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COCAINE SYMPOSIUM REPORT

U.S. DEPARTMENT OF JUSTICE
OFFICE OF THE
UNITED STATES ATTORNEY
DISTRICT OF MAINE
PORTLAND, MAINE

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OCTOBER, 1986

ACKNOWLEDGEMENTS

This report was prepared by the United States Attorney's Office, District of Maine, with the assistance of the Maine Alcohol and Drug Abuse Planning Committee (ADPC). We wish to express our appreciation to the following individuals for their assistance in all aspects of the symposium:

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INTRODUCTION

INTRODUCTION

Background

During the past year (1985-86), a dramatic increase in the sale, distribution and use of cocaine in the State of Maine has caused serious concern among law enforcement agencies, alcohol and drug abuse service agencies, local, county, state and federal government officials and the general public. Indictments for cocaine trafficking and conspiracies to possess with intent to traffic in cocaine brought by the United States Attorney's Office, rose from 2 in 1983, to 13 in 1984, to approximately 95 for the period of 1/1/85 to 6/30/86. These indictments do not include cases brought into the State Court system.

To meet this new challenge to the existing law enforcement structure, the creation of multi-jurisdictional task forces were undertaken by the United States Attorney in several areas of the State. The purpose was to bring together local, county, state and federal law enforcement resources and create a sophisticated investigative unit capable of long term investigations into organized drug trafficking distribution networks. Prosecutorial assistance, direction and coordination is provided by the United States Attorney's Office with assistance from the State Attorney General and the District Prosecutors.

In August, 1986, the Maine Alcohol and Drug Abuse Planning Committee conducted a survey of selected Maine alcohol and drug abuse agencies to determine the number of individuals being treated for cocaine use/abuse. Of the 239 individuals in treatment (detoxification and rehabilitation) on the day of the survey, 31% were being treated for cocaine use/abuse: 1% cocaine "only", 12% cocaine/alcohol, and 18% cocaine and other drugs (including alcohol as a third drug). It is estimated that 825 cocaine users/abusers were treated in Maine free-standing detoxification and rehabilitation programs during the period of 7/1/85 - 6/30/86: 126 in detoxification and 699 in rehabilitation.

It has become increasingly evident to law enforcement that if any long term effect on the drug/use abuse problem in Maine is to occur, law enforcement must become more interrelated with existing prevention, education, invervention and treatment programs/services. It is also felt that a multi-faceted approach must be developed to impact cocaine use/abuse in Maine. This approach must include representatives of law enforcement, concerned citizens and all agencies and programs currently providing services in this field. In addition, these groups must explore new and innovative strategies for on-going programs concerning community awareness, prevention and intervention.

A Cocaine Symposium

In August, 1986, the United States Attorney, District of Maine, invited representatives of law enforcement, the Judiciary, the media, State Government, the Legislature, alcohol and drug abuse service agencies, public education, industry, and health care to participate in a process of identifying (1) problems/issues related to and (2) multi-disciplinary strategies for addressing community education/awareness concerning cocaine. Prior to the symposium, participants were presented with informational materials concerning cocaine [1] as well as a survey of alcohol and cocaine abuse in Maine.[2]

The one day symposium[3] was designed to (1) up-date the participants' knowledge concerning law enforcement and treatment related to cocaine in Maine and (2) utilize the participants as interdisciplinary "think tanks" to identify the problems/issues and strategies concerning community education/awareness of cocaine use/abuse in Maine. The morning included a plenary session on the Maine law enforcement perspective and cocaine, cocaine "demystified", and community education and awareness. Summaries of these presentations are included in this report.

The remainder of the symposium involved workgroup sessions which focused upon community education and awareness issues/problems and strategies from an interdisciplinary perspective. Three workgroups were established with representatives from each of the groups invited to the symposium. The groups were staffed by facilitators with specific guidelines.

1. Each group was to consider broad based and interdisciplinary strategies for identifying and addressing community awareness and education concerning cocaine use/abuse.

