2. Improve quality of cannabis education to be more objective and fact based
3. Implement more effective data collection to understand effects of courts, police and prison forces.

Chapter 7 - Social & Health Perspectives

1. Increase resources (funding) for prevention and educational initiatives
2. Indicative Prevention - resources should be targeted to those who are at high risk for addiction and/or directed towards those who have been identified as persons manifesting symptoms/problems regarding addiction; rather than addressing prevention from a universal point of view.
3. Ensure the new master DNDC plan focuses on managing substance use from a health centered approach under direction from the Ministry of Health
4. Age of consent for access and consumption of Cannabis and alcohol should both be twenty-one (21).
5. Treatment continuum should create cannabis specific services to assist those with dependence
6. Companies providing group health insurance must offer insurance coverage to treat alcoholism and drug addiction

7. Government consult with employers, unions, and insurance companies regarding a substantial change in law and policy.

Chapter 8 - Economic Profile

1. Take steps to enable Government to save money by substantially reducing supply reduction costs associated with cannabis prohibition and enforcement
2. Redirect money saved towards prevention and treatment resources
3. Empower those currently in the illegal cannabis trade to have access to entrepreneurial opportunities in a legal trade
4. Promote and establish a framework for local production to mitigate the amount of funds that leave the island to pay for cannabis.
5. Enable legislation and policies which provide another source of taxation to increase revenue streams.
6. Consult with financial regulators on possible consequences and impacts of reform

Chapter 9 - Cannabis as a Medicinal Substance

1. Immediate action is taken to enable access to medical cannabis to individuals by way of a regulation under the existing legislation, until such time as revised legislation is drafted.
2. Provide resources to physicians to effectively prescribe cannabis as a medicine
3. Ensure that a balanced approach is taken with respect to medical policies which acknowledge the vast body of research demonstrating the medical potential of cannabis.
4. Ensure that a balanced view is taken in considering the potential harm posed by cannabis, compared to harmful side effects of other legally prescribed drugs, as well as other legally available substances, such as tobacco and alcohol.

Chapter 10 - Foreign Shifts in Cannabis Policy

1. Bermuda should take its place as a global leader in cannabis policy by implementing an efficient regulations model.
2. Bermuda's policy makers must review and carefully consider the impacts of various approaches to cannabis reform when considering an appropriate model for Bermuda.

Proposed Decriminalization Policies

Offence	Explanation	Penalty	Incarceration	Max Fine
Personal Possession	Under 10 grams of dried cannabis, resin or oil	No Penalty - Verbal Warning - Police to make record of incident - no confiscation of substance	None	None
	Over 10 grams but under 1 ounce of dried cannabis, resin or oil	1st Offence - verbal warning issued, Police to make report about incident(so as long as one does not receive another warning within 12 months - record cleaned) - 2nd Offence within 12 months - substance tribunal and subject to their direction: ie drug prevention education or community hours - confiscation of substance	None	3rd Offence within 12 months - subject to a fine of $1000 - handled as a civil penalty
	Personal possession in an increased penalty zone	Existing Statutes continue to apply	None	Existing Statutes continue to apply
	Public Consumption	Existing Statutes continue to apply	None	Existing Statutes continue to apply
Offence	**Explanation**	**Penalty**	**Incarceration**	**Max Fine**
With Intent to Supply	Persons caught with over 1 ounce of dried cannabis, resin or oil	Existing Statutes continue to apply	Existing Statutes continue to apply	Existing Statutes continue to apply

Offence	Explanation	Penalty	Incarceration	Max Fine
Sale or Distribution	Existing Statutes continue to apply	Existing Statutes continue to apply	Existing Statutes continue to apply	Existing Statutes continue to apply
Offence	**Explanation**	**Penalty**	**Incarceration**	**Max Fine**
Cultivation	Up to 8 mature plants and 6 seedlings are allowed on private property in a screened lockable location - posession of cannabis seeds is permitted	1st Offence - written warning issued - so as long as one does not receive another warning within 12 months - record cleaned - 2nd Offence within 12 months - substance tribunal and subject to their direction: ie drug prevention education or community hours -	Existing Statutes continue to apply	3rd Offence within 12 months - subject to a fine of $1000 per plant confiscated over the stated limit - handled as a civil penalty
	"Mature Plant" – means any plant that does not fall within the definition of a seedling or start. A mature plant can be in either the vegetative, or the flowering stage of growth.			
	"Seedling" – means a plant that has no flowers, is less than 12 inches wide and is less than 12 inches tall. All three criteria must be met to be a seedling.			

Areas of Consideration – Decriminalization		
Production	No production controls – solely law enforcement efforts to eradicate or intercept illicit production	Cannabis is sourced from the illicit market, where it is produced with no regulatory oversight
Preparation	The content of products is unregulated, unknown and highly variable. Adulterants are common in resin and have also been observed in herbal cannabis	No restrictions on the varied ties of cannabis or cannabis products available
Potency	No THC/potency limits and no information provided to user about the strength of what they are purchasing – except informally via illicit vendors	
Price	Price determined by the interaction of criminal supply and user demand in an unregulated market	
Age Access Threshold	No age access controls: illicit dealers do not enforce age restrictions	
Purchaser restrictions	Anyone can purchase cannabis and no sales limits are set	
Vendor	Illicit dealers have no duty of care to their customers and may not even be aware of the contents of the cannabis they are selling	
Outlet	illicit dealers can sell wherever they deem fit	
Tax	All revenue flows, untaxed, direct to illicit dealers and criminal organizations money is exported abroad	
Marketing	No marketing controls, although illicit vendors do not have access to conventional marketing channels	
Driving	Driving under the influence of cannabis is illegal	
Home growing	Permitted as per recommendations above	

