PRELIMINARY REPORT

The Bahamas National Commission on Marijuana

JANUARY 2020

Presented to
The Government of The Bahamas
Nassau, The Bahamas

The Bahamas National Commission on Marijuana
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21 January 2020

Dr. The Honourable Hubert A. Minnis, MP
Prime Minister
Office of the Prime Minister
Sir Cecil Wallace Whitfield Centre
West Bay Street
NASSAU

Dear Prime Minister:

PRELIMINARY REPORT OF THE BAHAMAS NATIONAL COMMISSION ON MARIJUANA

On behalf of the members of the Bahamas National Commission on Marijuana (the Commission), we are pleased to submit this ***Preliminary Report*** to you.

The Report represents the first phase of fulfilling our mandate, which was to:

> ***"codify the views of Bahamians on all things related to marijuana, and to make recommendations to the Government of The Bahamas on positions related to the legal, social, medicinal and ceremonial (religious) issues as they relate to marijuana."***

We recognise that our work is not yet complete as it is our intent to further engage with members of the public through a national survey and provide more detailed analysis of their views. It is hoped that with the release of this Report, though preliminary, it will encourage more discourse, based on facts, rather than emotions.

The Commission is of the view that it will be advantageous to, at the earliest opportunity, engage in a massive education campaign on the topic of cannabis (marijuana). In our interactions with members of the public, it was evident that more information is needed.

It is our hope that our efforts thus far will be useful to the Government as it deliberates and makes decisions that will impact our country. We are confident that the Final Report will add even more value to assist with your discussions and decisions.

We have been honoured to serve and thank you for the confidence reposed in us.

Sincerely,

Bishop Simeon B. Hall
Co-Chairperson

Quinn W. McCartney, QPM
Co-Chairperson

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ACKNOWLEDGMENTS

The members of the Commission wish to thank the Government of The Bahamas for the honour of serving on such a distinguished commission. The Commission understands the importance of the work entrusted and counts this opportunity a privilege to present its recommendations to the Government of The Bahamas regarding the use of cannabis in the country.

The Commission was assisted by a Secretariat located at Capitol House, Augusta and Virginia Streets. Individuals assigned to the Secretariat staff throughout the year are listed in the table below.

Name	Affiliation	Position
Dr. Bridgette Rolle	Deputy Permanent Secretary Ministry of Health	Administrator (January - October 2019)
Mrs. Coral Miller	First Assistant Secretary Ministry of Health	Administrator (October 2019 - present)
Dr. Olive Rolle	Ministry of Health	Sr. Nursing Officer (July 2019; November 2019 - present)
Ms. Valencia King	Ministry of Health	Dental Auxiliary (November - December 2019)
Mr. Bjorn Hunt	Commission Secretariat	Laboratory Technician (June 2019 - present)
Ms. Sasha Ferguson	Commission Secretariat	Administrative Associate (January - November 2019)
Mr. Terrance Hall	Commission Secretariat	Administrative Associate (May 2019 - present)
Mrs. Angelica Adderley-McIntosh	Commission Secretariat	Administrative Associate (October 2019 - present)
Ms. Celine Scott	Ministry of Health	Intern (June - August 2019)

The Commission thanks the Secretariat staff and all other staff members of the Ministry of Health who facilitated the work of the Commission. Gratitude is also extended to Ms. Annouch Armbrister, Administrative Cadet of the Ministry of Health for preparing the Commission's Report on the trip to Jamaica.

Appreciation is extended to the staff of the Ministry of Foreign Affairs for their assistance with respect to arrangements for the Commission's fact-finding trip to Jamaica.

Thanks are rendered to the various stakeholders who shared their views with the Commission. The Commission is also very grateful to the members of the public who participated in various fora, including those who attended town hall meetings or willingly engaged with Commissioners during community walkabouts.

The Commission is also thankful to the Government and people of Jamaica who met with Commissioners during the fact-finding trip to Jamaica, with special thanks to the staff of the Cannabis Licensing Authority (CLA), the Ministry of Industry, Commerce, Agriculture and Fisheries, the Ministry of Justice, the National Council on Drug Abuse (NCDA), former Minister Mr. Mark Golding, the Sensi Medical Cannabis House, and members of the Rastafarian community.

PREFACE

The Caribbean Community (CARICOM) Heads of Government were deeply concerned that thousands of young persons throughout the region suffered incarceration for cannabis use. It was noted that after these young persons had their first encounter with the law, they tended to resort to crime as a way of life. Further, deep resentment and non-cooperation with law enforcement agencies resulted due to inconsistent application of the law.[1]

Consequently, a regional approach was developed to address these matters. At its 25th Inter-Sessional Meeting of the Conference of Heads of Government of CARICOM held in St. Vincent and the Grenadines on 10th and 11th March, 2014,[2] the CARICOM Regional Commission on Marijuana (CRCM) was established with the mandate to "interrogate the issue of possible reform to the legal regimes regulating marijuana in CARICOM countries,"[3] and released a Report on 3rd August, 2018.

During their deliberations, CARICOM Heads discussed that cannabis was promoted for its medicinal properties, as evidenced by scientific research, and that the region could be left behind in the absence of law reform for cannabis.

The Government of The Bahamas thus agreed to explore the issues presented in the CARICOM Report.

In October 2018, the Bahamas National Commission on Marijuana (hereon referred to as the Commission) was established by the Cabinet of the Government of The Bahamas with the mandate as follows:

> *"To codify the view of Bahamians on all things related to cannabis, and to make recommendations to the Government of The Bahamas on positions related to the legal, social, medicinal and ceremonial (religious) issues as they relate to cannabis."*

The Commission consists of 20 Commissioners from a wide cross-section of the Bahamian community, led by two Co-chairpersons, Bishop Simeon Hall and Mr. Quinn McCartney. The Honourable Dr. Duane Sands, M.P., Minister of Health has ministerial oversight of the Commission, and the Ministry of Health established a Secretariat to assist the Commission in fulfilling its mandate.

The Commission convened its first meeting in December 2018 with the Minister of Health. The Commission was charged to complete the following:

- *Reach out to as many Bahamians, as possible, to garner views on the issue of cannabis.*
- *To assess the prevailing attitudes and opinions regarding policy and legislative changes.*
- *Monitor activities related to cannabis issues, regionally and internationally.*
- *Produce a report that offers practical recommendations, with the uniqueness and culture of The Bahamas in mind.*

[1] Report to the Caribbean Community Heads of Government by the CARICOM Regional Commission on Marijuana, Waiting to Exhale, Safeguarding Our Future through Responsible Socio-Legal Policy on Marijuana, June 2018
[2] Ibid
[3] Ibid

The Commission commenced its activities in January 2019 and worked diligently to implement the Minister's directives, with specific focus on how cannabis-related issues are being handled in CARICOM countries, the United States of America (US) and Canada.

LIST OF COMMISSIONERS

Name	Affiliation	Position
Bishop Simeon Hall	Pastor	Co-Chairperson
Mr. Quinn McCartney	Retired Deputy Commissioner of Police	Co-Chairperson
Dr. Kevin Bethel	Medical Association of The Bahamas	Member
Mrs. Nahaja Black	Media	Member
Dr. Lynwood Brown	Physician	Member
Ms. Al-leecia Delancy	Office of The Director of Public Prosecutions	Member
Mr. Terrance Fountain	Anti-Drug Secretariat	Member
Mr. Sherwin Johnson	Entrepreneur	Member
Mrs. Latice Knowles-Penn	Under 30 Youth Representative Entrepreneur	Member
Mr. Elliott Marshall–Hepburn	Cannabis Entrepreneur	Member
Mr. Rithmond McKinney	Rastafarian Priest	Member
Ms. Chargrega McPhee-McIntosh	Pharmacist	Member
Mrs. Kelly Meister	Caregiver	Member
Mr. Julian Mullings	Bahamas Nurse's Union	Member
Dr. Edrica Richardson	Marriage & Family Therapist	Member
Mr. Paul Rolle	Royal Bahamas Police Force	Member
Rev. Irene Russell	Bahamas Christian Council	Member
Dr. Thomas Smith	Psychiatrist	Member
Mr. Kenneth C. Wallace Whitfield	Under 30 Youth Representative	Member
Dr. Carlton Watson	University of The Bahamas	Member

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BC	Before Christ
BCC	Bahamas Christian Council
BCE	Before Common Era
BNCM	The Bahamas National Commission on Marijuana
BNHDPS	Bahamas National Household Drug Prevalence Survey
CARICOM	The Caribbean Community
CBC	Cannabichromene
CBD	Cannabidiol
CBN	Cannabinol
CE	Common Era
CLA	Cannabis Licensing Authority (Jamaica)
CND	Commission on Narcotic Drugs
CRCM	Caribbean Regional Commission on Marijuana
CSA	Controlled Substance Act (US)
DDA	Dangerous Drugs Act, Chapter 228 (The Bahamas)
DEU	Drug Enforcement Agency
ECDD	Expert Committee on Drug Dependence
EU	European Union
HIV	Human Immunodeficiency Virus
MCC	Medical Cannabis Card
NCDA	National Council on Drug Abuse
NORML	National Organization for the Return of Marijuana Laws
NSDUH	National Survey on Drug Use and Health
PR	Public Relations
RBPF	Royal Bahamas Police Force
ROA	Rehabilitation of Offenders Act (country)
TCP	Tenocyclidine
THC	Tetrahydrocannabinol
UK	United Kingdom
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
US	United States of America
WHO	World Health Organization

KEY TERMS AND DEFINITIONS

Adult-use cannabis	Recreational cannabis
Cannabis	A drug made from the dried leaves and flowers or resin of the hemp plant, which is smoked or eaten and which gives the user a feeling of being relaxed. Use of the drug is illegal in many countries. The term is used interchangeably with marijuana, Indian hemp and “holy herb”, and colloquialisms include ganja, weed and pot.
Cannabis sativa	An annual herbaceous flowering plant indigenous to eastern Asia but now of cosmopolitan distribution due to widespread cultivation. It has been cultivated throughout recorded history, used as a source of industrial fibre, seed oil, food, recreation, religious and spiritual moods and medicine. Each part of the plant is harvested differently, depending on the purpose of its use. The word "sativa" means things that are cultivated.
Cerasee	Cerasee, scientifically known as "Momordica charantia," is a very bitter herb. It is a native to Africa and the Middle East and can today be found in almost every part of the world, including in The Bahamas where it is very popular for its medicinal properties.
Decriminalization[6]	Eliminating criminal penalties for the unauthorized consumption and possession (typically of amounts small enough to be for personal use only) of a controlled substance.
Ecstasy	A colloquialism for MDMA ,3,4 methylenedioxymethamphetamine which is a synthetic, psychoactive drug chemically similar to the stimulant methamphetamine and the hallucinogen mescaline**.**
High	The state of being under the influence of a substance such as cannabis
Joint	Colloquialism for cannabis cigarette
Legalization[7]	The process of eliminating legal prohibitions on the production, distribution, and use of a controlled substance for other than medical or scientific purposes, generally through replacement with a regulated market.
Mule	courier or someone who personally smuggles contraband across a border (as opposed to sending by mail, etc.) for a smuggling organization. In the case of transporting illegal drugs, the term “drug mule” obtains.
Sacrament	Religious ceremony, religious ritual, or a ceremony having religious meaning
Summary offence	A summary offence is a crime in some common law jurisdictions that can be proceeded against summarily, without the right to a jury trial and/or indictment

[6] Scenarios for the drug problem in the Americas 2013 – 2025 (OAS official records series) ISBN 978-0-8270-5987-0
[7] Ibid

EXECUTIVE SUMMARY

Background

There is a new wind blowing across the planet with respect to cannabis, a word interchangeably used with *marijuana*, and The Commonwealth of The Bahamas (hereon referred to as The Bahamas) is in its path. The new wind essentially carries with it shifting attitudes and action with respect to cannabis and cannabis policies.

Heads of Government within The Caribbean Community (CARICOM), of which The Bahamas is a constituent, are deeply and increasingly concerned that thousands of young persons throughout the region continue to be incarcerated for cannabis use, including consumption. Compounding this issue is that after these youngsters have had their first encounter with the law, they resort to crime as a way of life. Further, deep resentment and non-cooperation with law enforcement agencies results due to inconsistent application of the law.

CARICOM Heads were advised by experts that cannabis possesses medicinal properties, as evidenced by scientific research, and that the region could be left behind in the absence of law reform concerning cannabis. Consequently, at its 25th Inter-Sessional Meeting of the Conference of Heads of Government of CARICOM held in St. Vincent and the Grenadines in March 2014, the CARICOM Regional Commission on Marijuana (CRCM) was established with the mandate to "interrogate the issue of possible reform to the legal regimes regulating marijuana in CARICOM countries" and released its Report in August 2018. The Government of The Bahamas agreed to explore the issues presented in said Report.

Purpose

It was against the foregoing backdrop that in October 2018 the Bahamas National Commission on Marijuana (hereon referred to as the Commission) was established by the Cabinet of The Bahamas with the following task:

> *"Making recommendation to the Government of The Bahamas on the issues related to cannabis*"

and with the following mandate:

> *"To codify the view of Bahamians on all things related to cannabis, and to make recommendations to the Government of The Bahamas on positions related to the legal, social, medicinal and ceremonial (religious) issues as they relate to cannabis."*

Composition

The Commission is led by Co-chairs, Bishop Simeon Hall and Mr. Quinn McCartney, and consists of 20 Commissioners from a wide cross-section of the Bahamian community. The Honourable Dr. Duane Sands, M.P., Minister of Health had ministerial oversight of the Commission up until January 2020, and the Ministry of Health established a Secretariat to assist it in fulfilling its mandate. In January 2020 the Commission was relocated to the Office of the Prime Minister.

Scope and Terms of Reference

The Commission convened its initial meeting in December 2018, with the Minister of Health. There the Commission was charged with undertaking the following:

- *Reach out to as many Bahamians, as possible, to garner views on the issue of cannabis.*
- *To assess the prevailing attitudes and opinions regarding policy and legislative changes.*
- *Monitor activities related to cannabis issues, regionally and internationally.*
- *Produce a report that offers practical recommendations from Bahamians, with the uniqueness and culture of The Bahamas in mind.*

Deliverables and Deadlines

The Commission was charged with producing a report by April 2019. The deadline was however extended for the production of a Preliminary Report by January 2020.

A Final Report will be presented to the Government in the first quarter of 2020.

Administrative Approach

The Commission commenced its activities in January 2019 and worked diligently to implement the Minister's directives, with specific focus on how cannabis-related issues are being handled in CARICOM countries, the United States of America (US) and Canada. Commission meetings were held regularly from January 2019 to January 2020, for strategic planning, delegation of tasks, discussion and decision-making.

The Commission was subdivided into six substantive Sub-committees to assist with the management of its objectives.

Several Commissioners were also tasked with preparing a national survey designed to gauge public opinion about recreational and medical use of cannabis.

Methodology

Methods in capturing the sentiment of the Bahamian community, with respect to cannabis and cannabis policies, were largely qualitative. The Commission actively engaged the public via various modes throughout 2019, meeting with and listening to Bahamians from all walks of life.

Said modes included formal and informal surveys, interviews and/or discussions at town hall meetings, community walkabouts, speaking engagements, stakeholder meetings, media shows and a press conference.

Members of the Commission also travelled outside of New Providence to Abaco, Eleuthera, Exuma and Grand Bahama to engage with the local populations there.

In addition to local and national engagement, several members of the Commission travelled to Jamaica on a fact-finding mission. They met with a wide cross-section of persons actively involved in or affected by the cannabis industry.

Public engagement, locally and regionally, as well as review of associated literature, immensely informed the content of the Final Report of the Commission, including the Report's Recommendations.

Preliminary Report Synopsis

- Chapter 1 introduces the primary context of study, The Bahamas, and the global context is also described.
- Chapters 2 provides a synopsis of the methods used in gathering information for this report.
- Chapter 3 speaks about what is cannabis and the various related products.
- A brief history of cannabis is provided in Chapter 4, and the issue of prohibition is also explored.
- The situational analysis of cannabis in The Bahamas is laid out in Chapter 5. Sections therein include access, use, effects (adverse and positive), policies, and legislation and consequences.
- Chapters 6 and 7 respectively speak to recreational use and medical use of cannabis, locally and internationally.
- Chapter 8 sets out the religious and ceremonial use of cannabis in The Bahamas, with particular focus on Rastafari. The content therein is prefaced with particulars on religion in The Bahamas.
- Respectively, Chapters 9 and 10 speak to the economic impact of a cannabis industry, and legal issues (e.g., expunging of records) or implications. Select jurisdictions within the region are considered.
- Chapter 11 presents a glimpse of the prevailing thoughts of the Bahamian public who shared their views at town hall meetings. These views and those obtained during the course of a survey will be the heart and pulse of the Commission's Final Report: the sentiments of The Bahamian people with respect to cannabis and cannabis policies.
- Chapter 12 cumulatively provides recommendations for the Government of The Bahamas, drawn from the mandated canvassing of the Bahamian people, literature or data consultation, and Commission discussion and debate.
- Chapter 13 concludes with a collective summary of the preceding chapters, and with highlighting of 24 recommendations for the Government of The Bahamas. In a nutshell, Commission's recommendations support for the most part the medical use and ceremonial use of cannabis; however, recreational use remains an unresolved issue.

Concluding Statements

The Commission is mindful that the recommendations within its Final Report, and any subsequent decisions made by the Government of The Bahamas, will have far-reaching implications for The Bahamas. The Commission advises in light of same that the nation proceed with prudence, practicality and caution. It is opined, however, that caution, scepticism or apprehension should not paralyse the nation into inaction, thereby allowing the cannabis-related issue to linger indefinitely.

CHAPTER 1: INTRODUCTION

Bahamas Context

The Commonwealth of The Bahamas is an archipelago situated in the Atlantic Ocean consisting of more than 700 islands and 2,400 cays. It has a population of approximately 389,000 spread out over almost 100,000 square miles of ocean. Roughly 65% of the population resides on the island of New Providence with the remaining 35% scattered across the remaining 22 inhabited islands.

The location and geography of The Bahamas, and challenges associated with policing such a wide expanse, has led to a history of trafficking and other illegal activities. These include wrecking during the 17th century, pirating during the 17th and 18th centuries and "rum running" during the Prohibition period in the US dating from 1919 to 1933.

There was a period of relevant calm until the 1980s when The Bahamas became a hotbed of cocaine trafficking between South America and the US as well as other parts of the Caribbean. During this period there was also significant trafficking of cannabis, predominately from Jamaica, that was destined for the US. Since then, cocaine trafficking appears to have decreased while cannabis trafficking has increased, according to local authorities.

According to the Dangerous Drugs Act, Chapter 228, Statute Laws of The Bahamas (DDA), possession of cannabis is illegal without proper authorisation from the appropriate Minister. In the law, cannabis falls within the definition of "Indian hemp" which includes all parts of any plant of the genus cannabis whether growing or not from which the resin has not been extracted; the resin extracted from any part of such plant; and every compound, manufacture, salt derivative, mixture or preparation of such plant or resin.

According to the latest Bahamas National Drug Household Survey (BNDHS), roughly 11% to 14% of persons in The Bahamas have tried cannabis.[9] Further, a recent telephone poll conducted by Public Domain revealed that approximately 60% of the population believe that cannabis should be legalized for medical use.[10]

While The Bahamas is not technically geographically situated in the Caribbean, it is a part of the Caribbean Community (CARICOM). CARICOM seeks to promote economic integration and cooperation among the 15 member countries. Further, The Bahamas shares similar history, culture and political governance as many of its Caribbean neighbours, hence the relation between the development of the CARICOM Regional Commission on Marijuana (CRCM) and Bahamas National Commission on Marijuana (the Commission). It is not a surprise that there has been increased momentum towards addressing the "cannabis issue" in The Bahamas, following decriminalization, legalization and/or the conditional legalization of the use of cannabis in several Caribbean countries. For example, Jamaica introduced legislation to decriminalize cannabis, and made provisions for medical use in 2015. Saint Kitts and Nevis, US, Virgin Islands, Bermuda, Antigua and Barbuda have all passed or are in the process of passing similar legislation.

[9] https://www.bahamas.gov.bs/wps/wcm/connect/71347a13-e49c-4555-a408-5408dfb4c3fe/Bahamas+National+Household+Drug+Survey+Results-120717.pdf?MOD=AJPERES

[10] http://www.tribune242.com/news/2018/jul/05/just-what-doctor-ordered-poll-gives-support-medica/

Global Context

Over the last decade, there has been steady increase in the number of jurisdictions that have legalized the use of cannabis. Shifting public opinion, as well as the realization of the potential for positive economic and medical benefits, have helped fuel this increase. Recent estimates project that the global cannabis market will approach upwards of $140 billion USD by 2025.[11] In 2013, Uruguay became the first country to pass legislation to legalize cannabis for non-medical use. In Colorado, the first US state to legalize recreational use of cannabis, sales have grown from a little less than one billion dollars in 2014 to approximately twice that amount in 2018[12]. There have been similar economic growth trends throughout the US where in 2017 33 states have fully or partially legalized cannabis use.[13] Canada has taken it a step further and has legalized cannabis for adult-use, nationally.