2. Both adolescents and adults were to be considered as target groups.

[1] These materials are available through the Maine Alcohol and Drug Abuse Clearinghouse, Department of Human Services, Augusta, Maine.

[2] Alcohol and Cocaine Abuse in Maine: A Follow-Up Survey. Alcohol and Drug Abuse Planning Committee, State House Station #11, Augusta, Maine (see Appendix B.)

[3] See Appendix A.

3. Each group was requested to organize its efforts by addressing the following areas:

   a. General education/awareness: e.g., what should the general public know about cocaine?

   b. Prevention education/awareness: e.g., what are the public education/awareness concerns/issues that need to be identified and addressed to prevent cocaine use/abuse among high risk groups?

   c. Intervention education/awareness: e.g., what are the public education/awareness issues that result in barriers to cocaine users/abusers or "concerned persons" in obtaining assistance?

4. Each group was requested to identify strategies to correct existing or establish new community education/awareness programs.

5. Each group was requested to collate and prioritize the identified problems, issues, and strategies. The workgroups accomplished this task in varying degrees due to time constraints.

The summary reports of these workgroups are contained in this document and this information will serve as the basis of future work sessions.

PLENARY SESSION SUMMARIES

The staff of the Alcohol and Drug Abuse Planning Committee (ADPC) summarized the presentations made during the plenary session. The purpose was to highlight the key points made by the presentors. These summaries are based upon recall as well as notes taken during the session. The summaries have been approved by the presentors as accurately reflecting the general ideas contained in their presentations.

[4] Dr. Dreher's presentation is available on videotape through the Resource Center of the Division of Alcohol and Drug Education, Maine Deparmtent of Educational and Cultural Services. The title of the videotape is "Cocaine - A Line is Too Many, A Thousand's Not Enough".

SUMMARY OF

COCAINE: THE LAW ENFORCEMENT PERSPECTIVE

Richard S. Cohen
United States Attorney
District of Maine
Portland, Maine

Historical Perspective

The attractive qualities of the State of Maine and its 3,500 square mile coastline that encourages tourism and recreation on our coast, unfortunately has a similar appeal to the smuggler. Smuggling in Maine is certainly not a new phenomenon, and during the late 1970's and through 1983 it became quite common to smuggle marijuana in large quantities into our State for distribution outside our boundaries. During this period, over 200 tons were seized and over 200 major traffickers were indicted.

In late 1983 and 1984, a change in the drug smuggling patterns and activities was identified, with less marijuana "mothership" traffic and more cocaine vehicular and aircraft traffic. Initially, large quantities of cocaine were flown to Maine directly from South America for distribution outside of the State; however, this soon gave way to smaller quantities coming in from other points in southern New England and the southeastern United States for trafficking within the State of Maine. Street trafficking became increasingly more prevalent and with it came a dramatic increase in violence and derivative crime.

It became imperative that Maine law enforcement agencies develop a response to address cocaine and its associated problems. Through the efforts of the United States Attorney, cocaine task forces were created which comprised local, county, state and federal investigators and prosecutors from the District Attorney's Office, the State Attorney General's Office and the United States Attorney's staff. These task forces were the first integrated and coordinated effort for the investigation and prosecution of cocaine cases. The Cumberland County Cocaine Task Force, the first to be established, is now beginning its second year. York County and the Tri-County area of Piscataquis, Penobscot and Hancock are two other task force areas.

Observations

In comparison to marijuana, a great deal of violence and derivative crime has been associated with cocaine trafficking. In 1985, 5 Maine homicides were directly related to cocaine trafficking. Increased numbers of Hispanic and Colombian traffickers began to show up in Maine because the demand for cocaine was there and law enforcement was relatively sparse. As the drug trafficking increased, it

became evident that larcenies and burglaries in many areas were directly related to cocaine use/abuse, and in the major metropolitan areas of southern Maine armed robberies related to cocaine use/abuse were identified.

