STATE OF MAINE

DRUG ABUSE PREVENTION PLAN

1973-1974

(Public Law 92-255, Sec. 409, 92nd Congress)

MAINE COMMISSION ON DRUG ABUSE
411 STATE OFFICE BUILDING
AUGUSTA, MAINE 04330

TELEPHONE (207) 289-3161

STATE OF MAINE

STEPHEN P. SIMONDS
CHAIRMAN

R. W. CARBONNEAU
EXECUTIVE DIRECTOR

August, 1973

William E. Bunney, Jr., M.D.
Director
Division of Narcotic Addiction &
Drug Abuse
National Institute of Mental Health
Parklawn Building, 5600 Fishers Lane
Rockville, Maryland 20852

Dear Dr. Bunney:

On behalf of the Maine Commission on Drug Abuse, I am transmitting the 1973-74 Maine State Drug Abuse Plan. This Plan was prepared to comply with Section 409 of the Drug Abuse Office and Treatment Act of 1972 (86 Stat 80, 21 USC 1176).

The Plan examines the incidence of drug abuse, existing resources and proposes specific policy, program and legislative action for the coming year.

The Plan reflects a cooperative effort by many individuals and agencies. Without their generous help and assistance, this Plan could never have been produced.

The Drug Abuse Office and Treatment Act of 1972 at this stage requires a heavy emphasis on planning and coordinating. For the future, we have much to accomplish towards better educating the general public about drug abusers developing greater concern about their needs and eliminating the scarcity of preventive services available for those at risk within our State.

The limited amount of time available (March 8, 1973 to June 30, 1973) to the State and its regional drug abuse prevention planning agencies to complete comprehensive planning required this State agency to request a 60-day delay which was approved. Still, the six-month planning period did not allow us to submit a fully-developed plan at this time. However, the extent and varied scope of activities represented by this planning effort fully demonstrates our sole state agency's capacity with

respect to program management and our coordinative capabilities have become better developed.

The plan, as a documentary process, gives full evidence that the Single State Agency is competent in the areas of responsibilities assigned by the Drug Abuse Office and Treatment Act of 1972 (86 Stat 80, 21 U.S.C. 1176.

We are convinced that, with the provision of an adequate Federal response, success in drug abuse prevention can be attained.

Sincerely,

Richard W. Carbonneau
EXECUTIVE DIRECTOR

RWC/pic

STATE OF MAINE
OFFICE OF THE GOVERNOR
AUGUSTA, MAINE
04330

KENNETH M. CURTIS
GOVERNOR

August 9, 1973

William E. Bunney, Jr., M.D., Director
Division of Narcotic Addiction & Drug Abuse
National Institute of Mental Health
5600 Fishers Lane, Parklawn Building
Rockville, Maryland 20852

Dear Dr. Bunney:

Reference is made to this State's drug abuse prevention plan for 1973/74. The worthiness of each individual is the precept which underscores this plan.

Drug abuse in its many forms stems from societal conditions which are most difficult to correct from the perspective of a single state government alone. Much has been written about the rationale and basis existing for drug abuse: technical alienation and dehumanizing experience, rejection and lack of family supports, self-gratification drive and peer influences, and unsatisfying work and vain educational pursuits.

We have learned that community drug abuse prevention programs directed at youth which provide education and treatment services go only so far. Programs undertaken thus far have only been directed at resolving a small portion of the existing problem. We recognize, though, that as meager as these attempts have been, they must be continued so as to demonstrate our concern for young people abusing drugs and alcohol. These measures, and newer responses required, must be supported with a view that youthful drug abusers and problem drinkers can realize their own potential and live a fuller and more meaningful existence.

Society must also realize that the larger issues remain untouched by treatment programs. Better laws can be passed calling for new preventative kinds of efforts; but until we as a society become committed to providing a better quality of life for all citizens alike, little change of any significant consequence can be brought about to curb drug abuse.

Before this can happen, our national society must regain its esprit, direction, purpose, vitality, honesty, and integrity before the indiscriminate use of drugs and alcohol can be diminished or eliminated.

Sincerely yours,

Kenneth M. Curtis
Governor of Maine

KMC/el

STATE OF MAINE
OFFICE OF THE GOVERNOR
AUGUSTA, MAINE 04330

November 14, 1972

Jerome H. Jaffe, M.D.
Director, Special Action Office for Drug Abuse Prevention
Executive Office of the President
Washington, D.C. 20500

Dear Dr. Jaffe:

Thank you for your letter of October 25 concerning the Drug Abuse Office and Treatment Act of 1972, Public Law 92-255. Richard W. Carbonneau, Executive Director of the Maine Commission on Drug Abuse, has been coordinating State efforts in drug abuse prevention and treatment within the State of Maine. Considering the intent and meaning of the Act, as well as the State agency which is in the most appropriate position to meet these needs, I designate the Maine Commission on Drug Abuse as the single State agency to administer and/or supervise the administration of the State plan under the provision of the Act. We are looking forward to an early release of pertinent Federal regulations and guidelines to Title IV, Section 409, Public Law 92-255.

The Maine Commission on Drug Abuse, composed of commissioners and members of departments providing services to drug abusers and members appointed by me to represent the public sector, will act as an interim State planning and advisory council on an ad hoc basis. The Maine Commission on Drug Abuse will be charged with developing recommendations concerning staffing for an advisory State council in accordance with Federal guidelines when these are promulgated in the Federal Register and initiation of State planning in concert with Federal regulations.

If deemed appropriate, your office may directly contact Mr. Carbonneau. This would expedite matters and allow for a coordination of these efforts. I approve of Mr. Carbonneau attending your conference scheduled for December 4-8, 1972.

Sincerely,

Kenneth M. Curtis
Governor

KMC:jk
(cc: Richard Carbonneau)

OUTLINE OF STATE PLAN

MEMBERS OF THE MAINE COMMISSION ON DRUG ABUSE

Mr. Stephen Simonds, Chairman of the Maine Commission on Drug Abuse
Human Services Development Center
University of Maine
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Mr. Gary Cook
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Ms. Pauline Gingras
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Health & Welfare
Dean Fisher, M.D. Commissioner
Representative: Owen Pollard

Mental Health & Corrections
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Carroll McGary, Commissioner
Representative: Carl Mowatt

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R. W. CARBONNEAU
EXECUTIVE DIRECTOR

April 1973

REGIONAL PLANNING COORDINATORS

(State Comprehensive Drug Abuse Planning Effort)

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AREAS V-VIII (Southern Maine)

Ronald S. Welch, Project Director
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ACKNOWLEDGMENTS

The Maine Commission on Drug Abuse would like to thank the following individuals for their help during the planning process:

Patsy I. Cameron	Secretary	Maine Commission on Drug Abuse
Mary Peirce	Statistician	Mental Health & Corrections
Daniel Oakes	Statistician	Mental Health & Corrections
Richard Fitzmaurice	Accountant	Mental Health & Corrections
Lowell Hawes	Accountant	Mental Health & Corrections
Frank Mack	Personnel Officer	Mental Health & Corrections
Tom Kane	Chief, CMHC Services	Mental Health & Corrections
Luisa Deprez	Mental Health Planner	Mental Health & Corrections
Paula Farren	Secretary	Mental Health & Corrections
Edward Hansen	Assistant Director	Bureau of Corrections
Gary Sawyer	Criminal Justice Planner	LEAA

Also: Robert Ericson, Lt. Albert Jamison, Darwin Hatheway, Dale Welch, Michael Fulton, Ken Ryder, Gail Horton.

DEFINITIONS & ABBREVIATIONS

Act means the Drug Abuse Office and Treatment Act of 1972 (86 Stat. 80, 21 USC 1176).

Secretary means the Secretary of the Department of Health, Education & Welfare and any other office of that department to whom the secretary has delegated authority.

State means the State of Maine.

Commission means Maine Commission on Drug Abuse (MCDA)

Single State Agency means Maine Commission on Drug Abuse. As of January 1, 1974 the single state agency will be the Office of Alcoholism and Drug Abuse in the Bureau of Rehabilitation of the Department of Health & Welfare.

State Advisory Council means the Maine Commission on Drug Abuse. On January 1, 1974 the Maine Council on Alcohol and Drug Abuse Prevention and Treatment will become the State Advisory Council.

Office means the Office of Alcoholism and Drug Abuse in the Department of Health & Welfare

NIMH means National Institute of Mental Health

SAODAP means President's Special Action Office for Drug Abuse Prevention

I. INTRODUCTION

A. Summary

The 1973-74 State Drug Abuse Plan is the first systematic attempt to assess the nature of drug abuse in Maine. The plan analyzes the reported incidence of drug abuse, existing resources and proposes specific policy, program and legislative action for the coming year.

Documenting the extent of the "problem" was in itself a problem. The reporting forms and indicators supplied by the federal Special Action Office for Drug Abuse Prevention (SAODAP) were designed to focus on the incidence of narcotic addiction and abuse, problems that are not prevalent in Maine.

The information collected indicates that both alcohol and drug abuse are percieved as problems. However, the data supports only the prevalence of alcohol abuse and alcoholism. This problem crossed all agency, age and sex barriers, although it was concentrated in the "over 35" age group. Substance abuse involving drugs other than alcohol did not constitute a problem of great magnitude. Only the use of marijuana could be substantiated in any quantity and was most prevalent in the "below 24" age group. The abuse of amphetamines, barbiturates and hallucinogens occurred mainly within the 15-24 year old age group. It appears that the "drug problem" in Maine is chiefly poly-drug abuse among juveniles and young adults.

The lack of innovative professional services for troubled adolescents, a low level of services to all youth and a lack of coordination among existing human service agencies are the principal problems identified through the planning process. There is evidence of a need for more effective use of existing resources and only limited development of specialized drug abuse services.

Implementation of P.L. 566, 1973 Alcoholism and Drug Abuse Act is the most important priority for the coming year. The Act establishes the basis for effective planning, programming and coordination of all drug abuse prevention services in the state.

B. State Planning Process

After the receipt of the Notice of Award of Federal formula grant funds, the Maine Commission on Drug Abuse awarded seven planning assistance contracts; four to community mental health centers, one to a Comprehensive Health Agency (B), one to a community drug abuse treatment and rehabilitation agency (Drug Rehabilitation, Inc.), and one to the State Department of Educational and Cultural Services.

Geography, economics and poor transportation combine to reinforce regionalism in Maine. More than miles lie between agricultural, French-speaking northern Aroostook County and the wealthy suburbs of Portland, Maine's largest urban area. Regional planning assures a diversity of views and encourages local participation.

An objective of the State Plan is the establishment of regionally-based prevention and treatment services. The planning process is intended to create the nucleus of a group that can assume responsibility for planning and evaluating local programs. These groups can assist the Maine Commission on Drug Abuse in the allocation of State/Federal funds and can act as advocates for youth services in the distribution of local revenue sharing money.

Drug Abuse planners worked closely with regional coordinators assigned to other State departments, e.g. LEAA, Health and Welfare, Alcoholism, Probation and Parole and Regional Planning Commissions.

Considerable planning efforts took place. Survey forms were mailed to key respondents in criminal justice, health and mental health agencies, hospitals, schools and local government were queried to determine the incidence and prevalence of drug abuse and to identify specific on-going activities serving those in need of treatment and ancillary services. Each planning agency has made recommendations regarding the status of existing services and, also, establish priorities for improving services within their regional areas.

Planning assistance furnished to this Commission to accomplish the established goals was rendered by:

Contract Recipient	Project Director	Principal Planner
Aroostook Mental Health Clinic Community General Hosp. Fort Fairfield, ME 04742	Robert Vickers, ACSW	Walter Cogswell
The Counseling Center 43 Illinois Avenue Bangor, ME 04401	James Clark	Anthony Birckhead
Kennebec Valley Mental Health Center P.O. Box 624 Waterville, ME 04901	Carmen Celenza, M.A.	John Dogherty

Contract Recipient	Project Director	Principal Planner
Tri-County Mental Health Services 106 Campus Avenue Lewiston, ME 04240	William Davis, ACSW	Christos Gianopoulos
Southern Maine Comprehensive Health Assoc., Inc. 583 Forest Avenue Portland, ME 04101	Stanley F. Hansen, Jr.	Ronald Welch Penelope Davis
Drug Rehabilitation, Inc. Cumberland County Sheriff's Office 122 Federal Street Portland, ME 04111	Sheriff Charles Sharpe	Warren Bartlett
State Department of Educational and Cultural Services Augusta, ME 04330	Carl Mowatt	Susan Scanlan

State Resource Planning Personnel:

Maine Commission on Drug Abuse 411 State Office Building Augusta, ME 04330	Richard W. Carbonneau Christine Gianopoulos	Gray E. Bromley Martha Geores
Department of Mental Health and Corrections 411 State Office Building Augusta, ME 04330	Thomas Kane, DMSW	Luisa Deprez
Maine Law Enforcement Planning and Assistance Agency 295 Water Street Augusta, ME 04330	Gary Sawyer	

Specifications of Work Performed by Regional Planning Agencies:

Preparation of a comprehensive Drug Abuse Plan for the regional area to include:

1. Assessment of drug abuse problem in the regional area.
2. Clear statement of goals and objectives of the planning process.
3. Inventory of existing services and gaps in services.
4. Detailed description of programs proposed to fill gaps, expand existing services and achieve goals.
5. Action plan for implementation which accomodates priorities and funding resources.
6. System for administering services and assuring coordination with allied human service agencies.

Identification of Regional Planning Drug Abuse Prevention Service Areas

1. The service area boundaries accepted for planning purposes are those designating Maine's mental health catchment areas. These geographic areas are in substantial agreement with Executive Order No. 6, January 26, 1972 by which Governor Curtis designated certain official planning and development districts. As of October 1, 1972, all state planning was to agree with these designations.

2. The mental health regional areas designated as V, VI, VII, VIII were functionally combined for planning purposes. One agency, the Southern Maine Comprehensive Health Association, Inc. (Comprehensive Health B Agency) was selected to prepare a plan for all of these agencies maintaining area distinctions insofar as possible.

3. Maps detailing these circumstances are included as Maps 1 and 2, respectively.

C. Description of the State

"The fine house, the beautiful harbors and islands, yes. But Maine is a museum of another kind, a collection of the deserted and abandoned, a preservation of the feel of long, catatonic winters. Its exhibitions tell of no money and nothing to do and no place to go. It preserves the face of lack, of minimum, the bottom -- the pure, lost negative... With the poor, and all of us, the truth is found in the rusting, immovable car."

Elizabeth Hardwick
"In Maine"
A Maine Manifest
by Richard Barringer and Others
Published by the Allagash Group, Bath, Maine.

Maine is the hinterland of the northeast and, as such, has always been somewhat cut off from events elsewhere in the nation. However, in the past twenty years the influence of the media, superhighway and tourism have drawn Maine closer to its neighbors.

With the decline of traditional industries, manufacturing and the independent rural way of life have given way to the prospect of suburbia and employment in the new industries: tourism, real estate, banking and social services. As Maine entered the 70's, its chronically-decreasing rate of population growth reversed. In 1971, for the first time, Maine population grew faster than the national average to pass the one million mark. In the past, young people left the state in large numbers -- for factory jobs in Massachusetts or white-collar jobs in the nation's large cities. During the decade 1960-1970, 100,000 of Maine's citizens, many of them young, left the state seeking opportunities not available at home.

1. Population Distribution

The Maine population is about equally divided between urban and rural. This pattern has remained constant since World War II. A rapid shift toward urban concentration is expected during the next decade.

The term "urban" means largely medium-sized communities separated by undeveloped areas. The urban-suburban-exurban sprawl has yet to affect Maine. Approximately 70% of the population lives in communities of 10,000 or less. The two largest population centers are Greater Portland (141,626) and Lewiston-Auburn (73,000).

URBAN-RURAL POPULATION
1970

	Size of Place	% of Total Population
Urban	50,000-100,000	6.6
	25,000- 50,000	7.6
	10,000- 25,000	31.8
	5,000- 10,000	11.1
	2,500- 5,000	8.0
	TOTAL URBAN	50.8%

URBAN-RURAL POPULATION (cont.)
1970

	Size of Place	% of Total Population
Rural	1,000- 2,500	8.6
	0- 1,000	40.6
	TOTAL RURAL	49.2%

It is important to note the highly uneven population distribution within the state. Approximately two thirds of the state's population lives in a 20-mile "corridor" along the Maine Turnpike, the state's only interstate route. Similarly, three fourths of all new jobs and plant expansions occur within this corridor.

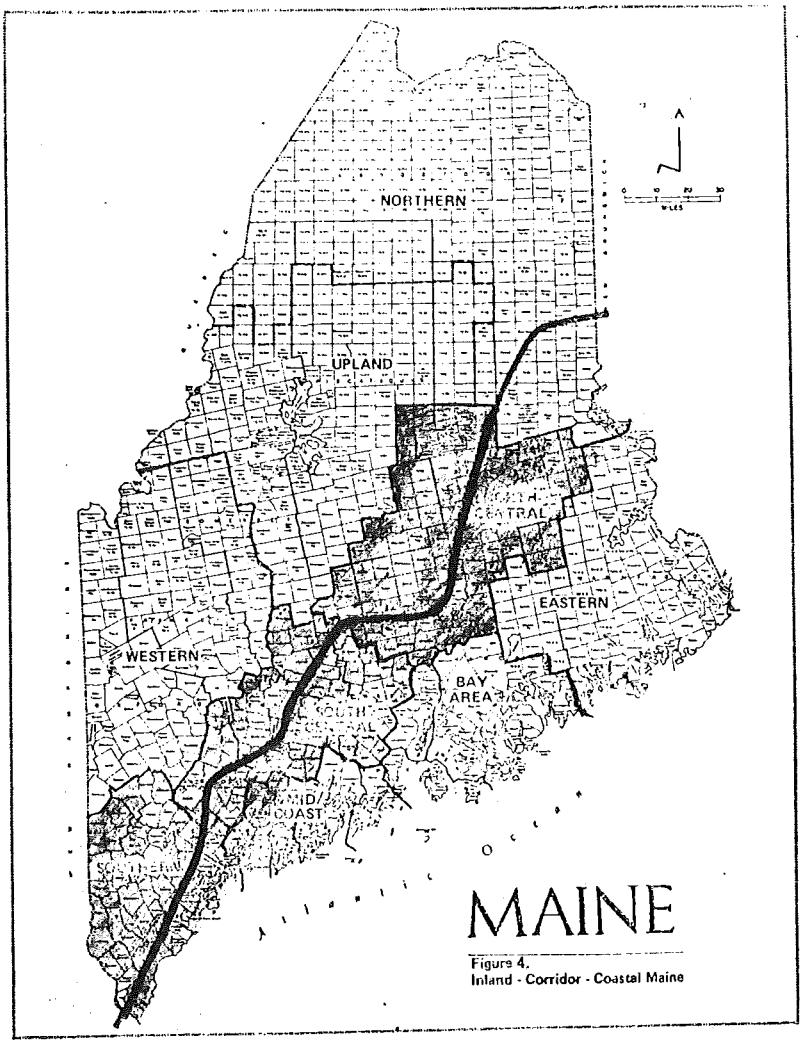

Figure 4.
Inland - Corridor - Coastal Maine

From 1960 to 1970 there were significant changes in the age trends of the population which may impact on future incidence of drug abuse within the state. In the ten-year period, the number of children in the 0-4 age range decreased 22%; there was less than a 1% increase in the 5-9 group and the 15-24 year age group increased 25%, confirming a reversal in the pattern of outmigration. Employment opportunities, housing, transportation and social services will have to expand to meet the demands of this age group.

AGE, RACE AND SEX DISTRIBUTION

		Male		Female	
Age	Total	White	Non-White	White	Non-white
Under 15	285,981	144,814	1,141	138,866	1,160
15-24	168,391	82,877	952	84,037	525
25-34	109,710	53,745	568	54,867	530
35-64	313,374	150,382	764	161,497	731
65+	114,592	47,423	199	66,768	202
Totals	992,048	479,241	3,624	506,035	3,148
		(482,865)		(509,183)	
Median Age	28.6	27.1	22.7	30.2	23.0
		(27.0)		(30.1)	

2. Economic Base

Manufacturing, government, trade and services employ 68% of Maine's workers. Between 1960 and 1970 the fastest growing sectors were services (+45%) and government (+43%).

MAINE EMPLOYMENT 1971
Annual Average

	Workers (1,000's)	Percent
Major Sources		
Manufacturing	102.8	24.8
Trade	67.5	16.3
Services	44.0	10.6
Government	69.0	16.7
Total	283.3	68.5
Minor Sources		
Construction	16.9	4.1
Finance	12.6	3.0
Transportation	17.5	4.2
All Other	38.1	9.2
Total	85.1	20.6
Agriculture	13.1	3.2
Unemployed	31.8	7.7
In Dispute	0.5	0.1
Total Maine Work Force	413.8	100.0

Maine employment trends can be seen in changes in sources of personal income during the period 1940-1970. Maine's traditional textile and leather industries have declined as the mills moved south or closed in the face of foreign competition. Re-training and re-employment programs have had little effect on the unemployment rate among workers laid off by these industries.

Total Personal Income: * Percentage by Source1	MAINE				NEW ENGLAND		UNITED STATES		PERCENTAGE CHANGE, 1950 - 1970		
	1940	1950	1960	1970	1950	1970	1950	1970	U.S.	N.E.	Me.
farm	7.7	8.0	5.4	3.0	2.2	0.6	7.1	2.4	-.66	-.73	-.63
mining	0.1	0.2	0.1	0.06	0.1	0.06	1.4	0.7	-.50	-.40	-.70
contract construction	1.6	2.4	3.5	4.1	3.1	4.2	3.5	4.0	+.14	+.35	+.71
manufacturing	22.7	26.7	22.8	21.1	29.8	23.0	21.9	19.8	-.10	-.23	-.21
trade (wholesale & retail)	10.4	10.9	10.9	10.3	11.7	10.9	12.1	11.1	-.08	-.07	-.06
finance, insurance & real estate	2.0	1.7	2.1	2.5	3.0	3.8	2.6	3.4	+.31	+.27	+.47
transport, communications & utilities	5.4	5.2	4.9	4.0	4.6	3.9	6.2	5.0	-.19	-.15	-.23
services	5.6	4.7	5.3	6.9	6.1	9.9	6.1	8.7	+.43	+.62	+.47
government	9.9	7.9	13.4	13.5	8.1	11.0	9.2	13.8	+.50	+.36	+.71
other industries	0.22	0.36	0.49	0.21	.0.24	0.17	0.14	0.13	-.07	-.29	-.42
proprietor's income (non-farm)2	10.4	10.2	9.2	7.4	8.4	6.2	10.1	6.4	-.37	-.26	-.27
property income3	19.6	14.2	13.1	13.8	15.4	15.5	12.6	14.1	+.12	+.01	-.03
transfer payments4	4.5	7.5	9.1		6.9	10.1	6.6	9.9	+.50	+.45	+.71

Note: 1. Total personal income is that received from all sources before direct personal taxes. Columns do not add to 100% as they include worker's contributions to social insurance programs, and exclude supplementary labor income such as contributions to pensions and group insurance programs.
2. Proprietor's income measures the earnings of unincorporated business enterprises, professional practitioners, partnerships, producer cooperatives, and others in self-employment.
3. Property income consists of dividends, rental income, and personal interest income.
4. Transfer payments are income not resulting from current production, as retirement and social security benefits and military pensions.
Source: U.S. Department of Commerce

*Barringer and Others, A Maine Manifest, Published by the Allagash Group.

Maine is a trading economy, sensitive to the vagaries of the national economy. The state's manufacturing and tourist industries are especially dependent on outsiders to buy products/services. Maine's license plates advertise "Vacationland" and as tourism becomes more important to Maine, Maine's prosperity becomes more closely tied to the nation's economic health.

Maine's deepwater ports, ideal for oil tankers and the refineries the tankers supply, may hold the key to a degree of economic revitalization. Conservationists oppose oil refineries because of the potential for spills which would threaten another important natural resource, the Maine coast. Others, painfully aware of the state's 9% unemployment rate, are willing to take the risk.

Mainers used to think that in politics, "as Maine goes, so goes the nation," but the reverse applies to Maine's economy.

3. Unique Points of Vulnerability/Resistance to Drug Abuse

While Maine may be a "backwater" of the national economy, it is important to note that Maine's young people are no longer divorced

from the national scene. Somewhat like every other young person born after World War II, their lifetime corresponds directly with an unprecedented period of economic growth and change. Even though most have not been able to directly witness some of the more telling events of the past decade, their lives are deeply affected, nevertheless. More significantly, youth in Maine are much like their contemporaries elsewhere in the nation in that their expectations exceed the traditional aspirations of their parents. Not even the more remote areas of the state are immune from the influences of television, the superhighway and tourism.

Young people in Maine are presently not willing to leave the state to seek either "fame or fortune" but they are not particularly anxious to remain in Maine only to join the ranks of the working poor. They are caught in a serious crossfire situation. There aren't that many jobs available locally that provide much more than the minimum wage; jobs that pay well are being filled by skilled persons, many from out of state, and still the expectations for real improvement in one's life grows stronger. Rising expectations not only manifest themselves in the form of demands for material gain; they also take form in increased pressure for social and political change. The economy has grown in Maine and there have been significant improvements in the way some communities handle social problems, but young people in Maine are terribly frustrated about living in a state that offers them such limited opportunity.

It's almost as if the background message being conveyed is this: we never have been able to adequately provide much in the way of opportunity for our young; the most we could offer in the past was the chance to fill in where an older person worked before, in the mill, or in the family business. The least offered was an adequate basic education so that one could better qualify for work elsewhere or go on in school: in simple terms, stay and take what is available or leave!

Maine's particular condition at this point in time is critical, and the situations being faced are tremendously complex. While this analysis oversimplifies, reasons for drug abuse and alcohol abuse extend beyond individual and family situations. Societal pressures, as never before, have considerable influence over individual behavior.

Poverty, alcoholism, unemployment, isolation and a breakdown in traditional institutions all affect the potential for prevalent abuse of drugs. The lack of recreational and employment opportunities for young people is a problem which bears heavily on future patterns of drug abuse.

Viewed in another way, the very factors which influence vulnerability may also explain why the State has not been affected with a prevalent addiction problem.

Drug abuse requires resources (or resourcefulness) to obtain drugs and an environment conducive to drug use. Poverty, widespread acceptance of alcohol and the social norms of small-town society all mitigate against flagrant abuse of drugs. Small communities in Maine have little tolerance for deviant lifestyles or social conflict. A young person who wishes to live by a different value system is subtly pressured to do it elsewhere. As a result, Maine's problem drug abusers are more likely to show up as a statistic for Boston or New York.

4. Political Description

There are two significant levels of government in Maine: State and municipal. In the absence of a strong county government structure, the State assumes the coordinating functions normally performed by county governments in other states.

Social services in Maine are delivered by the State, larger municipalities and private agencies. The State Department of Health & Welfare operates through a system of regional offices.

Maine does not rank high among the states in expenditures for social services. The table below compares Maine's per capita expenditures on selected items with the 50 state average.

Per Capita Amounts of Selected Financial Items 1971

	Total Expenditures	Education	Highways
50 State Average	433.64	170.75	72.06
Median State	440.77	170.10	80.90
Maine	442.03	159.13	91.01

	Public Welfare	Hospitals	Health
50 State Average	79.21	22.60	7.33
Median State	62.64	19.43	5.66
Maine	80.95	19.54	5.66

	Corrections	Natural Resources	Employment Security Administration
50 State Average	6.12	12.40	4.58
Median State	5.24	13.49	4.42
Maine	6.31	19.71	6.32

In January, 1972 Governor Curtis issued an Executive Order establishing a system of Official Planning and Development Districts for the entire state. Economic considerations, environmental factors, land and water use controls along with management implication were the basic consideration in the designation of these districts.

These sub-state districts are designed to serve as the framework for coordination and integration of local, state and federal activities, focusing on these major objectives:

1. Coordination of local government planning and programs.

2. Uniform Districts for the planning, programming and delivery of state services.

3. Uniform alignment with federal programs and administrative districts. (OMB Circular A-95 Review).

REGIONAL PLANNING COMMISSIONS IN MAINE - SEPTEMBER, 1972

ANDROSCOGGIN VALLEY REGIONAL PLANNING COMMISSION
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16½ Benton Avenue
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NORTHERN MAINE REGIONAL PLANNING COMMISSION
James A. Barresi, Executive Director — Robert G. Soucy, Chairman
P.O. Box 911
Presque Isle, Maine 04769 — Tel. 768-5511

PENOBSCOT VALLEY REGIONAL PLANNING COMMISSION
Talbot Averill, Planning Director — Richard Stratton, Chairman
Bangor City Hall
Bangor, Maine 04401 — Tel. 945-5769

SOUTHERN KENNEBEC VALLEY REGIONAL PLANNING COMMISSION
John B. Forster, Planner-Administrator — Roland Whittier, Jr., Chairman
154 State Street
Augusta, Maine 04330 — Tel 622-7146

SOUTHERN MAINE REGIONAL PLANNING COMMISSION
Arthur T. Lougee, Executive Director — Fred R. Lane, Chairman
County Court House
Alfred, Maine 04002 — Tel. 324-5780

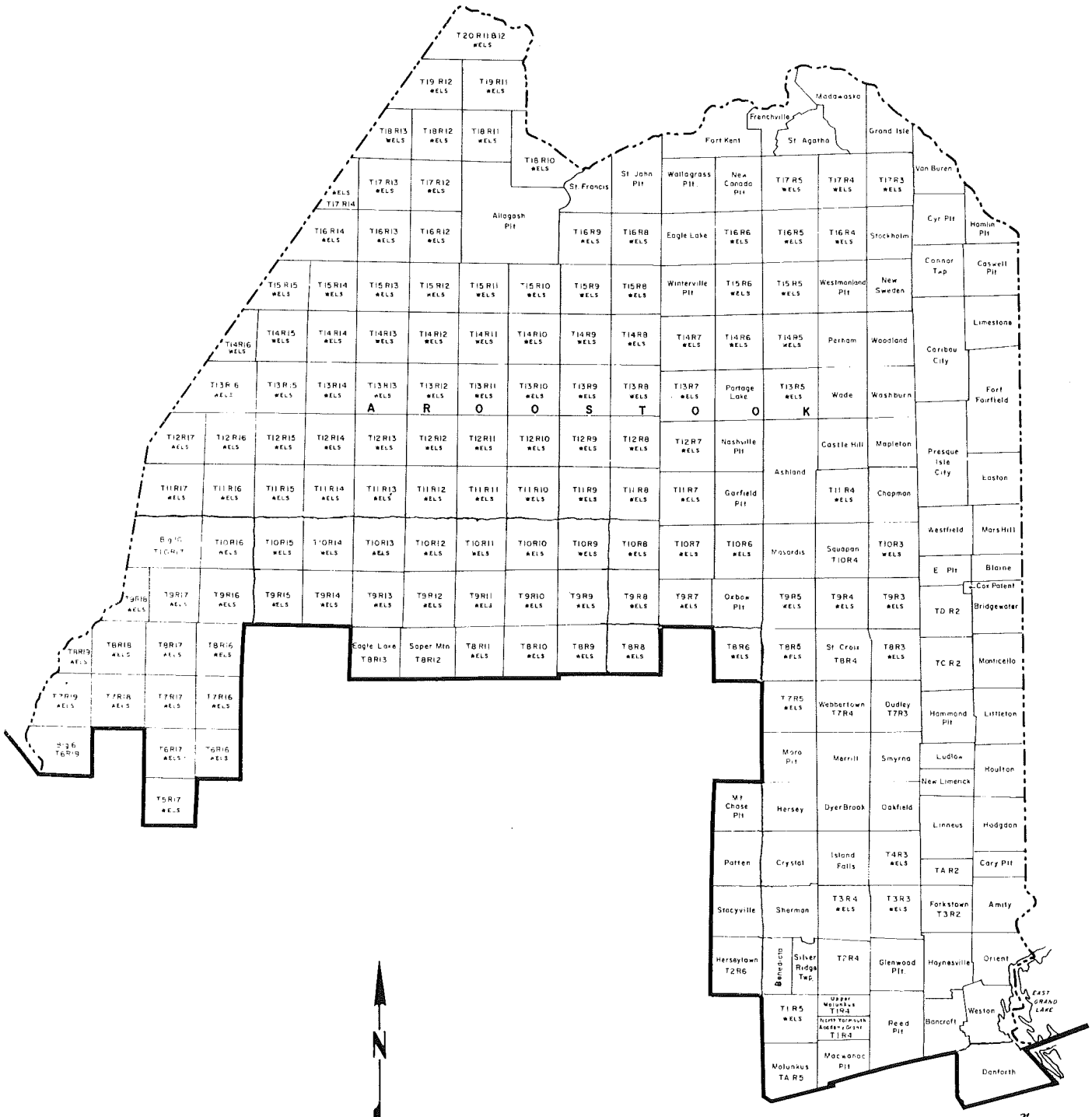
WASHINGTON COUNTY REGIONAL PLANNING COMMISSION
Donald J. Bushey, Director — Arlo Bates, Chairman
P.O. Box 273
Machias, Maine 04654 — Tel. 255-3971

The eleven Regional Planning Commissions only have review and comment authority. They do not have the power to tax, nor can they distribute funds, as a viable county government does.

There is a strong tradition of local government. Maine's 496 municipal governments (includes villages, towns and cities) raise revenues from property taxes and allocate the major portion for maintenance of school and roads. Occassionally modest amounts are set aside from "social services." It was expected that revenue sharing funds would be used to support the development of community-based social services. Instead, most towns chose either to use revenue sharing for capital expenditures or to stabilize their existing tax rate.

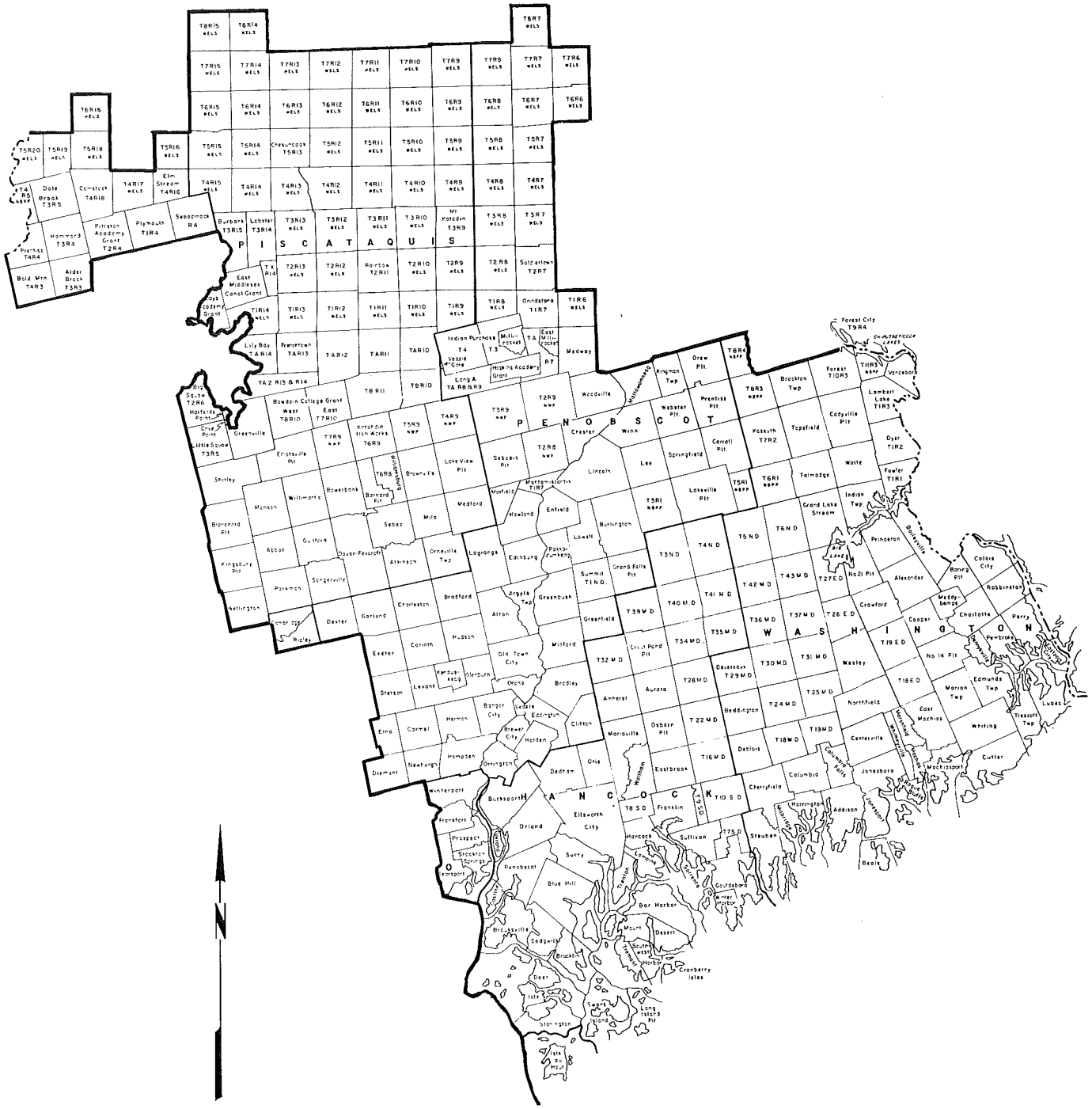
Maine's Congressional delegation includes two Representatives (one Democrat and one Republican) and two Democratic U.S. Senators.

AROOSTOOK DISTRICT



MAINE COMMISSION ON DRUG ABUSE PLANNING DISTRICT 1

PENOBSCOT DISTRICT

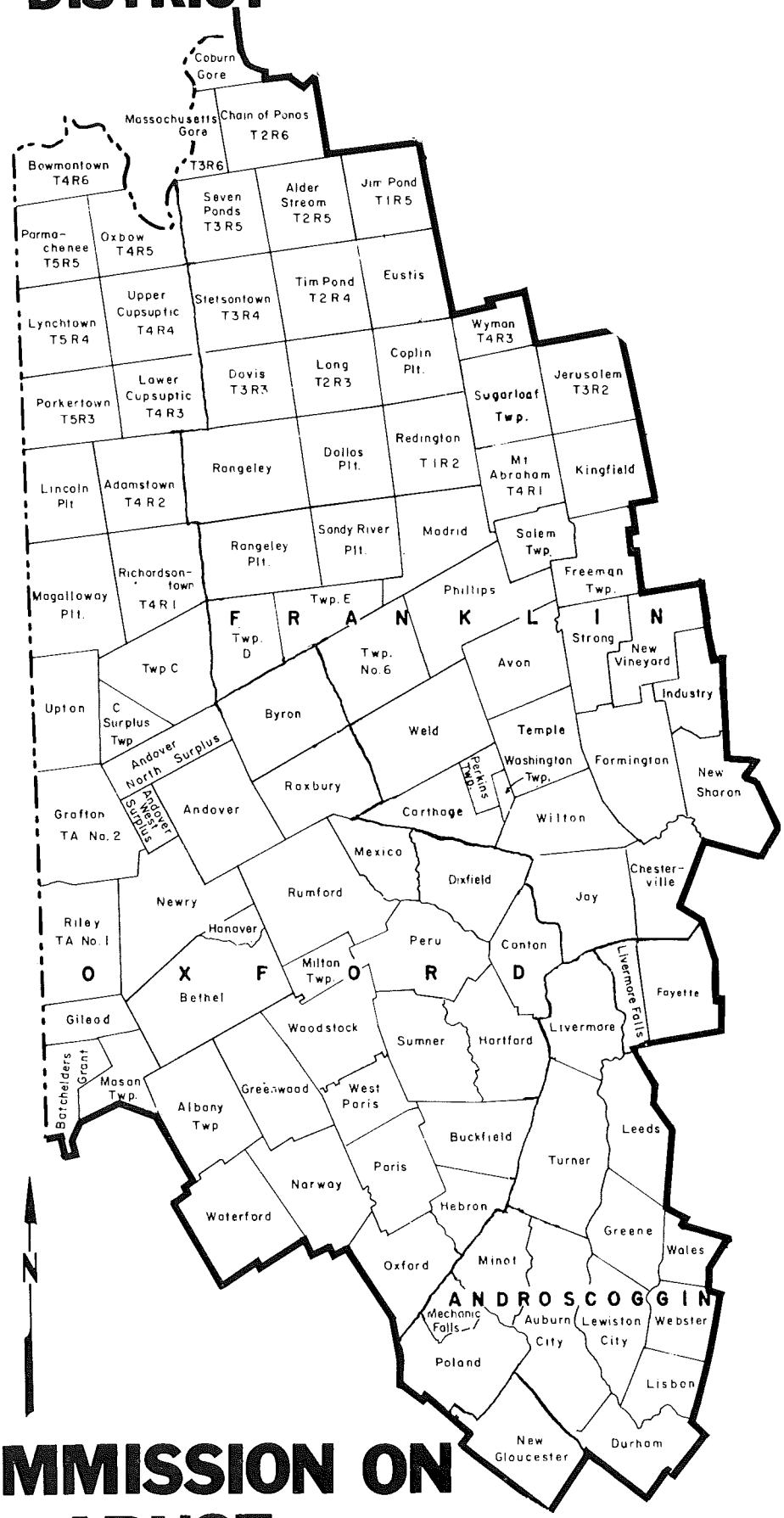


MAINE COMMISSION ON DRUG ABUSE PLANNING DISTRICT 2

KENNEBEC DISTRICT

MAINE COMMISSION ON DRUG ABUSE PLANNING DISTRICT 3

TRI-COUNTY DISTRICT

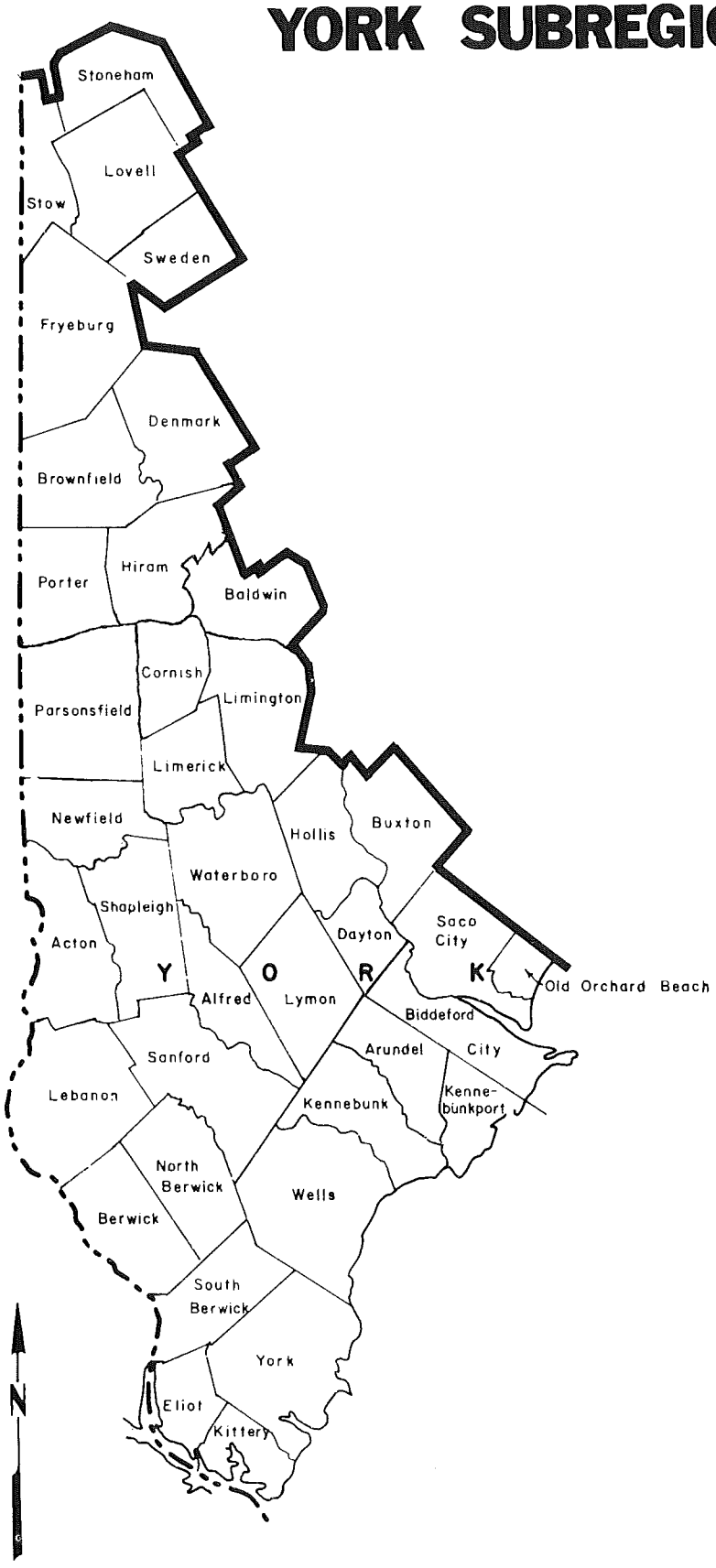


MAINE COMMISSION ON DRUG ABUSE PLANNING DISTRICT 4

CUMBERLAND SUBREGION

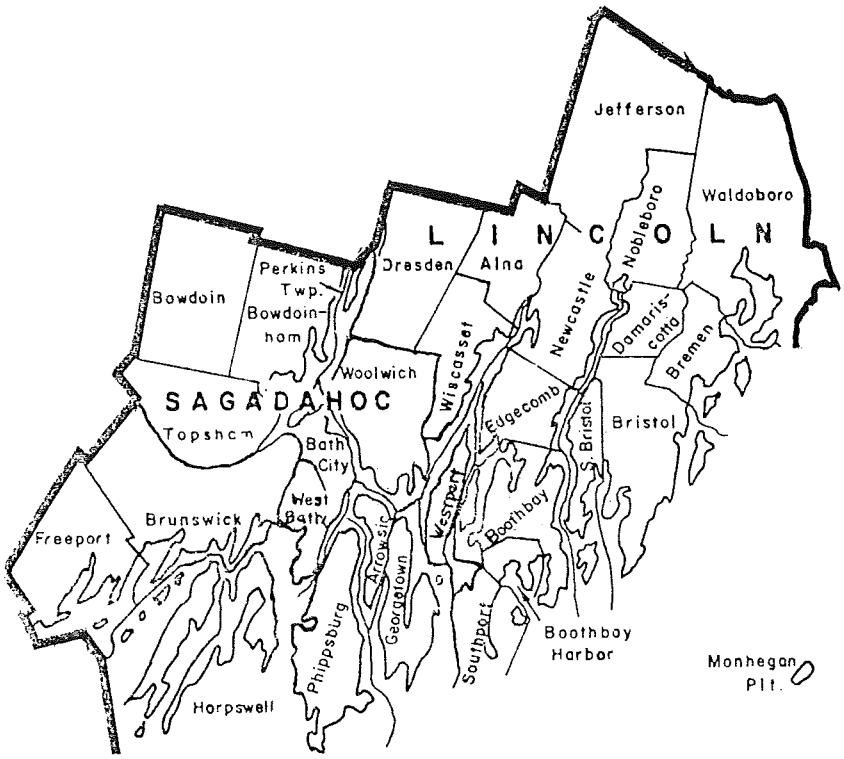
MAINE COMMISSION ON DRUG ABUSE PLANNING DISTRICT 5

YORK SUBREGION



MAINE COMMISSION ON DRUG ABUSE PLANNING DISTRICT 6

SOUTHERN MID-COASTAL SUBREGION



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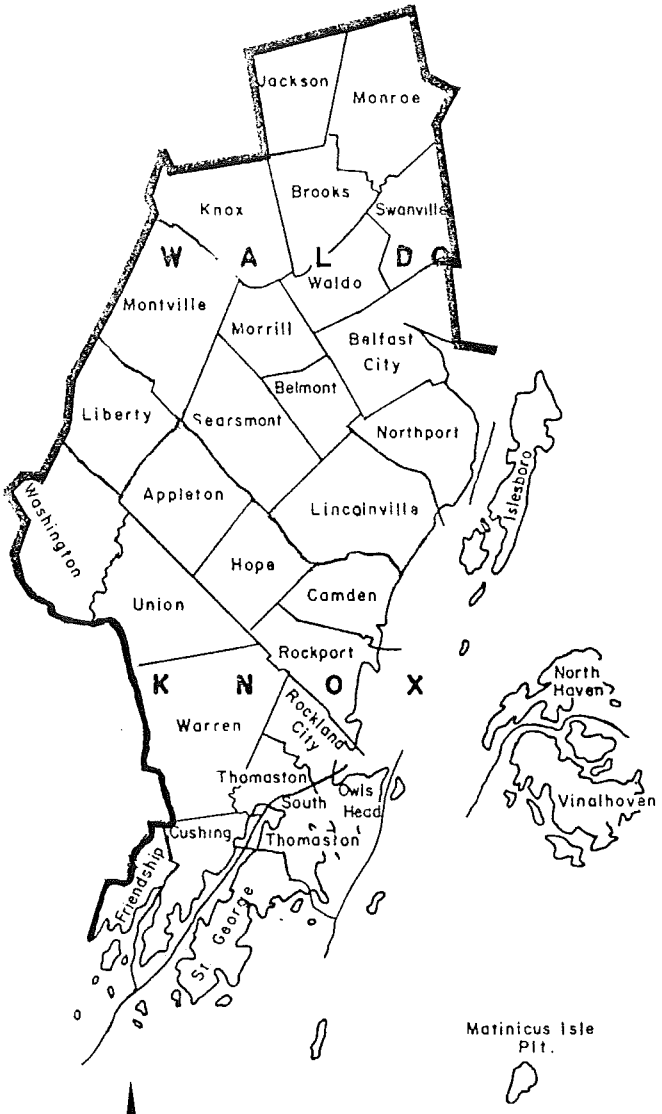
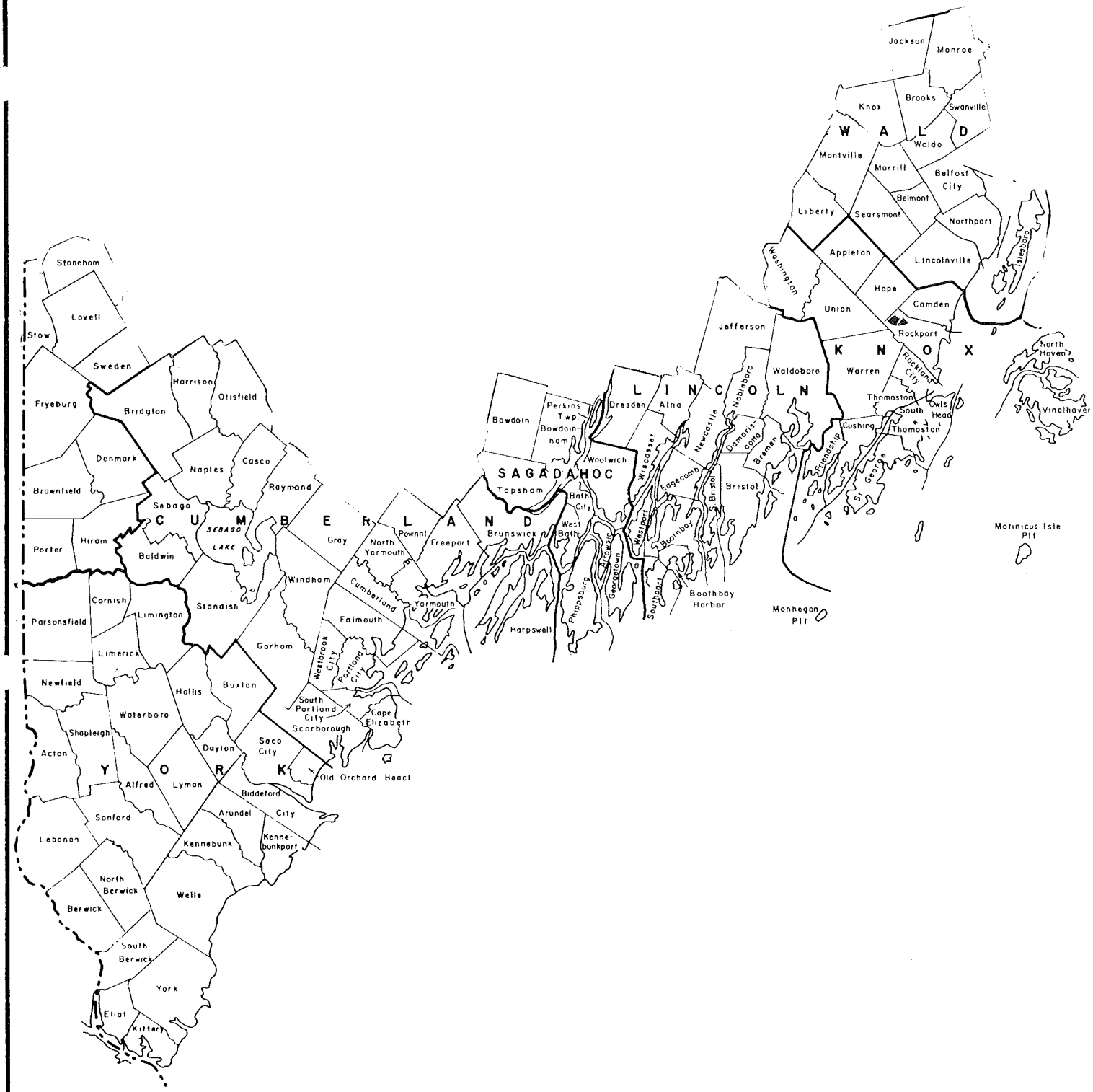
MAINE COMMISSION ON DRUG ABUSE PLANNING DISTRICT 7

PEN-BAY SUBREGION

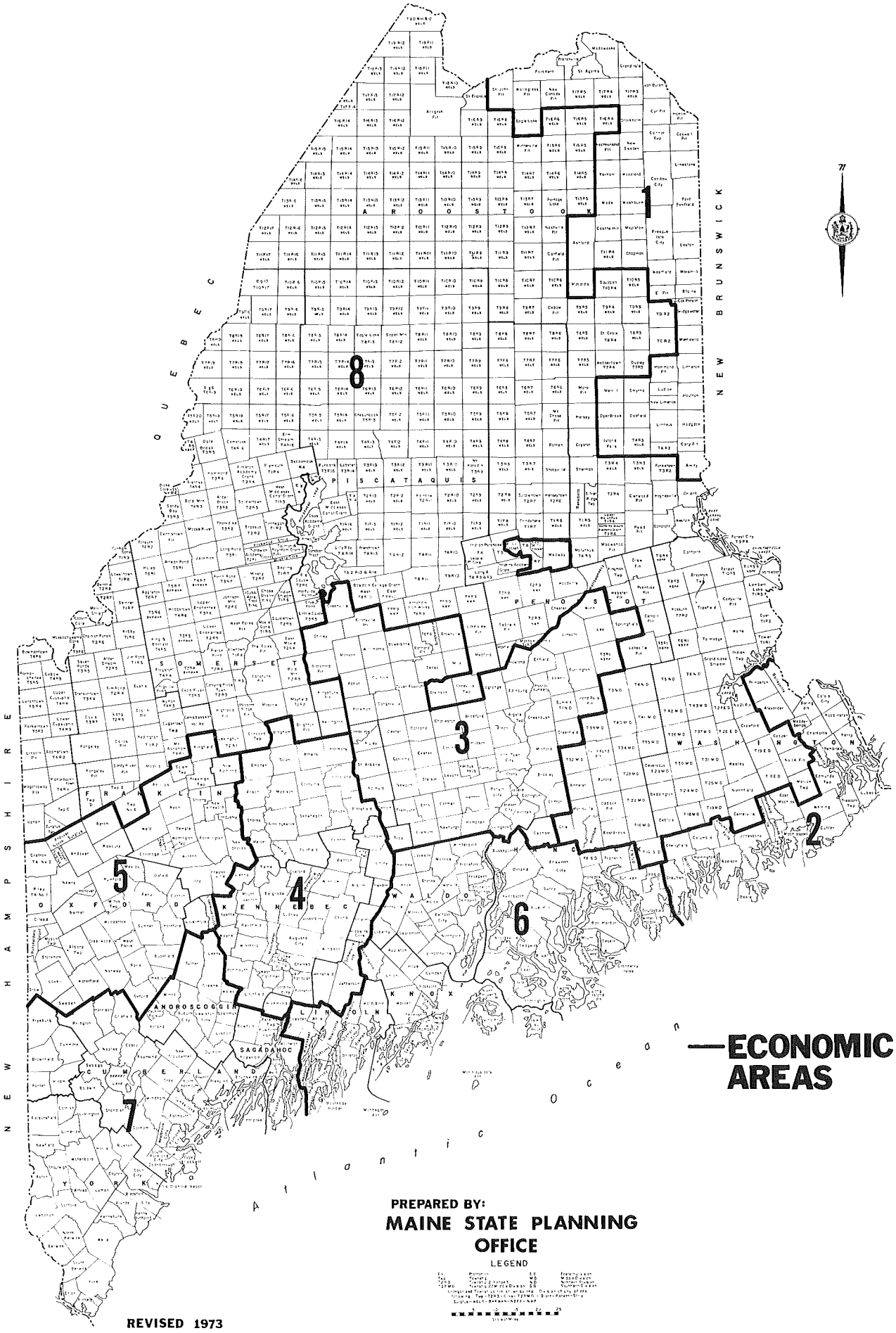


MAINE COMMISSION ON DRUG ABUSE PLANNING DISTRICT 8

SOUTHERN MAINE DISTRICT



MAINE COMMISSION ON DRUG ABUSE PLANNING DISTRICT



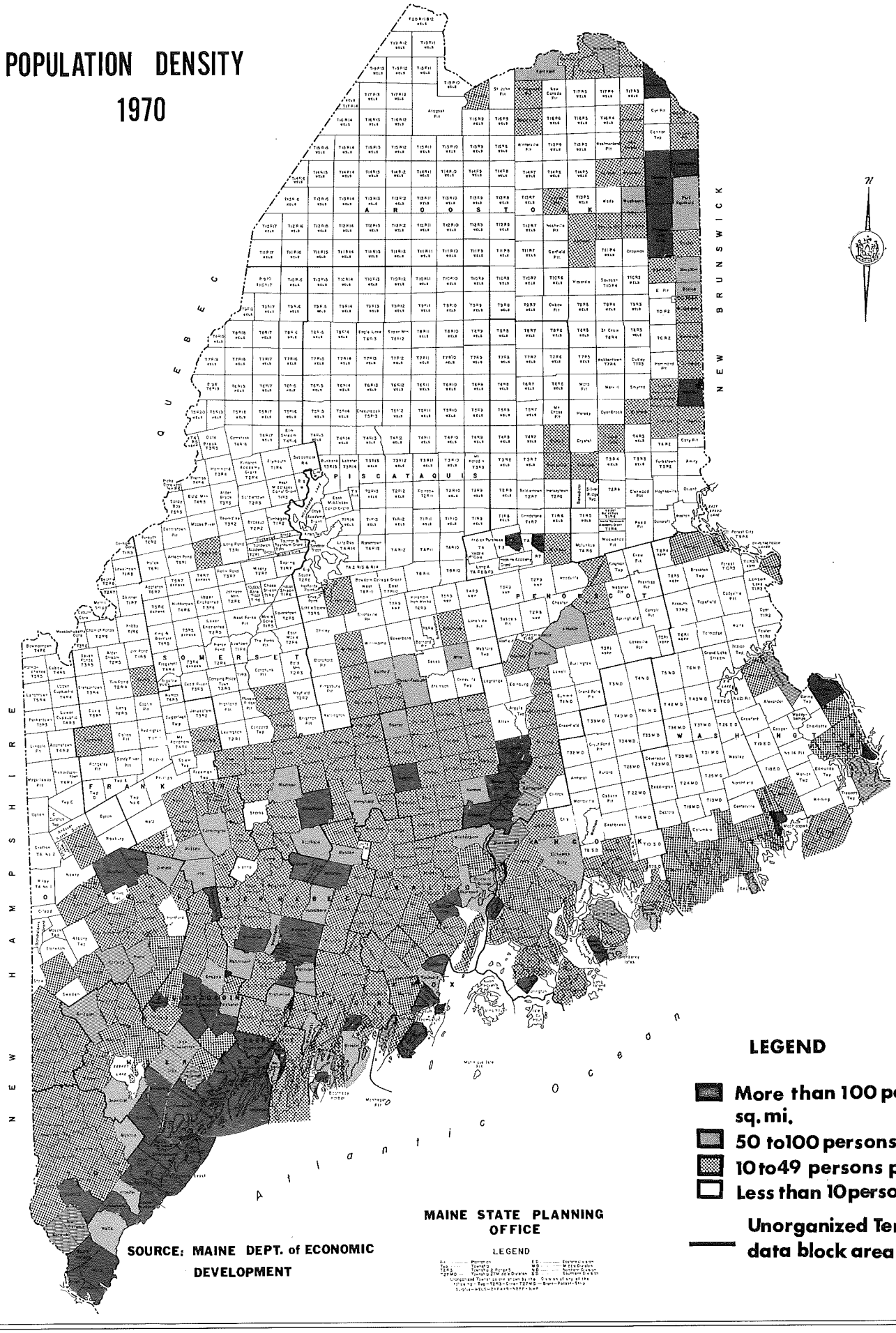
PREPARED BY:

MAINE STATE PLANNING OFFICE

LEGEND

REVISED 1973

POPULATION DENSITY
1970



LEGEND

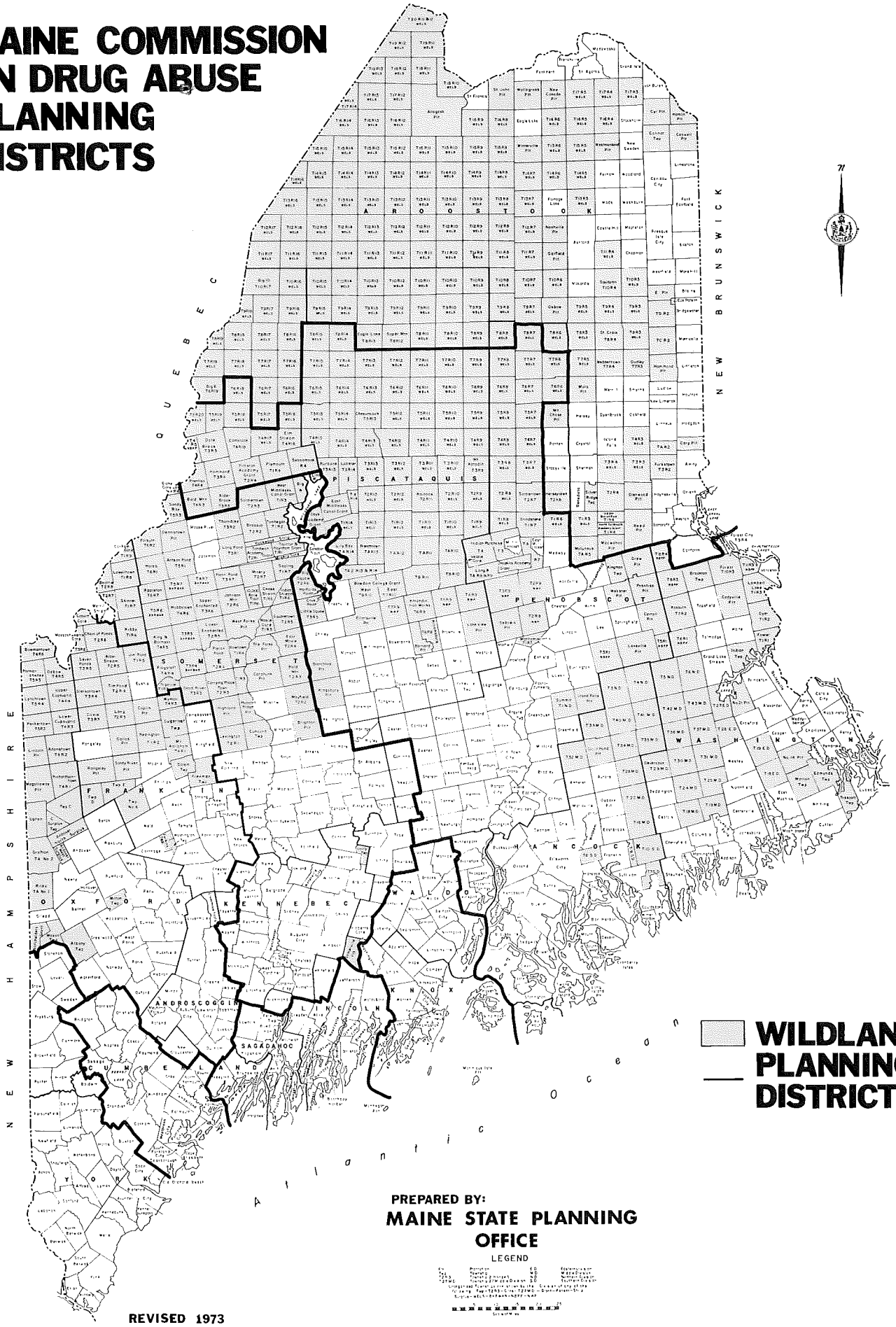
- More than 100 persons per sq. mi.
- 50 to 100 persons per sq. mi.
- 10 to 49 persons per sq. mi.
- Less than 10 persons per sq. mi.
- Unorganized Territory data block areas

SOURCE: MAINE DEPT. of ECONOMIC DEVELOPMENT

MAINE STATE PLANNING OFFICE

LEGEND

MAINE COMMISSION ON DRUG ABUSE PLANNING DISTRICTS



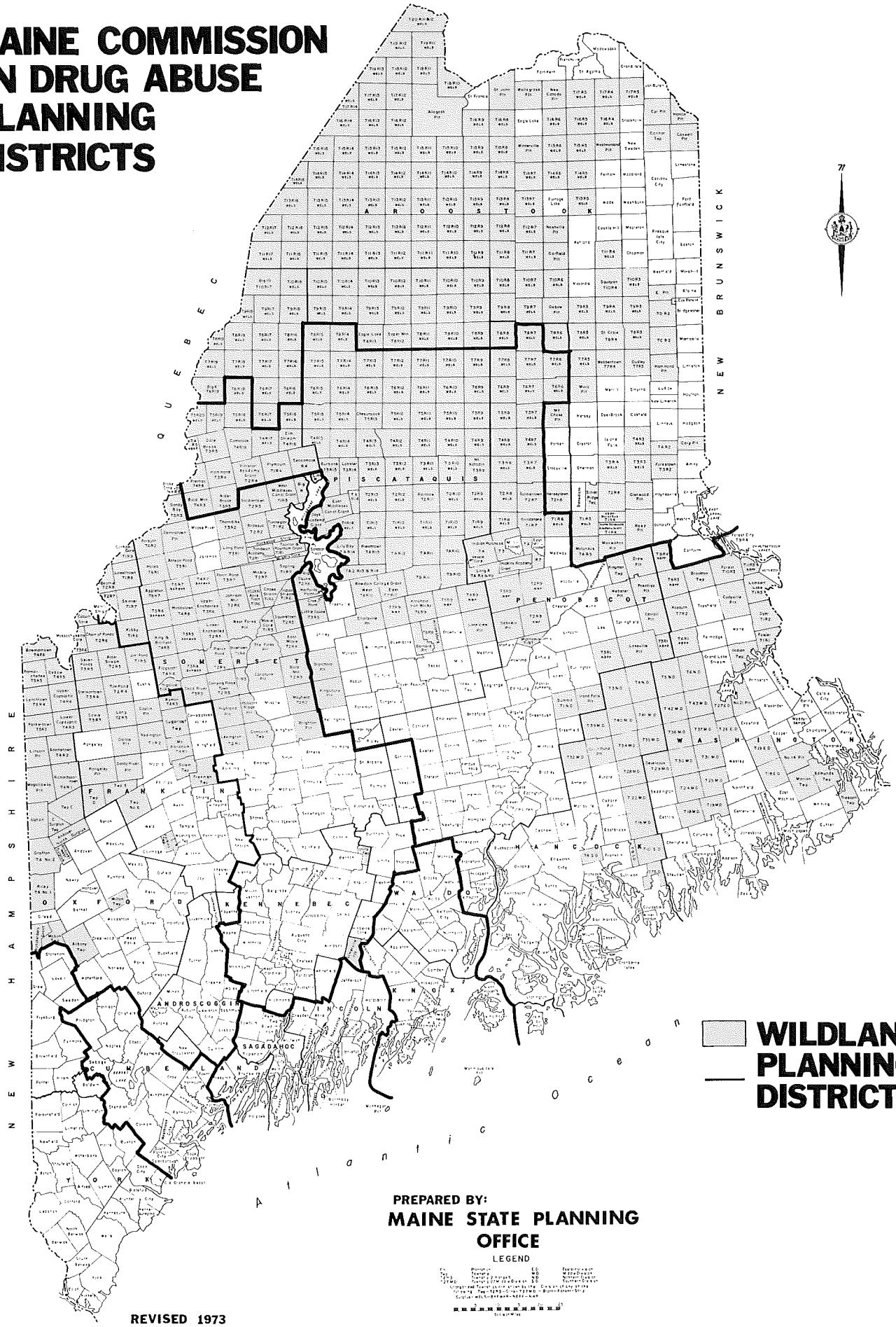
WILDLANDS PLANNING DISTRICTS

PREPARED BY:
MAINE STATE PLANNING OFFICE

LEGEND

REVISED 1973

MAINE COMMISSION ON DRUG ABUSE PLANNING DISTRICTS



WILDLANDS PLANNING DISTRICTS

PREPARED BY:
MAINE STATE PLANNING OFFICE

LEGEND

REVISED 1973

II. PROBLEM DEFINITION

A. Methodology

The Special Action Office for Drug Abuse Prevention's Model Plan guidelines required the Single State Agency to draw specific information from given types of agencies and display this information according to a given format. These requirements were the principle determinates of the methodology utilized by the Commission.