Efforts to legalize cannabis in the US and Canada were aided by shifts in public opinion. In the US, a 2017 opinion poll revealed that roughly 64% of the public supported legalization of cannabis for recreational use – up from 46% in 2010.[14] Similarly, more than 60% of Canadians support legalization for recreational use.[15]

In Germany, a recent poll suggests that approximately two-thirds of the public were opposed to legalization of cannabis for recreational purposes. Many regard medical cannabis as an effective alternative and improvement over traditional prescription drugs as there have been numerous studies that demonstrate cannabis' efficacy in reducing nausea, treating epilepsy, alleviating pain and stimulating the appetites of the critically ill. Since the 2017 legalization of medical cannabis in Germany, the market has experienced dramatic growth. It should be noted that while the long-term economic potential for medical cannabis is generally believed to be less than that of recreational cannabis, the global market potential for medical cannabis is still $50 billion of the $140 billion cited earlier.

The economic benefits of legalizing cannabis use extend beyond revenue generated from sales of cannabis. Many jurisdictions, like the United Kingdom (UK), which recently legalized cannabis for medical use, have begun to question the effectiveness of policies that criminalize recreational cannabis use and whether resources used for policing small scale recreational use could be directed elsewhere. As a result, efforts are underway to examine potential savings from decriminalizing cannabis. In addition to financial benefits, many countries, including the UK, see decriminalization as an effective means of tackling the problems of crime and violence often associated with black markets and criminal syndicates. Further, others argue for decriminalization on moral and ethical grounds, citing disproportionate drug arrests of ethnic minorities and the poor.

Despite its positive benefits, there are some reported health risks. While the risks have been used as arguments against legalization, many posit that legalization, with appropriate age limits, can help address negative health effects. Legalization of cannabis may facilitate better quality control and safer products

[11] Legal Marijuana Market Size, Share & Trends Analysis Report By Type (Medical, Recreational), By Product Type, By Medical Application (Chronic Pain, Mental Disorders, Cancer), And Segment Forecasts, 2018 – 2025 https://www.grandviewresearch.com/industry-analysis/legal-marijuana-market/request

[12] https://www.colorado.gov/pacific/revenue/colorado-marijuana-sales-reports

[13] Wikipedia ProCon.org (2017)

[14] https://news.gallup.com/poll/179195/majority-continues-support-pot-legalization.aspx

[15] https://www.macleans.ca/society/majority-of-canadians-support-marijuana-legalization-says-survey/

through regulated cultivators and dispensaries where the ratio of THC to CBD can be optimized for public health and safety.

1.3 Brief History of Cannabis in The Bahamas

According to information provided in the publication "The Story of the Royal Bahamas Police Force,"[16] in 1968 the first Drug Squad was established in the Police Force. It is reported that while drug use amongst Bahamians apparently only involved a small number of persons, the drug of choice was marijuana, that was usually brought in through The Bahamas by Jamaicans.

As The Bahamas began to be used more and more as a transshipment point for the illicit traffic in marijuana, predominately cultivated in Jamaica, and cocaine from Columbia, the prevalence of these drugs in our communities grew. As availability increased, so too did drug use. Records show that as early as the 1970s there were well organized smuggling enterprises in the country, and with this came the prevalence of drugs, and an increase in violent crimes and lawlessness.[17]

[16] Hanna, Chaswell; Khalfani, Altida; and Knowles, Kemuel. *The Story of the Royal Bahamas Police Force*, 2007, page 338
[17] Ibid, page 339

CHAPTER 2: METHODS

Methods in capturing the sentiment of the Bahamian community, with respect to cannabis and cannabis policies, were largely qualitative. The Commission actively engaged the public via various modes throughout 2019, meeting with and listening to Bahamians from all walks of life, including the following:

- national and local government officials
- medical doctors
- nurses
- pharmacists and other health professionals
- members of the religious communities, including members of the Rastafarian faith
- members of the legal profession
- Bahamians from varied age and socio-economic demographics

Said modes included formal and informal surveys, interviews and/or discussions at the following:

- town hall meetings
- community walkabouts
- speaking engagements
- stakeholder meetings
- media shows
- press conference

Members of the Commission also travelled outside of New Providence to Abaco, Eleuthera, Exuma and Grand Bahama to engage with the local populations there.

In addition to local and national engagement, several members of the Commission travelled to Jamaica on a fact-finding mission. They met with a wide cross-section of persons actively involved in or affected by the cannabis industry.

Public engagement, locally and regionally, as well as review of associated literature, immensely informed the content of the Final Report of the Commission, including the Report's Recommendations.

CHAPTER 3: WHAT IS CANNABIS?

Cannabis, the scientific name for marijuana, is a plant that has three species (or strains):

- cannabis indica
- cannabis sativa
- cannabis ruderalis (the less common)

Marijuana and hemp are both cannabis plants, but marijuana contains higher levels of THC (delta-9-tetrahydrocannabinol), the primary psychoactive ingredient that causes people to get high. Hemp can be cultivated for industrial uses such as rope and burlap fabric, or for a low-THC, non-psychoactive, medicinal product.

Cannabis is a generic term used to denote the several psychoactive preparations of the plant *Cannabis sativa*. The major psychoactive constituent in cannabis is Δ-9 tetrahydrocannabinol (THC). Compounds which are structurally similar to THC are referred to as cannabinoids. In addition, a number of recently identified compounds that differ structurally from cannabinoids nevertheless share many of their pharmacological properties.

The Mexican term 'marijuana' is frequently used in referring to cannabis leaves or other crude plant material in many countries. Cannabis oil (hashish oil) is a concentrate of cannabinoids obtained by solvent extraction of the crude plant material or of the resin.

Cannabis is by far the most widely cultivated, trafficked and abused illicit drug. Half of all drug seizures worldwide are cannabis seizures. The geographical spread of those seizures is also global, covering practically every country of the world. About 147 million people, 2.5% of the world population, consume cannabis (annual prevalence) compared with 0.2% consuming cocaine and 0.2% consuming opiates.

In the present decade, cannabis abuse has grown more rapidly than cocaine and opiate abuse. The most rapid growth in cannabis abuse since the 1960s has been in developed countries in North America, Western Europe and Australia. Cannabis has become more closely linked to youth culture and the age of initiation is usually lower than for other drugs.

An analysis of cannabis markets shows that low prices coincide with high levels of abuse, and vice versa. Cannabis appears to be price-inelastic in the short term, but fairly elastic over the longer term. Though the number of cannabis consumers is greater than opiate and cocaine consumers, the lower prices of cannabis mean that, in economic terms, the cannabis market is much smaller than the opiate or cocaine market.

The cannabis plant synthesises at least 144 unique compounds known as cannabinoids.[18]. The most abundant of these is Δ9-tetrahydrocannabinol (THC).

3.1 Δ9-tetrahydrocannabinol (THC)

THC produces the effects that people who use cannabis seek from the drug, such as feeling ‘high’ and relaxed with changes in the perception of colours and sounds. THC can also cause unwanted effects such

[18] Hanuš et al., 2016

as memory impairment, anxiety and paranoia. These adverse effects become more severe with higher doses of THC. Concentrations of THC in cannabis products have risen in recent years, and evidence suggests that users only partially adapt to changes in THC.[19] As a result, people who use cannabis may have been exposed to rising doses of THC over time. These changes may have increased the level of adverse health effects related to cannabis use. In Europe, the number of first-time admissions to drug treatment for cannabis problems increased by 76 % from 2006 to 2017.[20]

It is possible therefore that an increase in the concentration of THC in cannabis is associated with this increase in admissions to treatment.[21] However, conclusions in this regard need to be made with caution, as other factors — such as a greater awareness of cannabis-related treatment needs, an overall increase in the level of provision and changes in referral practice, including direct referrals from the criminal justice system in some countries — could also explain this increase.

3.2 Cannabidiol (CBD)

CBD is typically the second-most abundant cannabinoid produced by/in the cannabis plant. CBD is nonintoxicating and has shown promise as a treatment for several medical conditions including epilepsy, psychosis and anxiety disorders.[22,23,24] CBD has been found to offset some of the harmful effects of THC, such as memory impairment and paranoia, without influencing the 'high' sought by users.[25] Some evidence also suggests that the balance of THC to CBD may contribute to the level of harm experienced from long-term cannabis use. While frequent use of cannabis with high THC to CBD ratios has been associated with a greater risk of psychosis and dependence, it has been argued that this is less commonly observed with the use of cannabis with a more balanced THC to CBD ratio.[26],[27] It has also been suggested that encouraging the use of cannabis with a more balanced THC to CBD ratio may therefore be a strategy for harm minimisation.[28]

3.3 Herbal cannabis

The flowers of female cannabis plants contain the greatest density of capitate-stalked glandular trichomes and therefore the highest concentration of cannabinoids. For this reason, the flowers of female cannabis plants are preferentially harvested and dried to produce herbal cannabis. Leaves contain low concentrations of cannabinoids, while other parts of the plant, such as the stem, seeds and roots, contain minimal or no cannabinoids. After drying, the floral material is removed from the stems and is ready for use.

In 2017, there were 440 000 seizures of herbal cannabis in the EU, accounting for 40 % of the total number of drug seizures in the EU that year.[29] In broad terms, there appear to be two main types of herbal

[19] Curran et al., 2016
[20] EMCDDA, 2019
[21] Freeman et al., 2018
[22] Bergamaschi et al., 2011
[23] Devinsky et al., 2017
[24] McGuire et al., 2017
[25] Englund et al., 2017
[26] Di Forti et al., 2015;
[27] Freeman and Winstock, 2015
[28] Englund et al., 2017
[29] EMCDDA, 2019

cannabis in European markets, imported herbal cannabis and 'sinsemilla' or indoor-grown herbal cannabis, produced within the EU. While it is recognised that there are a few exceptions to this classification, the distinction is sufficiently widespread to make these categories valid. Under natural conditions, the pollination of female cannabis flowers by male plants results in the production of seeds. Herbal cannabis containing seeds is typically produced from outdoor-grown crops outside the EU. This is referred to here as 'imported herbal cannabis'. Imported herbal cannabis is often heavily compressed or vacuum packed after drying to facilitate international trafficking and is typically a dark green to brown colour. It may be sold in compressed blocks, as bundles of herbal material or as loose plant material containing flowers, stems and seeds. Data collected by the EMCDDA indicates that the Balkans and Sub-Saharan Africa are major sources of imported herbal cannabis.[30]

When herbal cannabis is produced under controlled conditions, female plants are almost exclusively cultivated in the absence of male plants. This process prevents fertilisation, enabling female plants to continue flowering for longer and to expend additional energy producing more trichomes, resulting in a greater concentration of cannabinoids. Herbal cannabis produced in this way is referred to as 'sinsemilla' (from the Spanish words 'sin' (without) and 'semilla' (seed)); it is also known as 'indoor-grown herbal cannabis', 'nederwiet' in the Netherlands and 'skunk' in the United Kingdom. This form of herbal cannabis is typically produced in the EU and appears to be the most common type of herbal cannabis used in the EU. The freshness of the product and the high abundance of glandular trichomes results in high levels of terpenes creating its strong and distinctive odour.

A number of other factors contribute to the cannabinoid profile of herbal cannabis.[31] The synthesis of THC and CBD is genetically determined, with plants either producing high levels of THC, high levels of CBD or a mixture of THC and CBD. THC and CBD are synthesised in the plant from a common precursor via distinct biosynthesis pathways, which means that CBD production limits the amount of THC synthesised and vice versa. As a result, THC-producing strains are almost exclusively selected to maximise THC yields. Cannabis plants are selectively bred for desirable characteristics such as a desirable profile of cannabinoids and terpenes (contributing to odour and taste), a high yield of cannabis flower and resistance to disease. There are many different strains available. An analysis of cannabis samples sold in coffee shops in the Netherlands from 2005 to 2015 found that the most commonly sold strains were 'White Widow', 'K-2', 'Power Plant', 'Amnesia Haze' and 'Jack Herrer'; all had mean THC concentrations of 16 – 17%.[32] The most recent (2016-2017) THC data published by the Trimbos Institute showed that domestic herbal cannabis (nederwiet) had an average THC concentration of 17%.[33] In addition to genetics, optimising growing conditions can have marked effects on cannabinoid production. Indoor cannabis production facilities therefore typically utilise powerful lighting systems, which maintain flowering throughout the year by manipulating the length of the day-night cycle, and CO2 generators, which enhance photosynthesis by increasing carbon dioxide levels. In addition, fertilisers and pesticides are commonly used to promote plant growth and prevent damage by mould or insects.

3.4 Cannabis resin

In addition to herbal cannabis, plant material can be used to produce cannabis resin. This can create products with higher THC concentrations than herbal cannabis preparations, increasing the value of the

[30] Ibid
[31] Potter, 2014
[32] Niesink et al., 2015
[33] Rigter and Niesink, 2017)

products relative to their weight. Cannabis resin is typically brown in colour and is compressed into bars, balls or other shapes. This facilitates trafficking by allowing relatively large quantities of the drug with a high retail value to be concealed in smaller packages than would be the case for herbal cannabis. Moreover, cannabis resin may not have the strong and distinctive odour of sinsemilla, reducing the risk of detection. These factors, together with consumer preferences in some countries, make cannabis resin a desirable product for international drug trafficking. In 2017, there were 311 000 seizures of cannabis resin in the EU, accounting for 28 % of all drug seizures.[34] Although there are currently a greater number of seizures of herbal cannabis than of cannabis resin, the total quantity of resin seized (424 tonnes) in 2016 exceeded that of herbal cannabis (124 tonnes).

3.5 Concentrated extracts of cannabis

In addition to resin production, there are several other methods for extracting cannabinoids from plant material. The methods of resin production previously described involve the physical removal of the trichomes, which removes the cells and basal structure of the trichome heads as well as their secretions. In the process, trichome stalks and leaf fragments are unintentionally captured in these crude sieving processes. Greater efficiency can be achieved through the use of solvents or gases. These methods can achieve significantly higher potencies by extracting only the resinous secretions from trichome cells. Concentrated extracts of cannabis are often consumed by 'dabbing', in which a small quantity is applied to a 'nail' after heating with a blowtorch, and the smoke is inhaled through a waterpipe. As a result of the high levels of THC exposure, cannabis concentrates may be associated with greater dependency and more mental health problems than standard cannabis products.[35]

3.6 Edibles

Another important type of cannabis product is 'edibles', an umbrella term referring to foods, often sweets or liquids, containing THC and/or CBD for oral administration. The addition of cannabis products to foodstuffs results in slower absorption and a longer duration of effects than inhalation. For this reason, careful dosing is especially important. In the United States, there is a limit of 10 mg THC per serving or recommended unit in Colorado and Washington, and 5mg THC in Alaska and Oregon (Gourdet et al., 2017). There is also a serious risk of unintentional exposure, as these products may be difficult to distinguish from other foods, sweets or drinks. Edible cannabis products were found to be responsible for 48 % of paediatric emergency hospital visits due to cannabis in Colorado in the 2009-2015 period.[36]

There is evidence that edibles currently form a significant and probably growing part of licit cannabis markets, representing for example approximately 10 % of all sales in Washington state.[37] Furthermore, the use of edible products is reported to be higher in US states with medical cannabis laws than in those without.[38]

Information about the use of edibles in Europe is limited, but the available data suggest that at present this is a rare route of administration among European cannabis users.[39] On the basis of recent trends in

[34] EMCDDA, 2019
[35] Chan et al., 2017; Meier, 2017
[36] Wang et al., 2016
[37] Caulkins et al., 2018
[38] Borodovsky et al., 2016
[39] Hindocha et al., 2016

the United States, it can be expected that the prevalence of edible products and cannabis concentrates might increase in Europe in the future as consumers become more aware of innovations taking place in licit markets in North America. Moreover, in Europe, there has been a recent increase in the availability of cannabis-based products that contain less than 0.2- 0.3 % THC. These are argued to be of such low potency that they do not fall under existing drug control regulations. Some of these are edibles; however, they may still be considered illicit in some countries even though only small amounts of THC are present.

3.7 Synthetic cannabinoids

Synthetic cannabinoids are a group of artificially made substances that act on the same receptors in the body as THC but are usually much more potent. This means that their effects can be markedly different from and more powerful than cannabis. They were originally developed by scientists to study how the body works and to explore the potential of cannabinoids as medicines. Since the mid-2000s, entrepreneurs and, increasingly, criminal groups have sold plant material mixed with synthetic cannabinoids in Europe as 'licit' replacements for cannabis. The first synthetic cannabinoid detected in Europe was JWH-018 in 2008. Since then, more than 180 synthetic cannabinoids have been reported to the EMCDDA, making them the largest group of new psychoactive substances monitored by the EU Early Warning System.[40]

Most synthetic cannabinoids in Europe are imported from China in powder form. They are then dissolved in solvents such as acetone and mixed with plant material to create a product that can be smoked. These 'smoking mixtures' are sold online, in 'head shops' or on the illicit market and are often packaged with brand names such as 'Spice', 'K-2' or 'Black Mamba' or increasingly in unlabelled bags. The brand and the name provide no guarantee of its contents, which vary within and between batches.

More recently, synthetic cannabinoids have also been found in products resembling cannabis resin and in e-liquids for vaping. The number of synthetic cannabinoids in smoking mixtures varies widely, both within batches and across different batches. In addition, mixtures of different synthetic cannabinoids may be used in the products. These factors, combined with the high potency of the substances, make it difficult for users to control the dose that they are exposed to and can lead them to unintentionally administer a toxic dose. The emergence of synthetic cannabinoids has led to the rapid introduction of various legislative approaches to their control in Europe.

The prevalence of synthetic cannabinoid use is low among the general population according to surveys carried out in Europe.[41] While it is thought that many people prefer the effects of cannabis over synthetic cannabinoids,[42] in some areas, these substances have developed a reputation as powerful and cheap intoxicants among vulnerable groups, such as the homeless and prisoners, who use them for their 'mind-numbing' effects. As synthetic cannabinoids are not included in routine drug testing, some people may use them (rather than cannabis or other drugs) to avoid detection. This is particularly important in the context of road safety, where more research is needed to assess the prevalence of use of these substances among drivers and the severity of the impairments they cause.[43]

The high potency and difficulties that exist in the detection of synthetic cannabinoids make them particularly attractive to those wanting to smuggle or use drugs in a prison setting. This is reflected in data

[40] EMCDDA, 2019
[41] EMCDDA, 2017b
[42] Winstock and Barratt, 2013
[43] EMCDDA and CCSA, 2018

from a survey conducted in nine prisons in the United Kingdom, which found that synthetic cannabinoids were the most widely used of all drugs.[44] Of the 635 people surveyed, 33 % had used synthetic cannabinoids in the last month compared with 14 % for cannabis and 8 % for heroin. A number of European countries have highlighted the role of synthetic cannabinoids in aggravating existing mental health conditions or mental states associated with self-harm (EMCDDA, 2018c). Severe poisoning is more common with synthetic cannabinoids than with cannabis. In some cases, the poisoning may even be fatal.[45]. Sometimes these products can cause explosive outbreaks of mass poisonings involving dozens or hundreds of people. This is because of the high potency of the synthetic cannabinoids as well as the large dose that users are exposed to in smoking mixtures. For further information on synthetic cannabinoids, see the EMCDDA Perspectives on Drugs Synthetic cannabinoids in Europe.[46]

3.8 Cannabis oils

Although uncommon, high-concentration cannabis oil has been available on the illicit drug market for many years. In recent years, however, there has been an increase in the sale on the high street and online of low-concentration THC products. These included a variety of product types with one of the more common of these being oils, often referred to as 'cannabis oils' or 'CBD oils'. Broadly speaking, cannabis oil is any oil that contains cannabis or cannabis compounds, and hence the composition can vary greatly depending on what type of cannabis was used in the manufacturing process, and whether the final product predominantly contains CBD, THC or a combination of both. Many CBD oils are manufactured using hemp. Hemp can be used to produce oils with high levels of CBD but with THC levels remaining below a threshold of 0.2 %. Below this level of THC, such oils may potentially not be controlled under drug legislation in many EU countries, although national practices vary and regulatory approaches differ in this area.[47] These products are often available as some sort of 'health supplement' or wellness product, although it is often unclear on what basis these claims are made.