Resolution of the Cocaine Problem in Maine

The State of Maine must develop a single, but comprehensive, response to address the cocaine problem. Law enforcement is only one component of the solution. Combined prevention, education, treatment, and enforcement efforts are necessary to solve this problem in Maine. A broad-based community alliance comprised of law enforcement, parents, government officials, educators, business, and other interested citizens must be established to identify local/state needs, develop meaningful strategies, and implement appropriate programs/services.

SUMMARY OF

COCAINE: DEMYSTIFIED

George (Joe) Dreher, M.D.
Medical Director
Chemical Dependency Unit, St. Mary's Hospital
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History

Cocaine is not a new drug. Natives in the Andes have chewed coca leaves for thousands of years as a means of relieving fatigue, stress, and hunger. In the 1840's cocaine was purified and found to have unparalleled capabilities as a local anesthetic. In the 1880's, Freud prescribed cocaine for patients suffering from gastritis, depression, and alcoholism. It soon became apparent that people had difficulty controlling their use of cocaine and that cocaine was a potent and potentially dangerous drug.

Cocaine is used because it gives the individual a feeling of power and mastery and makes them feel good. It stimulates the brain's reward center resulting in instant gratification. This short lived "upper" is followed by a "downside crash" with depression and fatigue. With continued use, tolerance develops and the user needs more cocaine to reach the high while experiencing greater "crashes" and depression. The increased use may lead to other medical problems such as increased heart rate and blood pressure, seizures, increased autonomic behaviors, sudden death, hyperthermia, strokes, infection, dental decay, and sexual dysfunction. Emotional effects include wide mood swings, a false sense of assurance, the lack of long term goals, little personal insight, self centeredness, restlessness, paranoia, etc.

Approximately thirty percent (30%) of cocaine users will have significant problems with cocaine. Ten percent (10%) will show recurring problems and dependency. Experiments conducted with rhesus monkeys reveal the profound effects of cocaine use. Three groups of monkeys were exposed to free (bar pressing) access to caffeine, or heroin, or cocaine. After becoming accustomed to the drug, the bar press no longer delivered the drug and the monkeys went through withdrawal. During this "no drug period", the caffeine monkeys pressed the bar an average of 250 times, the heroin monkeys averaged 4,000 bar presses, and the cocaine monkeys averaged 10,000 bar presses. Most of the cocaine monkeys died because they didn't care for themselves once they became cocaine dependent.

Indicators of Dependency

It's difficult to pre-determine who is likely to end up in trouble with cocaine. Individuals who have a family history of alcoholism appear to be at a higher risk of cocaine dependency. Other warning signs include compulsive use of the drug, "loving" the drug at first use, use of other drugs to take the "edge" off the cocaine, and the inability to control use.

Treatment

There are no obvious physical symptoms of withdrawal from cocaine. Psychologically, the reward centers have been dulled and the individual isn't experiencing much positive reinforcement, may be depressed and unstable, and has a strong craving to use cocaine. Treatment is often very difficult. The individual requires a lot of education to understand what's happened to him/her due to drugs and support to avoid drugs and begin the process of recovery. Help is available for the user and his/her family in the form of self-help groups, outpatient counseling programs, and rehabilitation programs. Recovery is a long term process. Relapse occurs most frequently among those individuals who are not strongly committed to participation in support groups and ongoing counseling.

SUMMARY OF

COMMUNITY EDUCATION AND AWARENESS

Dr. Gerald Edwards
Director, Northeast Regional Training Center
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Sayville, New York

Dr. Gerald Edwards led a brainstorming session of symposium participants to develop a list of reasons as to "why people use drugs." The list included, but was not limited to, the following: to feel good, alleviate stress, curiosity, excitement, a sense of power, rebellion, experimentation, and peer approval. He noted that although people often seek single methods for addressing the drug problem, the list developed by the participants showed that no one program or strategy can solve the problem. He called for a multidimensional approach to address the complexities of the drug problem and the mobilization of diverse interests and human and financial resources.