Proposed Legalization Policies

Offence	Explanation	Max Penalty	Incarceration	Max Fine
Personal Possession	One oz or less of dried cannabis/hash/or concentrate (oil)*	no penalty	none	$ 0
	Transfer of one oz. or less of dried cannabis/hash/or concentrate (oil) for no remuneration*	no penalty	none	$ 0
	1 - 2 oz of dried cannabis or	subject to substance tribunals decision	none	subject to substance tribunals decision
	Open and/or public displays or uses of less than 2 oz.	subject to substance tribunals decision	15 days	subject to substance tribunals decision
	Using cannabis around minors -	Civil Penalty	none	$1,000
	2 - 6 oz. of dried cannabis/hash/or concentrate (oil)*	Civil Penalty	1 year	$5,000
	6 oz. or more of dried cannabis/hash/or concentrate (oil)*	Civil Penalty	2 years	$ 10,000
	* by persons 21 years or older			
	** persons caught under the age threshold are subject to discretion of substance tribunal			

Offence	Explanation	Max Penalty	Incarceration	Max Fine
Sale or Distribution	5 lbs or less of dried cannabis*	Civil Penalty	0 - 3 years	$ 100,000
	5 - 100 lbs of dried cannabis*	Criminal Penalty	2 - 6 years	$ 500,000
	100 lbs of dried cannabis or more*	Criminal Penalty	4 - 12 years	$1000000
	Distribute, transfer, or possess with intent less than 1 lb - hash/or concentrate (oil)*	Criminal Penalty	1 - 3 years	$ 100,000
	Distribute, transfer, or possess with intent 1 - 100 lbs - hash/or concentrate (oil)*	Criminal Penalty	2 - 6 years	$ 500,000
	Distribute, transfer, or possess with intent more than 100 lbs - hash/or concentrate (oil)*	Criminal Penalty	4 - 12 years	$1000000
	*without appropriate GVT issued distribution license			
	Sale to a minor carries an additional penalty of 4 years mandatory minimum sentence.			

Offence	Explanation	Max Penalty	Incarceration	Max Fine
Cultivation	8 mature plants or fewer*	no penalty	none	$ 0
	More than 8 but fewer than 30 mature plants without license	Criminal Penalty	2 - 6 years	$ 500,000
	More than 30 mature plants without license	Criminal Penalty	6 - 12 years	$1000000
	* By persons 21 years of age or older.			

Areas of Consideration – Legalization		
Production	Government Department of Health specifies nature and potency of products and oversees monitoring of quality controls	Commercial producers licensed by government agency to grow product
Preparation	A range of quality and potency controlled products made available, with details determined by government regulatory body	Changes to market range introduced incrementally and carefully monitored
Potency	Range of products with various potencies available - Safer THC: CBD and other Cannabinoid ratios	Decisions on potency of retail products made by government agency
Price	Price parameters determined by government agency, using price as tool to achieve stated policy aims	Changes in price incremental and based on careful impact monitoring
Age Access Threshold	21 years of age	
Purchaser restrictions	Limits on individual transitions to minimize bulk buying and potential re-sales	Residents can purchase up to 1 ounce of cannabis per transaction; non-residents are restricted to a quarter of an ounce per transaction
Vendor	Vendors are required to adhere to licensing conditions and are subject to penalties for license violations, such as fines or loss of license	Mandatory training requirements for retail vendors, with additional training for vendors in sale and consumption venues

Outlet	Controls on location and hours of opening, determined in line with current alcohol regulations	Cannabis-only sales – no alcohol or other drugs. Food and drink sales allowed for retail and consumption venues
Tax	Tax models built into price controls and permit licenses	Proportion of monies raised to be earmarked for prevention and education initiatives
Marketing	Default ban on all forms of marketing and promotions, modeled on WHO Frame- work Convention on Tobacco Control guidelines	Storefront window displays of cannabis products are also banned
Driving	Clear message that cannabis impaired driving is risky and illegal	Driving under the influence of 5 or more Nano grams per milliliter is illegal - determined by road side blood tests
Home growing	Key aim is to protect minors and prevent for profit secondary sales	Home growing allowed within certain parameters set by GVT regulatory model

Thanks:

The CRC would like to acknowledge and thank Minister Michael Dunkley for enabling this group to provide meaningful fact based information by allowing us access to the various Departments in sourcing data related to this document. We would also like to thank the Departments and those individuals who provided much needed assistance and guidance on existing policy frameworks. The research into this document has confirmed that Bermuda is fortunate to be served by dedicated and hard working people in the Civil Service. We hope that finding of this paper might usher in a stronger dynamic, which sees further cohesion between the various Departments. In particular we hope that the preventive efforts of the DNDC will be given the additional funding to continue and expand their work in indicative and targeted prevention.

We would like to thank Richard Horseman for his insights and contributions with respect to the legal framework under which we are currently operating. We would also like to thank the US Consulate for his attendance at the Cannabis conversation and his unsolicited offer to meet with us and offer guidance with respect to any impacts of any policy reform on US immigration matters - it is greatly appreciated.

Although there are too many to mention all who have provided assistance and guidance in the research and preparation of this document, below is a list of others, which we would like to thank in particular:

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Ministry of National Security Head Quarters

Department for National Drug Control

The Community at large

Image on cover from: http://ppcnorthwest.com/cannabis-history

Appendix:

The appendix to this document is available online at the following link:

https://www.dropbox.com/sh/wux04204babesi0/pVLibLoSsl