Recent studies testing cannabis oils in Europe found that CBD concentrations often differed significantly from those claimed and, in addition, some contained THC, which would make them illicit in many jurisdictions.[48],[49]

[44] User Voice, 2016
[45] Trecki et al., 2015
[46] EMCDDA, 2017b
[47] EMCDDA, 2018a
[48] Hazekamp, 2018;
[49] Pavlovic et al., 2018

CHAPTER 4: THE HISTORY OF CANNABIS

4.1 History of Cannabis[50]

Cannabis sativa is one of the world's oldest cultivated plants (Russo,2007). Although the earliest written records of the human use of cannabis date from the 6th century B.C. (ca. 2,600 cal BP), existing evidence suggests that its use in Europe and East Asia started in the early Holocene (ca. 8,000 cal BP).[51]

Many 19th-century practitioners ascribed medicinal properties to cannabis after the drug found its way to Europe during a period of colonial expansion into Africa and Asia. For example, William B. O'Shaughnessy, an Irish physician working at the Medical College and Hospital in Calcutta, first introduced cannabis (Indian hemp) to Western medicine as a treatment for tetanus and other convulsive diseases.[52] At approximately the same time, French physician Jean-Jacques Moreau de Tours experimented with the use of cannabis preparations for the treatment of mental disorders.[53]

Soon after, in 1851, cannabis was included in the 3rd edition of the *Pharmacopoeia of the United States* (USP). Subsequent revisions of the USP described in detail how to prepare extracts and tinctures of dried cannabis flowers to be used as analgesic, hypnotic, and anticonvulsant.[54], [55] Growing concerns about cannabis resulted in the outlawing of cannabis in several states in the early 1900s and federal prohibition of the drug in 1937 with the passage of the Marihuana Tax Act. In response to these concerns, in 1942 the American Medical Association removed cannabis from the 12th edition of *U.S. Pharmacopeia.*[56]

The Prohibition of Cannabis[57]

In the United States at the turn of the 20th century, cannabis was generally used for medical rather than recreational purposes. As such, the production and use of cannabis was regulated by consumer safety laws such as the Pure Food and Drug Act of 1906, which required producers to disclose and label the quantity of cannabis present in any product sold as food or medicine. Although several U.S. states enacted bans on cannabis between 1911 and 1930, it escaped early federal prohibitions, such as the Harrison Act of 1914, which regulated opium and derivatives of the coca plant.[58]

Fear of "marihuana," as cannabis was beginning to be called, grew during the 1920s and 1930s as immigration from Mexico steadily increased in southwestern states. In the mid-1930s, the federal government, through the Federal Bureau of Narcotics, endorsed state-level actions and encouraged states to adopt the Marihuana Tax Act as a means to criminalize the unregistered and untaxed production and use of cannabis. National prohibition did not take shape, however, until Congress passed the Marihuana Tax Act of 1937, which regulated the production, distribution, and use of cannabis via Congress's power

[50] National Academies of Sciences, Engineering, and Medicine 2017. *The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research*. Washington, DC: The National Academies Press. https://doi.org/10.17226/24625.
[51] Long et al., 2016
[52] O'Shaughnessy, 1840
[53] Moreau de Tours, 1845
[54] Russo, 2007
[55] U.S. Pharmacopoeial Convention, 1916
[56] IOM, 1999
[57] Ibid
[58] Musto, 1999

to tax commerce. The act required those dealing with cannabis to register with federal authorities and pay a tax (Booth, 2005; Musto, 1999). The supply and use of the drug was not criminalized, but nonmedical supply or use was a violation and subject to a fine and imprisonment.

Today, cannabis is regulated by local, state, federal, and international law. State laws often mirror federal law, enshrined in the Comprehensive Drug Abuse Prevention and Control Act of 1970, which includes the Controlled Substances Act (CSA). The CSA modernized and consolidated earlier federal drug laws, making them consistent with international drug control conventions, specifically the United Nations Single Convention on Narcotic Drugs of 1961, which the United States ratified.[59] The CSA placed cannabis in Schedule I, the most restrictive category reserved for substances that have no currently accepted medical use, alongside heroin and lysergic acid diethylamide (LSD).

[59] Caulkins et al., 2016

CHAPTER 5: OVERVIEW OF CANNABIS SITUATION AND TRENDS IN THE BAHAMAS

5.1. Prevalence of Cannabis Use

The prevalence of cannabis use has received a lot of scrutiny lately commensurate with the globally evolving movement towards cannabis legalization. In particular, the debate on whether such legalization will result in an increase in prevalence rates, in general or among susceptible population groups, is the cause of concern.

The routine monitoring of the prevalence of psychotropic substance use provides current information on trends that can be used in the planning, implementation and evaluation of school, community and national level interventions intended to reduce and/or prevent the use and abuse of licit and illicit substances. It is therefore imperative that baseline measures of key indicators are available to researchers and policy makers involved in drug control to ensure both the efficient and effective use of scarce resources.

Drug usage, generally, is measured through three prevalence indicators:

- Lifetime prevalence – The use of a substance at any point in the students' life; whether it was 10 years ago, last year, last month or yesterday;
- Prevalence in the last year – The use of a substance within the 12 months immediately preceding the survey; and
- Prevalence in the last month – The use of a substance within the four weeks immediately preceding the survey.

These indicators were used in both the most recent adolescent survey and household survey of adult substance use.

5.1.1. Adolescent Marijuana Use

The most recent information on adolescent substance use comes from the 2011 Secondary School Drug Prevalence Survey. This survey was the third in a series of surveys conducted using the methodology devised by the Inter-American Drug Control Commission under its SIDUC program; the first having been completed in 2002[60] and the second in 2008. The goal of the survey was to provide a complete national assessment of the drug situation among adolescent girls and boys and collected data on the use of illicit drugs and other psychotropic substances, violence and associated risk and protective factors.

Results revealed that 13.7% of all students had tried marijuana at least once in their lifetime, with 9.7% having used within the past year and 5.0% in the 30 days immediately preceding the survey. Of those who did admit to smoking marijuana within the past year, 28.2% did so only once; 32.7% occasionally; and another 28.6% on a weekly or more frequent basis.

[60] Health Information and Research Unit, Ministry of Health. Secondary School Drug Prevalence Survey, 2003.

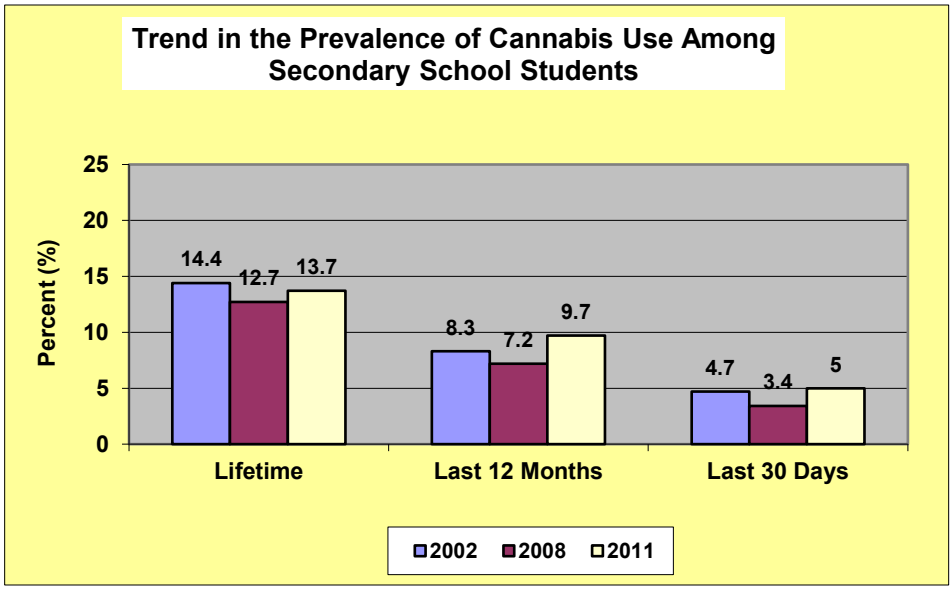

Figure 1: Trends in the Prevalence of Cannabis Use Among Secondary School Students

Usage rates differed across both gender and grade level, with males using marijuana at more than double the rate of their female counterparts and 12th graders using at almost four times the rate as did the 8th graders.

- 18.7% of all males had tried and 7.4% had used in the past 30 days as compared to 8.7% and 2.8% in females, respectively;
- 28.2% of all 12th grade males had tried marijuana at least once in their lifetime, while 20.3% had used within the past 12 months and 10.6% in the last 30 days (Table 1).

Table 1: Prevalence of Marijuana Use by Gender and by Grade Level

Selected Factors		Prevalence		
		Lifetime	Last 12 Months	Last 30 Days
Gender	Males	18.7	13.2	7.4
	Females	8.7	6.3	2.8
	Total	13.7	9.7	5.0
Grade Level	Grade 8	5.9	4.1	1.5
	Grade 10	16.2	11.7	6.8
	Grade 12	28.2	20.3	10.6

5.1.2. Marijuana Use Among the General Population

Based on the results of the 2017 Household Drug Survey, 13.4% of Bahamas residents have tried marijuana at least once in their lifetime; 20.3% of males and 7.0% of females. Within the 12 months and 30 days immediately preceding the survey, 3.1% and 2.8%, respectively, had smoked marijuana.

It is known that many persons have taken marijuana for reasons other than to get high, such as for medicinal purposes. To assess the extent of this practice, respondents in the 2017 Household Survey were specifically asked if they had ever used marijuana for a medical condition. Results revealed that 2% of the population had used some form of marijuana for medicinal purposes.

When asked the specific condition for which the marijuana as medicine was taken, while a few of the reasons given have been shown to benefit from cannabis, many of the conditions mentioned were not conclusively shown through research to benefit from cannabis use. See Table 2.

Table 2: Reported Reasons for taking Making Marijuana for Medicinal Purposes

Reported Reasons	
ADHD	Anxiety
Asthma	Back and ankle problem/ sciatica
Breathing problems	Car accident/ gun shot
Eye cataract/ sight/ glaucoma	Flu
For joint pains	Headache and sinus/ headaches
Just sick	Keep her aggression problem down
Kidney problems and pain/ pain	MS
Ovaries condition	Sleeping
Stress/ stress/ stress	Depression
Stroke body getting weak and need to relax mind	Sexual Problems - to keep the boy hard
Heart condition it revived and took pressure away, no longer on meds/ heart disease or pain killer	It assisted me with my diabetes.

As to whether the respondents in the Household Survey had used marijuana in a form other than smoking, results revealed that:

- 6.9% had tried marijuana edibles (pastries, candy/sweets, cooked/uncooked meals);
- 2.7% had consumed it in a liquid form (tea, juice etc.);
- 1.2% had used concentrates (Oils, shatter, budder wax etc.); and
- 2.2% had used marijuana in some other form.

5.2. Average Age of First Use

During the 11-year period between the 2002 and 2011 surveys, there were no major changes in the mean age of adolescent first use for those substances used most often by the teens (Table 3).

- The mean age of first use for the legal substances such as cigarettes (11.8 years) and alcohol (11.6 years) continues to be lower than the mean age of first use for illicit substances such as marijuana (13.3 years); in this case by almost 2 years.
- Males, on average, continued to try marijuana at a slightly earlier age than females.

Table 3: Trend in Average Age of First Drug Use, By Type of Drug and Gender

Gender	Marijuana			Cigarettes			Alcoholic Drink		
	2002	2008	2011	2002	2008	2011	2002	2008	2011
Male	12.9	13.1	13.0	11.2	10.9	11.3	11.2	11.2	11.3
Female	14.0	13.6	13.7	11.7	11.9	12.4	11.9	11.5	11.9
Total	**13.2**	**13.3**	**13.3**	**11.4**	**11.3**	**11.8**	**11.5**	**11.4**	**11.6**

Results from the Household survey was somewhat different and may reflect a cohort effect where those of the younger generations are, on average, experimenting with marijuana at a much younger age. For those persons 12 – 64 years included in the 2017 household survey who had tried marijuana, the mean age of the respondents' very first marijuana use was 17.2 years overall, 16.5 years for males and 19.0 years for females.

5.3. Source of Marijuana

The primary source of marijuana for those students who admittedly smoked within the year preceding the 2012 Adolescent Survey was from friends (50.2%), followed by street pushers (22.1%).

Adults in the 2017 household survey who had used marijuana at least once were also asked how they got the marijuana they last used. More than half (52.4%) responded that they got it for free or shared with someone else. Around a third (34.3%) bought it, and 4% grew it themselves.

Most marijuana users, who got their marijuana for free, last obtained it from a friend (63.6%). Another 10.6% got it from a relative, while 4.1% reportedly got it from someone they had just met/did not know well.

Of those adults who had used marijuana at least once in their life and had purchased marijuana, 80% last bought the drug within the month preceding the survey. When the estimated amount of money spent by those who purchased marijuana in the past month was looked at, 28.4% spent between $20 and $50; 11.8% spent $50 to $100; and more than a quarter (27.6%) spent $100 or more.

5.4. Ease of Access

When asked how easy it would be to get access to marijuana, a total of 30.2% of Bahamian students who participated in the 2012 Survey indicated that it would be "easy" to get marijuana. When these results were looked at by grade level, results revealed that as grade level increased, the proportion who felt that it was easy to access marijuana also increased significantly. Whereas 17.4% of all 8th graders held this opinion, this increased to 33.4% among 10th graders and to 41.3% for students in the 12th grade.

These results were even higher in the adult population included in the 2017 household survey. Approximately one-half (48.5%) of all survey respondents replied that it would be "easy" to get marijuana.

5.5. Attitudes and Opinions Regarding the Risk of Using Marijuana and Selected Marijuana Policies

5.5.1. Perception of the Level of Harm and Risks Associated with Marijuana Use

During the 2012 survey the students were also asked to indicate the level of harm they associated with engaging in substance use at various frequencies. Students rated these items on a scale of 1 to 5: 1 indicated the behaviour was seen as not harmful; 2 slightly harmful; 3 moderately harmful; 4 very harmful; and 5 indicated the students either didn't know the substance or how harmful that particular behaviour was.

When asked about smoking marijuana "sometimes", 20.3% of all students felt that this was slightly harmful or not harmful at all. A total of 21.4% thought the behaviour was moderately harmful and 45.6% very harmful.

When asked about smoking marijuana frequently, the percentage of students who felt that this was very harmful to their health increased to 66%.

For adults, the 2017 household survey sought to determine the perceived risk associated with substance use and categorized the data into 4 risk categories: no risk; low risk; moderate risk; and high risk. Respondents also had the option of reporting that they "Did not know" if unaware of any risk or the level of the risk.

Results revealed that more than one-half (53.2%) of all respondents were of the opinion that smoking marijuana "sometimes" presented a high risk with this proportion increasing to 70.4% when asked about the risk associated with smoking marijuana "often".

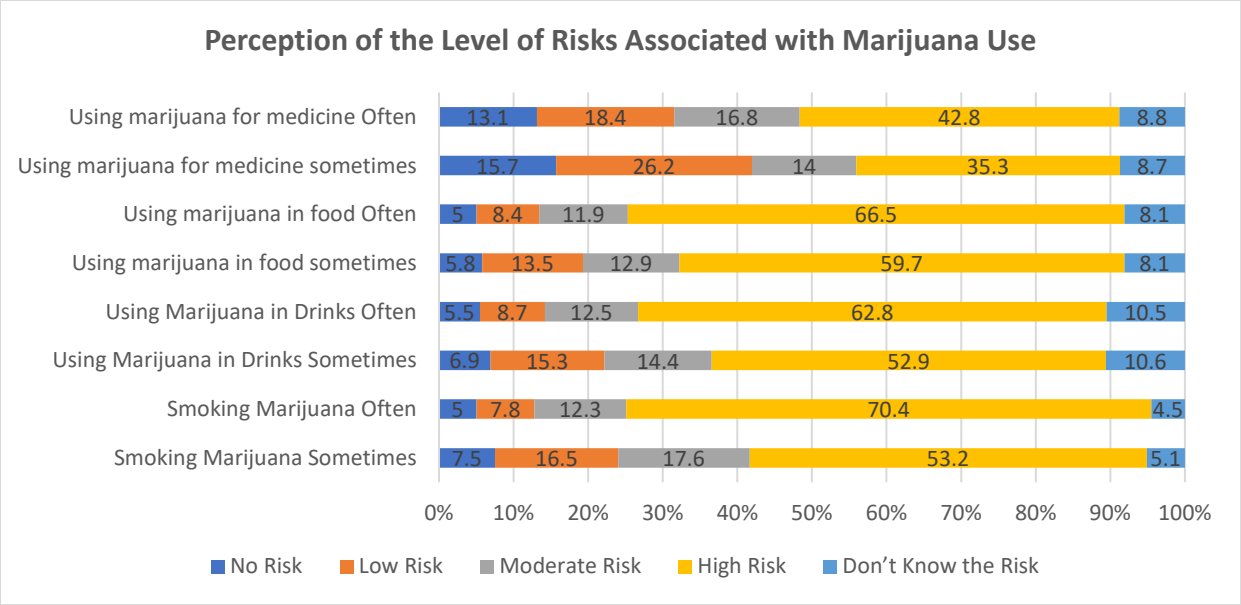

Figure 2: Perception of the Levels of Risk Associated with Marijuana Use

The perceived risk of using marijuana in drinks and food also was of concern to the respondents. Approximately 2 of every 3 respondents felt that using in food often presented a high risk (66.5%) and a similar percent felt the same of using marijuana in drinks often (62.8%).

The risk associated with using marijuana for medicine appeared to be less of a concern.

5.5.2. Marijuana Addiction Risk

Concerns have been expressed both locally and abroad about the amount of THC the available marijuana contained. In the absence of any scientific data, those adults in the 2017 survey who had tried marijuana were asked to estimate the potency of the marijuana they most recently used. Approximately 1 of every 2 persons who had tried indicated that it was either "strong" (25.1%) or "very strong" (20.4%). A sizeable amount however (17.4%) did not know or couldn't estimate the strength.

Accepting that the debate surrounding the addictive nature of cannabis is ongoing, during the survey, an attempt was also made to assess an individual's marijuana addiction risk using the Cannabis Abuse Screening Test (CAST). Using the tool, those persons who had smoked marijuana at least once in their lives were asked a series of six questions regarding their behaviour and perceived consequences over the past twelve months. The responses ranged from "Never" (0 points) to "Very Often" (4 points). Points were then totaled and subsequently categorized into three categories: No addiction risk; Low addiction risk'; and High addiction risk.

Results revealed that approximately 6 of every 10 persons (58.7%) who had tried marijuana were currently not at any risk of addiction. The proportions of users who fell within the categories of "Low addiction risk" and "High addiction risk" were 16.0% and 25.3%, respectively. These represented 1.1% and 1.8% of the adult household population, respectively.

5.5.3. Attitudes and Opinions Regarding Selected Marijuana Policies

Respondents in the 2017 Household Survey were asked to what extent they agreed with selected marijuana policies. Results are displayed in Figure 3.

Not surprisingly, Bahamians were strongly in favour of allowing persons who are addicted to marijuana and other substances, who commit crimes such as theft, to be put into a court supervised drug treatment program instead of prison. A total of 6 of every 10 (62.1%) respondents either agreed or completely agreed with this approach. This supported the popular opinion on the need to develop alternatives to incarceration to reduce the number of young males, in particular, being imprisoned and their contribution to society hampered by a police record.

Likewise, 59.3% of the respondents expressed agreement with allowing marijuana to be cultivated for scientific research, which is in line with the UNODC's recommendation in the Outcome Document of the 2016 United Nations General Assembly Special Session on the World Drug Problem.[61]

One of the specific charges that the Commission received was to assess the public's opinion on the possibility of introducing medical marijuana in some capacity. This proposal has received quite a bit of support in the public forums held by the Commission and from a number of stakeholder groups. The fact

[61] Outcome Document of the 2016 United Nations General Assembly Special Session on the World Drug Problem: Our Joint Commitment to Effectively Addressing and Countering the World Drug Problem. Thirtieth Special Session; General Assembly New York, 19-21 April 2016.

that 55.8% of the survey's respondents is in agreement with allowing marijuana to be used for medicinal and therapeutic purposes and only 25.4% disagree highlights the support for this policy change.

Currently in The Bahamas, marijuana prescribed for medicinal purposes is allowed for visitors, once written permission is obtained from the Minister of Health prior to their arrival. Notwithstanding this, it was interesting to observe the somewhat contradictory result where only 46.8% agreed to allow tourists, with a permit, to use marijuana for medical or therapeutic purposes, when 55.8% were in support of marijuana being used for medical purposes.

Additional results revealed that Bahamians, based on this 2017 survey, were strongly against allowing marijuana to be used for religious purposes (e.g. Rastafarians), marijuana to be grown in limited amounts by individual households and against allowing possession of marijuana, in limited amounts, for personal use. A total of 57.8%, 67.1% and 75.0%, respectively, either disagreed or completely disagreed with the introduction of these policies.

