

Maine

Drug Threat Assessment



National Drug Intelligence Center
U.S. Department of Justice



Maine Drug Threat Assessment

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Preface

This report is a strategic assessment that addresses the status and outlook of the drug threat in Maine. Analytical judgment determined the threat posed by each drug type or category, taking into account the most current quantitative and qualitative information on availability, demand, production or cultivation, transportation, and distribution, as well as the effects of a particular drug on abusers and society as a whole. While NDIC sought to incorporate the latest available information, a time lag often exists between collection and publication of data, particularly demand-related data sets. NDIC anticipates that this drug threat assessment will be useful to policymakers, law enforcement personnel, and treatment providers at the federal, state, and local levels because it draws upon a broad range of information sources to describe and analyze the drug threat in Maine.

Maine Drug Threat Assessment

Executive Summary

Cocaine and heroin are Maine's primary drug threats based on their addictive properties, availability, and abuse. Cocaine is transported to Maine from several locations primarily in privately owned, borrowed, and leased vehicles and by way of public transportation. Maine health department data show that cocaine abuse remains stable. However, law enforcement reports that powdered cocaine abuse is stable while the conversion of powdered cocaine into crack and the abuse of crack are increasing in the state. Powdered cocaine is distributed throughout the state while most crack cocaine distribution is limited to southern Maine. Despite a 40 percent drop in fiscal year 2000 Maine Drug Enforcement Agency crack cocaine-related arrests, 28 percent of all Maine Drug Enforcement Agency arrests were cocaine-related. Dominican criminal groups operating in Massachusetts are the primary suppliers of cocaine to Maine. Most powdered cocaine dealers are Caucasian while most crack cocaine dealers are Hispanic, particularly Dominican.

Heroin availability and use are increasing in the state, reflecting a trend noted throughout New England. Law enforcement authorities in Bangor, Lewiston, Lyman, and Portland report increases in heroin abuse in fiscal year 2000. The Bangor Police Department cites heroin as the primary drug threat in its city, Maine's third largest. Authorities in Aroostook and Washington Counties in northern Maine are the only ones reporting negligible heroin use. However, law enforcement sources believe that could change as people in those counties currently paying \$80 for an 80-milligram tablet of OxyContin discover that heroin use provides similar effects at a lower cost. The 29 percent jump in heroin treatment admissions in Maine during the first 9 months of 2000, and action taken by Acadia Hospital officials to obtain a state license to open the first methadone clinic in the city of Bangor are indicators of increasing heroin abuse. A 40 percent increase in Maine Drug Enforcement Agency heroin-related arrests and a 166 percent increase in heroin seizures in fiscal year 2000 are further indicators of the extent of the heroin threat in the state. Dominican criminal groups operating in Massachusetts are the primary suppliers of heroin in Maine. Independent, Caucasian dealers form the backbone of retail heroin operations in Maine.

Marijuana is the most readily available and widely abused drug in the state where 65 percent of those aged 26 to 34 report using marijuana at least once in their lifetime. The percentage only drops to 55 percent among those aged 35 to 50. While locally produced marijuana is readily available in Maine; most comes from Mexico. Marijuana produced in Canada from hydroponically cultivated cannabis sells for a premium in Maine because of its high THC content. Many distributors and small- and medium-sized grow operations function throughout the state; however, there are no dominant criminal groups. In November 1999, Maine became the first New England state and the sixth state in the nation to adopt a law supporting the use of marijuana for certain medical conditions; however, implementation of this law is unresolved and continues to be a matter of public debate.

An increase in the abuse of other dangerous drugs, particularly prescription drugs, is evident in Maine. Prescription drug abuse is a major concern for authorities. OxyContin, the diverted pharmaceutical drug of choice, retails on the street for \$1 per milligram. The abuse of pharmaceuticals is increasing throughout the state and has become the primary drug threat in Washington County. The increase in the number of treatment admissions for opiate addiction during 1999 and 2000—excluding those stemming from the abuse of heroin—is an indicator of the extent of the opiate-based prescription drug problem. Also, LSD and psilocybin mushrooms continue to be secondary drug problems while MDMA is just beginning to emerge. All three have been seized at rave dance parties held in the state.

Methamphetamine abuse is not a significant threat. In the past, methamphetamine primarily was available in the northern part of the state where it was shipped from the southwestern United States in express mail packages. In September 2000, law enforcement discovered the first methamphetamine laboratory in Maine since 1991, but the Maine Drug Enforcement Agency believes that it represents an isolated incident and is not an indicator of a more substantial problem.

Table of Contents

Executive Summary	iii
Overview	1
Cocaine	5
Abuse	5
Availability	5
Violence	6
Production	6
Transportation	6
Distribution	7
Heroin	8
Abuse	8
Availability	9
Violence	10
Production	10
Transportation	11
Distribution	11
Marijuana	12
Abuse	12
Availability	12
Violence	13
Production	13
Transportation	14
Distribution	14
Other Dangerous Drugs	15
Prescription Drugs	15
LSD	17
Psilocybin Mushrooms	18
MDMA	18
Methamphetamine	19
Outlook	21
Sources	23



Maine.



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Overview

Maine encompasses 35,387 square miles and is the thirty-ninth largest state. It shares the longest state border with Canada—600 miles—and has 228 miles of shoreline. The port of Calais at the Canadian border is one of the top 10 busiest ports of entry (POE) in the United States. Eastport, Portland, and Searsport are Maine's primary seaports, and international airports are located in Bangor and Portland.

Maine is the thirty-ninth most populous state with 1,253,040 residents. The per capita income was \$23,002 in 1998—\$3,480 lower than the national average. In the same year, 10.4 percent of the people lived in poverty, 2.3 percent below the national average of 12.7 percent.

Interstate 95 is the primary highway in Maine and it provides links to drug sources in Massachusetts and other East Coast states including New York and Florida. Interstate 95 terminates at the New Brunswick, Canada, border in Houlton, Maine. Once through the Houlton POE, Interstate 95 becomes Provincial Road 95 and this highway connects to Trans-Canada 2. Trans-Canada 2 runs north to St. Leonard, New Brunswick, and east to Fredericton, New Brunswick. Maine Routes 1, 11, and 201 link the state to Canada as well, and Route 2 links Maine with New Hampshire.

Fast Facts

Maine

Population (1999)	1,253,040
U.S. ranking	39th
Per capita income (1998)	\$23,002
Land area	35,387 square miles
Shoreline	228 miles
Capital	Augusta
Principal cities	Portland, Lewiston, Bangor, Auburn, South Portland, Augusta, Biddeford
Principal industries	Paper products, transportation equipment, electrical equipment, wood products, leather products, food products, rubber and plastic products

In a 1997 *Health Risk Behaviors Among Maine Youth* survey, the percentage of high school students reporting drug use at least once in their lifetime was as follows: over 50 percent used marijuana, 9 percent used cocaine, and 20 percent used other drugs such as LSD, MDMA, psilocybin mushrooms, and heroin. In Maine’s Office of Substance Abuse 1997 Prevention Data Report, 42.6 percent of adults used marijuana and 13.8 percent used other illegal drugs at least once in their lifetime. This report also showed that 61.5 percent of students interviewed said marijuana was “easy” or “very easy” to obtain and 31.8 percent said other illegal drugs were “easy” or “very easy” to obtain as well. Further, 54 percent of the students reported they had personal knowledge of adults using drugs in the past year, and 34.3 percent reported they had personal knowledge of adults who sold drugs in the past year.