The second basic determinant of methodology was the State Planning process adopted by the Commission (see Section I.C.). This process required the development of a network of planning-coordinators who were responsible for development of a profile of their planning regions. This profile included all descriptive materials and data collection. Commission staff, after careful review of the given data format, preliminary discussions with a sampling of regional coordinators and consultation with the Special Action Office of Drug Abuse Prevention representatives, modified the display characteristics of the given data format. These modifications were necessary to obtain summary data on reporting forms which could be understood and used by the regional planning-coordinators and, also, represented the most effective means of reporting the required data.

The third basic determinate of the methodology utilized by the Commission was time and the availability of funds to implement the planning network.

The Commission and the regional planning-coordinators developed a basic questionnaire and a series of agency-oriented supplements. The summary data sheets, basic questionnaires, and agency supplements were reviewed by all involved state agency representatives and the regional planning-coordinators (Appendix G).

The survey instruments were distributed to the regional planning-coordinators. They were instructed to deliver the questionnaire by mail or in person to the administrators of programs within their catchment areas which had a potential to, or were, serving substance abusers. The following resources were also brought to their attention: Medical Directory of Maine, County Extension Bulletin "Youth Services in Maine" and the Neighborhood Youth Corps. If possible, the regional planning-coordinators met with staff of the various agencies to provide background narrative material on the purposes of the Plan. Appropriate Federal and State agencies were surveyed and program directors were interviewed by Commission staff. Regional planning-coordinators met monthly with Commission staff. These meetings were intended to discuss problems, clarify inconsistencies in policy, check progress and assure uniform reporting practices. In addition, Commission staff were available to regional planning-coordinators in person or by telephone. Commission staff met informally with the planner at their own agencies on numerous occasions.

Once the surveys were returned to the regional planning coordinators, they were scanned for appropriateness of response and in limited cases additional interviews and survey forms were administered. Data from state institutions and agencies (displayed by region) was provided to the regional planning-coordinators for inclusion in their regional profile. Regional coordinators then summed their data, drew preliminary conclusions, and returned all raw data to the Commission. Data was analyzed for each region separately in relation to the remainder of the state to provide an informative regional profile from which the regional plannin-coordinators could draw their conclusions. Insufficient data precluded developing regional profiles for the two northernmost regions of the state.

A. Methodology (cont.)

1. Limitations

This survey represents one of the first attempts in the State to obtain actual information on drug abuse, consequently, an adequate data gathering process did not exist at the outset. The data presented in this report should be prefaced by a statement of the limitations inherent in the data gathering process which affected the reliability and validity of the results. The Maine Commission on Drug Abuse sought data on drug abuse problems, but there was no uniform interpretation of either "abuse" or "problem". Consequently the figures may reflect drug use among clients of health care agencies or they may reflect more severe problems such as overdoses. Under the data collection system employed, no information could be obtained about the drug-related problems that affect patterns of drug abuse.

Only established agencies were contacted, and so the responses do not reflect the general use pattern in the State. The sampling process employed was to send questionnaires to all of the law enforcement, educational and health care institutions within each region and to expect a response by mail. The generally poor response rate can be partially attributed to the mailing technique, but a variety of other factors should be considered, among them being a lack of time and interest on the part of administrators.

Another problem was that the requested data was not readily available because few of the agencies keep accessible records or record "drug problems" as such. Basically for socio-legal reasons, drug problems are recorded by mental health centers, hospitals and human service agencies as physical or psychological problems. Agencies were reluctant to share confidential information on clients.

Law enforcement agencies attempting to respond to the questionnaire found that their categories of drug offenses did not match the SAPDAP categories for arrests and convictions. There is as yet no means of uniform reporting for Maine's local law enforcement agencies although the Maine Law Enforcement Planning & Assistance Agency is presently seeking funds for a State Comprehensive Data System which will include a State Criminal Justice Data Analysis Center.

Another serious limitation was the time factor. No federal funds were received until mid-April which left only four months to organize and implement the survey and analyze the results.

The most basic limitation in the data gathering process was that the SAODAP guidelines were largely irrelevant to the drug problems in the State of Maine and encouraged duplicity in reporting. The guidelines are oriented toward opiate use and methadone treatment programs. There is no evidence of an opiate abuse problem, nor are there any methadone mainenance treatment programs in Maine at this time.

What follows is a detailed analysis of the data collected from a variety of community indicators: police, mental health centers, hospitals, schools and physicians. The age groupings presented additional analysis

problems because they were open-ended and unequal. Consequently, only "juvenile/adult" comparisons are valid. The drug categories on the reporting format prevented multi-drug use from being reported as anything but "Other". The instruments used in the survey were not used uniformly in the regions, perhaps because of their limited applicability to the local problems.

B. Narrative Description

The data furnished by institutions and agencies agree on one point: that the major drug abuse problem in Maine involves the use and abuse of alcohol. This problem crossed all agency, age and sex barriers. Alcohol abuse was concentrated in the "over 35" age group and the problem surfaced most often in the hospitals although it was a problem for all age groups and the major problem faced by all agencies surveyed. The law enforcement agencies reported that an overwhelming majority of their arrests involved alcohol.

Substance abuse involving drugs other than alcohol did not constitute a problem of great magnitude. Only the use of marijuana could be substantiated in any quantity and this was most prevalent within the "below 24" age group. The abuse of amphetamines, barbiturates and hallucinogens occurred mainly within the 15-24 year old age group. The agencies which were most likely to serve this population were human service agencies. Physicians also saw a large proportion of drug abusers, although not as large a proportion of drug abusers as human service agencies, and their clientele was decidedly older than that of the human service agencies. The only difference in the pattern of drug abusers seen by physicians was that they was a larger number of barbiturate abuser over the age of 45 than did any other agency type. The reported use of narcotics was negligible for all agencies and age groups.

On the basis of the data collected, the differences in drug abuse patterns by sex could not be determined. The overwhelming majority of substance abuse cases reported were men. It may be that female abusers did not seek help in great numbers from the agencies surveyed, that their problems were not diagnosed as drug related or that they were not abusing illicit drugs. In any case, the data collected in this study showed women were not termed drug abusers as often as men.

The study showed that most of the substance abusers were adults, but this is mainly due to the fact that the agencies surveyed primarily serve adults. Juveniles and young adults (18-24) accounted for most of the drug abuse, while adults accounted for most of the alcohol abuse. Younger drug abusers sought help form drug programs while adults sought help from more traditional agencies, e.g. physicians, hospitals, mental health centers.

The drug abuse problem was concentrated in Southern Maine, the most populated area of the state. This area also has more agencies and institutions which would serve a drug abusing population than do the other areas, so the problems in that area would come to the surface more often. There were fewer drug problems in Areas I and II than in Areas III and IV. This coincides with the distribution of the population. Alcohol was a statewide problem, occurring in all areas with a fairly equal intensity considering the population differences. Alcohol was a problem where drugs were a problem as well as where drugs were not a problem.

Although the data collected did not substantiate a drug problem, it does not show conclusively that there is no problem. The comments of the respondents to the questionnaire indicate that they believe Maine has a substantial "at risk" population. The risk of becoming substance abusers appears to be high especially for the youth of both rural and urban Maine because of the high unemployment, low incomes, and general lack of opportunities evident in the State.

Staff of drug treatment programs indicated a prevalent pattern of combined alcohol/drug use among younger people. Because the culture condones, even encourages, the use of alcohol many young people discontinue heavy drug use in favor of alcohol. Alcoholism is a progressive problem, its effects on the individual and his/her family may not be visible in the early stages. If the incidence of alcoholism and substance abuse is to be reduced, prevention and early intervention must parallel treatment and rehabilitation programs.

B. Narrative Description (Cont.)

1. Comprehensive Problem Description

(a) LAW ENFORCEMENT

Data describing arrests for substance abuse was gathered primarily from the Maine State Police. In a majority of cases, local police and county sheriffs did not respond to the Law Enforcement Supplement (response rate of 22%). The Law Enforcement Supplement was mailed or delivered in person by the regional planning coordinators to the individual police chiefs or sheriffs. Police chiefs and sheriffs did not respond to the Supplement for the following reasons: they did not have time to respond; they stated much difficulty in establishing the existence of a drug offense; they were tired of surveys; their data was not transferable; they preferred not to respond to a Maine Commission on Drug Abuse survey because it was not being conducted by a law enforcement agency; and they had a low profile problem under control and did not want to inflame the situation. Several Supplements were returned blank. Therefore, table LE-1 represents the proportions of substance use reported by sheriffs, local and State Police. State Police reported substance abuse as either an alcohol arrest or a drug arrest or a drug arrest only. No distinctions were made among drugs, therefore, Table LE-1 is heavily weighted by State Police data in the alcohol and other unknown categories.

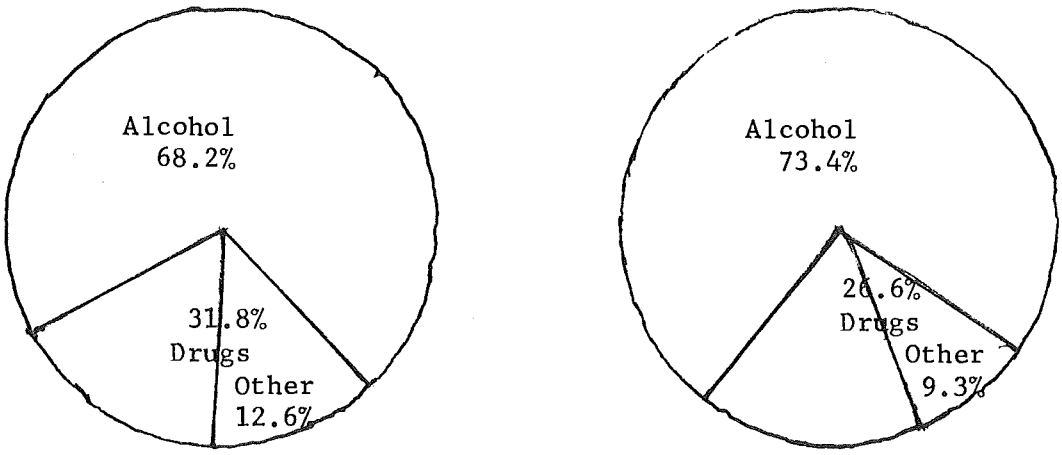
Table LE-1 ARRESTS BY LOCAL POLICE, SHERIFFS AND STATE POLICE FOR SPECIFIC SUBSTANCE ABUSE OFFENSES IN MAINE DURING 1972

Drug	Juveniles	Adults	Total Arrests
Narcotics	0.3%	0.3%	0.3%
Barbiturates	0.2	0.3	0.3
Amphetamines	0.0	1.1	1.0
Hallucinogens	0.0	0.6	0.6
Marijuana	7.2	6.4	6.5
Alcohol	77.9	81.0	80.7
Other	14.4	10.3	10.6
Total	(100.0%) (N=585)	(100.0%) (N-6233)	(100.0%) (N=6818)

Law enforcement data indicates less juveniles (8.6%) are arrested for alcohol offenses. Regional narratives indicate specific peculiarities in the treatment of juvenile offenders. These substance abuse trends correspond to the findings of other agencies surveyed. However, the percentages of arrests for specific drug charges varies considerably from other agency data presented (see Figure SP-1). Juveniles are protrayed as usually more heavily involved in drugs and other-unknown substances than into alcohol. Marijuana arrests remain the most common identifiable arrests for both juveniles and adults. The percentage of arrests falling into other-unknown categories of drugs was highest for drug offenses. However, as has been stated previously, this data sums the total State Police drug arrests and is biased. A further explanation follows when this data is analyzed by offense.

B.1.(a) Law Enforcement

Figure SP-1



Juveniles (669) Adults (6874)

Alcohol arrests accounted for 98.5% of the State Police substance abuse arrests and drug arrests for 1.5% of the State Police arrests. This strongly contrasts with the data obtained from the total law enforcement system (Table LE-1). The majority of drug-involved offenses are handled by local police and sheriffs. The regional law enforcement practices should be closely observed and forward-looking or innovative approaches to the drug abuse problem should be shared with local police across the State.

State Police data reflected no significant difference by sex among juvenile offenders. Adult substance abuse arrest data indicated that males were arrested for 92.7% of the substance abuse arrests and females for 7.3% of these arrests. The majority of all arrests were for alcohol offenses. Women were arrested more frequently for alcohol problems in relation to the percentage of alcohol offenses committed. This data differs from health care system data. Health care system data indicates significant differences among juvenile drug or alcohol use and in some cases distinct differences by sex.

Table SP-1

PERCENTAGE OF TOTAL
ALCOHOL OR DRUG OFFENDERS BY AGE

	0-17	18-24	25-34	35+over
Drug Offenses	13.5%	77.7%	6.4%	2.4%
Alcohol Offenses	9.9%	34.2%	20.6%	35.3%

Table SP-1 indicates that the majority (77.7%) of drug arrests occur in the 18-24 age group. This conforms with national patterns showing that use of illicit drugs is most frequent among this age group. Police and courts exercise more discretion in dealing with juvenile drug offenders, thus reducing arrests in that category. Arrests in the over-25 age group also reflect national studies indicating that this population abuses primarily prescription drugs, caffine, nicotine and alcohol.

Table SP-2 PERCENTAGE OF DRUG OFFENSES BY OFFENSE AND AGE

	0-17	18-24	25-34	35+over	Total % for Drug Offense
Operating Under the Influence	36.4%*	54.5%	9.1%	0 %	3.5%
Sale	4.3	87.2	6.4	2.1	7.6
Possession	12.8	78.3	6.3	2.6	86.8
Other	38.5	53.8	7.7	0	2.1
	(N=84)	(N=483)	(N=40)	(N=15)	(N=622)

*This graph should be read: 36.4% of those arrested for Operating Under the Influence are 0-17 years old.

Table SP-2 indicates those 0-24 represent the greatest percentages of those arrested for alleged drug law violations. Those in the 18-24 age grouping are most frequently arrested for all drug law violations. There is a very noticeable difference in the percentages of those arrested for Operation Under the Influence of Drugs in the 0-24 age groups as opposed to the 35+ age group (practically zero). This reduction is greater than would be expected from age variation alone. This difference is further emphasized when one is aware of the fact that for the most commonly used drugs in Maine, there are no tests to determine whether a person is under the influence. A similar difference is noted for the Other category.

It has been suggested that an additional reservation in interpretation be placed upon this law enforcement data. This data more accurately represents enforcement patterns as opposed to the use patterns of the general population.

Table SP-3 PERCENTAGE OF ALCOHOL OFFENSES BY OFFENSE AND AGE

	0-17	18-24	25-34	35+over	Total % for Offense	
Public Intoxication	4.3%*	31.9%	27.6%	36.1%	12.8%	
Intoxication	2.0	25.4	27.5	45.0	4.3	
Operating Under Influence	1.7	27.6	24.9	35.8	62.5	
Sale	0	100.0	0	0	0.1	(N=3)
Possession	47.7	51.1	0	1.1	11.1	
Transportation	36.0	63.6	0.4	0	7.6	
Procuring for a Minor	3.8	75.5	20.8	0	1.5	
	(N=338)	(N=1176)	(N=708)	(N=1211)	(N=3435)	

*This graph should be read: 4.3% of those arrested for Public Intoxication are 0-17 years old.

Alcohol arrests generally increase with age. This phenomena appears throughout the data and has been explained in the hospital section. However, when arrests are considered by offense, several factors intervene. Juveniles usually do not have access to alcohol or Therefore, overall arrests for alcohol offenses among this group are low. Possession, public intoxication, transportation and procuring of alcohol are the major juvenile offenses

because a juvenile in this situation is, according to law, always committing an offense.

The 18-24 age group evidence the greatest increase in the percentage of all alcohol offenses and more specifically a greater proportionate increase in those offenses juveniles are circumstantially unable to commit. This trend is reflected in all data and indicates increased experience with alcohol.

The percentage of arrests for alcohol offenses drops somewhat in most cases in the 25-34 age group, but this is to be expected because the novelty of the use of alcohol which led to the rapid increase in the 18-24 age group has waived. However, all alcohol use, with the exception of selling, dramatically increases for those over 35. It appears that intervention in the form of alcohol treatment, education and information would be most successful between 18 and 34 when behavior leading toward public intoxication, intoxication and operating under the influence are learned.

Conviction data indicates that, of those arrested for drug offenses by State Police, 57.9% are convicted, the remainder are dismissed, continued, suspended or filed. Among those arrested for alcohol offenses by State Police, 81.1% are convicted, the remainder are dealt with in the same way as above. Among those arrested, significant differences in treatment of drug and alcohol offenders are seen by area and community and are presented by area. 10.5% of those convicted of drug charges were placed on parole or probation and 10.9% of those convicted of alcohol charges were placed on probation or parole.

(b) EDUCATION

The information provided by the 51 school systems which returned the educational supplement (82 were surveyed) show that many of the schools feel they are facing a drug problem, but do not know how to deal with it. Although most of the public school systems (84.3%) provided an educational program designed to affect the students' attitudes toward drug use and abuse, the administrators who answered the questionnaire considered neither the program offering nor the method of presentation adequate or successful. The most frequent response under the "general comments" section was that the schools need guidelines on what to do for drug abuse education and how to do it (75%). Apparently there are few guidelines even within one school system because drug education courses are required by only eleven (21.6%) of the local school boards and only nineteen (37.3%) of the school systems had a uniform drug education policy within their own schools.

As the table below shows, the primary orientation of schools in their current drug education program is informational with the responsibility for that program falling most often on the classroom teacher and/or the health or physical education teacher. The schools utilized a variety of methods of presentation, however, lectures, group discussions and films were most often used.

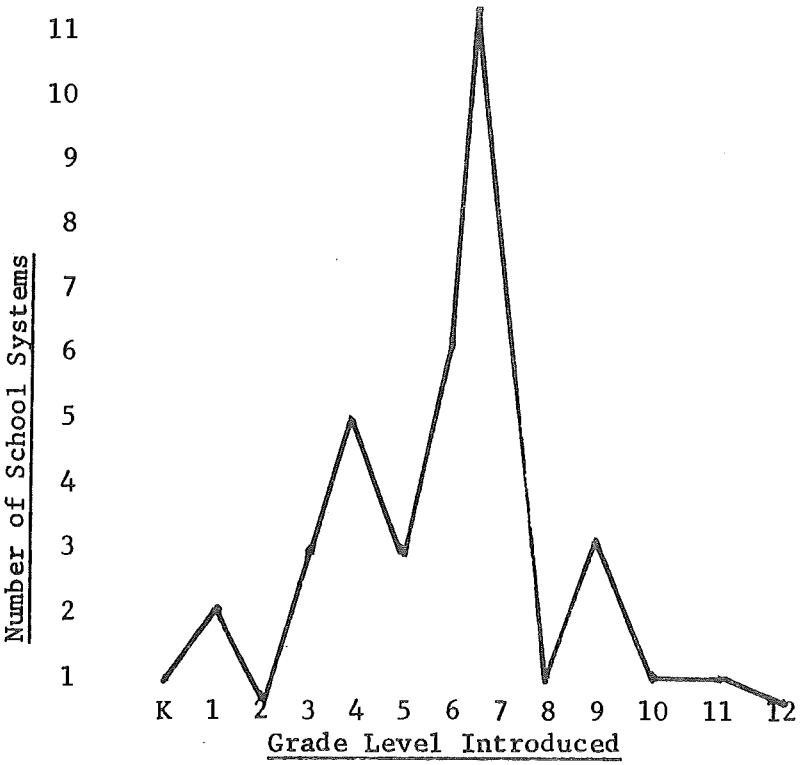
When the schools used outside agencies for drug education programs, they turned to the police most often, but also used counseling centers, rap centers and churches.

DRUG EDUCATION CURRENTLY USED IN SCHOOLS

Educational Approach			Program Responsibility		
Information	41	80.3%	Classroom Teacher	27	52.9%
Value-Orientation	19	37.3%	Health/Phys.Ed.Teacher	21	41.2%
Decision Making	16	31.4%	Program is integrated	20	39.2%
Psycho-Social Orientation	9	17.6%	Guidance Counselor	11	21.5%
Problem Solving	8	15.7%	None	3	5.8%
			Principal	1	2.0%
Presentation			**Source of Material**		
Lectures	31	60.7%	State Dept. of Education	32	62.7%
Group Discussions	26	50.9%	Commercial	24	47.0%
Films	23	45.0%	Teachers	23	45.0%
Standard Curriculum	18	35.4%	Publisher	19	37.3%
Assemblies	17	33.3%			
Student Research	14	27.3%			
Ex-Addict talks	12	23.6%			

The schools differed widely in both the grade level at which they introduce drug education and the amount of class time devoted to it. Only 37 of the 51 responding schools answered the question on the level of introduction. As the graph below shows, most programs were introduced between the 4th and 7th grades.

The average number of hours per week spent in drug education ranged from 1/2 hour per week to 3 weeks per year. The most frequent answer was one week per year which was a "Drug Education Week" in several schools when a variety of lectures and films were presented.



The school administrators felt that the legal aspects of drug abuse limited the responsiveness of the schools to students' drug problems. Teachers were allowed the privilege of confidentiality with students in 68.6% (35) of the school systems, so it would not be necessary to report drug abusers if the teacher could be of some help to the student. It is questionable whether any drug abuse counseling could be carried on by guidance counselors since there is a scarcity of counselors within the schools. The best counselor to student ratio was 1 to 200, but most of the schools reported a ratio of 1:500 or more with some schools having no counselors.

The majority of the schools (52.9%) reporting did not have a uniform policy for the discipline of drug abusers. When a policy was cited, it was most often that recommended by the State of Maine, but individual policies included calling the police.

The responses of the school systems indicated that they do not feel adequately prepared for either education regarding drug abuse or dealing with students who are involved in drug abuse. Perhaps the situation of "no guidelines" could be alleviated if the State Department of Educational and Cultural Services informed school administrators of the Maine Drug Education Program's pamphlet Developing School Drug Policy: A Guide for Administrators and encouraged its use. This report covers most situations regarding drug use which would occur in a school setting and how these situations can be intelligently dealt with. It suggests policies and explains the law in regard to issues such as confidentiality, the contents of pupil records, relationships with the police and discipline procedures. Because the schools are in a position to influence children from an early age, one area needing concentration for combatting drug abuse is educating educators to educate students.

(c) PUBLIC HEALTH LABORATORY

The State's Public Health Laboratory is a public, self-supporting agency. Samples of drugs, plant material, organs, food and other substances are mailed or delivered to the lab for content analysis. Public, health care agencies, private citizens, physicians and others with the required fee utilize this lab's services.

Table PH-1 DRUG SPECIMENS ANALYZED BY THE PUBLIC HEALTH LAB IN 1972*

Narcotics	1.6%	
Barbiturates	4.2%	
Methaqualone	0.7%	
Amphetamines	12.7%	
Cocaine	0.6%	
Cannabis	54.6%	
Hallucinogens	9.6%	
Other	16.0%	
Total	100.0%	N=1312

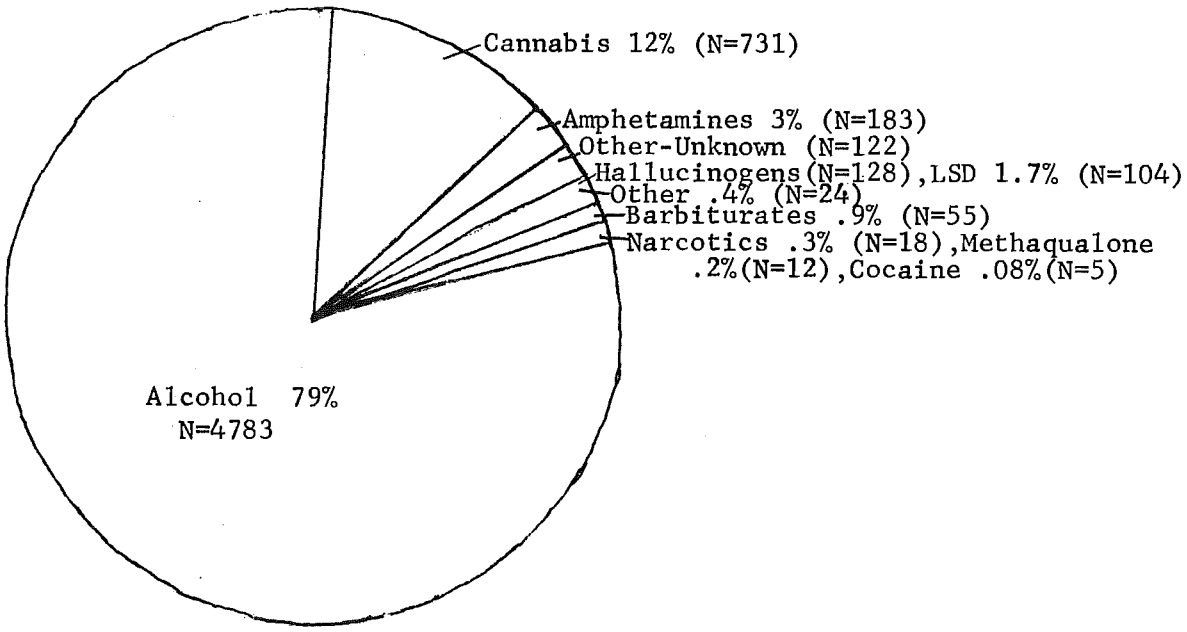
*These are representative percentages among drugs only, excluding alcohol.

This diverse source of data indicates the statewide drug of preference is cannabis. However, statewide, the substance most frequently analyzed was alcohol (N=4783). Alcohol was analyzed approximately four times more frequently than all other drugs combined. Figure PH-1 illustrates the percentages of specimens analyzed by the Public Health Laboratory in 1972.

The Public Health Laboratory recommends an anonymous statewide substance testing service be instituted in cooperation with those agencies concerned with substance use within the State. This service would allow substances with an abuse potential to be identified and the general public and individual submitting the sample to be aware of the potential problems associated with the use of the given substance. Several state models are available for modified use here in Maine.

Figure PH-1

PUBLIC HEALTH SAMPLES ANALYZED (N=6095)



(d) Deaths

Drug-related death data was drawn from the 1972 statistics collected by the Department of Health and Welfare, Division of Vital Statistics. These were coded according to the Eighth Edition of the International Classification of Diseases. Appropriate data was drawn from codes "Accidental Poisoning by Drugs and Medicaments" (E850-E859), "Accidental Poisoning by Other Solid and Liquid Substances" (E860-E869), "Suicide and Self-inflicted Injuries" (E950-#959) and "Injury Undetermined Whether Accidently or Purposefully Inflicted" (E980-E989).

In Maine in 1972 there were 34 drug-related deaths. Suicides accounted for 13 of these deaths. The remaining 21 were either accidental or it could not be determined whether or not they were suicides. The drug involved could be identified or classified within the given drug categories in only 8 cases. The remaining 26 cases fell within the Other-Unknown category. Males were involved in 16 cases and females in 18 cases. Two deaths fell in the age group 0-17, four at 18-24, seven at 25-34 and twenty-one at 35+; five of these deaths being due to barbiturates and and two being due to tranquilizers; the remainder being due to other-unknown drugs.

The Chief Medical Examiner for the State of Maine has provided death and autopsy data for FY 1969-71. This data describes natural, traumatic and total deaths. Within these broad categories, the number of autopsied is reported. Substance-related deaths are reported under the traumatic deaths category by alcoholism and overdose of drugs. The projections for FY72 are based upon the average number of cases for FY69-71 multiplied by the average percent of change in each category over FY69-71 (see Table D-1).

Table D-1 REPORTED DRUG DEATHS
(from Chief Medical Examiner)*

Traumatic Deaths

FY	Autopsy		Deaths		Drug Deaths		Alcohol Deaths		Substance Deaths	
	#	%	#	%	#	%	#	%	#	%
69	185	80.8	651	39.1	8	.5	24	1.4	32	1.9
70	183	71.5	552	30.7	10	.6	15	8.3	25	1.4
71	210	35.8	629	32.6	12	.6	27	1.4	39	2.0
Total FY69-71	578	74.3	1832	33.9	30	.5	66	1.2	96	1.8
Projected FY72	220	75.1	603	30.7	12	.6	31	1.6	44	2.2

FY	Natural Deaths				Total Deaths		
	Autopsy		Deaths		Total Autopsy		Total Deaths
	#	%	#	%	#	%	
69	44	19.2	1011	60.8	229	13.7	1662
70	73	28.5	1245	69.3	256	14.2	1797
71	83	14.2	1353	70.0	293	15.1	1932
Total FY69-71	270	34.7	3609	67.0	778	14.4	5391
Projected FY72	126	43.0	1368	69.7	293	14.9	1962

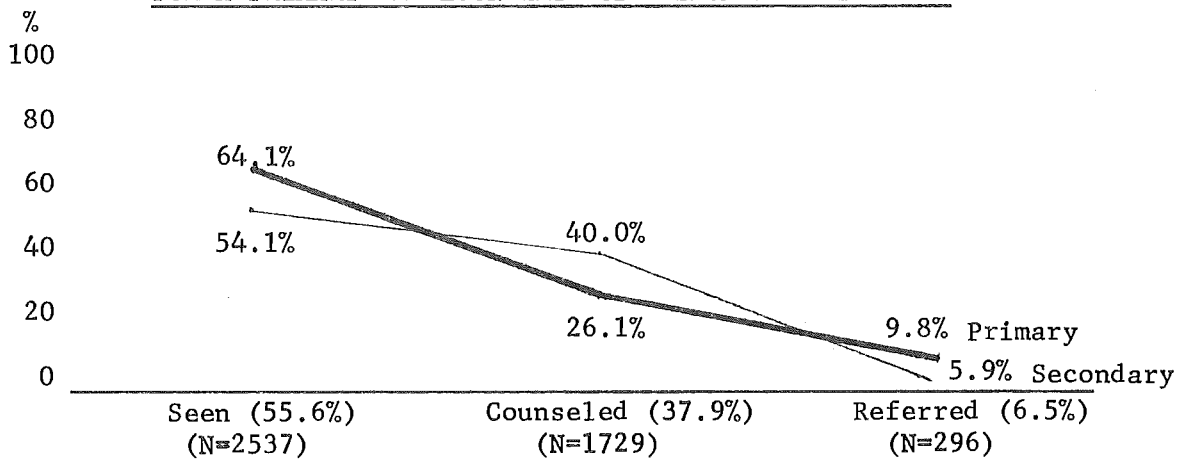
Natural deaths represent the greater percentage of deaths (76%). Within the Traumatic Deaths category (24%), substance-involved deaths have increased. The percentage of alcoholism deaths (2.2%) is significantly greater than drug overdose deaths (.6%). This projected data conforms to the findings reported from all other Health Care System sources.

Caution must be exercised in the interpretation of both Division of Vital Statistics and Chief Medical Examiner's drug-related death data because within the State of Maine there are limited requirements for a body fluids analysis or autopsy. Therefore, the reported incidence of drug-related deaths is very low. The only method of determining a drug-related death is if the above analysis or autopsy is requested, or physical evidence present at the scene of the death indicates drug involvement as the primary cause. However, this evidence is frequently unreported or disregarded to protect the families of those involved. Therefore, this data may represent only a portion of the total substance-involved deaths in the State of Maine.

(e) Human Service Agencies

Data describing human service agencies contact with substance abusers was gathered primarily through the use of the Human Services Supplement. This Supplement was mailed or delivered in person by the regional planning-coordinators to the administrators of human service agenceis listed in the Maine Human Resources Index or as yet unlisted programs within their catchment areas which had a potential to or served substance abusers. Area reports more specifically describe response variations within a particular region. Data was reported by level of contact, treatment and age of a particular type of substance abuser. 50% of the human service agencies in the State responded.

Figure HSA-1 THOSE CONTACTING HUMAN SERVICE AGENCIES FOR A PRIMARY OR SECONDARY SUBSTANCE ABUSE PROBLEM



Human service agencies' data indicated the majority (55.6%) of those contacting them for a substance abuse problem were seen on a one-time bases. The remainder (37.9%) were regularly counseled or referred (6.5%) to a more appropriate agency for treatment.

A greater percentage of those seen (64.1%) evidenced a problem in which substance abuse was a contributing factor (secondary), as opposed to the primary reason for contacting (54.1%) the human service agency. A smaller percentage of those with a secondary substance abuse problem were counseled (26.1%) in comparison to those with a primary substance abuse problem (40.0%) and a greater percentage of those with a secondary problem (9.8%) were referred to another agency than those with primarily a substance abuse problem (5.9%). Therefore, it appears human service agencies are selecting for counseling the most appropriate cases contacting them and referring the remainder of those approaching them to a more appropriate agency for treatment (see Figure HSA-1).

Table HSA-1 lists the percentage rankings of those substances preferred by users, seen, counseled or referred for primary or secondary substance abuse.

Table HSA-1

DRUG ABUSE DIAGNOSIS
(by treatment)

	Primary Drug Problem			Secondary Problem		
	Seen	Counseled	Refrd	Seen	Counseled	Refrd
Narcotics	3.5%	2.3%	3.1%	0.9%	1.1%	0 %
Barbiturates	8.5	7.3	10.1	12.0	2.7	4.3
Amphetamines	11.5	10.3	16.3	13.4	3.3	1.4
Hallucinogens	10.4	7.3	6.2	13.8	7.1	4.3
Marijuana	8.3	5.2	3.5	45.4	22.4	31.9
Alcohol	55.1	66.1	58.6	14.5	63.4	56.5
Cocaine	0.7	0.1	0	0	0	1.4
Other	2.1	1.4	2.2	0	0	0
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	(N=2085)	(N=1543)	(N=227)	(N=449)	(N=183)	(N=69)

Table HSA-2 presents the composite percentage rankings of those substances preferred by those seen, counseled or referred for primary, secondary, or total contact for substance abuse.

Table HSA-2

SUBSTANCE ABUSE
(by diagnosis)

	Primary Diagnosis	Secondary Diagnosis	Total Occurrence
Narcotics	3.0%	0.9%	2.7%
Barbiturates	8.1	8.8	8.2
Amphetamines	11.3	9.6	11.0
Hallucinogens	8.9	11.1	9.2
Marijuana	6.7	38.1	11.6
Alcohol	59.7	31.4	55.3
Cocaine	0.4	0.1	0.4
Other-unknown	1.8	0	1.6
	(100.0%)	(100.0%)	(100.0%)
	(N=3855)	(N= 701)	(N=4562)

Analysis of human service agencies data by type of substance abuse encountered and level of diagnosis indicate alcohol abuse accounts for the majority of substance abuse encountered (55.3%) and drug abuse accounted for 44.7% of the substance abuse encountered. Amphetamines appear to be the drug of preference. This overall trend of alcohol being the statewide substance of preference holds true for all data regardless of source. Human service agencies contact the greatest percentage of cases with amphetamines being the drug of choice.

Table HSA-1 indicates that, among those treated by human service agencies who evidenced a primary (59.7%) and secondary (31.4%) alcohol abuse problem, a significantly larger percentage were seen at a primary level (55.1%) than a secondary level (14.5%), and a slightly higher percentage were counseled (66.1%) at a primary level than a secondary level (63.4%). Alcohol case referrals remained approximately the same at both problem levels.

Those substance abusers who evidenced drug abuse problems were significantly different in both frequency of contact and drug preference profile. A

significantly larger percentage of drug-involved were seen at the secondary (85.5%) level than the primary level (44.9%) and a larger percentage were counseled at a secondary level (39.6%) than a primary level (33.9%). Drug problem referrals remained about the same at the primary (41.4%) and secondary levels (43.5%). However, amphetamines were the drug of preference at the primary level for all categories, whereas, marijuana was the overwhelming drug of preference.

Analysis of human service data by drug and age of those served (all seen, referred or counseled) is presented in Table HSA-3.

Table HSA-3

HUMAN SERVICE AGENCY
SUBSTANCE ABUSE CONTACTS
(by age)

	0-14	15-17	18-25	26-35	35+
Narcotics	0 %	3.1%	6.0%	1.3%	0.1%
Barbiturates	28.4	13.8	17.2	4.7	1.5
Amphetamines	14.8	26.0	18.9	4.9	0.7
Hallucinogens	9.9	19.8	17.5	3.6	0.1
Marijuana	14.8	19.8	21.2	3.1	1.0
Alcohol	24.7	16.1	17.5	80.8	96.4
Cocaine	0	0	0.3	0.3	0
Other	7.4	1.3	1.3	1.3	0
	100.0%	100.0%	100.0%	100.0%	100.0%
	(N=81)	(N=384)	(N=697)	(N=386)	(N=669)

Figure HSA-3 illustrates the percentages of drug and alcohol contracts with human service agencies by age.

Figure HSA-3

HUMAN SERVICE AGENCY
DRUG-ALCOHOL ABUSE CONTACTS
(by age)

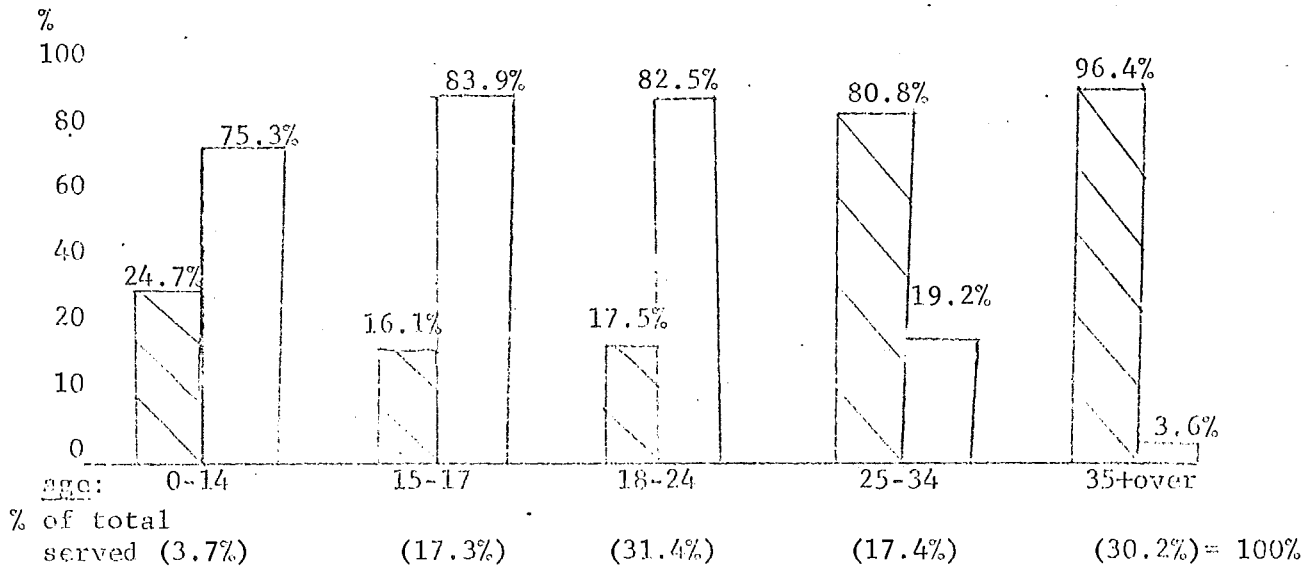


Table and Figure HSA-3 indicate the percentages of each substance abused within a given age group. Contacts in the groupings 18-24 (31.4%) and 35+over (30.2%) account for 61.6% of the total substance abuse problem. Age groupings 15-17 (17.3%) and 25-34 (17.4%) are closely matched and total all but a fraction of the remaining problem (3.7%). However, specific drug preferences within an age category very significantly. The 0-14 age group evidence a higher percentage (75.3%) of drug use as opposed to alcohol use. The drug of preference in this age group is barbiturates (28.4%) with alcohol following a close second (24.7%). Amphetamines are third in order of preference. All these drugs are legally obtained by prescription and readily available in the home. This suggests the source of drugs for youth of this age is the home.

Among those 15-17, drugs account for 83.9% of the substance abuse problem. The greater percentage of drugs of preference are street drugs: amphetamines (26%), hallucinogens and marijuana (19.8% each). Alcohol abuse ranks fourth at 16.1%.

Substance abusers in the 18-24 age group reflect a low preference for alcohol (17.1%) in relation to drugs (87.5%). Their drug of preference is marijuana (21.2%). Other drugs of preference followed the 15-17 age group patterns.

Substance abuse in the 25-34 age group abruptly shifts and reflects a high preference for alcohol (80.8%). Drug preferences accounts for only 19.2% of the substance abuse problems with amphetamines (4.9%) being the drug of preference followed closely by barbiturates (4.7%). Drugs available by prescription as opposed to street drugs evidence themselves as 9.6% of the drugs of abuse among this age group.

Barbiturates (1.5%) are the drug of preference for the 3.6% of those substance abusers 35+over who abuse drugs. The remaining overwhelming majority of 96.4% of this age group abuse alcohol. This "trend" runs true throughout the age-grouped data from all sources and accentuate the abuse of the most readily available substance for the segment of the Maine population being considered.

(f) PHYSICIANS

A majority (142 or 68%) of the 227 physicians who returned the "Physician's Supplement" felt that drug abuse has become a problem in the community which they serve. These physicians included 91 general practitioners and family medicine specialists, 19 various specialists and 114 doctors who did not give their specialty. Most of the doctors (73.5%) did not think that there had been increase in the drug use, but 45 doctors (22.5%) had seen an increase over the past two years. This minority may be made up of the doctors who actually treat drug abusers because most of the physicians in the sample admitted that they had little or no contact with that part of the population.

When the physicians were asked what drugs they felt were a problem in their community, a significant proportion of them felt that the "hard drugs" were as much of a problem as alcohol and marijuana. Young adults were involved in most of the drug abuse. As the table below shows, they saw problems with narcotics, barbiturates, amphetamines and hallucinogens.

DRUG PROBLEM BY AGE GROUP

Drug	School Age	Young Adult	45-65	65+	Total
Narcotics	3.7%	8.3%	3.7%	0	5.5%
Barbiturates	9.4%	12.2%	20.2%	13.7%	13.3%
Amphetamines	18.0%	18.1%	6.9%	2.9%	14.3%
Hallucinogens	14.7%	12.0%	0.5%	1.0%	9.2%
Alcohol	15.1%	25.6%	67.9%	81.4%	37.3%
Inhalants	6.9%	1.8%	0	0	2.5%
Marijuana	31.4%	20.9%	0.5%	0	17.1%
Other	0.8%	1.0%	0.5%	1.0%	0.9%
Total	100 % (N=245)	99.9% (N=492)	100.2% (N=218)	100 % (N=102)	100.1% (N=1057)

The physicians felt that school age children were abusing narcotics, barbiturates, amphetamines, hallucinogens and inhalants. Drugs abused by persons over 45 years of age included narcotics, barbiturates and amphetamines. Physicians felt that alcohol was abused by all age groups, but especially by adults over 45. Marijuana abuse occurred only among school age persons and young adults. However, doctors were divided on whether or not marijuana was a problem, some favored its legalization and some wanted stricter law enforcement.

Although most of the physicians felt that there were specific drug problems in their communities, 71.4% thought that few of the persons with those problems seek help from physicians. This probably reflects the fact that drug abusers tend to seek help from certain physicians

who will give them the best care with the least amount of condemnation.

The physicians most often used an outpatient method of treatment. When hospitalization was used, it was most often used for persons in the over-35-years age group. Only 8% of the doctors had ever prescribed treatment in a halfway house.

Almost half (45.8%) of the physicians felt that the State laws relating to the treatment of minors limited their effectiveness in treating youthful drug abusers. Another 20% of the physicians did not know if the laws hampered their effectiveness with youth because they had no way of knowing how many youths were kept away by the laws. A majority (62.8%) of the respondents did not feel that the Food and Drug Administration regulations relating to treatment limited their effectiveness. Those doctors who felt limited by the regulations considered them too restrictive and felt that reporting procedures kept patients away.

Over half (59.1%) of the physicians felt that drug abusers needed more than medical attention and that good treatment included the use of community resources such as drug rescue centers. However, when they were asked what community resources they referred patients to, Mental Health Centers (68) headed the list; rap and rescue centers (26) and AA (21) being the other major recipients of referrals. This indicates that perhaps doctors need to be educated to use the drug centers more since mental health centers do not really wish to deal extensively with drug abuse.

The physicians, too, seemed to question whether or not anyone knows how to prevent or deal with drug abuse. 48.9% of them considered the existing educational programs inadequate, but several of them questioned the effectiveness of any education program. Several physicians considered drug abuse the problem of an emotionally immature culture. Several others felt that Maine needs a rehabilitation center for drug abusers.

(g)MENTAL HEALTH

At least one mental health center or branch office in each of the eight regions returned the mental health supplement which requested information on the number of cases diagnosed in 1972 as a primary or secondary drug or alcohol problem. The Centers responded in numbers of cases. However, those numbers are only estimates and may not reflect either the actual substance abuse among clients or the actual number of clients. As the table below incidates, the mental health centers report very little contact with drug abusers. The total number of clients with any type of substance abuse problem way only 1,150 for the state. The drugs which mental health centers appear to be concerned with are alcohol and marijuana which account for 75% of the adult and 45% of the juvenile drug abuse for the primary level of diagnosis and 90% of the adults and 54% of the juveniles for the secondary level of diagnosis. The reported use of any narcotics or other "hard drugs" was slight.

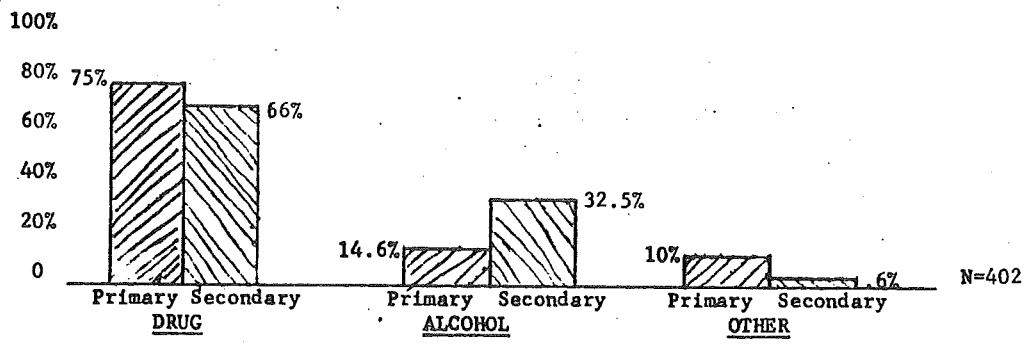
MENTAL HEALTH CENTERS

Drug	Primary Diagnosis			Secondary Diagnosis		
	0-17 Juvenile	18+over Adult	Total	0-17 Juvenile	18+over Adult	Total
Narcotics	2.1%	2.0%	2.0%	1.2%	.3%	.6%
Barbiturates	10.9%	5.6%	7.4%	10.4%	2.3%	5.1%
Amphetamines	15.5%	6.2%	9.4%	17.2%	4.3%	8.8%
Hallucinogens	16.7%	2.4%	7.4%	16.0%	2.3%	7.1%
Marijuana	30.1%	10.7%	17.4%	22.1%	7.9%	12.8%
Alcohol	14.6%	65.6%	47.9%	32.5%	82.9%	65.3%
Other	10.0%	7.6%	8.4%	.6%	0	.2%
Total	99.9% (N=239)	100.1% (N=450)	99.9% (N=689)	100.0% (N=163)	100.0% (N=304)	99.9% (N=467)

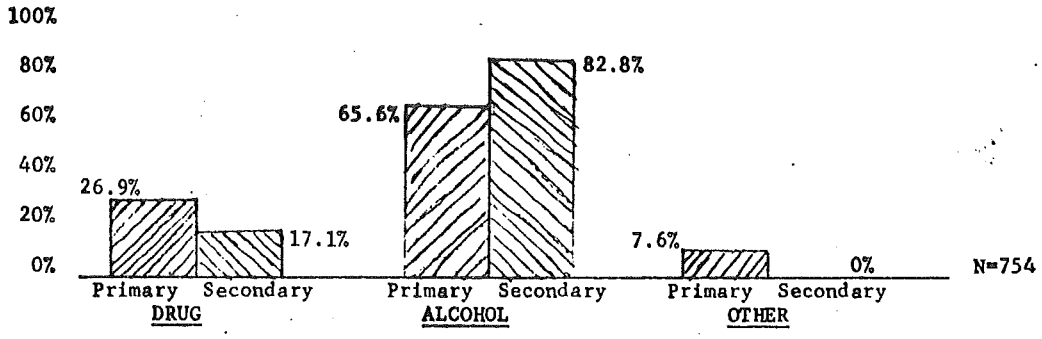
When the sex of the clients was considered, alcohol and marijuana were again the prime drugs abused on the primary level (70% of the men and 55% of the women) and the secondary level (80% for men and 74% for women). As would be expected from the national figures, women abused drugs more often than men while men abused alcohol more often than women for the primary level of diagnosis. There was no difference between men and somen on the secondary level of diagnosis and alcohol accounts for 2/3 of that abuse.

Even when all of the drugs (including marijuana) were summed and compared to alcohol, alcohol was the main substance abused by adults and accounted for nearly a third of juvenile drug abusers. Drugs were more often a primary abuse proglem while alcohol was more often a secondary problem.

JUVENILE MENTAL HEALTH LEVEL OF DIAGNOSIS



ADULT MENTAL HEALTH LEVEL OF DIAGNOSIS



The mental health figures for the state support the national trend that juveniles and adult women are the primary drug abusers. However, mental health centers reported that most of their clients were men and adult, which partially accounts for their lack of contact with drug abuse. Mental health centers do not consider it within their function to serve as drug treatment centers, so persons with drug problems are not likely to seek help from them. Mental health centers are primarily concerned with treating psychological problems, and if they do treat drug abusers, they probably treat them in relation to another problem, so they are not reported as drug abusers.

(h) Hospitals

Data describing the contact of hospitals with substance users was gathered primarily through the Blue Cross Data Service. This was necessary because of a poor response to the Hospital Supplement. The Supplement was mailed or delivered in person by regional planning coordinators to hospital administrators. In the majority of cases this supplement was either not returned, returned blank or returned with a statement of non-compliance. They gave the following reasons for not responding to the supplement: They did not have the time to fill out the survey; they were tired of surveys; their records were not kept in a manner which lent itself to this type of a report. Physicians usually disguesed drug abuse cases 1) to avoid causing embarrassment to the patient; 2) to provide the patient with an acceptable insurance claim; and 3) for reasons of confidentiality. Hospital records were confidential and not open for review by non-medical personnel. They saw no resulting benefit to themselves or their hospital if they replied. Our regional planning coordinators could review individual case folders for 1972 and pull the necessary data, but the hospital had neither the staff not the time to devote to this procedure.

The Blue Cross Data Service is a pilot project of the Blue Cross Medical Insurance System. This service collects data from the majority of hospitals in Maine. Data is displayed by diagnosis (primary and secondary levels), age, sex, and several other variables. The system has voluntary reporting requirements. Medical treatment for those with a primary or secondary diagnosis in the following categories: 10 categories of alcohol involvement and 10 categories of drug abuse based upon the substance abused. Data could not be collected for an individual hospital because waivers were not granted. However, data for the hospitals within an entire planning region could be collected.

Most hospitals responded well to this service. However, cases of drug and alcohol abuse are less likely to be reported than medical cases, alcohol abuse is more likely to be reported than drug abuse, and both categories are less likely to be reported by small hospitals and rural areas. The longer a hospital responded to this data service, the more likely the hospital was to report alcohol and drug abuse cases. Data from State Hospitals and the VA Hospital have been summed with general hospital data.

Data was collected from 79% of the state's hospitals. This data indicated 58.7% (N=769) of those treated by hospitals for substance abuse were treated for this condition as a primary diagnosis and 41.3% (N=541) were treated or observed to evidence this condition in association with another problem or as a secondary diagnosis.

Table H-1 and Figure H-1 indicate the percentages of substance abuse, age grouping of abuser and the diagnostic level of abuse reported by all Maine hospitals for 1972.

Figure H-1 Shows percentage of abuse of a substance in relation to all substances abused by primary and secondary diagnosis.

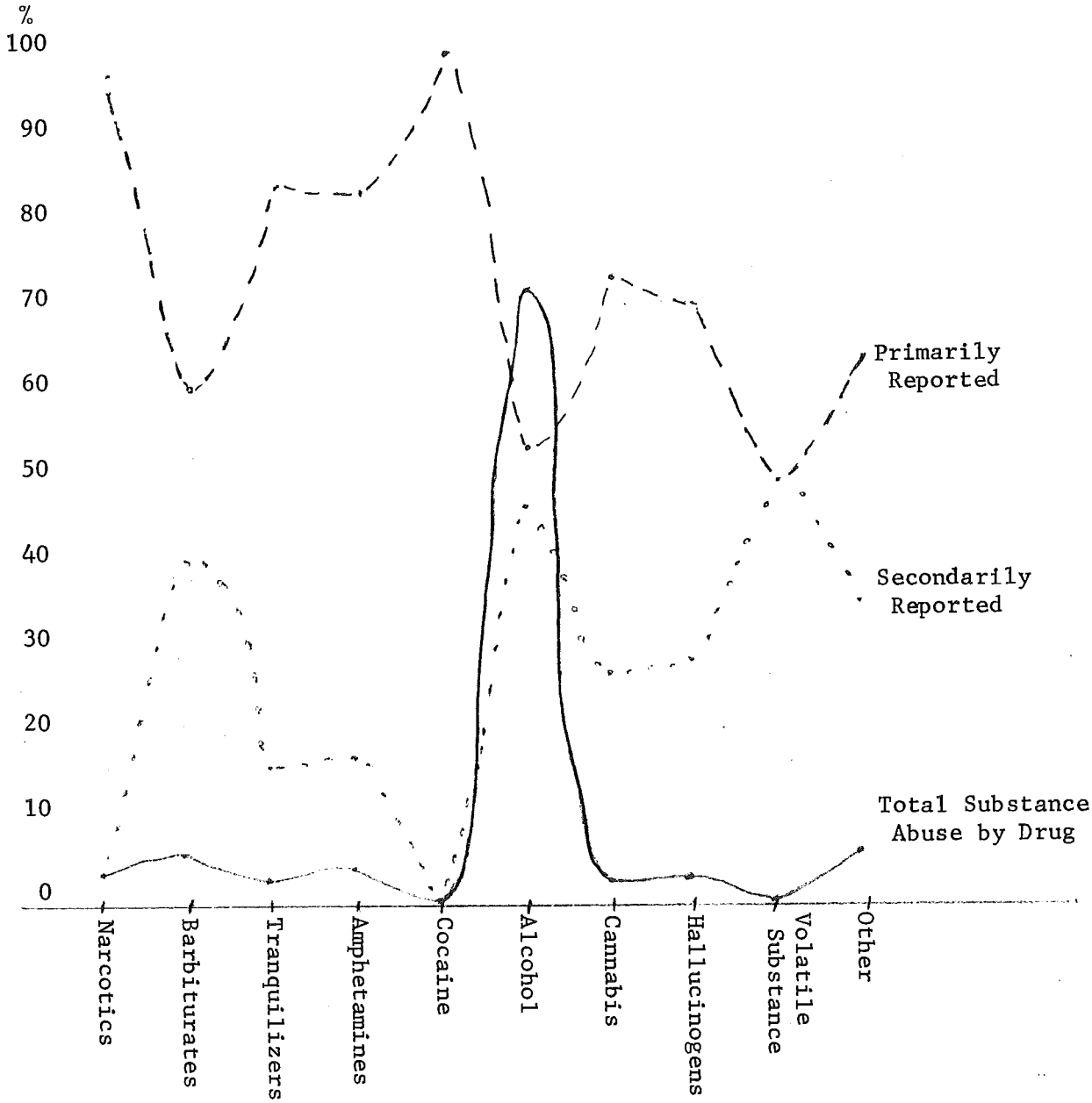


Table H-1

INDIVIDUAL SUBSTANCES ABUSED
IN RELATION TO ALL DRUGS
(primary or secondary diagnis)

	Primary	Secondary	% of Drugs Seen
Narcotics	97.1	2.9	2.7
Barbiturates	60.0	40.0	5.3
Tranquilizers	84.4	15.6	2.4
Amphetamines	83.0	17.0	4.0
Cocaine	100.0	0	0.2
Alcohol	53.2	46.8	72.3
Cannabis	73.5	26.5	2.6
Hallucinogens	71.1	28.9	3.4
Volatile Substances	50.0	50.0	0.3
Other-unknown	64.4	35.6	6.6
	(N=769)	(N=541)	(N=1201)

As Table H-1 indicates, alcohol which accounts for the majority of substance contact is treated about equally as a primary or secondary problem. Drugs which appear to have the greatest potential for fatal consequences as a result of abuse were treated as primary problems. Hospital reporting of substance abuse by age and level of diagnosis is represented in Table H-2, H-3, and H-4 and Figure H-2.

Table H-2

SUBSTANCE ABUSE BY AGE
AND LEVEL OF DIAGNOSIS

	0-17	18-24	25-34	35+over	Total
Primary Diagnosis	2.5%	10.8%	11.0%	75.7%	100%
Secondary Diagnosis	3.5%	11.8%	15.0%	69.7%	100%

Table H-3

HOSPITAL REPORTING OF SUBSTANCE ABUSE
by age, substance and primary level of diagnosis*

Substance	Age = 0-17	18-24	25-34	35+over	% of drugs abused
Narcotics	0 %	12.6%	3.1%	0.2%	1.9%
Barbiturates	11.4	4.7	2.6	1.7	2.4
Tranquilizers	6.8	1.6	3.6	1.0	1.5
Amphetamines	4.5	13.1	7.2	0.2	2.5
Alcohol	29.5	38.7	71.1	95.4	85.0
Cannabis	0	8.9	4.1	0	1.4
Hallucinogens	9.1	10.5	4.1	0	1.8
Volatile Substances	2.3	1.6	0.5	0	0.3
Other	36.4	8.4	3.6	1.3	3.2
N =	(44)	(191)	(194)	(1340)	(1769)
	(100%	(100%)	(100%)	(100%)	(100%)

*Cocaine eliminated because not enough cases for comparison.

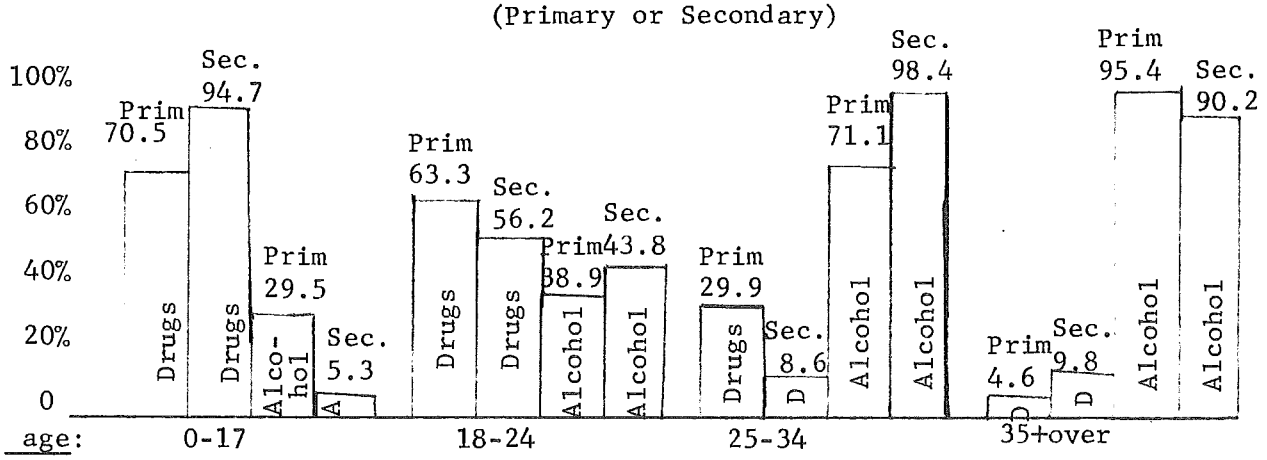
Table H-4 HOSPITAL REPORTING OF SUBSTANCE ABUSE
by age, substance and
secondary level of diagnosis*

Substance	Age = 0-17	18-24	25-34	35+over	% of drugs abused
Barbiturates	31.6	10.9	1.2	3.7	5.2
Tranquilizers	5.3	1.6	1.2	0.5	0.9
Amphetamines	10.5	6.3	1.2	0.5	1.7
Alcohol	5.3	43.8	91.4	90.2	81.9
Cannabis	15.8	6.3	1.2	0.3	1.7
Hallucinogens	10.5	10.9	0	1.1	2.4
Volatile Substances	5.3	0	1.2	0	0.4
Other	15.8	20.3	2.5	3.7	5.9
N =	(19) (100%)	(64) (100%)	(81) (100%)	(377) (100%)	(541) (100%)

*Narcotics eliminated because not enough cases for comparison.

Table H-3 and Table H-4 are comparison analyses of hospital data on substance abuse by age and level of diagnosis. Alcohol abuse accounts for 85% of those primarily diagnosed for substance abuse, and 81.9% of the secondary diagnoses.

Figure H-2 SUBSTANCE ABUSE BY DIAGNOSIS
REPORTED TO HOSPITALS - 1972
(Primary or Secondary)



Total substance abuse data sees to indicate that substance abuse increases with age. However, alcoholism is a progressive disease and the longer alcohol is consumed, the greater irreversable mental and physical damage, therefore the more frequent the hospital contact.

Substance abusers 0-17 are at both levels of diagnosis, primarily drug cases. Alcohol is diagnosed at the primary level as the second substance of preference, but at the secondary level is of a low preference. Barbiturates are five times more frequent in relation to all other substances. This is probably biased becaues of the severe medical consequences of barbiturate abuse.

Among those 18-24 drugs are still the major substance of abuse both primarily and secondarily. Specific drug preferences tend heavily toward amphetamines and narcotics. These preferences are 5 and 6 times that of these drugs in

relation to all substances. Those substance users with a secondary diagnosis of drug use prefer the other-unknown category. This data indicates hospitals receive only a select clientelle of very severe cases at the primary level and a conglomeration of substance users at the secondary level.

In the 25-34 age group of substance abusers, the relative proportions change with respect to drug and alcohol contact. Alcohol abuse represents the majority of those substance users contacted at the primary level and the minority of those contacted at a secondary level. This rapid change may be a direct result of the organic damage produced by alcohol abuse.

Those substance abusers 35 or older follow national trends and at both the primary and secondary levels almost exclusively abuse alcohol. Primary and secondary drug abusers in this age group prefer barbiturates to a very limited degree. The only striking differences by sex and level of diagnosis appear to be an overwhelming majority of substance abuse by males at both levels of diagnosis, a preference by both sexes at both levels of diagnosis for alcohol, a preference for barbiturates and tranquilizers by females at both levels and an increase from 0.4% to 6.3% in preference for barbiturates at a secondary level of diagnosis.

(i) Health Care Comparison Data

Comparisons between surveyed agencies of the health care system were made to assess the percentages of substance abusers serviced by each agency. Comparisons were made between agencies by age, agency and substance abused. Like comparisons were made within each agency. These comparisons serve to indicate which general category of agency is the most probable agency to service a select portion of the substance abusing population at a select point in their lives.