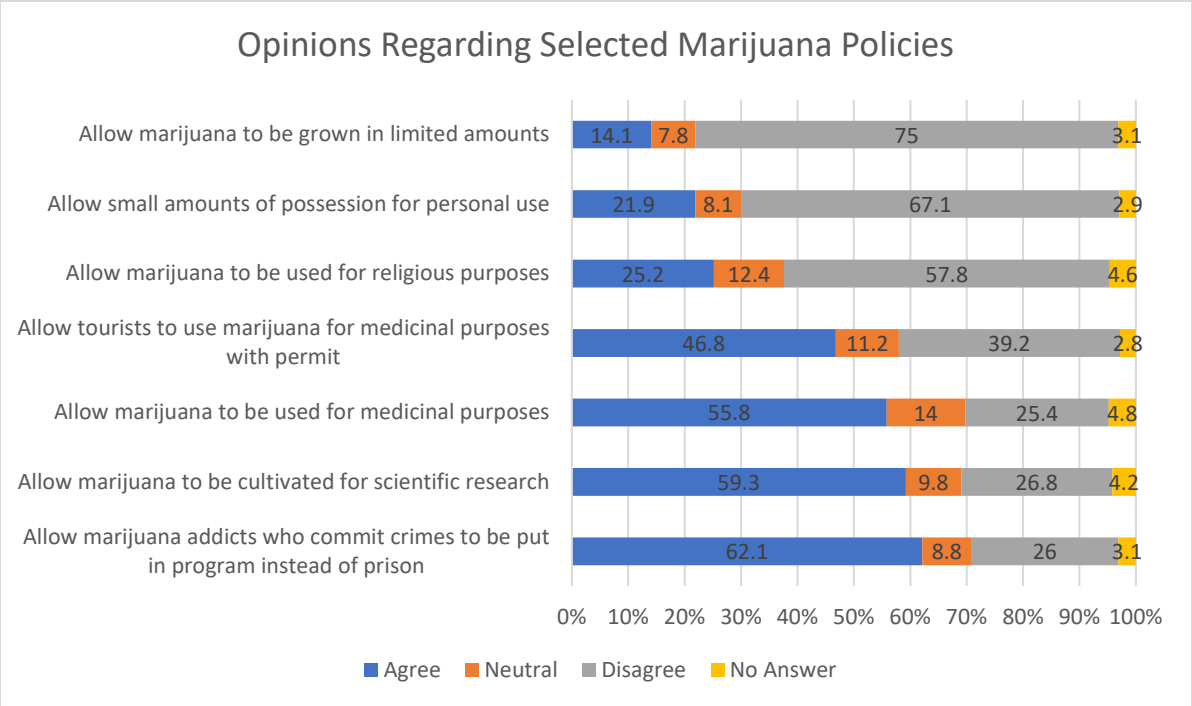

Figure 3: Opinions Regarding Selected Marijuana Policies

5.6. Cannabis Abuse Treatment and Rehabilitation

The availability of drug treatment services in The Bahamas is restricted, primarily, to the city of Nassau. There exists one public outpatient treatment centre, the Community Counseling and Assessment Centre (CCAC), and one public specialist hospital, the Sandilands Rehabilitation Centre, which serves the inpatient treatment needs of the entire country. On the second most populated island of Grand Bahama, the Rand Memorial Hospital diagnoses and treats cases of abuse that are accompanied by a comorbid psychiatric condition on the Diah Ward. However, persons that require inpatient treatment for marijuana abuse are referred to SRC in Nassau.

In addition, the drug dependence treatment services provided by the public sector was supported by services provided by a small number of private facilities offering anything from a small number of beds for residential care to rejabilitation and reinsertion to assists in the post treatment assimilation back into society.

The drug data presented in Tables 4 and 5 represent total discharges based only on the records coded and entered in the Keane management information system of the Public Hospital Authority.

During the 5-year period from 2014-2018, the SRC admitted and discharged a total of 1028 clients with a primary diagnosis of marijuana use with numbers increasingly steadily year over year. The 278 cases discharged in 2018 represented a 106.5% increase over the 139 cases discharged in 2014 (Table 4).

These primary diagnoses cases are those who were admitted for marijuana use as the primary reason for treatment. However, marijuana was also implicated in additional cases seen (Any diagnoses of marijuana) and which also had to be addressed during treatment. These were cases where marijuana use was revealed during the intake assessment, but such use was not the primary reason for treatment.

Table 4: Sandilands Rehabilitation Centre Inpatient Discharges: 2014 – 2018

Discharges	2014	2015	2016	2017	2018
Total Discharges – All Diagnoses	1,111	1,210	1,240	1,119	1,062
Total Discharges with primary diagnosis of Marijuana Use	139	167	204	240	278
Total Discharges with any diagnosis of Marijuana Use	308	371	383	477	465
% of Total Discharges – primary diagnosis of Marijuana Use	12.5%	13.8%	16.5%	21.4%	26.2%
% of Total Discharges – any diagnosis of Marijuana Use	27.7%	30.7%	30.9%	42.6%	43.8%

Source: Statistics Unit of the Public Hospitals Authority

As to the burden that persons treated for marijuana use is placing on the institution, in 2018 the cases with a primary diagnoses of marijuana use represented a total of 26.2% of the 1062 total discharges from SRC. However, even more worrisome was the 465 cases in 2018 with any diagnosis of marijuana use, which represented 43.8% of all discharges.

The number of discharges of marijuana related patients from the RMH in Grand Bahama is both significantly less and less of an economic burden on the institution as, unlike the SRC, which is a specialty psychiatric facility, the RMH is a full tertiary care hospital that treats limited psychiatric cases. Consequently, as revealed in Table …, the total number of cases during 2014-2018 with a primary diagnosis of marijuana use was 198. The 47 cases discharged in 2014 was the highest and the 28 in 2018, the lowest; a decrease of 47.4%.

Table 5: Rand Memorial Hospital Inpatient Discharges: 2014 – 2018

Discharges	2014	2015	2016	2017	2018
Total Discharges – All Diagnoses	5,915	5,717	4,813	4,751	4,890
Total Discharges with primary diagnosis of Marijuana Use	47	45	33	45	28
Total Discharges with any diagnosis of Marijuana Use	96	89	82	97	63
% of Total Discharges – primary diagnosis of Marijuana Use	0.8%	0.8%	0.7%	0.9%	0.6%
% of Total Discharges – any diagnosis of Marijuana Use	1.6%	1.6%	1.7%	2.0%	1.3%

Source: The Statistics Unit of the Public Hospitals Authority

5.7 Illicit Supply and Control of Cannabis

Currently in The Bahamas, the activities of those law enforcement agencies involved in drug control are guided by the Dangerous Drugs (Amendment) Act 2011, which makes it illegal to possess, cultivate and distribute all cannabis products except under very limited and very strict conditions for medicinal and scientific purposes. As a result, statistics related to drug supply reduction will reflect the illegal nature of cannabis.

During the 5-year period from 2014-2018, the amount of cannabis seized varied widely from a low of 4,077 lbs in 2016 to 20,600 lbs in 2014 (Table 6).

While The Bahamas is known, primarily, as a transit country for drug trafficking, these statistics also show that there is a significant amount of marijuana being cultivated locally. A total of 331,386 plants were confiscated by the Royal Bahamas Police Force (RBPF) from 2014-2018, with the largest seizures taking place in 2014.

Also of note is that in 2018, an increase was observed in both the variety and the number of "edible" products, such as caramel mix, cupcakes and cookies, seized by the RBPF. This supports the results from the 2017 National Household Drug Survey where respondents reported the consumption of a variety of edibles and drinks containing cannabis.

Table 6: Cannabis Products Seized In The Bahamas By Year

Cannabis Products	2014	2015	2016	2017	2018
Cannabis (lbs)	20,602.8	15,990.6	4,077.5	17,634.7	10,287.2
Cannabis Plants (#)	290,336	16,056	313	16,242	8,439
Cannabis Capsules (#)	-	-	11	-	-
Hashish (lbs)	71.1	0.2	0.02	56	54.2
Cannabis Caramel Mix	-	-	-	-	1
Cannabis Cupcakes	1.16 lbs	-	-	-	21
Cannabis Cookies/Dough	-	-	-	-	32

Source: Drug Enforcement Unit, Royal Bahamas Police Force

Table 7 shows statistics for drug arrests in The Bahamas during the period 2014 – 2018. During this period, a total of 6,809 persons were arrested for cannabis and of this total, 26% were arrested for possession and 36% were arrested for possession with intent to supply. In fact, greater than 90% of all cannabis-related arrests for each year during this 5-year period were due to these two causes alone.

The steady increase in the percentage of persons arrested for possession of drugs with intent to supply is a concern to many advocates for change in sanctions, as the addition of intent to supply places an additional burden on those charged by reducing the likelihood of their involvement in any alternative sentencing options.

Table 7: Persons Arrested For Possession of Marijuana Products

PERSONS ARRESTED	2014		2015		2016		2017		2018		5 Yr. Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Possession	919	75.6	891	66.6	799	59.4	838	57.4	833	57.4	4,280	62.86
Possession with Intent to Supply	283	23.3	435	32.5	537	39.9	605	41.4	592	40.8	2,452	36.11
Cultivation	8	.7	11	.8	8	.6	17	1.2	13	.9	57	0.84
Possession of Marijuana Capsules		.		.	2	.1		.		.	2	0.03
Possession of Baked Goods	5	.4		.		.		.	6	.4	11	0.16
Importation		.		.		.		.	5	.3	5	0.07
Conspiracy to Import		.		.		.		.	2	.1	2	0.03
TOTAL	**1,215**	**100**	**1,337**	**100**	**1,346**	**100**	**1,460**	**100**	**1,451**	**100**	**6,809**	**100**

Source: Data obtained from the Drug Enforcement Unit of the Royal Bahamas Police Force

5.8. Incarcerations for Drug-Related Offences

Specific data on marijuana-related admissions is not currently available from the Bahamas Department of Correctional Services (BDOCS) and therefore the statistics presented here represents incarcerations for all drugs combined. However, based on the arrest data from the Royal Bahamas Police Force, there is sufficient evidence to support the view that the large majority of the drug-related incarcerations at BDOCS are due to marijuana.

Drug offender admissions data by selected demographic indicators is presented in Table 8. Between 2015 and 2017, the total number of admissions for drug-related offences showed a steady increase with the 554 admissions in 2017 representing a 41.0% increase over the 393 admissions in 2015.

While still a relatively small percentage of the overall admissions, the percentage of females being admitted for drug-related offences showed a steady increase; from 4.6% in 2015 to 9.6% in 2017. This is of concern as it may reflect the vulnerability of those at high risk in society.

With respect to age, the largest percentage of persons incarcerated for drug offences between 2015 and 2017 was consistently those between 26 to 35 years, followed by persons 18 to 25 years and then 36 to 45 years. In 2017, fully 85.5% of the drug-related incarcerations were in these 3 age categories. These incarcerations, even for minor and non-violent offences, result in lasting collateral consequences while removing men and women out of communities at their peak income producing and child rearing years; a fact that is of concern to many.

For the 3-year period 2015-2017, the proportion of persons on remand versus sentenced for drug offences gradually approached a ratio of 1:1. In 2017, 50.9% of drug-related incarcerations were on remand versus the 49.1% who were sentenced.

With the new Correctional Services Act passed in 2014 that was drafted to encourage more of a focus on corrections and rehabilitation, the percentage of recidivists decreased from 12.2% in 2015 to 7.4% in 2016. However, this percentage increased again to a high of 16.4% in 2017.

Table 9 displays statistics on drug offender admissions by the type of offence. In interpreting the data presented, readers should note that a number of persons incarcerated are charged with or sentenced for multiple charges, hence the total number of charges for a given period will usually exceed the number of persons admitted.

The data reveals that between 2015 and 2017, the leading drug-related causes of admissions to BDOCS were possession of drugs with intent to supply and possession of dangerous drugs. In 2017, of all admissions for drug offences, 67.9% were charged with possession of drugs with intent to supply and 29.8% were charged with possession of dangerous drugs. A total of 15.9% were charged with conspiracy to supply drugs.

Table 8: Drug Offender Admissions by Selected Demographic Indicators

Demographic Indicators	2015		2016		2017	
	#	%	#	%	#	%
Gender						
Males	375	95.4	450	94.9	501	90.4
Females	18	4.6	24	5.1	53	9.6
Age						
≤ 17 yrs	3	.8	4	.8	7	1.3
18 – 25	114	29.0	146	30.8	151	27.3
26 – 35	127	32.3	173	36.5	192	34.7
36 – 45	94	23.9	89	18.8	130	23.5
46 – 55	44	11.2	47	9.9	54	9.7
56 and over	11	2.8	15	3.2	20	3.6
Remand Status						
Remanded	218	55.5	255	53.8	282	50.9
Sentenced	175	44.5	219	46.2	272	49.1
Recidivism Status						
First Offender	345	87.8	439	92.6	463	83.6
Recidivist	48	12.2	35	7.4	91	16.4
Total	393		474		554	

Source: Department of Correctional Services

Table 9: Department of Correctional Services – Drug Offender Admissions by Type of Offence

Type of Offence	2015			2016			2017		
	# Charges	% All Charges	% Persons Charged	# Charges	% All Charges	% Persons Charged	# Charges	% All Charges	% Persons Charged
Possession of dangerous drugs	151	33.3	38.4	145	24.1	30.6	165	22.9	29.8
Exportation of dangerous drugs	2	.4	.5	3	.5	.6	18	2.5	3.2
Importation of dangerous drugs	16	3.5	4.1	37	6.2	7.8	45	6.3	8.1
Conspiracy to supply drugs	29	6.4	7.4	79	13.1	16.7	88	12.2	15.9
Possession of drugs with intent to supply	220	48.6	56.0	324	53.9	68.4	376	52.3	67.9
Breech of Drug Act/Trafficking	21	4.6	5.3	10	1.7	2.1	10	1.4	1.8
Cultivation	2	.4	.5	3	.5	.6	7	1.0	1.3
Conspiracy to export dangerous drugs	1	.2	.3	0	.0	.0	0	.0	.0
Conspiracy to import dangerous drugs	5	1.1	1.3	0	.0	.0	0	.0	.0
Solicitation for the purpose of selling dangerous drugs	6	1.3	1.5	0	.0	.0	10	1.4	1.8
Total Charges	**453**	**100.0**		**601**	**100.0**		**719**	**100.0**	

5.9 Societal Costs of Cannabis Use and Abuse

Cannabis is currently the world's most commonly used illicit drug[62] and in The Bahamas it is no different; both among the youth and the adult population.[63,64]

In addition, because of the scientific advances in the cultivation of the plant Cannabis Sativa, designed to refine and enhance the product, there are growing concerns about the increased potency of marijuana due to elevated levels of THC; the psychoactive component of cannabis. While such data is not currently available for The Bahamas, a study in California revealed an increase in the average THC concentrations from 4.56% in 1996 to 11.75% in 2008.[65] Notwithstanding the ongoing debate about whether or not marijuana is harmful to one's health, which is complicated by its acknowledged medicinal benefits (**REF** WHO Expert Committee on Drug Dependence), the use of psychotropic drugs have a variety of consequences for the users, for their families and associates and for society at large.[66]

As outlined in "A Primer of Drug Action,"[67] in general, the effects of marijuana include the following:

- Mild euphoria
- Increased sense of well-being
- Relaxation
- Relief from anxiety
- Alterations in perception of time
- Hallucinations and illusions (infrequent)

The common negative effects of smoking marijuana include:

- Impairments in cognitive functioning.
- Impairments in learning.
- Disruption of all stages of memory.
- Impairments of motor control and reaction time.
- Acute depressive reactions at very high doses.
- Panic reactions.
- Mild paranoia.

Of interest is that the newest edition of the American Psychiatric Association's manual for diagnosing mental health and substance disorders, the DSM-5, now includes a diagnosis of Cannabis (Marijuana) Use Disorder, including a group of symptoms and diagnostic criteria for addiction. Among these are such issues as tolerance, withdrawal syndrome, craving and persistent or unsuccessful efforts to cut down or control use of this drug.[68]

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[62] World Drug Report 2019 (United Nations publication, Sales No. E.19.XI.8).
[63] Bahamas Secondary School Drug Prevalence Survey 2012. Ministry of National Security, The Bahamas. 2012.
[64] Bahamas National Household Drug Prevalence Survey Report 2018. The Ministry of Health, The Bahamas, 2018.
[65] Bergdorf, J.R., Kilmer, B., Pacula, R.L. (2011). Heterogeneity in the Composition of Marijuana Seized in California. Drug and Alcohol Dependence, 117(1), 59-61.
[66] WHO Expert Committee on Drug Dependence, Fortieth Report. Geneva: World Health Organization; 2018 (WHO Technical Report Series, No. 1013). Licence: CC BY-NC-SA 3.0 IGO.
[67] Julien, R.M., et al. (2011). A Primer of Drug Action. Twelfth Edition. New York, NY: Worth Publishing.
[68] American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5. Arlington, VA: American Psychiatric Publishing.

As a consequence and as alluded to earlier, there are societal costs to cannabis use and in the context of public policymaking, where priorities must be set for the allocation of scarce resources, it is important to have a measure of the overall magnitude of the social burden associated with such consequences. However, cost studies of the impact of drugs on society are not only essential for controlling resources, but they also have the following purposes.

- Provide justification for the prioritization that drug programs should receive within the government agenda.
- Encourage more effective decision making by identifying with greater precision the most important interventions and their policies
- Identify information gaps and research needs in aspects relevant to improving our understanding of the problem.
- Develop comparisons that provide the basis for a dynamic view of the magnitude of the problem.

In order to arrive at an estimate of the burden of cannabis on society, a number of direct and indirect costs must be taken into consideration. As outlined below, these include healthcare costs, productivity costs, costs due to law enforcement and crime and other costs.[69]

Healthcare Costs

- Substance abuse treatment costs
- Costs of treating morbidity associated with the use of psychoactive substances
- Costs of treating morbidity associated with combating drugs and drug trafficking (includes victims and victimizers).

Productivity Costs

- Productivity cost due to premature mortality
- Productivity cost due to mortality associated with combating drugs and drug trafficking (includes victims and victimizers).
- Productivity cost due to morbidity – lower employment or productivity
- Productivity cost due to mortality and morbidity among the non-working population
- Productivity cost due to incarceration and/or arrests

Cost due to Law Enforcement and Crime

In considering the social costs of cannabis use, the illegal status of this drug makes an enormous difference.[70] The consequences of criminalizing transactions in these drugs include the violence between rival drug-dealing organizations, crimes committed by addicts seeking funds to purchase drugs as well as the vast amounts of money spent in law-enforcement efforts.

- Police, judicial, legislative structure expenditures
- Prison system costs

[69] Encyclopedia.com. Social Costs of Alcohol and Drug Abuse. Encyclopedia of Drugs, Alcohol, and Addictive Behavior. (September 3, 2018). http://www.encyclopedia.com/education/encyclopedias-almanacs-transcripts-and-maps/social-costs-alcohol-and-drug-abuse

[70] Kleiman, M. A. R. (1992). Against excess: drug policy for results. New York: Basic Books.

Other Costs

- Research, education and law enforcement costs
- Costs of prevention and other public health actions
- Legislative branch expenditures for demand reduction efforts
- Costs related to the destruction or loss of value of property and assets due to crimes or accidents attributable to the use of psychoactive substances
- Welfare costs – Dept. of Social Services/Welfare
- Environmental impact costs of cultivating and processing illicit drugs

Unfortunately, such information on the actual measurable costs to society is unavailable in The Bahamas. One of the main reasons for the lack of this type of information is that such data is not routinely collected. Regardless of the policy decisions that are made by the government of The Bahamas regarding cannabis, it will be necessary to evaluate the impact of such decisions and thus specific information systems must be put in place to facilitate the collection and processing of such costs data.

CHAPTER 6: USE OF CANNABIS: RECREATIONAL

6.1 Overview of Recreational Cannabis

More than half of the US adult population, over 128 million people, have tried cannabis, despite it being an illegal drug under federal law. Nearly 600,000 Americans are arrested for cannabis possession annually – more than one person per minute. Public support for legalizing cannabis went from 12% in 1969 to 66% today. Recreational cannabis, also known as adult-use cannabis, was first legalized in Colorado and Washington in 2012.

Proponents of legalizing recreational cannabis say it will add billions to the economy, create hundreds of thousands of jobs, free up scarce police resources, and diminish the huge racial and socio-economic-related disparities in cannabis-related law enforcement. They contend that regulating cannabis will lower street crime, disrupt the drug cartels, and make cannabis use safer through stipulated testing, labelling, and child-proof packaging. They say cannabis is a relatively harmless herb, and that adults should have a right to use it if they wish.