Due to the confusion about and the misuse of the term prevention, Dr. Edwards expressed the need for clarity. He defined prevention activities as proactive experiences which increase the individual's capability to successfully manage potentially difficult life situations. The spectrum of programs in a system ranges from prevention (everything is ok), to early intervention (the problem is evident), to treatment (trauma has occurred).

Symposium participants were urged to "fire many bullets" at the problem and to build upon each other's expertise, rather than divide due to conflicting perspectives. Dr. Edwards outlined the potential spectrum of programs by the following acronym:

F Family programs
A Alternatives
C Counseling
E Education
S Social

WORKGROUP SUMMARY REPORTS

Each workgroup was requested to identify priority issues/problems and strategies related to public education and awareness. Whereas this was the first time that many of the group members had met to discuss these problems, and time was limited, a significant amount of time was spent identifying and clarifying the individual issues. Thus, while Group A collated and prioritized its material, Group B and C tended to focus upon the broad range of issues and potential strategies.

The following pages present the issues/problems and strategies identified by each workgroup. The material is organized to relate the issues/problems to the three areas of community education/awareness (General, Prevention, and Intervention). This is followed by a listing of strategies and workgroup participants.

The information was edited and organized by the ADPC staff to provide format and reporting consistency. The final product was reviewed by all participants to assure that their ideas were clearly reported.

WORKGROUP A SUMMARY REPORT

Facilitators: Steve Ranslow and Barbara Sparks

A. GENERAL EDUCATION AND AWARENESS (e.g., what should the general public know about cocaine?)

- o Cocaine use/abuse destroys families - socially, emotionally, and financially.
- o No one is immune to cocaine.
- o Cocaine abuse is only part of a larger chemical dependency problem.
- o Cocaine can be lethal.
- o The "cocaine problem" is real.
- o Information dissemination is difficult.
- o Existing resources are inadequate.
- o The public is apathetic.
- o The media glamorizes cocaine use/abuse.

B. PREVENTION EDUCATION AND AWARENESS (e.g., what are the issues that need to be identified and addressed to prevent cocaine use/abuse among high risk groups?)

- o Educational programs are needed within home and school settings to teach children about cocaine (and other drugs), self esteem, and decision-making.
- o Media glamorization of cocaine and other drug use.
- o Prevention resources are inadequate.
- o Drug use is a "learned" lifestyle.
- o Lack of an easily identifiable symbol (e.g., Smokey the Bear for fire prevention).

C. INTERVENTION EDUCATION AND AWARENESS (e.g., what are the barriers to obtaining assistance for cocaine users/abusers and concerned persons?)

- o Existing human and financial resources for intervention services are inadequate.

- Accessibility of intervention services is limited.
- Denial of "the problem" by the abuser and family members.
- Professionals need information concerning identification of "the problem" and available services.
- Family support groups are needed.
- The "big picture" must be considered and simplistic approaches avoided.
- More law enforcement personnel are needed.

D. STRATEGIES

- Apply the knowledge gained from the national and state efforts to reduce cigarette smoking to alcohol and other drug abuse.
- Conduct more education/awareness sessions regarding alcohol and other drugs.
- Encourage a "team" approach to problem solving and working together.
- Involve the private sector, community service organizations, and recovering individuals in program development and implementation.
- Educate all legislators concerning alcohol and other drug abuse.
- Increase the public's awareness regarding existing resources.
- Discuss problems and concerns regarding alcohol and other drug abuse openly.

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WORKGROUP B SUMMARY REPORT

Facilitators: Madonna Flanders and Peggy Thayer

A. GENERAL EDUCATION AND AWARENESS (e.g., what should the general public know about cocaine?)

- o Basic information concerning cocaine is needed; i.e., its effects on individuals, deceptive nature, potential costs to users/abusers, dangers, and consequences of "recreational" use.
- o Cocaine is a problem in Maine - both in rural and urban areas.
- o Law enforcement alone can't solve the cocaine problem.
- o The public needs to know the legal ramifications of cocaine use.
- o Information is needed regarding how to recognize whether someone is using cocaine and the available resources.
- o Cocaine is a major industry involving large amounts of money and violent crime.
- o Knowledge alone won't solve the cocaine problem.
- o Information is needed concerning the effects, outcomes, and relationship between cocaine and other drugs.
- o Cocaine use has been portrayed as being glamorous and acceptable as a recreational activity.
- o Existing funding for cocaine and other drug programs/services is inadequate.