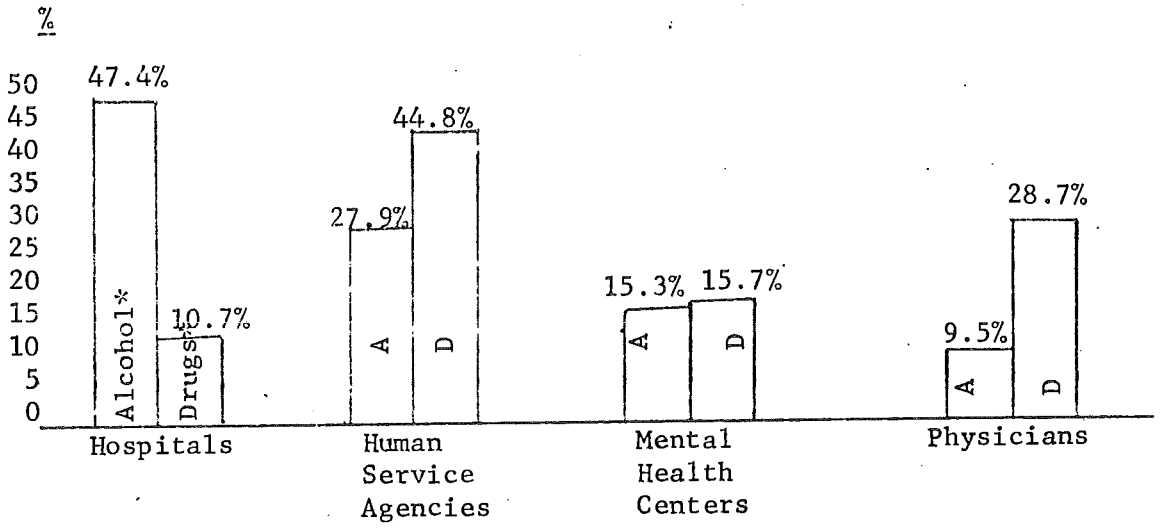
Table C-1

SUBSTANCE ABUSE COMPARISON
(by age, drug and alcohol)

	Hospital	Human Service Agencies	Mental Health	Physicians
Adult Alcohol Abuse	97.9%	92.9%	86.1%	90.6%
Juvenile Alcohol Abuse	2.1 (100.0%)	7.1 (100.0%)	13.9 (100.0%)	9.4 (100.0%)
Adult Drug Abuse	87.9%	63.9%	47.8%	68.8%
Juvenile Drug Abuse	12.1 (100.0%) (N=1201)	36.1 (100.0%) (N=4562)	52.2 (100.0%) (N=1156)	31.2 (100.0%) (N=1057)

Figure C-1

HEALTH CARE AGENCY
ALCOHOL-DRUG CONTACTS
(by agency)



*Alcohol abusers: N=4126
**Drug abusers: N=2301

Figure C-2

SUBSTANCE ABUSE CASE LOAD
(by age and drug and alcohol)

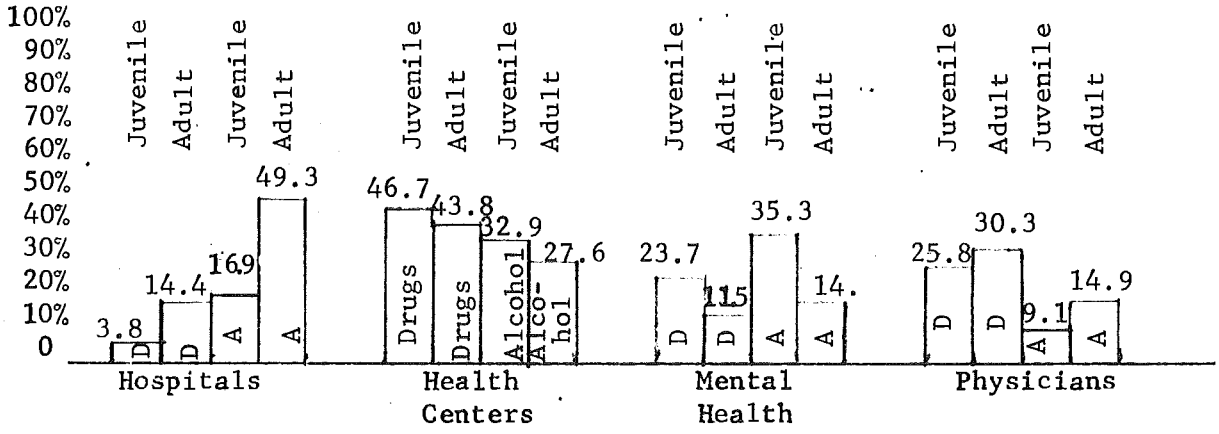
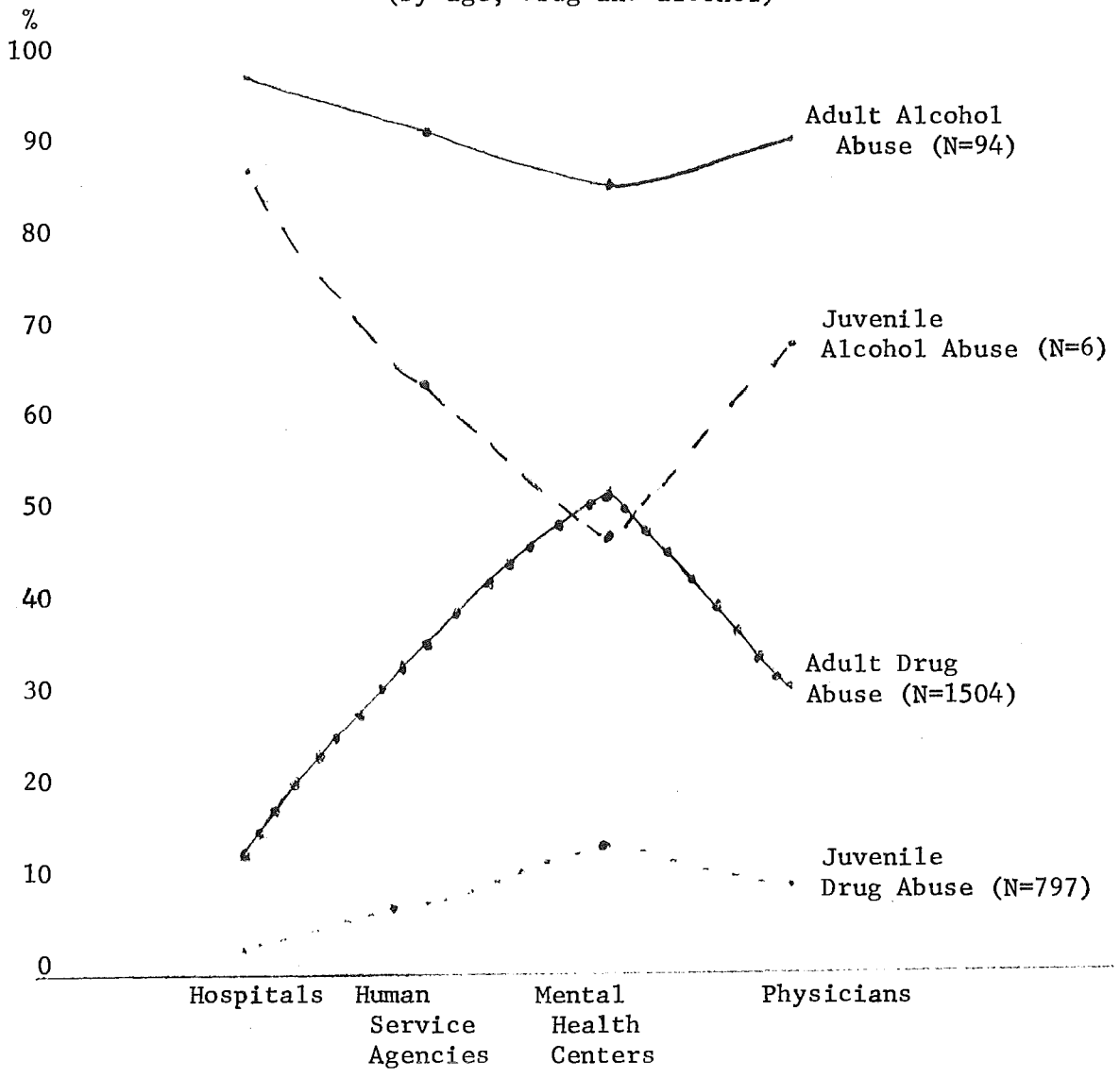


Figure C-3

SUBSTANCE ABUSE COMPARISON
(by age, drug and alcohol)



Tables C-1, and Figures C-1,2,3 indicate the distribution of treatment of drug abuse cases among the various health care agencies. Human service agencies role and potential in treating the substance abusing population are excellent. Their abilities and appeal are concentrated in the treatment of both adult and juvenile and adult drug cases. They also treat a considerable proportion of both juvenile and adult alcohol cases. They have the greatest locus for preventative youth and adult oriented approaches to substance abuse treatment. Human service agencies appear to be the returning point of social contact chosen by substance abusers. Agency responses indicate they desire to develop, indrease and diversify their youth and adult substance abuse programs. Human service agencies appear to be open enough and least institutionalized to be able to permit development of well-directed experimental treatment rehabilitation and referral programs which could prove to be the most effective means of dealing with Maine's youth and adult substance abuse problem.

Physicians' role and potential in treating substance abuse appears to be high. However, this is severely limited to the treatment of adult drug cases. They do not treat a significant percentage of juvenile drug or alcohol cases. Physicians indicate they are not seen as a viable point of contact by youthful substance abusers. Their function as alocus for preventative approaches is limited to a careful review of the reason for and quantities of prescribed drugs, development of a preference for the prescription of drugs with the least abuse potential, a complete explanation of a drug's indicated and side effects upon patients and a very strong written request to pharmacists to state the name of the drug on the prescription label. Physicians' direct service potential is limited primarily to the treatment of acute cases. However, they are most effective in the training of para-professionals within the human service agencies.

Mental Health Centers role and potential in treating substance abuse cases is limited. Their ability in relation to other agencies appear to be concentrated in the treatment of juvenile alcohol users. However, they show an expertise for the treatment of juvenile drug abusers, also. Mental Health Centers evidence a potential as a locus for juvenile substance abusers. Their abilities could be more effectively concentrated upon the problem of substance abuse and particularly that of juvenile substance abuse if they were to serve as a primary referral and training source for the Human Service Agencies.

When considering hospitals' roles in affecting the substance abusing population, it must be kept in mind that its potential is small in comparison to the effect of other human services agencies. Their potential is concen--trated almost exclusively among adult substance abusers, rimarily alcoholics. They have little potential as a locus for preventative or youth-oriented approaches to substance abuse treatment. They are limited in treatment of substance abusers to acute alcohol and drug cases. Hospital responses indicate they neither desire to develop, increase, or diversify their substance abuse programs.

(j) Conclusions

The regional planning coordinators, in conjunction with the representatives from various state agencies, have come to the following conclusions regarding the data. The survey did not identify or quantify the drug use/abuse problem in Maine. It did identify and describe the portion of the population who contacted the institutions and agencies surveyed for substance abuse problems. Based upon the data collected, it can not be concluded that there is or is not a severe substance abuse problem in Maine. Many substance users and abusers do not seek aid from established health care institutions or come into contact with the police. The data does indicate that among substances used or abused by the portion of the population surveyed, hard drugs did not represent a significant proportion of substance abuse reported. Alcohol is the major substance of use or abuse.

The data indicate that traditional services are not reaching potential clients. Therefore, contact points within agencies should be improved to refer potential clients to appropriate agencies for service. A state-wide uniform substance education policy and school discipline policy should be developed and implemented as soon as possible. Programs should be developed to fulfill a documented need and provide services to the population at risk regardless of internal state geographical divisions.

An improved data acquisition system is necessary. In the future all data should be reported in terms of substance abuse, not as a methodological dichotomy between alcohol and drug use. A central, uniform reporting procedure for health care agencies, social services, accident and illness investigators and law enforcement agencies is necessary. This system should also encompass a regular incidence and prevalence survey of the general population.

III. RESOURCE IDENTIFICATION

A. Existing Resources

When evaluating the nature of drug abuse services in Maine it is important to remember that, compared to other states, Maine is not extravagant in the human services provided for its citizens. It has been difficult to develop a comprehensive system of drug abuse services when the corollary health, mental health, social and criminal justice agencies to support such a system either do not exist or are in a developmental stage.

Detailed descriptions of existing services are contained in the regional reports. The following is a summary of services provided by state-operated facilities.

1. Legal and Legislative

Maine law presently makes almost no provision for the treatment and rehabilitation of drug abusers. This is a critical deficiency that ignores the strong advice of the National Commission on Marijuana and Drug Abuse and the Special Action Office for Drug Abuse Prevention.

The sole state agency for drug abuse prevention hopes to correct this situation by providing statutory mechanisms that will legitimate and control the process by which drug dependent persons are permitted to enter treatment programs. This legislation will be based on the recommendations and guidelines established by Maine's Drug Abuse Prevention Plan and the Uniform Drug Dependence Treatment and Rehabilitation Act (when developed).

Initially, State law should allow for pre-trial diversion:

1) voluntary participation in treatment programs for those not charged with a criminal offense.
2) voluntary diversion to treatment programs for those charged with a drug offense.
3) voluntary diversion to treatment programs for those charged with offenses other than drug offenses.
4) emergency treatment capabilities for those in need of immediate assistance.

In addition, the State, through legislation, should insure that private and public hospitals do not discriminate in admission or treatment policy against drug-using persons, that residential treatment facilities are available and properly licensed, and that patient records are kept strictly confidential.

Maine's attempts to control the supply of licit drugs also needs comprehensive legislative overhaul, for Maine's regulatory laws are based entirely on the Uniform Narcotic Drug Act of 1933, the Narcotic Control Act of 1956 and the Model State Drug Abuse Control Act of 1966. All three of these Federal acts were repealed in 1970 (Public Law 91-513, short title "Controlled Substances Act"). With the enactment of the Controlled Substances Act, it became "necessary that states update and revise their narcotic and dangerous drug laws," according to the National Conference of Commissioners on Uniform State Laws.

In order to facilitate this updating, the National Conference of Commissioners on Uniform State Laws drafted the Uniform Controlled Substances Act to "achieve uniformity between the laws of the several states and those of the Federal Government." As stated by the National Conference of Commissioners, "It was designed to complement the Comprehensive Drug Abuse Prevention and Control Act of 1970 and provide an interlocking trellis of Federal and State law to enable government at all levels to more effectively control the drug abuse problem."

Close to 40 states have adopted the Uniform Act in an attempt to combat the major increase in drug traffic experienced in the 1960's. Maine hopes to

also update its laws through adoption of the Uniform Act. Before being submitted to the legislature, however, members of the criminal justice system will be contacted and interviewed, the operation of similar laws in other states will be carefully studied, and appropriate modifications based on these studies will be made. In addition, this drafting will be closely coordinate with the work of the Maine Commission to Prepare a Revision of the Criminal Laws. The sole state agency for drug abuse prevention will make recommendations to the Revision Commission concerning criminal penalties for drug offenses, but it will not engage in the actual drafting of such legislation.

In summary, the sole state agency hopes to submit extensive legislative proposals to the next session of the Legislature (January, 1974) to remedy the inadequate drug abuse prevention statutory mechanisms.

(a) Methadone

In Maine methadone is used primarily for analgesia in severe pain and short-term detoxification. There are no approved treatment programs using methadone nor are there any treatment programs which use narcotic antagonists.

In June of 1972 the Maine Commission on Drug Abuse, in conjunction with the Bureau of Health, conducted a survey of all physicians to assess the need for methadone maintenance treatment programs in the State. Although a few physicians favored methadone treatment, most were opposed, seeing no real need for the program. Staff of the various drug treatment programs concurred in this judgement. The Maine Commission on Drug Abuse has not encouraged the establishment of treatment programs using methadone. All available data indicates that heroin is not a significant problem. Police and hospital estimates range from 15-50 addicts in the entire state. Only a handful of cases are actual. Maine lacks many of the social and rehabilitative services necessary to support a methadone program. Establishment of treatment and prevention programs for poly-drug abusers, who constitute the majority of the drug-abusing population, is a necessary first step.

When the new FDA methadone regulations were published in early 1973, the Commission, as the state's methadone authority, notified physicians, hospitals, and pharmacies of the revised application and approval procedures. A Committee was named to review applications for approval to use methadone. 12 hospitals applied for approval to use methadone for analgeisia in severe pain, for detoxification and for temporary maintenance treatment. One physician applied for approval to operate a treatment program using methadone. He later withdrew his application at the request of the Bureau of Narcotics and Dangerous Drugs.

The new regulations have eliminated the practice of temporary maintenance. In the past, Maine physicians have maintained, especially during the summer, methadone patients temporarily residing in Maine.

During the summer of 1973, the Commission plans to keep a record of all out-of-state requests for temporary maintenance. If warranted, we may apply for a waiver of the program standards that would allow for the treatment of a limited number of patients on a temporary basis.

(See attached copy of letter designating Maine Commission on Drug Abuse as the state methadone authority.)

STATE OF MAINE
OFFICE OF THE GOVERNOR
AUGUSTA, MAINE 04330

December 21, 1972

Jaffee H. Jaffe, M.D.
Director
Special Action Office for Drug
Abuse Prevention
Executive Office of the President
Washington, D. C. 20506

Dear Dr. Jaffee:

Thank you for your letter of December 1, 1972 regarding implementation of the Food and Drug Administration's methadone regulations.

At present, there are no approved methadone treatment programs in Maine. However, methadone is used for in-patient detoxification and analgesia.

The Maine Commission on Drug Abuse will act as the "appropriate State authority" to license, approve and regulate treatment programs using methadone. The Commission will name a committee of consultants to develop guidelines for the distribution and use of methadone. Representatives of the following agencies and professions will be included on the committee:

Director, Bureau of Health
Director, Bureau of Mental Health
Commission of Pharmacy
Attorney General
Medicine (2)
Psychiatry

You may contact Mr. Cabonneau of the Drug Abuse Commission for further information.

Sincerely,

KENNETH M. CURTIS
Governor

KMC/gwd
6687

(b) Bureau of Corrections

(1) Correctional Facilities

Maine has five correctional institutions, two juvenile training centers, two correctional centers and a maximum security facility. The total average monthly population of the institutions is 740.

Institution	Daily Average in Residence
Maine State Prison	373
Men's Correctional Center	103
Women's Correctional Center	29
Boy's Training Center	170
Stevens School for Girls	67

The majority of drug offenders are incarcerated at Men's Correctional Center and Maine State Prison. Although persons convicted of straight drug offenses make up a relatively small percentage, approximately 10%, both institutions report widespread drug experience among inmates.

Each of the five institutions provides services intended to better prepare the inmate for life outside the institution. Because many of the inmates have low socio-economic and educational attainment, treatment and rehabilitation programs are aimed at improving the inmate's potential in these areas.

Drug offenders constitute a different type of inmate. Often they are more motivated and have higher educational attainment. Staff of the institutions feel that existing treatment and rehabilitation programs do not "reach" the drug abusing inmate. They also feel a need for more training in dealing with adolescents and young adults.

Maine State Prison has conducted weekly "rap" sessions using facilitators from community drug abuse programs. Inmates have also participated in counselor training sessions at the nearby Rockland Drug Center. In February 1973, a self-help group, now called "Congenial House" was started. The purpose of this group is to help drug abusing inmates examine the reason for their drug use. This group sees a need for a full-time counselor trained in substance abuse, and, generally, more rehabilitation opportunities for inmates.

Indeterminate sentencing of inmates committed to Mens Correctional Center means a high turnover rate for the institutions population. Long-term drug abuse treatment groups have been difficult to organize. Several staff of Mens Correction Center were trained at the MDEP week-long leadership training institute. During the winter of 1973 the Lewiston Rap Place conducted several weekly rap sessions with inmates. This year Rap Place is proposing a therapeutic art program, focusing on art as a means of self-expression, and has applied to the Commission on Arts and Humanities and the Maine Commission on Drug Abuse for support of this program.

The Bureau of Corrections employs a part-time (4 hours a week) consultant to work with inmates and staff of Women's Correctional Center, Boy's Training Center and Stevens School around drug abuse issues. The consultant provides some counseling to inmates and, also, conducts training sessions for staff. This consultant feels that, like the Maine State Prison, these institutions could make good use of a full-time counselor trained in working with drug abusers.

The Bureau of Corrections also uses the services of two residential treatment programs, Kinsman Hall and Elan I. Both Kinsman Hall and Elan I are privately operated programs. They are versions of the Synanon therapeutic community concept and serve primarily out-of-state residents. Both programs accept limited referrals from the Bureau at fees allegedly lower than the cost to the program of maintaining a resident in treatment. The Bureau has been satisfied with services of both programs.

(2) Division of Probation and Parole

Maine's forty Probation and Parole officers were surveyed by mail to elicit their perceptions of the extent of drug abuse in their regions, and the clients in their caseload who might benefit from daycare, counseling or residential services. Prior to the mailing a staff member from the Commission met with the Probation and Parole staff to explain the purposes of the State Plan and the Probation and Parole questionnaire.

The Probation and Parole officers had a different type of contact with drug abusers than did others in the community as they deal specifically with persons convicted of drug abuse. Their feelings about the drug problem differ greatly from others who deal with drug abusers in a voluntary situation. The probation and parole officers returning the questionnaire (31 in all) felt that the drug problem is very real for Maine. Officers in all four of the probation and parole districts reported problems with marijuana, amphetamines, barbituates, hallucinogens and some codeine, cocaine and heroin.

The officers did not consider the Rap Center type of program an adequate treatment facility. They felt that it needed better trained staff members and closer supervision. They were suspicious of them as places for young people to congregate and continue the use of drugs rather than to stop drug use.

Only eight of the officers had ever used Kinsman Hall or Elan I for drug abuse treatment. Of these, three were entirely satisfied with the program, one was dissatisfied as the person he placed ran away and went home and four had not yet seen the results of the treatment. Those who had not used either facility gave no reason for that decision or indication as to whether or not they would ever use them.

As the table below shows, the officers felt that the greatest need is in the area of counselling, but there are over 100 persons currently under supervision who they feel would benefit from a residential treatment center.

PROBATION AND PAROLE

Region	Residential	Day Care	Counselling	Aftercare
I	15	6	20	19
II	43	30	65	0
III	47	10	118	2
IV	0	0	34	5
Total	105	46	237	26

(c) State Hospitals

The State Department of Mental Health and Corrections administers three state hospitals: Augusta State Hospital, Bangor State Hospital and Children's Psychiatric Hospital.

In a position paper prepared in March, 1972, by the Commissioner of Mental Health and Corrections the state hospitals expressed the opinion that "of all drug users in the state only a minor number need, want or will respond to 'treatment', particularly treatment in the psychiatric sense."

It is the policy of these hospitals to admit persons for treatment whose use of drugs is primarily rooted in the type of psychiatric or psycho-social problems the hospital is equipped to handle.

The Superintendent of the Augusta State Hospital indicated that he did not "see a need for specialized drug abuse programs as much as the need for special adolescent programs."

The Superintendent of the Bangor State Hospital indicated that specialized services emphasizing a behavior modification approach to treatment might be useful: "The specialized services should address directly and vigorously the ingestion of harmful and illegal substances, with the view of reducing such behavior patterns. While it may be possible that a variety of personality, cultural, class and economic factors tend to produce an atmosphere or climate in which drug abuse occurs, the important thrust of the specialized services that we are recommending should be toward reducing or eliminating that behavior and the specific reinforcements (motivations) which tend to sustain such behavior. Moreover, it is important that these services employ a carefully controlled, contingent, social and physical environment which is unremitting in the direction of changing, reducing, eliminating these personally destructive and socially unacceptable patterns of behavior."

State hospitals treated a total of 392 substance involved patients during the calendar year 1972. The majority of the substance involved patients hospitalized were involved with alcohol (80.4%/N=315) the remainder were drug involved (N=77). The drug of preference was amphetimines (N=13), however, the most frequent drug category was other-unknown (N=21). The majority of alcohol involved cases were over thirty-five. The state hospital data reflected the same trends as other hospital data. (See Hospital Supplement.)

(d) Togus Veteran's Administration Hospital Drug Treatment Program

Togus Veterans Administration Hospital operates a drug treatment program under the supervision of a psychiatrist for inactive service-connected drug users. Patients with any other medical or psychiatric problem are not admitted to the drug treatment program until the non-drug problem is resolved. The treatment program utilizes a combination of psychoanalytic and group therapy techniques. They treated a total of 56 patients during CY 1972. The majority of patients were poly-drug users. Therefore, there is quite a bit of overlap in the number of cases in which a particular drug is categorized as the primary drug of abuse (total 103).

The average length of treatment is as follows:

34 patients remained in treatment for 1-3 months.

15 patients remained in treatment for 2-5 days.

7 patients proved to be administrative problems who were not eligible for treatment were transferred from Togus to another facility.

2 patients were readmitted (2 remissions).

1 1972 patient is still undergoing treatment.

Drug and psychiatric patients share a single ward. Drug-involved patients are, upon the discretion of the supervising psychiatrist, issued weekend or weekly furloughs. While on furlough, a patient receives no supervision and limits are not placed upon his travel.

Three patients using barbiturates fell into the 35 and over age group. Ten patients age approximately 19 years were received from Viet Nam as opium smokers. Four of these were considered to be addicted. The remainder upon return to the U.S. chose to use a combination of marijuana and alcohol. Sixty percent of the total case load (33) were ages 20-23. The remainder (10) fall into the 25-34 age bracket.

Most patients progress from the primary drug of abuse to a combination of marijuana and alcohol, then fixate at this point until they are considered to be "drug free" or no longer in need of hospitalization. It is, therefore, safe to say that all patients in the 18-34 age groups can be categorized as cannabis and alcohol users.

The following is a list of the primary drug used by the Togus inmates.

Narcotics (Heroin, Opium, Morphine)	23
Barbiturates	8
Amphetamines (Methedrine, Speed)	29
Cocaine	3
Cannabis	20
Hallucinogens	19
Volatile Substances (glue)	1
TOTAL	103

3. Training/Public Information

A detailed description of existing training and public information resources is contained in Appendix F.

4. Maine Criminal Justice System

The Criminal Justice System in Maine is defined as those public agencies directed toward the enforcement of laws and the rehabilitation of law breakers.

The three major activities of that system in relation to drug abuse are:

1. Control of illegal substance traffic by monitoring and regulating manufacturers, wholesalers and practitioners.

2. Law enforcement activities involving persons having possession or performing illicit sales and distribution or manufacture of controlled drugs.

3. The administration of justice through the courts, correction, probation and parole.

In considering only the education and training which the Criminal Justice System requires or provides in the area of drug abuse in Maine, it is important to consider certain goals which have led to the activities described above.

Goal 1. Elimination of the traffic of illegal drugs through the apprehension of the seller who may or may not be addicted.

Goal 2. Increased community awareness through public education of the unlawfulness and personal danger involved in drug use and abuse.

Goal 3. Development of a relationship between the Criminal Justice System and other social services to provide proper treatment of drug dependent or drug abusing persons either before or in lieu of incarceration.

In the study "Police Services in the State of Maine Phase I" conducted by Public Administration Service of Chicago in 1971, it is evident that juvenile services are not a law enforcement priority in Maine.

It is estimated that slightly more than 12,000 juvenile cases were dealt with by police agencies in the State during 1970. Nevertheless, juvenile problems evoke less response from police agencies in terms of emphasis and resource commitment than do many other functional considerations. Police agencies across the State, for example, have chosen to appoint 122 full-time detectives, 41 full-time records employees, and 31 full-time evidence specialists, but have appointed only 19 full-time juvenile specialists. The 19 full-time and 4 part-time juvenile specialists are distributed among only 15 agencies, 12 percent of the State's total. There are nine counties in Maine which do not have even one part-time specialist.

It is customary in departments without functional specialists to have "all officers" perform a given function. This is true with respect to handling juveniles. Throughout the State the prominent practice is for the arresting or responding patrol officer to process a juvenile. In a small number of departments without a specialist, one particular officer will respond to all juvenile cases; this officer is usually the Chief.

Training data reinforce the notion that juvenile services receive less than priority emphasis. Twenty of the total 23 juvenile specialists have completed some form of advanced training in juvenile work, while only 18 of the remaining total number of sworn officers in the State have received training in juvenile work beyond that acquired in basic or recruit training.

The degree of intergovernmental and interlocal juvenile service cooperation among police agencies is barely measurable. Intergovernmental and interlocal cooperation among police and nonpolice agencies is more frequent. Sixty police departments have established relationships with social service agencies, agencies which will accept some or all responsibility for continuing welfare and counseling of juveniles referred by the police.

Delinquent acts, whether criminal or not, committed by juveniles create very real problems for police. The law provides that juveniles must be handled differently from the adult. Chapter 401 S 2501 of the Maine Revised Statutes clearly states "...they shall be treated not as criminals, but as young persons in need of aid, encouragement and guidance." This law implies a mandate that specialized police and youth service agencies learn the cause and provide the necessary treatment to help the delinquent youth become a responsible citizen. For a multitude of reasons, among which are budgets, facilities, equipment, etc., municipalities have neglected the development of juvenile police services adequate to deal with juveniles.

B. Underutilized Resources

Without some estimate of the numbers of individuals abusing drugs it is difficult to look at the utilization data for human service agencies and draw conclusions about under-utilization. Maine is characterized more by a paucity of drug abuse services than a program glut. Considering that there are only five active, identified, drug programs in the state at this time, duplication, overlapping services and competition for clients is unlikely.

The data collected during the planning process indicates that traditional service agents, hospitals, mental health centers do not see large numbers of drug abusers. If we assume that there is a large drug abusing population and that these traditional agencies could provide relevant services, then we might conclude that they are under-utilized resources. However, we have not been able to establish a baseline figure for the drug abusing population, and, these traditional agencies are quick to point out a sense of inadequacy in dealing with drug abusers.

C. Costs of Resources and Source of Financial Support - FY 1972-73

The total amount spent annually on the demand side of the drug abuse problem in Maine is approximately $500,000. Although it was not the purpose of this

plan to determine total funds spent on the supply side, they are probably in excess of $500,000.

This total of one-half million dollars does not include the costs of the two privately operated residential treatment centers.

Federal sources provide the bulk of financial support for drug abuse prevention activities. State and local funds account for a much smaller portion of the total cash expenditure. However, state and local agencies provide many in-kind resources.

D. Program Management Coordination Resources

Presently the MCDA is the only organization in the state responsible for planning, program management and coordination of drug abuse services.

The MCDA has used the resources of the State Planning Agency, local health planning organizations and regional drug abuse councils to coordinate funding and implementation of drug abuse programs.

Presently, the MCDA performs only limited administrative monitoring of drug abuse programs. Programs receiving funds from the MCDA sign agreements of work to be performed and must submit a statement of expenditures at the end of the project. The MCDA has no management information system and, hence, does not require caseload reporting.

The award to the MCDA of a NIMH rapid expansion contract for residential and day care services in Portland requires that we establish procedures for administrative monitoring and outcome evaluation.

Until March 1973, Portland's United Drug Abuse Council (UDAC) organized and coordinated public information and education services for the greater Portland area. Succeeding UDAC is the Ad Hoc Southern Maine Regional Drug Abuse Council which served as an advisory group in developing the drug abuse plan for the four southern catchment areas. (See Appendix E.)

The plan for the southern Maine area recommended that an areawide Drug Abuse Council be established to assist the SSA in implementing the drug abuse plan in southern Maine. The Ad Hoc Council will continue on a temporary basis until the State Plan is approved and funding is assured. A copy of the work plan for the staff of the Ad Hoc Council is contained in Appendix H.

SOURCES OF FINANCIAL SUPPORT
FY 1972-73

Program	Source	Federal	Source	State	Private	In-Kind
MCDA	NIMH	$119,781		$ 76,000		X
MDEP	USOE	23,200		30,000		X
Augusta Rap & Rescue	NIMH	71,775	MCDA	2,400	X	
Brunswick Drug Abuse Center	NIMH	68,946			X	X
Rap Place, Lewiston	USOE	32,000	MCDA	2,800	X	X
Knox County Drug Abuse Council	Social Security Act Title IV-A	11,624	MCDA	9,800	X	X
Drug Rehabilitation, Inc.			MCDA	2,500	X	X
Kinsman Hall	N.A.		Bureau of Corrections	20,275	X	X
Elan I	N.A.		Bureau of Corrections	1,875	X	X

IV. NEEDS AND GAPS IN SERVICES.

The 106th Legislature, recognizing that alcoholism and drug abuse are related problems, enacted P.L. 566, the 1973 Alcoholism and Drug Abuse Act. The Act establishes an Office of Alcoholism and Drug Abuse in the Bureau of Rehabilitation of the Department of Health & Welfare, beginning in January, 1974.

It is the intention of the Legislature that planning and administration be combined at the State level while maintaining separate treatment services.

The Powers and Duties section of the outlines broad objectives which are summarized below:

A. Objectives

1. Establish overall planning, policy, objectives and priorities for all drug abuse prevention functions, except prevention of drug traffic.
2. Encourage and assist the development of coordinated administration of resources and services available for drug abuse prevention.
3. Develop and maintain a management information system related to drugs, drug abuse and drug abuse prevention.
   a. establish uniform data collection and reporting system
   b. conduct a survey of the incidence and prevalence of drug abuse in the general population
   c. inventory existing services
   d. evaluation of drug abuse programs, services and facilities
   e. accreditation of all drug treetment programs
4. Help communities mobilize their resources to deal with drug abuse.
   a. Provide resources for alternative sentencing of drug offenders.
5. Provide training and public information in the area of substance abuse.
6. Review legislation and proposed drug abuse prevention activities of all state agencies.
7. Annually review and update the State Drug Abuse Prevention Plan.

B. Analysis of problems, present responses and identified gaps in services.

The anecdotal information collected during the planning process indicates that both alcohol and drug abuse are perceived as problems. However, the "hard" data supports only the prevalence of alcohol abuse and alcoholism. The difficulty in documenting the extent of drug abuse is discussed in Section II: Problem Definition.

It appears that the "drug problem" in Maine is chiefly poly-drug abuse among juveniles and young adults. This finding may reflect society's emphasis on drug abuse as a problem of youth and/or the youthful orientation of the state's drug treatment programs. The bulk of the drug abuse cases reported in this plan come from such non-traditional human service agencies as drug abuse centers.

That lack of innovative professional services for troubled adoliscents and a low level of services to youth in general are principle problems identified

through the planning process. Maine has its fair share of traditional youth-oriented employment and recreationprograms, but lacks the health, mental health and social services capable of meeting youth needs.

Drug abuse, even as reported by drug treatment programs, does not appear to be a problem of great magnitude. All reports indicated a need for more effective use of existing resources with only limited development of specialized drug abuse services.

C. Identification of increased response areas:

1. Treatment/Rehabilitation
   a. hospitals and community mental health centers must change existing models of service if they are to do justice to needs of young people. Staff should be trained in and capable of working with adolescents.
   b. improve quality and quantity of school-bases health and mental health services and community recreation/employment opportunities for youth.
   c. support existing residential services for children and youth.
2. Education/Training
   a. MDEP: expand teacher training programs
   b. improve quality of health and mental health education in elementary schools.
3. Criminal Justice:
   a. expand existing treatment and regabilitation services conducted in correctional institutions.
   b. training for police, probation & parole in dealing with youth.

D. Identification of New Responses

1. Treatment/Rehabilitation
   a. Implement DRI as a pilot program of daycare and residential treatment for drug abusers in southern Maine.
   b. Provide more alternate living situations (group homes, half-way houses, professional foster care) for adolescents who cannot live at home.
   c. Fund innovative, goal-oriented recreation/employment programs for youth.
   d. Require outcome evaluation of all funded programs.
   e. Accredit all residential treatment services.
2. Education/training
   a. Establish a drug abuse training center at the State level
   b. Organize a state clearinghouse to distribute public information on substance abuse.
   c. Publish a statewide Alcoholism/Drug Abuse Newsletter.
   d. Encourage local school districts to adopt curriculum/discipline guidelines developed by Maine's Drug Education Program.
3. Criminal Justice
   a. implement alternative sentencing for drug offenders
   b. fund full-time counselors at MSP and WCC who are trained in substance abuse counseling
4. Legal and Legislative
   a. Prepare a Uniform Controlled Substances Act for submission to Legislature in Jamuary, 1974.
5. Program Coordination
   Single State Agency should coordinate all activities at the state level and make provision for regional coordination of programs in Southern Maine.

E. Constraints

Reluctance to report instances of drug abuse, inadequate funding, fragmentation of existing services and a growing feeling the "drugs are not the problem" hamper the planning process.

The difficulty in obtaining drug-related data from the social and criminal justice system was discussed in Section II. It is impossible to plan services when the agencies upon whom one relies for information do not keep adequate records or, if they do, will not share them. Police for example, perceive a widespread drug abuse problem. Yet, only 22% of police responded to requests for "hard data" and the meagre information supplied does not support the existence of a serious drug problem.

Funding, at both the State and Federal level, is linked to the ability to quantify the drug abuse problem in Maine. We are faced with the dilemma of making a choice between speaking honestly about a low level, endemic, substance abuse probelm or, attempting to define our drug abuse problem in a way that will be acceptable to SAODAP and NIMH, but may not accurately reflect the picture in Maine.

Compounding the problem of inadequate funding is the problem of lack of coordination. Federal agencies work directly with the applicant and rarely investigate the extent to which services overlap, are inappropriate and/or inadequate to meet the need. There are, for example, five or six agencies of Maine State government planning alternative housing for children and youth. Fragmentation of services could be considerably reduced if funding agencies insisted on cooperation and practiced it themselves. Unlike other states where drug abuse prevention funding and programs have grown rapidly, Maine's existing drug abuse services are easily identified and manageable in size and scope; coordination is a realistic goal. P.L. 566 establishes the basis for true coordination of services. The Powers and Duties section of the Act (§7106) requires the Office of Alcoholism and Drug Abuse to:

> 3. Assist, with the advice of the council and cooperation of the coordinating committee, the Legislature and executive branches and Judicial Council of State Government, especially the Governor, commissioner, and Bureau of the Budget, to coordinate all state government efforts dealing with drug abuse prevention and control, including alcoholism, by:
>
> > B. Reviewing all proposed legislation, fiscal activities, plans, policies and other administrative functions relating to drug abuse prevention activities made by or requested of all state agencies. The office shall have the authority to submit to these bodies findings, comments and recommendations, which in the case of the Judicial Council, Legislature, Governor and commissioner shall be advisory; and which in the case of other state agencies shall be binding. Such findings, comments and recommendations shall specify what modification in proposals or actions shall be taken to make proposed legislation, fiscal activities and administrative activities consistent with such policies and priorities;
> >
> > C. Making recommendations to the respective branches of State Government concerning prevention of drug traffic and shall consult with and be consulted by all responsible state agencies regarding the policies, priorities and objectives of functions to prevent drug traffic.

4. Prepare and administer a comprehensive state plan mutually developed by the office, council and coordinating committee, relating to all drug abuse prevention and treatment of alcoholics and intoxicated persons and control of drug abuse. The comprehensive state plan shall be implemented for the purpose of coordinating all drug abuse prevention activities and of assuring compliance with applicable state and federal laws and regulation and with the state plan relating to drug abuse prevention. Implementation of this duty shall mean that the office shall have the authority to supervise through a review process the preparation and administration of any portion of any state plan relating to drug abuse prevention prepared and administered by any agency of State Government for submission to the Federal Government to obtain federal funding under federal legislation. Such state plans, or portions thereof, shall include, but not be limited to, all state plans dealing with education, employment and vocational services, medical, rehabilitation, social services, welfare, drug abuse prevention and treatment of alcoholism and intoxicated persons.

F. Coordination With Other State Plans

The single state agency's responsibility and authority to coordinate with other state plans is outlined in Section E above.

G. Ranked and Priced List of Needs in Priority Order

See attached Table.

OBJECTIVE	NEED	COST	SOURCE OF FUNDS	SERVICE DELIVERY AGENT
1. Establish planning, policy objectives and priorities for all drug abuse prevention functions.	Implement P.L. 566, 1973 Alcoholism and Drug Abuse Act.	T.B.D.	State and Federal	Office of Alcoholism and Drug Abuse (single state agency).
2. Develop coordinated administration of drug abuse prevention resources.	Implement relevant provisions of P.L. 566 Regional Coordination of drug abuse programs in southern Maine.	$ 25,000	Federal, State, Local	Regional Drug Abuse Advisory Council, CMHC's.
3. Develop and maintain a management information system.	Uniform data collection & reporting system, prevalence/incidence survey, inventory of existing resources, evaluation and accreditation of all funded programs.	$ 30,000	Federal, State	Single State Agency.
4. Help communities mobilize their resources to deal with drug abuse.	Community-based counseling.	$250,000	Federal, State, Local	CMHC, Brunswick Drug Center, Augusta Rap & Rescue, Lewiston Rap Place & D.R.I.
	Vocational Rehabilitation.	$ 50,000	Federal, State, Local	CMHC, Neighborhood Youth Corps. Vocational Rehabilitation.
	Residential Treatment-30 slots @$4,000.	$120,000	Federal, State	D.R.I., Health & Welfare, Bureau of Mental Health.
	Treatment/Rehabilitation Services in Correctional Institutions.	$ 30,000	State	Single State Agency or Bureau of Corrections.
5. Provide drug abuse training and public information.	State Training & Public Information Clearinghouse, Regional in-service training for health professionals.	$ 70,000	Federal, State	Single State Agency via contract with MDEP and others.
6. Review all proposed Legislation.	Uniform Controlled Substances Act for submission at 1974 Legislative Session.	$ 15,000	Federal, State	Single State Agency.
7. Annually review and update the State Plan.	Drug abuse planner on staff of Single State Agency.	$ 15,000	Federal	Single State Agency.

V. ACTION AGENDA

Section IV. Needs and Gaps in Services includes a list of unmet needs ranked in priority order. The Action Agenda describes how recommended programs will be implemented.

A. Local Resource Generation

1. Funding

All funded programs and activities will be expected to meet a portion of their budget out of local funds. Sources of local funds include revenue sharing, private voluntary money (United Fund) and client fees.

2. Manpower and Facilities

Programs will make optimal use of existing community resources and facilities to establish areawide, comprehensive prevention, treatment, rehabilitation and aftercare services.

3. Needs

a. Regional Coordination

The State Plan will be administered by a regional coordinator in southern Maine. The Ad Hoc Regional Drug Abuse Council will continue in an advisory capacity. The coordinator will be responsible for regional review and comment of grant applications, program monitoring and on-going area planning. A copy of the workplan for the regional coordinator is contained in Appendix H.

The single state agency will directly administer the State Plan for the four northern regions until a need for regional coordinator is demonstrated.

b. Treatment and Rehabilitation

(1) Counseling Services will be provided through community mental health centers and drug abuse programs:

Program	Implementation
York County Counseling Services	11/1/73
Maine Medical Center- C.M.H.C.	6/74
Bath-Brunswick Mental Health Assoc.	On-going
Mid-Coast Mental Health Clinic	1/1/74
Tri-County Mental Health Services	1/1/74
Kennebec Valley Mental Health	6/74
The Counseling Center	6/74
Aroostook Mental Health Center	6/74

V. Action Agenda

A. Local Resource Generation

3.b. Treatment and Rehabilitation

Program	Implementation
Rap Place, Lewiston	On-going
Brunswick Area Drug Abuse Center	On-going
Augusta Rap & Rescue	On-going
Drug Rehabilitation, Inc.	10/1/73

(2) Vocational Rehabilitation Services

Tri-County Mental Health Services	6/74

(3) Residential Treatment

Drug Rehabilitation, Inc. 15 slots by	10/1/73
Other residential services 15 slots by	6/74

(4) In-service Training of Health Professionals

The Counseling Center	6/74
Regional Drug Abuse Council (southern Maine)	3/74

B. State Resource Generation

1. Funding

State funds will include all legislative appropriations to the Office of Alcoholism and Drug Abuse and other state departments for drug abuse prevention activities. Special revenue sharing may also be available.

2. Manpower and Facilities

Staff of the Office of Alcoholism and Drug Abuse, the State Advisory Council and State Government Coordinating Committee. State facilities available for use in drug abuse prevention include state hospitals, correctional institutions and the Criminal Justic Academy.

3. Needs

a. Implement P.L. 566, 1973 Alcoholism and Drug Abuse Act. The single state agency will begin to implement all provisions of P.L. 566 including coordination of all State level drug abuse prevention functions by January, 1974.

b. Uniform Data Collection and Reporting System

The difficulty in defining and assessing the nature of the drug abuse problem in Maine supports the need for a reporting system that will indicate, at minimum, numbers of persons abusing drugs and numbers of persons receiving services. The development of a management information system is mandated by P.L. 566.

Although it may be feasible to integrate joint data collection for drugs and alcohol, an interim system for drug abuse should begin by October, 1973.

V. Action Agenda
B. State Resource Generation
3. Needs

c. Prevalence and Incidence Survey

The planning and organization for a survey should begin by January, 1974. It is recommended that the survey be conducted only if federal funds are available to hire competent, professional researchers. An alternative would be to rely on the uniform data collection and reporting system to reflect trends in patterns of drug abuse.

d. Evaluation and accreditation of all drug abuse treatment programs as an on-going activity by June, 1974.

e. State Training and Public Information Clearinghouse

See Appendix "F" for a discussion of the organization and implementation of a statewide training and public information activity. Implementation of a State Training Center is set at January, 1975 to allow time for the integration of existing training programs.

f. Treatment and Rehabilitation Services in Correctional Facilities

The single state agency will initiate discussions with Bureau of Corrections, LEAA and institutional superintendents to plan for: drug/alcohol counseling services, therapeutic alternative activities and in-service staff training.

g. Legislation

The Maine Commission on Drug Abuse has been funded by LEAA to prepare a draft Uniform Controlled Substances bill for submission at the January, 1974 session of the Maine Legislature.

C. Federal Resource Requirements

The attached table displays those program objectives which require federal financial and technical asssistance.

The single state agency expects to rely on NIMH, SAODAP and LEAA for assistance in planning and implementing programs.

Federal facilities which can provide drug abuse services are: Togus Veterans Administration Hospital, Brunswick Naval Air Station and Loring Air Force Base.

D. Implementing Services

The single state agency will be responsible for all overall planning, policy, objectives and priorities for all drug abuse prevention functions, except prevention of drug traffic.

The single state agency is not authorized to provide direct drug abuse services. The agency may enter into agreements with qualified agencies to provide such services. Contract agencies must meet the licensing and accreditation standards promulgated under P.L. 566 1973 Alcoholism and Drug Abuse Act.

The single state agency will coordinate with operating programs through review of grant applications, licensing and accreditation, training programs, planning and evaluation.

Section VI. PROGRAM MANAGEMENT contains a detailed description of the activities of the single state agency.

FEDERAL RESOURCE REQUIREMENTS

UNMET NEEDS	ANNUAL COST	LOCAL/STATE FUNDS	FEDERAL REQUIREMENTS	SOURCES OF FEDERAL FUNDS	IMPLEMENTATION
Regional Coordination	$ 25,000	$ 5,000	$ 20,000	Sect. 409 Formula Grant	11/73
Management Information System	$ 30,000	$ 15,000	$ 15,000	Sect. 409 Formula Funds	1/74
Counseling Services	$250,000	$ 40,000	$210,000	Sect. 409 Formula Funds NIMH H-80 Application[1]. NIMH Service Project Grants[2]. USOE Training Grant[2]. NIMH Rapid Expansion Contract[2]. CMHC Staffing Grants[2].	11/73-7/74
Vocational Rehabilitation Services	$ 50,000	$ 40,000	$ 10,000	SRS, 409 Formula Funds	7/74
Residential Treatment 30 slots @$4,000	$120,000	$ 20,000	$100,000	NIMH H-80 Application[1]. NIMH Rapid Expansion Contract[2]. LEAA	15 slots by 10/73 15 slots by 6/74
Treatment/Rehabilitation Services in Correctional System	$ 30,000	$ 3,000	$ 27,000	Sect. 409 Formula Funds LEAA	7/74
Training & Public Information Clearinghouse	$ 70,000	$ 10,000	$ 60,000	NIMH H-80 Application Sect. 409 Formula Funds LEAA	1/74-Public Info. 1/75-Training
Uniform Controlled Substances Legislation	$ 15,000			LEAA[2].	1/74

1. To be submitted 12/1/73.

2. Grants are funded and on-going.

E. Action Priorities

A ranked list of needs, in priority order, is contained in Section IV. G. "Ranked and Priced Lists of Needs in Priority Order."

The following criteria were used to assign action priorities:

1. Does the activity meet a need identified in the State Plan?

2. Will the program make optimal use of existing community resources and facilities?

3. Is there potential for stable, long-term funding, including local resources?

4. Is the activity mandated by the legislation establishing a single state alcoholism and drug abuse authority?

VI. PROGRAM MANAGEMENT

A. Organizational and Functional Responsibilities

1. Maine Commission on Drug Abuse

The Maine Commission on Drug Abuse was established in September, 1971, for the purpose of coordinating all State governmental efforts dealing with drug abuse (Appendix I, P.L. Chapt. 379 - An Act Establishing the Maine Commission on Drug Abuse). In carrying out its coordinating responsibilities, the Maine Commission on Drug Abuse was given authority to:

> **A. Examine all requests for appropriations or program grants relating to drug abuse made by state agencies and advise the Governor, Budget Bureau and Legislature of its findings and recommendations. It shall be the responsibility of all departments to advise the commission of their budgetary requests relating to drug abuse concurrently with their submission to the Governor. The departments shall, in the implementation of their programs, keep the commission fully informed of their progress and of any changes in policy;**
>
> **B. Supervise the disbursement of all state funds appropriated for the purpose of helping local and regional government agencies and private groups deal with drug abuse. All such local and regional governmental agencies and all such private groups seeking state assistance shall be required to file applications with the commission. The commission shall establish appropriate rules and regulations for the processing of these applications. No grants of state funds to local or regional governmental agencies or to private groups shall be made without commission approval.**

The Commission also exercises a review and comment authority on requests for Federal drug abuse prevention funds.

Ten State departments and agencies and five citizens designated by the Governor are represented on the Commission. The Chairman of the Commission is also appointed by the Governor for a term of two years. Organizational Chart A describes the current organization of the single state agency.

In November, 1972, the Commission was designated by the Governor as the single state agency to administer and/or supervise the administration of the State Drug Abuse Plan. To comply with all the provisions of Section 409 of the Drug Abuse Office and Treatment Act of 1972 (86 Stat 80, 21 USC 1176) the Commission submitted L.D. 665, An Act Reestablishing the Maine Commission on Drug Abuse, to the 106th session of the State Legislature in January, 1973. This bill would have formalized the Governor's designation of the Maine Commission on Drug Abuse as the single state drug abuse authority.

The State Government Committee heard the bill and, after thorough study, decided to merge L.D. 665 with the provisions of certain other drug-related bills. The amended version, L.D. 2008, An Act Reconstituting and More Effectively Coordinating the Maine Commission on Drug Abuse and the Division of Alcoholism and Providing an Alternative Sentencing for Violators of Drug Laws, was enacted by the Legislature on June 28, 1973 (Appendix I).

The new legislation, known as the 1973 Alcoholism and Drug Abuse Act, creates an Office of Alcoholism and Drug Abuse in the Bureau of Rehabilitation of the Department of Health and Welfare. This Office will assume the

organizational and functional responsibilities of the single state agency on January 1, 1974.

2. Office of Alcoholism and Drug Abuse

The Statement of Fact accompanying the legislation stated that:

> The purpose of this legislation is indicated by the title. It is a small but effective step toward more efficient organization of human service programs administered by State Government. This Act proposes unifying an independent commission and an operaing division. A single advisory committee will replace 3 advisory committees and a single director will administer a unified program now headed by 2 directors.
>
> It is anticipated that both the drug abuse and alcohol treatment programs will be strengthened by provisions of this Act which more clearly delineates powers and duties, while preserving the essential features of each program.

The objectives of the legislation are threefold:

> 1. The serious problem of drug abuse, including the use of alcohol which results in chronic intoxication or alcoholism, must be confronted with the immediate objective of significantly reducing the incidence of such abuse in the State within the shortest possible period of time.
>
> 2. In order to efficiently and effectively accomplish this objective, it is essential to adopt an integrated approach to the problem and to focus all the varied resources of the State on developing a comprehensive range of drug abuse prevention and treatment services, conducted by one administrative unit.
>
> 3. It is, therefore, the objective of this Act to establish one office to coordinate the planning and operation of all state drug abuse services, including those related to the abuse of alcohol, and excepting those relating to the prevention of drug traffic, and to provide support and guidance to individuals, public and private organizations and especially local governments, in their drug abuse prevention activities.

Powers and Duties of the Office include:

> The office shall establish in accord with the purposes and intent of this chapter, and with the advice of the council and the cooperation of the coordinating committee, the overall planning, policy, objectives and priorities for all drug abuse prevention functions, except prevention of drug traffic, which are conducted or supported in the State of Maine. In order to carry out the above, the office shall have the power and duty to:
>
> 1. Encourage and assist development of more effective, more coordinated, more efficient administration of resources and services available for drug abuse prevention;
>
> 2. Develop and maintain an up-to-date information system related to drugs, drug abuse and drug abuse prevention. The information shall be available for use by the people of Maine, the political subdivisions, public and private nonprofit agencies and the State. Educational materials shall be prepared, published and disseminated. Objective devices and research methodologies shall be continuously developed. Uniform methods of keeping statistical information shall be specified for use by public and private agencies, or-

ganizations and individuals. Existing sources of information shall be used to the fullest extent possible, while maintaining confidentiality safeguards of state and federal law. Information may be requested and shall be received from any state government or public or private agency. To the extent feasible, information shall maintain compatibility with federal information sharing standards.

Functions of the drug information system shall include, but not be limited to:

A. Conducting research on the causes and nature of drugs, drug abuse or people who are dependent on drugs, especially alcoholics and intoxicated persons;

B. Collecting, maintaining and disseminating such knowledge, data and statistics related to drugs, drug abuse and drug abuse prevention as will enable the office to fulfill its responsibilities;

C. Determining through a detailed survey the extent of the drug abuse problem, and the needs and priorities for the prevention of drug abuse and drug dependence in the state and political subdivisions. Included shall be a survey of health facilities needed to provide services for drug abuse and drug dependence, especially alcoholics and intoxicated persons;

D. Maintaining an inventory of the types and quantity of drug abuse prevention facilities, programs and services available or provided under public or private auspices to drug addicts, drug abusers and drug dependent persons, especially alcoholics and intoxicated persons. This function shall include the unduplicated count, location and characteristics of people receiving treatment, as well as their frequency of admission and readmission, and frequency and duration of treatment. The inventory shall include the amount, type and source of resources for drug abuse prevention;

E. Conducting a continuous evaluation of the impact, quality and value of drug abuse prevention facilities, programs and services; including their administrative adequacy and capacity. Activities operated by or with the assistance of the State and Federal Governments shall be evaluated. Included shall be alcohol and drug abuse prevention and treatment services as authorized by this and so much of the several Acts and amendments to them enacted by the People of the State of Maine, and those authorized by the United States Acts and amendments to them as relate to drug abuse prevention:

(1) The Drug Abuse Office and Treatment Act of 1972 (P. L. 92-255);

(2) The Community Mental Health Centers Act (42 USC 2688);

(3) The Public Health Service Act (42 USC);

(4) The Vocational Rehabilitation Act;

(5) The Social Security Act;

(6) The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P. L. 91-616) and similar Acts.

3. Assist, with the advice of the council and cooperation of the coordinating committee, the Legislature and executive branches and Judicial Council of State Government, especially the Governor, commissioner, and Bureau of the Budget, to coordinate all state government efforts dealing with drug abuse prevention and control, including alcoholism, by:

A. Submitting to each branch of State Government no later than September 1st of each year an annual report covering its activities for the immedi-

ate past fiscal year and future plans, including recommendations for changes in state and federal laws, and including reports of the council and coordinating committee;

B. Reviewing all proposed legislation, fiscal activities, plans, policies and other administrative functions relating to drug abuse prevention activities made by or requested of all state agencies. The office shall have the authority to submit to these bodies findings, comments and recommendations, which in the case of the Judicial Council, Legislature, Governor and commissioner shall be advisory; and which in the case of other state agencies shall be binding. Such findings, comments and recommendations shall specify what modification in proposals or actions shall be taken to make proposed legislation, fiscal activities and administrative activities consistent with such policies and priorities;

C. Making recommendations to the respective branches of State Government concerning prevention of drug traffic and shall consult with and be consulted by all responsible state agencies regarding the policies, priorities and objectives of functions to prevent drug traffic.

4. Prepare and administer a comprehensive state plan mutually developed by the office, council and coordinating committee, relating to all drug abuse prevention and treatment of alcoholics and intoxicated persons and control of drug abuse. The comprehensive state plan shall be implemented for the purpose of coordinating all drug abuse prevention activities and of assuring compliance with applicable state and federal laws and regulation and with the state plan relating to drug abuse prevention. Implementation of this duty shall mean that the office shall have the authority to supervise through a review process the preparation and administration of any portion of any state plan relating to drug abuse prevention prepared and administered by any agency of State Government for submission to the Federal Government to obtain federal funding under federal legislation. Such state plans, or portions thereof, shall include, but not be limited to, all state plans dealing with education, employment and vocational services, medical, rehabilitation, social services, welfare, drug abuse prevention and treatment of alcoholism and intoxicated persons.

The office shall advise the commissioner and Governor on preparation of and provisions to be included relating to drug abuse prevention and relating to alcoholism and intoxicated persons. Such state plans shall provide for methods of administration which will supplement, compliment and broaden related state plans, including, but not limited to, those developed under the U. S. Public Health Service Act, section 314 (2);

5. Plan, establish and maintain necessary or desirable prevention or treatment programs for individuals or groups of individuals, except that the office and its staff, whether assigned to the office or to operating units, may provide direct service only to a drug dependent individual or groups of such individuals, whose drug dependency is related to alcohol. The office may use the full range of its powers and duties to serve any drug dependent person through indirect services provided for by agreements;

6. Function as the organizational unit of Maine State Government with sole responsibility for conducting and coordinating, with the advice of the council and the cooperation of the coordinating committee, state programs and activities authorized by this chapter, and by the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act of 1970, as amended, and by the Drug Abuse Office and Treatment Act of 1972, as amended; and other programs or Acts of the State of Maine or United States related to drug abuse prevention which are not the specific responsibility of another state agency under federal or state law.

The Office is designated as the single agency of Maine State government solely responsible for administering the state plans required by those Acts;

7. Help communities mobilize their resources to deal with drug abuse. The office shall provide, or coordinate the provision of information, technical assistance and consultation to state, regional and local governments; and to public and private nonprofit agencies, institutions, organizations and individuals. The help shall be for the purpose of encouraging, developing and assisting with the initiation, establishment and administration of any plans, programs or services to prevent drug abuse.

Included in this duty is authority to coordinate the efforts and enlist the assistance of all public and private agencies, organizations and individuals interested in drug abuse prevention, especially alcoholism and treatment of alcoholics and intoxicated persons. The support and assistance of interested persons in the community, particularly recovered alcoholics and abusers of drugs, shall be utilized to encourage alcoholics and drug abusers voluntarily to undergo treatment;

8. Seek and receive funds from Federal Government and private sources to further its activities. Included in this function is authority to solicit, accept, administer, disburse and coordinate for the State in accordance with the intent, objectives and purposes of this chapter; and within any limitation which may apply from the sources of such funds, the efforts to obtain and the use of any funds from any source to treat alcoholism or prevent drug abuse. Any gift of money or property made by will or otherwise, and any grant or other funds appropriated, services or property available from the Federal Government, the State or any political subdivision thereof and from all other sources, public or private, may be accepted and administered. The office may do all things necessary to cooperate with the Federal Government or any of its agencies in making application for any funds. Included in this duty is authority to coordinate the disbursement of all state funds, or funds administered through agencies of State Government, appropriated or made available for drug abuse prevention. No fiscal transaction, including encumbrance or disbursement, shall be made for drug abuse prevention without approval of the office;

9. Enter into agreements necessary or incidental to the performance of its duties. Included is the power to make agreements with qualified community, regional and state level, private nonprofit and public agencies, organizations and individuals in this and other states to develop or provide drug abuse prevention and treatment facilities, programs and services. Such agreements may include provisions to pay for such prevention or treatment rendered or furnished to an alcoholic, intoxicated person, drug abuser, drug addict, drug dependent person or person in need of assistance due to use of a dependency related drug. Such contracts shall be executed only with agencies that meet the standards for treatment promulgated by the office under section 7115, subsection 1, and approved under section 7115, subsection 3, and licensed pursuant to section 5-A or other applicable provisions of law. The office may engage expert advisors and assistants who may serve without compensation, or to the extent funds may be available by appropriation, grant, gift or allocation from a state department, the office may pay for such expert advisors or assistants;

10. Prepare, adopt, amend, rescind and administer policies, priorities, procedures, rules and regulations to govern its affairs and the development and operation of facilities, programs and services. The office may adopt rules to carry out the powers and duties conducted under the authority in accordance with the purpose and objectives of this Act. It shall especially adopt such rules and regulations as may be necessary to define contractual terms, conditions of agreements and all other rules as are necessary for the proper administration of this chapter. Such adoption, amendment and rescission shall be made as provided under Title 5, chapters 301 to 307, Administrative Code;

11. Establish operating and treatment standards, inspect and issue a certificate of approval for any drug abuse treatment facility or program, including residential treatment centers, which meet the standards promulgated un-

der section 7115, subsection 1, and licensed pursuant to section 5-A and other applicable provisions of law. The office shall periodically enter, inspect and examine the treatment facility or program, and examine their books and accounts. It shall fix and collect the fees for such inspection and certificate. Insofar as licensing and certification of drug abuse prevention facilities and programs may also be the responsibility of another administrative unit of the department, the office may assign performance of this responsibility to such a unit or make other mutually agreeable arrangements with such a unit for assisting with performance of this responsibility;

12. Develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons and persons who abuse or are dependent on drugs. Assist in the development of, and cooperation with, alcoholic education and treatment programs for employees of state and local governments and businesses and industries in the State. Convene and conduct conferences of public and private nonprofit organizations concerned with the development and operation of drug abuse prevention programs. Included shall be the power to encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons who abuse or are dependent on drugs and to provide them with adequate and appropriate treatment. Also included is the power to encourage all health and disability insurance programs to include alcoholism as a covered illness;

13. Foster, develop, organize, conduct or provide for the conduct of training programs for all persons in the field of treating alcoholics and intoxicated persons and drug abusers;

14. Coordinate activities and cooperate with drug abuse prevention programs in this and other states for the common advancement of drug abuse prevention and alcoholism programs;

15. Establish and maintain a principal office at the department's general headquarters, and such other offices within the State as it may deem necessary;

16. Do other acts and exercise such other powers necessary or convenient to execute and carry out the purposes and authority expressly granted in this chapter.

3. Advisory Council.

The 1973 Alcoholism and Drug Abuse Act provides that the Maine Commission on Drug Abuse and the State Alcoholism Advisory Council merge to become the Maine Council on Alcoholism and Drug Abuse Prevention and Treatment.

The powers and duties assigned to the Council comply with the regulations of Section 409 of the Drug Abuse Office & Treatment Act of 1972 (86 Stat 80, 21 USC 1176).

§ 7107. Maine Council on Alcohol and Drug Abuse Prevention and Treatment

The Maine Council on Alcohol and Drug Abuse Prevention and Treatment, hereinafter in this chapter referred to as the "council," is created. The council may appoint from its membership subcommittees relating to particular problem areas or to other matters, provided that by January 1, 1975 the council shall function as an integrated committee. The office shall provide the council any administrative or financial assistance that from time to time may be reasonably required to carry out its activities. Any reasonable and proper expenses of the council shall be borne by the office out of currently available state or federal funds. The Maine Commission on Drug Abuse, as heretofore established by Title 5, chapter 317, as amended, and the advisory councils on alcoholism heretofore established in the department and by section 1352, as amended, shall, by this Act and implementation of it, be reconstituted and unified into a single unit.

The council shall consist of no more than 17 members who, excepting members representing the Legislature, shall be appointed by the Governor with the advice and consent of the Executive Council. To be qualified to serve, members shall have education, training, experience, knowledge, expertise and interest in drug abuse prevention and training. Members shall be residents of different geographical areas of the State who reflect experiential diversity and concern for drug abuse prevention and treatment in the State.

They shall be selected from outstanding people in the fields of education, health, law, law enforcement, manpower, medicine, science, social sciences and related areas. Members shall have an unselfish and dedicated personal interest demonstrated by active participation in drug abuse programs such as prevention, treatment, rehabilitation, training or research into drug abuse and alcohol abuse.

Membership shall include representatives of nongovernmental organizations or groups and of public agencies concerned with prevention and treatment of alcoholism, alcohol abuse, drug abuse and drug dependence. At least 2 members of the council shall be current members of the Legislature, consisting of one member from the House of Representatives appointed by the Speaker of the House to serve at his pleasure and one member from the Senate appointed by the President of the Senate to serve at his pleasure. Two of the private citizen members shall be between the ages of 16 and 21. At least 3 members shall be persons recovered from alcoholism, chronic intoxication, drug abuse or drug dependence. At least 3 members shall be officials of public or private nonprofit community level agencies who are actively engaged in drug abuse prevention or treatment in public or private nonprofit community agencies. Membership may also include, but not be limited to, representatives of professions such as law, law enforcement, medicine, pharmacy and teaching.

Members shall be appointed for a term of 3 years, except that of the members first appointed, 5 shall be appointed for a term of 3 years, 5 shall be appointed for a term of 2 years and 5 shall be appointed for a term of one year, as designated by the Governor at the time of appointment; except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of such term, and except that members who are members of the current Legislature and who are appointed by the President of the Senate or the Speaker of the House shall serve at their pleasure. Any vacancy in the council shall not affect its powers, but shall be filled in the same manner by which the original appointment was made.

Members shall be eligible for reappointment for not more than one consecutive term and may serve after the expiration of their term until their successors have been appointed, qualified and taken office. The appointing authority may terminate the appointment of any member of the council for good and just cause and the reason for the termination of each appointment shall be communicated to each member so terminated. The appointment of any member of the council shall be terminated if a member is absent from 3 consecutive meetings without good and just cause that is communicated to the chairman. An official, employee, consultant or any other individual employed, retained or otherwise compensated by or representative of the Executive Branch of the Government of the State of Maine shall not be a member of the council; but shall assist the council if so requested. The director of the office or his representative shall attend all meetings of the council.

The Governor shall designate the chairman from among the members appointed to the council. The council may elect such other officers from its members as it deems appropriate.

§ 7109. Meetings, compensation, quorum

The council shall meet at the call of the chairman or at the call of ¼ of the members appointed and currently holding office. The council shall meet at least 5 times a year and at least once every 3 months. The council shall

keep minutes of all meetings, including a list of people in attendance. Minutes of all meetings shall be sent forthwith to the Governor and leadership of the Legislature, who shall provide for their appropriate distribution and retention in a place of safekeeping.

Members of the council shall serve without compensation, but they may be reimbursed on the same basis as employees of state departments for the actual travel and other necessary expenses incurred in the performance of their duties.

A majority of the council members shall constitute a quorum for the purpose of conducting the business of the council and exercising all the powers of the council. A vote of the majority of the members present shall be sufficient for all actions of the council.

§ 7110. Powers and duties

The council, in cooperation with the office and coordinating committee, shall have the power and duty to:

1. Advise, consult and assist the Executive and Legislative Branches of the State Government and the Judicial Council, especially the Governor, on activities of State Government related to drug abuse prevention and treatment, including alcoholism and intoxication. The council may make recommendations regarding any function intended to prevent drug traffic. If findings, comments or recommendations of the council vary from or are in addition to those of the office or coordinating committee, such statements of the council shall be sent to the respective branches of State Government as attachments to those submitted by the office. Recommendations may take the form of proposed budgetary, legislative or policy actions. The council shall be solely advisory in nature and shall not be delegated any administrative authority or responsibility.