Opponents of legalizing recreational cannabis say it will increase teen use and lead to more medical emergencies, including traffic deaths from driving while "high". They contend that revenue from legalization falls far short of the costs in increased hospital visits, addiction treatment, environmental damage, crime, workplace accidents, and lost productivity. They say that cannabis use harms the user physically and mentally and that its use should be strongly discouraged, and not legalized.

However, while there are varying views as to the benefits and challenges of recreational cannabis use, it appears that more data needs to be explored to arrive at a definitive position one way or the other.

It should also be noted that some believe that decriminalization of cannabis will eliminate or reduce sales in the black market, however, some jurisdictions show patterns that suggest otherwise.

6.2 Global Usage

Globally, cannabis is the most commonly used illicit drug. Classified as a Schedule 1 controlled substance, cannabis is a mood-altering drug that affects almost every organ in the body. In 2017, six percent or about one in 16 high school seniors in the US reported using marijuana every day. The number of 12th graders who think marijuana use is risky has halved in the last 20 years.

According to the 2013 National Survey on Drug Use and Health (NSDUH), 19.8 million, or 80.6% of people who used illicit drugs in the US used marijuana in the month before being surveyed. People can smoke marijuana, inhale it through the vapour, brew it as a tea, apply it as a balm, or eat it in products such as brownies or chocolate bars.

CHAPTER 7: USE OF CANNABIS: MEDICAL

7.1 History of Medical Cannabis

Cannabis has been used as a medicine for more than 12,000 years. It was first recorded in "The Herbal", one of the oldest known pharmacopeias in the Chinese Emperor Shen Nung, who was considered a pioneer in both herbal medicine and Chinese agriculture in corporate cannabis in traditional Chinese medicine. [75] Something's missing in 2nd sentence.

Cannabis made its way to the western world, in particular the Caribbean, from its original place of Central Asia by way of the indent [indentured?] labour East Indian workers [East Indian indentured labourers/] who migrated to Jamaica in the late 1800s. It soon made its way into medicine as it was used in teas, tinctures, washes and rubs to treat many diseases and it was later adopted by the Rastafarian community where it is used as a religious sacrament.

Medical cannabis is the name given to a group of drugs made from the whole plant Cannabis sativa to treat diseases. It has many chemical by-products that have shown lots of promise in treating some diseases where "traditional medicine" has failed. However, it was met with a setback when in 1932 it was removed from the British pharmacopeia as a listing of medicine, and the US followed suit in 1942. To add to its decline in popularity in 1970 the USA Controlled Substances Act (CSA) was enacted and the act labelled cannabis as a Schedule I Drug, meaning that it has no medical properties and has a high potential for abuse.

Despite the ongoing debates about the value of cannabis as medicine, in 1976 the Netherlands "informally" decriminalised cannabis even though its possession remained prohibited.

In 2001 Canada became the first country to legalize medical cannabis, allowing for ill patients, as well as those with chronic conditions, to use cannabis to treat symptoms. The Dutch followed when they allowed pharmacies to stock cannabis in 2003. In the US there are 33 states where cannabis is now legal and is thus used medically, with California paving the way in 1996.[76]

7.2 The Science behind the Drug

Much of the research and advances in medical cannabis should be accredited to the researcher Dr. Raphael Mechaulan who was the first to discover and identify the psychoactive constituent THC in cannabis in 1964. As a follow up to this discovery, in 1990 he revealed the endo cannabinoid system (ECS) in the body. His research also demonstrated that the human body uses endogenous cannabinols which are key to the body maintaining good health, homeostasis and well-being. These discoveries led to more information about the human body and the ECS such as the finding of receptor sites, regulatory enzymes and control checks and balances.

The cannabis plant is known to have a wide variety of cannabinoids with different properties and effects. The more common ones are THC, CBD and CBN (cannabinol). There are also E, G, L, N and T cannabinoids.

[75] Cannabis in Chinese Medicine (2007) Frontier in Pharmacology .8(108)
[76] Wikipedia ProCon.org (2017)

The body produces naturally occurring cannabinoids and those help to maintain the body state of wellbeing. Some of these naturally occurring cannabinoids are anandamide, 2 arachidonoylglycerol (2AG) and N-arachdonoyldopamine (NADA). When the body is deficient in the naturally occurring cannabinoids, the body begins to experience imbalances, disease and sickness. Some sicknesses like chronic migraines, poor bone healing, asthma, seizures, digestive issues and many more can be due to these deficiencies. Studies have shown that providing the body with cannabis products may correct these deficiencies thereby correcting the disease state and giving symptomatic relief.

7.3 Uses of Medicinal Cannabis

Medicinal cannabis can be used to treat a number of medical conditions. The more common conditions that have seen successes are Parkinson's disease, asthma, epilepsy, migraines, motion sickness, Tourette syndrome, appetite stimulation, Alzheimer's, osteoporosis, vomiting, enhanced bone healing, chronic disease, post-traumatic stress disorder (PTSD), irritable bowel disease, glaucoma, inflammation, arthritis, fibro myalgia, menstrual cramps, endometriosis, and protracted vomiting.

With specific reference to cancer, cannabis has been proven to be useful for the following:

- Pain management
- Reduction of tumour cells
- Chemotherapy side effects

On its website, the Pennsylvania Medical Marijuana Program cites a number of conditions that could be treated by medical cannabis:[77]

- ALS
- Anxiety Disorders (Effective July 20, 2019)
- Autism
- Cancer
- Chronic Inflammatory Demyelinating Polyneuropathy
- Crohn's Disease
- Dyskinetic and Spastic Movement Disorders
- Intractable Spasticity (caused by damage to the spinal cord)
- Epilepsy/Seizures
- Glaucoma
- HIV/AIDS
- Huntington's Disease
- Inflammatory Bowel Disease (including Colitis and Crohn's)
- Intractable Seizures
- Multiple Sclerosis
- Neurodegenerative Diseases
- Neuropathies
- Opioid-Use Disorder
- Parkinson's Disease
- Post-Traumatic Stress Disorder (PTSD)
- Severe Chronic/Intractable Pain
- Sickle Cell Anaemia
- Terminal Illness
- Tourette's Syndrome (Effective July 20, 2019)
- Ulcerative Colitis

As with all drugs, there are adverse effects that medicinal cannabis can cause. It should not be used in patients who are prone to psychosis, patients with heart disease, and patients who may be allergic to cannabis products.

[77] https://www.marijuanadoctors.com/medical-marijuana/pa/qualification/

The side effects are increased heart rate, onset of psychosis (prone patients), decreased motor skills, psychosis conditions, changes in blood pressure (BP), chronic cough, and phlegm production.

Smoking can create health risks and studies have shown a direct correlation between smoking cannabis recreationally or therapeutically to having adverse effects like chronic respiratory symptoms such as cough, wheezing, and breathlessness. These affects are related to the chemicals in the smoke such as hydrocarbons, acetaldehyde, nicosamamide, carbon monoxide and are not necessarily due to the effects from the cannabis plant, itself. The smoking of cannabis for medical purposes is therefore not usually recommended by medical practitioners as the first route of administration.

However, there are many modes of delivery of medical cannabis other than smoking it. It can be in an oral spray, pills, tablets, oils, sublingual, tubes, topical sprays, edibles (such as cookies, gummy bears), ointments, creams, metered dose inhalers, tinctures and suppositories.

The global medical community remains divided on issues concerning medicinal cannabis. Many support the legalization as this would spur research and development of the medicinal uses of the drug by providing easier access to the plant. Others conclude that there insufficient evidence to prove the medicinal benefits of cannabis and refuse to recommend it to their patients.

A 2017 survey conducted at the University of Colorado School of Medicine revealed that 97% of medical students believed that there should be more research and that cannabis could aid in the treatment of some conditions. However, there was still some uncertainty as only 29% of students indicated that they would actually recommend cannabis to their patients (under current law), but 45% said that they would if it was legal.[78]

In 2005 a survey of the attitudes of medical doctors toward legal prescription of medical cannabis was conducted. This was based on a national sample of family doctors, general internists, obstetricians and gynaecologists (OBGYNs), and psychiatrists. When presented/posed with the statement "Doctors should be able to legally prescribe cannabis as a medical therapy," 36% said yes, 26% were neutral, and 37.8% said no.[79]

7.4 The World Health Organisation's (WHO's) Position on Cannabis[80]

Following its 41st meeting in 2018, the World Health Organization (WHO) Expert Committee on Drug Dependence (ECDD) recommended the rescheduling of cannabis and several cannabis-related substances.

The WHO's new position comes at a time when a growing number of countries are moving to reform their cannabis policies aimed at scaling back or repealing their prohibition laws and increasing access for medical and scientific purposes. The next step is for the United Nations (UN) Commission on Narcotic Drugs (CND) to vote on the recommendations of the ECDD, and it is expected to do so at the 63rd Session in March 2020.

[78] Chan, Knoepke, Cole, McKinnon and Matlock (2017)
[79] Charuvastra, Friedmann and Stein (2005)
[80] WHO Expert Committee on Drug Dependence: Forty-first Report. Geneva: World Health Organization; 2019 (WHO Technical Report Series, No. 1018). Licence: CC BY-NC-SA 3.0 IGO

After an analysis of the global drug situation, the CND votes to adopt the content of the international prohibition lists. In the case of cannabis, this is the United Nations Single Convention on Narcotic Drugs of 1961. While the CND of the UN has yet to vote on whether to recommend these changes to Member States, other countries are becoming more emboldened and are proceeding.

An extract of the proposed changes in the scope of control of cannabis and related products from the Report on the 41st Meeting of the Expert Committee on Drug Dependence (ECDD)[81] is outlined in the box below.

Changes in the Scope of Control of Substances: Proposed Scheduling Recommendations by the World Health Organization on Cannabis and Cannabis-Related Substances

Cannabis and cannabis resin

- The Committee recommended that cannabis and cannabis resin be deleted from Schedule IV of the 1961 Convention

Dronabinol (*delta*-9-tetrahydrocannabinol)

- The Committee recommended that dronabinol and its stereoisomers (*delta*-9-tetrahydrocannabinol) be added to Schedule I of the 1961 Convention. As indicated in the "Guidance on the WHO review of psychoactive substances for international control", to facilitate efficient administration of the international control system, it is not advisable to place a substance under more than one Convention.

  Accordingly:

- The Committee recommended the deletion of dronabinol and its stereoisomers (*delta*-9-tetrahydrocannabinol) from the 1971 Convention, Schedule II, subject to the Commission's adoption of the recommendation to add dronabinol and its stereoisomers (*delta*-9-tetrahydrocannabinol) to Schedule I of the 1961 Convention.

Tetrahydrocannabinol (isomers of *delta*-9-tetrahydrocannabinol)

- The Committee recommended that tetrahydrocannabinol (understood to refer to the six isomers currently listed in Schedule I of the 1971 Convention) be added to Schedule I of the 1961 Convention, subject to the Commission's adoption of the recommendation to add dronabinol (*delta*-9-tetrahydrocannabinol) to the 1961 Convention, in Schedule I. As indicated in the "Guidance on the WHO review of psychoactive substances for international control", to facilitate efficient administration of the international control system, it is not advisable to place a substance under more than one Convention. Accordingly:

- The Committee recommended that tetrahydrocannabinol (understood to refer to the six isomers currently listed in Schedule I of the 1971 Convention) be deleted from the 1971 Convention, subject to the Commission's adoption of the recommendation to add tetrahydrocannabinol to Schedule I of the 1961 Convention.

[81] WHO ECDD 41st Report

Extracts and Tinctures

- The Committee recommended deleting extracts and tinctures of cannabis from Schedule I of the 1961 Convention.

Cannabidiol Preparations

- The Committee recommended that a footnote be added to Schedule I of the 1961 Convention to read "Preparations containing predominantly cannabidiol and not more than 0.2 per cent of *delta*-9-tetrahydrocannabinol are not under international control."

Pharmaceutical Preparations of Cannabis and Dronabinol (*delta*-9-tetrahydrocannabinol)

- The Committee recommended that preparations containing *delta*-9-tetrahydrocannabinol (dronabinol), produced either by chemical synthesis or as preparations of cannabis that are compounded as pharmaceutical preparations with one or more other ingredients and in such a way that *delta*-9-tetrahydrocannabinol (dronabinol) cannot be recovered by readily available means or in a yield which would constitute a risk to public health, be added to Schedule III of the 1961 Convention.

CHAPTER 8: USE OF CANNABIS: RELIGIOUS OR CEREMONIAL

Cannabis has been used among humans for thousands of years, dating as far back as 500 BC Source. It was originally used as herbal medicine in Asia. In America and Europe it was used in industries such as clothing, paper, sails, rope, and food.[82] Throughout history ancient cultures became aware of the psycho-active properties of the cannabis plant and began to cultivate varieties to produce higher levels of THC which is the component responsible for mind altering effects, for use in religious ceremonies and healing practices.[83]

As posited by Stober,[84] "weed and religion have an ancient history that goes back thousands of years and spans across the world". Religions known for cannabis use include Taoism, Hinduism and Rastafari. Stober explains that many different people have used cannabis in their religious ceremonies to reach a higher plane. According to Religious Facts,[85] "ancient Chinese belief systems, the Scythian people group of Central Asia, ancient Germanic paganism, and Hinduism, all used marijuana for religious reasons". The "Jamaican-born Rastafari movement is the most well-known modern religion that uses marijuana for spiritual purposes".

8.1 Religious Freedom in The Bahamas

In its 2018 Report on International Religious Freedom for The Bahamas, the US Government estimates the total population at 333,000 (July 2018 estimate).[86] The report continues that according to the 2010 census, more than 90 percent of the population professes a religion. Of those, 70% are Protestant [includes Baptist (35%), Anglican (14%), Pentecostal (9%), Seventh-Day Adventist (4%), Methodist (4%), Church of God (2%), and Brethren (2%)], 12% are Roman Catholic, and "Other Christians" make up the other 13% which includes Jehovah's Witnesses, Greek Orthodox Christians, and members of The Church of Jesus Christ of Latter-day Saints). Five percent are listed as "Other", "Having no religion", or "Unspecified". Other religious groups include Jews, Baha'is, Rastafarians, Muslims, Black Hebrew Israelites, Hindus, and Obeah practitioners, which a small number of citizens and some resident Haitians practice.

The Report continues that the Constitution of The Bahamas provides for freedom of conscience, thought, and religion, including the right to worship and to practise one's religion. It forbids infringement on an individual's freedom to choose or change one's religion and prohibits discrimination based on belief. Parliament may limit religious practices in the interest of national defence, public safety, health, public order, or for the protection of the rights and freedoms of others, but there were no such actions reported during the year. The Constitution refers to "an abiding respect for Christian values" in its preamble; however, there is no state-established religious body or official religion.

The Report pointed out that Rastafarians continued to be arrested for possessing small quantities of cannabis they used in ceremonial rituals and subjected to having their hair (locks) cut in prison.

[82] History.com, 2018
[83] Ibid
[84] Stober, 2018
[85] Religious Facts (2015)
[86] US Department of State, 2018 Report on International Freedom: The Bahamas, Retrieved from https://www.state.gov/reports/2018-report-on-international-religious-freedom/the-bahamas/

Rastafarians also said the Government discriminated against them in discussions on the legalization of cannabis for medicinal use.

8.2 Freedom of Religion

The Rastafarian movement in The Bahamas, as in other countries in the region, argue that their use of cannabis as part of their ceremonies is a right which is protected by the Constitution of The Bahamas.[87]

The legalization of cannabis for religious purposes is based on these premises, that is, that it is their constitutional right to be able to use cannabis in the practice of their religion, as any other religion can use whatever they chose as their sacrament.

Rastafarians are of the view that due to the many years of oppression from laws and law enforcement against the "holy herb"/cannabis, Rastafari in The Bahamas have been forced into a position that if wanting to continue practising their faith using the "holy herb"/cannabis, they found it very challenging to avoid the use of polluted products grown by unknown farmers who do not know the importance of the "holy herb" among Rastafari adherents or just simply do not have no respect for it.

Among the concerns found with cannabis grown by unscrupulous or untrained farmers that are not a priest or adherent of Rastafari faith are hybridized or crossed fertilized crops. Many of the strains of cannabis readily available are not the grade or quality that Rastafari adherents prefer to use. Rastafari sacrament is spiritual and sacred and only a person of Rastafari faith, a devotee, should grow supplies of cannabis for Rastafari members or church.

8.3 Sacrament Use in Rastafari

Rastafari is a social movement and religion created in the 1930s by Jamaican preacher Leonard Howell. Howell claimed Emperor Haile Selassie I of Ethiopia as the Second Coming of Jesus Christ, and that Africans were the chosen people with Ethiopia as their promised land. Cannabis has become identified with Rastafari. Rastafarians however condemn the use of cannabis simply to get "high." They also condemn the use of other drugs, such as alcohol, tobacco, caffeine, heroin or cocaine, which are viewed as poison that defiles the body.[88] As for the Rastafarian, cannabis is viewed as "a gateway to understanding" and it is predominantly seen as "wisdom-weed".

There is high admiration for the cannabis tree in Rastafari and its first and main use is as a spiritual sacrament. Rastafari uses the "holy herb"/cannabis not only for sacramental purpose, but also for food and medicinal purposes. The "holy herb"/cannabis is used in many food dishes and drinks in Rastafari way of life.

It is the view of Rastafarians that many persons who adhere to the Rastafarian way of life, which includes the regular use of cannabis, are helped for aliments and diseases such as cancers, glaucoma, overweight, obesity, depression, insomnia, stress, sleep disorders, skin conditions, schizophrenia, scleroderma, rheumatism, osteoporosis and other diseases that are plaguing the community.

[87] The Constitution of the Commonwealth of The Bahamas, Statute Laws of The Bahamas
[88] Stober, 2018

8.4 Sacrament Use in Hinduism

Hinduism is the most dominant religion in India and the oldest religion in the world. It is characterized by a belief in reincarnation, "and a large pantheon of gods and goddesses."[89] According to Stober (2018)[90] cannabis has played a sacred and also practical role in the Hindu religion.

Since ancient times, Indians have consumed "bhang," a drink made up of cannabis and milk, with almonds, rosewater and ghee often added. The use of cannabis was not abused but taken in moderation to avoid any harm to the body. In India today, cannabis in the form of bhang is so common that it can be found in government licensed street stands.[91]

8.5 Sacrament Use in Taoism

Taoism was established in 6th century BC by Lao-Tzu, a Chinese philosopher.[92] The religion is based on a philosophy of simplicity and non-interference, meaning living a simple life and not disturbing the natural course of things. Taoism became the official religion of China during the Tang Dynasty (618-907). According to the Tao, a cosmic force "flows through all living beings and maintains balance in the universe."[93]

In addition, the religion (Taoism) involved experimentation with hallucinogenic smoke to eliminate self-desire, and promote feelings of well-being and naturalness. The use of cannabis in this religion was only shared among members.

[89] Encarta Dictionary
[90] Stober, 2018
[91] Ibid
[92] Encarta Dictionary
[93] Stober

CHAPTER 9: ECONOMIC IMPACT OF A CANNABIS INDUSTRY

Cannabis is reported to be the most widely used, produced and trafficked drug worldwide. In a paper entitled "The Economic Case for Marijuana Legalization in Canada," Larissa Ducatti Flister noted that notwithstanding that the war on drugs has increased cannabis seizures, data shows that the drug's availability in the market has also expanded while trends in consumption have remained stable.[94]

The 2019 World Drug Report produced by the United Nations Office on Drugs and Crime (UNODC) also reported that cannabis continues to be the most widely used drug worldwide.[95] The report states that the UNODC estimated that roughly 3.8% of the global population aged 15 – 64 years used cannabis at least once in 2017, the equivalent of some 188 million people. The report stated that the overall number of annual cannabis users is estimated to have increased by roughly 30% during the period 1998 – 2017.

Mike Moffat, in an article updated in December 2018[96] stated that the "the war on drugs … is undoubtedly expensive." He noted that a great deal of resources goes into catching those who buy and sell illegal drugs, prosecuting them in court, and housing them in jail. Moffat also noted that there is another cost to the "war on drugs" and that is the lost revenue by governments that do not collect taxes on the sale of illegal drugs.

In a 2018 paper for the Fraser Institute, economist Stephen T. Easton outlined what he considered to be the many advantages of legalising cannabis.[97] These include:

(a) Limiting the lucrative $7 billion market (in Canada);
(b) There are now 40,000 Canadians each year who will not face prosecution for cannabis possession;
(c) Governments have a new source of revenue;
(d) Cannabis has been prescribed for years for anxiety and chronic pain among other conditions, thus the legalization will make cannabis available for those who need it for medical purposes.

For balance, Easton's disadvantages to legalization will be listed here as well. These include:

(a) Deciding on the regulatory framework to make the system fair for everyone;
(b) Driving while intoxicated. There are no accepted legal standards specifically for cannabis intoxication;
(c) Impact on crossing the US-Canada border as Canadians admitting to consuming cannabis may prevent them from entering the US.