Drug-related deaths and treatment admissions have been on the rise in Maine. Thirty-one individuals died from drug overdoses in 1998 and there were 20 drug-related suicides. In 1999, there were 39 deaths in each category. Treatment admissions in the heroin category and in the other opiates and synthetics category rose sharply in the past few years (See Table 1.)

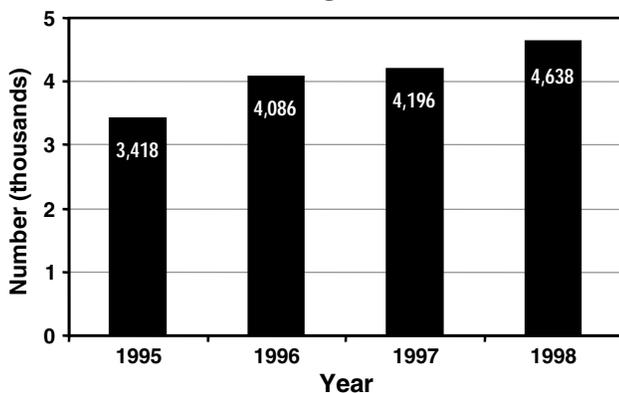
Cocaine and heroin are the primary drug threats in Maine. Heroin availability and abuse are increasing and Bangor law enforcement and the Maine Office of Substance Abuse rank heroin above cocaine as a drug threat. Marijuana is the drug of choice throughout the state, and the abuse of prescription drugs is common and rapidly escalating. This corresponds to the Maine Crime Report that shows drug arrests increasing despite the overall drop in the crime rate (See Charts 1 and 2.) Maine Drug

Table 1. Maine Primary Drug Treatment Admissions

Category	1995	1996	1997	1998	1999	September 2000
Crack Cocaine	225	248	238	229	229	235
Heroin	205	247	267	288	291	374
Marijuana	856	996	1,092	1,200	1,260	1,134
Other Opiates and Synthetics	73	87	112	199	355	521
Methamphetamines	24	17	24	28	22	28

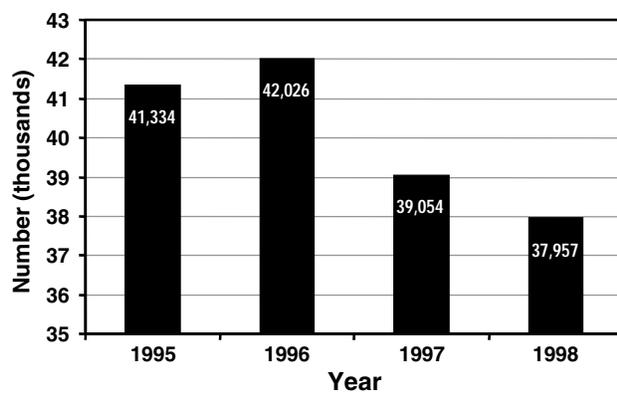
Source: Maine Office of Substance Abuse.

Chart 1. Maine, Drug Crimes 1995-1998



Source: Maine Department of Public Safety, *Crime in Maine Reports*.

Chart 2. Maine, Total Crimes 1995-1998



Source: Maine Department of Public Safety, *Crime in Maine Reports*.

Enforcement Agency (MDEA) arrests continue to grow as well (See Table 2.)

Table 2. Maine Drug Arrests FY1998-FY2000

	FY1998	FY1999	FY2000
Total Arrests	684	707	805
Cocaine	128	141	163
Crack Cocaine	56	73	44
Heroin	51	50	70
LSD	15	29	13
Marijuana	278	225	253
Methamphetamine	21	16	13
Pharmaceutical	47	80	156
Psilocybin	11	12	8

Source: Maine Drug Enforcement Agency, *Annual Report*, 1998, 1999, 2000.

Dominican drug trafficking organizations (DTOs) are the primary suppliers of cocaine and heroin in Maine. Dominican DTOs increased their drug trafficking activities in the Northeast during the past decade. In the 1980s, the Colombia-based Cali and Medellin Cartels employed Dominican criminal groups in the United States to distribute crack cocaine at the retail level in New York City. Today, aside from receiving their drug supply from Colombian DTOs, many Dominican traffickers operate independently. Dominican criminal groups operating at the wholesale or retail levels have been reported throughout New England and, in particular, in the Maine cities of Auburn, Augusta, Bangor, Houlton, Lewiston, Portland, and Waterville.

New York City remains the primary distribution center for the bulk of Maine's cocaine and heroin that is distributed by Dominican DTOs. New York City is also the focal point for their command-and-control activities. Cocaine destined for New York City is typically transported from the Caribbean hidden in

containerized air and maritime cargo while the heroin is transported from South America by couriers on commercial airlines.

Dominican DTOs also use the Boston area, including the cities of Lowell and Lawrence, as secondary wholesale distribution centers. The MDEA and the Drug Enforcement Administration (DEA) mention these cities in Massachusetts as important distribution centers for the cocaine and heroin market in Maine.

In the Northeast, two types of relationships exist between Dominican dealers operating in smaller towns and the distributors operating in wholesale distribution cities. The relationship is either one of direct command-and-control or one of network (buyer-seller). Dealers may be actual members of the supply organization or may be independent operators. Those working for a distribution organization likely know more about the organization than an independent buyer.

Dominican DTOs are adept at operational security and countersurveillance. They stay abreast of new technologies and use radio transceivers, alarm systems, police scanners, miniature video cameras, and other high-tech equipment to detect and monitor the activities of law enforcement. Dominican criminal groups are proficient at constructing false compartments or traps to hide drugs, guns, and money. Traps, found primarily in vehicles, are mechanical alterations requiring a sophisticated series of procedures to open. Traps can be categorized as transport or personal. Transport traps are large, normally inaccessible to passengers, and usually used for the interstate shipment of cocaine; however, they are also a way to transport currency from drug distribution operations. Personal traps are small, accessible to the passengers, and used in the day-to-day activities of drug traffickers. Personal traps contain items such as weapons, money, and drugs in quantities necessary for daily distribution within a local area.

Dominican DTOs take advantage of passenger van services to transport drugs along the Northeast coast. These van services make several scheduled runs each day from New York City to Boston and Lawrence, Massachusetts, stopping at other cities along the route. Unlike commercial bus lines, van services specialize in transporting passengers door to door. By avoiding bus terminals, Dominican cocaine couriers reduce the risk of law enforcement interdiction.

Dominican DTOs commonly begin the process of laundering drug proceeds by using remittance houses (*casas de cambio*) to wire money directly to the Dominican Republic. Dominican DTOs legitimize drug money in the Dominican Republic through hotels, casinos, import-export firms, auto dealerships, and auto parts stores. Federal law enforcement authorities in Boston report that Dominican drug traffickers are very sophisticated and efficient in their use of wire transfers. Drug proceeds obtained in Boston in the morning can be available for use in the Dominican Republic by the afternoon. Federal law enforcement authorities also report that a Geographical Targeting Order (GTO) for the New York City area, issued by the U.S. Department of the Treasury on September 2, 1997, documented significant increases in the number of wire transfers in the Boston area. The order encompassed 15 money transmitters and approximately 3,400 agents serving the Dominican market in New York City.