2. Serve as an advocate on alcoholism and drug abuse prevention and treatment, promoting and assisting activities designed to meet at the national, state and community levels the problems of drug abuse and drug dependence. The council shall serve as an ombudsman on behalf of individual citizens and drug dependent people as a class in matters under the jurisdiction of Maine State Government. It shall be a spokesman on behalf of drug abuse prevention to the director, commissioner, Governor, Legislature, public at large and National Government;

3. Serve as the advisory council on behalf of the State of Maine to the state agency as required by the federal regulations governing administration of the United States Drug Abuse Office and Treatment Act of 1972, as amended, and the United States Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended; and such other Acts of the United States as may heretofore or hereafter be enacted. The council shall advise regarding state and federal plans, policies, programs and other activities relating to the drug abuse and drug dependence in Maine. The council shall submit their recommendations and comments on the state plan, and any revisions thereof, and reports to federal or state agencies. Statements at variance or in addition to those of the office or the coordination committee shall be attached to the plan or reports upon submission by the office to agencies of the United States Government and to state agencies;

4. Serve, through a subcommittee of the council consisting of 5 persons including the chairman and 4 other members appointed by the chairman with the advice and consent of the Governor, as the review committee on behalf of the State of Maine responsible for analysis and recommendation to the director concerning the acceptability of proposals requesting award of state administered grant funds for drug abuse prevention and treatment under the United States Comprehensive Alcohol Abuse and Alcoholism Prevention,

Treatment and Rehabilitation Act of 1970 and the United States Drug Abuse Office and Treatment Act of 1972, and in order to insure coordination and prevent duplication of services shall review and comment on, under its own initiative or at the request of any state or federal department or agency, any application from any agency or organization within the State to a state or federal department or agency for financial assistance related to meeting the needs of people who abuse or are dependent on drugs;

5. Review and evaluate on a continuing basis, in cooperation with the office, for the purpose of determining the value and impact on the lives of people who abuse or are dependent on drugs, state and federal policies and programs relating to drug abuse and other activities affecting the people who abuse or are dependent on drugs, conducted or assisted by any state departments or agencies;

6. Inform the public in cooperation with the office, to develop a firm public understanding of the current status of drug abuse and drug dependence among Maine's citizens, including information on effective programs elsewhere in the State or Nation, by collecting and disseminating information, conducting or commissioning studies and publishing the results thereof, and by issuing publications and reports;

7. Provide public forums, including the conduct of public hearings, sponsorship of conferences, workshops and other such meetings to obtain information about, discuss and publicize the need of and solutions to drug abuse and drug dependence. The council may hold a state-wide conference, regional conferences and meetings;

8. Administer in accordance with current fiscal and accounting regulations of the State, and in accordance with the philosophy, objectives and authority of this Act, any funds appropriated for expenditure by the council or any grants or gifts which may become available, accepted and received by the council; and make, to be included in the annual report of the office, an annual report to the director, commissioner, Governor and Legislature not later than September 1st of each year concerning its work, recommendations and interests of the previous fiscal year and future plans; and shall make such interim reports as it deems advisable.

4. State Government Coordinating Committee

A State Government Coordinating Committee will also be established. Its function will be to cooperate with the Advisory Council and Office of Alcoholism and Drug Abuse in recommending policy to be established and implemented by State agencies. Interagency coordination will be a primary function of this Committee.

§ 7111. State Government Coordinating Committee

1. The State Government Drug Abuse Coordinating Committee is established. It shall, in cooperation with the advisory council and office, recommend policy to be established and implemented by state government agencies. It shall assist with the coordination of, and exchange of information on, all drug abuse prevention and control activities of the State of Maine. It shall act as a permanent liaison among the branches of Maine State Government and their agencies engaged in or expected to engage in activities affecting drug abuse or drug dependent people. The committee shall assist the Legislative and Executive Branches and Judicial Council in formulating and implementing a comprehensive plan, mutually developed by the advisory council, coordinating committee and office for prevention and control of drug abuse and drug dependence, especially treatment of alcoholics and intoxicated persons. The office shall provide any ordinary administrative and financial assistance to the coordinating committee as may be reasonably required from time to time to carry out its activities. Reasonable and proper expenses of the committee shall be paid from currently available state or federal funds. The committee shall meet at least twice annually at the call of the commissioner, who shall be its chairman.

2. In exercising its coordinating functions, the committee shall assure that:

A. The appropriate agencies of State Government shall provide all necessary career, educational, employment, health, judicial, law enforcement, legal, medical, penal, psychiatric, psychological, rehabilitative, social, treatment and vocational services for drug abusers and drug dependent persons and for prevention and control of drug abuse and drug dependency without unnecessary duplication of services;

B. The agencies of the several branches of State Government cooperate in the use of facilities and in the treatment of drug abuses and drug dependent persons;

C. All agencies of State Government shall adopt policies to control use of drugs, prevent drug abuse and to treat drug abusers and drug dependent persons, especially alcoholics and intoxicated persons in a manner consistent with the policy of this chapter;

D. Minutes of all meetings shall be sent to the Governor and leadership of the Legislature, who shall provide for their appropriate distribution and retention in a place of safekeeping.

3. The committee membership shall consist of not more than 17 members, who shall include, but not be limited to, the following members, who shall serve ex officio, or their designated representatives:

The Attorney General;

The Chief Justice, as Chairman of the Judicial Council;

The Director of Law Enforcement Planning and Assistance;

The Director, Office of Alcohol and Drug Abuse Prevention;

The Commissioner of Educational and Cultural Services;

The Commissioner of Health and Welfare;

The Commissioner of Manpower Affairs;

The Commissioner of Mental Health and Corrections;

The Commissioner of Public Safety;

The Commissioner of Transportation;

The Governor;

The President of the Maine Senate;

The Speaker of the Maine House of Representatives;

The State Youth Coordinator;

and other appropriate officials.

§ 7112. State agencies to cooperate

State agencies proposing to develop, establish, conduct or administer drug abuse prevention programs or to assist with such programs as covered by this chapter shall, prior to carrying out such actions, consult with the office to obtain the approval of the office to conduct such action.

All agencies of State Government shall advise the office of their proposed fiscal activities, especially budget requests and expenditures, concurrently

with their submission to the Budget Office or to the Governor. All agencies of State Government, concurrent with submission to that agency's approval authority, shall advise the office of proposed legislation, fiscal activities and administrative activities relating to drug abuse prevention. No such action shall be taken related to drug abuse prevention without approval of the office. State agencies shall, in the implementation of their activities, keep the office fully informed of their progress and of any proposed changes in fiscal matters and policy.

State agencies shall cooperate fully with the office and council in carrying out this chapter. The office and council are authorized to request such personnel, financial assistance, facilities and data as will assist the office and council to fulfill its powers and duties.

The office shall cooperate with the Department of Mental Health and Corrections and all institutions under its control in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons and for people who abuse or are dependent on drugs in or on parole from penal or special treatment institutions.

The office shall cooperate with the Department of Public Safety and the Department of Transportation in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while under the influence of drugs or intoxicating liquor.

The office shall coordinate all drug abuse education, information and training programs conducted within the State through cooperation with the Department of Educational and Cultural Services, school administrative districts, municipal schools, police departments, courts and other public and private agencies, organizations and individuals. Such coordination may assist with: Establishing educational programs for the prevention of alcoholism and drug abuse; treatment and rehabilitation of alcoholics, intoxicated persons and persons dependent upon or abusing drugs; training in the prevention, treatment and rehabilitation of such persons; and with preparation of curriculum materials thereon for use in all levels of educational programs.

5. State Drug Abuse Strategy

An additional responsibility placed with the new single state agency is the development of a comprehensive state stategy for drug abuse prevention and drug traffic prevention no later than January 1, 1975. The Office, Advisory Council and State Government Coordinating Committee are to mutually participate in the preparation of the strategy. The strategy is to contain:

1. An analysis of the nature, character and extent of the drug abuse problem in Maine, including examination of the interrelationships between various approaches to solving the drug abuse problem and their potential for interacting both positively and negatively with one another;

2. A comprehensive plan, with respect to both drug abuse prevention functions and drug traffic prevention functions, which shall specify the objectives of the strategy and how all available resources, funds, programs, services and facilities authorized under relevant law should be used; and

3. An analysis and evaluation of the major programs conducted, expenditures made, results achieved, plans developed and problems encountered in the operation and coordination of the various drug abuse prevention functions and drug traffic prevention functions.

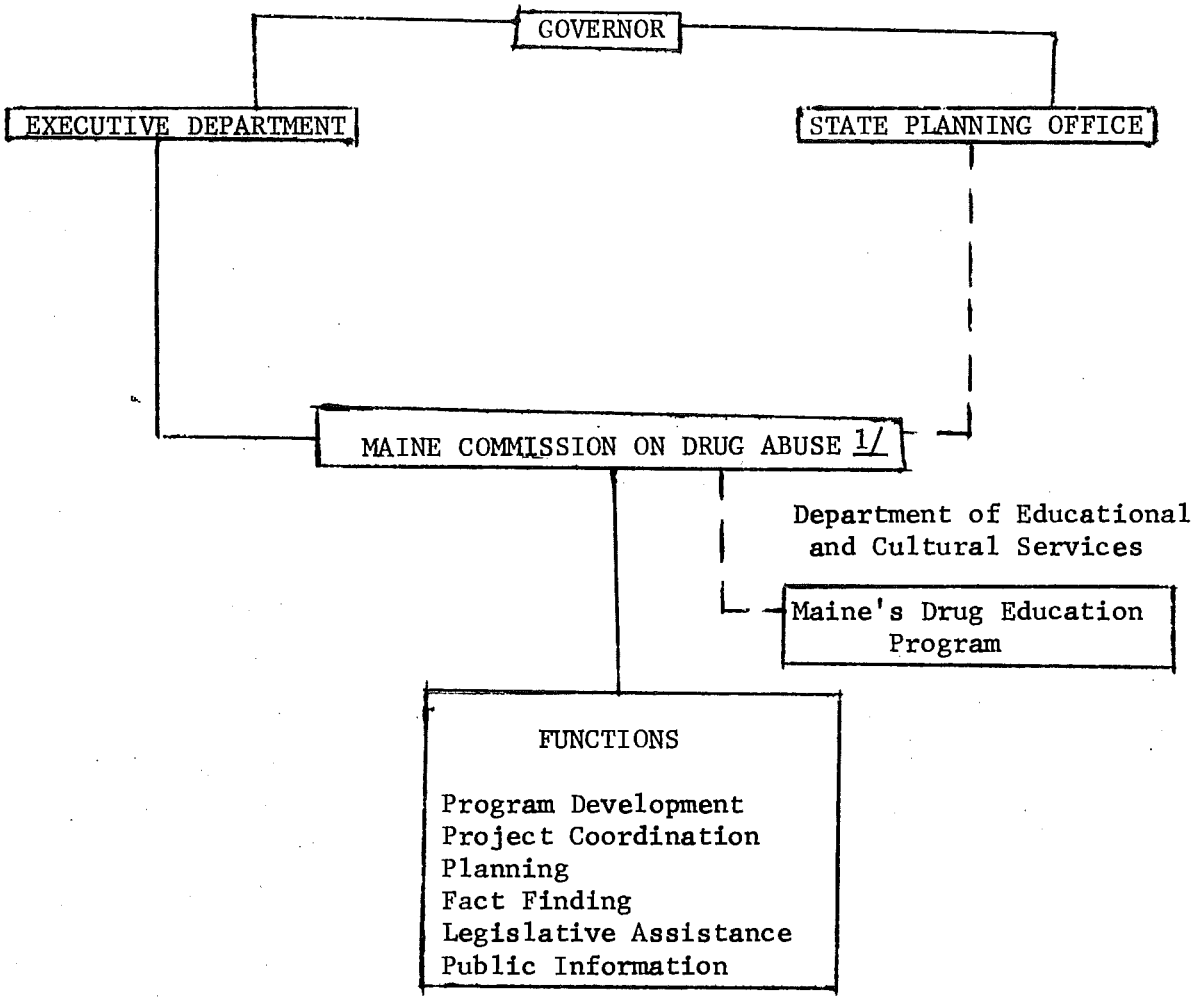
The strategy shall be reviewed, revised as necessary and promulgated as revised from time to time as the Governor deems appropriate, but not less often than once every 2 years.

ORGANIZATIONAL CHART A

STATE OF MAINE

SINGLE STATE AGENCY

Current Organization: August 1973



1/ List of Agencies Legislatively Included in Membership, Maine Revised Statutes, Section 3361 of Title 5, as enacted by chapter 379 of the Public Laws of 1971:

Departments:

Health and Welfare	Executive
Mental Health & Corrections	Manpower Affairs
Educational & Cultural Services	Public Safety

Separate Agencies and Institutions

Attorney General

Maine Law Enforcement Planning & Assistance Agency

University of Maine

Maine State Health Planning Council

Private Sector

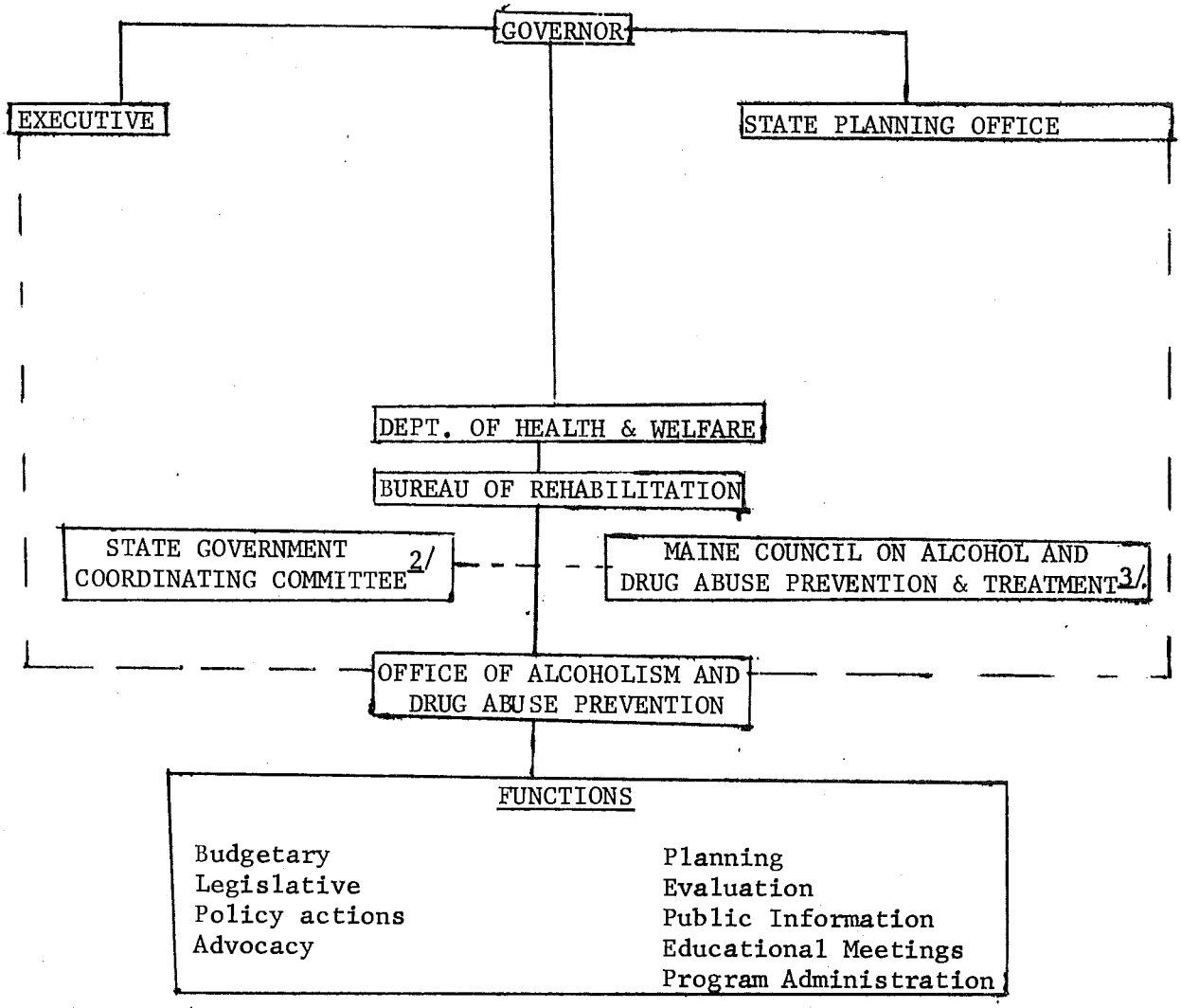
5 citizens designated by the Governor

ORGANIZATIONAL CHART B

STATE OF MAINE

ORGANIZATION LEGISLATIVELY AUTHORIZED ON JANUARY 1, 1974[1/]

SINGLE STATE AGENCY



1/ Public Law 566, June 28, 1973, Revised Maine Statutes, effective 1 January 1974, Sec. 1, R.S. Additional (Drug Abuse).

2/ State Government Coordinating Committee, to be established under the statutory provisions, P.L. chapter 566, will act as a permanent liaison among state governmental branches and agencies assisting the State Legislature, Executive and the Judicial Council in formulating and implementing a comprehensive plan mutually developed by the advisory

council (see Note 3/) for the prevention and control of drug abuse and drug dependence, especially treatment of alcoholics and intoxicated persons. Members are these:

The Attorney General

The Chief Justice, as Chairman of the Judicial Council

The Director of Law Enforcement Planning & Assistance

The Director, Office of Alcohol and Drug Abuse Prevention

The Commissioner of Educational and Cultural Services

The Commissioner of Health and Welfare

The Commissioner of Manpower Affairs

The Commissioner of Mental Health and Corrections

The Commissioner of Public Safety

The Commissioner of Transportation

The Governor

The President of the Maine Senate

The Speaker of the Maine House of Representatives

The State Youth Coordinator

and other appropriate officials.

3/ The Council, to be established under the statutory provisions P.L. chapter 566, will consist of 17 members who, excepting the Legislative members, will be appointed by the Governor with the advice and consent of the Executive Council. Membership will include representatives of non-governmental organizations or groups and of the public agencies concerned with prevention and treatment of alcoholism, alcohol abuse, drug abuse and drug dependence. At least two members of the council shall be current members of the Legislature -- one from the House of Representatives and one member from the Senate. The House member shall be appointed by the Speaker of the House, and the President of the Senate will appoint a Senate member.

B. Management Information
1. Data Collection System

In order for the State of Maine to know the scope of its drug abuse problem and how agencies within the state are dealing with the problem, it must have a data collection system which will provide reliable and valid information. There are several segments of the population which should be sampled to obtain an overall view of drug abuse in the State: 1) the general population; 2) persons accused and/or convicted of drug abuse or related crimes; 3) persons seeking treatment for drug problems. A representative sample of these populations could supply information of the incidence and types of drug abuse. Additionally, these data should be collected at regular intervals, preferably quarterly, from at least the two latter groups.

The general population is perhaps the most crucial group to be surveyed because it will give some indication of the actual drug use and abuse within the State. It is strongly suggested that the single State Agency contract for a prevalence and incidence survey of the general population. The results of this survey would serve as a base for planning services for drug abusers.

Data on persons accused and/or convicted of drug abuse would be obtained from police departments, courts and penal institutions. At the present time the LEAA is seeking funds for the State Comprehensive Data System which includes Uniform Crime Reporting and a State Criminal Justice Data Analysis Center. If funded, this center would provide statistical analyses and profiles on the drug problems dealt with by law enforcement agencies. The State Agency may be able to use the data when it becomes available. A sample of police departments would be chosen as indicators which would be checked at regular intervals. Court decisions would be obtained from a sample of district and superior courts either through their cooperation or a search of their records.

Data on persons seeking help for drug related problems could be obtained by sampling the mental health centers and human service agencies listed in the Maine Human Resources Index and securing their cooperation. Interviewers would have to be used to obtain information in some cases while other agencies would simply return information forms. Agencies which receive federal funds and are required to report to NIMH quarterly could forward that information to the State Agency. This category of information also includes data from physicians and hospitals (Blue Cross data may be used for hospitals). Students and administrators in school systems chosen by a similar method of random sampling would fill out questionnaires on the incidence of drug abuse which they know of or are involved in.

Those programs funded by the Single State Agency and those whose funds are channeled through the agency will be expected to cooperate with the data collection system.

Wherever possible existing sources of data will be utilized. The format for gathering information will be as concise as possible. Hopefully, the information obtained through this system will serve as an indicator of who is using drugs, what drugs they are using and in which area of the state they reside. The population characteristics (age, sex, education) of abusers of specific drugs and the type of institution or agency which most oftem serves them can be analysed using the information gathered. The results will also be examined for increases or decreases in abuse and in case loads

of agencies dealing with that abuse. Steps should be taken to assure respondents that the State Agency is interested mainly in group trends, not individuals, towns or school systems. This precattion may encourage truthful responses.

The cooperation of the agencies involved must be secured at the outset of this project as they must supply information on a regular basis. Their response rate may be better when sampled and visited by an interviewer than it would be with a mail questionnaire sent to every agency. At the present time no mechanism exists for the collection of data on a statewide basis; any comprehensive planning or evaluation requires such a mechanism.

B. Management Information
2. Client Oriented Data Acquisition Process (CODAP)

The Maine Commission on Drug Abuse and NIMH funded programs in Maine will comply with the reporting requirements of the Client Oriented Data Acquisition Process (CODAP). However, we share the concern of Massachusetts and other states about the usefulness of this system, its applicability to programs serving poly drug abusers and, more importantly, the potential for client identification. We anticipate that SAODAP will respond to these concerns by revising the CODAP system.

C. Mangement Control

The following submission, review and appeal procedures have been established for applicants for subgrants under Section 409 of P.L. 92-255 , Drug Abuse Office and Treatment Act of 1972:

1. Assure that agencies or authorities which have interests or responsibilities related to theprogram proposals have been afforded a reasonable opportunity to review such proposals;

2. Obtain such data and information from organizations and individuals as may be necessary to implement and/or modify the State Plan. Such data and information will be incorporated into a management information system at the State level, which shall be consistent with federal information systems;

3. Inform interested agencies and organizations and the general public about the agency's activities and recommendations;

4. Applications must be submitted in writing to the single state agency;

5. The Single State Agency will notify an applicant in writing of the rejection of an application or the termination of funds. Reasons for the action will be expressly stated and appeal procedures outlined.

6. The Single State Agency will review all applications for drug abuse assistance under:
   Drug Abuse Office and Treatment Act of 1972;
   Community Mental Health Ceneters Act (42 USC 2688);
   Public Health Service Act (42 USC);
   Vocational Rehabilitation Act;
   Social Security Act.

The fiscal administration of grants shall be subject to such further rules, regulations and policies concerning accounting and records, payment of funds, cost allowability, submission of financial reports etc. as may be prescribed consistent with the purposes and authorizations of P.L. 92-255 Drug Abuse Office and Treatment Act of 1972.

The Single State Agency will establish fiscal control and fund accounting for grant funds and required non-Federal expenditures. This applies to funds disbursed by grantees as well as to funds disbursed in direct operations of the State agency.

Aecounting procedures shall provide for an accurate and timely recording of receipt of funds by source, of expenditures made from such funds and of unexpended balances. Controls shall be established which are adequate to ensure that expenditures charged to grant activities are for allowable purposes and that documentation is readily available to verify that such charges are accurate.

Except where inconsistent with federal requirements, State procedures and fiscal practices shall apply to funds disbursed by the State agency.

Accounts and records of the Single State agency and of grantees which disburse or utilize grant funds shall be accessible to authorized Federal and State officials for the purpose of audit and examination.

All required financial records shall be maintained until an audit is completed and all questions arising therefrom are resolved or until Federal disposition of records is obtained.

Funds shall normally be made abailable pursuant to rules and procedures at to establishment, withdrawals, issured by the State.

The Single State Agency pursuant to Federal regulations shall, prior to granting funds, require applicant agencies to file certain assurances. Information and details will be made available to applicants at the time when they make application for project funding.

D. Licensing and Accreditation

Licensing and accreditation will be standard procedures for treatment programs, including residential treatment facilities, under two bills enacted during the current legislative session.

The first, P.L. 164, amends the powers and duties of the Department of Health and Welfare to include inspection and licensing of residential facilities for the care, treatment or rehabilitation of drug users (see Appendix I).

The Division of Hospital Licensing in the Department of Health and Welfare will inspect these facilities to determine whether they conform to health, samitary and Life Safety codes.

The second, P.L. 566, 1973 Alcoholism and Drug Abuse Act, requires the single state agency to:

> "Establish operating and treatment standards, inspect and issue a certificate of approval for any drug abuse treatment facility or program, including residential treatment centers, which met the standards promulgated under Section 7115, subsection I, and licensed pursuant to Section 5-A and other applicable provisions of law. The office shall periodically enter, inspect and examine the treatment facility or program, and examine their books and accounts. It shall fix and collect the fees for such inspection and certificate. Insofar as licensing and certification of drug abuse prevention facilities and programs may also be the responsibility of another administrative unit of the department, the office may assign performance of this responsibility to such a unit or make other mutually agreeable arrangements with such a unit for assisting with performance of this responsibility;...."

The single state agency will develop minimum standards applicable to all drug abuse treatment programs. These standards will include guidelines for selection and training of staff, record keeping, advisory boards, referrals, community relations, fiscal and program audit and client rights.

E. Evaluation

The single state agency will comply with regulation 54b.112 (42 CFR Part 54b) which requires monitoring and reporting the performance of all programs funded from appropriations under Section 409 of the Drug Abuse Office and Treatment Act of 1972 (86 Stat. 80, 21 USC 1176). The single state agency will also be responsible for evaluation of all drug abuse prevention programs which are funded directly by the single state agency or whose funds are channeled through the single state agency.

Program review will employ both process and outcome evaluation. Process evaluation will include administrative monitoring of fiscal and recordkeeping procedures and progress reports from program administrators. The program's internal data system can also supply useful iiformation. Outcome evaluation, the comparison of program costs to program outcomes, is essential to continued financial support of any program. Outcome evaluation will attempt to answer the following questions:

1) Does the program establish reasonable and measurable goals?
In measuring the effects of a drug abuse program on the participants we should establish specific social, vocational, recidivist or educational goals rather than talk in vague terms of "increased social adjustment." Failure to ask rigorous questions about proposed objectives can compromise the projects potential from the outset. We should not rely on the program administrator and/or clients alone for a measure of whether the program is attaining or falling short of its goals.

2) What is the cost of the program? How does the cost compare to the benefits?
In this instance we might compare the annual cost per client in a treatment program with the cost of maintaining the same client in jail or on public assistance.

3) What difference did the program make?
This question attempts to compare the characteristics of program participants and non-participants. An example would be to compare arrest rates of program participants and a group of non-participants with similar characteristics.

Evaluation of drug abuse and youth services proposed in this plan is not easy; the process is fraught with political and technical difficulties: how to measure objectives, inability to predict human relations problems and the relative short history of these kinds of programs.

F. Planning Next Year's Program

The Office of Alcoholism and Drug Abuse will be responsible for planning next year's program. Timetable responsibilities and activities to be followed will be determined by the Director of the Office.

The present single state agency hopes that a revised Action Plan and progress report can be submitted by June 30, 1974.

VII. ASSURANCES

STATE OF MAINE
DRUG ABUSE TREATMENT AND PREVENTION PLAN
ASSURANCES FORM

The following assurances required by DHEW regulations have either already been given in our application for the Sec. 409 grant (1-3) or are written into the State Plan (4-13) on the referenced pages.

The certificate completed at the end of these assurances indicates our intention to comply with them.

1. Grant funds requested for the preparation of the State Plan will be used as intended to meet the requirements of Section 409(e), PL 92-255. Regs. Sec. 54b.105. Contained in Application for Section 409 Plan.(Attached)

2. Grant funds for the preparation of a State plan will be used to supplement State, local and other Federal funds but will not supplant such funds. Regs. 54(b)105(b)(4). Contained in Application for Section 409 Plan.(Attached)

3. The views of representatives of State and local governments, public and private agencies or organizations concerned with drug abuse problems and the views of the general public will be sought and considered in the development of the State plan. Regs. 54(b)105(b)(5). Contained in Application for Section 409 Plan. (attached)

4. Equal Employment Opportunity will be assured in the State Merit System. Discrimination in any aspect of personnel administration because of political or religious opinions or affiliations, or discrimination because of age, sex, or physical disability will be prohibited except where age, sex, or physical requirements constitute a bona fide occupational qualification. Regs. 54(b)113(b)(2).

5. The single State agency will establish safeguards to prohibit employees from using their positions for private gain to themselves or others. The State Statute covering conflict of interest is M.R.S.A. T.17 §3104 Regs. 54(b)(3)(i).

6. No qualified applicant will be denied employment in a position wholly or partly supported by funds authorized by Sec. 409, PL 92-255, solely on the basis of a prior history of drug abuse or drug dependence. Regs. 54(b)113(b)(3)(ii).

7. All records required by Sec. 409, PL 92-255 and the regulations of this subpart (42CFR 54(b)) will be kept intact and accessible in accordance with the provisions of Section 54(b)118,42 CFR54(b). Regs. 54(b)118(a) through (h).

8. The State Agency will make reports as required by the regulations of this subpart, (42 CFR 54(b), and any additional reports as the Secretary may require from time to time. Regs. 54(b) 119(a) and 54(b) 119(b)(1)(2)(3).

9. Federal funds for the maintenance of effort under Section 409, PL 92-255, and the regulations of this subpart, (42 CFR 54(b), will be used to supplement State, local and other non-Federal funds but not to supplant such funds. Regs. 54(b) 120(a)(1)(2).

10. Federal funds available to the State under Section 409, PL 92-255, and the regulations of this subpart, (42 CFR 54(b), will not be available to hospitals that refuse admission or treatment to drug abusers suffering from emergency medical conditions solely because of their drug abuse or drug dependence. Regs. 54(b) 120(c).

11. Facilities, programs and services supported in whole or in part with Federal funds will be so located as to be readily accessible, available and responsive to the needs of the population to be served without discrimination because of sex, creed, or duration of residence and that their services for drug abuse prevention or treatment be publicized so as to be generally known to the population to be served. Regs. 54(b) 120(b)(1)(2)(3)(4).

12. The State Agency will comply with the Uniform Relocation Assistance and Real Property Acquisition Act of 1970, PL 91-464, which provides for fair and equitable treatment of persons displaced as a result of Federal and Federally assisted programs and applicable regulations issued there under (45 CFR 15); (36 FR 18838), 9/22/71. Regs. 54(b) 120(d).

13. The requirements of Civil Rights Act, 1964, on nondiscrimination because of race, color, or national origin will be fully observed under programs or activities receiving Federal financial assistance (42 USC 2000(d); 78 Stat. 252; 45 CFR 80).

I do hereby certify that these assurances are made in good faith and will be maintained by the SSA as a condition of continuing funding.

Richard J. Carbonneau
Director, SSA, or other authorized official

8/7/1973
Date

STATE OF MAINE
OFFICE OF THE GOVERNOR
AUGUSTA, MAINE 04330

January 23, 1973

Dr. William E. Bunney, Jr., M.D.
Director
Division of Narcotics Addiction & Drug Abuse
Parlaun Building
5600 Fishers Lane
Rockville, Maryland 20852

Dear Dr. Bunney:

Re: Secretary Richardson's letter of January 16, 1973.

I have designated the Maine Commission on Drug Abuse as the single state agency responsible for developing and administering the state plan. (See attached letter)

The Maine Commission on Drug Abuse will assume the following coordinate functions:

1. Prepare or supervise the preparation of a comprehensive State drug abuse plan which takes into account the total needs of the State for treatment and prevention programs and sets forth an orderly plan for meeting these needs.

2. Be responsible for administering or supervising the administration of the comprehensive State plan.

3. Assume a major role in coordinating all drug abuse treatment and prevention programs in the State.

Maine will need $119,781 for the preparation of its comprehensive State plan. Any unexpended funds will be held in reserve until the plan is approved.

The Federal funds made available under this grant will not supplant the present level of state, local and other non-federal funds that would, in the absence of this grant, be made available to carry out these drug abuse program planning activities.

STATE OF MAINE
OFFICE OF THE GOVERNOR
AUGUSTA, MAINE 04330

We look forward to the earliest possible approval of this application for inttial planning funds.

Sincerely,

KENNETH M. CURTIS
Governor

KMC:js

Enclosure

Blind cc: Richard W. Carbonneau
Dr. Stephen Simonds
Dr. Dean Fisher
Commissioner William Kearns

ADDITIONAL ASSURANCES

The State Agency, the Maine Commission on Drug Abuse, responsible for the administration of this State plan assures that:

1. Federal funds made available to the State under this plan will be used to make a significant contribution toward strengthening drug abuse prevention/treatment services in the various political subdivisions of the State in order to improve the quality, scope and extent of such services.

2. Resources, state and Federal will be made available to public or nonprofit private agencies and organizations in accordance with the provisions established in this plan.

3. Federal formula grant funds will be used to supplement and, to the extent practicable to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds were provided and not to supplant non-Federal funds. There will be reasonable State financial participation in the cost of carrying out this State plan in accordance with applicable Federal regulations.

4. Financial procedures for properly charging the costs of activities under the plan will be established and maintained in accordance with Federal Formula grant administrative requirements. Financial reports will be submitted on a timely basis to the Secretary, Department of Health, Education, and Welfare.

5. In accordance with Title VI of the Civil Rights of 1964 (42 U.S.C.2000d et.seq.) and the Regulations issued therunder by the Secretary, Department of Health, Education, and Welfare, no individual shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefit of, or be otherwise subjected to discrimination under this plan. The Single State agency will utilize the State's methods of personnel administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with applicable Federal Civil Rights regulations.

6. **Confidentiality of patient records.** (Sec. 408, P.L. 92-255):

(a) Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function authorized or assisted under any provision of this Act or any Act amended by this Act shall be confidential and may be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b)(1) If the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed

(A) to medical personnel for the purpose of diagnosis or treatment of the patient, and

(B) to governmental personnel for the purpose of obtaining benefits to which the patient is entitled.

(2) If the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, does not give his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management or financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

Penalty.

(e) Except as authorized under subsection (b) of this section, any person who discloses the contents of any record referred to in subsection (a) shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

7. Methods of program administration will be established and maintained as are necessary for the proper and efficient implementation of this State Plan.

8. The single State agency will utilize the state government's methods of personnel administration which are wholly in accord with Federal regulations.

9. The single state agency will insure that no full-time officer or employee of the State agency or any firm, organization, corporation or partnership which such officer owns, controls or directs, shall receive funds from an applicant under this legislation, directly or indirectly, in payment for any services rendered in connection with any activity intended for Federal funding under this program.

10. Policies and procedures will be developed and implemented by the single state agency for the expenditure of funds under this State plan to assure effective and continuing State planning, evaluation, and delivery of services (under both public and private programs).

11. The single State agency is developing methods to assess this State's effectiveness and accomplishments in meeting drug abuse service needs in accordance with the Special Action Office for Drug Abuse Prevention requirements.

12. The single State agency, will make reports, keep records, and afford access thereto, in accordance with applicable Federal regulations.

13. Financial and technical assistance shall be furnished to public and nonprofit private agencies and organizations engaged in providing services and facilities serving persons with drug abuse problems on a statewide basis.

14. Every applicant for a service project will have an opportunity for a fair hearing before the single state agency if the applicant is dissatisfied with any action of the State agency regarding funding applications or program administrative matters.

15. The single state agency will provide the Secretary of Health, Education and Welfare from time to time, but not less than annually, an up-date of the State plan for Federal approval.

16. The single state agency has solicited from the general public through the newspaper media advising also that a copy of this plan is available for public inspection. Advertising attesting to the foregoing has been accomplished through the Kennebec Journal which is circulated throughout the State. Review of this plan and comments from the public sector has been accomplished during the normal State business hours at the State Office Building in the office of the single state agency.

17. The single state agency will report on the methods (evaluation approach, system, process, and evaluative design and analysis) used to assess the effectibeness and accomplishments of the State in meeting the needs of persons at risk or those having drug abuse problems: preparignspecial reports, additional information and assurances that the Secretary of the Department of Health, Education, and Welfare may find necessary to carry out the provisions and purposes of P.L. 92-255.

REGION I
AROOSTOOK DISTRICT
APPENDIX A

COMPREHENSIVE DRUG ABUSE PLAN
REGIONAL PROFILE

Region I - Aroostook

I. Geography

Area 6,453 sq. miles
Location (boundaries, etc.) Bordered East and North by the Province of New Brunswick; West by Province of Quebec, and South by Maine Counties, Somerset, Piscataquis, Penobscot, and Washington.

Principal Population Centers North: Fort Kent, Madawaska, and Van Buren; Central: Caribou, Fort Fairfield, Limestone, Presque Isle and Mars Hill; Southern: Houlton, Patten, and Island Falls.

Transportation
Major Roads, Highways 1, 1A, 2, 2-A, I-95, and 11
Public Transportation Yes_____ No X

II. Population
Total Population for Catchment Area 96,000 (Provisional - 1973)
Males % 41 Females % 59 White % 98.5
Non-White % 1.5 0 - 14 30,720 (33.2%) 15 - 24 17,184 (17.9%) 25 - 44 21,696 (22.6%) 45+ 24,960 (26.0%)
Average Family Size 4.29

III. Socio-Cultural

Briefly describe the cultural and religious backgrounds represented in your area North: Acadian French Catholic; Central: Mixture of French Catholic and Anglo-Saxon Protestant; and, Southern: Mixture of Anglo-Saxon Catholic and Protestant. There are some Russians, Swedes, Irish who identify themselves as ethnic subgroups.
Briefly describe local government in your area. Is it relatively organized/disorganized, responsive/unresponsive? Organized into Townships--some townships are unorganized and have no population. Responsiveness of local government varies according to the relative wealth of the township. Caribou, Presque Isle, and Houlton are wealthier and generally more responsive to identified needs. Townships are largely preoccupied with concern for sewerage, land management, tax abuse, etc., rather than services per se.

IV. Economy

Industry
Who are the major employers? Forest Industry, Agriculture, Foods, and Tourism (in that order). Most of the unincorporated townships are covered by forest owned by one of the

Appendix A (Continued)

seven large paper companies.

Employment

Labor Force 54,886 (Based on Provisional estimates)
Male % 42 Y Female % 58
Unemployment % 11.4
School age unemployment % State of Maine 9.9% male; 11.3% female

Housing

% Sub-standard 29.8 by 1960 census figures

Income

Median Income 7,796
% Families in Poverty 16.3
DHEW Poverty Designation Yes X No

Education

Average School Year Completed 9.4
School Dropout % 4.1 (1973 figures from Maine Department of Education)

Include any other demographic data which you feel influences patterns of drug abuse in your area: 50.8% of families earn less than $7,000. Selective Service rejected 3.3% or third highest in state of mental reason on draft physical. 50.6% of Aroostook County population classified as rural. Recreational facilities (organized) extremely underdeveloped with only major population centers having summer programs and only three or four have winter programs.

II. The Problem

Although the primary focus of this survey has been on problems of substance abuse, an attempt was also made to obtain some perspective on the substance abuse problem in relation to other problems affecting youth as observed by our many participants. Several agencies, groups, and individuals were asked to list three problems they consider most prevalent among Aroostook County youth in order of their importance. By a heavy majority, there was agreement that the problems of greatest importance were:

1) Lack of meaningful and comprehensive community activities;
2) Lack of opportunities for employment or employment training;
3) Drug Abuse (especially alcohol).

Although an attempt was made to collect statistics, estimates were also erratic (i.e., varying estimates from 150 to 5,000 alcohol abusers in Presque Isle) that they were considered unusable. In nearly all instances, estimates exceeded the number reported from official sources.

The problem related to substance abuse is defined in the following pages under the headings, "Criminal Justice System," "Educational System," "Treatment and Rehabilitation System," and, "Miscellaneous."

A. CRIMINAL JUSTICE SYSTEM:

1. Superior Court:

Statistics were obtained from the Superior Court by a detailed reading of court records. Many convictions presented here represent duplicate data of the non-convictions in the District Court data. Because of the preponderance of evidence of alcohol abuse obtained from District Courts and because of time pressure, no effort was made to obtain conviction data on alcohol abuse in the Superior Court. The following data covers all substance abuse convictions. Many of the non-convictions represent actions dropped by the prosecution.

Out of thirty-three cases tried, twenty-four were convicted for possession of Canabis leaving twenty-two to be convicted for possession, sale, or use of "harder" drugs. This would appear to complement an earlier study by AMHC suggesting a very low usage of "hard" drugs in Aroostook County.

Region I

SUPERIOR COURT

SUBSTANCE ABUSE DATA

ITEM	CONVICTION		MALE	FEMALE
	YES	NO		
Illegal Possession - Canabis	2	3	4	1
Illegal Possession - Amphet.	4	4	5	3
Illegal Possession - LSD	3	2	5	
Illegal Possession - Narcotics	12		12	
Possession & Sale - Heroin	1		1	
Possession - Paraphenalia	1		1	
OUI - Narcotics	1		1	
GRAND TOTAL	24	9	29	4

2. District Courts

The six District Courts yielded the following data:

DISTRICT COURTS

SUBSTANCE ABUSE DATA

ITEM	CONVICTION		MALE	FEMALE
	YES	NO		
OUI - Alcohol	457		451	6
Intox. - Alcohol	300		274	26
Other Alcohol Abuse	47		41	6
Illegal Possession - Canabis	104	4	85	23
Assoc. - Canabis	44	18	48	14
Sale - Canabis	1		1	
OUI - Narcotics	1		1	
Illegal Possession - Amphet.	11		11	
All Other Drugs	3	10	11	2
GRAND TOTAL	968	32	923	77

A brief look at the District Court statistics suggests that the total recorded, court recognized substance abuse accounts for 968 cases or 1.01% of the Aroostook County population. If the 804 cases of alcohol abuse or 83% of all court reported drug abuse is removed, and if the 149 cases of canabis abuse or 15.2% of the substance abuse cases reported is removed, the use of hard drugs as reported by the courts appears negligible.

3. Police--Local, County, and State:

The following table contains data reported by local towns and city police, the Sheriff's office, and the state police. The data from the Sheriff's office and that from the state police is recorded as it was reported. Since only a small number of town and city police departments were contacted, it was necessary to project from the data received to the county-wide figure presented on the table on the basis of population. That data, therefore, has a probable error of plus/minus 5% of the figures projected but appears consistent with the rest of the data.

POLICE--LOCAL, COUNTY, AND STATE

SUBSTANCE ABUSE DATA

	SEX		DRUG						
UNIT	M	F	NARCOTICS	AMPHET.	HALLUC.	MARIJ.	ALCOHOL	OTHER	TOTAL
Local Police	4,043	446		89	89	306	4,005	64	4,553
County Sheriff	119	4	1			5	117		123
State Police	533	63					351	245	596
TOTAL	4,695	513	1	89	89	311	4,473	309	5,272

Of the 5,272 reported arrests, 312 are classified as juveniles, of whom 231 or 74.1% are male and 81 or 25.9% female. The total arrest figure of 5,272 represents 5.5% of the county's population. Of that figure, 4,473 or 84.8% involves alcohol abuse. The remainder of 799 equals approximately .8% of the county population.

B. EDUCATIONAL SYSTEM:

A brief look at statistics gathered from the law enforcement systems, suggests that, except for alcohol abuse which seems to favor no particular age group, drug abuse was probably greatest among adolescents and young adults and especially those in the junior high (age 13) through college (22 or 23 years of age) group. Because of this observation and because of time and manpower limitations, we elected to contact school officials most likely to know about behavior problems in junior highs, high schools, and colleges.

1. The Public Schools:

Since AMHC has an established relationship with the public schools in Aroostook County through its educational consultation staff, a youth services questionnaire was distributed through the consultants to the schools. Although we were not able to get data back from all schools, sufficient data was obtained to allow us to extrapolate the figures contained in the following table. As with the local police data above, probable error would be plus/minus 5% of projected data.

AROOSTOOK COUNTY PUBLIC SCHOOLS
DRUG ABUSE DATA

RELEVANT POPULATION	SUBSTANCE	SEX		AGE		
		M	F	0-14	15-17	18-24
8,188	Alcohol	313	103	20	333	63
	Marijuana	96	33	7	103	19
	Other Drugs	48	23	9	52	10

The above data is taken from widely varying estimates based on observation and not on any accurate set of records. The ratio of approximately two males for every female identified with drug abuse is consistent with other drug abuse data. The use curve, which peaked between 15 and 17 years of age, came as a surprise. Three factors, two of them unique to Aroostook County and one peculiar to adolescents would suggest a possible explanation: 1) statistics supplied by the 1970 census and dropout data supplied by the Maine Department of Education tell us that school attendance runs at a rather static level around 2,200 in Aroostook County until the 11th grade (16 or 17 years of age), when it drops somewhat precipitously to 1,740 in the senior year to account for a dropout rate of 4.1%; 2) Statistics from the Comprehensive Juvenile Delinquency Study demonstrate that Aroostook County courts heard 460 juvenile cases in 1972 or an incidence of 497 cases per 100,000 compared to 254 per 100,000 as an average for the remainder of the state; and, 3) the May 14, 1973, issue of the Washington Bulletin (Page 39, states, ". . . the best indicator of subsequent use of illegal drugs is rebelliousness toward authorities and rules."

A possible explanation would then appear to be that youngsters who are in rebellion are getting into difficulty with school officials and rules and are dropping out, thus moving those individuals from the schools who would ordinarily be more strongly identified with drug use. If this projection is accurate, a similar drug curve applied to youngsters in the community should show a slight increase around 18 years of age and carrying the peak on into the early 20s.

2. Colleges:

Although questionnaires were submitted to the four colleges in the County, respondents were unable to provide us with statistical estimates of the number of substance users among college students. It was the generally expressed opinion that alcohol abuse far outweighed other types of abuse and that there was some marijuana abuse. The respondent from University of Maine at Presque Isle indicated that the drugs on campus were usually brought in by girls dating Loring Air Base men.

It may be of some interest to note that upwards of 80% of those cases of reported marijuana and other drug abuse in Houlton were out-of-state residents between the ages of 18 and 23 years who were probably Ricker College students.

One of the facts apparent from reported data is that students who are experiencing substance abuse problems are generally not seeking assistance from college officials.

C. TREATMENT AND REHABILITATION SYSTEM:

1. Aroostook Mental Health Center:

During calendar year 1972, AMHC admitted and treated 157 cases in which substance abuse was a primary diagnostic entity. Of those, 148 involved the abuse of alcohol and 9 involved abuse of some other drug. Of those abusing alcohol, all were adults above 18 years of age. Of the nine abusing drugs, six were juveniles under 15 years of age and three were adults over 45 years of age.

The following table presents this data in somewhat more graphic form.

AROOSTOOK MENTAL HEALTH CENTER

SUBSTANCE ABUSE DATA

	SEX		AGE				
SUBSTANCE	M	F	0-14	15-17	18-25	26-44	45+
Alcohol	130	18			8	68	72
Other Drugs	5	4	6				2

2. Bangor Mental Health Institute (State Hospital)

Data from Bangor Mental Health Institute indicates that 24 cases were treated from Aroostook County for an emergency in which alcohol was the primary diagnosis in 23 cases and secondary in 1 case. Of these 24 cases, 20 were males and 4 females. All were adults over the age of 18 years. Although we lack specific supporting data, the chances are that most of these cases were admitted through AMHC and represent duplicate data.

Separate data indicates that 13 patients were admitted for drug related problems other than alcohol. Since, according to other statistics, approximately one of every five patients at Bangor is from Aroostook County, it would appear that as many as three of the 13 might be attributable to Aroostook County.

3. Hospital Emergency Rooms and Physicians:

Informal contacts with both hospital emergency rooms and physicians indicate that hard data on drug abuse and/or abusers is simply not retrievable from this source. The emergency

rooms record the nature of the medical emergency rather than the cause of the emergency--a drunken driver who has an accident is listed as "facial lacerations and fractured left femur." Physicians have very limited data retrieval systems on other than fiscal matters. There is undoubtedly some felt need to protect their patients from law enforcement or public scrutiny.

D. MISCELLANEOUS:

1. Drug Related Deaths:

According to a report from the Department of Health & Welfare, 4 persons from Aroostook County, all adults, two males and two females, from 30 to 78 years of age, died of drug related causes. One of the drugs was an anti-diabetic drug and the others were unidentified.

III. PRESENT RESOURCES:

A. SERVICE PROGRAMS:

Several agencies, groups, and individuals mentioned many of the agencies contained in Appendix "B" as being helpful to individuals or groups about whom they had had some knowledge. Among the most frequently mentioned agencies were AA, AMHC, Youth Corps Workers, Health and Welfare Social Services, and guidance counselors in the school systems.

Junior and senior high school officials pointed out that the larger schools such as Caribou, Houlton, Madawaska, and Presque Isle, had drug "teams" trained at Poland Springs to work with individuals and groups having drug problems.

Smaller schools handle the problems on a one-to-one basis between a sympathetic teacher and a youngster who approaches the teacher for counsel.

The most comprehensive summary of the current situation regarding service resources for substance abusers in Aroostook County came from the Director of Treatment Program, Aroostook County Sheriff's Department, who seemed to summarize best what most respondents were suggesting:

"I know of no community based services that provide youth with a day-to-day, door-to-door problem-solving. Each activity seems so specialized that it cannot see the total picture. Guidance counseling aims at school related problems, mental health clinics are either too busy or unable to handle youth without specific problems; other youth agencies are spread so thin that their value is questionable."

B. EDUCATIONAL PROGRAM:

It was generally agreed that effective or comprehensive educational programs about drug abuse or directed toward drug abusers were extremely rare in Aroostook County.

Resources mentioned as currently available included: 1) AA or Alcohol Information and Rehabilitation meetings, speakers or printed media; 2) some drug education material integrated with college and high school classes in biology, government, psychology, and sociology; 3) library resource material in college and some high school libraries; 4) the Maine Drug Education Program; 5) Drug Dependency Institute at Yale University; 6) guidance programs in the public schools; 7) drug "teams" in some of the larger public schools; 8) AMHC speakers and community programs; 9) some people mentioned drug information kits which were present in most schools but seldom used.

IV. NEEDED RESOURCES:

A. SERVICE PROGRAMS:

Although there was a smattering of suggestions covering the whole of potential human experience, the preponderance of suggestions included: 1) a generally available, highly visible "Hot Line" to deal with emergency situations; 2) a series of drop-in centers where youth could talk freely with someone whom they recognize as their advocate; 3) increased opportunities for employment and employment related training; and, 4) establishment of strong year-round recreational facilities and programs for youth.

It was also strongly suggested that the people providing counseling services should be trained to provide a comprehensive relationship to programs already established and operating so that appropriate services can be brought to bear on the total range of problems experienced by a given individual or group.

B. EDUCATIONAL PROGRAMS:

It was generally agreed that educational programs on substance abuse should be an integral part of every Aroostook County Child's educational experience; that program planning and implementation should provide opportunities for youth to participate in the process; that material on substance abuse should be integrated into curriculum (K-12)--especially, in biology, psychology, and social studies courses; that AMHC, through its educational consultation program, be more heavily involved in assisting schools with the development of educational and service programs relating to substance abuse; that Parent Effectiveness Training-type courses be readily available to assist parents and youth to communicate more freely and effectively; that more and better adult education classes be developed to assist in the development of general and job-related education; and, that a comprehensive program of program effectiveness be developed to assess current and future programming for human services.

V. SUMMARY AND CONCLUSION:

This survey was designed to provide an overview of the nature and extent of substance abuse (alcohol and drugs) in Aroostook County, Maine, in preparation for the development of a comprehensive state drug abuse plan.

Because the use of alcohol is a generally accepted practice which contains no illicit aspects until the abuser presents a specific threat to society (e.g.; operating a motor vehicle under the influence, public intoxication, drunk and disorderly conduct), statics other than those in the arrest and conviction records are not generally kept (e.g.; physician treat damaged livers and vitamin deficiencies but seldom treat alcoholism per se). It is, therefore, difficult to assess the exact nature and extent of alcohol abuse.

On the other hand, possession, sale, and, in the case of marijuana, association with drugs is a punishable offense. Its possession, sale, or even knowledge of such possession or sale is a closely guarded secret. Physicians and hospitals are not keeping records which are likely to bring them to the attention of the criminal justice system, and the criminal justice system probably intercepts only those offenders who draw attention to themselves through excessive of flagrant use of drugs.

Whatever the reasons, "hard" data about substance abuse in Aroostook County is extremely limited.

Many respondents believe that there is extensive use and abuse of drugs by youth in the county and there may well be, but available data suggests a relatively limited usage.If one removes Alcohol and Marijuana abuse from the statistics, the evidence of abuse is negligable.

Of greater concern to most respondents were opportunities for employment and job related training and opportunities for stimulating social and recreational activities for youth. Most felt that whatever substance abuse exists is directly attributable to lack of acceptable alternatives.

Schools in Aroostook County experience a 4.1% drop out rate and most of those occur between the 10th and 12th grades. Unemployment statics indicates a rate of 11.4% in Aroostook County. That figure is probably misleading in that it is an average and it does not reflect those who have never been employed, those who are seasonally employed or marginally employed or those who have exhausted their unemployment compensation benefits. Census data also suggests a heavy out-migration of young adults who are unable to obtain employment locally.

There is apparently strong support locally among officials in the educational, treatment/rehabilitation, and criminal justice systems to provide educational and service programs to potential and actual substance abusers but even greater perceived need and support for provision of acceptable alternatives to substance abuse.

It is clear that programs of service and education must involve the people served in the process of development and implementation; must relate to already existing programs in a comprehensive and integrative fashion; and, new programs must be available to all youth and not just substance abusers.

REGION II

PENOBSCOT DISTRICT

APPENDIX B

I. - DESCRIPTION OF THE CATCHEMENT AREA:

Region II is a large geographic area comprising 12,497.7 square miles and bounded on the northwest by the Providence of Quebec, Canada, on the north by Aroostook County, parts of Piscataquis and Penobscot Counties, on the east by the Atlantic Ocean and on the West by Somerset County, Kennebec County, Waldo County and Penobscot Bay of the Atlantic Ocean. The counties in the area are Hancock, Washington, Penobscot, Piscataquis. Even though Penobscot is increasing in population, the closing of Dow Air Force Base, Bangor, in July, 1968, may have reversed this trend.

Area II has a permanent appr[illegible]te population of 214,600. The primary concentration is in the Penobscot River Valley where 85,000 live near the Bangor area, the largest city in Area II. There is a seasonal (summer) population influx of 76,861. The population density of the entire area is 16.6 persons per square mile.

TABLE :
POPULATION OF MAINE MENTAL HEALTH AREA II
by County

County	1960 Census Population	1966 Census Population	1970 Census	1972 Estimate Population
Washington	32,087	30,203	29,859	31,300
Penobscot	123,531	132,387	125,393	129,700
Hancock	32,293	32,095	34,590	36,900
Piscataquis	17,379	16,072	16,285	16,700
Total	205,290	210,757	206,127	214,600

Population concentrations occur in the north and northwest around Millinocket (7,742), Lincoln (4,759), Dover-Foxcroft (4,173), and Milo (2,572); in the south and southeast around Ellsworth (4,683), Bar Harbor (3,716), Bucksport (3,756), Machias (2,441), Eastport (1,989), Calais (4,044), and Lubec (1,949); in the south southwest area in Newport (2,260) (see Figure I). The remainder of Area II is a vast, sparsely populated farm area in which productivity has been diminishing, or vast wilderness covered with forests (see Figure II).

The population is largely white with a few Negroes (804) and 1,308 American Indians of the Penobscot and Passamaquoddy tribes. The white population is largely Protestant, about 74% with 26% Catholic divided between two ethnic groups, the French and the Irish.

The economy is primarily dependent upon paper and pulp manufacture, allied chemicals, agriculture and small industrial enterprises. Shoes, textiles,

pottery, furniture and wood products are the leading manufactured products. A major, though seasonal, industry is tourism. Minimum wages tend to prevail in those areas not touched by the large paper manufacturing industries. In the outreach areas there is a lack of economic opportunity and considerable poverty; in fact, two years ago, Area II was designated as a Federal poverty area. The percentage of households earning less than $3,000 per year (according to "The Maine Handbook") by counties, is as follows: Aroostook 25.8%; Washington 33.9%; Hancock 26.5%; Penobscot 21.5%; Piscataquis 24.8% (see Figure III).

Along the coast, small boat manufacture is carried on by skilled craftsmen who receive low wages. Fishing for lobster, herring, mackerel and shrimp, contributes to the economy. All this entails hard work at long hours, often under dangerous conditions and with little financial returns for the effort and risk.

The Area II is self-contained in many ways. Bangor tends to be the commercial hub for the distribution of goods and services to eastern and northern Maine. It is also the financial, medical, social welfare, educational and cultural center of the Area. Bangor is the third largest city in Maine with a population of 33,163 and a trading population of approximately 360,000. The twin cities, Bangor and Brewer, have a combined population of 41,463, a twenty-five mile radius, 98,000 people and a fifty-mile radius, 135,000 people.

Public transportation is negligible. All passenger service by train was discontinued in 1961 and reliance is now placed on bus service for public transportation within the area, and air service for public transportation beyond the area. Bus service exists between the larger populated areas and the in-between towns on a limited schedule.

An interstate freeway, U.S. Route 95, bisects the southerly part of the area, making travel time from Newport to Millinocket and in-between towns good. However, quick and easy access exists only to a small part of Area II.

Several of the larger cities have recreation departments offering summer programs of supervised playground activities and swimming. Bangor has an extensive year-round recreation program for all age groups.

As indicated, tourism and outdoor recreation contribute substantially to the economy of the area. Large ski areas have developed in sections of the catchment area that were isolated and out-of-the-way. Snowmobiling has developed as a major winter recreational activity with many snowmobile clubs. This recreation and skiing are expensive and largely available to the middle and upper income families.

Bangor is the center of higher education and educational institutions are an important factor. The University of Maine has its principal campus at Orono, eight miles from Bangor, and a subsidiary campus, known as the Penobscot Valley Community College, in Bangor at the former Dow Air Force Base. At the two campuses, there are approximately 7,000 undergraduate students and 585 graduate students with a faculty of 700.

The area has a high drop-out rate from high school, with many students not entering high school after completing the eighth grade. The adult population

of the area shows a low educational level. 23% of the adults over 25 years of age have eight years or less education. The mean school years completed for adults of both sexes in the area is 10.8 years. The percentage of students going on to higher education after graduation from high school is low. Only 4.7 percent of the adult population over 25 years of age have one to three years of college.

The suicide rate in Maine is high. Over a two-year period, 1962 and 1963, the rate was 27.6 recorded suicide deaths per 100,000 population. The suicide rate in the United States is 10.5 per 100,000 population. The rate, however, for the seven counties into which the Mental Health Area II reaches, is 33.8 suicides per 100,000 population, considerably higher than the nation. The number of suicide deaths in the period 1962-1963 in the counties touched by the catchment area was 220.

Also indicative of the mental and emotional upset and extreme immaturity of personality, is the incidence of homicide. In 1965, Maine had twenty homicide deaths, giving a rate of 4.9 homicides per 100,000 population. This is slightly lower than the United States rate, which is 6.6 per 100,000 population. However, the homicide rate of the four counties with areas included in Mental Health Area II is 5.3 per 100,000 population, which is higher than the state rate, but lower than the national rate.

Unquestionably, the traditional values have contributed to the quality of Maine life, but they have also hindered in some ways. Innovations are often suspect or even disdained, and the striving for independence and individual problem-solving means that the recognition of pressing ills, let alone outside "help" may be denied. Like any ill not addressed head-on, economic and social difficulties in Maine fester and worsen until often the individual's or his community's response is pathological, contributing to higher per capita averages in homicide, suicide, incest, alcoholism in Area II.

II. - SCOPE OF THE PROBLEM:

Because of geographic and economic situations in nort-central Maine, it is felt that there are few, if any, persons with severe addiction problems. Persons who develop large habits move to New York or Boston where narcotics and barbiturates are more plentiful and easier to finance through larceny and drug sales.

As in most areas in the country, hallucinogens, marijuana, amphetamines and other drugs are usually available. School officials estimate that up to 55-60% of high school students have experimented with drugs, but that only 5-10% are consistent users of drugs. The number of barbiturate addicts is impossible to estimate according to hospital and law enforcement officials because it is impossible to assay prescription misuse of barbiturates. Street use of barbiturates is common, but it is difficult to say how many persons are in fact addicted.

School officials are becoming increasingly concerned about the abuse of alcohol among high school students.

III. - BASIS FOR ESTIMATES:

Local hospitals in Bangor refused to give drug abuse information, claiming either that they did not compile such information or were not permitted to release it to anyone other than insurance companies. The same was true at the Dover-Foxcroft area hospital. Law enforcement agencies in Bangor, however, estimated on the basis of police and ambulance calls an incidence of 2-4 drug overdoses per month including both substance-abuse overdoses and suicide attempt overdoses. One death was reported in 1972 due to substance abuse; a 21-year old man died of an overdose of intravenous meperidine.

Law enforcement data came primarily from local Police Departments and from County Sheriff Departments. The Bangor Police Department reported the following numbers of drug violations in the period 1969-1972:

Years	Drug Violations
1969	1
1970	20
1971	37
1972	47

The Special Investigating Unit of the Bangor Police estimate that there are no more than 10-15 true narcotic addicts in Area II (total population approximately 206,000). They further report a recent rash of burglaries of drug stores and physician/dentist offices:

Years	Pharmacies	Drs. Offices
1972	8-10	7-8
1973 to date	6	0

The Penobscot County Sheriff's Department reported the following information for 1972 and noted there may be some overlap with Bangor Police Department statistics since both agencies often coordinate operations:

Total narcotic violations	42
Total narcotic convictions	23

Incarcerations at Penobscot County Jail, 1972:

Possession of marijuana	6
Being knowingly in presence of marijuana use	19
Sale of LSD	21
Sale of marijuana	13
Sale of opium	1
Sale of unlawful drugs	7
Possession of amphetamines	4

The Ellsworth Police Department reported 50 drug-related complaints in 1972 resulting in 12 arrests and two convictions.

The Hancock County Sheriff's Department (Ellsworth area) reported approximately 70 arrests in 1970, but provided no breakdown of these arrests, saying only that about 75% were for what they termed only "possession" and that the rest were for "combined sale and possession."

The Piscataquis County District Court (Dover-Foxcroft area) reports handling only possession of marijuana and being in the presence of marijuana violations totaling the following for 1963-1973 to date:

Years	# Violations
1963-1968	0
1969	9
1970	22
1971	39
1972	95
1973(t.d.)	19

The 1972 breakdown of the above was:

Possession	82
Presence	13

The disposition of cases for all years has been about 80% convicted and 20% dismissed or continued.

The University of Maine at Orono offers clinical and other mental health services for students at the Center for Counseling and Psychological Services. The Center reports fewer than 15 students have come with drug abuse difficulties as a significant presenting problem. The Center feels that many students use or experiment with drugs at the University but very few have problems connected with drug use. There are approximately 8,000 students at the Orono campus.

The number of The Counseling Center's cases with presenting problems of drug abuse in this catchment are remains low. Drug-related diagnostic impressions per Admission Form MS-5(S-70) almost never appear. "Narcotics, Other Drugs" in the Problem Appraisal section of that form is checked between 0-7% as part of admission impressions. The breakdown of the frequency of this item in 1972 per Counseling Center service location is as follows:

Location	% Checking "Narcotics, Other Drugs"
Bangor Outpatient	3%
Bangor Inpatient	7%
Bangor Day Treatment	1%
Alcoholic Rehabilitation Center	6%
Millinocket Inpatient	0%
Millinocket Outpatient	5%
Hancock County (Ellsworth)	4%
Dover-Foxcroft	2%
Machias	3%
Mt. Desert Island	2%
Calais	1%

It is hypothesized that while the use of drugs has not decreased in this area, drug users have, after a number of years, settling into more familiar patterns of use and are subsequently experiencing relatively fewer proglems with drugs in spite of remaining disturbing to parents, etc. Furthermore,

because of the development of a more comprehensive 24-Hour Service and Crisis Unit at The Counseling Center, many situations which might have become outpatient cases are now being effectively handled by telephone workers.

The Counseling Center Inpatient Unit at Bangor State Hospital reports that while no doubt an occasional patient may use drugs while hospitalized, there has been no significant problem.

IV. EXISTING RESOURCES

Resources dealing with substance abuse problems are considered with respect to their function and contact with the problem. In general, few resources devote even a small fraction of their time to drug and alcohol problems, although a handful devote all their time to these areas (e.g. Alcoholics Anonymous). Resources are considered with respect to their function in the following areas:

1. Law Enforcement. The larger law enforcement agencies either have a division or at least one officer who spends full or part-time on drug abuse law enforcement (State Police, Bangor Police Department, Penobscot County Sheriff's Department). These larger agencies also contribute time to educational ventures, usually in the form of public speaking engagements to show samples of different illegal and abusable prescription substances, etc. The four remaining agencies are the County Attorney's offices. Technically, the County Attorneys engage only in prosecution, but in the course of collecting evidence for prosecution, they are engaged in a significant amount of investigative work. In addition, there are courts existing on three levels, Municipal, District and Superior. In area II there are four Superior Courts. There are under 10 Municipal and District Courts in the area, located in the larger towns and cities. The Courts are involved only in trying accused violators except that often in the case of drug law enforcement, the grand jury is requested to issue secret indictments in connection with the County Attorneys' Offices and the Police and Sheriff's Departments. Law enforcement agencies, therefore, are well co-ordinated. For example, the most recent drug raid in Area II involved 105 secret grand jury indictments for alleged sales violations with 139 counts and 40-50 individuals apprehended. The effort involved Bangor police and Sheriff's personnel working with State and some local police agencies.

The Penobscot County Division of Probation and Parole now has a full-time phychologist consultant. The Consultant is employed by The Counseling but consults full time with probation officers concerning their caseloads. He gives some direct clinical service, both evaluative work and psychotherapy, to probationers, at the request of the individual officers. He serves also as the direct liaison between the criminal justice system and the Community Mental Health Center.

2. Schools. There are 212 primary schools and 50 secondary schools in Area II (including public and private, but not including special schools, e.g., schools for blind, etc.). The school systems in the area have not engaged in a formal, co-ordinated approach to drug abuse education and prevention, but do include some nominal attack on the subject matter, usually as a 2-6-week "unit" in a course like health, social studies, or physical education. Many schools have sent teams to the Office of Education's Maine

Drug Education Project and have conducted extra-curricular drug education activities, however there are fewer than ten such viable teams in Area II. (Bangor, the largest city has none currently functioning.)

3. Hospitals. There are 16 general hospitals in the Area and one private psychiatric hospital. Some are better equipped than others to handle drug abuse problems. One (Eastern Maine Medical Center) has on one occasion conducted a sketchy lecture to the medical staff on the incidence of drug abuse, and another (Saint Joseph's in Bangor) has held drug abuse inservice training for some of its nurses.

In Area II, drug problems may be seen at any of the general hospitals on an emergency basis, but the medical staffs have demonstrated little proficiency in diagnosis and management of drug problems. Eastern Maine Medical Center is the only known hospital in Area II which will admit drug cases to its inpatient unit, where only a handful of physicians know how to manage detoxification. Drug cases are routinely admitted to the Psychiatric Section. Bangor State Hospital is equipped to handle drug patients psychotherapeutically, but not medically; detoxification problems are handled at Eastern Maine Medical Center. Only Eastern Maine Medical Center has a Psychiatric Service and offers psychotherapy of all the general hospitals.