The cost of new regulation and enforcement is seen as an additional burden.

[94] Flister, Larissa Ducatti, The Economic Case for Marijuana Legalization in Canada, Journal of Alternative Perspectives in the Social Sciences (2012) Volume 5 No. 1, 96 - 100
[95] World Drug Report 2019 (United Nations publication, Sales No. E.19.XI.8)
[96] Moffat, Mike. "Should Governments Legalize and Tax Marijuana?" ThougthCo. Dec. 10, 2018, thoughco.com/should-governments-legalize-and-tax-marijuana-1147575.
[97] Easton, Stephen T. Published on Fraser Institute (https://www.fraserinstitute.org/article/canada-land-of-the-free-and-legal-weed.

The economic benefits of a legalized industry have proven to be quite substantial for a number of states in the US. For example, in an article published on cnbc.com written by Eric Rosenbaum,[98] since it legalized cannabis in 2014, a mere five years ago, Colorado has generated more than $1 billion in total state revenue from the legal cannabis industry.

According to the article, there was more than $6 billion in total sales of cannabis. Monthly sales are estimated at roughly $24.2 million. At an event held in Denver, Colorado on 1st May, 2019, Colorado's Governor Jared Polis is quoted as saying, "It's going very well … It's creating tens of thousands of jobs, tax revenue for the state, filling up buildings for landlords and reducing crime … "

Colorado is reported to have 2,917 licensed cannabis businesses and 41,076 individuals who are licensed to work in the industry.

Other US states are also seeing dramatic increases in revenues as a result in the increase in tax revenue. The revenue generated comes from retail taxes on the product itself, an excise tax on the retail cannabis, and from licences and fees.

9.1 Economic Benefits of Regulation

It is a common view that taxed and well-regulated medical cannabis programmes will create numerous economic benefits to a country. This includes, but is not limited to the following:

▪ Increased Revenues without Tax Increases	Through regulation and taxation money being secured by the Government as taxable revenue instead of going to the cartels and criminal gangs
▪ Licensing Fees	Regulation will require that all businesses and individuals working in the industry be licensed. This will generate additional revenue.
▪ Job Creation	A well-regulated cannabis industry will create a variety of jobs that will create new opportunities for persons to be employed. Globally, wages in the industry are among the highest in the world.
▪ Real Estate and Other Assets	Businesses will be required to purchase property, building and other assets for their operations. Cultivation and processing centres demand vast amounts of land.
▪ Decreased Government Spending	Cannabis prohibition is expensive. Millions of dollars will be saved reducing resources needed to fund the Police Force, the Criminal Justice System and the Prison to deal with persons arrested for drug possession.
▪ Fortified Infrastructure and Social Programmes	The "new" money received from taxation of the industry will provide more resources to invest in education, health care, roads and other infrastructure, and social programmes.
▪ Weakened Criminal Organisations	A significant amount of the funds collected by organised crime groups will be diverted to the legal market.

[98] https://www.cnbc.com/2019/06/12/colorado-passes-1-billion-in-marijuana-state-revenue.html

9.2 The Potential for a Cannabis Industry in The Bahamas

With current changes on the horizon – the potential rescheduling of cannabis in America and the recommendations of the WHO – options appear to be most favourable for the development of a successful cannabis industry in The Bahamas.

This Report does not address this, but greater focus is needed to gauge the various impacts a cannabis industry will have on the Bahamian economy. There is a need to consider the possibilities for establishing markets for both type plants involved – those for medical and recreational use, and those designed for the hemp industry. The potential exists for a sustainable industry for each one.

9.3 The Industrial Hemp Industry vs. Cannabis for Medical and Recreational Use Industry

Cannabis for medicine, religious purposes, and even recreational use, would involve the cultivation of products specifically for these purposes. Cannabis for the hemp industry will require a different strain or species of the plant.

The plant used for industrial hemp is traditionally high in cannabidiol or more commonly known as CBD. There are many uses for hemp-based products in the general population, from hempcrete to clothing and hardware such as ropes and other building materials.

However, looking at the global trends, it is not expected that there will be an explosion of products into the industrial hemp market. This is because the prohibition on industrial hemp has been lifted for the majority of the world. Hemp clothing is available, but not in large amounts. The same applies for other hardware hemp that can be and is being produced.

What is seen is an explosion in the health and recreational uses of hemp-derived CBD and products. Products range from every aspect of the consumer experience: smokable products, as well as edible, topical and pet wellness products.

The absence of explosion of the hemp industry compared to the production of cannabis products for human consumption may be attributed to the initial start-up costs for production of the hemp products, coupled with a low market demand. This therefore does not make production a priority for businesses operating in this space. On the other hand, the costs to set up operations designed to cultivate and extract for human consumption are much more cost effective with a much higher return on investment.

Studies have shown the plants grown for medical, religious and religious purposes cannot co-exist with plants grown for the hemp industry. The more dominate hemp strain will cross-pollinate with other strains of cannabis and replace them, thereby diminishing the usefulness for other purpose. If The Bahamas wishes to engage in the growth of both products, consideration will have to be given to zoning separate regions to avoid this issue.

9.4 Ownership of the Industry

The creation of a cannabis industry, for medicinal and/or recreational purposes, must provide opportunities for all Bahamians to get involved, and at all levels, including ownership of the major components of the system.

The cost of operating a cannabis business is expensive. It is appreciated therefore that the average Bahamian may not have the resources to fully participate in the industry. It is imperative that safeguards are put in place that will encourage Bahamians to partner with foreign investors at a ratio that is mutually beneficial. It is proposed that any company formed must be at least 51% Bahamian owned, with no more than 49% of the shares being owned by non-Bahamians.

9.5 Taxation

As discussed before, a significant portion of the economic benefits to the country will be from taxing the industry, at several levels. It is important that the amount of taxes is not so great as to discourage persons from investing. Over taxation of the legal market would ensure a robust and healthy black market.

9.6 Cannabis Industry Impact on Businesses

Listed below are the businesses that could be impacted by a cannabis industry in The Bahamas by the provision of jobs or the need for services they offer. For example, the high regulation of the industry will require a strong security staff complement.

- Accounting Services
- Banking and Payment Solutions
- Compliance Solutions
- Clothing and Apparel
- Eco Sustainable Solutions
- Extracting and Processing Equipment
- Human Resources/Payroll and Staffing
- Laboratory Equipment
- Manufacturing Equipment
- Packaging Supplies
- Professional Services
- Security Solutions
- Software and Technology
- Training and Educational Services
- Advertising/Marketing/PR
- Business Insurance
- Consulting Services
- Consumption Products
- Cultivation Products and Services
- Events and Conferences
- Financing and Investment Capital
- Lab Testing Services
- Legal Services
- Media and Publishers (Cannabis only)
- PPR Design/Build/Display
- Real Estate
- Shipping
- Tourism

CHAPTER 10: LEGAL ISSUES

The laws regulating dangerous drugs, and in particular cannabis may be found in the Dangerous Drugs Act, Ch. 228 (DDA), Dangerous Drugs (Amendment) Act, 2011 and the Dangerous Drugs (Prescription of Minimum Amounts) Rules, 1989.

The DDA was enacted to regulate the importation, exportation, manufacture, and sale of dangerous drugs. The term "dangerous drugs" is not defined by the Act, but has the general meaning of a substance with no medicinal value[99].

The legal term for cannabis or the plant Cannabis sativa for the purposes of the DDA is "Indian hemp", and has been defined by the Act as:

> *"All parts of any plant of the genus cannabis whether growing or not from the resin has not been extracted??; the resin extracted from any part of such plant; and every compound, manufacture, salt derivative, mixture or preparation of such plant or resin.[100]"*

The Act states that it is an offence to be found in possession[101] of Indian hemp to which a person convicted of this offence would be liable:

- On information (Supreme Court), to a fine of one hundred and twenty-five thousand dollars ($125,000) or to imprisonment for ten (10) years or to both[102];
- On summary conviction (Magistrates Court), to a fine of fifty thousand dollars ($50,000) or to a term of imprisonment within the range of five (5) to seven (7) years or to both[103].

However, a person convicted of supplying dangerous drugs in excess of ten (10) pounds would be liable to term of life imprisonment[104], and in cases whereby a child or young person is found guilty of supplying the same, they may be committed to an industrial school or a place of detention for a period not exceeding five (5) years[105].

Also provided for in the DDA is the offence of possession of Indian hemp with the intent to supply[106]. It specifies that if a person is found in possession of two (2) or more packets containing dangerous drugs or a quantity exceeding 500 grams,[107] it is presumed, until the contrary is proved, that it was that person's

[99] Report of the CARICOM Regional Commission of Marijuana 2018, page 20 para 4.6
[100] Dangerous Drugs Act, Ch. 228: Section 2
[101] Where any drug to which this Act applies is without the proper authority, found in the possession of any person or stored or kept in a place other than a place described for the storage or keeping of such drug, such person, or the occupier or owner of such place or the owner of or other person responsible for the keeping of such drug unless he can prove such drug was deposited there without his knowledge or consent, shall be guilty of an offence against this Act. Dangerous Drugs Act, Ch. 228: Section 29(6)
[102] Dangerous Drugs Act, Ch. 228: Section 29(2)(a)
[103] Dangerous Drugs (Amendment) Act 2011: Section 29(2)(b)
[104] Dangerous Drugs Act, Ch. 228: Section 22(8)(a)
[105] Dangerous Drugs Act, Ch. 228: Section 22(5)
[106] It is an offence for a person to have a dangerous drug in his possession whether lawfully or not, with intent to supply it to another in contravention of the provisions of this Act. Dangerous Drugs Act, Ch. 228: Section 22(1)
[107] Dangerous Drugs (Prescription of Minimum Amounts) Rules, 1989: Section 2

intent to supply that dangerous drug to another or others[108]. Anyone found guilty of this offence may be liable:

- On Information (Supreme Court) to a fine of five hundred thousand dollars ($500,000) or to imprisonment for thirty (30) years or to both;

- On summary conviction (Magistrates Court) to a term of imprisonment within the range of four (4) to seven (7) years or to both imprisonment and a fine of two hundred and fifty thousand dollars ($250,000):

  Provided that where the offence occurs within one mile of a school, such person shall be liable to a term of imprisonment within the range of six to seven years or to both imprisonment and a fine to two hundred and fifty thousand dollars ($250,000)[109]

It is noted, however, that Parliament sought to rectify the disparity in by enacting The Abolition of Mandatory Minimum Sentences Act, No. 47 of 2014, allowing the adjudicator greater discretion during sentencing. This Act provides:

> *"Where a provision in any law has the effect of requiring a court to impose a minimum term of imprisonment, that provision, to the extent of that requirement shall be of no effect."*

The DDA further makes it an offence to be in possession of[already stated], to cultivate, trade in, import, export, manufacture and sell Indian hemp.

10.1 Medical Cannabis

Under the laws of The Bahamas, a qualified person[110] with special authority of the Minister[111] may cultivate, trade in, import or bring into The Bahamas Indian hemp for medical or scientific purposes. To do otherwise would be an offence against this Act[112].

The Commission notes that a "qualified person" for the purposes of this Act appears to not only give any person capable of proving their qualifications in any of the listed professions the ability to apply to the Minister responsible, but rather the way in which the Act is drafted any person may have the ability to apply to the Minister who alone has the discretion to give an individual "special permission" to cultivate, trade in, import or bring into The Bahamas Indian hemp. Moreover, the Act further allows a qualified

[108] For the purposes of subsection (1), where a person is found in possession of two or more packets containing dangerous drugs, or a quantity of dangerous drugs in excess of such quantity as may be prescribed in regard to that drug, it shall be presumed, until the contrary is proved, that he was in possession of that drug with intent to supply it to another or others, irrespective of whether that other or others be within The Bahamas or elsewhere. Dangerous Drugs Act, Ch. 228: Section 22(3)

[109] Dangerous Drugs (Amendment) Act 2011: Section 22(2)(b)

[110] "Qualified Person" means a registered medical practitioner or a registered dentist or a licensed veterinary surgeon or a licensed pharmacist or the public analyst or any person to whom special permission is granted by the Minister by Order to import or export any drug to which this Act applies and which may be imported or exported thereunder. Dangerous Drugs Act, Ch, 228- Section 2

[111] "Minister" means the Minister responsible for Dangerous Drugs and Poisons. Dangerous Drugs Act, Ch, 228- Section 2

[112] Dangerous Drugs Act, Ch. 228: Section 3

person to be granted authorization, as may be necessary, for the practice or exercise of his profession, function or employment, including being in possession of and supplying Indian hemp[113]. In fact, according to the DDA, the Minister may issue or grant, for the purposes of this Act, licenses and authorities on such terms and subject to such conditions, including that of a fee, as the Minister thinks fit[114]. This authorization, however, requires the qualified person to secure Indian hemp in a locked receptacle which can only be opened by him or some other person "authorized" by the DDA to be in possession of it[115].

The DDA provides the Minister with a very broad spectrum on what may be lawful in terms of *inter alia* possession for medical and scientific purposes. However, the Act is very unclear as to whether "any" authorization granted by the qualified person to supply Indian hemp covers the recipient. It is thought that if one can lawfully supply Indian hemp then it must also follow that the recipient of the Indian hemp, to whom the lawful supply of Indian hemp is provided, must also be in possession lawfully. This, in the view of the Commission, is a lacuna that ought to be addressed legislatively.

The Commission is also of the view that the Act provides an arbitrary position in relation to the grant and issuance of Indian hemp and provides no actual structure or criteria in law as to how such permission ought to be granted. Furthermore, it presumes that simply because an individual is of any of the listed professions he/she automatically should be allowed to apply for permission, which in turn, will be considered by the Minister. Though, this is not to say that there is no structure or criterion placed in the form of policy or practice, but in the Commission's view, these sections of the Act are lacking clarity and ought to be regulated legislatively, specifying that individuals possessing qualifications in line with the listed professions ought to apply and satisfy other requirements, which should also be listed, before being considered by a Board instituted by the Minister to avoid arbitrariness or the perception of the same.

It is also noted that the use of Indian hemp is not expressly prohibited by the Act, but simply// its possession, cultivation, importation, exportation and sale. This is consistent with the fact that no arrests can be made on routine stops by law enforcement simply on the basis that the scent of Indian hemp emanated from the vehicle or on that individual, and/ or that the individual appeared to have been under the influence of Indian hemp. Evidence must exist of the individual's possession of the plant which includes undergoing tests verifying its content. Additionally, there is no prohibition of being in possession of paraphernalia or utensil associated with the use or consumption of Indian hemp.

10.2 Expunging of Records

In The Bahamas drug offences are usually heard in the Magistrates Court and assigned to Court No. 8. What is also of particular note within our laws is the ability for offenders who have not been reconvicted of any serious offence for periods of years to be rehabilitated[116], penalise any unauthorised disclosure of spent convictions[117] and amends the law of defamation[118]. This is currently administered by way of the Rehabilitation of Offenders Act, Ch. 100 ("ROA").

[113] Dangerous Drugs Act, Ch. 228: Section 24(1)
[114] Dangerous Drugs Act, Ch. 228: Section 26
[115] Dangerous Drugs Act, Ch. 228: Section 24(2)
[116] Rehabilitation of Offenders Ch. 100
[117] Rehabilitation of Offenders Ch. 100: Section 8
[118] Rehabilitation of Offenders Ch. 100: Section 7

The ROA provides for [the rehabilitation of?] an individual convicted of any offence not excluded by the ROA, and the individual has not been convicted for another/ or separate offence during the applicable rehabilitation period for the offence not excluded by this Act, at the end of the applicable rehabilitation period that individual for the purposes of the ROA shall be treated as a rehabilitated person in respect of the first mentioned conviction and that conviction shall, for these purposes be treated as spent[119].

The rehabilitation period to a conviction for an indictable offence (Supreme Court) is ten years and to a conviction for a summary offence or and indictable offence tried summarily (Magistrates Court) the applicable rehabilitation period is five (5) years. Additionally, where the individually is under the age of eighteen (18) years, the applicable rehabilitation period would be half of the applicable rehabilitation period[120].

The effect of rehabilitation was outlined in the ROA permitting the individual for the purposes of this Act to be treated as a person who has not committed, or been charged with or prosecuted for or convicted of a sentence for the offence for which was the subject of the conviction[121]. An individual who has been refused to be treated as a rehabilitated person for the purposes of the ROA may appeal to the Minister[122] against the refusal of a public officer[123].

Offences excluded for the purposes of the ROA are Manslaughter (carrying a sentence of five (5) or more years on conviction, Murder, Possession with intent to supply, Treason, Armed Robbery, Rape and Unlawful carnal knowledge[124].

In 2015 Parliament amended the ROA removing arbitrary powers from a public officer to determine the rehabilitation of an offender and established a Rehabilitation of Offenders Committee, specifying who may be qualified for appointment, the Committee's role, duties, powers and considerations. However, this Amendment Act provides that their main role is to hear applications of "*Young Offenders*" and "*First-time Offenders*"[125] resulting in them making recommendations to the Minister who will then review their decision and approve or reject the application of the Committee[126]. Once the Committee and the Minister has approved an individual, the Applicant shall be treated as having been rehabilitated for the purposes of this Act and his conviction or convictions as so approved shall be treated as spent[127].

The Commission notes that although this legislation exists and removes convictions from an individual's criminal record, this is not an automatic process, as outlined above, and does not provide for a definite or absolute grant of rehabilitation and spent convictions for the purposes of this Act. Furthermore, the Act clearly outlines that an application for rehabilitation cannot commence until completion of any and all sentences imposed[128].

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[119] Rehabilitation of Offenders Ch. 100: Section 3(1)
[120] Rehabilitation of Offenders (Amendment) Act: Section 4(2)
[121] Rehabilitation of Offenders Ch. 100: Section 5
[122] "Minister" means the Minister responsible for Rehabilitation. Rehabilitation of Offenders Ch. 100: Section 2(1)
[123] Rehabilitation of Offenders Ch. 100: Section 3(4)
[124] Rehabilitation of Offenders Ch. 100: Section 4(1) and the First Schedule
[125] Rehabilitation of Offenders (Amendment) Act: Section 12(1)(a)
[126] Rehabilitation of Offenders (Amendment) Act: Section 14(2)
[127] Rehabilitation of Offenders (Amendment) Act: Section 14(3)
[128] "A person shall not become a rehabilitated person for the purposes of this Act in respect of a conviction unless he has served or otherwise undergone or complied with any sentence imposed on him in respect of that conviction but- (a) failure to pay a fine or other sum adjudged to be paid by or imposed on a conviction; or (b) breach of a

10.3 Summary of the Laws in Other Jurisdictions

Before the Commission could make any recommendations towards amending the current laws in The Bahamas governing Indian hemp or the Cannabis sativa plant, it was necessary for it to consider other jurisdictions who had already amended their legislation to reflect the legalization and/ or decriminalization of the Cannabis sativa plant.

The Commission agreed to consider Commonwealth countries but thought it prudent to specifically consider countries within the region.

Although Canada was and still is a country of interest, we were unable to participate in a fact-finding exercise in that Commonwealth country, but were able to participate in a very productive fact-finding exercise in Jamaica.

(i) Jamaica

Jamaica has been the leading country in the region when it comes to the legalization and decriminalization of the plant Cannabis sativa. In its 1948 Dangerous Drugs Act, which was enacted to address all illegal substances, cannabis or the plant Cannabis sativa was referred to as "ganja" and defined as follows:

> *"Includes all parts of the plant known as Cannabis sativa from which the resin has not been extracted and includes any resin obtained from that plant but does not include medicinal preparations made from that plant[129]."*

This Act made all use and possession of ganja illegal with the exception of medicinal preparations from the plant. Additionally, it decriminalized ganja to the extent that a person may be in possession of no more than 0.057kg (2 ounces) of the plant or any such amount as the Minister may by order prescribe[130].

In 2015, Jamaica further developed its laws on Cannabis sativa in its Dangerous Drugs (Amendment) Act 2015, commencing with a completely different definition of the term "ganja" which

> *"includes all parts of the plant Cannabis sativa from which the resin has not been extracted and includes any resin obtained from that plant, but does not include the following:*
>
> (i) *Medicinal preparations made from that plan*
> (ii) *Hemp[131]."*

This redefinition of cannabis resulted in the legalization of the Cannabis sativa plant for medicinal purposes and any part of the plant falling within the definition of hemp[132]. Moreover, this Amendment

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condition of a recognizance or of a bond to keep the peace or be of good behavior, shall not prevent a person from becoming a rehabilitated person for those purposes." Rehabilitation of Offenders (Amendment) Act: Section 3(3)

[129] Dangerous Drugs Act (1948) (Jamaica): Section 2

[130] Dangerous Drugs Act (1948) (Jamaica): Section 7C(2)

[131] The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 2(a)

[132] "Hemp" means the plant cannabis sativa, or any part thereof, with a THC concentration of no more than 1.0% or such other concentration as may be prescribed by the Minister by order published in the Gazette." The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 2(b)

Act made it legal for persons suffering from cancer or any other serious chronic illness, or a person by whom a registered medical practitioner has recommended the use of ganja for medicinal and therapeutic purposes[133], to use and be in possession of cannabis but not exceeding the amount that has been recommended by the registered medical practitioner[134].