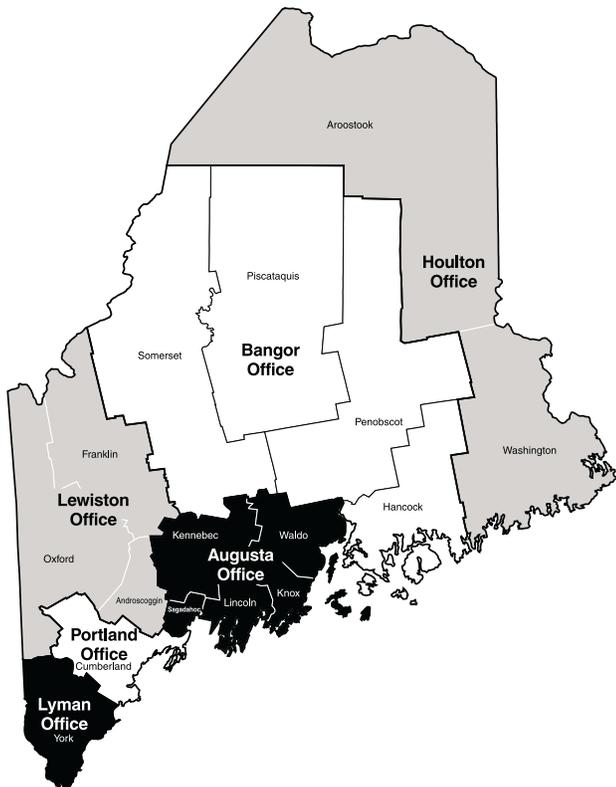


Figure 1. Maine Drug Enforcement Agency Task Force Offices.

The U.S. Department of the Treasury has the authority to issue GTOs under revisions made to the Bank Secrecy Act in 1988. A GTO requires that during a 60-day period, agents of money-transmitting outlets file weekly reports containing customer identification on all currency transactions over an arbitrary figure chosen by the U.S. Department of the Treasury.

There are no reports of Dominican money laundering operations taking place in Maine. It is likely that the proceeds from drug transactions are transported south to Massachusetts. Dominican traffickers operating in cities surrounding Boston most likely use wire transfers and currency smuggling to safely move drug profits generated in Maine to the Dominican Republic.

Currency from drug proceeds is smuggled into the Dominican Republic as well. Dominican traffickers use express package services, couriers (mules), and containerized cargo shipments to smuggle currency to the Dominican Republic. Federal law enforcement authorities report investigations involving Dominican currency couriers in Boston. There have also been investigations involving the use of containerized cargo to transport Dominican drug proceeds from Boston to the Dominican Republic.

Cocaine

Cocaine is one of the primary drug threats in Maine. Powdered cocaine is distributed throughout the state while most crack cocaine distribution is limited to southern Maine. Cocaine is transported into Maine from several locations primarily in privately owned, borrowed, and leased vehicles and by way of public transportation. Crack cocaine abuse and the conversion of powdered cocaine into crack are increasing while the abuse of powdered cocaine remains steady, according to law enforcement authorities. Health data indicate that cocaine abuse overall is stable.

Most powdered cocaine dealers are Caucasian while most crack cocaine dealers are Hispanic, particularly Dominican. Dominican criminal groups operating in Massachusetts are the primary suppliers of cocaine to Maine.

The United States Attorneys in Maine, New Hampshire, Vermont, and Massachusetts joined with the DEA in 1995 to create the Cross Borders Task Force to address the significant cocaine problem in those areas.

Abuse

Maine health data show that cocaine abuse remains stable. The number of deaths caused by cocaine used in combination with other drugs increased by only three from 1995 to 1998. The total number of clients in Maine admitted to drug treatment programs for powdered and crack cocaine abuse shows little growth from 1995 (225) through September, 2000 (235). A 1997 *Health Risk Behaviors Among Maine Youth* survey reported that 9 percent of Maine's senior high school students used cocaine at least once in their lifetime compared with 8 percent nationwide.

Law enforcement reports that powdered cocaine abuse is stable while crack cocaine abuse is rising. The MDEA Augusta (Kennebec, Knox, Lincoln, Sagadahoc, and Waldo Counties) Task

Force reports that powdered cocaine abuse is stable, although it remains the Schedule W (see text box) drug of choice. The MDEA Lewiston (Androscoggin, Franklin, and Oxford Counties) Task Force reports that crack cocaine abuse is increasing in Auburn and Lewiston, noting that crack has been the drug of choice for several years. The DEA reports that crack cocaine abuse is rapidly increasing in the southern and central sections of the state.

Maine Criminal Code contains Drug Schedules W, X, Y, and Z. Drugs listed in Schedule W include cocaine, crack cocaine, ecstasy, heroin, LSD, methamphetamine, and Vicodin.

Availability

Powdered cocaine is distributed throughout the state while most crack cocaine distribution is limited to southern Maine. The MDEA Augusta Task Force reports that crack cocaine became available in Augusta after a Lewiston Dominican distribution group expanded its market in 1999. Powdered cocaine arrests have consistently increased during the past three fiscal years

while crack cocaine arrests reached their highest level in FY1999. The percentage of MDEA arrests for powdered or crack cocaine dropped from 34 percent (214) in FY1999 to 28 percent (207) in FY2000. However, there were 195 percent more cocaine-related arrests than heroin-related arrests in FY2000. MDEA seizures of powdered cocaine and crack cocaine dropped

from FY1999 to FY2000. Between FY1999 and FY2000, the amount of powdered cocaine seized decreased from 11.6 kilograms to 5.8 kilograms. In that same period, the amount of crack cocaine seized decreased from 0.5 kilograms to 0.2 kilograms. Retail prices for powdered cocaine in

Portland range from \$80 to \$120 per gram with purity ranging from 30 to 80 percent. Crack cocaine prices at the retail level in Portland range from \$20 to \$50 per rock with purity ranging from 75 to 100 percent.

Violence

Statistics correlating cocaine distribution and abuse in Maine with violence are not available. However, anecdotal information indicates the two are closely related. The MDEA Augusta Task Force notes that when cocaine availability increases, there is a “discernible rise in thefts, burglaries, assaults, and home invasions,” as well as a rise in violent crimes “from disputes over

owed money.” The investigation of a long-standing cocaine distribution group in Portland led to several arrests of group members involved in a car bombing and two armed robberies—including one in which a clerk was shot—illustrating the connection between cocaine distribution activities and violence in Maine.

Production

Coca cultivation and cocaine production occur on a significant level only in Colombia, Peru, and Bolivia. There have been no reports of coca cultivation or cocaine production in Maine; however, conversion of powdered

cocaine into crack cocaine is increasing. The conversion process involves adding baking soda and water to powdered cocaine and then heating the mixture, converting the powder into crack, a crystal-like substance.

Transportation

Cocaine is transported into Maine primarily from Lowell, Lawrence, and Lynn, Massachusetts, on Interstate 95. It also is transported to Maine from New York and Florida along I-95 and, to a much lesser extent, from the western United States. Distribution centers in Florida and New York are Maine’s second and third largest cocaine suppliers, respectively, after Massachusetts, according to the MDEA. The I-95 corridor from Florida to Maine is a significant route in illegal drug transportation since it links all eastern seaboard states.

Privately owned and rented automobiles are the primary conveyances used to transport cocaine to Maine. Also, couriers carry drugs

concealed in or on their person or in luggage, and travel to Maine on commercial airlines and buses. Parcels containing cocaine are also shipped to Maine using commercial package delivery and mail services.