4. Mental Health Centers. Area II is served by one comprehensive community mental health center, The Counseling Center in Bangor. The Center operates branch offices in Millinocket, East Millinocket, Calais, Dover-Foxcroft, Machias, Ellsworth, Bar Harbor and Lincoln.

The Counseling Center is equipped to provide services to any person with any type of drug abuse difficulties except those individuals requiring long-term residential care. Patients receive inpatient detoxification through collaterally-arranged service at Eastern Maine Medical Center and acute psychological and social services from The Counseling Center's Inpatient Unit. Followup and/or outpatient service is available through Outpatient and Day Treatment elements. The 24-Hour Service and Crisis Unit furthermore are trained to provide either direct services via telephone for bad trips, etc., or referrals to other service elements when indicated. The Counseling Center entered into a cooperative agreement with the Division of Narcotic Addiction and Drug Abuse (DNADA) under provisions of the Narcotic Addict Rehabilitation Act of 1966 (NARA). In 1971 one patient from the NARA program received aftercare services following discharge from the Clinical Research Center at Lexington, Kentucky, for approximately eight months.

A mental health program may serve some preventive functions if one feels that healthy parents produce healthy children. To this end, The Parent Effectiveness Training program (PET), while not aimed at preventing drug abuse specifically, offers new ideas and approaches for parents. The program is national in scope, and is co-ordinated locally by The Counseling Center. While PET has to some extent proven its effectiveness, availability is a problem. Since it is voluntary and not offered as psychotherapy, it attracts a population who may not need the program as much as others. Also, the $65 workshop fee is not within the limits of some families who might benefit from the program.

5. Human Service Agencies. There are 83 agencies in Area II providing a wide range of human services, but only those who devote program time to drug abuse or youth problems or whose function brings them into contact with youth are listed.

Bar Harbor YWCA. Provides teen-center, recreation, etc.; educational and cultural workshops, accomodations for transients.

Bureau of Rehabilitation. (Maine Health and Welfare), Machias. Vocational placement for qualified laborers. Voc/Rehab counseling. Any physically or mentally handicapped person is eligible.

Bureau of Social Welfare. Bangor, Calais, Ellsworth, Machias. Provides counseling and referral to anyone, but mostly to actual or potential Welfare recipients. Also adoption, foster care, employment day care for children of recipients and others, health services, homemaker services, and transportation.

Co-operative Extension Service. Penobscot, Piscataquis, Hancock and Washington Counties. Dispenses advice, assistance and information aimed at improving economic and social conditions. Some education occasionally.

Hancock County Opportunity Council, Inc. Trenton. Neighborhood Youth Corps for drop-outs, work-study opportunities, tutoring, counseling, referrals.

Mt. Desert Public Health Nursing Assoc. Northeast Harbor. Referrals.

Pine Tree Legal Assistance, Inc. Calais. Civil cases only, also referral.

Washington County Regional Action Agency. Machias. Rural Youth Corps, youth recreation, arts and crafts, referral.

YMCA. Ellsworth, Bangor. Teen center, recreation, education.

Abnaki Girl Scout Council. Brewer. Education, recreation, residential facilities (Bangor only).

Ala-Teen. Bangor and Old Town. Group meetings for adolescents with alcoholism in their homes, or their own alcoholism.

Bangor-Brewer Mobile Ministry. Bangor. Counseling and referrals.

Bangor-Brewer TB and Health Assn. Bangor. Advice and referral, some pamphlet distribution on drugs.

Bangor Department of Health. Counseling, education, referrals, free medical (including VD) clinic for youth and others.

Bangor Rescue Mission. Residential treatment for alcoholism, religious.

Maine Health & Welfare Bureau of Rehabilitation. Bangor, Alcoholism counseling, voc-rehab counseling and placement for any physically, emotionally or mentally handicapped person. Education and public information. Referrals.

Center for Counseling and Psychological Services. Orono. For University of Maine students, faculty and families. All types counseling, therapy, vocational testing, psychological evaluation, referrals, consultations.

Division of Indian Services. Bangor. Counseling and referral.

Health and Welfare Public Health Nursing. Education.

Good Samaritan Home Association, Bangor. Unmarried mothers, all services; counseling, maternity home placement, adoption if appropriate.

Human Relations Services, Inc., Orono. Short term counseling, referrals.

Institute for Psychological Applications. Therapy, consultation with other professionals. Training facility for doctoral students in clinical psychology.

Millinocket Community RAP, Inc., Millinocket. 24 hour emergency phone, counseling and referral, public information on drug abuse

Orono Health Service. Education, referrals.

Penquis CAP, Bangor. Operates a number of programs useful to young people; family planning, education, referrals, pre and post natal care clinics; "Mainstream" vocational training and placement; information and referral.

Salvation Army Neighborhood Corps Center, Bangor. Counseling, all types, including alcohol and drug, home visits, casework, crisis intervention, foster placement.

Upward Bound, University of Maine at Orono. Residential study program for drop-outs, disadvantaged, etc., rap group meetings, cultural activities, financial aid.

Women's Center, Bangor. Counseling (pregnancy and abortion), birth control information, referrals.

There is only one Federally funded program in Area II which is a "drug program". The Indian Island Drug Council is a group of 5-10 citizens of Indian Island who were funded as a community team to be trained in a national training workship with the goal of returning to the Island and working in the community. The funds of the "mini-grant" cover only the expenses of training the team members. There are no paid staff nor will there be as the program exists now. Mrs. Lorraine Nelson, Director of the project, stated that she could not even speculate as to the function of the project at this time, i.e., all that depends on what they end up being trained for (See form marked "Maine Commission on Drug Abuse Management Information Survey").

There is also one other Federally funded substance-abuse program in Area II, The Counseling Center's Alcohol Services Department. The unit is involved in all phases of alcohol services including treatment and rehabilitation, training, education, research, administration, coordination and planning. The unit utilizes both the regular Counseling Center inpatient ward and its own Alcoholic Rehabilitation Center (ARC) for inpatient and residential treatment services. An active outpatient and aftercare/followup caseload is maintained (See form "Maine Commission on Drug Abuse Management Information Survey").

6. Physicians. The distribution of physicians by county with frequencies per thousand population is as follows:

	#MD's	Population	#MD's/1000
Hancock	39	36,900	1.056
Washington	16	31,300	.511
Piscataquis	10	16,700	.598
Penobscot	108	129,700	.832
Total	173	214,600	.806

Families are frequently wary of turning for mental health services and therefore consult the family doctor instead. This is especially true of known or suspected drug use in a family. The physicians therefore are an important resource not only by virtue of their training and experience, but also their availability and position of respect in the community. Unfortunately, physicians in Area II are often not well versed in some of the effects and symptomatology of street and other abusable drugs.

	Law enforcement	Education/information	Referral	Counseling	Psychotherapy	Inpatient Custodial	Inpatient Medical	Vocational counseling and services	VD, pregnancy information and services	Residential treatment	Recreation	Outpatient medical clinic	Crisis Intervention
Mobile Ministry-Bangor		x	x	x									
TB & Health-Bangor-Brewer		x	x										
Bangor Department of Health		x	x	x					x			x	
Bangor Rescue Mission										x			
UMO Counseling Center Serv.			x	x	x			x				x?	
Divis. Indian Services, Bangor			x	x									
Good Samaritan Home, Bangor			x	x					x	x			
Bureau of Human Relations			x	x	x								
Institute of Psych. Applic.			x	x	x								
Millinocket RAP Center			x	x					x				x
Salvation Army Corps - Bangor				x									
UMO Upward Bound				x				x		x	x		x
Women's Center - Bangor		x	x	x					x				
Private Physicians		x	x	x	some				x				some

	Law enforcement	Education/information	Referral	Counseling	Psychotherapy	Inpatient Custodial	Inpatient Medical	Vocational counseling and services	VD, pregnancy information and services	Residential treatment	Recreation	Outpatient medical clinic	Crisis Intervention
Police Departments (30)	x	x	x										x
Sheriff's Departments (4)	x	x	x										x
Courts (10)	x		x										
County Attorney's Offices (4)	x												
Probation & Parole Div. (4)	x		x	x				x					
Primary Schools (212)		?											
Secondary Schools (50)		x	x	x				x					
Hospitals, general (16)			x	x	one	x	x		x				x
Hospitals, private (1)			x	x	x	x	x						
Bangor State Hospital		x?	x	x	x	x		x		x			x
The Counseling Center		x	x	x	x	x	x	x					x
Red Cross			x										
YMCA & YWCA's (6)											x		x
Bureau of Rehabilitation			x	x				x					
Bureau of Social Welfare			x	x									
Cooperative Extension		x	x										
Hancock Co. Opportunity Council								x					
Wash. Co. Region. Action Agency			x					x			x		
Abnaki Girl Scouts Council		x									x		
Ala-Teen		x	x	x									

IV. GAPS IN SERVICE

Poor Co-ordination. The survey of existing resources reveals that while many agencies and groups provide inroads to treatment via referrals and education via literature distribution, etc., there is no consistency of referrals, i.e. some go to the mental health center, others to the hospital, others to physicians, almost in random fashion. While flexibility in the referral process must be encouraged, nevertheless some awareness should exist concerning who is proficient at what.

In fact, misinformation and ignorance of both the nature of the beast and available resources constitute one of the most glaring problems in the area. Emergency room physicians can often only treat symptomatically because they are untrained in the differential diagnosis of drug intoxication. Not only is this treatment stop-gap in nature, it is potentially dangerous.

Unfortunately, any person who shows up in an emergency room for treatment of a "drug problem" almost always receives Valium and a lecture and is sent home. Even in the mental health center only a handful of workers have the slightest notion of what the different drugs of abuse are, let alone the psychodynamic factors involved.

Consequently, the shortage of trained workers becomes evident not only in the areas of direct service to client populations, but also in areas of consultation, planning and program development, and public information programs.

A good case can be made for not having "drug programs" per se since labeling a person a "drug abuser" is as harmful as labeling them an "alcoholic" or a "juvenile delinquent". On the other hand, until local existing treatment sources are flexible enough to handle persons with drug problems among their difficulties with expertise, Area II lacks any acceptable form of inpatient or residential treatment for this population.

With respect to prevention, it remains to be seen what is preventive in Area II. In the interim, the PET program has limited availability to the high-risk population, and Maine's Drug Education Program has not stayed alive and viable in the region, nor has it been evenly or consistently introduced into the communities.

In general, the tremendously wide range of perceptions evident in the incidence survey reveal a fragmented community perception of drug usage resulting in inconsistent and fragmented approaches to the problem.

V. SERVICE PRIORITIES AND PRELIMINARY IMPLEMENTATION AGENDAS

A. Regional Co-ordination of Drug Abuse/Youth Services affairs including prevention, education, consultation, treatment, and collateral services.

1. Could operate under auspices of sole State Drug Abuse Authority.

2. Explore feasibility of state system of regional coordinator's offices similar to mental retardation system, i.e. with regional coordinators employed by CMHC's but working under auspice of State agency.

3. Explore feasibility of regional coordination handled under auspices of regional "B" agencies.

B. Creation of Youth Advocate Workers, working with/under Regional Coordinatiors, consultative functions, training of other professional(s), wide range of field work.

C. Inservice to Physicians and Other Professionals

1. Increase skills in differential diagnosis, knowledge of the abusable drugs, management of acute cases, counseling and therapeutic work, etc.

2. Create region-wide channels of referral to minimize (a) "bouncing of clients" (b) inappropriate referrals.

a. negotiations with CMHC, hospital and medical staff representatives

b. regional training team could "make the rounds" of cooperating agencies, insuring consistency.

D. State-Wide Drug Abuse Information Clearinghouse

1. Clearinghouse hopefully could provide alternatives to trash literature now being distributed by business, citizens' groups, churches.

E. Access to Residential Treatment when appropriate

F. Community Education

1. PET and Maine's Drug Education Program type programs freely available

2. University of Maine Continuing Education Division (CED), Community Services College, UMB

G. Further investigation as to what the most viable and realistic approach to education and prevention.

H. Statewide Legislative Advisory Committee.

REGION III

KENNEBEC VALLEY DISTRICT
APPENDIX C

This report deals with drug abuse in the Kennebec Valley region of Maine. Sources of information include physicians, hospitals, law enforcement officials, court records, a "rap and rescue" center, schools and a number of young adults in the region. This information, though admittedly incomplete, provides a basis for comparison with other regions and a hint about the existence of several common social and environmental problems of which drug abuse is symptomatic.

The recommendations included as part of this report, focus on correction of the conditions which foster the several types of deviant behavior common to youth and suggest improved coordination of the wealth of youth-oriented services now independently provided by many agencies in this region.

I. BOUNDARIES AND CHARACTERISTICS

Region III follows the county lines of Kennebec and Somerset and corresponds to the recently-adopted State Planning and Development Districts, Southern Kennebec Valley, and Northern Kennebec Valley. The area encompasses approximately 4,780 square miles, 3,905 square miles of which are in Somerset County and 875 square miles in Kennebec County.

The southern area has the greatest concentration of population and is, for the most part, an urban setting. The northern area, with the vast land coverage, is principally rural and, in much of the area, uninhabited. This contrast is shown by the population existing in each county and the density of persons per square mile.

	1970 Population	Density/Person Per Sq. Mile	Density Rank In State
Kennebec	94,247	109.0	4
Somerset	40,597	10.4	15
TOTAL	134,844	28.2	

SOURCE: U.S. 1970 Census

Only one other county in Maine, Piscataquis, is more sparsely populated than Somerset County.

Both counties recorded a population increase in 1970 over 1960, the greatest gain occurring in Kennebec County which was nearly three times the increase reported for the entire state.

	Population Change 1970/1960
Kennebec	6.8%
Somerset	2.1%
State	2.4%

SOURCE: U.S. 1970 Census

II. THE ECONOMY

Geography played a major role historically toward evolving the economic make-up of the Kennebec Valley. In 1605, at the mouth of the Kennebec River in Popham, the first colony of settlers was established in Maine. Shipbuilding evolved as the major industry in the area and timber became the necessary item in the enterprise. Thus began the travel up the Kennebec River in search of new timberland. Additionally, with industrialization, the abundant water supply in the area attracted textile and leather mills.

Steel replaced wood in the construction of ships and many of the textile industries migrated south. However, the vast supply of timber and water continues to attract the pulp and paper industry which today makes up the major economic support in the area.

The lake regions are increasingly attracting the tourists and there have been efforts to lure small businesses and glamour industries into the area. The cost of transportation has hampered these latter efforts.

About 47% of the population in Kennebec County are employed while only 40% of the Somerset population is in the work force.

Maine, in the last two years, has been hit hard by rising unemployment, as has the nation. However, the Maine rate has consistently been higher than the national rate. National average rate is around 5.9%, Maine is 8.0%. Unemployment in the two counties within the region differs markedly. Kennebec County is below the national rate while Somerset County is more than double the nation. An average unemployment rate, covering fourteen months from April, 1971 to May, 1972 shows the following:

	% of Unemployed
Nation	5.9
Maine	8.0
Kennebec County	5.2
Somerset County	13.5

SOURCE: Maine Employment Security Commission

Somerset County has shown the highest rate of unemployed of any county in the State. This is in an area where the terrain is mountainous and the climate is one of bitter cold in the winter. Furthermore, the average wages of those employed is low, barely over $5,000/year. These wages vary by type of area in which employed. A comparison of average wage scales by type of employment and by county appears as follows:

	Kennebec	Somerset
All Areas of Employment	$5,585	$5,119
Agriculture, Forestry	6,167	4,513
Mining	7,265	5,713
Contract, Construction	6,754	6,802
Manufacturing	5,864	5,275
Transportation & Utilities	7,210	5,959
Wholesale & Retail Trade	4,906	4,309
Finance, Insurance	6,382	5,443
Service	3,520	3,114

SOURCE: Maine Employment Security Commission

About 18% of families living in Somerset County and 14% of those in Kennebec County have been classified as poor by the Division of Economic Opportunity.

Maine has one of the lowest per capita personal incomes in the United States. It also rates lowest in a comparison of all New England States. It is also lowest in Effective Buying Income.

	Per Capita Personal Income 1970	Effective Buying Income - 1970
United States	$3,921	$3,308
New England	4,277	3,595
Maine	3,257	2,879
New Hampshire	3,590	3,237
Vermont	3,465	2,917
Massachusetts	4,360	3,640
Connecticut	4,856	4,021
Rhode Island	3,902	3,302

SOURCE: Survey of Current Business, Augusta 1971
1971 Sales Management

The effective buying income of Kennebec County is about the same as the State; Somerset County is considerably lower.

	Effective Buying Income 1970
Maine	$2,879
Kennebec	2,811
Somerset	2,505

SOURCE: 1971 Sales Management

In summary, one finds a differing set of economic conditions existing between the southern and northern sections of the region. The northern area is poorer and plagued by the highest unemployment rate in the State. In addition, there are more severe climatic conditions plus a pronounced sparcity of population.

III. VITAL STATISTICS

Maine has the highest death rate of any of the New England States. This overall statistic has to be tempered by the fact that Maine also has a greater proportion of people 65 and over in its total population make-up.

Kennebec County's death rate is about the same as the State average, whereas Somerset County's is higher. The figures for county data are somewhat dated as the Maine Department of Health and Welfare has not, as yet, tabulated Maine vital statistics into regional or county break-downs.

Problem:

Identification of the actual number of individuals in Kennebec and Somerset Counties who are using drugs is considered by many as impossible and irrelevant. In this study, certain statistical data was gathered by questionnaires and a number of people were interviewed in an effort to roughly identify both extent and trends in drug use in the region.

A great concern was expressed by many people that they were tired of surveys of any type. They felt that nothing was ever done with the data. This may account for the small return of the questionnaires.

It is pertinent to note that the agencies contacted with a written questionnaire were all social service or "establishment" agencies. It is likely that people with drug abuse problems do not necessarily seek assistance from the majority of these agencies.

Physicians:

Of the total number of physicians (149 M.D.'s and 24 D.O.'s) in Kennebec and Somerset Counties, questionnaires were sent to 30. Of those queried, and 12 respondents included two internists, two pediatricians, and eight general practitioners.

When asked if drug abuse was a problem in their community, 99% answered that it was.

Of those doctors who responded, all thought that very few drug abusers would seek assistance from them or their associates.

Generally, it can be concluded that doctors do recognize a drug problem in their communities, but are not the ones to whom drug abusers seem to turn first for assistance. See Tables 1 through 14 for Physician Supplement.

Hospitals:

There are eight voluntary general hospitals providing health services in the Kennebec, Somerset planning region. (Augusta State Hospital and the Veterans Administration Hospital at Togus are covered in a separate report being compiled by the Maine Commission on Drug Abuse). The hospital administrators were contacted and four completed questionnaires in conjunction with a number of departments within each hospital.

These hospitals treat drug emergencies in their emergency room, as well as provide in-patient services for drug cases.

At least three of the hospitals felt that doctors sometimes might not report a drug case that may come through the emergency room for fear of "labeling" the patient as a drug abuser. The same holds true with in-patient cases that might be "masked" as a medical problem. See Tables 15 through 23 for Hospital Supplement.

Mental Health Clinic:

The Kennebec Valley Mental Health Clinic has a 135,000 population in its service area which covers 1,200 square miles.

It provides community education and consultation services when requested. It also does some group and family therapy with clients who have drug-related problems.

In addition to the main facility located adjacent to Thayer Hospital in Waterville, a satellite clinic has been established in Augusta next to the Augusta General Hospital.

Lack of transportation makes it extremely difficult for those in rural areas to travel to the existing facilities.

The Mental Health Clinic provides consultation to school districts, which includes technical assistance and consultation with school personnel in the area of mental health. This service should be broadened to include a greater number of school districts in Region III.

Police chiefs and school superintendents have all expressed a desire for additional mental health services in their area. They see a need for additional clinics located throughout the region to service their needs. See Tables 24 through 28 for Mental Health Supplement.

"Rap and Rescue":

This section of the study dealing with the Rap and Rescue Center was completed by Mr. Robert Marks, Director of the Center:

"Augusta Rap and Rescue, Inc. serves eight towns in the Southern Kennebec Valley with a total population of 42,530 (1970 census). This figure increases by 10,000 during the summer months. The towns range in size from Augusta, the State Capitol, with 21,945 permanent residents, to Manchester with 1,331. The other communities served are Hallowell (2,814), Winthrop (4,335), and Monmouth (2,062). It should be noted that this area includes several urban industrial centers (Augusta, Hallowell, Gardiner, and Winthrop) along with the other smaller rural towns. Thus Rap and Rescue, Inc. in its services must deal with both the problems of an urban environment and those problems associated with rural America. The 1970 census indicated that there were 5,001 young people between the ages of 14 and 20 years in this area.

With the exception of Kennebec Valley Mental Health Services and one other full-time rescue facility in Brunswick, no other crisis-counseling

facilities were identified in the area. Most of the problems that Rap and Rescue deals with fall into the following categories: suicidal preoccupation, depression, alcohol or drug abuse, domestic conflicts, and law enforcement difficulties. The Center consists of several loosely-organized branches which relate to one another when they coordinate in providing help for the client. The major thrust of Rap and Rescue are:

1. Crisis intervention
2. Alternate activities
3. Follow-up
4. Community outreach programs

The crisis portion of the Center consists of a twenty-four hour facility with telephone and staff support. The operation requires trained staff in the elements of first-aid and general counseling. During the course of 1972-1973, more than ten staff members completed American Red Cross Training and participate presently in training sessions on counseling techniques offered by the Kennebec Valley Mental Health Center. Crisis staff receives training in pharmacology (how to use the PDR), telephone counseling techniques, and emergency crisis procedures. Most of Rap and Rescue's paid staff serves in volunteer positions until they acquire competence in the above areas.

A handbook developed by Rap and Rescue is issued to each worker. It details staff responsibility, emergency cirsis procedures, pharmacological information, referral information, and basic counseling techniques. Each staff member is trained to remain objective (calm and cool) during a crisis.

The crisis portion of Rap and Rescue also can provide emergency food and housing for limited time periods, and can dispense drug and health information. Often the Augusta Police Department will bring a case (LSD bummer, alcoholic, speed freak) there rather than incarcerate that individual, if they feel that criminal sanctions would not serve justice. Often, Rap and Rescue gets referrals from Augusta General Hospital, in cases who have received emergency aid at the hospital and now must be discharged, but whose recuperation is not complete, are homeless, or have an intolerable home life.

Resources utilized by the Center include Augusta General Hospital Clinics and Emergency Room, Ace Ambulance Service, Augusta Police Rescue, two medical doctors who are on call and are members of the Board of Directors of Rap and Rescue, Augusta State Hospital, Fairfield Institute, Togus Veterans Administration, Gardiner General Hospital, Thayer, Seton Hospitals in Waterville and Augusta, and the local, regional and State Departments of Health and Welfare resources where clients qualify to receive service. Emergency and rehabilitation services beyond the Augusta area which are frequently contacted are ARC (Alcohol Rehabilitation Center in Bangor), Kinsman Hall drug rehabilitation center, and an out-of-state residential treatment facility, Odyssey House, Inc., Hampton, New Hampshire.

The Alternate Activity Program of Rap and Rescue has set the following objectives:

1. To provide through the availability of a craft workshop, writing classes, rap sessions, etc., a vehicle to combat apathy, boredom, and restlessness, thus stimulating within the individual a sense of worth and accomplishment, an awareness of his or her creativity,

and a meaningful outlet for it. A major goal of the workshop is to produce craftsmen proficient enough in various craft techniques to exhibit and offer finished handcrafts for sale.

2. To provide contact with peers and staff in the form of games, music, and rap sessions. Here is an opportunity to develop a mutual trust and a place to find help in dealing with day-to-day problems, such as staying in school, seeking employment, or just plain getting one's head straight.

To fill these needs, the Alternate Activities Program was developed in a vacant Augusta State Hospital building known as the Burleigh Building. Here, on the second floor (3,500 sq. ft.), recreational and craft facilities exist as well as meeting area where group sessions and staff meetings are held. Currently, several crafts are being tought. They are photography, macrame, candlemaking, leather-craft, Karate, batik, and writing workshop. It is expected that pottery, weaving, jewelry-making, and painting will be available by September 1973.

The Burleigh facilities serve a walk-in population of young people of the Augusta area for the most part, but also serve many older people from beyond the Augusta area. Many of the users of the facilities are clients who are initially seen in crisis and who are currently being counseled by the follow-up program of Rap and Rescue.

"Rap" sessions, (consciousness raising groups) that are offered include one open to anyone, one for women only, and one for adults and non-related children. It is felt that these groups serve the above objectives of providing peer contact, developing interpersonal relationships, educating participants as to varying life philosophies, and offering participants a forum to discuss their problems openly.

During the week the Burleigh Building is open to the public from 5:00 P.M. until 11:00 P.M. On weekends the facilities open at 12 Noon and close at 11 P.M. Although attendance fluctuates from night to night, it has been increasing and attracting new people since the opening of the Burleigh Building in March. Average attendance would probably fall between 20 and 25 people per night.

The staff of Alternate Activities Program consists of a director/coordinator, an assistant, several part-time staff members who may also serve as crisis or follow-up staff as well, and craft instructors. Weekly staff meetings are held at the Burleigh Building as well as the crisis center, when active cases are discussed for the purpose of staff training and education, and to engage in group problem solving.

Follow-up Services:

Because practically all crisis cases handled by Rap and Rescue indicate personal problems beyond the emergency situation, those clients need a continuity of care mechanism to insure that they receive the best services available to them. To accomplish this goal, it is necessary to carefully identify a client's problems and set goals once the client has emerged from his or her "crisis". This task is given to the follow-up portion of Rap and Rescue.

Each client is assigned to a staff worker who will serve as the counselor. Together with the Follow-up Coordinator and his assistant, they discuss the client's problems in terms of the services Rap and Rescue can provide. If Rap and Rescue services cannot solve the immediate problem, a referral is made. At that point, Rap and Rescue becomes supportive to the other agency. Referrals are made frequently to KVMH - (Augusta office) and Maine Health and Welfare (family counseling, child abuse, financial aid, and food stamp offices). Rap and Rescue will refer clients for employment problems to Vocational Rehabilitation, Work Incentive, Concentrated Employment, Project Daybreak, University of Maine at Augusta (work-study program), and Maine Employment Security. When making a referral to anyone of the above agencies with the exception of KVMH, Rap and Rescue considers its position as a counseling agency, as primary.

If a client has legal or medical problems the Board of Directors of Rap and Rescue has two doctors and an attorney who offer freely of their time, and make referrals to AGH clinics. If it is determined (by KVMH evaluation if possible) that residential treatment is indicated, Follow-up often sends its indigent clients to Augusta City Welfare for emergency food and or housing coupons.

The community outreach programs of Rap and Rescue have existed for several years, but in the past year have formalized and now serve a specific need in the catchment area. Rap and Rescue runs a program at the Kennebec County jail which is a thorough success both from the standpoint of being accepted positively by the Sheriff's Department and the use prisoners have made of the leather-craft programs. Starting June 18, through the combined efforts of Rap and Rescue, the Sheriff's Department, Division of Adult Education (Maine Department of Education) and SCAR (State Correctional Alliance for Reform), a three-night per week effort will cut into the recidivism rate and offer the prisoners a chance to improve their education. The Jail Program is an established part of the overall emphasis of Rap and Rescue. Several former jail and State Prison inmates have worked in conjunction with the program and lended the initial credibility needed to convince the prisoner of the value and wisdom of preparing the prisoner for the outside. In this regard, several inmates have become leaders in the newly-emerging SCAR which has done much to focus public attention on the injustices, abuses, and ineffectiveness/waste of many current approaches in penology.

The basic objectives of the Jail Programs are several fold. Ideally, it is to provide prisoners with any of the services that the Center has available. They cannot come to Rap and Rescue, so Rap and Rescue goes to them. This is based on the assumption that has been verified that many of the prisoners had a history of drug use and abuse and that they would be returning to the community.

It should be noted that Rap and Rescue's purpose is not therapeutic in the psychological sense of the term. The rap sessions attempt to aid the inmates in developing a more realistic picture of themselves and their circumstances. It is hoped that by giving and receiving group support, individuals will find their own self concepts strengthened.

The leather-craft and macrame workshops offered by the Jail program are a way to a constructive alternative to sitting in a cell vegetating and thinking about how much dope to do when they get out or how much money they're going

to steal. It is not rehabilitative in the usual sense. It is meant simply to provide the kind of activity which a prisoner can engage in which may develop confidence in that man, or alleviate some of his depression.

The program has been reasonably successful in attracting ex-prisoners to the Center once they are out on the street. The biggest difficulty, since this is a county jail, is that the Center can only make contacts with men who are in close proximity. An additional success is the willingness of the Sheriff's Department to bring some people to the Center as an alternative to arrest. This newly-developed credibility is a beneficial side effect of the program.

Another component of the Center is the speakers bureau. Information is disseminated and speakers respond to service clubs and groups of adults and schools who seek information or guidance in the subject area of youth problems and drug abuse. This portion of the Center operation has expanded in the past year and will continue to do so as the community learns that drugs are only symptomatic of a myriad of other social and individual problems.

Rap and Rescue has extended itself into other areas. It has developed an information bank regarding private educational schools in Maine. It furthers community drug education by communicating through relevant information on drug abuse, and drug problems, and public service spots on WRDO radio. It provides to its clients when possible, free legal and medical attention through an attorney and two doctors on the Board of Directors. It provides space in its Burleigh Building for a GED program run by Work Incentive Program for its ADC mothers. It will by the end of July provide room for a GED program run by Project Daybreak in its lounge above the crisis center at 79 Sewall Street.

Whereas no one client of Rap and Rescue receives all of the services that are offered, the spectrum of services from crisis intervention, counseling, referrals, crafts, games, and raps make Rap and Rescue a paraprofessional in the area of people problems."

In addition to Mr. Mark's report, we would like to add that the rap center is dealing with individuals with a number of emotional and psychological problems. It's influence could be strengthened by the addition of a 24-hour residential treatment facility and a halfway house for short-term referrals. The center fulfills a real need in the community though they are dealing primarily with adolescents. See Tables 29 through 38 for Rap and Rescue Supplement.

Law Enforcement:

Of all groups, agencies, or organizations involved in the "drug phenomenon" the law enforcement aspect seems the most frustrating.

A quote received from the Gardiner Police Department explains this:

> "We have received an increase in the amount of drug-related complaints. There is a vast amount of marijuana and hashish around--cocaine is showing up in increasing amounts. For the first two months of 1973, we have had three drug arrests and several pending cases involving cocaine. I feel that there should be more effort placed on

education and prevention directed at younger children.

Another problem is treatment and rehabilitation of drug users. The state should have some facility because the crisis centers such as Rap and Rescue are not adequate.

On the enforcement end, there should be some type of regional or county-wide drug squads formed to work drug traffic. This should be a full-time effort to get to the pushers and suppliers."

This shows the scope of the problem that law enforcement personnel are faced with. There is great pressure from the community to "stop drugs", pressure to get the suppliers and pressures from social service agencies for rehabilitation in lieu of court action.

The police officers find their multifaceted role very frustrating and they feel very much isolated from the other agencies in the drug rehabilitation field.

The low number of arrests compared to the actual amount of marijuana available indicates that most policemen are not primarily interested in "busting the kid for using grass". Law enforcement people have to be actively included into the social rehabilitation aspect of drug abuse.

At least three chief's of police said that the number of arrests in no way gives the true picture of the amount of drug use in their area. See Tables 39 through 48 for Law Enforcement Supplement.

Education:

Twelve of the larger school districs were contacted whose jurisdictions in most cases involved both urban and rural populations.

Of the eight that returned questionnaires, six stated that they have a program to affect student attitudes toward drugs.

In two schools, the students actually take part in the development of drug programs.

None of the schools have a special budget for drug education. Three of the schools' programs deal with value-orientation while the remaining seven are strictly informational.

Four of the schools reported a uniform school policy on drug education and one school reported a uniform discipline policy.

"The only social institution to reach all you, and to affect every family is the school. The facts clearly indicate that the school can become one of the greatest deterrents of juvenile delinquency of any of our social institutions," according to the Juvenile Delinquency Study sponsored by the Maine Law Enforcement Planning and Assistance Agency.

The school has the potential of becoming a great resource in the area of the preventive aspects of drug abuse and delinquent behavior of youth. See Tables 49 through 62 for Education Supplement.

Veterans:

In the course of the study, we found a high percentage of those who are abusing drugs of one form or another to be Veterans.

The statistics obtained from the Veterans Administration Hospital at Togus, the Department of Corrections, and the Kennebec County Sheriff's office are significant.

There are presently a total of 37 individuals in the State Prison System at this time on a variety of drug charges. Of that total, 24 are Veterans.

Sheriff Stan Jordan of Kennebec County reported that his facility is used by the military as a holding station in Maine for captured AWOL personnel. He estimates that of the approximate 25-30 AWOL's who pass through is door every month, at least 20 have a serious problem with drugs.

RECOMMENDATIONS:

Our recommendations for Kennebec and Somerset Counties are in two areas:

1. Added services and care for the minority of people who are addicted to drugs.

2. Improving the every-day experiences of the remainder of the population with emphasis on youth.

The raw data along with the verbal data collected would have to lead one to believe that for the most part these persons using drugs in one form or another, use them with sophistication. This is verified in the small numbers of persons who are exposed as drug abusers through an established agency.

The small minority of persons who do have serious problems that may be observed as drug problems can be cared for within the existing structure if certain necessary accommodations are made.

These individual needs of people must be cared for in conjunction with an effort of improving the quality of life for the total population.

Recommendations for Changes--Additions for Drug Abuse Services:

1. An overall re-education of emergency room, ambulance, and mental health personnel in the unique treatment of drug abuse.

2. Extension of satellite mental health clinics to other areas of the two counties. This would not only meet the needs of drug-dependent individuals, but have a positive effect on the entire community.

3. Establishment of a residential treatment facility located in Maine for individuals unable to deal with their drug problem any other way.

4. Establishment of an advisory group made up of representatives of each agency in a community who are dealing in direct service to drug abusers. This would help to eliminate duplication and also help to improve cooperation between these agencies.

5. Establishment of halfway houses for short-term referrals from all agencies. These would accommodate those youth with a need to be removed from their environment until such time as a crisis situation has passed or additional services are obtained.

6. Establishment of a Drug Information Clearinghouse to insure that all accurate and current information on drugs is available to such agencies as may require this type of assistance.

Recommendations for Community with Emphasis on Youth:

Society mass produces: drug abuse, eating abuse, black abuse, government abuse and woman abuse. When we try to solve these individually, what we actually are doing is a cop-out. These problems are not separate entities unto themselves and when detached, they become superficial issues set apart from the very factors that help to perpetrate these problems, we are doomed to failure.

Drug abuse is really a minor problem compared to poverty, unequal health care and unemployment that as a society we tolerate.

If we as a society are really interested in eliminating many of the problems facing us, we must stop placing shields before our eyes, such as this drug study plan, that prohibit us from getting at the root cause of society's problems.

Given this general philosophy arrived at through the collection of data and personal interview, we propose that a Youth Services Agency be established within the framework of an independent, non-profit agency.

The agency would serve to offer assistance to communities in Kennebec and Somerset Counties in exploring methods of improving the quality of life for its youth.

The first year would be an organizational period for the Youth Services Agency. During this period, the agency would serve as a catalyst through which communities could begin to explore alternative ways of dealing with youth.

A Youth Advisory Board would be formed with active participation from youth and representatives from communities at large for the purposes of assessing their own problems and needs.

REGION IV

TRI-COUNTY DISTRICT
APPENDIX D

"Maine has never been a lavish provider. Even in its heydey as supplier of raw materials and foodstuffs to an expanding America, it yielded a living only to hard work, perseverance, and ingenuity. And today, as the backwater of a vast industrial system, Maine participates more fully in the fruits of economic bust than of boom. From the very beginning, Maine's children have left for more hospitable climes, for a better chance at the opportunity, abundance, and prosperity of America. Their parents wished them well. And through it all, the land -- its fields and forests and waters -- returned enough in currency and in kind to make a hardscrabble existence for those who stayed behind...."

The tri-county area approximates the counties of Androscoggin, Franklin and Oxford; this region is located in the south-central quadrant of the state, reaching north to Canada. Total land area is 4,228 square miles, and a central natural feature is the Androscoggin River.

Total population in the Androscoggin District is 154,568 with the twin cities of Lewiston-Auburn comprising the major population center (76,000). Other major towns include the Norway-South Paris (7,000) and Rumford-Mexico (15,000) areas in Oxford County, and the Farmington-Wilton (10,000) area in Franklin County.

The composition of the region's population is almost exclusively Caucasian. The southern half of Androscoggin County has been strongly influenced by emigration from Quebec. Franco-Americans arrived in large numbers in the latter part of the 19th and beginning of the 20th centuries to work in the burgeoning textile mills. They constitute approximately 80% of Lewiston's 44,000 people and 85% of the city is Catholic. Over 10% of Androscoggin County's population is foreign-born, and over 25% of the population have parents from foreign or mixed lineage.

Outside the Lewiston-Auburn area, one mostly finds small rural towns, some of which are fast becoming more suburban than rural in appearance. Nevertheless, dominant cultural influences in this part of the county are still strongly white, anglo-saxon protestant: YANKEE, in other words. Yankee cultural influences predominate both Franklin and Oxford Counties as well.

Androscoggin County has been described as the "industrial heart of Maine", but it might be more appropriate to check its pulse before accepting the label. The county's traditional industrial structure is largely based on the manufacture of goods which face severe competition from foreign producers. The shoe industry has been considerably weakened by competition from Italy, Spain and Japan; and another mainstay of Maine's industrial past -- textiles -- is also not on the most secure footing.

Years back, large textile firms like Bates Manufacturing Co. employed as many as 7,000 people; now, Bates probably employs no more than 1,000 people in Lewiston. Textile manufacturers began leaving New England in the 1950's for the deep south where they could be closer to raw materials and an even cheaper labor supply. A low wage structure, high unemployment (approximately 10%) and/or the constant threat of layoffs appear to be the chronic results of Androscoggin's dependence on fading manufacturing enterprises.

Both Oxford and Franklin Counties depend heavily on the paper industry. Oxford Paper Co. in Rumford is the prime employer for the county, and International Paper Co. in Jay is the largest single employer in the state, let alone Franklin County. The paper industry is comparatively strong but it, alone, cannot absorb manpower from other fading industries nor, alone, can it provide adequate employment opportunity for young people in the area. The paper industry witnessed the greatest amount of capital investment and the greatest return in Maine during the 60's, but even then employment had a net decline statewide for the same period.

Most recently, we see a shift away from traditional manufacturing toward increased activity in the service sector of the regional economy. There are several new shopping centers in the Lewiston-Auburn area, and there are shopping centers cropping up on Route 4 outside of Farmington, and others in the Norway-Paris area. Obviously, these provide jobs in the retail trade, but again, work is not plentiful nor is it highly paid. Somewhat similar to the shoe and textile industry, a low wage structure in the service sector encourages a proportionately high rate of female employment.

The tri-county area has significant economic problems. It carries the designation of a poverty area by the Department of Health, Education and Welfare. The combined unemployment rate for the area in 1971 was 9.6%, and additional figures indicate that about 10% of all families live in poverty. These families earn less than $3,745 per year. What is more significant is the large segment of the population that can be classified as "working poor". Approximately 40% of all families earn less than $7,000 and the median family income for the area is only about $8,000; national median income, by comparison, was $9,794 per year (1970 census). and during the years 1967-70, when Maine as a whole enjoyed its greatest growth, the number of families making over $10,000 annually increased four times as fast as the number of families under $3,000 declined.

This economic profile has serious social consequences. Androscoggin County has an annual school dropout rate of approximately 6%, and leaving school often means having to leave the area to look for work. During the sector of the 60's, one hundred thousand residents of Maine -- mostly members of younger and low-income families -- left to seek employment elsewhere. A standard employment outlet for the dropout in most economically depressed areas is military service, but 50% of the persons from Androscoggin requesting entrance into the military were rejected in 1971. Those that remain in the local areas commonly find low-paying unsteady jobs, and most are probably not able to take advantage of the increased opportunities for higher education and/or training. Roughly 60% of the young people in Maine attending college come from families earning more than $9,000. What we see when we look carefully enough at the regional

What we see when we look carefully enough at the regional economic system is a trading economy built upon the import and export of goods. It is not

a self-sufficient economic constellation for it depends heavily on national (and even international) economic forces which dictate the value and quantity of goods to be produced. Traditional manufacturing (i.e., shoes, textiles) in the area is hard-pressed to keep up with foreign competition, thereby further reducing the opportunity for local work force expansion. The strained performance of this narrow-based economy produces a considerable amount of painful human dislocation and distress.

> "....Thus the 'Maine way of life' maintanined itself from generation to generation as long as there were enough low-skill jobs in Massachusetts' and Connecticut's factories to absorb the natural growth in Maine's labor force; enough local activity and jobs to support the numerous rural communities around which life was organized, and the few public services they provided; and access for all, by purchase or permit, to the natural wealth of the land and its harvests of sustenance and pleasure...."

(Quotes extracted from: A Maine Manifest,
by Richard Barringer & Others,
The Allagash Group, 1972, Page 2)

INCIDENCE OF DRUG ABUSE

Physicians:

Every doctor (149) belonging to an existing county medical society in the tri-county region was asked to respond to a questionnaire allowing him or her to assess the nature of the drug abuse problem. 74.1% of the 31 respondents felt that drug abuse was a community problem and, significantly, a greater percentage 70% indicated that alcohol was a leading drug problem for both young adults and adults. Marijuana was also considered a community drug problem affecting school-age youth and young adults, although the sketchy figures suggest that fewer doctors responding considered any soft drug (cannabis, amphetamines, etc.) problem as common as alcohol abuse.

The physicians responding also indicated that few persons with drug problems use the existing medical system. 74% of those responding said that few persons seek help from physicians, and 80% said there had been no increase in the number of persons seeking help for drug problems over the past two years.

58% of the doctors responding said that optimal treatment included use of community resources such as Rap Centers, yet only 6% (2 doctors) used such facilities if they were available. Resources most ofent consulted were mental health centers. Fifty-two of the doctors said that there was inadequate drug abuse education in their communities.

Hospitals:

Individual questionnaires were sent to all the hospitals in the tri-county area, and responses from those institutions provided us with little usable information about persons being admitted for drug-related reasons. Some of the hospitals even refused to acknowledge our initial request for data.

Working with data provided through Blue Cross sources, it was possible to document the number of recorded admissions to either area or state-wide hospitals for a drug-related diagnosis. Two hundred seven people were admitted in 1972, and only four (1.9%) entered because of an abuse of a drug other than alcohol; whereas, exactly two hundred (96.6%) persons were admitted for alcohol abuse. Three other persons were admitted for abuse of an unknown substance.

	Tri-County		Remainder State			
Drugs:	4	(1.9%)	257	(12.3%)	261	(11.4%)
Alcohol:	200	(96.6%)	1747	(83.7%)	1947	(84.8%)
Other:	3	(1.4%)	84	(4.0%)	87	(3.8%)
	207	100%	2088	100%	2295	100%

The table above indicates that a smaller percentage of persons in the tri-county area (1.9%) were admitted to hospitals for drug abuse problems (not alcohol) than were hospitalized for the same reasons in other parts of Maine (12.3%). A greater percentage, however, (96.6% vs 83.3%) were admitted because of alcohol abuse.

Mental Health Centers:

There is a regional mental health system which is composed of a network of community mental health clinics: Tri-County Mental Health Services. Central administration emanates from a main clinic in Lewiston (the former Child and Family Service building), and unit directors are assigned to local centers: one location in Franklin County (Wilton); two locations in Oxford (Rumford and Norway), and another inter-city location in Lewiston, "The Depot".

Responses from Tri-County Mental Health Services produced the following information:

In 1972, over 300 persons from the Tri-County area were seen either on an inpatient or outpatient basis for a drug-related problem, of this total number, 283 received outpatient care and most of these persons (74.9%) were adults having what might be called primarily a problem with alcohol. Records further indicate that a total of 22 people were hospitalized at the PSYCHIATRIC unit, St. Mary's General Hospital in Lewiston for reasons related to drug abuse, and 68.1% of these were adults with a drinking problem.

Put differently, the drug abuse problem witnessed by the Mental Health System in this region does not appear to register directly on the types of drugs commonly thought to be most abused by young people especially. Only twenty-five percent or 71 persons were diagnosed as having a substance abuse problem other than alcohol. No one was reported to have been abusing narcotics, and only 36.6% of the persons abusing drugs were diagnosed as having a primary drug problem: emotional difficulty directly caused by the abuse of drugs. After alcohol is factored out as the major drug abuse category, the mental health system considers drug abuse essentially a secondary problem affecting young people more commonly abusing either marijuana or hallucinogens.

Human Service Agencies:

Questionnaires were mailed to every social service agency operating in the tri-county region. Few (7) written responses were received, and they offered almost no statistical information. The only human service agencies to provide numbers were Rap Place and the Neighborhood Youth Corps, both in Lewiston. This reception is not surprising, for most human service agencies, by their admission, offer little help to the drug abuser; most refer people in trouble with drugs to the mental health system.

Even though it appears that most referrals from physicians and other agencies are made to the mental health clinics, Rap Place in Lewiston documented their extensive contact with people having drug problems. The figures that follow offer some insight into the nature of urban drug abuse problems in Androscoggin County.

PRIMARY DRUG PROBLEM

	Seen		Counseled		Referred	
Narcotics	10	(2.0%)	10	(2.0%)	2	(3.1%)
Barbiturates	43	(8.6%)	43	(8.6%)	8	(12.5%)
Amphetamines	72	(14.5%)	72	(14.5%)	15	(23.4%)
Hallucinogens	18	(3.6%)	18	(3.6%)	3	(4.7%)
Marijuana	10	(2.0%)	10	(2.0%)	1	(1.6%)
Alcohol	328	(65.9%)	328	(65.9%)	31	(48.4%)
Cocaine	2	(0.4%)	2	(0.4%)	0	(0.0%)
Other	15	(3.0%)	15	(3.0%)	4	(6.3%)

Once again, alcohol gains status as the leading substance being abused. Nearly two-thirds (328) of all the people seen by Rap Place last year had some difficulty with booze. It is also significant to note that few people using marijuana (10) had reason to seek help at Rap Place -- perhaps lending further substance to the claim that marijuana is not as dangerous a drug as was once feared.

Next to alcohol, amphetamine and barbiturate abuse appears to be ranked in second and third place, respecively. Seventy-two persons (almost 15%) had an amphetamine abuse problem, and this percentage is somewhat consistent with figures prepared for the rest of Maine (approximately 11%).

Age classifications reveal that 44.5% (222) of the persons seen by Rap Place are over 35 years of age, and 91.4% (203) of these had a drinking problem. By comparison, not many youngsters under 15 years need Rap Place's help (18), but 15-25 age group sought assistance most commonly for amphetamine abuse, with alcohol a close second.

Law Enforcement:

Questionnaires were mailed to all county sheriffs, to all city police chiefs, and to other selected towns large enough to support their own forces. Only one response was received, and the overall dearth of information presented forced us to rely on local court records and state police arrest data.

Collected figures from the State Police reveal that arrests for offenses related to the abuse of alcohol exceeded sixfold those for drug abuse. In fact, 86.7% of all the arrests for substance abuse in the tri-county area were connected with alcohol, a figure exceeding comparable statistics for the rest of Maine (80.4%). Most of the alcohol offenses (60%) were for operating a motor vehicle under the influence - 190 total cases.

Most of the 56 drug offenses recorded by the State Police were for possession (80.4%) of some illegal substance (i.e., cannabis,etc.).

Superior Court conviction data presents us with even more startling findings. In 1972, only 2 people from both Franklin and Oxford Counties (1 in each) were convicted in Superior Court for possession of illegal drugs. Both individuals were between 18-24 years of age. By comparison, there were in the same period 100 convictions for offenses related to alcohol abuse in Oxford County and 26 convictions in Franklin County.

Data collected from Androscoggin Superior Court presents a somewhat different picture. There, only 44.6% of all persons convicted of substance abuse were either operating under the influence or intoxicated. Most persons were convicted of either selling and/or possessing both cannabis and amphetamines. There were 77 separate charges for these offenses.

Schools:

Little statistical information was requested in the questionnaires mailed to the 16 school districts in the tri-county area. Seven responses were received, and four school systems reported the existence of some educational effort related to drug abuse. The approach most widely utilized was showing films and audio-visuals. These educational activities cost less than $600 and, in most cases, drug education seemed to be the responsibility of the classroom teacher -- sometimes shared with the school administration.

One school reported a current pilot program in the 7th and 8th grades, and two schools said that drug education started at the primary level. Only one school reported the development of a uniform drug policy relating to disciplinary action for drug abuse, and one community school committee published a rather excited warning to parents about drug peddling.

Rap Place, Inc.

Rap Place is a "street-oriented" service which has been operating in Lewiston since 1970. Since its inception, Rap Place has attempted to provide services for the benefit of the entire community, not simply the youthful drug abuser. Rap Place staff actively participate in the Model Cities program through membership on Model Cities task forces. Last summer, Rap Place operated a hot breakfast program and a children's summer theater with Model Cities' support. Also, Rap Place initiated the idea of a neighborhood Health Clinic and had the support of the Community Mental Health Center and local "B" agency in obtaining Model Cities approval of the Health Clinic proposal.

Because Rap Place is staffed primarily by young paraprofessionals, a youth will often make this his "first stop" in seeking assistance for some problem.

1. 24-Hour Telephone Service

Rap Place maintains a 24-hour-a-day phone service. Rap Place, Inc. is manned by volunteers and/or part staff. In the past year, Rap Place had over 900 calls covering a variety of situations.

2. Outreach

The purpose of outreach is to further identify the target population and to inform them of what services are available.

The size of the catchment area poses difficulty in any outreach effort. Distances between population centers are great and there is no public transportation outside Lewiston-Auburn.

Target areas/agencies for outreach work include schools, state hospitals and correctional institutions, police and sheriff, social services agencies, local courts and the street. Rap Place has an agreement with the Androscoggin County Sheriff whereby Rap Place is informed when someone is booked for a drug offense.

Beginning in the Fall of 1973, Rap Place will conduct a counseling program in Lewiston area schools, as a supplement to existing school guidance services.

3. Counseling

A large number of initial contacts with a client are made when the client seeks relief from a crisis situation that has been precipitated by an emotional and/or drug-related problem. The counselor will tend immediately to the client's crisis by seeking that medical attention and/or crisis counseling is provided.

When a client seeks assistance for a problem that is not of emergency proportions, Rap Place aids the individual in resolving the problem either through short-term counseling or referral to a more appropriate agency. Rap Place provides counseling to anyone on a 24-hour basis either by phone or face-to-face. Rap Place also helps those who are seeking help in dealing with another person. For example, Rap Place is sponsoring Parent Effectiveness Training groups using staff from the Depot, the Community Mental Health Center

satellite clinic in the Model Cities neighborhood. Rap Place and the Community Mental Health Center would like to expand this program. Rap Place, through non-emergency counseling, will screen clients for referral to the Community Mental Health counseling services.

4. Referrals

The public, especially young people and the elderly, in the tri-county area are largely uninformed about the variety of available health, mental health and social services.

Rather than provide a full range of new services for its clients, Rap Place will continue to rely whenever possible on the resources of other community agencies and provide directly only those services not available elsewhere. Primary referral resources for Rap Place are the Community Mental Health Center, St. Mary's Hospital, Regional Health and Welfare Office, Project Youth, Neighborhood Youth Corps, A.A., school guidance personnel, Tenants Union and Housing Alliance. Other community agencies use Rap Place in much the same way.

5. Correctional Programs

For six months in 1972, staff from Rap Place acted as facilitators for a group of inmates (predominately drug offenders) in Maine State Prison. The aim of this group was to provide the inmates with some personal goals and skills that will ease the process of re-entry into the community. Since the group began six prisons have been released; all have had contact with Rap Place and two have volunteered to work on the staff. The success of the Maine State Prison group facilitated the development of a similar program at Men's Correctional Center, a reformatory for 18 to 26-year old offenders. Sentences at Men's Correctional Center are comparatively short, 3 months to one year. Therefore, outreach will be a primary function of the groups there. Rap Place will work with the Probation/Parole Consultant on the staff of the Community Mental Health Center to provide follow-up and aftercare of inmates.

Both the Community Mental Health Center and Rap Place are committed to the concept of community-based care. They would much prefer to work with youthful offenders before/instead of sentencing them to jail, e.g., court diversion program. However, until mandatory sentencing and other punitive aspects of the Maine juvenile justice system are modified, prison will be the only place to reach drug offenders.

SUMMARY:

There is very little hard data to add at this point. The remainder of the text will be devoted to concluding observations. It seems obvious that what one is faced with primarily is the existence of an alcohol abuse problem that has become almost endemic. Alcohol abuse is long standing in this region and, while searchers for causal factors can be frustrating, widespread heavy drinking has got to be related in some way to socio-economic factors. Lack of opportunity for self advancement must produce the type of frustration that hardly discourages heavy drinking. Still, this is an oversimplification, for there are strong cultural influences at work which make drinking a socially acceptable practice, even desirable behavior -- but, of course, cultural approval is not only evident in Maine.

If there were a significant drug abuse problem in the tri-county area, figures suggest it is confined to the greater Lewiston-Auburn area. Conversations with reliable sources maintain that abuse of illegal drugs seem to have declined in Lewiston, and they cite these as primary related reasons: a growing reluctance to experiment with chemicals and increased interest in the organic movement (grow it). Still, it is difficult to really know the exact dimensions of the problem because the same sources point out that those who still use drugs heavily have gone underground, and they often resort to mixing drugs with alcohol -- a grave combination.

Nevertheless, drugs seem to be beside the point. People who were called together from the corners of the tri-county region to talk about the drug problem didn't think that drug abuse ought to be a focal point of concern. They cited as real problems: communication difficulties in families; value conflicts within Maine families; rural and urban poverty; frustration about inability to openly express oneself where one lives; and no vehicle for making young people feel part of their communities if they look or act differently than the "town fathers". Finally, of even greater concern to many working group members, was the lack of acceptable alternative activities for youth. These were some of the issues they most strongly felt ought to be considered -- not whether there is or isn't a drug problem in the region.

RECOMMENDATIONS:

What has been presented is a comprehensive summary of information documenting the incidence of drug abuse and a description of most of the resource capabilities in the tri-county region. Most of the services available are offered to the general public and are not focused on giving special care to the drug abuser. There is Rap Place in Lewiston (other organizations like it in the region have folded) but efforts like these, however much needed, are not supported nor are they appreciated by the general public. Perhaps one of the reasons for this is the perceived difference in values, thought, and/or behavior between those who identify with an organization like Rap Place and those who don't. In any event, the two separate worlds' mentality does not contribute to the development of a concerted effort to help the drug abuser.

The plainer it becomes that "drug abuse" is not a central problem, the greater the need to concentrate on integrating service efforts directed toward young people. Specialized services for the drug abuser and the problem drinker ought to be available in areas where they are most needed, but custom care is expensive, and service alliances forged by different agencies can minimize those costs. Since the mental health system and Rap Place (Lewiston) appear to be resources most frequently utilized, it might be appropriate if those organizations got together with another quite different organization (i.e., police, school systems) to talk about doing more things together -- under contract.

The following recommendations are more specific:

1. That these findings be shared immediately with the regional alcoholism coordinator so that he may utilize the infomation for his planning purposes.

2. Emphasis can be placed on developing credible educational programs in the schools which could deal with a whole range of issues, i.e., life, family life, health, etc.

3. School systems in the area ought to consider the adoption of uniform discipline policies for drug use.

4. Attention ought to be focused on achieving greater collaboration in the youth services field. This might be done through the organization of a self-help economic development project which would hire and train young people in a skill that could be used constructively; for example, the development of a self-help housing project using young people who are learning on the job.

5. That Rap Place continue to receive financial support from state funding sources provided it demonstrates an interest in integrating its efforts with other community services.

6. The support of a halfway house to provide residential space for troubled youngsters of the region.

7. Closer liaison must be established with the law enforcement segment of the tri-county community. This relationship might be fostered with help from the L.E.A.A. regional coordinator.

REGIONAL PROFILE
TRI-COUNTY DISTRICT

Region: Tri-county

I. Geography

Area: 4,228 sq. miles.
Location (boundaries, etc.): The tri-county area approximates the counties of Androscoggin, Franklin and Oxford. Bordered on the west by New Hampshire, on the north by Canada, on the south by other Maine counties.
Principal Population Centers (estimates):

Lewiston-Auburn	70,000
Norway-Paris	8,000
Rumford-Mexico	15,000
Wilton	4,000
Farmington	5,650

Transportation:
Major Roads, Highways: Maine Turnpike goes through southern half of Androscoggin; Route 4 intersects Maine Turnpike and proceeds to northern Franklin County. Route 121 - Route 26 connects Oxford and Androscoggin Counties.
Public Transportation? YES X NO ___
But limited to metro areas - Lewiston-Auburn buses are in danger of being discontinued.

II. Population

Total Population for Catchment Area: 154,568
Males: 74,129 (47.9%) Females: 80,457 (52.1%) White: 154,141 Non-White: 427
0-14: 45,358 (29.3%) 25-34: 16,670 (10.6%)
15-17: 9,221 (6.0%) 35+: 67,023 (43.6%)
18-24: 16,294 (10.5%)

III. Socio-Cultural

Briefly describe the cultural and religious backgrounds represented in your area: Large Franco-American community in Lewiston, the area's largest city, 44,000 total population. 85% of Lewiston's population is Catholic. Many ethnic groups are found in the southern half of Androscoggin County. Northern and western portions of rural Androscoggin County are Anglo-Saxon Protestant. Oxford and Franklin Counties are predominately Anglo-Saxon Protestant with few identifiable ethnic groups.

Briefly describe local government in your area. Is it relatively organized/disorganized, responsive/unresponsive? The entire area is organized in Townships. There are some unorganized areas in the tri-county region and a few Plantations. Responsiveness of local government varies according to the size and fiscal capability, but most are mainly preoccupied with tax assessment, road maintenance, land use, etc. Little interest in support of human service programs. County government is horribly weak and unresponsive.

IV. Economy

Industry

Who are the major employers? Paper (International Paper Co. and Oxford Papter Co. in Oxford & Franklin Counties), shoes, textiles - traditional manufacturing. These forms of employment are not terribly strong. Greater unemployment than national average; low wage structure encourages high amount of female employment in shoe and textile industries. For example, figures for Androscoggin County indicate that 48% of those employed in the textile industry are females. 55% of the labor force in shoe factories are females. In order to survive economically, many families have a minimum of two adults working fulltime, and in some cases younger members of the family hold part-time jobs.

Employment

Labor Force: Androscoggin 38,761; Oxford 16,588; Franklin 8,911 = 64,260
Male 55.6% Female 46.4%
Unemployment

400 (10.9%)	Androscoggin County	
800 (9.7%)	Oxford County	
400 (8.4%)	Franklin County	= 3,600

Housing

% Substandard: Androscoggin 30.5%; Oxford 44%; Franklin 53%

Income

Median Income: Androscoggin $8,273; Oxford $8,060; Franklin $7,993
% Families in Poverty: Androscoggin 9.0%; Oxford 9.9%; Franklin 9.0%=9.3%
DHEW Poverty Designation? YES X NO ___

Education

Average School Years Completed: 11.9 years, median
School Dropout Percentage Rate: Androscoggin 6%; Oxford 2%; Franklin 4%

SOUTHERN MAINE DISTRICT

CUMBERLAND SUBREGION
Description of Subregion

APPENDIX E

AREA
This subregion covers Cumberland County, (less Brunswick, Freeport, Harpswell, New Glouster), and nine towns in Southern Oxford region (Stow, Lovell, Sweden, Fryburg, Denmark, Brownfield, Porter, Hiram, Stoneham). The subregion has three cities, (Portland, South Portland and Westbrook) and 23 towns which collectively cover 1,039 square miles.

POPULATION
The total population of this area is 171,899 of which approximately 28% is between 0-14 years of age, 27% between 15-34 years, 22% between 35-54 and 22% are 55 or over. Approximately 27% (47,132) of the population are in the high risk age category in terms of incidences of drug abuse, i.e. between 14-34 years of age. With 102,827 people, Greater Portland area is the largest metropolitan area in Maine. The region's population is 37.2% rural.

During the summer months the region's population in this subregion increases by some 50%. This influx is largely centered aroung the coastal towns and the lakes of Windham, Naples, Bridgton and Gray area. Many people come to this area for the entire season and many more travel to the area for shorter periods of time.

POLITICAL STRUCTURE
In the Cumberland Subregion there are twenty-two towns and three cities. All of the twenty-two towns have selectmen and in addition nine have town managers. The three cities have city councils and city managers. The Subregion has six senators and twenty-six representatives (16 Democrats and 10 Republican) in Augusta. There are 3 Republican and three Democratic senators. 48,678 registered voters are Republican, 31,693 are Democrats.

The 106th Legislature has many bills before it which deal with some of the crucial issues in drug laws and treatment. Bills sponsored by members of the Cumberland Subregion delegation include a bill to require licensing of treatment facilities, several dealing with the legalization of marijuana, and a bill to establish treatment centers.

SOCIOLOGICAL DATA
According to statistics taken from the district courts in Cumberland County, there were 723 divorces in this area in the year ending June 30, 1971. This is a 4.2 increase per 1000 persons, a figure higher than the State rate of 3.8 divorces per 1000.

A suicide statistic is made available for Cumberland County through the 1970 U.S. Bureau of Census Report. This statistic is not an absolute figure, but a general indicator of the incidence. For 1970 there were 25 recorded cases of known suicides and two suspected cases with no positive determination.

EDUCATION

The school systems of Cumberland County (minus Brunswick) are listed in the following chart along with pertinent data on the systems. There are three SAD's, one school union, and nine school districts in the area.

In the subregion there is one guidance counselor for each 249 students. Seven systems have no full time consulting psychologist, and only one system has a social worker. Drop out rates vary from 3% to 5% in these self reports, but the area's average is 5.28% as reported by the Department of Education and Cultural Services.

CUMBERLAND COUNTY (minus Brunswick)

SCHOOL SYSTEM	Elementary STUDENTS	TEACHERS	Secondary STUDENTS	TEACHERS	Guidance ELEMENTARY	SECONDARY	SOCIAL WORKER	DROP-OUTS	PSYCHOLOGISTS
S 51	1051	40	638	41	0	1	0	est. 3%	1 aftnoon perweek
S 61	738	31	778	53	0	2	0	18 18	0
S 62	175	8			0		0		0
U 15	1147	43	846	55	0	3	0	est. 5%	0
Cape Elizabeth	1263	53	1021	76	0	3	0	Not avail	0
Falmouth	1001	47	702	53	1	2	0	1%	Consut. psy 0 for guid & teach.
Gorham	1120	40	894	49	0	2	0	4.6%	0
Portland	7798	286	6229	330	1	18	5	319	2 psycho. 1 examiner
South Portland	3193	133	2478	152	4	3	0	3.7%	Part-time cons. psychology
Scarborough	1112	44	1006	65	0	2 4/5	Pt-time	est. 4%	1 day/wk for whole sch. sys.
Westbrook	2195	81	1632	98	0	4 1/2	0	60	0
Yarmouth	837	40	530	41	1	2	0	9	Cons. psycho for 0 quid and teach
Freeport	897	37			0		0		0

ECONOMY

The employment opportunities in this subregion are quite diversified with manufacturing leading the way. 23% of the total labor force is involved in the manufacturing of such products as leather goods, paper, electrical machinery, etc. Due to the population concentration in the Greater Portland Area there are numerous jobs in the services and retail sales. At the present time 20% of the work force is employed in services and another 20% in retail sales.

Approximately 10% of all the residents in this area are living at or below the poverty level. According to the 1970 U.S. Bureau of Cnesus, the mean income of families where the male is the head k f the household is $9,341 annually. In households with a female as the head of the household it is $6,368.

For the year 1972 Cumberland County had an unemployment rate of 5.5% according to the Maine Employment Security Commission. This is somewhat lower than

the 7.2% unemployment rate for the planning region.

RECREATION

Recreation in the Greater Portland Area is largely directed by organized programs such as the Parks and Recreation Department, YMCA, YWCA, Boys club, etc. Some of these programs are based on membership and therefore are limited to those who can pay the membership fee. In the area outside of Greater Portland there are few organized recreation departments and activities are largely centered around church and school. The only organized activities in areas outside of Portland are the scouting programs and the 4-H programs. Of all the boys and girls in the Cumberland County area between the ages of 7 and 19 who are eligible to participate in organized scouting or 4-H, almost 30% do participate in these activities (Juvenile Delinquency Study).

VULNERABILITY

There are several factors which make for a high vulnerability to drug abuse in the Cumberland Subregion. These are the concentration of the youthful population in and around the Portland Area, the influx of summer visitors, the port, the area colleges, and the lack of alternatives.

CUMBERLAND SUBREGION
Existing Resources

COMMUNITY MENTAL HEALTH CENTER (MAINE MEDICAL CENTER)

The Community Mental Health Center at the Maine Medical Center provides the following services to the community through its divisions: outpatient services, a 32 bed acute psychiatric inpatient unit, patient care treatment center, 24 hour emergency and consultation service, community psychiatry and child psychiatry services. These services are available to all area persons. The fee for services is based on the ability ot pay. Although the services listed do not include specialized drug counseling, persons with this type of problem are seen by the center staff.

WESTERN MAINE COUNSELING SERVICE

Western Maine Counseling Service in Bridgton is a satellite of the Community Mental Health Center. It provides rural residents of Northern Cumberland and Southern Oxford Counties with group and individual counseling. They report that few of their clients are involved with drug abuse.

COMMUNITY COUNSELING CENTER

Counseling is available, without restrictions and with the fee based on the ability to pay, through the Community Counseling Center. The center serves Greater Portland. Services include individual and group counseling, family counseling, and counseling for unmarried parents. The staff reports that the majority of clients come in for school, family, or other problems and secondary problems with drug abuse are exposed in the subsequent counseling sessions.

HOSPITALS

Maine Medical Center, Mercy Hospital, Osteopathic Hospital of Maine, Inc., and Portland City Hospital in Portland; Westbrook; and Northern Cumberland Memorial Hospital in Bridgton are the subregion's medical facilities.

Maine Medical Center, Osteopathic Hospital of Maine, Inc., Northern Cumberland Memorial, and Mercy Hospital all treat drug emergencies in their 24-hour emergency rooms. The largest number are seen at Maine Medical Center. All the area hospitals treat drug abusers on an inpatient basis, although the number seen on an inpatient basis is a small percentage of those seen on an outpatient basis. A full range of services are available to those seen on an inpatient basis, including contact with social workers and referrals to other agencies when it is deemed necessary.