The decriminalized amount of possession for persons not qualified for any of? the exceptions? remained at two ounces in this Amendment Act as it was in the principal 1948 Act[135]. Consequently, it is still an offence in Jamaica to smoke or to be in possession of any amount of ganja exceeding two ounces. It further expressly states that if a person found in possession of the prescribed amount or less *shall not be liable to arrest or detention, but liable to a fixed penalty of $500[136].*

The Act also made it legal for a household to cultivate no more than five (5) plants[137]. Any amount exceeding the five (5) plants is an offence, and for the purposes of this amendment, where there is more than one household on any premises, each household shall be treated as a "separate premises"[138].

Further, this Act made it legal to be in possession of ganja for religious purpose as a sacrament in adherence to the Rastafarian faith[139], and for scientific research conducted by a duly accredited tertiary institution or otherwise approved by the Scientific Research Council or such other body as may be prescribed by the Minister.

The Act also defined the following essential terms:

a. "Handling" includes use, cultivation, processing, importation, exportation, transit, manufacture, sale, possession and distribution[140].
b. "Medical, therapeutic or scientific purposes" includes research, clinical trials therapy and treatment, and the manufacturer of nutraceutical and pharmaceuticals[141].

It further mandates that the handling of ganja for medical, therapeutic or scientific purposes requires a licence, permit or other authorization issued under this amended Act[142], and prohibits the smoking of ganja in public places[143].

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[133] "Medical or therapeutic purposes" as prescribed or recommended in writing by- (i) a registered medical practitioner; or (ii) other health practitioner, or class of practitioners, approved for that purpose by the Minister responsible for health by order published in the Gazette; The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 7C(2)(b)

[134] The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 7A(4)

[135] The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 7A(3)(a)

[136] The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 7G(1)

[137] The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 7B(4)

[138] The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 7B(5)

[139] The amended Act further allows for exempt events for the purposes of the celebration or observance of the Rastafarian faith The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Sections 7(8) and 7(9) and provides for the registration of Rastafarian worship for the purposes of the definition of "public place" The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 7H(1)

[140] The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 7D(2)

[141] The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 7D(2)

[142] The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 7D(1)

[143] The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 7E

The Act addresses the use and possession of ganja by "foreigners" or non-residents of Jamaica, and provides that persons falling into the above category may purchase and be in possession of two ounces or less of ganja at a time, provided that that person produces a voluntary declaration signed by that person, or any other satisfactory evidence, that the person's use of ganja is for medical or therapeutic purposes as prescribed or recommended in writing by a medical practitioner entitled to practise in the jurisdiction where the person is ordinarily a resident, and in possession of a valid permit issued by the Minister of ?, upon an application made, accompanied by such fee that may be prescribed by the Minister[144].

Moreover, this Act established a Cannabis Licensing Authority, outlining their duties and powers for the purposes of this Act in overseeing and controlling the handling of hemp and ganja[145].

(ii) Cayman Islands

The Cayman Islands also took a step towards the legalization of cannabis in 2017. According to its Misuse of Drugs Law (2017 Revision), the Cayman Islands maintained its position on the use of the cannabis plant, with the exception of medicinal purposes, as their Act now provides for the lawful importation and use of CBD oil for medicinal purposes only.

In this Law "cannabis" is defined as:

> *"(except in the expression "cannabis resin") means any plant of the genus Cannabis or any party of such plant (by whatever name designated) except that it does not include cannabis resin or any of the following products after separation from the rest of the plant, namely-*
>
> *(a) The mature stalk of any such plant*
> *(b) Fibre produced from mature stalk of any such plant."*

The Law further provides that the use of cannabis extracts and tincture of cannabis[146] for medical or therapeutic purposes, where prescribed by a licensed medical doctor as part of a course of treatment for a person under that medical doctor's care, is lawful. The medical doctor establishes the required dosage for that person[147].

(iii) Antigua and Barbuda

Antigua and Barbuda, on the other hand, made a great leap towards the evolution of their laws pertaining to the Cannabis sativa plant. In 2018 they enacted legislation that was very similar to that of Jamaica's 2015 Amendment Act. The main object of its Misuse of Drugs (Amendment) Act, 2018 (No. 3 of 2018) appears to have been focused on the decriminalization of cannabis.

[144] The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 7D(10)- 7D(12)
[145] The Dangerous Drugs (Amendment) Act (2015) (Jamaica): Section 9A
[146] "Cannabis extracts and tinctures of cannabis" means the separated resin, crude or purified, obtained from the cannabis plant, and "ganja" means cannabis and cannabis resin. Misuse of Drugs Law (2017 Revision) (Cayman Islands)
[147] Misuse of Drugs Law (2017 Revision) (Cayman Islands): Section 2A

This 2018 Amendment Act permits persons to be in possession of cannabis, provided it does not exceed the prescribed 15 grams of cannabis or cannabis resin[148], to which no penalty can be imposed under this Act[149]. Notwithstanding the aforementioned, this Act prohibits the smoking of any part of the genus cannabis in a public place[150]; or being the owner, occupier or concerned with the management of such premises knowingly permitting another to sell, supply or smoke the plant[151]. If found in breach of either offence, that individual would be liable on the first (1st) occasion to a warning by the police[152], issued with a violation ticket[153] of $500 on the second (2nd) occasion[154], and on the third (3rd) or subsequent occasion on summary conviction to a fine not exceeding $1,500[155]. Furthermore, any penalty imposed relative to the foregoing shall not form part of that individual's criminal record[156].

Additionally, the Act defines *"public place"* as any structure, facility, space used for gathering by individuals; other place, for the use of, or open or accessible to the public (bars, restaurants, clubs, tourist establishments, Government offices)[158].

Child offenders were also considered in this Act and it provides that a person under the age of eighteen (18) years old[159] found in possession of cannabis shall be required to participate in a drug counselling program approved by the Minister, and required to financially contribute to that programme[160].

The Act encourages public education programmes to discourage the use of cannabis by persons with mental disorders, pregnant women, youth and other vulnerable groups[161], and programmes to treat and rehabilitate persons suffering from drug related illnesses[162].

Moreover, the cultivation of the genus cannabis was outlined as unlawful[163], however, it was made lawful for the head of a household[164], owner lessee, tenant or other person having control of the property[165] to cultivate no more than four (4) plants per household on his property[166].

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[148] Misuse of Drugs (Amendment) Act, 2018: Section 6A(1)
[149] Misuse of Drugs (Amendment) Act, 2018: Section 6A(2)
[150] Misuse of Drugs (Amendment) Act, 2018: Section 6B(1)(a)
[151] Misuse of Drugs (Amendment) Act, 2018: Section 6B(1)(b)
[152] Misuse of Drugs (Amendment) Act, 2018: Section 6B(2)(a)
[153] "Violation ticket" means a ticket issued pursuant to section 13A to a person in possession of 15 grams or less of Cannabis or Cannabis resin contrary to the Act. Misuse of Drugs (Amendment) Act, 2018: Section 2 Additionally, the Act further gives the Minister the responsibility to make regulations to provide for the issue of violation tickets and specify to what extent. Misuse of Drugs (Amendment) Act, 2018: Section 13A
[154] Misuse of Drugs (Amendment) Act, 2018: Section 6B(2)(b)
[155] Misuse of Drugs (Amendment) Act, 2018: Section 6B(2)(c)
[156] Misuse of Drugs (Amendment) Act, 2018: Section 6B(3)
[158] Misuse of Drugs (Amendment) Act, 2018: Section 2
[159] Misuse of Drugs (Amendment) Act, 2018: Section 6C(1)
[160] Misuse of Drugs (Amendment) Act, 2018: Section 6C(2)
[161] Misuse of Drugs (Amendment) Act, 2018: Section 6D(a)
[162] Misuse of Drugs (Amendment) Act, 2018: Section 6D(b)
[163] Misuse of Drugs (Amendment) Act, 2018: Section 8(1)
[164] "Household" means a house and its occupants regarded as a unit. Misuse of Drugs (Amendment) Act, 2018: Section 2
[165] "Property" means land and house on which the person lawfully resides. Misuse of Drugs (Amendment) Act, 2018: Section 2
[166] Misuse of Drugs (Amendment) Act, 2018: Section 8(1A)

Like The Bahamas and other jurisdictions, Antigua and Barbuda has legislation providing for the rehabilitation of offenders and this was acknowledged and considered in its 2018 Amendment Act when addressing the expunging of records of individuals convicted of being in possession of the cannabis sativa plant. The Act provides:

> *"Notwithstanding the provisions of the Criminal Records (Rehabilitation of Offenders) Act 2013, No. 19 of 2013, any notation on the record of a person prior to the passing of this Act for conviction of offences involving the drug Cannabis or Cannabis resin in a quantity of 15 grams or less, shall be regarded as spent and expunged accordingly"*[167]*.*

The Commission found it interesting to note that the expunging of records did not apply to possession of the cannabis sativa plant as a whole but rather it is only applicable to persons who were found in possession of the decriminalized amount of 15 grams that was still, for the purposes of this Act, unlawful, but not capable of forming a conviction.

In April 2019, Antigua and Barbuda thought to tighten what was implemented in 2018 and provided another amendment entitled The Misuse of Drugs (Amendment) Act, 2019 (No. 2 of 2019), establishing a National Drug Council comprising of the following persons or their nominee, some of whom were appointed by the Minister[168]:

- Commissioner of Police
- Director of the Office of the National Drug and Money Laundering Control Policy
- Chief of Defence Staff of the Antigua and Barbuda Defence Force
- Director of Analytical Service
- Ministry of Health representative
- Social Transformation
- Ministry of Education representative
- Ministry of National Security representative
- Barbuda Affairs
- A person with training in drug addiction, counselling and rehabilitation
- Christian Council or other religious organizations representative

The Act further outlined their duties and responsibilities[169], including advising the Minister on measures which should be taken to prevent the misuse of drugs, and establishing and outlining the duties of the Executive Secretary[170] and Technical Working Group[171].

10.4 CARICOM Report 2018

It would be remiss of the Commission not to consider the 2018 Report of the CARICOM Regional Commission on Marijuana ("the Report"). CARICOM in their report considered the legitimacy of the law and surmised that there ought to be clear rationales to support law making and that of criminal penalties. The Report submitted:

[167] Misuse of Drugs (Amendment) Act, 2018: Section 39
[168] The Misuse of Drugs (Amendment) Act, 2019: Section 3A
[169] The Misuse of Drugs (Amendment) Act, 2019: Section 3B
[170] The Misuse of Drugs (Amendment) Act, 2019: Section 3C
[171] The Misuse of Drugs (Amendment) Act, 2019: Section 3D

> *"The law seeks to consider what is termed the "mischief" or "harm" that must be cured and creates solutions to address the specific problem. That 'harm' is usually harm done to others, or in some cases to oneself. Another sound, although more controversial basis for law-making is, morality. Yet, none of these rationales were demonstrably present when the status of the plant cannabis was changed to one of a narcotic or dangerous drug in the early 20th century, in Jamaica, in 1913 and in other countries 1930s and beyond, with the result that criminal penalties were imposed and mandated.[172]"*

The Report provides that the lack of legitimacy engulfing the laws of cannabis has been due to the lack of support surrounding its initial illegality, particularly bearing in mind *inter alia* the scientific evidence and long history of use unobstructed by legal regulations[173]. The Report further noted the conspiracy alleged that prohibition on cannabis resulted from the tobacco and alcohol industries not wanting to be stifled by competition, race and social prejudices aimed at oppressing the Mexican and black race[174], the alleged harm to oneself was combated with queries surrounding the rationale behind the legalization of alcohol, tobacco and even cassava and ackee[175], and its moral and ethical standpoint predicated on its classification of the plant as being unlawful and banned[176].

CARICOM's Report found that the region's common denominator concerning cannabis is its strict liability to offences of possession, use, control, trade and other related offences to the plant regardless of intent and/or applicable mitigating circumstances[177]. This resulted in law enforcement turning the blind eye in some instances and disparity in penalties when placed before the courts. It further contradicts proposed alternatives (Non-custodial sanctions such as: education, rehabilitation and social reintegration, treatment, aftercare rehabilitation and social reintegration in the case of those who are drug abusers) provided for in the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988[178]. For example, in Guyana, an elderly lady in her 80s had been incarcerated for possession of one 'joint' she apparently took to relieve pain[179].

The Report provided a view that although regionally, sentencing handed down for cannabis related offences is typically much lighter than that of North America, sentencing, nonetheless, appears to be arbitrary, inconsistent and out of sync with social realities. CARICOM stated:

> *"It is an unfortunate truism that otherwise law-abiding CARICOM citizens can receive a much harsher sentence, including imprisonment for many years, for possessing a single 'joint' of marijuana, a victimless crime, than a person convicted of wounding another with intent and similar serious crimes.[180]"*

Another very important point considered in the Report is the ancillary laws supporting the illegality of cannabis affecting a country's or the region's financial sector and the need to have patent laws, change

[172] Report of the CARICOM Regional Commission of Marijuana 2018, page 19 para 4.1
[173] Report of the CARICOM Regional Commission of Marijuana 2018, page 20 para 4.1
[174] Report of the CARICOM Regional Commission of Marijuana 2018, page 20 para 4.3
[175] Report of the CARICOM Regional Commission of Marijuana 2018, page 20 para 4.4
[176] Report of the CARICOM Regional Commission of Marijuana 2018, page 20 para 4.5
[177] Report of the CARICOM Regional Commission of Marijuana 2018, page 21 para 4.7
[178] Report of the CARICOM Regional Commission of Marijuana 2018, page 21 para 4.8
[179] Report of the CARICOM Regional Commission of Marijuana 2018, page 21 para 4.10
[180] Report of the CARICOM Regional Commission of Marijuana 2018, page 23 para 4.17

to customs laws, regulation of pharmacies and the amendment to laws regarding anti-money laundering and the proceeds of crime[181]. In fact, these concerns have been optimised with companies currently operating cannabis businesses who have found legal difficulties transacting with banks and financial institutions given the fact that their businesses are viewed as participating in the proceeds of crime, the effects of which have far reaching international consequences.

CARICOM concluded:

> *"As a first step, the Commission is unanimous in its view that any legal reform should continue to prohibit the use (especially smoking) of cannabis/ marijuana in public spaces, as is currently done for tobacco smoking. This would also preserve the rights of non-users. Possible exceptions would be a regulatory regime that permits 'regulated spaces', such as the 'coffee shops' of the Netherlands or the cooperatives of Spain. On the other hand, regulatory regimes for private households which criminalise persons for use are untenable for the reasons mentioned above.[182]"*

The Report further states:

> *"The Commission is persuaded that hemp should be differentiated from other types of cannabis in the relevant legislation, using provisions that define hemp according to minimal THC levels and thereby excluding these from any regulatory or legal prohibitive regime. This will liberate hemp and encourage its use in important industry development. In the cultivation of hemp, careful zoning is needed to prevent cross-fertilisation.[183]"*

[181] Report of the CARICOM Regional Commission of Marijuana 2018, page 25 para 4.31
[182] Report of the CARICOM Regional Commission of Marijuana 2018, page 24 para 4.25
[183] Report of the CARICOM Regional Commission of Marijuana 2018, page 25 para 4.35

CHAPTER 11: VIEWS OF THE BAHAMIAN PUBLIC

During 2019 the Commission interacted with the Bahamian public in several fora to get their views on cannabis. As stated before, these interactions included town hall meetings, community walkabouts and stakeholder meetings.

The Commission visited in Abaco, Eleuthera, Exuma, Grand Bahama and New Providence. Listed below are the major issues raised.

- There is a need for a massive public relations exercise to educate Bahamians about all things marijuana. Members of the public must be sensitized about this issue so that they can make informed decisions.
- More research is needed to determine the benefits and disadvantages of cannabis use in The Bahamas.
- There is great support for the medical use of cannabis.
- Cannabis is a plant, and just as aloes and cerasee are used for medical purposes, cannabis should be allowed to be used similarly.
- An individual indicated that as a former employee in the Court system she witnessed too many young lives being ruined by being given criminal records, and in many instances, being incarcerated for possession of small amounts of cannabis.
- There is support for decriminalization of cannabis and for the expungement of criminal records for persons convicted of possession of small amounts of cannabis.
- There is also support for the legalization of cannabis for any use – including recreational use.
- The Bahamas has the climate and condition to grow cannabis and thus this should be taken advantage of.
- Bahamians should be allowed to grow cannabis in their backyards.

> ***"Governments have been avoiding this topic too long. They should move faster so that we do not lose out as a country. Should make this issue straightforward, and not complicate it."***

- With the legalization of cannabis, the Government can gain revenue through imposing a tax. Revenue gained could be used to fix roads, build schools, etc.
- The industry should be 100% Bahamian owned.
- Tourists should be allowed to use cannabis. This would boost the tourism industry.
- A participant indicated that he had a problem with comparisons being made with other countries when it comes to legalization and education of marijuana use. Except for medical use, the speaker has a problem, especially because he used to smoke marijuana it and he feels that the young people are not sufficiently informed on how to use it.
- A participant indicated that he not only grew marijuana, but he smoked it as well, but he came to realise, especially participating in the forum he attended, that the issues of marijuana, if not properly vetted and informed, can destroy many Bahamians. He thinks the entire issue is about control, having regulations, and most of all, mature discussions on the topic. He said that where there is a lack of knowledge, people will suffer.

> ***"Marijuana is a sacrament between me and God. It is my culture. It's not about getting high; it is about meditation."***

- It was suggested that co-operatives be formed to fund a cannabis industry in The Bahamas.
- Crime statistics need to be examined to see if there is a correlation between drug use and crime in The Bahamas.

"In this whole process of legalising marijuana, I would hope that the government would level the playing field to include the opinions of everybody, so that everybody can benefit."

In these interactions the similarities in views were found to be interesting. These views will be discussed in greater detail in the final report.

It should also be noted that a survey will be conducted that will scientifically codify the views of the Bahamian public. The results of the survey will be presented and discussed in the final report.

CHAPTER 12: RECOMMENDATIONS

The recommendations contained in this Preliminary Report represent the consensus of the members of the Commission. They are made based on available research, engagement with members of the Bahamian public and limited stakeholders, fact-finding mission to Jamaica, and a review of changes made or being made in other countries in the CARICOM region, North America and Europe.

In making these recommendations, the Commission recognises that the most recent nationally representative scientific household survey of the Bahamian public on the topic was in 2017 and opinions may have changed. Consequently, as was intended when it began its work, a new household survey has been commissioned and it is expected that the results will be analysed and available early in 2020. The Commission will ensure that any more recent views and recommendations of the public are duly reflected in the Final Report when it is released.

Commissioners are acutely aware too of its mandate, which is the preparation of this report and all subsequent recommendations for the Government of The Bahamas. Understandably, the ultimate decision on the way forward will be the Government's. However, it is hoped that these recommendations will be given due consideration. The Commission wishes to make it clear however, that this report and the work completed to date, is only the first step in this journey and that much more work needs to be done to bring to fruition any of these recommendations or other considerations by the Government.

Recommendation 1 Terminology	That the Dangerous Drugs Act (DDA) be revisited and amended, as appropriate, e.g., as it relates to definitions relating to cannabis.
Recommendation 2 Legalization and Regulation of Cannabis for Medical Purposes	That the necessary amendments be made to the DDA that will facilitate the legalization and regulation of cannabis for medical purposes and provide for the proper regulation as it relates to cultivation, processing and distribution of cannabis and cannabis-based products for persons prescribed to utilise cannabis for medical purposes.
Recommendation 3 Registration and Medical Cannabis Cards	That persons who are prescribed cannabis for medical use be required to register and obtain a Medical Cannabis Card (MCC).
Recommendation 4 Access to Cannabis for Medical Use	That the prescription of cannabis be treated the same as any other psychoactive drug.
Recommendation 5 Cultivation of Cannabis for Medical Use	That persons who are prescribed cannabis for medical use be allowed to grow sufficient plants (at various stages of growth) to ensure that they have access to amount of product for their condition, and where they are not capable to grow the plant themselves, to allow a licensed relative or caregiver, over the age of 21 years, to grow quantity of plants they need.