The MDEA Portland (Cumberland County) Task Force reported in 1999 that there was a significant decrease in the transportation of crack cocaine into the area and a marked increase in the local conversion of powdered cocaine into crack. Sentences for possessing crack cocaine are lengthier than those for powdered cocaine, so retail distributors generally convert crack in the areas where it is to be distributed. A Connecticut-based cocaine distribution group operating in the

Bath-Brunswick area of Maine transported powdered cocaine to Maine, converted it into crack cocaine, and distributed it locally. A Puerto Rican member of the Ñeta, a Connecticut street gang, was head of this distribution group. Carlos LaSombra founded the Ñeta in a prison in Puerto Rico in 1970. It originally was a street and prison

gang but remains primarily a prison gang found in many correctional facilities in Connecticut. Most of the members are Hispanic but there are some African American and Caucasian members. Action against this organization by a DEA-led task force in December 1999 led to the arrest of 26 members (18 on federal charges).

Distribution

Dominican drug trafficking organizations (DTOs) operating in Massachusetts supply the wholesale cocaine market in Maine. Dominican DTOs increased their drug trafficking activities in the Northeast during the past decade and have developed sophisticated methods of operation. Cocaine destined for New York City is typically transported from the Caribbean hidden in containerized air and maritime cargo. While New York City remains the primary distribution center, Dominican DTOs now use Philadelphia and the Boston area, including Lowell and Lawrence, as secondary wholesale distribution centers. Dominican criminal groups operating at the wholesale or retail levels have been reported throughout New England and, in particular, in the Maine cities of Auburn, Augusta, Bangor, Houlton, Lewiston, Portland, and Waterville.

A 1998 investigation involving the arrest of four Dominicans on federal cocaine distribution and conspiracy charges provides an excellent example of the Massachusetts connection. This particular Dominican distribution group, which included three illegal aliens, supplied 1 kilogram of cocaine monthly from its base in northern Massachusetts to two local Caucasian dealers in Hancock County, Maine. Hancock County includes the cities of Bar Harbor, Bucksport, and Ellsworth; the county line is approximately 12 miles from the city of Bangor.

Most of the powdered cocaine retailers in Maine are independent, Caucasian dealers. They travel to Lawrence, Lowell, and Lynn, Massachusetts, on a regular basis, returning with powdered cocaine packaged for retail distribution. The

MDEA reports that numerous independent cocaine dealers along with highly organized cocaine distribution groups are active throughout the state. A 1999 Organized Crime Drug Enforcement Task Force (OCDETF) investigation resulted in the prosecution of two brothers responsible for the monthly distribution of multi-kilogram quantities of powdered cocaine. One of the brothers and his father were members of the Saracens Motorcycle Club. The mere association with the Saracens, an outlaw motorcycle gang (OMG) allied with the Hells Angels, was enough to intimidate witnesses and hamper progress of the investigation for a significant period.

The Saracens Motorcycle Club is an OMG operating in the state of Maine. It is allied with and subservient to the Hells Angels. In 1997, the Hells Angels formed a Canaan, Maine, chapter, which many Saracens joined at that time. However, the Saracens remain active and distribute cocaine and marijuana in western and central Maine. The MDEA reports that the Saracens also have been involved with the distribution of methamphetamine. The Saracens' Internet site provides news and a schedule of events.

Dominican criminal groups are the predominant crack cocaine dealers in Maine. The MDEA reports that Dominican dealers in some instances sold powdered cocaine along with crack. A typical crack cocaine dealer in Lewiston or Auburn establishes a relationship with a local crack addict and works out of a bedroom in the addict's apartment. In turn, the addict conducts retail drug transactions and keeps one rock of crack for

every four or five rocks sold. The “Flaco” distribution network, a Dominican-led group from Lawrence, Massachusetts, operated several crack houses in Auburn and Lewiston with the assistance of local crack addicts. The network was disbanded through a joint operation of the MDEA Lewiston and Portland Task Forces in 1999. In 2000, the MDEA reports that many of these dealers now favor motel rooms instead of apartments. The dealers are able to maintain a low profile while at the motel by using pagers and telephones to contact customers and by sending out runners with the crack cocaine.

Dealers other than Dominican criminals sell crack cocaine in Maine but to a more limited extent. A 1999 MDEA investigation of the New York “ROZ” organization discovered young African American dealers who traveled from Brooklyn with crack cocaine, conducted retail drug transactions in Portland and Lewiston, Maine, and then returned to New York with the cash. The MDEA Lewiston Task Force reports that this organization sold some of the highest quality crack cocaine ever distributed in the area and was responsible for a sharp rise in local crack abuse.

Heroin

Heroin availability and abuse are increasing in Maine, reflecting a trend noted throughout New England. South American heroin is the predominant type in the state. The MDEA Task Forces in Augusta, Bangor (Hancock, Penobscot, Piscataquis, and Somerset Counties), Lyman (York County), and Portland all report increases in heroin abuse during FY2000. Only authorities in northern Maine (Aroostook and Washington Counties) report no significant heroin abuse

problem. However, law enforcement sources believe that could change as individuals in those counties currently paying \$80 for an 80-mg tablet of OxyContin discover that heroin use provides similar effects at a lower cost. Dominican criminal groups operating in Massachusetts are the primary suppliers of heroin in the state. Independent Caucasian dealers form the backbone of retail heroin operations in Maine.

Abuse

High purity South American heroin retailed in Maine is attractive especially to youth because it can be effectively snorted, eliminating the risk and stigma associated with injection. At the same time, many new users believe snorting will not lead to addiction. Unfortunately, as addiction develops and tolerance levels increase, those users often switch to the more “efficient” method of administration—injection.

Maine health data show the abuse of heroin is increasing and Maine’s Office of Substance Abuse reports that heroin has surpassed cocaine as the primary drug health threat in the state. The number of heroin overdose deaths increased from two in 1995 to eight in 1998. The total number of clients admitted to drug treatment

programs for heroin abuse continues to increase; there was a 29 percent rise during the first 9 months of 2000. Moreover, heroin treatment admissions have consistently surpassed cocaine admissions since 1997, and during the first 9 months of 2000, heroin treatment admissions outpaced cocaine admissions by 59 percent. The number of clients admitted to treatment facilities for heroin abuse increased steadily from 1995 (205) through September 2000 (374). Correlating with this data, employees at Shaw House, a shelter for teens in Bangor, first noticed clients using heroin in the fall of 1999.

Because of the increase in the number of heroin and other opiate addicts admitted to treatment facilities, Acadia Hospital officials

attempted to open the first methadone clinic in the city of Bangor and the third in the state. Hospital officials planned to offer a methadone treatment program in the spring of 2000, but opposition by Bangor City officials led to a contracted public debate. City and state officials finally reached an agreement to open the facility. The projected opening date is April 2001.

Law enforcement also notes that heroin abuse is rising in the state. The MDEA reports a growing heroin abuse problem in most areas of the state in FY2000. The MDEA Task Force in Augusta reports that heroin abuse is a significant problem, especially in coastal areas. The Bangor Police Department (BPD) reported a dramatic increase in heroin abuse in 1999 based on fatal heroin overdoses, heroin-related treatment center admissions, and crimes attributed to addicts seeking money to support their heroin habits. The BPD further cites heroin as the primary drug

threat in the community, Maine's third largest city. The MDEA Bangor Task Force reports that the heroin addict population is growing significantly with treatment facilities overwhelmed by the number of addicts seeking help. The Lyman MDEA Task Force reports that heroin abuse continues to increase, and is reflected in the number of methadone clinic clients. The MDEA Portland Task Force reports there are over 900 hardcore addicts in the Portland area and notes that the number of younger users and the number of heroin overdoses are increasing. Only authorities in Aroostook and Washington Counties in northern Maine report insignificant heroin use. However, law enforcement sources believe that could change as people in these counties that are currently paying \$80 for an 80-mg tablet of OxyContin discover that heroin use provides similar effects at a lower cost.