B. PREVENTION EDUCATION AND AWARENESS (e.g., what are the issues that need to be identified and addressed to prevent cocaine use/abuse among high risk groups?)

- o High risk groups need to be identified (who? where? characteristics?)
- o Prevention activities need to teach more than just drug education, e.g., social skills, decision making skills, etc.

- o The role of peer pressure needs to be understood and approaches/methods which use positive peer pressure need to be developed.

- o Realities of unstable social environments, poverty, dysfunctional families (chemically dependent), low self-esteem, and inappropriate adult role models.

- o Need for immediate gratification, "quick fix" mentality, and media glamorization of cocaine.

- o Lack of early detection of those at risk - potential hereditary or biochemical factors.

- o Role of drug testing in prevention of cocaine use/abuse.

- o Reasons why some individuals who are at risk do not become involved with drugs.

- o Need to define the cocaine issue (is it cyclical, a phase, etc.)

- o Information is needed regarding the health effects of cocaine.

C. INTERVENTION EDUCATION AND AWARENESS (e.g., what are the barriers to obtaining assistance for cocaine users/abusers and concerned persons?)

- o Denial that drug use is a problem by the abuser and concerned persons.

- o Fear of repercussions and reprisal.

- o Lack of knowledge regarding abuse/addiction, when/where to seek treatment, and how to intervene as a concerned person.

- o Lack of and/or inaccessibility of treatment (geographic, economic barriers, etc.)

- o Lack of confidence in treatment providers and of treatment effectiveness.

- o Personal attitudes: shame, guilt, remorse, negative peer pressure; parental rejection of addicted child; treatment's unnecessary; etc.

- o Treatment/recovery is a long-term process.

- o Lack of adequate child care.
- o Lack of E.A.P. programs and support from schools and employers.
- o Poor family communication.
- o Gatekeepers (guidance counselors, physicians, lawyers, clergy, etc.) need training concerning drug use/abuse.
- o Enforced treatment (as part of probation or sentencing) is not effective.
- o No way to intervene with family members of defendents who are addicted.

D. STRATEGIES

- o Develop a variety of educational programs: in schools, communities, Head Start, and for parents.
- o Identify geographic areas where the risk of drug use is high and develop programs that allow for family involvement.
- o Increase access to programs through the provision of transportation.
- o Provide opportunities (in addition to sports) for children to excel and build self-esteem.
- o Develop a long range plan for programming.
- o Target the school age population - involve students in developing strategies and local initiatives (school/community teams with tie in to State), work with kids outside of schools, and develop school substance abuse teams to deal with individual cases.
- o Develop a comprehensive adolescent treatment program (including peer programs).
- o Involve social and service clubs in developing and implementing programs.
- o Develop local task forces to share information and coordinate activities in their community.

- Recognize the inter-relationship of alcohol and other drugs (don't focus on one drug) and provide flexibility in program funding.

- Work through corporate groups to bring pressure on the media to discourage drug use.

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WORKGROUP C SUMMARY REPORT

Facilitators: Lisa Kavanaugh and Ron Speckmann

A. GENERAL EDUCATION AND AWARENESS (e.g., what should the general public know about cocaine?)

- Public isn't aware of the physiological and psychological effects of cocaine; e.g., highly reinforcing, addictive, long-term harmful effects, physical and social costs, etc.
- Cocaine is illegal - public may not be aware of legal sanctions and these sanctions must be enforced.
- Cocaine is too available and its use/abuse can affect anyone - need to be aware of and understand why individuals use cocaine.
- Individuals need to know that crack is cocaine.
- Individuals need to be aware of the "costs" of using/abusing cocaine - lost production, family disintegration, personal health, legal consequences, etc.
- Glamorization of cocaine use and users by the media.
- The extent of the "problem" must be determined - need local and state statistics.