Recommendation 6 Cultivation of Cannabis for Medical Use	That provisions be made for persons who are prescribed cannabis for medical use, and who cannot cultivate or who do not have a person to cultivate for them, to be able to have affordable access to a supply of cannabis from regulated dispensaries or pharmacies.
Recommendation 7 Existing Medical Body(ies) to Develop Regulations and Guidelines for the Use of Cannabis for Medicine	That the appropriate agency(ies) now in existence, in conjunction with other professionals, inclusive of persons already engaged in the Medical Cannabis Industry, and business persons, develop regulations and guidelines to regulate the medical cannabis industry, inclusive of establishing guidelines for the prescribing of cannabis and cannabis-based products for medical use, for issuing Medical Cannabis Cards (MCC), regulating dispensaries and pharmacies, and all other matters related thereto.
Recommendation 8 Authorization for Tourists to Be Able to Obtain Cannabis for Medical Use	That provisions be made for tourists who are prescribed cannabis for medical use in their own countries to obtain cannabis for medical use in The Bahamas. This can be facilitated by a Visitors Medical Cannabis Card issued by the appropriate authority.
Recommendation 9 Importation of Cannabis Based Products	That amendments be made to the DDA to allow for the importation of regulated cannabis-based products (such as CBD oils and other products) for the treatment of ailments.
Recommendation 10 Legalization of Cannabis for Medical and Scientific Research	That the necessary amendments be made to the DDA that will facilitate and regulate the legalization of cannabis for medical and scientific research, thus bringing the country a step closer to compliance with the relevant international conventions.
Recommendation 11 Decriminalization of Possession of One Ounce or Less for Personal Use for Persons 21 Years or Older	That the necessary amendments be made to the DDA to maintain that possession of cannabis is illegal for recreational use, but to decriminalise the possession of small amounts. That the amount of cannabis that a person over the age of 21 years can possess and for personal use and not receive a criminal record be one ounce. However, it is recommended that further consideration is needed in establishing the age that a person can be in possession of cannabis without obtaining a criminal record

	so that those persons under the set age will not be excluded as a beneficiary of any decriminalization policy change.
Recommendation 12 Increase in Drug Treatment Facilities & Professionals	That if cannabis possession is decriminalised, sufficient Drug Treatment and Rehabilitation facilities and health care professionals be made available, should drug use rise.
Recommendation 13 Regular Review of the Amount of Cannabis Approved for Decriminalization	That the amount set for decriminalization be reviewed every two years after comprehensive analysis/impact studies are conducted.
Recommendation 14 Expungement of Criminal Records for Simple Possession of Cannabis	That the relevant laws be amended at the earliest opportunity for the immediate expungement of the criminal records of all persons convicted of possession of cannabis. It is also recommended that consideration be given to reviewing, on a case by case basis, instances where persons were convicted for possession with intent to supply and the amount was less than the threshold amount considered for any decriminalization policy change.
Recommendation 15 Protection of Rights of Employees prescribed Cannabis for Medical Use	That legislation be drafted that will protect the rights of all employees from discrimination or job loss who are using cannabis for medical purposes and are the holders of an MCC.
Recommendation 16 Legalization of Cannabis for Sacramental Use by Rastafarians	That the DDA be amended to allow Rastafarians, and other religious groups with cannabis as a sacrament, to possess and use cannabis for sacramental purposes.
Recommendation 17 Allowance of Rastafarians to Cultivate Cannabis for Sacramental Use	That the DDA be amended to allow for authorised Rastafarian groups, and other religious groups which use cannabis as a sacrament, to cultivate cannabis for sacramental use in zoned and regulated areas.
Recommendation 18 Establishment of a Rastafarian Council to Regulate Rastafarian Groups	That provision be made for the establishment of a Rastafarian Council or Board to register and regulate approved and established Rastafarian organisations.
Recommendation 19 Establishment of an Independent Authority to Regulate and Oversee the Cannabis Industry	That an independent Authority be established that will have responsibility for regulating the Cannabis Industry, with responsibility for overseeing and granting licences for the procurement of seeds, the cultivation, processing, distribution and transportation of cannabis within The Bahamas for medical, research and export purposes.

Recommendation 20 Businesses in Cannabis Industry to be a Minimum of 51% Bahamian Owned	That provisions be made in law to ensure that any business involved in the Cannabis Industry is Bahamian owned with Bahamian ownership being at least 51%, and that foreign companies can partner with Bahamians and can hold up to a maximum of 49% equity in the company. Provisions must be made to ensure that there is active involvement of Bahamians in all aspects of a licensed business.
Recommendation 21 Taxation of the Cannabis Industry	That provisions be made for the taxation of the Cannabis Industry and that the funds generated from the taxation be utilised to operate the Independent Authority and to regulate the industry. It is recommended that taxation should not be excessive.
Recommendation 22 Country Wide Education & Public Relations Campaign	That a country wide appropriately funded education and public relations campaign be immediately launched. This launch should be done before any changes to legislation or policies. That a campaign be launched which includes infomercials, documentaries, public service announcements (PSAs), and the use of local celebrities and personalities. That the material in said campaign be age appropriate and target all segments of society, with particular focus being placed on school children and persons under the age of 21 years.
Recommendation 23 Development of Drug Information Systems to support evidence-based decision making at all levels	That adequate resources be made available to ensure the periodic implementation of societal cost studies, drug prevalence and other surveys targeting the general population and other high-risk groups. That a cultural shift be introduced to ensure that all drug-related institutional and/or administrative data is complete, accurate and timely and that the information generated is made available in appropriately detailed reports at every organizational and national level.
Recommendation 24 Legalization of Recreational Use of Cannabis	That more data be explored to enable the Commission to come to a consensus regarding the legalization of cannabis for recreational use.

COMMENTARY ON DECRIMINALIZATION vs LEGALIZATION FOR RECREATIONAL USE

It should be noted that the Commission recommended decriminalization of up to one ounce of cannabis (Recommendation 11) but did not come to a consensus on the legalization of the recreational use of cannabis (Recommendation 24).

Commissioners are aware that decriminalization is in effect a form of legalization of the recreational use of cannabis, as it is in effect authorising persons to possess up to an ounce of cannabis. It is recognised that this poses a paradox, as decriminalization on its own does not provide a legitimate and legal means for persons to obtain their supply of cannabis. It is appreciated that decriminalization may further facilitate the already existing illegal "black market" for persons to obtain cannabis, which has its inherent law enforcement challenges. Over the years, statements from the Ministry of National Security and the Royal Bahamas Police Force (RBPF) have confirmed that "turf wars" in the illicit drug market, which on the local scene involves predominantly cannabis, has resulted in the commission of violent crimes.[184], [185]

If, alternatively, provisions are made for regulated facilities to supply less than an ounce to persons 21 years and older in an attempt to eradicate or reduce the "black market", this is in effect the legalization of the use of cannabis for recreational purposes.

Some Commissioners were not prepared, at this time, to recommend the legalization of cannabis for recreational use. While Canada recently legalised cannabis for recreational purposes, as well as several states in the US, these Commissioners are of the view that there is insufficient information to assess the full societal impact of moving in this direction.

Some Commissioners therefore recommended that more research be done, and additional data be obtained to make an informed and responsible decision on the legalization of recreational use of cannabis at this time. It is also suggested that if cannabis possession is decriminalised in The Bahamas, comprehensive data be collected over the next few years to determine the societal impact this will have on drug prevalence, crime and other social issues. After this information is collected and analysed, it is suggested that this issue be revisited.

Alternatively, other Commissioners are of the view that cannabis should be legalised for recreational use for persons 21 years and older. They are of the view that legalization of cannabis for recreational use will reduce the inherent criminal activities associated with the "black market" and will provide avenues for cannabis users to get better products from legitimate sources.

This group of Commissioners are also of the view that the revenue generated from the sale of cannabis for recreational cannabis will provide enormous economic benefits for The Bahamas.

[184] www.bahamasb2b.com/news/2011/06/44-per-cent-of-murders-committed-in-bahamas-are-drug-related-9284.html

[185] https://www.refworld.org/cgi-bin/texis/vtx/rwmain?page=printdoc&docid=58a5abff4

CHAPTER 13: CONCLUSION

This Preliminary Report outlines the initial findings of the Commission in fulfilment of its primary mandate to codify the views of Bahamians on all things related to cannabis.

In its engagement with members of the public, through various fora, it was obvious that there were divergent levels of knowledge about this issue. The need for more education is essential to ensuring that Bahamians engage in informed discussions that are based on facts, and not just emotions. The content of this report will stimulate and inform the debate allowing persons to have the "facts" to support their reasoning.

Another part of the Commission's mandate was to make recommendations to the Government on all things cannabis, and thus the 24 recommendations are provided for their consideration. The recommendations are not all inclusive, and Commissioners recognise that more work has to be done to ensure that whatever decisions the Government makes, same are made after reviewing the best available information. The recommendations, though, give sufficient impetus to further the debate and guide the decision-makers.

In summary, the Commission's recommendations support, for the most part, the medical use and ceremonial use of cannabis; however, recreational use remains an unresolved issue. Further data will be explored, and more persons engaged in discussion, to enable the Commission to come to a consensus regarding the legalization of cannabis for recreational use.

It is recognised that there are a number of significant, pressing issues. Amongst these are the following:

- Amendments to the DDA, and any other legislation, that will ensure that there is a comprehensive legislative framework in place to regulate all issues relating to cannabis
- Alternatives to incarceration

  There are many models and suggestions that have been considered by established organizations that may achieve the desired objectives related to the issue of decriminalization.

During the ensuing process of reform, a culture must be established that will ensure that any decisions or changes made take into consideration issues such as:

- human rights
- proportionate application of the laws
- evidenced-based decision making
- public health issues relating to use, abuse and mental health issues
- compatibility with internationals standards and conventions

Moving forward, it will be necessary to ensure that relevant and critical information is properly collected, collated and analysed, and that this information is easily accessible to ensure that decisions are made based on scientifically supported data.

This Report is the culmination of the critical and diligent work of the Commission. It is one small step on a long journey that this country must embark upon, moving forward. It is not the end of the Commission's

work as the Commission has agreed to conduct a national survey and to present the findings of the survey, with the analyses of the results, to the Government within the shortest possible time.

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APPENDICES

Appendix I: List of Meetings with the Public and Stakeholders

TABLE 1: TOWN HALL MEETINGS HOSTED BY THE COMMISSION

Date of Meeting	Island	Location
24th January, 2019	Marsh Harbour, Abaco	St. John The Baptist Anglican Church Hall
22nd March, 2019	Central Eleuthera	St. Patrick's Hall
10th April, 2019	George Town, Exuma	Community Centre
26th June, 2019	New Providence	St. John's College Auditorium
27th June, 2019	Grand Bahama	Foster B. Pestaina Auditorium, Freeport

TABLE 2: SPEAKING ENGAGEMENTS

Date of Meeting	Organisation	Location
16th January 2019	Rotary Club of South East Nassau	New Providence
11th March 2019	Rotaract Club of East Nassau	New Providence
20th June 2019	Bar Association & University of The Bahamas Public Forum	University of The Bahamas New Providence
26th June 2019	New Providence	St. John's College Auditorium
27th June 2019	Grand Bahama	Foster B. Pestaina Auditorium, Freeport

TABLE 3: OTHER STAKEHOLDERS MEETINGS

Date of Meeting	Organisation	Location
24 January 2019	Abaco Christian Council	Abaco
10th April, 2019	Nursing & Allied Health Staff	Exuma
10th April, 2019	Chief and Deputy Chief Councillor et al	Exuma

Appendix II: Prepared Questionnaire used by the Commission in Conversations with the Bahamian Public

BAHAMAS NATIONAL COMMISSION ON MARIJUANA
OPINIONS ON MARIJUANA

Sex		Male		Female

AGE		18 – 24 years		25 – 34 years		35 – 44 years		45 – 54 years
		55 – 64 years		65 years or older				

	Indicate whether your rating where 1= strongly disagree 5 = strongly agree				
	1	2	3	4	5
I feel that I have enough information about the benefits or harm of marijuana.					
I feel that marijuana is physically addicting.					
I feel that marijuana makes people less violent.					
Using marijuana makes people more likely to try other drugs.					
Marijuana possession and use should be decriminalized.					
People who are arrested for small amounts of marijuana (e.g. with one cigarette) should only have to pay a fine.					
People who are arrested for possession of large quantities of marijuana should be fined and/or sent to jail.					
I feel that marijuana should be legalized for medical use.					
I feel that marijuana should be legalized for recreation (personal) use.					
I feel that marijuana should be legalized for religious/ceremonial purposes.					
I feel that marijuana should be legalized for research purposes.					
If marijuana is legalized for medical purposes, the sale should be restricted to pharmacies and designated stores.					
If marijuana is legalized for medical purposes, persons should be allowed to grow sufficient for their medical needs.					
If marijuana is legalized for recreational purposes, persons should be allowed to grow sufficient for their personal use.					
If marijuana is legalized for recreational purposes, persons should be allowed to use it in public.					
If marijuana is legalized for recreational purposes, I feel that there should be a minimum age for persons who should be allowed to use it.					
If marijuana is legalized for industrial/economic purposes, the majority of shareholders of that business should be Bahamian.					

APPENDIX III: Report of the Commission's Trip to Jamaica

Mission:

Fact Finding Mission - Bahamas National Commission on Marijuana
Date: Tuesday 8th – Friday 11 October 2019
Location: Kingston, Jamaica

Delegation:

- Co-Chairs: Mr. Quinn McCartney and Bishop Simeon Hall
- Commissioners: Mrs. Chargrega McPhee-McIntosh, Mr. Kenneth Wallace-Whitfield and Mr. Rithmond McKinney
- MoH Representative: Mrs. Annouch Armbrister

Jamaica Overview

- Every household can grow five (5) plants within their home for medicinal or therapeutic use, no restriction on size of plant;
- Possession of two (2) ounces or less of cannabis no longer a criminal offence;
- Can be used for sacramental purposes for the Rastafarian faith
- Only Cannabis Licensing Authority (CLA) can issue licenses. There are five (5) licensing categories for cannabis: cultivation, research and development, transportation, processing and retail.
- Cannabis is still illegal, cannot be traded on the open market.

Meeting Notes:

1. Meeting with Cannabis Licensing Authority (CLA)

Several presentations were conducted on Regulatory/Legal Framework; Licensing /Application; and Enforcement.

The CLA is the regulatory body charged with oversight of all things related to raw cannabis regardless of form i.e. liquid, solid or powder. Any alteration of or the addition to cannabis from its raw state removes authority from CLA to the Ministry of Health.

CLA serves as a broker during the sale process i.e. they take control of cannabis from farmers under tripartite agreement.

The need for strong involvement of herbalist/traditional bush medicine expertise recommended as they were involved or were users of cannabis before medical restrictions. There is a need to control their intellectual property.

Licensing process extremely lengthy and detailed, can take between 6 months to 1 year for approval due to license type and set up requirements. Very stringent guidelines in place for licensing and enforcement, which are sometimes viewed as a hindrance i.e. only accepting completed applications, companies must have 51% or more local ownership, individuals can only apply for cultivation license.

Strong security and monitoring in place as CLA is required to be present during harvesting. A track and trace software is used to remotely monitor all sites; the system has the capability to identify, reconcile, access control and conduct surveillance.

Agency funded by the government, but fees are retained by the CLA and not transferred to government. Approximately 65 staff across 9 units.

Current focus on:

- need to create/sustain strong barriers between legal and illegal trade;
- need to ensure the safety and security of the average man to remain in the industry; and
- review of models to develop standards programmes to teach how to properly cultivate – how to go from seed to sale.

2. Site Visit – Retail Herb House with consumption

The group was given an oversight of the operations of the Herb House.

It was noted that the consumption room was located in a separate enclosed area with the store but away from the retail operations of the business.

There was no resident physician onsite, but one was readily available via phone. Staff were very knowledgeable about the products and provided a basic overview. Appeared to be a standard as another site was visited by one of the delegates who had the same experience, without the retailer being aware that they were part of a fact-finding mission.

3. Meeting with Mr. Mark Golding, Former Minister of Justice

Former Minister responsible for overseeing the reform of legislation in 2015.

It was noted that policy position of the United States at that time made it easier to regulate the industry.

A Statutory Rastafarian Advisory Council/Committee was established to oversee all things specific to this grouping i.e. application process, ensure that is group has access to land, ensure authenticity of persons claiming to be part of the faith. Seen as a strong component, however, the law limits economic advances for the Rastafari faith. No attempts were made to describe/define who and what is a Rasta in the Act. Council no longer functioning. Concerns of this grouping does not appear to be a major concern or priority.

Process took about 2 – 3 years from consultation to passing of Act. Regulations were created 6 months following establishment of Licensing Authority. A parliamentary review of all laws is needed. The short time frame created minor challenges but there was no real criticism of the process used.
The report to support the decriminalization of cannabis was prepared by BOTEC Analysis, a research and consulting firm.

It was noted that cigarettes and cannabis are treated equally.

Export still remains an issue, no legal authority or export regulations. There was one (1) case processed through the Ministry of Health for the transfer of a small quantity of cannabis between Jamaica and Canada, but it was more of an exploratory process to determine whether it could be done.

4. ***Meetings with:***
   (1) Ms. Monique Gibbs, Chief Technical Director – Ministry of Industry, Commerce, Agriculture and Fisheries;
   (2) Hon. Floyd Greene, Minister of State - Ministry of Industry, Commerce, Agriculture and Fisheries and Team;
   (3) Ministry of Justice

Still in the process of building the industry. Significant strides made especially the apology to the Rastafarian Community for action taken during the 1963 Coral Gardens Incident.

Cannabis is basically a weed in Jamaica and the process was relatively smooth as it was engrained in the culture.

All education conducted by CLA as they are the authority; strong support and collaboration between CLA, Ministry of Industry, Ministry of Bureau and Standards and Ministry of Health.

It was noted that there is concern about the negative connotation with the placement of cannabis under the Dangerous Drugs Act; considering changing which Act it should fall under.

In the process of developing medical tourism policy; as well as cannabis policy to ensure no sector is excluded or persons disadvantaged, especially religious groupings.

An Alternative Development Project was developed to ensure small farmers remain in the field. A step towards moving farmers from illicit to licit operations and a way to boost entrepreneurship. Encouragement of community groupings as there is a high cost for development.

Extensive research and development being conducted by University of the West Indies (UWI), University of Engineering and Technology (UTEC) and The Howard Institute.

It was suggested that if significant change regarding cannabis, the region needs to speak as one versus individually.

It was noted that expunged records are fully expunged and not only removed from the police database; no record of the conviction exists once it is expunged. Previous convictions cannot not be disclosed to anyone.

No specific training or certification needed to prescribe or recommend cannabis as treatment.

There is great collaboration between the Ministry of Health and the Cannabis Licensing Authority.

A review of “A Report of the National Commission on Ganja to the PM of Jamaica” by Barry Chevannes was recommended.

Suggested attention be given to the issue of culture change and culture management especially as it relates to: general public, law enforcement and the international arena.

5. Meeting with National Council on Drug Abuse (NCDA)

The agency made a presentation titled "The Aftermath of Marijuana Decriminalization", covering the following topics: local and regional context, NCDA's Response; and Gaps and Strengths.

The NCDA stressed the need for sustainability of any programmes/interventions, as well as need for appropriate infrastructure i.e. treatment centres.

It is imperative that proper protocols are established concerning the prescription of cannabis. Access to the medical cannabis must be monitored.
Several youth programmes developed with strong involvement of the youth population: STEP UP programmes – cannabis intervention programme and "Talk Di Truth" Campaign. The programmes were designed around youth needs and wants.

6. Meeting with Rastafarian Leaders

The main focus or aim of the community is on freedom, reparations and international repartition.

The amendments to the law have not resulted in any real change as they use it mainly for sacrament/ceremonial or medicinal purposes not general everyday use. Police do not search the camp for cannabis as they are aware that it is there, and it is used on spiritual grounds. Community has a strong foundation on the do's and don'ts of cannabis use i.e. do not smoke in public, or walking the streets, not to abuse the intended purpose as ordained by God.

The community a significant benefit from decriminalization. The youth are now able to receive clean police records and have the ability to obtain visas to attend college in the United States.

Commonalities

Throughout discussions the following comments/sentiments were noted:

- No backlash from the Christian community – appeared more concern with issues of gender, violence, etc. compared to the decriminalization of cannabis.
- Although smoking (cigarette/cannabis) in public is a ticketed offense, no tickets were produced for the smoking of cannabis in public.
- Strong public relations campaign needed to distinguish between decriminalization and legalization.
- Clear distinction between Pharmacy and Retail Herb Houses.

Expressions of concern:

Major downfall is the ability to utilise the banking system for the cannabis industry. It is predominantly a cash-based industry. Trade still seen as illegal and funds generated from same are viewed as gained from illegal means.

Special consideration should be given to the following areas:

- Impact on public health
- Indigenous impact
- Licencing
- Criminal defence
- Workplace safety
- Taxation
- Cannabis law
- Federalism and politics
- Protection on intellectual property

- Stakeholder involvement in drafting of Regulations

Major focus on enforcement and monitoring versus cultivation.

Lack of education on cannabis use especially youth use.