Availability

Heroin availability is increasing in Maine. Typically, South American heroin, the predominant type in the state, is transported to Maine packaged in glassine bags ready for retail distribution. However, the MDEA and the DEA report an atypical seizure of 3 ounces of unmilled heroin in the Bangor area in the fall of 1999. This seizure may indicate that the heroin market in Bangor has developed to the point where some organizations consider it feasible to mill heroin within the state. An August 2000 heroin seizure was the first major seizure on Mount Desert Island—home of Acadia National Park and the shopping mecca of Bar Harbor. Five island residents were arrested, and over 1,000 bags of heroin intended for the more than 40 Mount Desert Island heroin addicts were seized.

The MDEA reports that heroin availability is increasing in most areas of the state. The Augusta MDEA Task Force reports that heroin prices are down and purity is up. The Bangor MDEA Task Force reports heroin availability is surging with

Bulk heroin must be milled before it can be sold to street-level users. Milling is a process by which bulk heroin is cut with adulterants, such as lactose and Mannitol, and then separated into user quantities. User quantities of heroin are often packaged in glassine bags that contain one dose of heroin. Often, multiple glassine bags are packaged together for retail sale; a group of 10 glassine bags is called a bundle, and a group of 10 bundles is called a brick. One kilogram of nearly 100-percent-pure heroin can be processed into approximately 30,000 user quantities.

many individuals once noted for dealing cocaine switching to heroin because of the growing demand. Heroin is also available in increasing quantities and higher purity levels in the Portland area, according to the MDEA Portland Task Force. At the retail level, prices for heroin in Portland range from \$8 to \$40 per bag with purity ranging from 50 to 87 percent. The increasing

availability of heroin is reflected in MDEA statistics. MDEA heroin-related arrests rose 40 percent from FY1999 (50) to FY2000 (70). The percentage of MDEA arrests that are heroin related increased

from 7.7 percent in FY1999 to 9.6 percent in FY2000. During the same time period, MDEA heroin seizures increased by 166 percent, from 194 grams in FY1999 to 517 grams in FY2000.

Violence

Statistics correlating heroin distribution and abuse with violence in Maine are not available. Heroin users generally do not commit violent acts while under the influence of the drug. However, the BPD notes that property crimes go up

with increasing heroin abuse as addicts seek cash to pay for their costly addictions. Moreover, the potential for violence exists at the distribution level during disputes over drug territories and profits.

Production

There are no known incidents of opium poppy cultivation or heroin production in Maine. However, there is a possibility that a heroin milling operation exists in Maine since 3 ounces of unmilled heroin were seized in the Bangor area in the fall of 1999.

Heroin is produced in four source regions: Southwest Asia, Southeast Asia, South America, and Mexico. Heroin is refined from opium harvested from the opium poppy, an annual plant with a 3- to 5-month life cycle. Only one crop per year is grown in regions with distinct seasons but it can be cultivated year round in areas with more temperate climates such as Mexico and Colombia.

South America, primarily Colombia, is a significant source of heroin smuggled into the United States. South American heroin predominates in the northeast market (Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, and Pennsylvania) because of its low price and high purity, according to the DEA's Domestic

The DMP is a heroin purchase program designed to provide data on the purity, price, and origin of retail-level heroin available in 23 major U.S. metropolitan areas.

The HSP was developed to enhance DEA's ability to identify the source of heroin seized and purchased within the United States through in-depth chemical analysis of heroin samples. The HSP is able to identify 90 percent of the samples analyzed under the program each year.

Monitor Program (DMP) and Heroin Signature Program (HSP). Dominican DTOs are the primary wholesale heroin suppliers in Maine insuring the predominance of South American heroin in the state.

Transportation

Private automobiles are most commonly used to transport heroin to Maine. Many heroin dealers from Maine travel Interstate 95 to reach their suppliers in cities such as Lawrence, Lowell, and Lynn, Massachusetts. In some instances, these dealers conceal the heroin within their body cavities during the drive to Maine. In the

neighboring state of Connecticut, the Hartford Police Department reports that it is not unusual to seize an automobile en route from New York City containing traps concealing over 4,000 glassine bags of heroin. It is probable that heroin is transported to Maine in the same manner by larger distribution groups.

Distribution

Dominican DTOs are the primary suppliers of South American heroin in Maine. They supply independent dealers who travel from Maine to several Massachusetts cities including Lawrence and Lowell. The MDEA Augusta Task Force reports the pattern of heroin distribution from Massachusetts suppliers to dealers who travel from market areas in Maine remains steady. Heroin dealers from Rockland and Waldoboro, Maine, travel to New Bedford, Massachusetts; dealers from Kennebec County, Maine, travel to Worcester, Massachusetts; and dealers from Bath and Brunswick, Maine, travel to Lawrence, Lowell, and Lynn, Massachusetts.

Dominican DTOs increased their drug trafficking activities in the Northeast during the past decade and have developed sophisticated methods of operation. Most of the heroin distributed by Dominican DTOs is transported to New York City from South America by couriers on commercial airlines. While New York City remains the primary distribution center, Dominican DTOs now use Philadelphia and the Boston area, including Lowell and Lawrence, as secondary wholesale distribution centers. Dominican criminal groups operating at the wholesale or retail levels have been reported throughout New England and, in particular, in the Maine cities of Auburn, Augusta, Bangor, Houlton, Lewiston, Portland, and Waterville.

Although the user-to-dealer transformation is common, there also are larger distribution operations within the state. The MDEA, the DEA, the Brunswick Police Department, and the Immigration and Naturalization Service (INS) investigated a Dominican criminal group distributing cocaine, crack cocaine, and 87-percent-pure heroin through local street dealers in Portland. As a result of this 1997 investigation, 16 suspects were arrested and convicted.

Independent Caucasian dealers form the backbone of retail heroin operations in Maine. These dealers travel to cities in Massachusetts and to New York City to purchase heroin. Most heroin retailers sell the drug to support their own heroin habits. Often, new addicts travel out of Maine seeking lower heroin prices and, after finding a source, the addicts purchase more than they need for personal use. They sell the excess heroin in Maine, taking advantage of the retail cost differential between distribution cities like Lowell and Lynn and Maine market cities like Bath and Portland. The MDEA reports that heroin can be purchased in distribution cities in Massachusetts for \$4 to \$6 per retail unit and sold in cities in Maine for \$8 to \$45.

Marijuana

Marijuana is the most readily available and widely abused drug in Maine. While locally produced marijuana is readily available in Maine, most of the marijuana comes from Mexico. No single criminal organization or group dominates Maine's wholesale or retail marijuana market;

however, many small- and medium-sized criminal groups are active. In November 1999, voters passed the Maine Medical Marijuana Initiative, Bill LD 2109, authorizing the legal use of marijuana for medical purposes within the state.

Abuse

Marijuana is the most commonly abused drug in Maine. Both MDEA and DEA report that marijuana is the drug of choice in the state. According to a 1998 report by the Maine Task Force on Substance Abuse, approximately 95,000 Maine adults routinely use marijuana. Sixty-five percent of adults aged 26 to 34 and 55 percent aged 35 to 50 report using marijuana at least once in their lifetime. In a 1997 Health Risk Behaviors Among Maine Youth survey, 30 percent of Maine high school students reported using marijuana within the 30 days preceding the survey, compared with 26 percent nationally. Focusing on twelfth graders, the survey found that 59 percent reported using marijuana at least once in their lifetime. This prevalent use is reflected in admissions to marijuana treatment programs in Maine, which continue to increase. The number of clients admitted to

treatment facilities for marijuana abuse increased steadily from 1995 (856) through September 2000 (1,134).