PREVENTION & EDUCATION

The greatest influence and force behind drug education in this area is the Maine Drug Education Program (MDEP) operating under the auspices of the State Department of Educational and Cultural Affairs. The following is a partial list of the drug education resources. 1) MDEP works with school personnel to develop better student/teacher relations and communication. 2) There are approximately 85 people in the subregion who have attended indepth week-long training sessions in communications, organizational development, and other skills which they apply to their drug education workshops.

d) To provide the opportunity for drug-dependent patients requiring supervised detoxification to receive appropriate medical treatment.
e) To provide the opportunity for all participants in the program to receive vocational counseling and educational services through existing agencies.
f) To provide an opportunity for all members of the community to receive valid and accurate drug and drug-related information through telephone services, clinic visitation, or other forms of personal contact with staff and/or clients.

Drug Rehabilitation, Inc., will attempt to develop drug-free individuals who can reintegrate themselves within the community as law-abiding citizens. The services of DRI will be available to drug-dependent individuals residing in Southern Maine.

HEALTH, JOB TRAINING, AND SOCIAL SERVICE AGENCIES

Other agencies which have varying degrees of contact with drug abusers in the area are: Vocational Rehabilitation, First Stop, an information and referral agency for human service agencies, the Visiting Nurse Association, the Neighborhood Youth Corps, Health and Welfare, several work programs (National Alliance of Businessmen, Maine Concentrated Employment Program, Work Incentive Program) all of which counsel, train and place individuals, the Industrial Health Council and the Public Health Department.

The Cumberland County Area has seven residence programs, three serve alcoholics: Serenity House, Milestone, and the 24-Hour Club; the other four are:
Shalom House which serves as a residential midway living environment which provides services to emotionally and mentally ill people sixteen years and older. It is available following hospitation or as an alternative to it.
Huckleberry House is run by the Little Brother Association and serves juvenile boys who have no viable home situation and who may or may not be an adjudicated delinquent.
Elan I which has recently moved from Naples to Sebago, is this area's only therapeutic community. The majority of its clients come from the Boston area. Elan I treats a variety of problems, most of which are associated with drug abuse.
Pharos House is a resident program for male ex-offenders.

Alcoholic Services

The Portland Area has a newly-formed program for alcoholics known as Community Alcoholism Services, which offers counseling and related services. Alcohol Safety Action Program is a multi- service organization which refers clients for treatment. They reported seeing 245 clients in 1972, the majority of these were thirty-five or older.

PHYSICIANS

There are 322 physicians in the Cumberland County Area. Of these, 125 (39%) returned the questionnaire. Among these respondents, there were 39 in general or family practice.

Asked whether they think the abuse of drugs has become a problem in the community where they practice, 67 replied yes and 18 replied no. 67 felt that few of those in trouble with drugs sought the help of physicians; only 7 physicians felt that meny did, while 35 indicated they did not know. 23 physicians felt that the laws relating to the treatment of minors did limit their effectiveness in treating youthful abusers.

It is interesting to note that while physicians do see drugs as a problem in their community, they do not feel that many drug abusers seek the help of physicians. It also appears there is some confusion as to the State law governing the treatment of monors, and the law itself is seen as limiting by some physicians.

ANECDOTAL INFORMATION

A questionnaire was distributed to the personnel managers of the majority of businesses and industries in the Greater Portland Area. 23 businesses replied to the questionnaires. In 1972 the personnel managers estimated that a total of 71 fulltime employees in their businesses had a drug problem which came to their attention. These incidences were handled in various ways: 8 were handled by in-house counseling, 8 by referring to a helping agency, 4 by referral to clergy, and 1 by referral to a physician. In only 4 of the incidents were the employees dismissed. It was also stated that 16 of the individuals who had alcohol or other drug problems were no longer employed as a result of their problem.

Seventeen employers indicated an interest in drug education, six indicated they did not know if drug education should be presented. Ten of the employers indicated they provided a drug education program. These programs varied from distribution of pamphlets, to workshops given by a trained team. It is interesting to note that only one employer felt his business definitely did not need a drug education program.

CUMBERLAND SUBREGION
Service Needs

EMPLOYMENT

Although there are several job training programs in the Cumberland subregion, there is an overall lack of meaningful, long-term, lucrative employment opportunities for young people. Needs in the area of job training placement are varied and include:

1. Increased job opportunities.
2. Increased coordination of services and programs to eliminate "program hopping", duplication and program rivalries.
3. Increased placement personnel.
4. Increased counseling staff with special skills enabling them to meet the needs of the poor and disadvantaged.

While many businesses and industries have initiated personnel counseling services and attempted to positively respond to their employment community through management training programs, more work, particularly within the small business establishment, is imperative.

RECREATION

The provision of organized leisure services is probably the one major alternate to most unacceptable social behavior, including drug abuse or substance abuse in general. The provision of leisure services in the Cumberland County Area is fractionalized and even nonexistent in most communities. Very few of the communities that do provide services have professionally directed services and delivery systems. Consequently, coordination is extremely difficult, problems remain unidentified, gaps and duplication of services exist and the public remains ignorant of existing services and the importance of leisure activity.

The present emphasis and provision of most services is on "treatment", rather than "prevention". Obviously the treatment process can be measured and is readily available for the conpletion of forms, but at some point more emphasis must be put on prevention which is not easily measured. The prevention element of concern is leisure services, whether it applies to juvenile delinquency, substance abuse or mental health. Previously mentioned coordination is urgently needed in dealing with this element.

EDUCATION

This subregion is fortunate to have a core of well-trained and responsive people involved in its drug education programs. In addition to these people who are mostly volunteers, there are professional resources to strengthen their efforts. These professional resources exist on both the state and local levels. The gap in service, when it comes to drug education, is an underutilization of these trained individuals and a general reluctance on the part of the part of the public to accept MDEP's humanistic approach. There are few school systems who have a uniform drug education policy, curriculum, or a uniform discipline policy. There is a lack of trained teachers in drug education, and there is the general lack of good factual drug information for the public.

Guidance counseling varies greatly even within school systems, the approach used appears to depend upon the individual counselor's willingness and ability to communicate and respond to the needs of young people. In some areas, social workers support the work of the guidance counselor, but again the service to the individual depends upon the skills of the counselor. Reluctance by guidance personnel to fully respond to the young person using drugs is frequently due to a feeling of not being able to adequately deal with the problem because of a lack of training or experience. Other factors which influence the contact between student and guidance counselor are fear of legal consequences, the lack of confidentiality, a lack of a strong administrative code to gride the counselor in responding to such problems, and a lack of a mandate to go out and deal with problems. All these factors may cause the guidance counselor to be frustrated in the role as "counselor" and therefore be of no specific help to the student involved in drug abuse.

TREATMENT AND REHABILITATION

Although there are several mental health and rehavilitation services in this subregion, these programs have not, traditionally, been responsive to the particular needs of those individuals involved with the use of drugs. The need for a service which specializes in the treatment of drug users has been mentioned. Such a program would facilitate and support the work of various other service agencies. The lack of treatment and rehabilitation programs is evident, especially as relates to the areas of law enforcement and criminal justice.

The problem of the individual incarcerated on one of the various drug charges or drug-related crimes is particularly acute. Both the individual and the court authorities may be of the opinion that a period of incarceration is not the appropriate solution to the problem. On the other hand, the court realizes the dangers and improbability of success in simply returning the individual to the street. Unfortunately, at the present time, there are few alternatives anailable. With the exception of those few individuals accepted by Elan I, which is not primarily designed to meet the needs of low or middle income clients, drug abusers have no rehabilitation program available to them within the City of Portland, Cumberland County, or the subregion.

Many police officials, attorneys, prosecutors, judges, probation and parole personnel speak openly of the need for some form of referral agency having a special understanding and skill in working with drug dependent individuals as well as some form of rehabilitation program.

The residential program now being established in Cumberland County will provide day care for those drug users who are able to maintain a relatively stable existence outside of the clinic, as well as provide a residential program for those individuals needing total supportive services. The program, in short, must offer an alternative environment and peer group, within a comfortable and secure setting.

SPECIAL NEEDS

This subregion has a need for a resource person skilled in drug education and counseling who will make himself available to the rural areas. The inaccessibility of the services which exist as well as proposed services only serve to perpetuate the information/education problem in the rural areas. School officials and community people do not understand the problems involved

in drug abuse and therefore are unreceptive to attempts to provide services for youth. It appears that there is a strong need for education, information, and counseling on all levels, and a program of this sort should be actively pursued.

The ongoing collection of data to monitor trends and needs is a constant problem which is presently not being met in this subregion.

In all comsiderations of service needs it should be remembered that the majority of drug abusers are not youth and that nonyouthful drug abusers are a vast unidentified population who may have distinct needs. At the present time few efforts are directed at these middle-aged, middle America drug abusers.

CUMBERLAND SUBREGION
Action Agenda

Recommendation	When, How and Cost
-Data collections continue beyond the completion of the State Plan for the purpose of: designing an ongoing evaluation system to connect programming and changing needs, exploring unexposed problem areas, designing new forms of treatment.	-Data collection to begin immediately in conjunction with the state data collection system. Estimated cost is $25,000 for the first year.
-That support be given to a State Resource Center for alcohol/drug information/training. That this information and personnel resource be utilized within this subregion in all areas where needs are identified.	
-Personnel should be provided to identify areas of need, approach educators, physicians, courts, law enforcement personnel, etc., to determine and develop their interest in drug education and design appropriate programs using the State Resource Center.	-Through Regional Coordinator's Office - $15,000.
-That Law Enforcement Assistance Agency financially support drug education for law enforcement and other personnel and that such education go beyond the use of Bureau of Narcotics and Dangerous Drugs training and explore the humanistic approach to the drug problem.	
-All area drug programs to be licensed be required to cooperate with the Regional Coordinator's Office to insure effective regional programming.	-To be established by licensing body at the time of issuance of license and subsequent renewals as outlined in LD #735.
-A strong cross agency referral system be fostered between treatment programs, other human service agencies, and the mental health centers.	-To be accomplished through the Regional Coordinator's Office as an ongoing process.

Recommendation	When, How and Cost
-That three counseling specialists be assigned to existing agencies to increase cooperation in substance abuse services, to provide agencies with an inhouse resource, and to provide treatment programs with referral options. One such person to be assigned to the rural service area. Such a person will be charged with initiating awareness among school personnel, courts, etc., and, also will serve as a counseling resource.	-Funding application and initiation of negotiations for counseling services should come from the Regional Coordinator's Office. Application can be made through the Single State Agency. Yearly contracts should be negotiated with agencies to insure responsiveness to changing needs. Estimated cost for three counselors is $45,000.
-A formal written relationship be established between DRI and area hospitals for the purpose of providing appropriate detoxification services for clients of DRI.	-To be accomplished by the staff/board of DRI prior to the opening of DRI. Cost and methods of payments to be established during negotiations.
-The United Drug Abuse Council should neet to consider its position relative to the Regional Drug Abuse Plan.	-This should take place after the Regional Drug Abuse Plan has been made public.

YORK SUBREGION
Description of Subregion

AREA

The York County Subregion is the southern most section of the planning area. Encompassing 989 square miles, york County borders, on the East, approximately 45 miles of Atlantic coastline. By population, 43.2% of York County is rural.

POPULATION

The total population of this subregion is approximately 111,576 people. Of the total population, approximately 28% of the population is in the 0-14 age group, 28% in the 15-34 age group, 22% in the 35-54 age group and 22% are 55 and over.

The ethnic charcateristics of the population is described in the 1971 Mental Health Staffing Grant for York County Counseling Services:

> French is the major ethnic group in the County, consequently, the Catholic religion (sic) is the predominant religion. Although there are no numerical statistics the heaviest concentrations are in the largest communities, estimated ate 80% for Biddeford and 60% for Sanford. They tend to be bilingual and blue collar workers. Voting as a block is evident as the majority of political office holders (county and municipal) are of French extraction.

There is an influx of summer visitors to this subregion numbering in excess of 100,000 persons annually. The coastal communities are a summer paradise for tourists. Visitors migrate inland for tenting, boating, and historical sites. Included among those visiting York County are large numbers of youth who are attracted to the beach areas. Their impact in relation to the subregion's vulnerability to drug abuse will be discussed later.

Although such statistics as divorce rate and suicide rate have no established correlation with drug abuse, the incidences of divorce and suicide are mentioned here in the description of the subregion, as possible variables in the degree of drug abuse. According to statistics from the district courts, there were 386 divorces in York County in the year ending June 30, 1971. This represents 3.5 divorces per 1,000 persons, a figure lower than the State rate of 3.8 divorces per 1,000 persons. A figure on the number of suicides is made available for York County by the 1970 U.S. Census Report. One must bear in mind that, due to the nature of what is being measured, such a statistic holds only relative worth. Accordingly, for 1970 there were 18 cases of known suicide and one case with no positive determination.

EDUCATION

The school systems of York County are listed in the following chart along with population data for each system.

In summary, York County has one guidance counselor for every 247 students. The dropout rate for the total school population in the subregion is 4.9%.

YORK COUNTY EDUCATIONAL STATISTICS *

YORK COUNTY--

School System	ELEMENTARY STU.	ELEMENTARY TEA.	SECONDARY STU.	SECONDARY TEA.	GUIDANCE ELEM	GUIDANCE SEC.	DROP OUTS	SOCIAL WORKER	PSYCHOLOGISTS
S.A.D 6	1359	53	1086	52	0	3	29	0	0
S.A.D. 35	1114	44	814	50	1/2	2-1/2	Not Available	0	0
S.A.D. 57	772	34	547	34	0	1-1/2	9	0	0
S.A.D.60	1152	46	768	40	0	2	17	0	0
S.A.D. 71	1258	53	836	44	0	2	4.2%	0	0
Union 2	683	27	384	28	0	1-2/3	4.8%	0	0
Union 4	1626	55	1658	94	0	3	60	0	0
Union 7 Thornton Academy	2943	100	325	22	0	1	8	0	0
York	756	30	549	54	0	3	7	0	0
Sanford	1664	68	1160	616	0	5	.0062	1	0
Kittery	1249	53	559	41	1	2		0	0

*Juvenile Delinquency Study University Of Maine Orono Extension Service

Political Structure

York County includes twenty-six towns, two cities and one village corporation (Ogunquit). Both cities, Biddeford and Saco, have mayors. The remaining 26 municipalities have a selectmen form of government with five of those having town managers. There are sixteen state representatives from York County. Nine are Democrats while the remaining seven are Republican. The four state senatorial districts are split evenly between the two parties. The three county commissioners are all Democrats. The more urban areas tend to be strongly Democratic, while the smaller "exclusive" resort towns on the coast tend to be more Republican. While there are 72,365 registered voters in York County, the major party distribution is about even with 25,238 Republican enrolled voters and 25,125 Democrat enrolled voters.

ECONOMY

A very large percentage (43.3%) of the total work force of the subregion is in manufacturing; transportation equipment, leather, and textiles being the largest employers. Affected somewhat by the shift of textiles manufacturing to the South, the populations of the Biddeford-Saco and Sanford areas nevertheless are predominately employed by textile manufacturers, while Southern York County is the home of the Kittery Navy Yard, commonly known as the Portsmouth Navy Yard. Consequently, the economy of the area has been primarily dependent upon the shipbuilding industry. The small seacoast towns in Southern York County afford a major economic resource as it is a recreational area for many people along the eastern seaboard of the United States and Canada.

Approximately 11.6% of all the residents of the subregion or about 12,568 are living below the poverty level. This is shightly higher than in the rest of the planning region which is 11.3%.

According to the 1970 U.S. Bureau of Census, the mean income in the subregion for a male as head of household is $8,546 and $5,283 with a female as household head.

For the year 1972, York County had an unemployment rate of 7.7% according to the Maine Employment Security Commission. This is higher than the rate of 7.2% for the total planning region. One variable in this high incidende of unemployment may be due to the temporal nature of the many seasonal tourist-linked jobs.

VULNERABILITY

There are several factors which make for a high degree of vulnerability to drug abuse in York County. With 28% of the population falling between the ages of 15 and 34 and with the presence of two colleges, one im Springvale and one in Biddeford, a substantial number of young people live in the York Subregion. Although youth by no means comprises the entire population of drug abusers, it is recognized that drug abuse in substantially higher among younger persons. In addition, many more younger people come into this subregion every summer for recreational reasons; especially to the beach areas. As certain drugs, e.g. marijuana, and L.S.D. are seen as "fun" or recreational by those who use them, the recreational environment of the coastal towns is condusive to drug experimentation and use.

There is little by way of organized leisure time activities in York County. As is the case with most areas which have a considerable rural population, there are limited positive "things to do" to the point that "riding around" is defined as recreation. With such a lack of recreational alternatives, the potential for experimentation with, and the use of drugs is considerable.

There are 12,568 family units defined as living below the poverty level in York County. The Juvenile Delinquency Study also states that, when questioned, the social workers and psychologist answered that poverty does contribute to delinquency and further, they answered that drug abuse is a result of delinquency not a cause. The number of persons living below the poverty level might, therefore, be considered a variable in the vulnerability of York County to drug abuse.

Lastly, as has already been pointed out, the socio-familial variables of suicide and divorce, strenghten this statement and the extent of occurance in the subregion should be kept in mind when considering the vulnerability of the subregion to drug abuse.

YORK SUBREGION
Existing Resources

York County Counseling Services

Mental Health Area VI, which encompasses York County, is served by York County Counseling Services (YCCS). With the receipt of a staffing grant from NIMH in 1972, YCCS moved to its present location in Saco with three branches in Biddeford, Sanford, and Kittery. Sweetser Children's Home continues to provide children's services through residential treatment and diagnostic services, while YCCS has expanded its services to include: outpatient services; a 24 hour emergency service which is used by individuals, police, fire departments, etc., and also handles the drug emergencies for York County as these calls are referred to the YCCS's drug specialist; a consultation and education program geared towards assisting individuals ans groups in more effectively handling their given roles; and outreach program; inpatient services at the Goodall Hospital and at Webber Hospital and drug counseling. In conjunction with the work at YCCS, a drug education program has been operating in York County by a group of volunteers trained in a two-week drug education program at Yale University. The Assistance in Drug Education (AIDE) team has various programs for community and school groups basically aimed at developing quality drug education. This group is now sponsoring efforts to open an AIDE Center which will be a drug related crisis information program. It is AIDE's objective to increase community understanding of the drug pfoblem while stimulating community interest and action. The services proposed include: drug education and information dispensed on a walk-in basis or by telephone; a referral service for area agencies and schools; and eventually group discussions led by professional counselors.

Department of Health and Welfare - Region I

Its office is located in Portland and provides some counseling for drug abusers and their families, but most often serves as a source of information and referral. Vocational regabilitation services provided by the Division of Vocational Rehabilitation are wide-ranging and include a conplete diagnostic evaluation to determine both abilities and disabilities. Services include; counseling, guidance, physical restoration, individual or group therapy, training, job placement and follow-up.

Schools

The survey of this subregion's educational facilities show that of the eleven superintendents and administrators who replied to the survey, ten have an educational program in their schools designed to affect students' attitude toward drugs. The technique used is largely informational, with some programs concerning themselves with some programs concerning themselves with decision-making and value-orientation. Only five of the schools have a uniform drug education policy, and five a uniform policy of discipline.

Physicians

There are 64 physicians in the York County Subregion. Of those, 28.1% or 18 physicians returned the questionnaire. Almost 60% of those are in general practice and hence most likely to come in contact with drug abusers.

All but two of the physicians who returned the questionnaire believe that few persons with drug problens tend to seek help from physicians for that problem. Nevertheless, twelve physicians see the abuse of drugs as a definite problem in the community in which they practice. Six physicians felt that present State laws relating to treatment of minors does limit the effectiveness of treating youthful drug abusers.

Although this sample of the population of physicians returned was not of great magnitude, several facts are hinted at. First of all, most physicians do feel there is a drug problem in the area. Secondly, those physicians state that, for whatever reason, drug abusers do not seek help from physicians. And lastly, there seems to be an opinion that State laws relating to treatment of minors does impede the physicians' ability to treat drug abusers and hence gives the physicians low visability as a resource in the community for drug abuse treatment and/or rehabilitation.

Hospitals

As discussed before, Goodall and Webber Hospitals provide for inpatient services for mental health. All but one of the York County hospitals (tri-County) have emergency rooms which treat drug abuse cases.

YORK SUBREGION
Service Needs

I. PREVENTION AND EDUCATION

a. Recreation

Although several municipalities within the subregion do have organized recreational programs, many more do not. Existing programs are generally not utilized by the "high risk" segment of the population. Consequently, if it can be granted that recreation is a possible alternative to drug use, then a reorientation and coordination of existing recreational programs is needed. Such a reorientation would call for making available to all youth acceptable recreational alternatives. An expanded definition of "recreation" is likewise called for, so that the term might connote more than such traditionals as baseball, basketball, and swimming.

Those towns which offer no recreational alternatives at all are in a good position in that the development of such programs can include innovative and responsive recreational possibilities. Such development should include positive and responsible roles in the education and maturation of the young people of any particular towns and of the subregion. Recommendations as to how this can be realized are dealt with in the next section, Action Agenda.

b. Education

There is also a need for educators to refocus their vision so that the student is seen as a "whole person" and not only in the role of "student". This perception is in concert with the position that drug use is not an isolated activity but related to, and contingent upon, the many variables of the human condition.

It follows that a curriculum is needed in which drug use, as well as other physical and mental health issues, are dealt with and related to all subjects of study and not merely discussed on a one-shot basis in health class. Furthermore, attitude change on the part of teachers is needed if any effective curriculum dealing with substance abuse is to be implemented.

Current attempts at teacher training need to be augmented. Present teachers should participate in continuous training sessions until more fruitful and effective teaching methods have evolved. Furthermore, a curriculum at the undergraduate and graduate levels for education majors needs to be developed. Such a curriculum should include ways of dealing productively with those students who have been or may become involved with drugs. Again, the emphasis should be on the "whole person".

c. Education of the Public

Police departments within the York County Subregion have requested training sessions on drug abuse. Several other professional agencies ahve likewise requested training. Such training programs whould be developed and implemented within a particular profession by knowledgeable persons of that profession. "Significant Others" should be mobilized to bring about effective training in such groups or organizations as schoolboards, public health

agencies, the Department of Health nad Welfare, the clergy and physicians.

Public education in general can effectively be delivered via the mass media, not by way of public announcement, which historically have utilized "scare tactics", but by informative, sophisticated, and intelligible programming which to date has been lacking.

II. TREATMENT AND REHABILITATION

Since one man constituted the major thrust in professional drug counseling services in the York Subregion, and since that person is also responsible for program development, the need for expanded professional services to drug abusers is evident. Expansion of services is expecially needed in the rural segments of York County.

A residential facility has also been cited as a definite need within the subregion. Such a facility would offer short-term residential service and counseling. There are apparently many situations in which it would be desirable for a youngster to live outside of his present family setting, yet still within his community. A residential program would help to fulfill this need, as well as provide a common working point for such services as crisis intervention and day care.

York County Counseling Services (YCCS) has had substantial difficulty in reaching a level of cooperation with local hospitals in allowing drug detoxification. Lack of"security arrangements" has been given as the reason. Again, although detoxification is not a need of great magnitude, a facility and staff must be available should that need arise.

III. COURT SYSTEM

As is presently being established in the Cumberland Subregion, a court referral system to rehabilitation programs for drug abusers is needed also in the York Subregion. This need relates directly to the present gap in residential services, as a court referral system would require complete residential and day care facilities.

A family court system has also been cited as a need. This type of system calls for a total consideration of the matrix of any family within the legal deliberations of any member of the family.

IV. AFTERCARE

It is felt that any treatment or rehavilitative program established in the York Subregion should offer aftercare services. What type of aftercare program would best suit the drug abuser in York County will be dealt with as a recommendation within the section called Action Agenda.

V. OTHER SERVICE NEEDS

The need for coordination between this subregion and the other subregions is much needed. In fact, prior to this plan, there had been little if any communication between the staffs of the various drug abuse programs within the region.

Funding, eternal problem it seems, is a problem which a regional coordinator should have the time and expertise to deal with.

There is a vital need for an accurate and comprehensive data collection system. This is necessary in evaluation programs, in determining whether or not the approach being used is indeed the best. Consistent regional and state data collection is consequently imperative.

YORK SUBREGION
Action Agenda

The following recommendation constitute an action agenda, a delineation of proposals which, when enacted, will serve to coalesce presently frgmented programs and services relative to drug use and thus put into motion a responsive and comprehensive delivery system.

RECOMMENDATIONS:

- That York County Counseling Service (YCCS) be funded to hire additional staff counselors, and that those counselors be available to;
  a) the Assistance in Drug Education (AIDE) Center in Sanford,
  b) the YCCS, as additional staff, experienced in youth problems and substance abuse.
- That Drug Rehabilitation, Inc. (DRI) be funded so that long-term rehabilitation services will be available for the entire planning region. It is further recommended that representatives from York County be allowed to a take a seat on the Board of DRI.
- That the availability of detoxification services on the part of York County hospitals be explored so that detoxification services can be made available when needed.
- That the expressed desire of the York County Cooperative Extension Service to contine to participate in the development and execution of a consistent educational curriculum and workshop program be accepted and utilized by YCCS staff, as well as other appropriate persons in education and the human services.
- That the cooperation and assistance of the Maine Teacher's Association be sought in an attempt to change outmoded and inappropriate attitudes towards drug abuse on the part of many Maine teachers. It it further recommended that this be done via inservice workshops.
- That active recreational and police personnel be invited to participate in the training workshops
- Investigate the possibility of opening school recreational facilities during the summer.
- Inform legal authorities of the therapeutic alternatives for drug offenders.
- Seek LEAA funding for a probation officer trained to work with drug offenders.
- That individualized aftercare be a part of any program of services to drug abusers.
- That a regional coordinator, directed by a regional drug abuse council, be involved in the implementation of these recommendations.

RECOMMENDATIONS REQUIRING FUNDING
York County

Recommendations	Cost
YCCS Staff Counselors (2)	$ 30,000.
Educational Workshops	10,000.
Probation Officer	11,000.
Aftercare Services	N.A.

SOUTHERN MID-COAST SUBREGION
Description of the Subregion

AREA

This subregion, encompassing 574½ square miles, includes a coastal section of the State just north of Maine's largest metropolitan area, Portland. Extending from Freeport on the southwest to Nobleboro on the northeast, it borders the Atlantic Ocean a distance of 50 miles as the crow flies and extends inland from 20-25 miles. This subregion is composed of 1 city and 25 municipalities. Portions of it are located in Cumberland, Sagadahoc, and Lincoln Counties.

POPULATION

The Southern Mid-Coast Subregion has a year-round population of 58,721 persons. By age category, 28% of the population is under fifteen years of age, 29% fall between 15-34 years of age, 21% between 34-54 and the remaining 22% of the population is 55 of older. There are two "urban" communities within the subregion, the City of Bath (population 9,680) and the Town of Brunswick (population 16,059). Within this subregion, Lincoln County has a 100% rural population, while Sagadahoc has a 47.2% rural population.

The Brunswick Naval Air Station, located in Brunswick, has approximately 2,238 active duty military personnel with an additional 710 on deployment at any one time. These active duty personnel have a total of 7,529 dependents who live in the immediate area. There are approximately 2,600 retired military personnel with nearly 4,000 dependents. Thus, the naval air station directly contributes over 17,000 persons to the population of the subregion. There is no concentration of any particular ethnic group in the subregion and can only be considered "Old Yankee".

The subregion does experience the influx of summer visitors indicative of the rest of the State. With an annual influx of 40,468 persons, the total population at peak season approaches 100,000 persons. Most of the summer visitors swell the coastal areas. Although many of the coastal areas in this subregion are privately owned, there are several beach and recreational areas open to the public.

ECONOMY

The Town of Brunswick, at one time a basically industrial community, is no longer such. Its citizens are employed in supporting the large military base, the college, providing services, merchandising, and many are employed outside of Brunswick. The City of Bath, on the other hand, relies heavily on the Bath Iron Works, a shipbuilding industry, as its major economic influence. Retailing has diminished considerably since 1960 with the closing of seven major retail outlets. In addition to tourism, lobstering and fishing are the main economic thrust of the coastal towns of the subregion, while inland towns are largely agricultural. Much of the economic activity of the area is seasonal and consequently unemployment is high during the long "off season".

The unemployemnt rate according to the Maine Employment Security Commission

was 7.4% for Sagadahoc County and 7.5% for Lincoln County. Both percentages are higher than that of 7.2% for the entire Southern Maine planning region.

According to the 1970 reports of the U.S. Bureau of Census, the mean income for families with a male head in Sagadahoc County was $8,474 and $7,362 in Lincoln County. In cases where the household head was female, the mean salary was $4,877 in Sagadahoc County and $5,162 in Lincoln County.

Approximately 11.7% (7,191) of all the residents of the subregion are living in poverty. This is higher than in the rest of the planning region in which 11.3% of the residents live in poverty. The ramifications of these statistics will be discussed later when the vulnerability of the subregion to drug abuse is discussed.

EDUCATION

The school systems of the Southern Mid-Coast Subregion include 4 unions, 1 town under a district superintendent, and 1 town with individual supervision. Population data for each system is charted on the table below. Sagadahoc County has one guidance for every 196 students while Lincoln County has one guidance counselor for every 623 students. Sagadahoc County has a dropout rate of 4.17% while Lincoln County has a rate of 5.4%.

SAGADAHOC COUNTY

School System	Elementary Students	Elementary Teachers	Secondary Students	Secondary Teachers	Guidance Elementary	Guidance Secondary	Drop-outs	Social Worker	Psychologists
Bath Union 47	1515	62	1366	80	1	3	6-7%	0	0

LINCOLN COUNTY

School System	Elementary Students	Elementary Teachers	Secondary* Stu.	Secondary* Tea.	Guidance Elementary	Guidance Secon.	Social Worker	Dropouts	Psychologists
Union 48 Wiscasset	1224	58	270	22	0	1	0	4%	0
Union 49 Boothbay Harbor	775	34	265	21	0	1	0		0
Union 74 Damariscotta	1120	42	922	50	0	1	0	-	0

CUMBERLAND COUNTY

SCHOOL SYSTEM	STUDENTS	TEACHERS	STUDENTS	TEACHERS	ELEMENTARY	SECONDARY	SOCIAL WORKER	DROP-OUTS	PSYCHOL-OGISTS
Brunswick	1742	65	2356	129	0	4	1	Not Avail	10
									0
Freeport	897	37			0		0		0

RECREATION

Organized recreational programming is available only in the more urban areas of the subregions, i.e. -Bath-Brunswick. There are several Boy Scout and Girl Scout Troops as well as 4-H programs in the subregion. Where there are programs, the Juvenile Delinquency Study states, " activities are heavily oriented toward sports and serve only a small part of those youth who become delinquent or who are potentially delinquent".

POLITICAL STRUCTURE

The Southern Mid-Coast Subregion includes 25 towns and one city, Bath. Selectmen govern 24 towns while Brunswick has a town council and Bath a city council. In Lincoln County all but 2 representatives are Republican. The Towns of Brunswick and Freeprot (Cumberland County) have 3 Democratic representatives. The 2 senators from the subregion are both Republicans.

Sagadahoc County has 13,307 registered voters; 5,062 are registered Republicans and 3,141 are registered Democrats. Lincoln County has an even stronger Republican population with 8,098 of the 13,866 registered voters being Republican and 2,624 registered Democrats.

VULNERABILITY

The vulnerability of the subregion to drug abuse is brought to light by several factors. With 29% of the population falling within the high risk age range of 14-35 including the 1,000+ students of Bowdoin College and the 2,500+ personnel associated with the Brunswick Naval Air Station, there is as significant concentration of younger people in the urban areas of the subregion. Such urban population (25,739 persons in the Bath/Brunswick Area) tend to see substantial incidence of drug abuse.

A general lack of year-round recreational alternatives, especially in the more rural areas of the subregion, leave much time for possible experimenting with drugs and/or alcohol.

Even the urban areas fall far short of being able to provide "creative" recreational programming for its youth and general population in summer months, as well as through the long Maine winter.

Another variable is the lack of vocational schools. If such a school were established its graduates would face another problem-that of securing job offerings in the subregion. Indeed, Sagadahoc and Lincoln Counties have extremely high unemployment rates. The seasonal nature of many jobs is surely a contributing factor to this high percentage.

Lastly, without computing correlations between drug abuse and such socio-familial variables as suicide and divorce, the degree of the latter, should be kept in mind when considering the vulnerability of the subregion to drug abuse.

SOUTHERN MID-COAST SUBREGION
Existing Resources

BATH-BRUNSWICK MENTAL HEALTH ASSOCIATION

Mental Health Catchment Area VII or the Southern Mid-Coast Subregion is served by the Bath-Brunswick Mental Health Association (BBMHA) which maintains an office in each of the four hospital communities - Bath, Brunswick, Boothbay Harbor, and Damariscotta.

The BBMHA offers outpatient psychiatric and psychological evaluation and therapy, for both individuals and groups. No long-term rehabilitation is offered other than long-term psychotherapy or casework.

In light of the strong working relationships between the BBMHA and the Brunswick Area Drug Abuse Center (BADAC), services for certain drug abusers are not lacking. There are still some segments of the drug using population that the center does not serve, i.e. the hard core user. Indeed, because of the concentration of younger people in the catchment area, and because of the fact that the younger population generally seems to be attracted to "street" programs, the BBMHA finds the BADAC a functional and hence valid approach to providing services to the drug abuser.

BRUNSWICK AREA DRUG ABUSE CENTER (BADAC)

BADAC was established in 1970 through local funding. In the Summer of 1972, BADAC was awarded an eight year Federal staffing from the National Institute of Mental Health. Through these funds the BADAC has initiated five service components which cover:

1. Monitoring of the area drug situation.
2. Offering school age adolescents alternative programs to prevent drug abuse.
3. Offering an alternative to law enforcement agencies.
4. Providing group and individual counseling.
5. Providing confidential drug analysis and identification.

The Alernatives Program, begun in January of 1973, is the major and most visible thrust of the BADAC's attempt to grapple with the task of prevention. It operates on the theory that people use drugs for fun and because of peer pressure, but primarily because something is missing in their lives. This program seeks to help people find a meaningful alternative to drug abuse.

BADAC maintains the Wick Coffee House in Brunswick, at which such programs as film making, pottery, theater, dance, etc. are sponsored. Counseling is offered either on a short-term or long-term basis, and is available for both drug users and parents - directly through BADAC in collaboration with the BBMHA. Group counseling is another integral part of the programming of the BADAC.

Another aim of BADAC involves an experimentla program of joint referrals for the law enforcement system. A manual for referral has been put together by the staff and volunteers of BADAC. The referral system has brought

about formal and informal agreements with other agencies such as town welfare offices, Odyssey House in New Hampshire, Bath Memorial Hospital, the Bath-Brunswick Mental Health Association, Augusta State Hospital and Togus Veterans Administration Center.

The BADAC has very close and working ties with local law enforcement agencies, the Brunswick Naval Air Station, and the area's physicians and hospitals. An obvious service area problem does exist with the BADAC. The center serves the greater Brunswick Area while its most important referral agency the BBMHA, serves a much larger geographical area.

BRUNSWICK NAVAL AIR STATION

The U.S. Navy, with the advent of its exemption program, maintains a sophisticated system of counseling and rehabilitation services for military personnel and their dependents. The Brunswick Naval Air Station has one full-time trained Drug Abuse Education Specialist. The educational component takes place at all levels of command and is structured to a great extent around audio-visual aids.

The Drug Abuse Education Specialist of the BNAS sees the base as an integral part of the Brunswick community. There is a very strong rapport and practical communication with the BADAC. A good number of the thirty volunteers who donate their time to the BADAC are servicemen from the Brunswick Naval Air Station.

DEPARTMENT OF HEALTH & WELFARE

The Southern Mid-Coast Area is served by two district offices of the Department of Health & Welare; Region I serves the Cumberland Area which includes the City of Brunswick; while Region III includes the City of Bath, as well as all of Sagadahoc, Lincoln, Knox and Waldo counties.

Region I Health & Welfare, with office in Portland, offers some counseling for durg abusers (usually children referred by parents). Primarily, however, the information andreferral to treatment facilities are the services provided. It is generally felt that adequate staff and programming are lacking within the service capabilities of this regional office.

Although Sagadahoc and Lincoln Counties are in Region III, the Regional Office in Rockland sees no drug abuse related cases from these area. It is assumed that such persons approach local drug abuse programs. Consequently, Bath and outlying areas are partially served by the BADAC. However, since BADAC's service area is so restricted, Lincoln County goes virtually unserved.

SCHOOL DISTRICTS

Of the superintendents who responded to the questionnaire, all stated that informational programming was available within their districts. Such session are generally optional and take the form of school assemblies, lecturing by experts, films, ex-addict talks and almost always conclude with small group discussions.

When the class approach to drug abuse is empllyed, usually within the context of a health education course, the instructuor seldom is found to have had training specifically in drug abuse prevention. On the other hand, most superintendents feel their instructors are quite capable relative to the intensity of the local problem.

PHYSICIANS

There are seventy-five physicians in the Southern Mid-Coast Study Area. Of those, twenty-three (30.6%) returned the questionnaire. Almost half indicated they were in general proctice and hence most likely to come in contact with drug abusers. Most physicians do feel there is a drug problem in their area. Secondly, they state, for whatever reason, drug abusers do not seek help from physicians. And lastly, state laws relating to treatment of minors are not generally regarded as a barrier to the physician's ability to treat yothful drug abusers. This is in contrast to prevailing opinions in the Cumberland and York Subregions.

HOSPITALS

There are five hospitals in the Southern Mid-Coast Area providing inpatient and emergency services which are occasionally sought out by the drug abusers. Bath Memorial Hospital serves Southern Sagadahoc and Lincoln Counties; Miles Memorial Hosptial serves most of Lincoln County; Parkview Memorial Hospital serves the Greater Bath/Brunswick Area; Regional Memorial Hospital serves Brunswick and communities within a twenty mile radious; and St. Andrew's Hospital serve the Boothbay region.

SOUTHERN MID-COAST SUBREGION
Service Needs

Explicit within each of the following subregional service needs is the need for coordination at the regional level.

I. PREVENTION

a. Employment

There is a definite need in this subregion for a greater variety of vocational training opportunities and vocational counseling for out of school youth. A post high school counseling program involving follow-up, especially relating to employment is much needed. Unemployment has been shown to be a variable in the incidence of drug abuse.

b. Recreation

Although organized recreational activities do exist within the more urban parts of the subregion, these traditional activities have not gained the interest and participation of the drug using population. Recognizing this need, the BADAC has developed a package of innovative recreational alternatives. The BADAC, however, realizing that it is unable to provide an alternative program to meet very need, also recognizes a need for continued coordination of all recreational programming in the subregion, whether traditional or "innovative."

The rural areas,moreover, are for the most part grossly lacking in youth oriented programming in general. There is a feeling that the school system "should take care of" youth activities.

II. EDUCATION

a. Public Education

The need for informing and educating the public of factors behind drug use presents a continual and difficult task.

Increased advertising of those existing programs which deal with these subjects would be a start. However, the responsibility of such public education must fall on all community agencies, not only those agencies who provide direct services to drug abusers.

Futhermore, a public information effort to increase parental awareness of the family's role in preventing and dealing with drug use is needed. A follow-up mechanism should accompany this effort so that a two-way channel of communication can be established.

b. School System

There should be a greater emphasis on drug abuse information and guidance in teacher training curriculum at state colleges. Current curriculum is inadequate.

Within the school's systems, a consistent drug education policy and discipline code is needed. Whether the existing program outlined by the Maine Drug Education Program is used or whether a new subregional or regional policy is generated, the need is there and must be met.

c. Primary Contact Personnel and Agencies

There are many professional persons within existing service agencies who might come in contact with persons involved with drug abuse. Increased coordination and dialogue between such persons, especially between personnel of the various youth service agencies, is much needed. In fact, much more than coordination and dialogue is needed. A training program at the subregional level for doctors, lawyers, health and welfare workers, school counselors, Y.M.C.A. personnel, police, and other appropriate persons would be of great benefit. In short, there is a need for total positive awareness in recognizing and working with the problems our youth encounter today.

III. TREATMENT AND REHABILITATION

Both the Bath-Brunswick Mental Health Assn. and the Brunswick Area Drug Abuse Center recognize a need for closer communication and continued sharing of certain staff menbers. In addition, both agencies cited a profound need for access to a full detoxification unit and local inpatient psychiatric treatment.

In terms of crisis intervention, the feasibility of the combining of forces of such agencies as the Drug Center, the Mental Health Center, Rescue, Inc. should be investigated, as such an arrangement would be at least more economical.

IV. COURT SYSTEM

Given the fact that drug abuse is probably the symptom of a deeper problem, and not the problem itself, the wasted expense and manpower utilized in pumping drug abusers through the penal system is in the opinion of many professionals just that - a waste. The establishment of a court referral system would help deal with this problem. Such a system would give offenders the option of attending a treatment or rehabilitation program.

V. REPORTING AND IDENTIFYING

So that direction in programming can be facilitated, an improved statistical mechanism that would, on a regular basis, report information on drug contacts to and by concerned individuals and agencies needs to be established. It should provide information which is easily comparable with other regional and statewide data.

SOUTHERN MID-COAST SUBREGION
Action Agenda

The following recommendations constitute an action agenda, a delineation of proposals, which when enacted, may serve to integrate presently fragmented programs and services relative to drug use and thus put into motion a responsive and comprehensive delivery system.

RECOMMENDATIONS

-That a comprehensive and thorough reevaluation of the Brunswick Area Drug Abuse Center be initiated and carried out by a team of capable persons. This reevaluation should include a formal research effort to determine incidences and patterns of use and abuse of all drugs. Current programs, directions, and philosophies should be restructured relative to the findings of that research.

Resolution of some of the following recommendations will be contingent upon the results of the reevaluation suggested above.

-That some professional attention be paid to the problem of alcohol among youth.
-That an adequate number of professional foster homes for short-term placement for youth with no viable home situation be developed.
-That negotiations with Regional Memorial Hospital be initiated with the purpose in mend of prearranging detoxification services so that such services could be made available should the need arise.
-That a subregional training session by physicians for physicians be initiated with the end in mind that physicians assume greater responsibility in emergency treatment, recognition, and referral of drug users and abusers.
-That a joint funding effort be undertaken to provide at least one, year-round counselor in high schools of the subregion where such services are deemed inadequate.
-That an indepth inventory be made of all recreational resources within the subregion. Data indicating which progrmas are utilized by which people, by how many people and how often should be obtained.
-That BADAC and BBMHA become familiar with accepted State and National school drug policies and discipline codes, so that they might serve as resources to local schools.
-That the court referral system which is being developed, be supported by all subregional service agencies so that program might come to fruition.
-That a subregional "hot line" be so developed and supported by all crisis intervention agencies. Evaluation of current "hot line" logs should precede such development.
-That a regional coordinator, directed by a regional drug abuse council be consulted on the development of, and involved in, the implementation of these recommendations.

FUNDING

Request for funding will be contingent upon the decisions arrived at after the reevaluation has been completed.

PENOBSCOT BAY SUBREGION
Description of the Subregion

AREA

The Pen-Bay Subregion is the most northeasterly section of the planning area. The subregion comprises all of Knox County, 21% of Lincoln County, and 70% of Waldo County. Encompassing 898 square miles, the subregion borders the Atlantic Ocean with about 50 miles of coastline as the crow flies. Within the subregion, 41.4% of Knox County, 0% of Lincoln County and 48.0% of the section of Waldo County which is in the subregion are urban areas.

POPULATION

The total population of the subregion is 38,268. Of that figure, approximately 28.5% are between 0 and 14 years of age, 27% between 15 and 34, 22% between 35 and 54, and 22.5% are 55 or over. Basically the subregion has been "downeast Yankee" for many generations. Of the total population there are 73 nonwhite persons according to the 1970 census report. The subregion experiences a seasonal influx of summer visitors which numbered 28,887 in 1970. There are many beach areas in the subregion which are maintained for public use.

The incidence of suicide is not great for the subregion. There were 16 cases reported in the 1970 census. There were 149 divorces in Knox County, 72 in Lincoln County and 85 in Waldo County according to the 1970 census report.

EDUCATION

Population data on each school system of the subregion follows. The ratio between counselor and students is 1 to 430 for Knox County and 1 to 623 for Lincoln County. The drop out rates are 6.39% and 5.42% respectively for Knox and Lincoln Counties.

WALDO COUNTY

School System	Elementary Stu.	Elementary Tea.	Secondary Stu.	Secondary Tea.	Guidance Elem.	Guidance Secon.	Drop Outs	Social Worker	Psychologists
#3	1874	43	736	33	0	1	12	0	0
#34	1392	57	810	53	0	2	2.3%	0	0
#56	603	31	503	27	0	1	3%	0	0
Union 69	510	21	26	2	0	0	0	0	0
Winterport	489	20	-	-	0	-	-	0	0

S.A.D. #3 Mount View High (Thorndike)
S.A.D. #34 Belfast Area High
S.A.D. #56 District High (Searsport)
U. 69 Isleboro

KNOX-LINCOLN COUNTY

School System	Elementary Students	Elementary Teachers	Secondary* Stu.	Secondary* Tea.	Guidance Elementary	Guidance Secon.	Social Worker	Dropouts	Psychologists
S.A.D.#28 Camden	755	34	926	91	0	1-1/5	0	4%	0
S.A.D.#5 Rockland	1806	70	756	45	0	2	0	6.8%	0
S.A.D.#8 Vinalhaven	141	9	113	7	0	0	0	.	0
S.A.D.#7 North Haven	48	3	40	4	0	0	0		0
S.A.D.#40 Waldoboro	1082	48	1022	56	0	3	0	5%	0
S.A.D.#50 Thomaston	699	39	318	24	0	1	0	2%	0
Union 48 Wiscasset	1224	58	270	22	0	1	0	4%	0
Union 49 Boothbay Harbor	775	34	265	21	0	1	0		0
Union 51 Jefferson	1120	42	-	-	0	0	0	0	0
Union 74 Damariscotta	1120	42	922	50	0	1	0	-	0

* Inc. Junior High Schools

ECONOMY

Knox, Lincoln and Waldo Counties are three of Maine's smallest counties with a high degree of poverty. By Economic Opportunity Act standards, Waldo is considered the second most impoverished county in Maine. Much of the employment in Waldo County is seasonal, but poultry raising and processing is year-round.

Knox County has a printing plant, a woolen mill, a large cement plant, a plant for processing sea products, an electrical machinery factory, leather tanning and plastic factory and a hearing aid microphone industry. It does, as well as Lincoln County, have large industries such as commercial fishing and packing, and the harvesting of blueberries.

According to the Maine Employment Security Commission, Lincoln County has 7.5% unemployment, Knox has 7.3% and Waldo has 7.8%. This high rate of unemployment definitely has a bearing on the vulnerability of the subregion to drug abuse and will be discussed later.

The 1970 U.S. Bureau of Census reports that the mean income for a family with male head is$7,362 for Lincoln and Knox Counties and $7,344 for Waldo. For a household with a female head the mean income is $5,162 for Lincoln, $4,849 for Knox and $4,881 for Waldo.

Approximately 13.2% of all the residents of the subregion or about 4,863

people are linving in poverty. This is much higher than in the rest of the planning region (11.3%).

It is interesting to note that Waldo County has, for Maine, the highest rate of admissions to mental hospitals and is high in draft rejection (46% of those being called are rejected due to poor health or low educational achievement). In addition, this county is lowest in Maine for sending students to college.

RECREATION

Excepting Rockland, Camden and Belfast, the Juvenile Delinquency Report cited no other municipalities maintaining organized recreation. As is the case throughout most of the planning region, recreational programs exist basically only in urban areas, leaving most rural areas without such leisure time alternatives.

POLITTCAL STRUCTURE

The Penobscot Bay Subregion includes 17 towns in Knox County, 3 towns in Lincoln County, and 15 towns in Waldo County. All municipalities except Rockland have selectmen governing them. Rockland is governed by a City Council and City Manager. All of the State Representatives of the subregion are Republican excepting one Democrat from Waldo County. The one senator from the subregion is also Republican. Lincoln County has 13,866 registered voters - 8,098 Republicans and 2,624 Democrats. Knox County has 17,022 registered voters - 8,572 Republicans and 3,893 Democrats. Waldo County has 13,625 registered voters - 6,862 Republicans and 3,569 registered Democrats.

VULNERABILITY

The subregion realized an increase of summer visitors in 1970 to the extent of 28,887 tourists. A good portion of these people were young. About 27% of the year-round population falls within the age range of 14-34. The extremely high percentage of young people, coupled with the recreational atmosphere of the coastal area, make for a vulnerable situation for drug abuse.

The lack of recreational alternatives, especially in the winter months leaves ample time for drug and alcohol experimentation and use. As is the situation in the Southern Mid-Coast Subregion, this subregion seems to be more vulnerable to alcohol abuse than drug abuse, especially as relates to the stable year-round popluation.

The unemployment problem is a socioeconomic one which should be considered when attempting to determine the vulnerability of the subregion to drug abuse.

PENOBSCOT BAY SUBREGION
Existing Resources

MID-COAST MENTAL HEALTH CENTER

The catchment area of the Mid-Coast Mental Health Center includes approximately 55,000 people from rural areas. The center operates for the following general purposes: 1) to increase and maintain the individual functioning of the citizenry to as close as possible to its optimum potential; 2) to decrease the incidence of mental and emotional illness in the catchment area. The services of the Mid-Coast Mental Center (MCMHC) include inpatient services,outpatient services, this includes two branch offices. The MCMHC fells that a drug abuse service should be added to its present spectrum of services.

KNOX COUNTY DRUG ABUSE COUNCIL

It is the philosophy of the Knox County Drug Abuse Council and its newly appointed director to provide alternative programming for youth. The Rockland Rap Center, a drop-in coffee house (a drug free area) is open seven days a week to make such alternatives possible. Both long-term and short-term individual counseling are available at the rap center. In addition, a group therapy session is now functioning for girls. Accurate drug information on a confidential basis is also offered.

The greatest shortcoming of the KCDAC is its defined service area and target population. The council will serve children from Knox County in Region III of the Department of Health and Welfare who are eligible recipients as indicated in the Bureau of Social Welfare guidelines. The service area of the council is much smaller than that of the Mid-Coast Mental Health Center, its closest and perhaps most necessary community affiliation. Lincoln County remains unserved in drug programming.

WALDO-KNOX COMMUNITY ALCOHOL SERVICES (CAS)

Staffed by a director, counselor, and counselor-aide, this agency offers training in dealing with alcohol abuse and alcoholism to various agencies in the two county area. It also provides direct services to low-income alcoholics and their families including case finding, individual counseling/family counseling/group therapy, and referrals to treatment faciliteis, all of which are out of the catchment area. The main office is in Belfast. In cooperation with KCDAC, this agency provides training in alcoholism and will be handling referrals for alcohol-related family problems.

CAS is committed to establish more direct services in the catchment area to facilitate comprehensive treatment. At present, it has a working agreement with Mid-Coast Mental Health Clinic, and is actively working toward closer coordination with hospitals and other social agencies. CAS is sponsored by the Waldo County Committee for Social Action, and works closely with Community Action Staff for outreach and supplementary services for clients. There are 45 families being served on an ongoing basis and this number will increase as a public aware of the program increases.

PENOBSCOT BAY SUBREGION
Service Needs

Many ofsthe defined needs in the Pen-Bay Subregion exist because of the lack of regional coordination and consequently reflict a regional need as much as they reflect singular needs among the subregion's agencies. In addition, the lack of a reliable data base is another regional shortcoming which should be kept in mind when considering gaps in service within the Subregion.

I. PREVENTION

A. Employment

Given the fact that drug abuse is a sympton of a deeper problem, or at least, of a more complex "uneasiness", then the issue of unemployment is most assuredly a contributing factor. With over 7.5% of the subregional population unemployed in 1972, there is an obvious need for :

1. Increased job opportunities.
2. Increased placement personnel.
3. In-service training for employment counselors so that potential drug abusers can be recognized as such and counseled appropriately.

B. Recreation

The need for organized recreational activities is evident in the Pen-Bay Subregion, especially in the more rural towns. Furthermore, alternatives programming is likewise missing. Indeed, there are some such programs available with the subregion, however, proper coordination of those recreational programs is lacking.

Coordination of existing resources is not the total answer. Many youth are not attracted to the more traditional sports-oriented recreation programs. Consequently, so called creative alternatives, e.g. pottery, photography, etc. should fill the gap of recreation possibilities.

C. Family

The MCMHC recognizes a need for a Parent Effectiveness Training Group within the subregion. Such a program would provide parents with information about and training in raising children. The ramifications of such a program are obvious: if successful it would gelp curb potential use of drugs through family solidarity, as well as provide parents with ways to approach and communicate with children who are already involved with drugs.

II. EDUCATION

A. Public

There is as much need to educate the public in drug use and abuse within this subregion, as there is elsewhere in the planning region. Although local groups play a vital part in public education, there is a greater need for regional, state and national participation to assist in that effort. Specifically, there is a need for greater educational use of television and other forms of the media in the process.

EDUCATION

Of the nine area superintendents, six returned the questionnaire. All but one of those indicated that their school systems do provide educational programming designed to affect student's attitude toward drug use and abuse. The most commonly employed approach is an informational one, although one district concentrates on value orientation and decision making.

Only one superintendent indicated that his district employs a uniform drug education policy, while most stated that they employ a uniform discipline policy relating to incidences of drug abuse. The responsibility for drug educational courses falls mostly on health education teachers. An integrated program is also popular where each instructor is responsible for relating his course of study to drug abuse. Drug education courses, in all cases but one, were developed by teachers who had received no training in drug abuse problems, but with the assistance of the State Department of Education in many cases. In all districts but one, the teachers are allowed to extend the priviledge of confidentiality to students. All superintendents cited the MCMHA as a referral agency fkr drug abuse cases of a severe degree, most districts offer some counseling by way of in-house guidance personnel.

PHYSICIANS

Twenty of the 45 physicians in the Penobscot Bay Study Area returned the questionnaire. Eleven physicians saw drugs as a definite probelm in the community in which they practice, but all but 3 of them believe that few persons with drug problems tend to seek help from physicians for their drug problems. There were three physicians who said that present state laws relating to treatment of minors does limit the effectiveness of treating youthful drug abusers.

As in other study areas, from the data available, several facts are hinted at. First of all, most physicians do feel there is a drug problem in their area. Secondly, those physicians state that, for whatever reason, drug abusers so not seek out the help of a physician. State laws relating to treatment of minors do not seem to be a barrier to the physician's ability to treat youthful drug abusers.

HOSPITALS

There are three hospitals in the Pen-Bay Area providing inpatient and emergency services which are occasionally utilized by the drug abuser. Knox County General Hospital serves Knox County and part of Lincoln and Waldo Counties; Camden Community Hospital serves Camden, Rockport, and Lincolnville; Waldo County General Hospital serves Waldo County. In addition, the Penobscot Bay Medical Center has received funding for the building of a Regional Medical Center for the Pen-Bay Area. It currently provide services to low income families and individuals through its clinics.

B. Schools

There is a need for a comprehensive policy and a consistent means of introducing such a policy to superintendents of the subregion. There is a need for a consistently implemented training program for teachers. Such an in-service program should deal not only with how to develop a curriculum for drug education, but also how to work with students who potentially might be, or are currently involved with drugs, alcohol included. The Maine Drug Education Program of the State Department of Education has done a considerable amount of work in this area. Indeed, their input and advise should be sought.

PENOBSCOT BAY SUBREGION
Action Agenda

The following recommendations constitute an action agenda, which when enacted, may serve to integrate presently faagemmted programs and services relative to drug use and thus put into motion a responsive and comprehensive delivery system.

RECOMMENDATIONS:

-That the Knox County Drug Abuse Council phase out its direct service program components while retaining its advocacy role relevant to youth involved with substance use and abuse.

-That at least one staff person, professionally capable of dealing with persons who have substance abuse problems, especially those funded and housed within the MCMHC. That staff person would have the KCDAC as a resource. ($15,000)

-That a 24 hour telephone service be funded and maintained by all sub-regional agencies involved in crisis intervention, and at least the MCMHC and the CAS.

-That detoxification facilities and appropriate manpower be made available via local hospitals and be ready to accept a person needing detoxification should the case arise.

-That the Community Alcohol Services and the Mid-Coast Mental Health Center combine forces in an attempt to provide educational workshops within the local schools. ($10,000)

-That a Parent Effectiveness Training Group be established and administered by the MCMHC. ($6,000 part-time trainer)

-That the possibility of opening local schools for summer recreational programs be investigated, and if possible, be carried out.

-That the City of Rockland Recreational Departemnt, working with other local agencies, should provide year-round recreational programs, aimed at all youth.

-That all agencies, which provide services geared toward the drug user, take on additional staff during the peak seasonal rise in population; e.g., a summer intern.

-That a regional coordinator, directed by a Regional Drug Abuse Council be consulted on the development of, and involved in, implementation of these recommendations.

SOUTHERN MAINE REGIONAL ACTION AGENDA

Two unanimously supported recommendations emerged from the planning process - the establishment of an areawide drug abuse council, and the establishment of a coordinative staff. When these recommendations are implemented, they will provide the major thrust in putting other regional and subregional recommendations into motion. The following recommendations constitute an "action agenda" which is geared toward the eventual resolution of those regional service needs which will be identified and discussed in the following sections.

RECOMMENDATIONS:

- That an areawide council be formed initially from those presently on the Ad Hoc Regional Drug Abuse Committee who express a desire to continue their involvement. It would be the responsibility of the council to assist in the implementation of this plan. The council would also be responsible for exercising the Review and Comment Process, relative to all new programs concerned with substance abuse within the region and would report their findings to the appropriate State authority. The council would have equitable representation from all four subregions by both professionals and citizens at large.
- That a regional coordinating staff be established. That staff would include a full-time regional coordinator, two full-time education specialists (one to serve rural areas, and one to serve urban areas), and any additional staff that may be needed. The council and staff will be financed by the Maine Commission of Drug Abuse with Southern Maine Comprehensive Health Association assuming fiscal administrative responsibility for no more than one year. The Regional Drug Abuse Council would assume the administrative responsibility of all activities and functions of the staff. The regional coordinator would assume primary responsibility for carrying out the mandates of the council. This would be done through the resourceful coordination of existing resources and the critical development of new programming.
  The education specialists would be the liasons between area programs, the community, and the State Resource Center (recommendation below). It would be the primary responsibility of the education specialists to see that the recommendations of the plan, relative to alcohol/drug education, be carried out. Special attention will be given to the regional need for a uniform discipline policy and curriculum.
- That the Regional Drug Abuse Council enter into formal discussion with the Southern Alcoholism Council, relative to:
  a) the necessary development of a strong and working relationship between the two councils;
  b) the desirability of joint, or closely located, offices for the respective staffs of the two councils; and,
  c) the justification for, and possibility of, combining these two councils under the singular, and more embracing problem - the area of Substance Abuse.
- That an ongoing, statewide data collection system be established to keep abreast of regional needs, and that such data be collected through the regional coordinator's office. This data should be used to insure

effective and responsive programming throughout the region.

- That the proposed State Drug/Alcohol Education Resource Center (to meet area information and training needs) be so developed, and that considerable input be provided by the office of the Southern Maine Coordinator.
- That an inservice training workshop in drug abuse for physicians, conducted by physicians, be developed by the education specialists in cooperation with the hospitals of the planning region.
- That full support be given to Drug Rehabilitation, Inc. (DRI), and that strong communication links be established between DRI and other human service agencies. It is further recommended that DRI be used for long-term or intensive treatment within the region and that all subregional programs serve as resources to DRI, as DRI will serve as a resource to them. The establishment of any other residential facilities within the region is not recommended at this time.
- That the areawide Drug Abuse Council seek representation on the State liscensing authority for residential drug abuse treatment facilities.

TRAINING AND PUBLIC INFORMATION

APPENDIX F

INTRODUCTION

Both the Information and the Training sections of the State Plan fall under the category of drug education. They represent the two basic components of education: knowledge and skills. These sections of the Plan will identify many of the resources and needs in the area of drug education. Each section will close with a comprehensive recommendation for meeting the needs identified by using available resources more effectively and by developing new resources economically.

Maine is a state with a large land area and a small population; this makes the delivery of services to the public somewhat difficult. Any plan to offer services must, therefore, build in means of overcoming this problem. Elsewhere in this Plan are data which suggest that the incidence and prevalence of documented drug abuse in Maine is relatively small. It follows logically that the focus of Maine's attack on the drug abuse problem must be on prevention and program evaluation, with a secondary emphasis on such areas as law enforcement, treatment and rehabilitation.

It is largely due to these factors that drug education in Maine has tended to have an identifiable character, or essence. Drug education in Maine may be characterized by the following statements:

1. The focus is on prevention.

2. Prevention is approached causally; through the identification of causes and the generation of alternatives based on available resources.

3. Drug abuse is seen as a behavior, the problem is a behavioral problem, and if preventive education is to be effective, it must, therefore, assist people to develop behavioral alternatives.

4. Prevention programs are most effective when they are developed locally and with the assistance of a cross-section of those who will be affected by the programs.

5. Schools, because of the time kids spend in them, have a major effect on the attitudes and behaviors the kids develop, and therefore may have a significant impact toward developing alternative attitudes and behaviors.

6. Training is the sine qua non of drug education.

7. Regionalization of services and development of local resources are necessary for the success of a statewide service program in Maine.

The recommendations in these sections will call for the creation of a drug abuse resource center and a training center. In each instance, the recommendations represent a continuation and expansion of the statements of the previous paragraph, rather than a radical shift of emphasis or direction. There would, however, be many changes in the efficiency and effective of Maine's drug education efforts. Problems and needs would be collectively identified, resources would be found developed and shared, and there would be a coordination of programs. All this would mean a greater responsiveness to local and individual needs and an increase in the effectiveness of primary prevention in Maine.

I. TRAINING

A. MAINE DRUG EDUCATION PROGRAM

The Maine Drug Education Program has been in operation for three years. Throughout this time, the MDEP has developed a comprehensive training program in drug abuse prevention.

The MDEP recognizes the futility of trying to scare young people into acceptable behavior, and has developed and promoted programs which affect the self-concept and problem solving abilities of youth. The National Drug Education Program of the U.S. Office of Education has published management objectives for FY '73 programs which reflect the philosophy the State of Maine has been operating from for three years.

> "The program purpose of the National Drug Education Program of the U.S. Office of Education is to bring about certain conditions in communities which are thought to relate to a reduction in drug abuse:
>
> Open communication among youth, parents and teachers.
>
> An availability of meaningful alternatives to the abuse of drugs.
>
> Potential abusers having a purpose in living and a feeling of control over their own lives.
>
> A willingness on the part of people to accept the validity of experimenting with alternative life styles not involving the abuse of drugs.
>
> A shift in immature individuals' value structures away from placing immediate gratification first and foremost.
>
> An improved perception of what the consequences of drug abuse are — physiological, psychological, social and legal."

During the first two years, the MDEP training program consisted of one week, live-in Leadership Training Institutes for community teams. Six workshops trained 66 community teams and a total of 450 people. One result of this training was a multiplier effect, whereby the teams, trained by the MDEP in skills for diagnosing problems and planning community action, trained additional community people who in turn created action programs.

During the past year, and as a result of lower funding, the MDEP, conducted no community team training. Instead, regional future planning conferences were held for teams already trained, and two pilot workshops for teachers were offered. The MDEP trained 60% of the staff and students at the Stevens School for Girls, a corrections institution, and members of the administration and staff of Augusta State Hospital. Follow-up conferences were held for each workshop.

During FY '74, the MDEP will conduct the following training:

1. Seven workshops for elementary teachers to train them to use the Human Development Program. This program focuses on children's skills in the areas of awareness, self-concept, and social interaction. Two workshops will be financed by local school districts and will be for all the elementary teachers in those districts. The others will be conducted in five different regions of the state and will be attended by teachers from a large number of school districts. Approximately 580 teachers and administrators will receive training.

2. Three to five one-day follow-up conferences will be held for those who attend the teacher workshops. The purpose will be to share problems and successes with the Human Development Program.

3. Training of trainers workshop. The MDEP will co-sponsor a workshop with the Department of Mental Health and Corrections in which trainers from N.I.M.H. will conduct training in the use of the Social Seminar Series within their communities. The workshop will be offered first to members of school/community teams trained by MDEP and to representatives from Mental Health and Corrections. A second phase of the Social Seminar Series will be the co-sponsorship of a one (1) day showcase for 75 school/community representatives from throughout the state.

4. Several days of follow-up will be conducted at Augusta State Hospital, where the MDEP sponsored training for administration and management this spring.

5. The MDEP has received requests for training from the New Brunswick Ministry of Youth and the Non-Medial Use of Drugs Directory of Canada. Exploration of this possibility and planning will take place this fall.

We recommend that the MDEP continue to function as a service and training resource for other programs, organizations, groups and individuals in the State. Its primary focus should remain with training and support of those trained, and it should continue to approach preventive education by attempting to respond to drug abuse at the causal level.

In addition, the MDEP should be adequately staffed and have the following responsibilities: provide initial input into proposals developed in the areas of training, information and education related to drug abuse; establish guidelines and policy and approve programs in these areas; conduct research into the effectiveness of its programs.

Our recommendations concerning curriculum follow the intent of the Second Report of the National Commission on Marijuana and Drug Abuse, which states,

> "In recognition of ignorance about the impact of drug education, the Commission recommends that policy makers should also seriously consider declaring a moratorium on all drug education programs in the

> schools, at least until programs already in operation have been evaluated and a coherent approach with realistic objectives has been developed."

Accordingly, we recommend that all drug education curricula and materials developed for use in Maine schools conform to guidelines established by the MDEP, and that they include evaluation procedures.

B. TEACHER EUDCATION

The role of the University of Maine in preparing individuals who will work in drug abuse programs or come in contact with drug abusing persons is minimal. A description of services follows:

1. Teacher Education

A summer course dealing with drugs, alcohol and tobacco was offered at the Orono Campus during the summers of 1971-1972 but it has been discontinued. Drug related information is included in Health Education courses; however, these courses are not a requirement for individuals preparing to be teachers. CSS.01 Drugs: Attitudes and Behavior

The University of Maine Portland-Gorham is offering a 45 hour program for teachers and others confronted with drug abuse and its related problems. The program is taught by a team of four professionals and stresses factual information, attitude identification, causes of drug abuse and individual and community response to the drug problem. The program incorporates a variety of teaching methods and group dynamic techniques in order to allow the participants both the informational and experiential background needed to understand the nature of the drug problem and what can be done about it.

The University offers a variety of courses in group dynamics, group interaction in the classroom and group counselling. These human relations courses are optional, and are probably not taken by a majority of teachers.

Each campus seems to have counsellors or other personnel who run various kinds of personal growth groups. These are very informal and not a part of the University program of studies and not necessarily viewed as an integral part of its counselling services. These groups would not be participated in by a majority of teachers.

2. University Counsellor Training Program

There are no programs in the counselling curriculum which prepare counsellors for dealing with drug abusing individuals.