B. PREVENTION EDUCATION AND AWARENESS (e.g., what are the issues that need to be identified, and addressed to prevent cocaine use/abuse among high risk groups?)

- Individuals are labeled and categorized by the drug(s) they use/abuse.
- Many educational approaches/programs lack credibility because they emphasize the negative aspects of drug use/abuse (i.e., "scare tactics").
- People need to learn life management and decision making skills, e.g., saying "no" to drugs.

- o Drugs are illegal - consequences of illegality must be publicized.
- o Approaches to addressing drug abuse are often inconsistent.
- o Knowledge of cocaine and other drug abuse as a disease is needed.
- o "High risk" groups need to be identified. (Note: Workgroup C expressed concern regarding this term.)
- o Individuals deny that cocaine and other drug use/abuse is a problem.

C. INTERVENTION EDUCATION AND AWARENESS (e.g., what are the barriers to obtaining assistance for cocaine users/abusers and concerned persons?)

- o Addiction is often denied by the abuser and significant others.
- o Users/abusers aren't certain that it's "safe" to seek treatment.
- o "Code of silence" exists regarding drug use/abuse and sources of drugs.
- o Personal attitudes prohibit individuals from seeking treatment; i.e., seeking treatment isn't "cool", only wimps seek treatment.
- o Treatment professionals lack credibility with users/abusers and the general public.
- o Adequate funding for treatment programs does not exist.
- o Access to treatment programs is limited (e.g., transportation problems, inability to pay, etc.).
- o Public apathy regarding the use and abuse of cocaine and other drugs.
- o "Messages" (public service announcements, commercials, etc.) aren't available which provide information for the public regarding where to go for help.

D. STRATEGIES

- o Develop K-12 curriculum regarding all drugs and implement statewide.
- o Further develop and implement a variety of enforcement methods and swift court action.
- o Recriminalize marijuana.
- o Provide better drug education and training to professionals, i.e., physicians, judges, teachers, etc.
- o Develop a variety of approaches which use former cocaine abusers as role models.
- o Develop and provide high quality treatment programs.
- o Develop a variety of approaches/methods to convince the criminal justice system that cocaine and other drug use is a problem.
- o Encourage local community groups, schools,and agencies to work together to develop meaningful local strategies and programs.
- o Support employers regarding their efforts to ensure a drug-free workplace, e.g., drug testing of workers, E.A.P.s, etc.
- o Develop activities that are alternatives to drug use/abuse.
- o Develop a comprehensive, multi-faceted approach to cocaine and other drug abuse - education, prevention, treatment, and enforcement are necessary components.
- o Identify societal conditions which contribute to drug abuse and develop appropriate solutions.

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APPENDIX A

Symposium Agenda

APPENDIX A

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COCAINE SYMPOSIUM

Holiday Inn
Western Avenue
Augusta, Maine
August 14, 1986

AGENDA

8:30 - 9:00	Registration/Coffee-Juice-Danish
9:00 - 9:30	Symposium Purpose/Goals/Objectives Cocaine: The Law Enforcement Perspective United States Attorney Richard S. Cohen
9:30 - 10:30	Cocaine - "Demystified" George (Joe) Dreher, M.D. Chemical Dependence Unit St. Mary's Hospital Lewiston, Maine
10:30 - 10:45	Coffee/Juice
10:45 - 12:30	Work Groups Cocaine - Community Education and Awareness Issues/Problems/Strategies 1. Work Group Charge Dr. Gerald Edwards Director, Northeast Regional Training Center Adelphi University Sayville, New York 2. Work Group Sessions
12:30 - 1:30	Lunch
1:30 - 3:00	Reports of Work Group Sessions 1. Report on Issues and Strategies 2. Discussion of Strategies 3. Future Activities Dr. Gerald Edwards Richard S. Cohen, United States Attorney
3:00	Summary and Conclusion United States Attorney Richard S. Cohen