Marijuana is considered by some experts to be a gateway drug that may lead to the abuse of more harmful substances. A recent medical study suggests that middle-aged and elderly marijuana smokers may increase their risk of heart attack within the first hour of using the drug. Another study indicates that marijuana may put abusers at risk for lung cancer. Smoking marijuana causes large tar deposits in the respiratory tract and experiments demonstrate that tetrahydrocannabinol, the psychoactive component of the drug, reduces the body's ability to produce cytokines, immune suppressors that are known to limit tumor growth.

Availability

Marijuana is available throughout the state according to the DEA and the MDEA. While locally produced marijuana is readily available in Maine; most of the marijuana comes from Canada, Jamaica, and Mexico. MDEA estimates between 50 and 60 percent of the marijuana consumed in Maine is from Mexico, particularly Mexico-grown Sativa, while local growers supply about 25 percent. Some marijuana is also smuggled into Maine from Canada; the higher THC content of this hydroponically cultivated cannabis brings premium prices. Marijuana

prices in Portland range from \$2 to \$5 for a joint (marijuana cigarette) of sinsemilla and from \$3 to \$5 for a joint of commercial grade marijuana. The widespread availability of marijuana in the state is not reflected in MDEA statistics. MDEA marijuana-related arrests are down from 278 in FY1998 to 253 in FY2000 and seizures are down from 819 kilograms to 163 kilograms during the same time period. However, marijuana arrests continue to make up the bulk of all MDEA arrests, representing 34.7 percent of the arrests in FY2000. The MDEA notes that the drop in

arrests and seizures reflects the reallocation of limited resources to investigations involving other drug types, not a decrease in the supply of marijuana.

The use of marijuana for medical purposes is an issue in Maine. In November 1999, Maine voters passed the Maine Medical Marijuana Initiative, Bill LD 2109, authorizing the legal use of marijuana for medical purposes. The law contains several restrictions limiting marijuana use to those suffering from specific, physician-diagnosed conditions. Those conditions include nausea, vomiting, or loss of appetite caused by AIDS or chemotherapy or radiation therapy used to treat cancer; glaucoma; epileptic seizures or seizures associated with other chronic diseases; or persistent muscle spasms normally associated with multiple sclerosis or other chronic diseases.

On May 18, 2000, the governor signed into law Bill LD 2580 entitled, "Resolve, Regarding Access To Marijuana For Medical Use." This law directed the Attorney General of Maine to form a task force to study implementation of LD 2109, to recommend steps toward implementation, and to plan ways to provide access to marijuana for this

purpose. Further, the law required this task force to report to the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Criminal Justice by December 1, 2000. On September 27, 2000, this task force ended its last regularly scheduled meeting without forming a consensus on any of the three implementation approaches under consideration. The Maine legislature was expected to address the issue when it reconvened in 2001.

Three Implementation Approaches Reviewed By The Marijuana Task Force

Research Bill: Qualified patients could legally use marijuana through a state-sponsored clinical research program.

Registry and Patient-to-Patient Distribution Bill: On a voluntary basis, qualified patients could be listed on a marijuana registry and each qualified patient would have the legal right to share marijuana with one other qualified patient.

Marijuana Distribution Center Concept Draft: A nonprofit center would be created to sell marijuana to registered patients.

Violence

Marijuana abuse normally is not associated with violent behavior. Although the psychological effects of marijuana are dependent on the mood of the user, most individuals experience physical relaxation and sedation. Violence associated with

cannabis cultivation in Maine is limited; however, growers often arm themselves or set traps in order to prevent the discovery of their plants. There have been no reports of violence associated with marijuana distribution.

Production

Most marijuana used in Maine is produced in Canada, Jamaica, and Mexico with the bulk being produced in Mexico. Within the state, growers cultivate cannabis indoors and outdoors. Law enforcement officers with Maine's Domestic Cannabis Eradication/Suppression Program (DCE/SP) eradicated over 130,000 cannabis

plants and arrested over 1,200 people during a 10-year period beginning in 1989. In 1999 alone, 11,329 cultivated cannabis plants with an estimated value of \$15 million were seized and 216 people were arrested. Cannabis growers have reduced the size of outdoor grows and increased indoor cultivation in response to eradication efforts.

The MDEA considers York County in southern Maine as the primary cannabis growing area within the state. Marijuana labeled “Green Bud” is produced from cannabis cultivated in this area and it sells between \$3,000 and \$4,000 per pound in the state of Florida. The MDEA considers this marijuana to be of high quality because it is produced from cannabis buds and readily sells for such high prices. Aroostook and Washington Counties in northern Maine also contain many

large-scale indoor and outdoor cannabis growing operations. Authorities seized large amounts of cash from York County growers in the last few years indicating the substantial profits generated by cannabis-growing operations in Maine. In June 1998, the Buxton Police Department and the MDEA Lyman Task Force seized \$210,000; in an unrelated incident in March 2000, the DEA and the MDEA Lyman Task Force seized \$210,000.

Transportation

Marijuana is transported to Maine from the Southwest Border area as well as from Florida and Massachusetts, in automobiles, campers, trucks, and by package delivery and mail services. In one MDEA investigation, marijuana distributors paid individuals in Lewiston, Poland, and Monmouth, Maine, to accept 10- to 20-pound packages of marijuana delivered to their homes. Although marijuana is also transported from Canada into Maine, it is impossible

to obtain an accurate estimate of the annual quantity and the means of transportation because of the remoteness of the border area and the lack of law enforcement personnel available to patrol it. However, a mid-1990s DEA investigation revealed that traffickers used backpackers to carry marijuana across the border. The backpackers were heavily armed with machine guns and used night vision goggles to aid in their smuggling activities.

Distribution

Typically, independent Caucasian distribution groups of various sizes operate within the state. In a 1998 investigation, the MDEA focused on a man living in Athens, Maine, (between the Kennebec River and Great Moose Lake), who annually distributed multihundred-pound lots of Jamaican marijuana in Somerset County. This investigation led not only to the seizure of \$30,000 in cash and 10 pounds (4.5 kilograms) of marijuana, but also to the identification of a Jamaican supplier. A 1999 investigation conducted by the Royal Canadian

Mounted Police, the DEA-Miami, and the U. S. Customs Service (USCS)-Miami led to the seizure of 8,000 pounds (3,629 kilograms) of marijuana, and 1,200 pounds (544 kilograms) of hashish oil in Miami, Florida. This investigation included the MDEA because the major facilitator of this shipment resided in Bucksport, Maine. New dealers continually appear, but law enforcement agencies do not have the investigative resources to handle all of the available leads.

Other Dangerous Drugs

Authorities in Maine report an increase in the abuse of other dangerous drugs (ODD), noting the abuse of prescription drugs as their major concern. OxyContin, the diverted pharmaceutical drug of choice, retails on the street for \$1 per mg (\$80 per 80-mg tablet). The abuse of pharmaceuticals is increasing throughout the state, and has become the primary drug threat in Washington County according to the MDEA. The large increase in the number of Maine treatment admissions for opiate addiction during 1999 and 2000—excluding those resulting from heroin abuse—is an indicator of the extent of the prescription drug problem. LSD and psilocybin mushrooms continue to be secondary drug problems in Maine while MDMA is just beginning to emerge. LSD, psilocybin mushrooms, and

MDMA are attractive to younger users and have been seized at raves in Maine.