The University of Maine's Counsellor Education Programs at the Portland-Gorham and Orono Campuses have a number of group guidance, group counselling and other courses which are human relations studies. These courses are required for counsellors who are seeking a Master's Degree in Guidance or a Certificate of Advanced Study in Guidance. The courses stress a balanced approach to using group work in the schools. This is particularly valuable in Maine, since few school systems permit personal growth sessions that are intensive or seen as sensitivity training to operate. Counsellors themselves are exposed to a number of group experiences in human relations training. The Maine Personnel and Guidance Association has sponsored a number of workshops in psychodrama, group dynamics and other human relations concepts for counsellors.

3. The University's eight campuses offer Continuing Education Courses for

adults which usually include courses in sociology and psychology, group dynamics and mental hygiene.

4. University Student Services

a. Drug Education Programs

No organized and continuing programs appear to exist.

b. Counselling services available to students.

Each campus has a system of student counselling services that is growing as a result of the recognition of the need for this service in recent years. Most of these people are highly trained Professionals and they are assisted by other Counsellors in dorms, etc.

We recommend that should the University develop programs in drug abuse, the proposed Manpower Training Center be utilized in the planning.

Mental Health Clinics in the State have been responsible for organizing human relations workshops for community people such as the Parent Effectiveness Training (P.E.T.) and Teacher Effectiveness Training (T.E.T.) courses. These courses stress active listening, empathy and other commu- skills as means of improving relationships between these target groups and young people. The Bangor Counselling Center is operating training sessions for trainers in P.E.T. and T.E.T. People being trained as trainers include social workers, Community Action workers, mental health center personnel, teachers, ministers, and school counsellors.

This training has no University degree credits attached, but we believe that the University should recommend this training as part of pre-service training in the helping professions.

C. TRANSCENDENTAL MEDITATION

We believe that Transcendental Meditation is one special training resource that should not be overlooked. It is being recognized and endorsed on an ever increasing scale. Two state legislatures, Michigan and Illinois, have taken official positions in support of TM, and New Hampshire's legislature is currently reviewing the program.

There is a tremendous amount of research on TM which consistently indicates positive effects. These findings have been reported in a wide range of publications including Scientific American, Journal of the American Medical Association, Science, Kentucky Law Journal, Yale Alumni Magazine, The American Journal of Physiology, and Phi Delta Kappan.

We recommend that the sole state agency conduct or appoint someone to conduct a study of the usefulness of TM in Maine. This study should include a review of literature; interviews with TM trainers and people who have received the training, and actual participation in the TM initiation program. The report should make recommendations to the sole state agency for action.

The following statement was developed by TM trainers and submitted for inclusion in the State Plan.

TM

The technique of Transcendental Meditation (TM) has been found to be an effective deterrent to drug abuse. The program does not involve drug education, or "don't do it" lectures. Rather it provides a technique which fulfills the quest of youth and humanity in unfolding full development of the personality.

Each person is seeking fulfillment, and wants to be happy. Society provides legitimate channels for achievement. Transcendental Meditation provides a technique so that each person may use full mental, emotional, and physical ability in all activity.

When a person is not able to fulfill his desires legitimately, then he may turn to illegal activity. TM provides a means of improving a person's mind so that any legitimate desire can be legally fulfilled.

Furthermore, the practice of TM will be found useful to all strata of society. This is not a program solely for deviates but enables a normal or even extraordinary person to increase his abilities. Thus, a deviate may be inspired by example as well as by education.

"Notwithstanding the simplicity of the practice, meditators unanimously report improvements in the energy and enthusiasm with which they approach their activities and in their clarity of mind, mental and physical health, and ability to interact harmoniously with their environment."[1] Thus, the technique provides increased competency while decreasing tension. One gains in both ways.

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[1]Paul Levine, "Transcendental Meditation and the Science of Creative Intelligence," Phi Delta Kappan, (December 1972) vol. 54, no. 4: p232.

The technique simultaneously effects mental and physiological changes. While the mind is engaged in an effortless practice, the body naturally settles down to a profound state of rest. This deep state of rest dissolves the stresses and strains that cloud the mind and impair the body. Anti-social and incompetent behavior is correlated with a stressed mind and, with deep rest, the body is normalized.

Scientific investigation has found that during the period of TM, oxygen consumption, carbon dioxide elimination, cardiac output, heart rate and respiratory rate significantly decrease. The metabolic rate is reduced by an average of 20%.[2]

Afterwards a person feels more relaxed, energetic, and clear-headed. Activity following mediation is enhanced by increased perceptual and motor abilities as well as a sense of increased energy and creativity. "The process is one of direct perception. The technique of TM is easily learned by anyone, regardless of intellectual ability or cultural background. No concentration, contemplation or mental or physical control is involved. No belief or faith is required for the practice to work. There are no moral tenets involved; TM is not a religion or a philosophy and there is no conflict with one's existing affiliations. No changes need be made in diet, posture or personal preferences."[3]

The basic TM program consists of 7 stages: an introductor lecture, a preparatory lecture, a personal interview and four consecutive days of instruction, for about 2 hours each day. A new meditator is requested to attend advanced meetings at least once a month for the first 2 years. TM is taught only by qualified teachers who have attended intensive training courses and have been certified to teach TM, having passed examinations.

Teacher-training courses are conducted by Maharishi International University (M.I.U.)[4] based in Los Angeles, California. MIU offers courses in the Science of Creative Intelligence (SCI) which are recommended for a deeper understanding of TM in its practical and theoretical aspects. TM is the systematic procedure for directly experiencing the nature, origin and development of Creative Intelligence.

A study of 1,862 subjects by R. K. Wallace and H. Benson reported in "Hearings Before the Select Committee on Crime, House of Representatives" stated that, "individuals who regularly practiced Transcendental Meditation a) decreased or stopped abusing drugs, b) decreased or stopped engaging in drug selling activity, and c) changed their attitudes in the direction of discouraging others from abusing drugs. The magnitude of these charges

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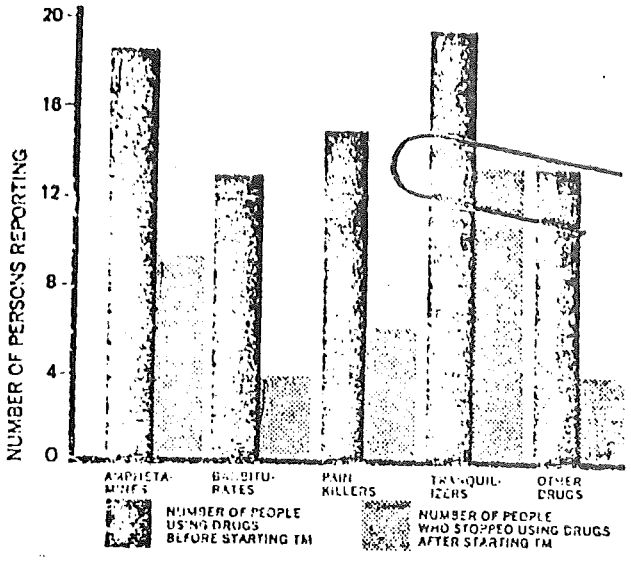
[2]R. Keith Wallace and Herbert Benson, "The Physiology of Meditation," Scientific American, (February 1972) vol. 226, no. 2 pp. 84-90

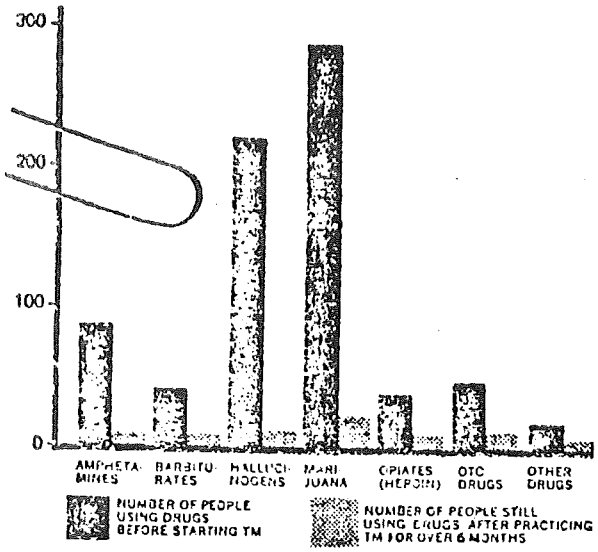
[3]Al E. Rubottom, "Transcendental Meditation and its Potential Uses for Schools," Social Education, (December 1972), p. 853.

[4]M.I. U. Administration Center, 1015 Gayley Avenue, Los Angeles, California, 90024, U.S.A.

REDUCED USE OF PRESCRIBED DRUGS



REDUCED USE OF NON-PRESCRIBED DRUGS



increased with the length of time that the individual practiced the technique. Similar decreases were noted in the use of 'hard' alcoholic beverages and cigarette smoking."[5]

The results of a study of 540 subjects by Leon Otis of Stanford Research Institute is shown in the charts.[6] There is a dramatic reduction in the use of non-prescribed drugs as well as in prescribed drugs.

The State of Illinois, House of Representatives passed House Resolution #677, May 24, 1972, endorsing the entire TM program. It reads in part:

> "Be it resolved that all educational institutions, especially those under State of Illinois jurisdiction, be strongly encouraged to study the feasibility of courses in Transcendental Meditation and the Science of Creative Intelligence (SCI) on their campuses and in their facilities; and be it further resolved, that the Department of Mental Health of the State of Illinois, Drug Abuse Section, be encouraged to study the benefits of T.M. and insofar as the Drug Abuse Section deems it to be practical and medically wise, to incorporate the course in T.M. in the drug abuse programs."[7]

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[5]Benson & Wallace, "Decreased Drug Abuse With Transcendental Meditation: A study of 1,862 Subjects, "Hearings Before the Select Committee on Crime, House of Representatives, 92nd Cong. 1st Sess., Ser 92-1 part 2 at 684 (1971).

[6]Stanford Research Institute, Menlo Park, California, study (Jan. 1972).

[7]"House Resolution No. 677," State of Illinois Seventy-Seventh General Assembly House of Representatives (May 24, 1972).

A sample of other endorsements follows:

> -"Transcendental Meditation is without question a non-chemical alternative to drug abuse."[8]
>
> -"We consider the Transcendental Meditation program a necessary ingredient to every drug abuse education effort seriously concerned with providing strong and useful alternative life styles for its participants."[9]
>
> -"I have followed their program since October of 1968 when I began meditating in accordance with their teaching. Frankly, I am enthusiastic about their program and its effects...(it operates) directly, measurably and significantly in opposition to drug abuse... (TM) should be carefully considered whenever drug abuse preventive and rehabilitative measures are implemented."[10]
>
> -"I unhesitatingly recommend Transcendental Meditation to people of all ages interested in bettering themselves and the world we live in."[11]

TM is being studied in 2 American prison systems, the La Tuna Federal Penitentiary in Texas and the Stillwater State Prison in Minnesota.[12]

Jack Forem in his excellent book, "Transcendental Meditation" writes:

> "Campaigning against drug abuse is like fighting the smoke instead of the fire. Happy, creative, productive people do not even think of using drugs. Therefore the answer to the "epidemic" of drug use lies in strengthening individual lives, in strengthening the personality of individuals so that drugs have no allure. A contented mind and heart would have no use for drugs. Rather than campaigning <u>against</u> drug use, we need to campaign <u>for</u> more whole, integrated personalities, for broadened awareness, for improved health and more relaxed, spontaneously loving, harmonious relationships. Then the question of drugs will never arise."[13]

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[8]Paul J. Andrews, Project Director, Drug Education, Commonwealth of Massachusetts, in a letter to Students International Meditation Society (February 14, 1972).

[9]Chris Merriam, Prevention Manager, Governor's Office of Drug Abuse, 311 Hollister Building, Lansing Michigan, 48913, in a letter, (June 29, 1971).

[10]Dale Warner, State Representative, House of Representatives, Lansing, Michigan, in a letter, (December 7, 1970).

[11]W.J. Murphy, Majority Leader, House of Representatives, Springfield, Ill., in a letter, (June 10, 1972).

[12]David E. Sykes, "Transcendental Meditation-as Applied to Criminal Justice Reform, Drug Rehabilitation and Society in General," <u>The University of Maryland Law Forum</u>, Vol. 3, no. 2 (Winter 1973).

[13]Jack Forem, "Transcendental Meditation," E.P. Dutton & Co., Inc., New York, 1973, p. 147.

The effects of Transcendental Meditation may be summarized as follows:

"Physiological: TM produces a deep state of restful alertness which rejuvenates and normalized the functioning of the nervous system.

"Psychological: TM eliminates mental stress, promotes clearer thinking and greater comprehension; it enriches perception, improves outlook and promotes efficiency and effectiveness in life.

"Sociological: TM eliminates tension and discord and promotes more harmonious and fulfilling interpersonal relationships, thus making every individual more useful to himself and others and bringing fulfillment to the purpose of society.

"The combined physiological, psychological and sociological changes produce an overall effect of fullness of life."[14]

For further information please contact the American Foundation for the Science of Creative Intelligence (AFSCI), Jonathan L. Miller, George C. Humphrey 11, Back River Road, Boothbay, Maine 04537, phone 207-633-2209, or Students International Meditation Society, (SIMS), 1015 Gayley Avenue, Los Angeles, California 90024, phone 213-478-1569.

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[14] "Scientific Research on Transcendental Meditation" (Los Angeles: M.I.U. Press, 1972).

D. TRAINING RECOMMENDATIONS

The data presented throughout this plan support the need for several kinds of training for several groups of people. There is a general need for traning and education to effect attitudinal change. This includes redefinitions of what the drug problem is, and especially, what it is in Maine. Claims by law enforcement, for instance, about the magnitude of the legal aspects of the drug problem are not substantiated by statistics. What is evident, however, is that when legislation and law enforcement in Maine accept the definitions and priorities of the national level, the result is contradiction, inequality and a lack of responsiveness to the needs of Maine citizens.

There is a need for technical/medial information and training for professionals and paraprofessionals, especially with reference to alcohol, diagnosis and referral.

Teachers and school administrators state needs in areas of drug curricula, policy development, and prevention skills.

In addition, there is a need for greater cooperation among groups faced with various aspects of the drug problem: schools and police, schools and community, medical and mental health.

Maine has resources to respond to many of these training needs, but there has been a lack of coordination of training which has resulted in duplication and inefficient use of these resources. Increased cooperation among groups needing training and among training resources would result in a more efficient and effective training model which could be replicated in states similar to Maine.

We recommend, therefore, that Maine implement a planning project which will result in the creation of a training center capable of meeting all drug training needs which have been or will be identified. The planning project would consist of the following phases:

Phase I

The planning project should be initiated with the creation of a full-time planning position. The Maine Drug Education Program (MDEP) is the most comprehensive training resource in the state. They have trained school, hospital and corrections institution staffs, and have created a statewide network of community teams composed of cross-section of professional and non-professional personnel. Therefore, we recommend that the training center planner be assigned to the MDEP.

The planner's initial task would be to become familiar with the training needs and resources in Maine. This would necessitate making contact with the various groups and agencies needing and providing training. As this were done, the planner would describe the planning process and the training center which would be the result of the planning. The planner would solicit commitments for planning assistance from the groups contacted.

Phase II

The next phase of the planning process would result in the preparation of a preliminary narrative of the purposes and functions of the training center.

To do this, the planner would conduct planning meetings, conferences, surveys, etc., in cooperation with the representatives of the agencies identified in the first phase of planning. This planning group would be responsible for describing all aspects of the training center. The following are some of the areas which would be defined and some alternatives for action within each area.

Trainig Center Objectives

- Development of a new, replicable model for statewide training.
- Creation of a variety of training formats.
- Reduction of duplication of planning, training and evaluation efforts.
- Increased cost/effectiveness ratio through sharing of resources.
- Capability of "think tank" planning between and among several agencies.
- Uniqueness of plan joined with wide variety of support (Depts., agencies, etc.) Increases the potential for fund-raising.
- Ability to develop specialized training to meet particular needs.
- Increased number of local people capable of training through training of trainers and apprenticeship programs.
- Development of training materials which could be distributed and/or marketed.
- Evaluation data on program effectiveness.
- Groups and individuals throughout Maine who have received training, skills, and information relevant to their personal and professional needs.

Training Program Formats

A training center could offer varied curriculum of programs. The following are some alternatives for training formats.

1. The training program might consist of one, large model (4 to 6 weeks, e.g.) which could be repeated throughout the year. The program would be comprehensive in its approach to drug abuse, and would be composed of many discrete but related modules lasting from one to five days. Individuals and groups could elect to complete the whole cycle, or any part or parts, according to their needs.

2. The program could include two formats similar to the one described above. The distinction might be medical-non medical, professional-non professional or other. The two tracks could run concurrently and come together at times to receive combined training and to share information.

3. Several shorter, more specific models could be developed and offered sequentially. The protocols for these programs could be tailored to the target groups they are intended for (police, teachers, mental health, etc.) or could be developed as skill clusters (counseling, drug

curricula, crisis intervention).

4. Training of trainer programs could be conducted regardless of the form the training takes. Trainees could be participants in the other programs offered in the center, could receive special workshops in training skills, and could serve as assistants, apprentices or co-trainers with the training staff. This would generate additional local training resources which would both reduce the operating cost of the training center and increase its potential for programs.

Content of Training

The training center staff would create a bank of information, processes, workshop formats, training materials and resource people which could then be drawn upon to design training content. Most of these resources could be available from a clearinghouse.

The training staff could be trained to conduct programs already developed and found effective, e.g., the Social Seminar, the Human Development Program, and Parent Effectiveness Training.

In addition, the staff would be able to design workshops which could meet special needs of groups requesting training.

Organizational Placement

The organizational placement of the training center could have a critical impact on its effectiveness. This would be a matter of high priority in the examination of the practicability of establishing a training center. A planning group would have to consider many alternatives for placement, and ask the following questions about each: What would be the effects of the center placement regarding interagency cooperation, bureaucratic restrictions, staff, support services, availability of financial support and entry to the target groups? Would it be possible to create a unique status for the center and design its relationship to the existing structures? Could the center be completely independent, e.g., a private, non-profit organization?

Interagency Cooperation

One of the objectives of the training center would be to reduce duplication of effort and increase effectiveness of training conducted by various agencies within Maine. This could occur if the center were planned and supported cooperatively by some or all of the agencies now doing training. Training formats, carefully designed, could meet the needs of more than one agency. Some agencies already have developed programs which could be used by the center and/or adapted with little additional planning effort. Depending on the organizational placement of the center, some agency personnel might function as training or administrative staff.

Staff

A factor that often prevents plans such as this from being implemented is the cost and difficulty of staffing. With some creative uses of people, these negative factors could be minimized. The permanent staff should be as small as possible. Priority should be given to those people who could perform more

than one function within the center. In addition to a small, salaried staff, people could be "borrowed" from cooperating agencies. Staff trade-offs could be made with other programs in or outside of Maine. It would be necessary to have an adjunct staff to design and train. These people could be contracted by the job. A free training resource would be available through apprentice or intern training programs.

Evaluation

Evaluation of all aspects of the training program should be continuous and used both formatively, to improve the training program, and summatively, to demonstrate the program's results to others. By having evaluation of several training formats conducted by the center, comparative data could be collected which would be valuable to the center staff and which would be unique research. If the research were of high quality (consultants could be contracted to ensure this), the uniqueness of the project would increase the likelihood of its being published.

Funding

This project would be developed with the assumption that costs are reduced by coordination, cooperation, and sharing of resources. Some of the ways this could be done have already been mentioned (creative staffing, use of the clearinghouse). Additional sources for funds would have to be found once the budget were completed. Some potential sources would be the cooperating agencies, the Maine Legislature, USOE, NIMH, SAODAP, private foundations, organizations and individuals requesting training, and staff development monies from state agencies. Obviously, if we were able to demonstrate the effectiveness of the program through evaluation, continued funding would be less problematic.

Phase II would be completed when the report of the planning group was submitted to the sole state agency for approval.

Phase III

Following approval of the training center plan, the planner would coordinate the development of a plan for implementation of the training center. The planning group would make at least two contingency plans, one for minimal and one for maximal funding. The implementation plans would be detailed and complete, and would be submitted to the sole state agency for approval.

Phase IV

This is the funding phase. The planning group would make the decisions and take necessary action to secure money to make the training center operational. These actions might include transfers of funds from participating agencies, requesting legislative appropriations, development of funding proposals to obtain federal money.

Phase V

Once the funds were raised, the final phase of implementation would begin. Training center positions would be created and filled in accordance with the implementation plan. Initial staff would at least include a training center

director, a planner/evaluator, a training coordinator and support personnel. The training center staff would follow the implementation plan in planning the first year training program and making all arrangements necessary to begin training. This phase, and the planning project itself, would end when the training center became operational.

Constraints

This planning project will be faced with several challenges and potential constraints and, it will be the task of the planner and the planning group to develop contingency plans for meeting these. Some of the difficulties and alternatives have been suggested in Phase II, above.

One of the initial problems will be the establishment of interdepartmental cooperation for planning and support of the training center. One advantage of the placement of the planner in the MDEP office will be that the MDEP has a history of jointly planned and jointly funded training programs. It also seems that an era of greater cooperation among state agencies may be beginning, which will decrease the impact of this constraint. Project Tri-Plan is an example, in which Education, Health and Welfare and Mental Health and Corrections are cooperating to fund and implement a program of screening and diagnosis of learning disabilities among children.

A second major constraint could be a lack of available funds. We cannot assume any firm level of funding, and it is because of this that the plan calls for at least two implementation alternatives. We believe that by including representatives from participating agencies at the very first stages of planning, we would be encouraging the agencies to feel a sense of ownership in the program, and that this would increase their willingness to provide financial support for the training center.

If it happens that the training center is forced to go into operation with only minimal funds, this plan can be adapted to operate under that constraint. At the very lowest level of funding, no additional staff would be hired to implement the training program. Instead, the planner could function as a coordinator of training programs being conducted by other agencies. In this way, the planner could encourage cooperation and sharing of resources among groups conducting training, while continuing to seek funds to implement the training center.

Major Events Time Line

2/1/74 Training Center Planner position filled

3/1/74 Resource assessment completed and commitments for planning assistance obtained

6/1/74 Preliminary training center description submitted to sole stage agency for approval

8/1/74 Implementation plans completed

10/1/74 Funding phase completed; implementation alternative selected

12/1/74 Training center positions filled
1/1/75 1st year training program design completed
1/1/75 Beginning of training program

E. CRIMINAL JUSTICE SYSTEM

Goal 1. Elimination of the traffic of illegal drugs through the apprehension of the seller who may or may not be addicted.

The Maine Criminal Justice Academy offers two week and three day Drug Schools for law enforcement personnel taught by agents of the Federal Bureau of Narcotics and Dangerous Drugs. The courses focus on drug identification, laws of search and seizure, undercover techniques, and other enforcement related areas, and are offered throughout the nation.

Recommendation: We recommend that this training be continued as a necessary part of enforcement of drug laws. However, we fear that BNDD training is too urban oriented, and that persons completing the training may be more aware of enforcement techniques with hard-core heroin addicts, while the reality in Maine will require them to deal with a high school student experimenting with marijuana. A copy of the BNDD curriculum is attached.

Data collected through the state plan indicates a low evidence of drug abuse and drug addiction in Maine. We question the applicability of a nationally developed training program to the needs in Maine. We recommend that the sole state authority on drug abuse and the Maine Law Enforcement Planning and Assistance Agency conduct a survey of a sample of persons within the criminal justice system with the following objectives:

1.) Assessment of the nature of the individual's contact with the drug problem.

2.) Knowledge and skills which are requisite to the performance of his job during that contact.

3.) An evaluation of the applicability of the Criminal Justice Acedemy's BNDD program to the individuals needs.

Should the survey identify any discrepancies between the field needs and the BNDD program, the survey can be used as a resource in developing courses to eliminate the discrepancies.

Goal 2. Increased community awareness through public education of the unlawfulness and personal danger involved in drug use and abuse.

Goal 3. Development of a relationship between the Criminal Justice System and other social services to provide proper treatment of drug dependent or drug abusing persons either before or in lieu of incarceration.

The State of Maine relies heavily on training resources out of state in training juvenile officers. The Mott Institute in Minnesota and the Delinquency Control Institute in California are the primary resources for police training.

Other juvenile workers in the Criminal Justice field receive training within their own specialty and out of state. There is no effort to coordinate this training, and the LEAA is the only agency in Maine with funding for this type of training.

Goal 3. Maine Law Enforcement Planning and Assistance Agency and the Youth Services Coordination Agency are developing a proposal to create a Delinquency Control Institute in Maine. The institute will be modeled after the Delinquency Control Institute in California and the Mott Institute in Minnesota, but will draw on Maine resources and expand its focus to include all persons within the Criminal Justice System who work with youth.

We recommend that this Institute be developed in conjunction with the University of Maine, LEAA, and the Criminal Justice Academy. Funding for this training resource center will be drawn from the variety of agencies it serves - Department of Mental Health and Corrections, LEAA, and the University of Maine.

We recommend that the DCI draw on the expertise available in Maine and New England, and develop programs to meet these training needs.

I. Drugs and Youth Component in the Residential Juvenile Delinquency Program.

The Residential Program will include juvenile police officers, probation and parole officers, court officials, half-way house and group home staffs institution staffs, and others within the Criminal Justice System who work with youth. The focus of the Drugs and Youth component should be on the youth in trouble -- his motivations, pressures, needs, the effects his drug abusing behavior can have on him -- and on the youth worker as a helper -- what is the goal of his contact with the youth, how can the goal be achieved, what is a helpful relationship. Communication skills should be taught, along with resource identification -- based on the kind of problem this young person has, who else can help me with him. Drug identification can also be useful to the youth worker in crises intervention.

The Residential Juvenile Delinquency Program should emphasize an understanding of human behavior, particularly in the component on drugs, a self-destructive behavior. Of importance in the area of drug abusing behavior is an understanding of alienation, changes in values, breakup in traditional family structures, and behavior patterns of persons in trouble.

The entire Residential Juvenile Delinquency Program should be flexible to meet the particular needs of each participating role group.

II. Delinquency Control Program at the Criminal Justice Academy

Many law enforcement officers can expect to deal with the problem of a young person in possession of or under the influence of drugs sometime during his career. Most will at least respond to a situation involving young people. The Delinquency Control Institute should design a shortened curriculum on Drugs and Youth to be included in the Criminal Justice Academy basic training program as a requirement.

This program should also be available at the Academy for police retraining and to local police departments for regional workshops.

III. Community Caretakers Program

The new emphasis in law enforcement is on integration of law enforcement

and the social services. DCI should develop a team of individuals and a curriculum to conduct community workshops on Drugs and Youth designed to identify youth problems and the responsibility of the total community and youth services as requiring the commitment and expertise of all agencies. The program will help these individuals working with youth to establish common goals and to develop ways of meshing their services into a community wide youth service bureau.

IV. University of Maine Criminal Justice Program.

DCI should develop a mini-course on Drugs and Youth for inclusion into the curricula of the Criminal Justice degree programs at all the campuses of the University. Further, individuals working for a degree in Criminal Justice who wish to specialize in juvenile delinquency should be required to attend the DCI Residential Juvenile Delinquency Program.

V. Community Service Agency Drug Programs.

Local Police Departments, the County Sheriff's Office and the State Police receive a number of requests from community groups such as the PTA, the Lions Club, etc. for drug lectures. DCI should develop a program available to the whole state to relieve this time and manpower burden and to ensure an accurate program of drug information and youth behavior.

frustration voiced by the media over the lack of good programs, advertisements and stories for them to use. The Maine Times aked that someone "let us know when something happens that isn't the same old circular movement... We don't try to sucker merchants into paying for such ads as, "National Heroin Prevention Week."

We recommend that the proposed Resource Center for Drug Abuse Information assist news media in Maine in developing good programs, advertisements and articles on the drug problem, and that ads like those developed by the New England Braodcasters Association stressing the need for more family activities be used.

RESOURCE CENTER ON DRUG ABUSE RECOMMENDATIONS

Resources and materials on drugs and drug abusing persons are scattered in a number of agencies in Maine. The University of Maine and the Department of Educational and Cultural Services maintain film libraries, the Maine Commission on Drug Abuse, the State Police, the Maine Drug Education Program, and a number of service organizations have pamphlets, books and speakers available.

This diversity prevents a careful review of materials available to the public to assure current and accurate drug information. Also, individuals seeking information may not be able to locate the most relevant information since they must rely on the materials the source they choose has on hand.

Further, the sole state authority advocates a human behavior approach to drug education as the most meaningful. The chance of this philosophy filtering through these many sources to the people is minimal, since each source supports its own perspective and bias.

The groups responsible for regional plan development have all identified the need for a central, coordinated source of information on drugs and drug abusing persons.

We therefore recommend the development of a Resource Center on Drug Abuse and Human Bahavior to provide an accessible and coordinated source of information. Programs in drug abuse will be improved by the Resource Center, which will offer a clearer perspective on the drug problem as it relates to all human problems. The Center will give individuals assistance in identifying the best resource materials, and will bring individuals and programs designed to assist present or potential drug abusers in closer touch with each other.

We propose that the functions of the Resource Center include, but not be limited to the functions mandated in P.L. 566, relating to Alcoholism, Intoxication and Drug Abuse Prevention, Treatment and Rehabilitation. P.L. 566 states that the Office of Alcoholism and Drug Abuse Prevention shall develop and maintain an up-to-date information system related to drugs, drug abuse and drug abuse prevention which will be responsible for:

A. Collecting, maintaining and disseminating such knowledge, data and statistics related to drugs, drug abuse and drug abuse prevention as will enable the office to fulfill its responsibilities;

B. Maintaining an inventory of the types and quantity of drug abuse prevention

II. PUBLIC INFORMATION

A. MAINE DRUG EDUCATION PROGRAM

The Maine Drug Education Program (MDEP) has been the state agency charged with providing schools and the public with information on drug abuse. Requests for information from the MDEP have been steadily increasing and generally fall into the following categories: drugs and their effects, causes of drug-related behavior, curriculum guides, guidelines, resources, films, materials relating to policy, affective education and problem solving.

In response to these requests, the MDEP distributes: materials which have been collected and evaluated, films and a film catalog, training materials, curriculum guidelines and sample curricula, and a policy guide for school administrators. MDEP staff visit groups to make presentations, answer questions and assist with planning.

We recommend that the MDEP continue to meet needs for materials and guidelines until the Resource Center is in operation, at which time that Center would assume these functions.

COMMINITY EDUCATION

The sole agency in Maine having community education about drugs as a goal is the Maine Drug Education Program, described in the previous section.

The teams trained by the MDEP are, at this time, from one to two and one-half year old. Some of these voluntary associations have disbanded or become non-operational as a unit. However, there is considerable evidence of individual effots by team members to work within their professional roles to help drug abusers and other youths. These individual activities are taking place in classrooms, through extracurricular activities, as well as in the home and throughout the community.

Teams that are still active have been involved in a variety of activities from coffee houses to adult education courses. They initiate many community activities designed to deal with the causes of drug abuse including recreational programs and youth service programs.

Maine people have been trained at the Yale University Drug Dependence Institute (D.D.I.), which, like the MDEP, advocates community action to meet community responsibility for the problems of its youth. A number of teams have been trained and several community education and youth advocacy programs have resulted.

The data collected through survey of Maine newspapers, radio and television stations, indicates that these media services consider community education about drugs their responsibility. The Portland Press Herald states there is a "continued need to reach younger people in schools" with drug education. WLAM-Radio, in Lewiston, reports a need to offer information on what help is available for people with drug abuse problems. There was considerable

facilities, programs and services available or provided under public or private auspices to drug addicts, drug abusers and drug dependent persons, especially alcoholics and intoxicated persons. This function shall include the unduplicated count, location and characteristics of people receiving treatment, as well as their frequency of admission and readmission and frequency and duration of treatment. The inventory shall include the amount, type and source of resources for drug abuse prevention.

The Resource Center staff will be involved in a number of activities which will include providing technical assistance to community programs, recommending school drug curricula and media advertisements and operating a speakers bureau.

ORGANIZATIONAL PLACEMENT

It is recommended that the Resource Center be located within the Department of Educational and Cultural Services because of that Department's commitment to the educational needs of Maine's youth, and its experience in providing drug information.

INTERAGENCY COOPERATION

The Resource Center will be located in the Department of Educational and Cultural Services and will also be responsible to the sole state authority on drug abuse within the Department of Health and Welfare. The services of the Resource Center will be available to any individual group or agency in Maine. We feel that this cooperative direction and use of the Resource Center will reduce duplication of effort and promote openness and mutual aid among those working in drug abuse programs.

STAFF

We recommend an immediate search for staff for the Resource Center, and see the need for one professional person, one secretary, and one clerk during the Initial Implementation Phase. Additional staff may be added at any time to fulfill the responsibilities give to the Resource Center by the Sole State Agency.

EVALUATION

Evaluation of all the services of the Resource Center should be continuous, and will be conducted by the Department of Educational and Cultural Services and the sole state authority on drug abuse in Department of Health and Welfare. The Resource Center staff will be responsible for evaluating all films and materials to assure they are consistent with new research and trends.

FUNDING

The sole state authority on drug abuse in Department of Health and Welfare will be responsible for fund raising and proposal development to assure the Resource Center of adequate funds to implement its service goals.

APPENDIX G

Questionnaires

Drug Abuse Planning Project Survey

Correct errors on label

1. Agency Contact _____ Tel. _____

2. Type of Agency:

☐ Public ☐ Private ☐ Voluntary ☐ Other _____

3. List the Names and Populations (1970) of the Communities in your Service Area. (attach outline or a map if available).

4. Describe (briefly) Drug Abuse Service (s) available by your agency in:

   a) Prevention & Education

   b) Treatment

   c) Rehabilitation

   d) Aftercare

5. Describe briefly your agency facilities for dealing with problems of drug abuse relating to:

   a) Prevention & Education

   b) Treatment

c) Rehabilitation

d) Aftercare

6. Please describe the location of your facility.

☐ Urban ☐ Rural ☐ Other_____.

7. Is this facility in operation?

☐ Fulltime ☐ Part time ☐ Seasonally_____.

8. How adequately does your present staff/program meet the demand for drug abuse services?

9. If your clients need a service your agency is unable to provide, to whom do you refer them?

10. Without duplicating available services, what new or expansion of present services should be added?

11. In your opinion which of the following programs need greater development in your service area? _____Education____Prevention ____Treatment____Rehabilitation____Law Enforcement____Aftercare.

BUSINESS SUPPLEMENT (1972)

1. How many full time persons does your organization employ?

2. Can you estimate the number of full time employees in your organization who have had a drug problem that has come to your attention in the last year?

   Specify number in each category.

   1. Alcohol_____
   2. Marijuana____
   3. Depressants____
   4. Amphetamine____
   5. Narcotics____
   6. Other (please specify)____

   7. Drug unknown____

3. How are these handled?

   _____Counseling (in house)

   _____Refer. to a helping agency

   _____No action

   _____Through police

   _____Clergy for counseling

   _____Other (please specify)

4. How many of the above people are not now employed as a result of their alcohol or drug problem?

5. Does your organization have a drug education program or does it provide your employees with information on the subject? If so please describe briefly.

   a) If not, would your firm be interested in such a program? ____yes ____no ____don't know

HOSPITAL SUPPLEMENT

For the calander year 1972 (January through December.)

1. State the total number of admissions (emergency & general hospital) in the year 1972. _____

2. State the number of patients seen in your hospital during 1972 with either primary or secondary drug problems by filling in the following charts.

Primary Drug Problem

	EMERGENCY ROOM ADMISSIONS									
AGE	0-14		15-17		18-25		26-35		35-above	
SEX	M	F	M	F	M	F	M	F	M	F
1. Narcotics										
2. Barbituates										
3. Amphetamines										
4. Hallucinogens										
5. Marijuana										
6. Alcohol										
7. Cocaine										
8. Other										

Secondary Drug Problem

	EMERGENCY ROOM ADMISSIONS									
AGE	0-14		15-17		18-25		26-35		35-above	
SEX	M	F	M	F	M	F	M	F	M	F
1. Narcotics										
2. Barbituates										
3. Amphetamines										
4. Hallucinogens										
5. Marijuana										
6. Alcohol										
7. Cocaine										
8. Other										

Primary Drug Problem

	GENERAL HOSPITAL ADMISSION									
AGE	0-14		15-17		18-25		26-35		35-above	
SEX	M	F	M	F	M	F	M	F	M	F
1. Narcotics										
2. Barbituates										
3. Amphetamines										
4. Hallucinogens										
5. Marijuana										
6. Alcohol										
7. Cocaine										
8. Other										

Secondary Drug Problem

	GENERAL HOSPITAL ADMISSION									
AGE	0-14		15-17		18-25		26-35		35-above	
SEX	M	F	M	F	M	F	M	F	M	F
1. Narcotics										
2. Barbituates										
3. Amphetamines										
4. Hallucinogens										
5. Marijuana										
6. Alcohol										
7. Cocaine										
8. Other										

3. Are these cases actual? _____Yes_____No

4. Do you use the "Problem Appriasal Scale" available via the State Dept. of Mental Health and Corrections?

a) _____yes_____no

b) If so, do you find it useful?____yes___ no____don't know.

LAW ENFORCEMENT AGENCY SUPPLEMENT

For calendar year 1972 (January through December)

1. What was the total (including drugs) number of arrests in the year 1972?_____(including juveniles)

2. Number of arrests relating to:

	1972			
	Juvenile		Adult	
	M	F	M	F
a) Narcotics				
b) Barbituates				
c) Amphetamines				
d) Hallucinogens				
e) Marijuana				
f) Alcohol				
g) Inhalants				
h) Other				

3. Can you estimate the number of these cases that were:

a) _____ Misdemeanors
(actual or estimate)

b) _____ Cases not prosecuted
(actual or estimate)

MENTAL HEALTH CENTERS SUPPLEMENT

For calander year 1972 (January through December)

1. State the number of cases in the following services:

a) Are these cases actual? ____Yes ____No

	INPATIENT								OUTPATIENT							
	Primary Drug Problem				Secondary Problem				Primary Drug Problem				Secondary Problem			
	Juve.		Adult		Juve.		Adult		Juve.		Adult		Juve.		Adult	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. Narcotics																
2. Barbituates																
3. Amphetamines																
4. Hallucinogens																
5. Marijuana																
6. Alcohol																
7. Other																
8. Cocaine																

2. What is the accumulative number of visits for 1972?

_____Inpatient _____Outpatient

3. In the above data, how many incidences found within the following age groups?

	0-14	15-17	18-25	26-35	35-above
1. Narcotics					
2. Barbituates					
3. Amphetamines					
4. Hallucinogens					
5. Marijuana					
6. Alcohol					
7. Cocaine					
8. Other					

3. Do you use the "Problem Appraisal Scale" available via the State Dept. of Mental Health and Corrections?

a)_____yes____no

b) If so, do you find it useful?____yes____no____don't know.

HUMAN SERVICE AGENCIES (including Rap Centers/Drop In Program)
SUPPLEMENT

for calander year 1972 (January through December)

1. State the number of cases in the following services:

a) Are these cases actual? _____Yes ____No

	Primary Drug Problem			Secondary Problem		
	Seen	Counseled *	Refrd	Seen	Counseled *	Refrd
1. Narcotics						
2. Barbituates						
3. Amphetamines						
4. Hallucinogen						
5. Marijuana						
6. Alcohol						
7. Cocaine						
8. Other						

2. In the above data, how many incidences found within the following age groups?

	0-14	15-17	18-25	26-35	35-above
1. Narcotics					
2. Barbituates					
3. Amphetamines					
4. Halluciogens					
5. Marijuana					
6. Alcohol					
7. Cocaine					
8. Other					

3. Do you use the "Problem Appriasal Scale" available via the State Dept. of Mental Health and Corrections?

a)_____yes____no

b) If so, do you find it useful?____yes____no____don't know.

4. How many cases have you seen through your agency in 1972?_____

* Includes phone counseling

Educational Supplement Statistics 1972

1. Does the public school system in your jurisdiction provide any educational program designed to affect student's attitudes toward drug use and abuse?

   YES_____ NO_____

2. What is your annual local budget for drug abuse education?

   $_____

   a) Office of Education $_____

   b) Other (please specify)

   _____ $_____

3. What best describes the educational approach used in your schools? (Check all applicable)

   _____Value orientation _____Psycho-social orientation

   _____Decision making

   _____Problem solving

   _____Information

   Does the public school in your jurisdiction have a uniform drug education policy? _____YES_____NO

   Does the public school in your jurisdiction have a uniform drug policy relating to discipline incidences of drug abuse.

   _____Yes_____No

   If so, please include a copy of that policy.

4. Are drug education courses required by your local school board?_____YES_____NO

5. Who in the school system has responsibility for programming drug educational courses? (Check all applicable)

   _____Classroom teacher

   _____Health or physical education teacher

   _____Guidance counselor

   _____Program is integrated: each instructor is responsible for relating course of study to drug abuse.

6. How is information on drugs usually presented?(Check all applicabl

_____Standardized curricula _____Films and audiovisuals

_____Assemblies _____Student initiated research

_____Lectures by experts _____Group discussions(Small)

_____Ex-addict talks

7. Are teachers who are responsible for drug education courses trained? _____YES _____NO

If YES,
1. Who finances the training?_____
2. How long is the intial training period? (State in weeks)

_____
3. How often are refresher coursed required? (Check one)
_____every month
_____every 6 months
_____every year
_____other (specify)_____

8. Do students actively participate in formulating drug related school policies and educational programming?_____YES_____NO

9. At what grade level is cur ' \lum introduced?_____

10. What is the average number of hours per week per student devoted to drug related curriculum?_____

11. What sources are utilized for course materials?(Check all applicable).

_____State Dept. of Education _____Teachers develop their own
_____Publisher _____Commercial firm

What is the ratio of counselors to students?_____to_____

Are teachers allowed to extend the privilege of confidentiality to students?_____YES_____NO

Do counselors normally make referrals in acute cases?_____YES
_____NO

12. Are there education/prevention programs outside the public school system?_____YES_____NO

Who conducts the programs?_____

Please feel free to offer any general comments you may wish. Areas of interest might include but are not limited to:

a) level of satisfaction with your city's response to the drug abuse problem,
b) areas of response most in need of improvement.

PHYSICIANS SUPPLEMENT

1. In your opinion has the abuse of drugs become a problem in the community in which you practice?

_____Yes _____No _____Not Aware

2. In your best judgement, which of the following drug categories is a problem in your community, please check by type and age group.

	School Age	Young Adult	45-65	Over 65
1. Narcotics				
2. Barbituates				
3. Amphetamines				
4. Hallucinogens				
5. Alcohol				
6. Inhalants				
7. Marijuana				
8. Other				

3. Do persons with these above problems tend to seek help from physicians?

_____Few _____Many _____Don't Know

4. Has there been an increase in the number of persons with drug problems seeking help from you in the past two years?

_____Yes _____No

5. In your opinion, does optimal treatment of such persons frequently include use of community resources such as drug abuse Rap Centers?

_____Yes _____No

6. Please list any such resources which are available in your community, and indicate to which you have referred patients.

7. Do present State laws relating to treatment of <u>minors</u> (under 18 years of age) limit the effectiveness of treating youthful drug abusers?

_____YES _____NO

8. Do present Food and Drug Administration regulations relating to treatment limit a physician's effectiveness in treating drug abuse problems?

_____ YES _____NO

a) If so, how?

b) Were you requested or did you prescribe any methadone maintenace and/or withdrawal for the year 1972?

_____YES, see breakdown in following chart. _____NO

	MAINTENANCE		WITHDRAWAL	
	Requested	Prescribed	Requested	Prescribed
Jan-Mar				
April-June				
July-Sept				
Oct-Dec.				

9. Are the abuse of opiates or synthetic narcotics a contributing factor to other physical condition such as hepatitis, VD, etc. observed in your practice?

_____YES, during 1972, see breakdown in following chart.

_____NO OTHER_____

	Jan.-Mar.	Apr.-June	July-Sept.	Oct.-Dec.
Male				
Female				

10. How many people with suicidal tendency (apparently related to alcohol and drugs) have you been called upon to treat during the past year?

	0-17Yrs.		18Yrs.-over	
	M	F	M	F
Alcohol				
Drugs				

11. From your direct knowledge we need specific information regarding those who take alcohol and drugs simultaneously.

a) WHICH ABUSE IS MOST PREVALENT AMONG YOUR PATIENTS?
   1. Alcohol - alone
   2. Drugs - alone
   3. Alcohol with Drugs

b) HOW MANY ARE TREATED AS FOLLOWS?
   1. Hospitalization
   2. Outpatient
   3. Halfway House

AGE:	0-14		15-17		18-25		26-35		36+	
SEX:	M	F	M	F	M	F	M	F	M	F

12. In your opinion, do adequate educational programs exist regarding drug abuse?

13. Your comments on any and all of these questions will be of great value to us.

14. What is your speciality?_____

15. (optional)_____
(Signature)

16. City or Town of practice._____

DEFINITIONS

DRUG:

"Any chemical that modifies the function of living tissue, resulting in physiologic or behavioral changes."**

DRUG USE:

"Where the effects of a drug sought can be realized with minimal hazard, whether or not used therapeutically, legally, or as prescribed by a physician."**

DRUG ABUSE:

"Where drugs are taken or administered under circumstances and at doses that significiantly increase their hazard potential, whether or not used therapeutically legally, or as prescribed by a physician."**

PSYCHOLOGIC DEPENDENCE:

"A tendency or craving for the repea[illegible] or compulsive use (not necessarily abuse) of an agent because its effects are deemed pleasurable or satisfying, e.g. drugs, food, or as with TV watching, skiing or relationship to another person."**

PHYSICAL DEPENDENCE:

"Dependence of the body tissues on the continued presence of a drug (even in the absence of psychologic dependence), revealed by disturbing or life threatening withdrawal sysptoms that develop when the drug is discontinued."**

DRUG TOLERANCE:

"Development of body or tissue resistance to the effects of a drug so that larger doses are required to reproduce the original effect."**

ADDICTION:

"An overwhelming involvement with, and craving for, a substance, often accompanied by PHYSICAL DEPENDENCE, which motivates continuing usage, resulting in a syndrome of identifiable symptoms appearing when the drug is suddenly withdrawn."*

AMPHETAMINES:

Drugs having stimulating effect upon the central nervous system. Long continued use of excessive amounts may produce a condition similar to paranoid schizophrenia. Psychological dependence may develop. Commonly called: Speed, Meth; Crystal; Uppers. Amphetamines may be snorted, ingested or injected.

BARBITURATES:

Drugs (sedatives) which act to depress the central nervous system. An individual high on barbiturates may show symptoms similar to intoxication (e.g. poor coordinati slurred speech, etc.) Excessive use may produce both psychological and physical dependence. Withdrawal from barbiturates is considered most dangerous and should be done under medical supervision. Commonly called: Downs, Barbs. Barbiturates are most commonly ingested.

HALLUCINOGENS (PSYCHEDELICS):

Drugs which act upon the central nervous system and interfere with the minds ability to perceive and interpret images. Under the drug's influence (the "trip"), perception is altered. On a "good trip" one might experience vibrant images of colo and sound. On a "bad trip" one may experience discomfort, paranoia, fear/anxiety or the like. The various drugs: LSD (acid), Mescaline, Psilocybin and numerous others. The hallucinogens are not physically addictive: an individual might experience some propensity toward psychological addiction.

INHALENTS:

Substances such as airplane glue, c ing fluids, aerosol sprays, etc., which are inhaled for their intoxicating effect.

MARIJUANA:

A drug (THC) which produces a mild intoxication much like that induced by small quantities (e.g. increased sociability, relaxation.) Individual reactions to large quantities vary widly. Marijuana produces no physical addiction; psychologica addiction may develop. Common name: Pot, Grass, Weed, Cannabis. Marijuana is commonly rolled in cigarette paper (a "joint") or placed in a pipe and smoked.

NARCOTICS:

Drugs (opium, its derivatives heroin, morphine or codeine or similar synthetic drugs, e.g. methadone,) which acts upon the central and parasympathetic nervous system inducing numbness (freedom from pain and anxiety,) lethargy, drowsiness. The narcotic drugs are highly addictive both physically and psychologically. Immediate withdrawal is relative painful and anxiety inducing but generally not physically dangerous. Heroin is the most widely used opiate; it is commonly called: Junk, "H", Smack, Stuff. Heroin can be snorted but it is generally injected.

* Lingeman, Richard R., Drugs from A to Z: A Dictionary. (New York: McGraw-Hill Book Company, 1969)

** Irwin, Samuel, Drugs of Abuse: An Introduction to Their Actions and Potential Hazards. (Wisconsin: Student Association for the Study of Hallucenogens, Inc., 1970

REGIONAL DRUG ABUSE COUNCIL
WORK PLAN
July - November, 1973

APPENDIX H

Activites are listed in the order in which they are to be performed:

1. Establish a subcommittee from the Ad Hoc Regional Drug Abuse Council to meet with a similar subcommittee from the Southern Regional Alcoholism Council, regarding the feasibility of beginning to work in cooperation with each other.

2. Aid in the implementation of the Drug Rehabilitation, Inc. program.

3. Work with the Brunswick Area Drug Abuse Center in their evaluation of the BADAC programs and priorities and help explore reasonable alternatives to their present activities.

4. Work with York County Counseling Service to devise an appropriate program in drug abuse, and establish a mechanism whereby that program will be reviewed on an on-going basis.

5. Assist York County Counseling Services in writing an LEAA grant application to fund a special Probation Officer for drug offenders.

6. Assist the single state agency in writing an NIMH H-80 Service Project Grant which will enable the implementation of the recommendations contained in the Plan. To be submitted on December 1, 1973. Negotiate preliminary agreements with agencies who will perform services under the grant.
7. Implement the education recommendations of the Regional Drug Abuse Plan.

APPENDIX I

Public Law Chapter 164 AN ACT Relating to Inspection and Licensing of Resdiential Facilities for the Care, Treatment or Rehabilitation of Drug Users.

Public Law Chapter 379 AN ACT Establishing the Maine Commission on Drug Abuse

Public Law Chapter 566 AN ACT Reconstituting and More Effectively Coordinating the Maine Commission on Drug Abuse and the Division of Alcoholism and Providing an Alternative Sentencing for Violators of Drug Laws. (This Act is cited as the 1973 Alcoholism and Drug Abuse Act).

CHAPTER 379

AN ACT Establishing the Maine Commission on Drug Abuse.

Be it enacted by the People of the State of Maine, as follows:

R. S., T. 5, Part 10, additional. Title 5 of the Revised Statutes is amended by adding a new Part 10 to read as follows:

PART 10

DRUG ABUSE

CHAPTER 317

COMMISSION ON DRUG ABUSE

§ 3361. Declaration of policy

The Legislature declares that it is the policy of the State to confront the serious problem of drug abuse through the wisest possible use of governmental and private resources. The Legislature further declares that the State can best encourage such use through the establishment of a Maine Commission on Drug Abuse which can coordinate the work of all state agencies dealing with the drug abuse problem and, at the same time, provide support and guidance to the drug abuse efforts of local government and private groups.

§ 3362. Commission

There is established the Maine Commission on Drug Abuse consisting of the Commissioner of Health and Welfare, the Commissioner of Mental Health and Corrections, the Commissioner of Education, the Chairman of the Employment Security Commission, the Chief of the State Police, Attorney General, State Planning Director, Federal-State Coordinator, Director of the Office of Economic Opportunity, Chairman of the Law Enforcement Planning and Assistance Agency, Chancellor of the University of Maine, Chairman of the Maine State Health Planning Council, Director of the Maine Youth Corps, a representative of the Governor's Youth Task Force and 4 citizens of the State appointed by the Governor. The Governor shall designate the chairman of the commission to serve a term of 2 years, subject to a single reappointment.

§ 3363. Term of service

Each appointed member shall serve a term of 2 years, subject to a single reappointment. Each appointed member shall serve for the term of his appointment and thereafter until his successor is appointed, and, in cases of vacancies occurring before the completion of a term, these vacancies shall be filled for the balance of the unexpired term.

§ 3364. Assistance from other state agencies

The Maine Commission on Drug Abuse, for administrative purposes, shall be lodged in the Executive Department, with authority to request any state department or agency, whether or not represented on the commission, to provide such personnel, financial assistance, facilities and data as will help the commission fulfill its responsibilities. All agencies of State Government are to cooperate fully with the commission in carrying out its responsibilities.

§ 3365. Responsibilities

1. Duties. The responsibilities of the Maine Commission on Drug Abuse shall include the following:

A. The coordination of all state governmental efforts dealing with the problems of drug abuse;

B. Helping communities mobilize their resources to deal with drug abuse;

C. Making grants to state, local and regional governmental agencies, and to private groups, for drug abuse control programs within such appropriations as may be made available to the commission for this purpose from time to time;

D. Seeking and receiving grants in furtherance of its responsibilities from the Federal Government and from private sources;

E. Working with comparable agencies of state government in the other New England states, and with New England regional agencies, in developing a regional approach to the drug problem;

F. Making an annual report to the Governor and the Legislature of its activities. Such report shall contain recommendations for changes in the laws of Maine relating to drug abuse which, in the opinion of the commission, are necessary to the best interests of the State and its people. In preparing such recommendations and reports, the commission may engage expert advisors and assistants who may serve without compensation or, to the extent that funds may be made available by appropriation, grant, gift or allocation from a state department, the commission may pay for such expert advisors and assistance.

§ 3366. Authority

1. Authority. In carrying out its coordinating responsibilities at the state level, and in providing support and guidance to the drug abuse efforts of local government and private groups, the commission shall have the authority and obligation to:

A. Examine all requests for appropriations or program grants relating to drug abuse made by state agencies and advise the Governor, Budget Bureau and Legislature of its findings and recommendations. It shall be the responsibility of all departments to advise the commission of their budgetary requests relating to drug abuse concurrently with their submission to the Governor. The departments shall, in the implementation of their programs, keep the commission fully informed of their progress and of any changes in policy;

B. Supervise the disbursement of all state funds appropriated for the purpose of helping local and regional government agencies and private groups deal with drug abuse. All such local and regional governmental agencies and all such private groups seeking state assistance shall be required to file applications with the commission. The commission shall establish appropriate rules and regulations for the processing of these applications. No grants of state funds to local or regional governmental agencies or to private groups shall be made without commission approval.

APPROVED APR 4 '73 BY GOVERNOR

CHAPTER 164 PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-THREE

S. P. 256 — L. D. 753

AN ACT Relating to Inspection and Licensing of Residential Facilities for the Care, Treatment or Rehabilitation of Drug Users.

Be it enacted by the People of the State of Maine, as follows:

Sec. 1. R. S., T. 5, § 2301, sub-§ 1, ¶ H, additional. Subsection 1 of section 2301 of Title 5 of the Revised Statutes, as amended, is further amended by adding a new paragraph H to read as follows:

H. All facilities licensed under Title 22, section 5-A.

Sec. 2. R. S., T. 22, § 5-A, additional. Title 22 of the Revised Statutes is amended by adding a new section 5-A to read as follows:

§ 5-A. Inspection and licensing of residential facilities for the care, treatment or rehabilitation of drug users.

No person, firm, corporation or association shall operate, conduct or maintain in the State any residential facility for the care, treatment or rehabilitation of drug users, not otherwise licensed as a medical care facility, without having in full force, subject to the rules and regulations of the department, a written license therefor from the department. The term of such license shall be for one year and the license may be suspended or revoked for just cause. The annual fee for such license shall be $25. When any such facility, upon inspection by the department, shall be found not to meet all requirements of this section and departmental regulations then the department is authorized to issue either a temporary license for a specified period not to exceed 90 days, during which time corrections specified by the department shall be made by said facility for compliance with this section and departmental regulations thereunder, if in the judgment of the commissioner the best interest of the public will be so served, or a conditional license setting forth conditions which must be met by the facility to the satisfaction of the department or the department may refuse to issue any license. Failure of said facility to meet any of such conditions shall immediately void such conditional license by written notice thereof by the department to the conditional licensee or if the said licensee cannot be reached for personal service by notice thereof left at the licensed premises. The fee for such temporary or conditional license for facilities shall be $25. A new application for a regular license may be considered by the department if, when and after the conditions set forth by the department at the time of issuance of such temporary or conditional license have been met and satisfactory evidence of this fact has been furnished to said department. When the department believes a license should be suspended or revoked, it shall file a statement or complaint with the Administrative Hearing Commissioner designated in Title 5, chapters 301 to 307. Whenever, on inspection by the department, conditions are found to exist which violate this section or departmental regulations issued thereunder which, in the opinion of the commissioner, immediately endanger the health or safety of persons, or both such health or safety, living in such facilities so

such an extent as to create an emergency, the department by its duly authorized agents may suspend said license until such time as the department determines that the emergency no longer exists or until a decision is rendered by the Administrative Hearing Commissioner. The department shall give written notice of such emergency suspension by delivering notice in hand to the licensee. If the licensee cannot be reached for a personal service, the notice may be left at the licensed premises. Whenever a license is suspended by the department under this emergency provision, the department shall file a complaint with the Administrative Hearing Commissioner requesting suspension or revocation of such license. A person aggrieved by the refusal of the department to issue a license may file a statement or complaint with said Administrative Hearing Commissioner. No such license shall be issued until the applicant has furnished the department with a written statement signed by the Commissioner of Public Safety or his duly authorized representative or the proper municipal official designated in Title 25, chapters 311 to 321 to make fire safety inspections that the facility and premises comply with said Title 25, chapters 311 to 321 relating to fire safety. The department shall establish and pay reasonable fees to the municipal official or the Commissioner of Public Safety or his duly authorized representative for such inspection. Said written statement shall be furnished annually thereafter.

Whoever violates this section shall be punished by a fine of not more than $500 or by imprisonment for not more than 60 days.

IN HOUSE OF REPRESENTATIVES,.....1973

Read twice and passed to be enacted

.....*Speaker*

IN SENATE,.....1973

Read twice and passed to be enacted.

.....*President*

Approved.....1973

.....*Governor*

APPROVED
JUN 28 '73
BY GOVERNOR

CHAPTER
566
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-THREE

S. P. 635 — L. D. 2008

AN ACT Reconstituting and More Effectively Coordinating the Maine Commission on Drug Abuse and the Division of Alcoholism and Providing an Alternative Sentencing for Violators of Drug Laws.

Be it enacted by the People of the State of Maine, as follows:

Sec. 1. R. S., T. 22, Subtitle 4, Part 3, additional. Subtitle 4 of Title 22 of the Revised Statutes is amended by adding a new Part 3 to read as follows:

PART 3

DRUG ABUSE

CHAPTER 1601

ALCOHOLISM, INTOXICATION AND DRUG ABUSE PREVENTION, TREATMENT AND REHABILITATION

SUBCHAPTER I

GENERAL PROVISIONS

§ 7101. Short title

This Part may be cited as the 1973 Alcoholism and Drug Abuse Act.

§ 7102. Declaration of objectives

1. The serious problem of drug abuse, including the use of alcohol which results in chronic intoxication or alcoholism, must be confronted with the immediate objective of significantly reducing the incidence of such abuse in the State within the shortest possible period of time.

2. In order to efficiently and effectively accomplish this objective, it is essential to adopt an integrated approach to the problem and to focus all the varied resources of the State on developing a comprehensive range of drug abuse prevention and treatment services, conducted by one administrative unit.

3. It is, therefore, the objective of this Act to establish one office to coordinate the planning and operation of all state drug abuse services, including those related to the abuse of alcohol, and excepting those relating to the prevention of drug traffic, and to provide support and guidance to individuals, public and private organizations and especially local governments, in their drug abuse prevention activities.

§ 7103. Definitions

As used in this Act, unless the context otherwise indicates, the following words shall have the following meanings.

1. Administrative activities. "Administrative activities" means an activity related to guidelines, criteria, regulations, requirements or procedures for operations related to drug abuse prevention.

2. Agreement. "Agreement" means a legally binding document between 2 parties including such documents as are commonly referred to as accepted proposal, contract, grant, joint or cooperative agreement, or purchase of services.

3. Alcoholic. "Alcoholic" means a person who habitually lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted.

4. Approved treatment facility. "Approved treatment facility" means a public or private nonprofit agency meeting the standards promulgated by the office pursuant to section 7115, subsection 1, and approved under section 7115, subsection 3 and licensed pursuant to section 5-A or pursuant to other applicable provisions of Maine law. An approved public treatment facility is a treatment agency operating under the direction and control of the office or providing treatment under this chapter through a contract with the office under section 7114, subsection 6.

5. Commissioner. "Commissioner" means the Commissioner of Health and Welfare.

6. Department. "Department" means the Department of Health and Welfare.

7. Dependency related drug. "Dependency related drug" means alcohol or any substance controlled under chapter 551, subchapter II, and chapters 557 and 558.

8. Director. "Director" means the Director, Office of Alcohol and Drug Abuse Prevention.

9. Drug abuser. "Drug abuser" means a person who uses any drugs, dependency related drugs, or hallucinogens in violation of any law of the State of Maine.

10. Drug abuse prevention. "Drug abuse prevention" means all facilities, programs or services relating to drug abuse control, education, rehabilitation, research, training and treatment, and includes these functions as related to alcoholics and intoxicated persons. The term includes such functions even when performed by an organization whose primary mission is in the field of prevention of drug traffic or is unrelated to drugs. This term does not include any function defined under section 7103, subsection 18 as prevention of drug traffic.

11. Drug addict. "Drug addict" means a drug dependent person who, due to the use of a dependency related drug has developed such a tolerance thereto that abrupt termination of the use thereof would produce withdrawal symptoms.

12. Drug dependent person. "Drug dependent person" means any person who is unable to function effectively and whose inability to do so causes or results from the use of a dependency related drug.

13. Emergency service patrol. "Emergency service patrol" means a patrol established under section 7123.

14. Incapacitated by alcohol. "Incapacitated by alcohol" means that a person, as a result of the use of alcohol, is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment.

15. Incompetent person. "Incompetent person" means a person who has been adjudged incompetent by a court.

16. Intoxicated person. "Intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol.

17. Office. "Office" means the Office of Alcoholism and Drug Abuse Prevention in the department established under section 7104.

18. Prevention of drug traffic. "Prevention of drug traffic" means any functions conducted for the purpose of preventing drug traffic, such as law enforcement and judicial activities or proceedings;

A. Investigation, arrest, prosecution. The investigation, arrest and prosecution of drug offenders and offenses; or

B. Detection and suppression. The detection and suppression of illicit drug supplies.

19. Standards. "Standards" means criteria, rules and regulations of the department that are to be met by and during operation of any treatment facility or treatment program.

20. Treatment. "Treatment" means the broad range of emergency, outpatient, intermediate and in-patient services and care including career counseling, diagnostic evaluation, employment, health, medical, psychiatric, psychological, recreational, rehabilitative, social service care, treatment and vocational services, which may be extended to an alcoholic, intoxicated person, drug abuser, drug addict, drug dependent person or to a person in need of assistance due to use of a dependency related drug.

21. Treatment program. "Treatment program" means any program or service, or portion thereof, sponsored under the auspices of a public or private nonprofit agency providing services especially designed for the treatment of those persons listed in subsection 20.

SUBCHAPTER II

ORGANIZATION

§ 7104. Office of Alcoholism and Drug Abuse Prevention

There is created within the Bureau of Rehabilitation of the Department of Health and Welfare the Office of Alcoholism and Drug Abuse Prevention. The office shall be under the immediate and full supervision of the Director, Bureau of Rehabilitation. The office shall be the sole agency of State Government responsible for administration of this chapter. It shall be a separate, distinct administrative unit, which shall not be in any way integrated as a part or function of any other administrative unit of the department.

The Maine Commission on Drug Abuse, as heretofore established by Title 5, chapter 317, as amended, and the Division of Alcoholism Services heretofore

fore established in the Department shall, by this Act and implementation of it, be reconstituted and unified into a single administrative unit, functioning as an integrated agency of State Government.

§ 7105. Director

The Office of Alcoholism and Drug Abuse Prevention shall be administered by a director, who shall be appointed, subject to the Personnel Law, under the classified service by the commissioner after consultation with the Maine Council on Alcohol and Drug Abuse Prevention and Treatment. The director shall be a person qualified by training and experience with drug abuse, or alcoholism and intoxication, or who has had satisfactory experience of a comparable nature in the direction, organization and administration of prevention or treatment programs for persons affected by drug abuse or drug dependency. He shall be immediately and fully responsible to the Manager, Office of Resource Development and shall not be indirectly responsible to any other official of the department.

The director shall serve full time in a position that is separate from and not in any way integrated with another position in the department. He shall not concurrently hold another title and shall perform duties solely germane to the powers and duties of the office as provided for in this chapter.

The director shall possess full authority and responsibility for administering all the powers and duties of the office provided in section 7106, except as otherwise provided by statute. He shall, with the advice of the Maine Council on Alcohol and Drug Abuse Prevention and Treatment, assume and discharge all responsibilities vested in the office. He shall not in any case assign to another unit of the department which is not responsible to him any powers and duties granted to the office by statute, or by rules, regulations or procedures adopted pursuant to this chapter. He shall make full use of existing support services available in State Government to assist with carrying out the responsibilities set by this chapter.

The director may employ, subject to the Personnel Law and within the limits of funds available, competent professional personnel and other staff necessary to carry out the purposes of this chapter. He shall prescribe the duties of staff and assign a sufficient number of staff full time to the office to achieve its powers and duties. He may arrange to house staff or assign staff who are responsible to him and who are to provide direct service to individuals or small groups of individuals needing drug abuse treatment, to operating units of the department, such as the Bureau of Rehabilitation, which are responsible for similar functions.

§ 7106. Powers and duties

The office shall establish in accord with the purposes and intent of this chapter, and with the advice of the council and the cooperation of the coordinating committee, the overall planning, policy, objectives and priorities for all drug abuse prevention functions, except prevention of drug traffic, which are conducted or supported in the State of Maine. In order to carry out the above, the office shall have the power and duty to:

1. Encourage and assist development of more effective, more coordinated, more efficient administration of resources and services available for drug abuse prevention;

2. Develop and maintain an up-to-date information system related to drugs, drug abuse and drug abuse prevention. The information shall be available for use by the people of Maine, the political subdivisions, public and private nonprofit agencies and the State. Educational materials shall be prepared, published and disseminated. Objective devices and research methodologies shall be continuously developed. Uniform methods of keeping statistical information shall be specified for use by public and private agencies, or-

ganizations and individuals. Existing sources of information shall be used to the fullest extent possible, while maintaining confidentiality safeguards of state and federal law. Information may be requested and shall be received from any state government or public or private agency. To the extent feasible, information shall maintain compatibility with federal information sharing standards.