APPENDIX B

Alcohol and Cocaine Abuse in Maine

A Follow-Up Survey

APPENDIX B

DRAFT

Alcohol and Drug Abuse Planning Committee
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TEL: (207) 289-2595

Alcohol and Cocaine Abuse in Maine
A Follow-up Survey
August, 1986

Prepared by the staff of the Alcohol and Drug Abuse Planning Committee

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ALCOHOL AND COCAINE ABUSE IN MAINE

A Follow-up Study

August, 1986

In October, 1985, The Alcohol and Drug Abuse Planning Committee (ADPC) conducted a survey of selected Maine alcohol and drug abuse agencies to determine the number of individuals being treated for cocaine use/abuse. Of the 235 individuals in treatment (detoxification and rehabilitation) on the day of the survey, 42% were being treated for cocaine use/abuse; 9% were cocaine "only" and 33% were cocaine/alcohol.

Since this survey, the news media, alcohol and drug abuse service agencies, and concerned individuals have reported a significant increase in the sale, distribution and use of cocaine. For example, the United States Attorney, District of Maine, reported that the number of Federal indictments for cocaine conspiracy and trafficking rose from 2 in 1983 to 13 in 1984 to approximately 95 for the period between 1/1/85 - 6/30/86. Informal discussions with service providers suggested that there was a dramatic increase in the number of clients being treated for cocaine use/abuse. Based upon this information, it was determined that a follow-up survey of service agencies was necessary.

The purpose of this follow-up survey was to determine if the reported increases in the availability and use of cocaine was having an effect upon the client populations in Maine alcohol and drug abuse detoxification and rehabilitation programs. In August, 1986, the ADPC staff surveyed 12 detoxification (3 free standing and 9 hospital) and 11 rehabilitation (5 free standing and 6 hospital) programs. The following data was requested: (1) the number of individuals with the presenting problem of cocaine abuse, cocaine/alcohol abuse, or the abuse of cocaine and other drugs, (2) the number of these individuals who had used crack, and (3) the number of these individuals that had used drugs intravenously and the drug injected.

Results:

a. At the time of the survey, 239 individuals were in treatment in Maine alcohol and drug abuse detoxification (N = 52) and rehabilitation (N = 187) programs.

b. 31% (N = 73) of the treatment population were being treated for cocaine use/abuse; 1% "cocaine only", 12% cocaine/alcohol, and 18% cocaine/other drugs (this could include alcohol as a 3rd drug).

   (1) Detoxification Programs: 27% of the clients being detoxified were being treated for cocaine use/abuse; 1% "cocaine only", 8% cocaine/alcohol and 18% cocaine/other drugs.

(2) Rehabilitation Programs: 32% of the rehabilitation clients were being treated for cocaine use/abuse; 1% "cocaine only", 13% cocaine/alcohol and 18% cocaine/other drugs.

c. Hospital based and free standing facilities: The results do not clearly differentiate between these two types of facilities in terms of % of cocaine users/abusers in detoxification and/or rehabilitation.

d. The data collected regarding crack and IV drug use indicates that:
   (1) 2 (3%) of the 73 cocaine users/abusers had used crack
   (2) 7 (10%) of the 73 cocaine users/abusers had used cocaine intravenously at least once.

e. Age/Sex: Of the cocaine users/abusers identified in the survey, approximately 1/4 are under 20 years old and 1/4 are female.

f. Overall: In FY86 (July 1, 1985 - June 30, 1986) free standing alcohol and drug abuse treatment facilities in Maine provided services to 505 individuals in detoxification and 1,589 in rehabilitation programs. Applying the rates of cocaine use/abuse identified in this survey, it is estimated that free standing facilities treated 825 cocaine users/abusers in FY86: 126 in detoxification and 699 in rehabilitation.

Discussion:

A major reason for undertaking the follow-up survey was to assess the impact of the perceived increase in the use of cocaine in terms of the number of cocaine users/abusers being treated in Maine detoxification and rehabilitation programs. In contrast to expectations, comparisons between the 1985 and 1986 surveys do not show an increase in the number or percentage of individuals being treated for cocaine use/abuse in Maine detoxification and rehabilitation programs. Although there are a number of reasons for this discrepancy, two reasons will be examined.