Throughout the 1990s, high energy, all-night dances known as “raves,” which feature hard pounding techno-music and flashing laser lights, increased in popularity among teens and young adults. Rave clubs can be found in most metropolitan areas of the country. They can be either permanent dance clubs or temporary “weekend event” sites set up in abandoned warehouses, open fields, empty buildings, or civic centers. “Club drugs,” a group of synthetic drugs often sold at the club and used by club goers, are common to raves. MDMA is one of the most popular club drugs.

Prescription Drugs

Abuse

The abuse of prescription drugs is on the rise. OxyContin is the most widely abused prescription drug and retails for \$1 per mg (\$80 per 80-mg tablet). The total number of clients admitted to drug treatment programs for opiate abuse—excluding heroin—has risen rapidly, outpacing the percentage increases in all other types of drug addiction admissions in Maine. According to the Maine Office of Substance Abuse, these admissions stem from the abuse of OxyContin and other opiate-based prescription drugs. The 78 percent increase from 1998 to 1999 (199 to 355) and the 47 percent increase from 1999 through September 2000 (355 to 521) are indicators of a rapidly escalating problem.

Law enforcement also reports that the use of diverted prescription drugs is rising in the state. MDEA reports that the abuse of pharmaceuticals, primarily OxyContin, is the leading drug problem in Washington County. The Police Chief in Calais, Washington County, believes the

OxyContin is the controlled-release version of oxycodone (14-hydroxy-7, 8-dihydrocodeinone), a strong opioid with both analgesic potency and abuse potential comparable to morphine. Purdue Pharma L.P. developed OxyContin and received approval for it in May 1996. It is designed to treat moderate to severe pain lasting for more than a few days. Due to its controlled-release formulation, it is taken every 12 hours. Until recently, OxyContin was available only in 10, 20, 40, and 80 mg doses, but as of July 2000, it became available in a 160 mg dose.

increase in crime in Calais is the result of individuals attempting to obtain money for the illegal purchase of costly prescription drugs. Burglary, bad check writing, prostitution, and shoplifting are among the criminal activities in Calais linked to prescription drug abuse. The MDEA Augusta, Bangor, Houlton, Lewiston, Lyman, and Portland Task Forces all report an increase in the use of diverted prescription drugs.

In May 2000, prescription drug abuse and its impact on the general public triggered a special report in *The Bangor Daily News* entitled, “*Prescription for Abuse*.” In the article, the author outlined a step-by-step method one addict used to get high on OxyContin, documented crimes committed to pay for prescription drugs, reported on the child protection cases involving addicted mothers, listed symptoms of withdrawal from opiates, reported on the abuse of prescription drugs on the two Passamaquoddy Indian reservations in Washington County, and looked at the dilemma facing physicians with regard to patient pain management versus potential patient drug abuse. Another article was published in the same newspaper on May 26, 2000, in which the author reported that a Washington County grand jury indicted 10 people on May 25, 2000, on charges involving prescription drugs. Those indicted included a couple, aged 18 and

20, accused of stealing pain pills belonging to a cancer patient. The pills were stolen while the patient and his wife were attending a benefit dinner being held to raise funds for his care.

Both the state and federal governments have launched new initiatives because of the rising concern over OxyContin and other prescription drug abuse. Currently, the Maine Attorney General’s Office is proposing a legislative initiative seeking to control the illegal diversion and abuse of prescription narcotics. At the same time, the U.S. Attorney for the state of Maine is issuing a letter warning health care providers about the abuse of OxyContin, is actively supporting a group of doctors touring the state lecturing physicians on the proper prescribing of OxyContin, and is raising the issue with the media to increase public awareness.

Availability

The MDEA reports that diverted pharmaceuticals are readily available throughout the state and combating the problem is heavily taxing law enforcement resources. The DEA reports that diversions usually occur when physicians and pharmacists illegally sell prescriptions and when physicians overprescribe pain medications. MDEA diverted pharmaceutical seizures increased by 800 percent between FY1997 (1,327) and FY1999 (11,938) prior to dropping by 62 percent in FY2000 (4,563). MDEA pharmaceutical drug-related arrests increased by 218 percent from FY1997 (49) to FY2000 (156), representing 21 percent of all MDEA arrests in FY2000, up sharply from 6 percent in FY1997.

The MDEA Augusta Task Force reports that prescription drug diversion is an “ever-burgeoning” problem. The MDEA Bangor Task Force reports diversion cases have tripled over previous years. The MDEA Houlton Task Force reports that more defendants were charged with distribution of synthetic prescription drugs than any other drug in FY2000. The MDEA Lewiston Task Force reports pharmaceutical investigations increased eightfold in the previous 5 years. The MDEA Lyman Task Force reports an “alarming” increase in the illegal sale of prescription drugs and reports a 1999 seizure of 55,000 units of OxyContin with a street value of \$2.2 million. The MDEA Portland Task Force reports a large increase in pharmaceutical related cases due to the popularity of OxyContin which is consistently available on the street at \$1 per mg.

Transportation

Prescription drugs are transported into Maine through legitimate pharmaceutical distribution channels and are intended for the treatment of illness. Some pharmaceutical

drugs, Dilaudid in particular, are smuggled from Canada to supply the local market in Maine. The MDEA reports individuals travel from Calais, cross the border to St. Stephen,

New Brunswick, purchase Dilaudid—either at pharmacies using prescriptions or illegally from Canadian dealers—and return to the United States.

Dilaudid is the brand name for hydromorphone, which is created by refining morphine. Hydromorphone is approximately eight times more powerful and faster acting than morphine.

Distribution

Pharmaceuticals are diverted or distributed in several ways. Addicts often meet their own needs by stealing, forging, and altering prescriptions, or by becoming a patient of several doctors to obtain multiple prescriptions for the same pain medication. First-time dealers also supply pharmaceuticals to addicts. First-time dealers include those covered by some form of insurance who deceive doctors with false symptoms, and those who have seriously ill family members or are themselves seriously ill and have access to pain medication prescriptions. There are also experienced cocaine and heroin dealers that turn to prescription drug sales because of the profits involved. They supply individuals who are addicted to prescription drugs but cannot meet their own needs through personal diversion activities.

One MDEA investigation in 1999 was pursued at the request of a large pharmaceutical chain with stores throughout the state. The investigation determined that an individual obtained tens of thousands of dosage units of medication from this chain's pharmacies by claiming Social Security and Medicare benefits under different names. The investigation resulted in drug- and fraud-related charges being filed against the individual. In June 2000,

a man was arrested for selling \$8,000 worth of OxyContin per week. The man and his wife received Medicaid and Social Security benefits, and the wife was prescribed OxyContin to control cancer-related pain. The husband was accused of selling the excess pills. In February 2000, 18 individuals were charged with supplying prescription drugs—including OxyContin and Dilaudid—to individuals on the Passamaquoddy Tribe's two reservations in Washington County. The action of one of those charged clearly illustrates the strain on law enforcement resources resulting from these distribution activities. This person pled guilty to the February offense on October 2, 2000, remained free on post-conviction bail, and was arrested again on October 6, 2000, for felony trafficking that was ongoing since his arrest in February. A 2000 DEA investigation of a prescription drug distribution group led to the identification of the group's supplier, a local Portland neurologist. The doctor diverted large quantities of pharmaceuticals, including OxyContin, to this group in order to support his own crack cocaine habit. The neurologist committed suicide before the investigation was completed, but the distribution group was successfully disbanded.