Functions of the drug information system shall include, but not be limited to:

A. Conducting research on the causes and nature of drugs, drug abuse or people who are dependent on drugs, especially alcoholics and intoxicated persons;

B. Collecting, maintaining and disseminating such knowledge, data and statistics related to drugs, drug abuse and drug abuse prevention as will enable the office to fulfill its responsibilities;

C. Determining through a detailed survey the extent of the drug abuse problem, and the needs and priorities for the prevention of drug abuse and drug dependence in the state and political subdivisions. Included shall be a survey of health facilities needed to provide services for drug abuse and drug dependence, especially alcoholics and intoxicated persons;

D. Maintaining an inventory of the types and quantity of drug abuse prevention facilities, programs and services available or provided under public or private auspices to drug addicts, drug abusers and drug dependent persons, especially alcoholics and intoxicated persons. This function shall include the unduplicated count, location and characteristics of people receiving treatment, as well as their frequency of admission and readmission, and frequency and duration of treatment. The inventory shall include the amount, type and source of resources for drug abuse prevention;

E. Conducting a continuous evaluation of the impact, quality and value of drug abuse prevention facilities, programs and services; including their administrative adequacy and capacity. Activities operated by or with the assistance of the State and Federal Governments shall be evaluated. Included shall be alcohol and drug abuse prevention and treatment services as authorized by this and so much of the several Acts and amendments to them enacted by the People of the State of Maine, and those authorized by the United States Acts and amendments to them as relate to drug abuse prevention:

(1) The Drug Abuse Office and Treatment Act of 1972 (P. L. 92-255);

(2) The Community Mental Health Centers Act (42 USC 2688);

(3) The Public Health Service Act (42 USC);

(4) The Vocational Rehabilitation Act;

(5) The Social Security Act;

(6) The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P. L. 91-616) and similar Acts.

3. Assist, with the advice of the council and cooperation of the coordinating committee, the Legislature and executive branches and Judicial Council of State Government, especially the Governor, commissioner, and Bureau of the Budget, to coordinate all state government efforts dealing with drug abuse prevention and control, including alcoholism, by:

A. Submitting to each branch of State Government no later than September 1st of each year an annual report covering its activities for the immedi-

ate past fiscal year and future plans, including recommendations for changes in state and federal laws, and including reports of the council and coordinating committee;

B. Reviewing all proposed legislation, fiscal activities, plans, policies and other administrative functions relating to drug abuse prevention activities made by or requested of all state agencies. The office shall have the authority to submit to these bodies findings, comments and recommendations, which in the case of the Judicial Council, Legislature, Governor and commissioner shall be advisory; and which in the case of other state agencies shall be binding. Such findings, comments and recommendations shall specify what modification in proposals or actions shall be taken to make proposed legislation, fiscal activities and administrative activities consistent with such policies and priorities;

C. Making recommendations to the respective branches of State Government concerning prevention of drug traffic and shall consult with and be consulted by all responsible state agencies regarding the policies, priorities and objectives of functions to prevent drug traffic.

4. Prepare and administer a comprehensive state plan mutually developed by the office, council and coordinating committee, relating to all drug abuse prevention and treatment of alcoholics and intoxicated persons and control of drug abuse. The comprehensive state plan shall be implemented for the purpose of coordinating all drug abuse prevention activities and of assuring compliance with applicable state and federal laws and regulation and with the state plan relating to drug abuse prevention. Implementation of this duty shall mean that the office shall have the authority to supervise through a review process the preparation and administration of any portion of any state plan relating to drug abuse prevention prepared and administered by any agency of State Government for submission to the Federal Government to obtain federal funding under federal legislation. Such state plans, or portions thereof, shall include, but not be limited to, all state plans dealing with education, employment and vocational services, medical, rehabilitation, social services, welfare, drug abuse prevention and treatment of alcoholism and intoxicated persons.

The office shall advise the commissioner and Governor on preparation of and provisions to be included relating to drug abuse prevention and relating to alcoholism and intoxicated persons. Such state plans shall provide for methods of administration which will supplement, compliment and broaden related state plans, including, but not limited to, those developed under the U. S. Public Health Service Act, section 314 (2);

5. Plan, establish and maintain necessary or desirable prevention or treatment programs for individuals or groups of individuals, except that the office and its staff, whether assigned to the office or to operating units, may provide direct service only to a drug dependent individual or groups of such individuals, whose drug dependency is related to alcohol. The office may use the full range of its powers and duties to serve any drug dependent person through indirect services provided for by agreements;

6. Function as the organizational unit of Maine State Government with sole responsibility for conducting and coordinating, with the advice of the council and the cooperation of the coordinating committee, state programs and activities authorized by this chapter, and by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended, and by the Drug Abuse Office and Treatment Act of 1972, as amended; and other programs or Acts of the State of Maine or United States related to drug abuse prevention which are not the specific responsibility of another state agency under federal or state law.

The Office is designated as the single agency of Maine State government solely responsible for administering the state plans required by those Acts;

7. Help communities mobilize their resources to deal with drug abuse. The office shall provide, or coordinate the provision of information, technical assistance and consultation to state, regional and local governments; and to public and private nonprofit agencies, institutions, organizations and individuals. The help shall be for the purpose of encouraging, developing and assisting with the initiation, establishment and administration of any plans, programs or services to prevent drug abuse.

Included in this duty is authority to coordinate the efforts and enlist the assistance of all public and private agencies, organizations and individuals interested in drug abuse prevention, especially alcoholism and treatment of alcoholics and intoxicated persons. The support and assistance of interested persons in the community, particularly recovered alcoholics and abusers of drugs, shall be utilized to encourage alcoholics and drug abusers voluntarily to undergo treatment;

8. Seek and receive funds from Federal Government and private sources to further its activities. Included in this function is authority to solicit, accept, administer, disburse and coordinate for the State in accordance with the intent, objectives and purposes of this chapter; and within any limitation which may apply from the sources of such funds, the efforts to obtain and the use of any funds from any source to treat alcoholism or prevent drug abuse. Any gift of money or property made by will or otherwise, and any grant or other funds appropriated, services or property available from the Federal Government, the State or any political subdivision thereof and from all other sources, public or private, may be accepted and administered. The office may do all things necessary to cooperate with the Federal Government or any of its agencies in making application for any funds. Included in this duty is authority to coordinate the disbursement of all state funds, or funds administered through agencies of State Government, appropriated or made available for drug abuse prevention. No fund transaction, including encumbrance or disbursement, shall be made for drug abuse prevention without approval of the office;

9. Enter into agreements necessary or incidental to the performance of its duties. Included is the power to make agreements with qualified community, regional and state level, private nonprofit and public agencies, organizations and individuals in this and other states to develop or provide drug abuse prevention and treatment facilities, programs and services. Such agreements may include provisions to pay for such prevention or treatment rendered or furnished to an alcoholic, intoxicated person, drug abuser, drug addict, drug dependent person or person in need of assistance due to use of a dependency related drug. Such contracts shall be executed only with agencies that meet the standards for treatment promulgated by the office under section 7115, subsection 1, and approved under section 7115, subsection 3, and licensed pursuant to section 5-A or other applicable provisions of law. The office may engage expert advisors and assistants who may serve without compensation, or to the extent funds may be available by appropriation, grant, gift or allocation from a state department, the office may pay for such expert advisors or assistants;

10. Prepare, adopt, amend, rescind and administer policies, priorities, procedures, rules and regulations to govern its affairs and the development and operation of facilities, programs and services. The office may adopt rules to carry out the powers and duties conducted under the authority in accordance with the purpose and objectives of this Act. It shall especially adopt such rules and regulations as may be necessary to define contractual terms, conditions of agreements and all other rules as are necessary for the proper administration of this chapter. Such adoption, amendment and rescission shall be made as provided under Title 5, chapters 301 to 307, Administrative Code;

11. Establish operating and treatment standards, inspect and issue a certificate of approval for any drug abuse treatment facility or program, including residential treatment centers, which meet the standards promulgated un-

der section 7115, subsection 1, and licensed pursuant to section 5-A and other applicable provisions of law. The office shall periodically enter, inspect and examine the treatment facility or program, and examine their books and accounts. It shall fix and collect the fees for such inspection and certificate. Insofar as licensing and certification of drug abuse prevention facilities and programs may also be the responsibility of another administrative unit of the department, the office may assign performance of this responsibility to such a unit or make other mutually agreeable arrangements with such a unit for assisting with performance of this responsibility;

12. Develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons and persons who abuse or are dependent on drugs. Assist in the development of, and cooperation with, alcoholic education and treatment programs for employees of state and local governments and businesses and industries in the State. Convene and conduct conferences of public and private nonprofit organizations concerned with the development and operation of drug abuse prevention programs. Included shall be the power to encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons who abuse or are dependent on drugs and to provide them with adequate and appropriate treatment. Also included is the power to encourage all health and disability insurance programs to include alcoholism as a covered illness;

13. Foster, develop, organize, conduct or provide for the conduct of training programs for all persons in the field of treating alcoholics and intoxicated persons and drug abusers;

14. Coordinate activities and cooperate with drug abuse prevention programs in this and other states for the common advancement of drug abuse prevention and alcoholism progra

15. Establish and maintain a principal office at the department's general headquarters, and such other offices within the State as it may deem necessary;

16. Do other acts and exercise such other powers necessary or convenient to execute and carry out the purposes and authority expressly granted in this chapter.

SUBCHAPTER III

ADVISORY COUNCIL

§ 7107. Maine Council on Alcohol and Drug Abuse Prevention and Treatment

The Maine Council on Alcohol and Drug Abuse Prevention and Treatment, hereinafter in this chapter referred to as the "council," is created. The council may appoint from its membership subcommittees relating to particular problem areas or to other matters, provided that by January 1, 1975 the council shall function as an integrated committee. The office shall provide the council any administrative or financial assistance that from time to time may be reasonably required to carry out its activities. Any reasonable and proper expenses of the council shall be borne by the office out of currently available state or federal funds. The Maine Commission on Drug Abuse, as heretofore established by Title 5, chapter 317, as amended, and the advisory councils on alcoholism heretofore established in the department and by section 1352, as amended, shall, by this Act and implementation of it, be reconstituted and unified into a single unit.

§ 7108. Membership

The council shall consist of no more than 17 members who, excepting members representing the Legislature, shall be appointed by the Governor

with the advice and consent of the Executive Council. To be qualified to serve, members shall have education, training, experience, knowledge, expertise and interest in drug abuse prevention and training. Members shall be residents of different geographical areas of the State, who reflect experiential diversity and concern for drug abuse prevention and treatment in the State.

They shall be selected from outstanding people in the fields of education, health, law, law enforcement, manpower, medicine, science, social sciences and related areas. Members shall have an unselfish and dedicated personal interest demonstrated by active participation in drug abuse programs such as prevention, treatment, rehabilitation, training or research into drug abuse and alcohol abuse.

Membership shall include representatives of nongovernmental organizations or groups and of public agencies concerned with prevention and treatment of alcoholism, alcohol abuse, drug abuse and drug dependence. At least 2 members of the council shall be current members of the Legislature, consisting of one member from the House of Representatives appointed by the Speaker of the House to serve at his pleasure and one member from the Senate appointed by the President of the Senate to serve at his pleasure. Two of the private citizen members shall be between the ages of 16 and 21. At least 3 members shall be persons recovered from alcoholism, chronic intoxication, drug abuse or drug dependence. At least 3 members shall be officials of public or private nonprofit community level agencies who are actively engaged in drug abuse prevention or treatment in public or private nonprofit community agencies. Membership may also include, but not be limited to, representatives of professions such as law, law enforcement, medicine, pharmacy and teaching.

Members shall be appointed for a term of 3 years, except that of the members first appointed, 5 shall be appointed for a term of 3 years, 5 shall be appointed for a term of 2 years and 5 shall be appointed for a term of one year, as designated by the Governor at the time of appointment; except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of such term, and except that members who are members of the current Legislature and who are appointed by the President of the Senate or the Speaker of the House shall serve at their pleasure. Any vacancy in the council shall not affect its powers, but shall be filled in the same manner by which the original appointment was made.

Members shall be eligible for reappointment for not more than one consecutive term and may serve after the expiration of their term until their successors have been appointed, qualified and taken office. The appointing authority may terminate the appointment of any member of the council for good and just cause and the reason for the termination of each appointment shall be communicated to each member so terminated. The appointment of any member of the council shall be terminated if a member is absent from 3 consecutive meetings without good and just cause that is communicated to the chairman. An official, employee, consultant or any other individual employed, retained or otherwise compensated by or representative of the Executive Branch of the Government of the State of Maine shall not be a member of the council; but shall assist the council if so requested. The director of the office or his representative shall attend all meetings of the council.

The Governor shall designate the chairman from among the members appointed to the council. The council may elect such other officers from its members as it deems appropriate.

§ 7109. Meetings, compensation, quorum

The council shall meet at the call of the chairman or at the call of ¼ of the members appointed and currently holding office. The council shall meet at least 5 times a year and at least once every 3 months. The council shall

keep minutes of all meetings, including a list of people in attendance. Minutes of all meetings shall be sent forthwith to the Governor and leadership of the Legislature, who shall provide for their appropriate distribution and retention in a place of safekeeping.

Members of the council shall serve without compensation, but they may be reimbursed on the same basis as employees of state departments for the actual travel and other necessary expenses incurred in the performance of their duties.

A majority of the council members shall constitute a quorum for the purpose of conducting the business of the council and exercising all the powers of the council. A vote of the majority of the members present shall be sufficient for all actions of the council.

§ 7110. Powers and duties

The council, in cooperation with the office and coordinating committee, shall have the power and duty to:

1. Advise, consult and assist the Executive and Legislative Branches of the State Government and the Judicial Council, especially the Governor, on activities of State Government related to drug abuse prevention and treatment, including alcoholism and intoxication. The council may make recommendations regarding any function intended to prevent drug traffic. If findings, comments or recommendations of the council vary from or are in addition to those of the office or coordinating committee, such statements of the council shall be sent to the respective branches of State Government as attachments to those submitted by the office. Recommendations may take the form of proposed budgetary, legislative or policy actions. The council shall be solely advisory in nature and shall not be delegated any administrative authority or responsibility.

2. Serve as an advocate on alcoholism and drug abuse prevention and treatment, promoting and assisting activities designed to meet at the national, state and community levels the problems of drug abuse and drug dependence. The council shall serve as an ombudsman on behalf of individual citizens and drug dependent people as a class in matters under the jurisdiction of Maine State Government. It shall be a spokesman on behalf of drug abuse prevention to the director, commissioner, Governor, Legislature, public at large and National Government;

3. Serve as the advisory council on behalf of the State of Maine to the state agency as required by the federal regulations governing administration of the United States Drug Abuse Office and Treatment Act of 1972, as amended, and the United States Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended; and such other Acts of the United States as may heretofore or hereafter be enacted. The council shall advise regarding state and federal plans, policies, programs and other activities relating to the drug abuse and drug dependence in Maine. The council shall submit their recommendations and comments on the state plan, and any revisions thereof, and reports to federal or state agencies. Statements at variance or in addition to those of the office or the coordination committee shall be attached to the plan or reports upon submission by the office to agencies of the United States Government and to state agencies;

4. Serve, through a subcommittee of the council consisting of 5 persons including the chairman and 4 other members appointed by the chairman with the advice and consent of the Governor, as the review committee on behalf of the State of Maine responsible for analysis and recommendation to the director concerning the acceptability of proposals requesting award of state administered grant funds for drug abuse prevention and treatment under the United States Comprehensive Alcohol Abuse and Alcoholism Prevention,

Treatment and Rehabilitation Act of 1970 and the United States Drug Abuse Office and Treatment Act of 1972, and in order to insure coordination and prevent duplication of services shall review and comment on, under its own initiative or at the request of any state or federal department or agency, any application from any agency or organization within the State to a state or federal department or agency for financial assistance related to meeting the needs of people who abuse or are dependent on drugs;

5. Review and evaluate on a continuing basis, in cooperation with the office, for the purpose of determining the value and impact on the lives of people who abuse or are dependent on drugs, state and federal policies and programs relating to drug abuse and other activities affecting the people who abuse or are dependent on drugs, conducted or assisted by any state departments or agencies;

6. Inform the public in cooperation with the office, to develop a firm public understanding of the current status of drug abuse and drug dependence among Maine's citizens, including information on effective programs elsewhere in the State or Nation, by collecting and disseminating information, conducting or commissioning studies and publishing the results thereof, and by issuing publications and reports;

7. Provide public forums, including the conduct of public hearings, sponsorship of conferences, workshops and other such meetings to obtain information about, discuss and publicize the need of and solutions to drug abuse and drug dependence. The council may hold a state-wide conference, regional conferences and meetings;

8. Administer in accordance with current fiscal and accounting regulations of the State, and in accordance with the philosophy, objectives and authority of this Act, any funds appropriated for expenditure by the council or any grants or gifts which may become available, accepted and received by the council; and make, to be included in the annual report of the office, an annual report to the director, commissioner, Governor and Legislature not later than September 1st of each year concerning its work, recommendations and interests of the previous fiscal year and future plans; and shall make such interim reports as it deems advisable.

SUBCHAPTER IV

COOPERATING STATE AGENCIES, PROGRAMS AND TREATMENT

§ 7111. State Government Coordinating Committee

1. The State Government Drug Abuse Coordinating Committee is established. It shall, in cooperation with the advisory council and office, recommend policy to be established and implemented by state government agencies. It shall assist with the coordination of, and exchange of information on, all drug abuse prevention and control activities of the State of Maine. It shall act as a permanent liaison among the branches of Maine State Government and their agencies engaged in or expected to engage in activities affecting drug abuse or drug dependent people. The committee shall assist the Legislative and Executive Branches and Judicial Council in formulating and implementing a comprehensive plan, mutually developed by the advisory council, coordinating committee and office for prevention and control of drug abuse and drug dependence, especially treatment of alcoholics and intoxicated persons. The office shall provide any ordinary administrative and financial assistance to the coordinating committee as may be reasonably required from time to time to carry out its activities. Reasonable and proper expenses of the committee shall be paid from currently available state or federal funds. The committee shall meet at least twice annually at the call of the commissioner, who shall be its chairman.

2. In exercising its coordinating functions, the committee shall assure that:

A. The appropriate agencies of State Government shall provide all necessary career, educational, employment, health, judicial, law enforcement, legal, medical, penal, psychiatric, psychological, rehabilitative, social, treatment and vocational services for drug abusers and drug dependent persons and for prevention and control of drug abuse and drug dependency without unnecessary duplication of services;

B. The agencies of the several branches of State Government cooperate in the use of facilities and in the treatment of drug abuses and drug dependent persons;

C. All agencies of State Government shall adopt policies to control use of drugs, prevent drug abuse and to treat drug abusers and drug dependent persons, especially alcoholics and intoxicated persons in a manner consistent with the policy of this chapter;

D. Minutes of all meetings shall be sent to the Governor and leadership of the Legislature, who shall provide for their appropriate distribution and retention in a place of safekeeping.

3. The committee membership shall consist of not more than 17 members, who shall include, but not be limited to, the following members, who shall serve ex officio, or their designated representatives:

The Attorney General;

The Chief Justice, as Chairman of the Judicial Council;

The Director of Law Enforcement Planning and Assistance;

The Director, Office of Alcohol and Drug Abuse Prevention;

The Commissioner of Educational and Cultural Services;

The Commissioner of Health and Welfare;

The Commissioner of Manpower Affairs;

The Commissioner of Mental Health and Corrections;

The Commissioner of Public Safety;

The Commissioner of Transportation;

The Governor;

The President of the Maine Senate;

The Speaker of the Maine House of Representatives;

The State Youth Coordinator;

and other appropriate officials.

§ 7112. State agencies to cooperate

State agencies proposing to develop, establish, conduct or administer drug abuse prevention programs or to assist with such programs as covered by this chapter shall, prior to carrying out such actions, consult with the office to obtain the approval of the office to conduct such action.

All agencies of State Government shall advise the office of their proposed fiscal activities, especially budget requests and expenditures, concurrently

with their submission to the Budget Office or to the Governor. All agencies of State Government, concurrent with submission to that agency's approval authority, shall advise the office of proposed legislation, fiscal activities and administrative activities relating to drug abuse prevention. No such action shall be taken related to drug abuse prevention without approval of the office. State agencies shall, in the implementation of their activities, keep the office fully informed of their progress and of any proposed changes in fiscal matters and policy.

State agencies shall cooperate fully with the office and council in carrying out this chapter. The office and council are authorized to request such personnel, financial assistance, facilities and data as will assist the office and council to fulfill its powers and duties.

The office shall cooperate with the Department of Mental Health and Corrections and all institutions under its control in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons and for people who abuse or are dependent on drugs in or on parole from penal or special treatment institutions.

The office shall cooperate with the Department of Public Safety and the Department of Transportation in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while under the influence of drugs or intoxicating liquor.

The office shall coordinate all drug abuse education, information and training programs conducted within the State through cooperation with the Department of Educational and Cultural Services, school administrative districts, municipal schools, police departments, courts and other public and private agencies, organizations and individuals. Such coordination may assist with: Establishing educational programs for the prevention of alcoholism and drug abuse; treatment and rehabilitation of alcoholics, intoxicated persons and persons dependent upon or abusing drugs; training in the prevention, treatment and rehabilitation of such persons; and with preparation of curriculum materials thereon for use in all levels of educational programs.

§ 7113. State drug abuse strategy

Immediately upon the day this Act becomes effective, the Governor shall direct the development of a comprehensive, coordinated long-term state strategy for all drug abuse prevention functions and all drug traffic prevention functions conducted, sponsored or supported by any agency of State Government. The strategy shall be initially promulgated by the Governor no later than January 1, 1975.

To develop the strategy, the office, council and coordinating committee shall mutually participate to achieve its preparation. The strategy shall be subject to review and written comment by those state officials participating in its preparation.

The strategy shall contain:

1. An analysis of the nature, character and extent of the drug abuse problem in Maine, including examination of the interrelationships between various approaches to solving the drug abuse problem and their potential for interacting both positively and negatively with one another;

2. A comprehensive plan, with respect to both drug abuse prevention functions and drug traffic prevention functions, which shall specify the objectives of the strategy and how all available resources, funds, programs, services and facilities authorized under relevant law should be used; and

3. An analysis and evaluation of the major programs conducted, expenditures made, results achieved, plans developed and problems encountered in

the operation and coordination of the various drug abuse prevention functions and drug traffic prevention functions.

The strategy shall be reviewed, revised as necessary and promulgated as revised from time to time as the Governor deems appropriate, but not less often than once every 2 years.

§ 7114. Comprehensive program on alcoholism and drug abuse

1. A comprehensive and coordinated program of drug abuse prevention and treatment, especially of alcoholics and intoxicated persons, is established. Nothing in subsequent sections shall be interpreted as preventing the establishment of additional drug abuse prevention and treatment programs, including programs which the office considers necessary or desirable for intoxicated persons and alcoholics.

2. The program shall include:

A. Emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

B. Inpatient treatment;

C. Intermediate treatment; and

D. Outpatient and followup treatment.

3. The office shall provide for adequate and appropriate treatment for alcoholics and intoxicated persons admitted under sections 7117 to 7120. Treatment may not be provided at a correctional institution, except for inmates.

4. The office shall maintain, supervise and control all facilities operated by it subject to policies of the department. The administrator of each facility shall make an annual report of its activities to the director in the form and manner the director specifies.

5. All appropriate public and private resources shall be coordinated with and utilized in the program, if possible.

6. The office may contract for the use of any facility as an approved public treatment facility, if the director, subject to the policies of the department, considers this to be an effective and economical course to follow.

§ 7115. Standards for public and private alcohol or drug abuse treatment facilities; enforcement procedures; penalties

1. The department shall establish standards for approved treatment facilities, that must be met for a treatment facility to be approved as a public or private treatment facility, and fix the fees to be charged by the department for the required inspections. The standards may concern only the health standards to be met and standards of treatment to be afforded patients.

2. The department periodically shall inspect approved public and private treatment facilities at reasonable times and in a reasonable manner.

3. The department shall maintain a list of approved public and private treatment facilities.

4. Each approved public and private treatment facility shall file with the department on request data, statistics, schedules and information the department reasonably requires. An approved public or private treatment facility

that without good cause fails to furnish any data, statistics, schedules or information as requested, or files fraudulent returns thereof, shall be removed from the list of approved treatment facilities.

5. The District Court may restrain any violation of this section, review any denial, restriction or revocation of approval and grant other relief required to enforce its provisions.

6. The department may at reasonable times enter and inspect and examine the books and accounts of any approved public or private treatment facility refusing to consent to inspection or examination by the department or which the department has reasonable cause to believe is operating in violation of this Act.

§ 7116. Acceptance for treatment of alcoholics and intoxicated persons; rules

The director shall adopt and may amend and repeal rules for acceptance of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of alcoholics and intoxicated persons.

In establishing the rules, the director shall be guided by the following standards.

1. If possible, a patient shall be treated on a voluntary rather than an involuntary basis.

2. A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment.

3. A person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment.

4. An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

5. Provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will have available and utilize other appropriate treatment.

§ 7117. Voluntary treatment of alcoholics

1. An alcoholic may apply for voluntary treatment directly to an approved public treatment facility. If the proposed patient is a minor or an incompetent person, he, a parent, a legal guardian or other legal representative may make the application.

2. Subject to rules adopted by the director, the administrator in charge of an approved public treatment facility may determine who shall be admitted for treatment. If a person is refused admission to an approved public treatment facility, the administrator, subject to rules adopted by the director, shall refer the person to another approved public treatment facility for treatment if possible and appropriate.

3. If a patient receiving inpatient care leaves an approved public treatment facility, he shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the treatment facility that the patient is an alcoholic who requires help, the office shall arrange for assistance in obtaining supportive services and residential facilities.

4. If a patient leaves an approved public treatment facility, with or against the advice of the administrator in charge of the facility, the office

shall make reasonable provisions for his transportation to another facility or to his home. If he has no home, he shall be assisted in obtaining shelter. If he is a minor or an incompetent person, the request for discharge from an inpatient facility shall be made by a parent, legal guardian or other legal representative or by the minor or incompetent, if the minor or incompetent was the original applicant.

§ 7118. Treatment and services for intoxicated persons and persons incapacitated by alcohol

1. An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated and to be in need of help, if he consents to the proffered help, may be assisted to his home, an approved public treatment facility, an approved private treatment facility or other health facility by the police or the emergency service patrol.

2. A person who appears to be incapacitated by alcohol shall be taken into protective custody by the police or the emergency service patrol and forthwith brought to an approved public treatment facility for emergency treatment. If no approved public treatment facility is readily available, he shall be taken to an emergency medical service customarily used for incapacitated persons. The police or the emergency service patrol, in detaining the person and in taking him to an approved public treatment facility, is taking him into protective custody and shall make every reasonable effort to protect his health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself. A taking into protective custody under this section is not an arrest. No entry or other record shall be made to indicate that the person has been arrested or charged with a crime.

3. A person who comes voluntarily or is brought to an approved public treatment facility shall be examined by a licensed physician forthwith. He may then be admitted as a patient or referred to another health facility. The referring approved public treatment facility shall arrange for his transportation.

4. A person, who by medical examination is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission, may not be detained at the facility once he is no longer incapacitated by alcohol, or if he remains incapacitated by alcohol for more than 48 hours after admission as a patient, unless he is committed under section 7119. A person may consent to remain in the facility as long as the physician in charge believes appropriate.

5. A person, who is not admitted to an approved public treatment facility, is not referred to another health facility and has no funds, may be taken to his home, if any. If he has no home, the approved public treatment facility shall assist him in obtaining shelter.

6. If a patient is admitted to an approved public treatment facility, his family or next of kin shall be notified as promptly as possible. If an adult patient who is not incapacitated requests that there be no notification, his request shall be respected.

7. The police or members of the emergency service patrol who act in compliance with this section are acting in the course of their official duty and are not criminally or civilly liable therefor.

8. If the administrator in charge of the approved public treatment facility determines it is for the patient's benefit, the patient shall be encouraged to agree to further diagnosis and appropriate voluntary treatment.

§ 7119. Emergency commitment of an incapacitated or intoxicated person

1. An intoxicated person who has threatened, attempted or inflicted physical harm on another and is likely to inflict physical harm on another unless committed, or is incapacitated by alcohol, may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not in itself constitute evidence of lack of judgment as to the need for treatment.

2. The spouse, guardian or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section, directed to the administrator of the approved public treatment facility. The application shall state facts to support the need for emergency treatment and be accompanied by a physician's certificate stating that he has examined the person sought to be committed within 2 days before the date of the application for admission and facts supporting the need for emergency treatment. A physician employed by the admitting facility or the division is not eligible to be the certifying physician. The certifying physician shall be someone other than the person making the written application for commitment.

3. Upon approval of the application by the administrator in charge of the approved public treatment facility, the person shall be brought to the facility by a peace officer, health officer, emergency service patrol, the applicant for commitment, the patient's spouse, the patient's guardian or any other interested person. The person shall be retained at the facility to which he was admitted, or transferred to another appropriate public or private treatment facility, until discharged under subsection 5.

4. The administrator in charge of an approved public treatment facility shall refuse an application if, in the opinion of a physician or physicians employed by a facility, the application and certificate fail to sustain the grounds for commitment.

5. When on the advice of the medical staff the administrator determines that the grounds for commitment no longer exist, he shall discharge a person committed under this section. No person committed under this section may be detained in any treatment facility for more than 5 days. If a petition for involuntary commitment under section 7120 has been filed within the 5 days and the adminstrator in charge of an approved public treatment facility finds that grounds for emergency commitment still exist, he may detain the person until the petition has been heard and determined, but no longer than 10 days after filing the petition.

6. A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's right to counsel, shall be given to the person within 24 hours after commitment by the administrator, who shall provide a reasonable opportunity for the person to consult counsel.

§ 7120. Involuntary commitment of alcoholics or incapacitated persons

1. A person may be committed to the custody of the office by the District Court upon the petition of his spouse or guardian, relative or the administrator in charge of any approved public treatment facility. The petition shall allege that the person is an alcoholic who habitually lacks self-control as to the use of alcoholic beverages and that he has threatened, attempted or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another or is incapacitated by alcohol. A refusal to undergo treatment does not in itself constitute evidence of lack of judgment as to the need for treatment. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within 2 days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact

of refusal shall be alleged in the petition. The certificate shall set forth the physician's findings in support of the allegations of the petition. A physician employed by the admitting facility or the division is not eligible to be the certifying physician. The certifying physician shall be someone other than the person bringing the petition.

2. Upon filing the petition, the court shall fix a date for a hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, a parent or his legal guardian, the administrator in charge of the approved public treatment facility to which he has been committed for emergency care and any other person the court believes advisable. A copy of the petition and certificate shall be delivered to each person notified.

3. At the hearing, the court shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person shall be present, unless the court believes that his presence is likely to be injurious to him; in this event, the court shall appoint a guardian ad litem to represent him throughout the proceeding. The court shall examine the person in open court, or if advisable, shall examine the person out of court. If the person has refused to be examined by a licensed physician, he shall be given an opportunity to be examined by a court-appointed licensed physician. If he refuses and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may make a temporary order committing him to the division for a period of not more than 5 days for purposes of a diagnostic examination.

4. If, after hearing all relevant evidence, including the results of any diagnostic examination by the office, the court finds that grounds for involuntary commitment have been established by clear and convincing proof, it shall make an order of commitment to the office. It may not order commitment of a person, unless it determines that the office is able to provide adequate and appropriate treatment for him and the treatment is likely to be beneficial.

5. A person committed under this section shall remain in the custody of the office for treatment for a period of 30 days unless sooner discharged At the end of the 30-day period, he shall be discharged automatically, unless the office before expiration of the period obtains a court order for his recommitment upon the grounds set forth in subsection 1 for a further period of 90 days, unless sooner discharged. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the office shall apply for recommitment, if after examination it is determined that the likelihood still exists.

6. A person recommitted under subsection 5 who has not been discharged by the office before the end of the 90-day period shall be discharged at the expiration of that period, unless the office before expiration of the period obtains a court order on the grounds set forth in subsection 1 for the recommitment for a further period not to exceed 90 days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the office shall apply for recommitment if after examination it is determined that the likelihood still exists. Only 2 recommitment orders under this subsection and subsection 5 are permitted.

7. Upon the filing of a petition for recommitment under subsection 5 or 6, the court shall fix a date for hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner the original petitioner under subsection 1, if different from the petitioner for recommitment, one of his parents or his legal guardian and any other person

the court believes advisable. At the hearing the court shall proceed as provided in subsection 3.

8. The office shall provide for adequate and appropriate treatment of a person committed to its custody. The office may transfer any person committed to its custody from one approved public treatment facility to another, if transfer is medically advisable.

9. A person committed to the custody of the office for treatment shall be discharged at any time before the end of the period for which he has been committed if either of the following conditions is met:

A. In case of an alcoholic committed on the grounds of likelihood of infliction of physical harm upon another, that he is no longer an alcoholic or the likelihood no longer exists; or

B. In case of an alcoholic committed on the grounds of the need of treatment and incapacity, that the incapacity no longer exists, further treatment will not be likely to bring about significant improvement in the person's condition or treatment is no longer adequate or appropriate.

10. The court shall inform the person whose commitment or recommitment is sought of his right to contest the application, be represented by counsel at every stage of any proceedings relating to his commitment and recommitment and have counsel appointed by the court or provided by the court, if he wants the assistance of counsel and is unable to obtain counsel. If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel for him regardless of his wishes. The person whose commitment or recommitment is sought shall be informed of his right to be examined by a licensed physician of his choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician.

11. If a private or public treatment facility agrees with the request of a competent patient or his parent, sibling, adult child or guardian to accept the patient for treatment, the administrator of the public treatment facility shall transfer him to the private treatment facility.

12. A person committed under this chapter may at any time seek to be discharged from commitment by writ of habeas corpus.

13. The venue for proceedings under this section is the place in which the person to be committed resides or is present.

§ 7121. Records

1. The registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

2. Notwithstanding subsection 1, the director may make available information from patients' records for purposes of research into the causes and treatment of alcoholism and drug abuse. Information under this subsection shall not be published in a way that discloses patients' names or other identifying information.

§ 7122. Visitation and communication of patients

1. Subject to reasonable rules regarding hours of visitation which the director may adopt, patients in any approved treatment facility shall be granted opportunities for adequate consultation with counsel and for continuing contact with family and friends consistent with an effective treatment program.

2. Neither mail nor other communication to or from a patient in any approved treatment facility may be intercepted, read or censored. The director may adopt reasonable rules regarding the use of telephone by patients in approved treatment facilities.

3. Except to the extent the director determines that it is necessary for the medical welfare of the patient to impose restrictions, and unless a patient has been restored to legal capacity and except where specifically restricted by other statute or regulation, but not solely because of the fact of admission to a mental hospital, to exercise all civil rights, including, but not limited to, civil service status, the right to vote, rights relating to the granting, renewal, forfeiture or denial of a license, permit, privilege or benefit pursuant to any law, and the right to enter contractual relationships and to manage his property.

§ 7123. Emergency service patrol; establishment; rules

1. The office, counties and municipalities may establish emergency service patrols. A patrol consists of persons trained to give assistance in the streets and in other public places to persons who are intoxicated due to the use of alcohol or dependency related to drugs. Members of an emergency service patrol shall be capable of providing first aid in emergency situations and shall transport intoxicated persons to their homes and to and from public treatment facilities.

2. The director shall adopt rules for the establishment, training and conduct of emergency service patrols.

§ 7124. Payment for treatment; financial ability of patients

1. If treatment is provided by an approved public treatment facility and the patient has not paid the charge therefor, the office is entitled to any payment received by the patient or to which he may be entitled because of the services rendered, and from any public or private source available to the office because of the treatment provided to the patient.

2. A patient in an approved treatment facility, or the estate of the patient, or a person obligated to provide for the cost of treatment and having sufficient financial ability, is liable to the office for cost of maintenance and treatment of the patient therein in accordance with rates established.

3. The director shall adopt rules governing financial ability that take into consideration the income, savings and other personal and real property of the person required to pay, and any support being furnished by him to any person he is required by law to support.

Sec. 2. R. S., T. 5, § 2301, sub-§ 1, ¶ I, additional. Subsection 1 of section 2301 of Title 5 of the Revised Statutes, as amended, is further amended by adding a new paragraph I to read as follows:

I. Approved treatment facilities as defined in Title 22, section 7103.

Sec. 3. R. S., T. 5, c. 317, repealed. Chapter 317 of Title 5 of the Revised Statutes, as enacted by chapter 370 of the public laws of 1971, is repealed.

Sec. 4. R. S., T. 22, §§ 1351 and 1352, repealed. Sections 1351 and 1352 of Title 22 of the Revised Statutes are repealed.

Sec. 5. R. S., T. 34, § 1631, sub-§§ 5 and 5-A, additional. Section 1631 of Title 34 of the Revised Statutes, as amended, is further amended by adding 2 new subsections 5 and 5-A to read as follows:

5. Sentence to drug abuse treatment facility. In any case in which the offense relates to violation of any statutes concerning controlled or illegal

drugs or the sale or possession of drugs or narcotics, the court may impose sentence and place the person on probation. The court may require as a condition of probation that such person shall participate in, as a resident or nonresident, programs at an approved treatment facility as defined under Title 22, chapter 1601, provided the Office of Alcohol and Drug Abuse Prevention certifies to the court that such approved treatment facilities, personnel and programs are available and in compliance with all state licensing and certification laws, standards, rules and regulations.

Any person so sentenced to probation shall be required to participate in programs at the facility for a period not to exceed the period of probation ordered by the court. The professional staff of the facility may determine that the person's participation in treatment should be terminated. The supervisor or professional staff of the treatment facility may make such a determination when in their judgment the person:

A. Has successfully completed treatment or will derive no further significant benefits from such participation, or both, or

B. Will adversely affect the treatment of other participants by his continued participation, or

C. Has not conducted himself in accordance with the provisions of his sentence or probation.

When the professional staff of the treatment facility determines that the person's participation should be terminated, the supervisor of the treatment facility or the probation officer shall make a report to the court, which may thereupon make such provision with respect to the person's probation as the court deems appropriate.

5-A. Definition. For purposes of this section, "drug abuser" shall mean any person convicted of any violation of any statutes relating to controlled or illegal drugs.

Sec. 6. Transitional provisions.

1. Effect of transfer of powers, duties and functions. The Office of Alcoholism and Drug Abuse Prevention of the Department of Health and Welfare shall be the successor in every way to the powers, duties and functions of the former Division of Alcoholism Services and the former Maine Commission on Drug Abuse, or any of their administrative units, except as otherwise provided in this Act. The Director, Office of Alcoholism and Drug Abuse Prevention shall be the successor in every way to the responsibilities of the former Executive Director, Maine Commission on Drug Abuse and the former Director, Division of Alcoholism Services.

2. Rules, regulations and procedures. All existing regulations in effect, in operation or promulgated in or by the Maine Commission on Drug Abuse and the Division of Alcoholism, or in or by any administrative units or officer thereof, are hereby declared in effect and shall continue in effect until rescinded, revised or amended by the proper authority.

3. Contracts, agreements, compacts. All existing contracts, agreements and compacts currently in effect in the Maine Commission on Drug Abuse and the Division of Alcoholism shall continue in effect.

4. Personnel. Any positions, authorized and allocated subject to the Personnel Law, to the former Maine Commission on Drug Abuse and the former Division on Alcoholism are transferred to the Office of Alcoholism and Drug Abuse Prevention and may continue to be authorized to the office. Initial appointments to such positions vacant as of the effective date of this Act shall be made on an open competitive basis. Any employee and official of such former agencies subject to the Personnel Law on the effective date

of this Act may be transferred to the office and continue their employment after the effective date of this Act, without interruption of their state service, unless personnel positions or such office is terminated or abolished or method of appointment or employment is altered or changed by the provisions of this Act. Any positions in the unclassified service allotted to the Maine Commission on Drug Abuse are abolished. The office and title of Executive Director, Maine Commission on Drug Abuse and of Director, Division of Alcoholism are abolished.

5. Records, property and equipment. All records, property and equipment previously belonging to or allocated for the use of the Division of Alcoholism or the Maine Commission on Drug Abuse shall become on the effective day of this Act, part of the property of the Office of Drug Abuse and Prevention, Department of Health and Welfare.

6. Conflicts. All acts or parts of acts and rules inconsistent with this Act are repealed or amended to conform hereto.

7. Funds and equipment transferred. Notwithstanding the Revised Statutes, Title 5, section 1585, all accrued expenditures, assets, liabilities, balances of appropriations, transfers, revenues or other available funds in any account, or subdivision of an account, of any agency to be reallocated to another administrative unit as a result of this Act, shall be transferred to the proper place in an account for the office, by the State Controller, upon recommendation of the department head, the State Budget Officer and upon approval by the Governor and Executive Council. A proper accounting shall be made by activity within the account.

8. Effective date. This Act shall become effective October 1, 1973 in the event the Legislature adjourns on or before July 1, 1973 or otherwise shall become effective January 1, 1974.

IN HOUSE OF REPRESENTATIVES,.....1973

Read twice and passed to be enacted.

.....*Speaker*

IN SENATE,.....1973

Read twice and passed to be enacted.

.....*President*

Approved.....1973

.....*Governor*

APPENDIX J

Special Action Office for Drug Abuse Prevention

Data Formats

APPENDIX J

I. DRUG-RELATED DEATH FORM (A)

YEAR 1972

Drug related deaths	WHITE						NON-WHITE						TOTAL		TOTAL		TOTAL		TOTAL White	TOTAL Non-White	TOT
	Under 14		14-25		Over 25		Under 14		14-25		Over 25		Under 14		14-25		Over 25				
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female			
A. Drug overdose or other death directly attributed to a drug (excluding accident, disease, and withdrawal)																					
1. Accidental																					
a) Opiates																					
(1) Heroin (2) Metnadone (3) Other opiates	0	0	1	0	0	0							0	0	1	0	0	0	1		1
b) Barbiturates or other depressants excluding alcohol	0	0	0	0	1	1							0	0	0	0	1	1	2		2
c) Amphetamines and amphetamine-like stimulants excluding cocaine																					
d) Alcohol																					
e) Volatile substances																					
f) Others	1	0	2	0	8	7							1	0	2	0	7	8	18		1

APPENDIX J

I. DRUG-RELATED DEATH FORM (B)

YEAR 1972

	WHITE						NON-WHITE						TOTAL		TOTAL		TOTAL		TOTAL White	TOTAL Non-White	TOTAL
	Under 14		14-25		Over 25		Under 14		14-25		Over 25		Under 14		14-25		Over 25				
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female			
2. Intentional																					
a) Opiates																					
(1) Heroin (2) Methadone (3) Other opiates																					
b) Barbiturates or other depressants excluding alcohol	0	0	0	0	1	2							0	0	0	0	1	2	3		3
c) Amphetamines and amphetamine-like stimulants excluding cocaine																					
d) Alcohol																					
e) Volatile substances																					
f) Others	0	0	0	4	2	4							0	0	0	4	2	4	10		10

APPENDIX J

I. DRUG RELATED DEATH FORM (C)

YEAR 1972

Drug was contributing factor to death

1. Accident

a) Opiates

(1) Heroin
(2) Methadone
(3) Other opiates

b) Barbiturates or other depressants excluding alcohol

c) Amphetamines and amphetamine-like stimulants excluding cocaine

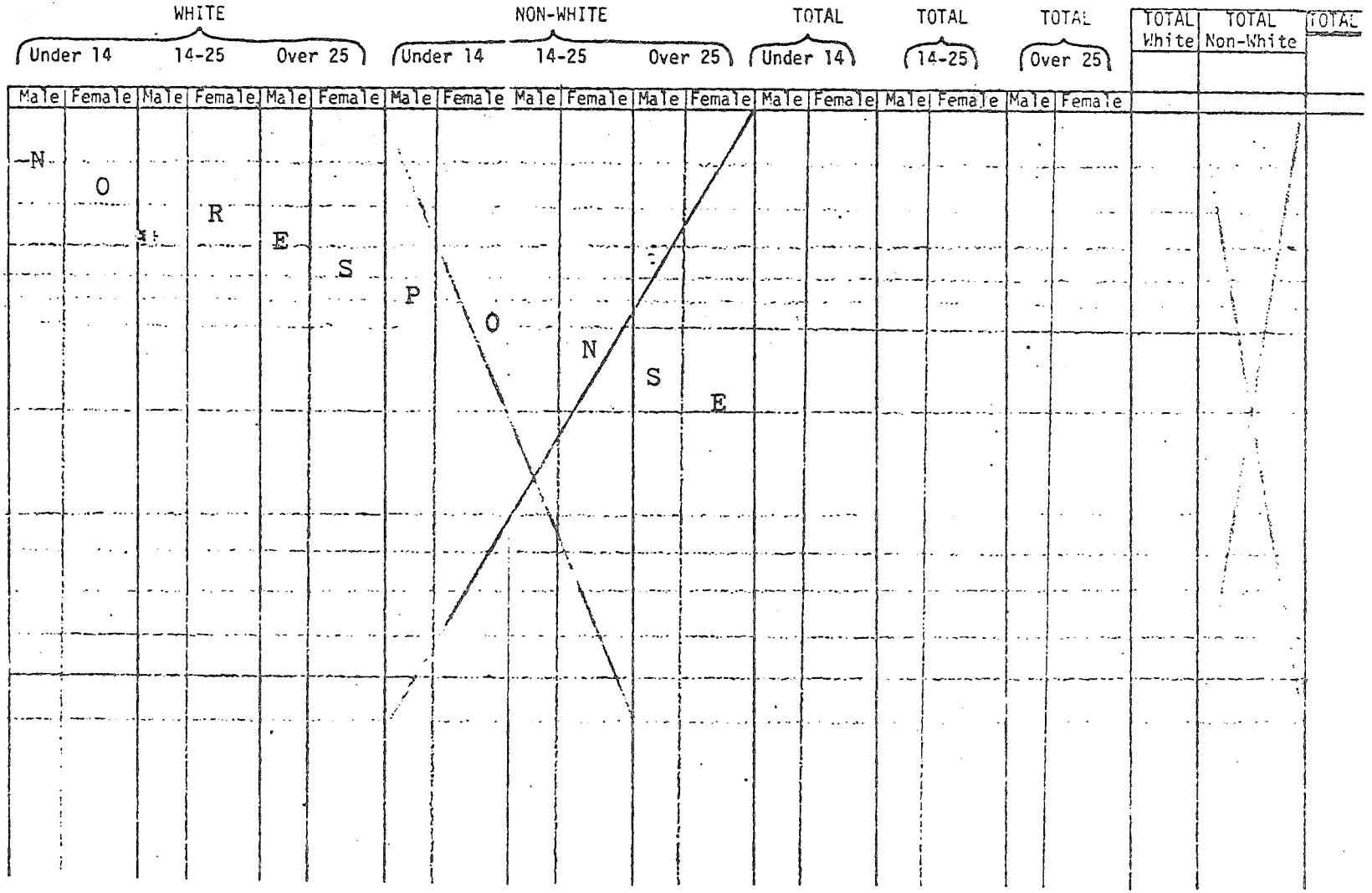
d) Alcohol

e) Cocaine

f) Hallucinogens

g) Volatile substances

h) Others



APPENDIX J

I. DRUG-RELATED DEATH FORM (D)

YEAR 1972

2. Diseased state

a) Opiates

(1) Heroin
(2) Methadone
(3) Other opiates

b) Barbiturates or other depressants excluding alcohol

c) Amphetamines and amphetamine-like stimulants excluding cocaine

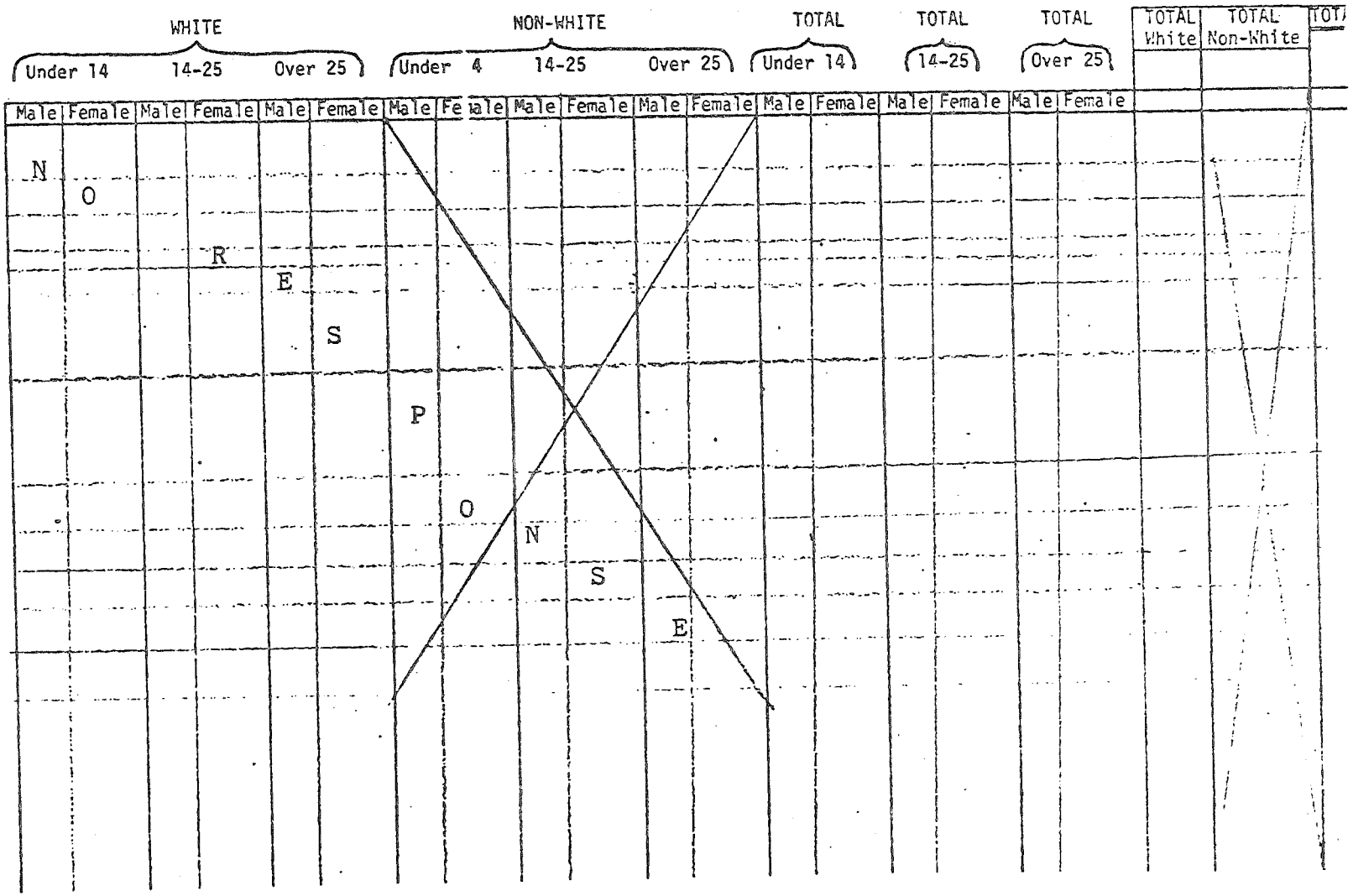
d) Alcohol

e) Cocaine

f) Hallucinogens

g) Volatile substances

h) Others



APPENDIX J

I. DRUG-RELATED DEATH FORM (E)

YEAR 1972

Withdrawal syndrome	WHITE Under 14 Male	WHITE Under 14 Female	WHITE 14-25 Male	WHITE 14-25 Female	WHITE Over 25 Male	WHITE Over 25 Female	NON-WHITE Under 14 Male	NON-WHITE Under 14 Female	NON-WHITE 14-25 Male	NON-WHITE 14-25 Female	NON-WHITE Over 25 Male	NON-WHITE Over 25 Female	TOTAL Under 14 Male	TOTAL Under 14 Female	TOTAL 14-25 Male	TOTAL 14-25 Female	TOTAL Over 25 Male	TOTAL Over 25 Female	TOTAL White	TOTAL Non-White	TOTA
a) Opiates																					
(1) Heroin																					
(2) Methadone																					
(3) Other opiates																					
b) Barbiturates or other depressants excluding alcohol																					
c) Alcohol																					
d) Others																					

NO RESPONSE

GR. TO 3

DIVISION OF VITAL STATISTICS DATA FOR 1972 REPORTED ON THIS FORM ---------- 3

PROJECTED FIGURES OF CHIEF MEDICAL EXAMINER FOR 1972 ----Drug 12--Alcohol 31---------- 4

APPENDIX J
II. HEALTH CRISIS REPORTS

CALENDAR YEAR 1972 (J-6)

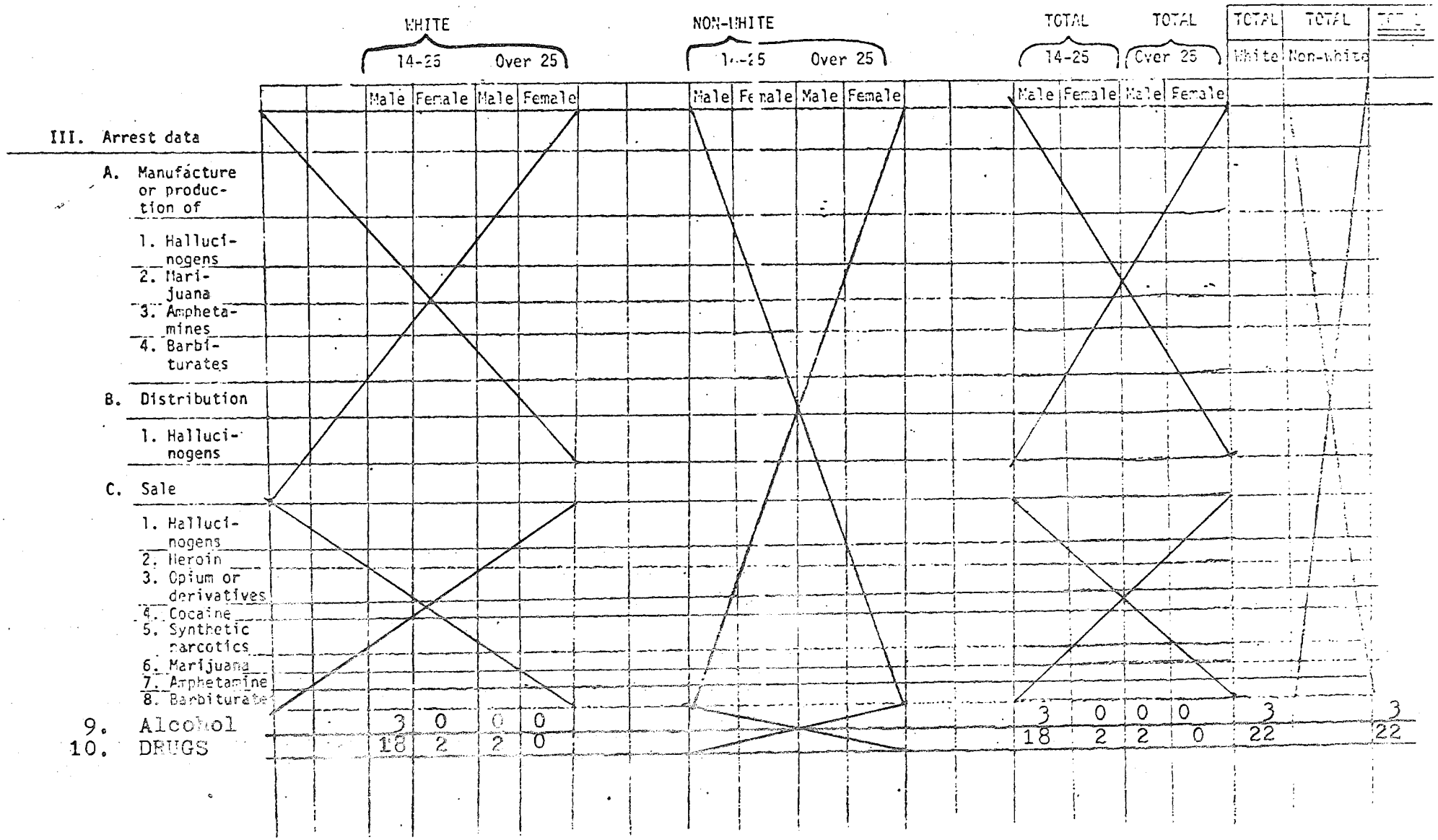
NUMBER OF CASES 9085**

A. Hospital Emergency Rooms	
1. Opiates	
a) Heroin	
b) Methadone	
c) Other opiates	
2. Barbiturates or other depressants excluding alcohol	
3. Amphetamines and amphetamine-like stimulants excluding cocaine	
4. Alcohol	
5. Cocaine	
6. Hallucinogens	
7. Cannabis	
8. Volatile substances	
9. Other, unknown or combination	
B. Other medical (clinics, etc.)	INCLUDES HOSPITAL EMERGENCY ROOMS
1. Opiates	
a) Heroin	0
b) Methadone	0
c) Other opiates	110
2. Barbiturates or other depressants excluding alcohol	320
3. Amphetamines and amphetamine-like stimulants excluding cocaine	310
4. Alcohol	2976
5. Cocaine	3
6. Hallucinogens	226
7. Cannabis	395
8. Volatile substances	30
9. Other, unknown, or combination	156

C. Hot lines/crisis intervention centers (Requests for referral or medical assistance received by such institutions)	TOTAL CASES TREATED BY CENTERS	# CASES REFERED BY CENTERS
1. Opiates		
a) Heroin	0	0
b) Methadone	0	0
c) Other	0	0
2. Barbiturates and other depressants excluding alcohol	124	7
3. Amphetamines and amphetamine-like stimulants excluding cocaine	324	26
4. Alcohol	502	38
5. Cocaine	2522	172
6. Hallucinogens	18	1
7. Cannabis	421	17
8. Volatile substances	530	30
9. Other, unknown or combination	0	0
TOTAL CASES	71	5
RACE: WHITE (9085*) NON WHITE (----)	9085*	296
AGE: UNDER 14 (791) 14-25 (1828 OVER (4121)		
SEX: MALE (2985) FEMALE (1046)		

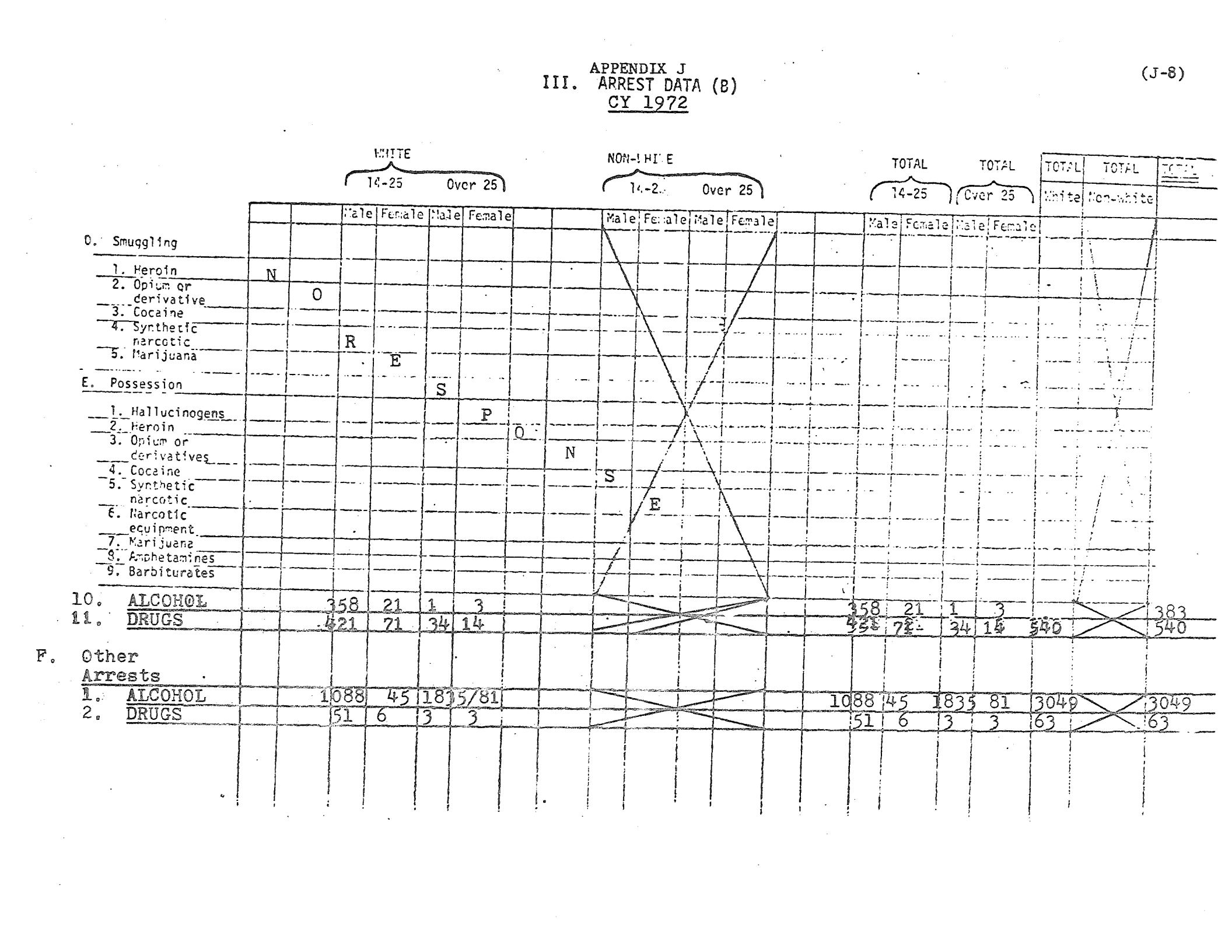
*ALL AGENCIES DID NOT REPORT BY AGE & SEX.
**THIS TOTAL DOES NOT INCLUDE PUBLIC HEALTH LABRATORY SAMPLES ANALIZED.

APPENDIX J
III. ARREST DATA (A)
CY 1972



III. Arrest data	WHITE 14-25 Male	WHITE 14-25 Female	WHITE Over 25 Male	WHITE Over 25 Female	NON-WHITE 14-25 Male	NON-WHITE 14-25 Female	NON-WHITE Over 25 Male	NON-WHITE Over 25 Female	TOTAL 14-25 Male	TOTAL 14-25 Female	TOTAL Over 25 Male	TOTAL Over 25 Female	TOTAL White	TOTAL Non-White	TOTAL
A. Manufacture or production of															
1. Hallucinogens															
2. Marijuana															
3. Amphetamines															
4. Barbiturates															
B. Distribution															
1. Hallucinogens															
C. Sale															
1. Hallucinogens															
2. Heroin															
3. Opium or derivatives															
4. Cocaine															
5. Synthetic narcotics															
6. Marijuana															
7. Amphetamine															
8. Barbiturate															
9. Alcohol		3	0	0	0				3	0	0	0	3		3
10. DRUGS		18	2	2	0				18	2	2	0	22		22

APPENDIX J
III. ARREST DATA (B)
CY 1972

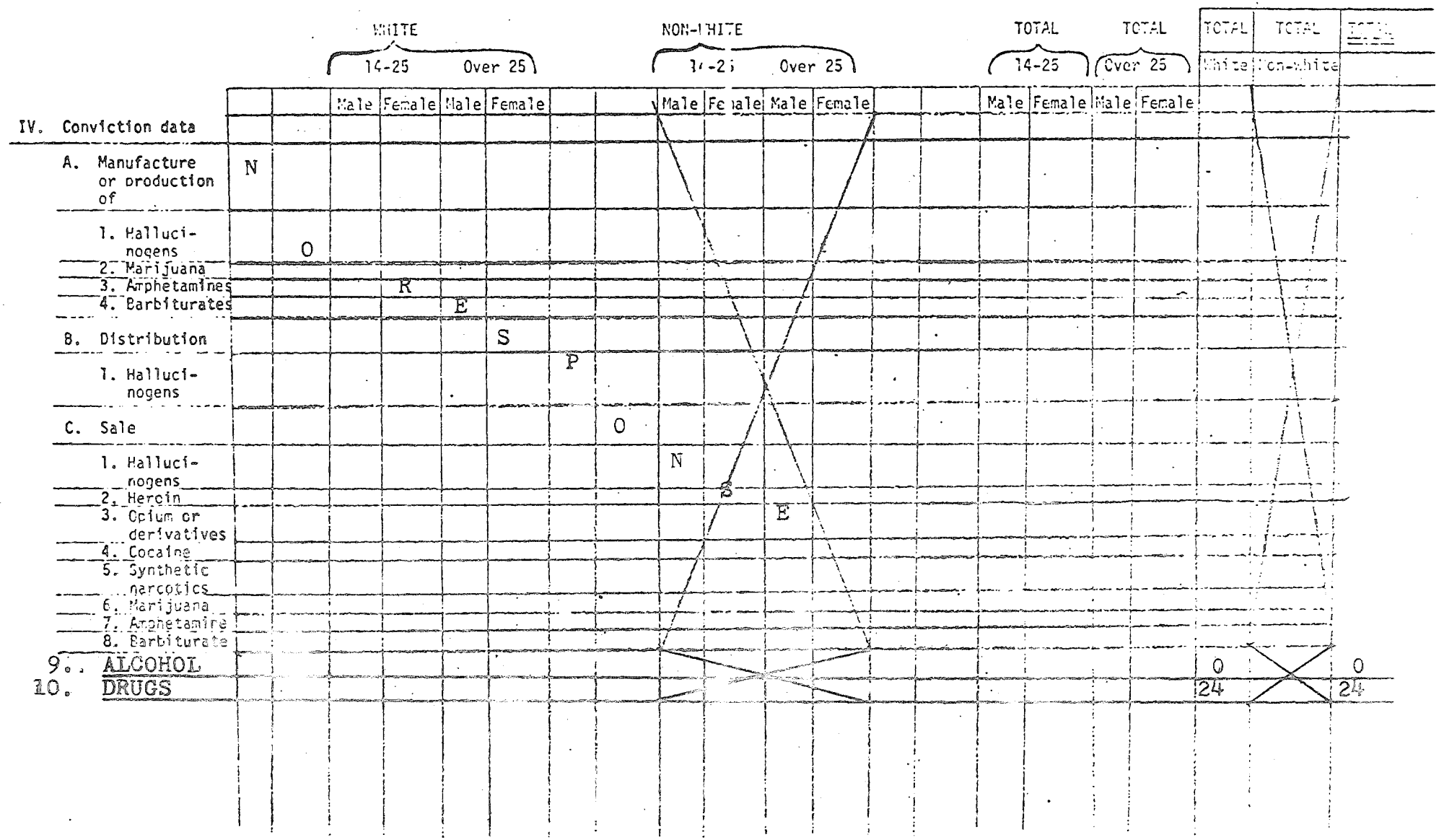


D. Smuggling																			
1. Heroin																			
2. Opium or derivative																			
3. Cocaine																			
4. Synthetic narcotic																			
5. Marijuana																			
E. Possession																			
1. Hallucinogens																			
2. Heroin																			
3. Opium or derivatives																			
4. Cocaine																			
5. Synthetic narcotic																			
6. Narcotic equipment																			
7. Marijuana																			
8. Amphetamines																			
9. Barbiturates																			
10. ALCOHOL			358	21	1	3							358	21	1	3			383
11. DRUGS			421	71	34	14							455	71	34	14	540		540
F. Other Arrests																			
1. ALCOHOL			1088	45	1835	81							1088	45	1835	81	3049		3049
2. DRUGS			51	6	3	3							51	6	3	3	63		63

APPENDIX J

IV. CONVICTION DATA (A)

CY 1972



APPENDIX J

IV. CONVICTION DATA (P)

CY 1972