When first asked a question concerning cocaine use among their clients, many of the treatment providers estimated the number of cocaine users/abusers. However, upon reviewing case records and systematically "counting", the actual number of cocaine users/abusers was often less than their initial estimate. This also applied to estimates and actual counts involving IV drug and crack use. The lower than expected numbers identified in the survey data do not negate the significance of the problem. Rather, caution must be exercised when estimates are made of the number of individuals being treated in these programs for cocaine use/abuse.

A second area which may account for the lower than expected number of individuals in treatment for cocaine use/abuse is the time required to reach the later stages of abuse/dependency. It has been suggested that many cocaine users/abusers may be in the early stages of use/abuse and may be receiving outpatient counseling services rather than detoxification or rehabilitation services. Although earlier literature suggested that the transition from "recreational use" to "trouble with" cocaine took about 5 years, recent observations and perceptions of treatment providers suggests that the transition from use to trouble with cocaine may occur within 12-18 months. Further, time from first use to problem use is dependent upon the form of administration of cocaine used, the frequency, dose, and purity of the drug. Considering all these factors, it is highly unlikely that time alone accounts for the lack of increase in the number of individuals being treated for cocaine use/abuse in Maine detoxification and rehabilitation programs.

Limits of this Survey:

The results of this survey must be considered within the limits of the methodology employed. The data reflects only the treatment population on a given day. However, it was apparent that many treatment providers were surprised upon checking their estimates of use/abuse against actual client data. The results of this follow-up study indicate that cocaine abuse is a major problem and that a significant number of individuals are being treated for cocaine use/abuse in the Maine alcohol and drug abuse service system. However, the actual number of clients receiving treatment services for this problem may be lower than the number treated last year and is definitely lower than the estimates made by some treatment providers.

Summary Tables

Table I: Detoxification Programs

		Cocaine Only					Cocaine & Alcohol					Cocaine & Other Drugs				
		Under 20		Over 20		T	Under 20		Over 20		T	Under 20		Over 20		T
	Census	M	F	M	F		M	F	M	F		M	F	M	F	
free std. (3)	16	-	-	1	-	1	-	-	1	-	1	-	-	2	-	2
hospital (9)	36	-	-	-	-	0	-	1	2	-	3	2	-	2	3	7
total (12)	52	-	-	1	-	1	-	1	3	-	4	2	-	4	3	9

Table II: Rehabilitation Programs

		Cocaine Only					Cocaine & Alcohol					Cocaine & Other Drugs				
		Under 20		Over 20		T	Under 20		Over 20		T	Under 20		Over 20		T
	Census	M	F	M	F		M	F	M	F		M	F	M	F	
free std. (5)	43	-	-	-	-	0	1	-	5	2	8	3	1	5	2	11
hospital (6)	144	-	-	1	-	1	1	1	12	2	16	6	2	12	3	23
total (11)	187	-	-	1	-	1	2	1	17	4	24	9	3	17	5	34

Table III: Combined (Detoxification & Rehabilitation)

		Cocaine Only					Cocaine & Alcohol					Cocaine & Other Drugs				
		Under 20		Over 20		T	Under 20		Over 20		T	Under 20		Over 20		T
	Census	M	F	M	F		M	F	M	F		M	F	M	F	
detox. (12)	52	-	-	1	-	1	-	1	3	-	4	2	-	4	3	9
rehab. (11)	187	-	-	1	-	1	2	1	17	4	24	9	3	17	5	34
total (23)	239	-	-	2	-	2	2	2	20	4	28	11	3	21	8	43

Census: Represents the total number of clients (regardless of the substance of choice) being treated on the day of the survey.

Cocaine/other: Other was sometimes referred to as "garbage users" or the use of a wide variety drugs (including marijuana, alcohol, tranquilizers, etc.)