LSD

LSD (lysergic acid diethylamide), also known as acid, boomers, and yellow sunshines, is a hallucinogen that induces abnormalities in sensory perceptions. The effects of LSD are unpredictable depending on the amount taken, the environment in which it is used, and the user's personality, mood, and expectations. Users may feel the effects of the drug for 30 to 90 minutes. Physical

effects include dilated pupils, higher body temperature, increased heart rate and blood pressure, sweating, loss of appetite, sleeplessness, dry mouth, and tremor. LSD users report that numbness, weakness, trembling, and/or nausea are common. Two long-term disorders associated with LSD are persistent psychosis and hallucinogen persisting perception disorder (flashbacks).

LSD is typically taken by mouth and is sold in tablet, capsule, and in liquid form, as well as on pieces of paper that have absorbed the drug.

LSD is a secondary ODD problem in Maine. LSD seizures and arrests by MDEA sharply peaked in FY1999. LSD dosage unit seizures increased from 1,894 in FY1998 to 11,956 in FY1999. LSD arrests nearly doubled, from 15 in FY1998 to 29 in FY1999. The Augusta Task Force Office reports that LSD is the “hard” drug of choice for individuals in their early twenties or younger. The Bangor Task Force reports an

increase in LSD in its area when colleges are in session. The other task forces report very little LSD activity with the Portland Task Force noting that strong enforcement actions designed to keep raves in check may have had a positive impact on the use and availability of LSD in its region. College students who purchase their drugs from West Coast distributors at rock concerts are a major retail source for LSD in Maine. LSD is normally retailed at music concerts and raves in college towns.

Psilocybin Mushrooms

Psilocybin is the primary psychoactive ingredient in psilocybin mushrooms. Known as “Teonanacatl” or “divine flesh” by the Aztecs, this mushroom is consumed dried or as a white powder. Consuming 10 to 60 mg can cause altered states of consciousness, but there may be fewer or less intense feelings of panic than those experienced with LSD.

Both the MDEA and the DEA report that psilocybin mushrooms are widely available

throughout the state. The market for these mushrooms is similar to that for LSD—users in their early twenties or younger. Abusers are known to make connections with suppliers through music concerts. Overnight package delivery services are used to ship mushrooms from suppliers in the southwestern United States. Abusers also grow their own supply by using commercially available cultivation kits.

MDMA

MDMA (3,4-methylenedioxymethamphetamine), also called Adam, ecstasy, XTC, E, or X, is a stimulant and low level hallucinogen. MDMA was patented in Germany in 1914 and was sometimes given to psychiatric patients to assist in psychotherapy, a practice never approved by the American Psychological Association or the Food and Drug Administration. Sometimes called the hug drug, users say it makes them feel good. However, use of the drug may cause psychological effects similar to those associated with methamphetamine and cocaine abuse including confusion, depression, sleep problems, anxiety, and paranoia. The physical effects include muscle tension, involuntary teeth clenching, blurred vision, and increased heart rate and blood pressure.

MDMA use can cause a marked increase in body temperature leading to muscle breakdown, kidney failure, and cardiovascular system failure. MDMA use may also lead to heart attack, stroke, and seizure as reported in some fatal cases. Recent research links MDMA to long term, possibly permanent damage to parts of the brain that are critical to thought and memory. There is also evidence that individuals who develop a rash after using MDMA may risk severe liver damage or other serious side effects.

Both the MDEA and the DEA report that MDMA is an emerging threat. The MDEA reports some low level MDMA distribution in areas covered by the Augusta and Lewiston Task Forces with increasing distribution noted by the Lyman and

Portland Task Forces. The Lyman Task Force reports that several of the cocaine dealers in the area now sell MDMA along with cocaine. Early in 1999, the MDEA Task Force in Portland launched an investigation of the Metropolis, a local nightclub that held rave parties on a regular basis. The April 1999 execution of a search warrant led to the arrest of six people accused of selling MDMA and ketamine, and five others accused of possession of various drugs. Law enforcement encourages media coverage of such arrests because it quickly alerts parents to the fact that these types of dance parties, despite assurances to the contrary by their children, are illegal drug parties. In May 2000, the DEA in Portland reported that MDMA abuse was beginning to emerge and predicted that raves would be held

north of Portland in the future. Expectation became reality with the arrest of some rave participants at the Maine Civic Center in Lewiston—north of Portland—in both June and October 2000.

In a unique and successful approach to the problem posed by the Metropolis investigation, a grand jury indicted the company that owned the nightclub, holding it criminally liable for the drug dealing that took place there. In a plea bargain in October 2000, the corporation, Vision Capital, was dissolved and, in turn, the state dropped four trafficking charges against it. This was the first time a Maine corporation was charged with drug trafficking.

Methamphetamine

Methamphetamine, also known as meth, crank, ice, and crystal, is a synthetic stimulant. It mimics adrenaline, stimulating the central nervous system, and is very addictive, causing withdrawal symptoms more intense and longer lasting than cocaine. Long term use can cause psychological effects that resemble schizophrenia. Individuals can experience anger, panic, aggression, paranoia, delusions of insects on the skin, and homicidal and suicidal thoughts. Researchers report that methamphetamine users show signs of brain damage as well.

In 1999, methamphetamine was beginning to emerge as a drug threat in Maine, particularly in Aroostook County. All six MDEA Task Forces reported some level of methamphetamine activity; the Houlton Task Force reported the most, followed by the Bangor Task Force. Methamphetamine seizures by MDEA sharply increased from 1.01 kilogram in FY1997 to 4.22 kilograms in FY1999. Aroostook County methamphetamine

seizures represented over 4 kilograms of the FY1999 total, outpacing those in all the rest of New England combined. Employees of an Aroostook mental health facility found that abuse of methamphetamine was spreading to white collar workers and a growing number of male and female nurses were seeking treatment for their methamphetamine addictions in 1999. According to the MDEA, violence and property crimes linked to methamphetamine abuse were occurring throughout Aroostook County.

In the year 2000, authorities no longer considered methamphetamine an emerging threat in Maine. Although methamphetamine abuse continues and there are active dealers, a strong statewide demand has not developed and a proactive law enforcement effort by the DEA and the MDEA has reduced availability.

Production

Mexican DTOs producing methamphetamine in laboratories in Mexico and the western United States are the primary suppliers of methamphetamine found in New England, according to U.S. law enforcement. A large number of independent producers also operate laboratories in many areas of the United States, contributing significantly to the supply of methamphetamine. There are four primary methods of producing methamphetamine. In September 2000, a joint operation between the DEA and the MDEA seized the first methamphetamine laboratory in Maine since 1991. An individual who recently moved from Arizona to Maine was responsible for the establishment of this methamphetamine laboratory in an apartment in Vassalboro, a city northeast of Augusta. The DEA reports that the red phosphorus (ephedrine/pseudoephedrine) method was used to produce methamphetamine in this instance. The MDEA believes this methamphetamine laboratory represents an isolated incident and does not heighten the diminished methamphetamine threat.

Primary Methamphetamine Production Methods

Ephedrine/pseudoephedrine—This method uses the precursors ephedrine/pseudoephedrine, hydriodic acid, and red phosphorus to produce d-methamphetamine. It normally results in large quantities of high-quality methamphetamine.

“Nazi”—This method uses the primary precursor ephedrine/pseudoephedrine and more exotic secondary chemicals including sodium metal and anhydrous ammonia. It produces high-quality, low-quantity d-methamphetamine.

Cold cook—This method uses the primary precursor ephedrine and the secondary precursors iodine and red phosphorus. The reaction is typically catalyzed either by using heat from direct sunlight or by burying the chemicals in containers in hot desert sand. It produces high-quality, low-quantity d-methamphetamine.

P2P—This method uses the precursors phenyl-2-propanone and aluminum to produce lower-quality methamphetamine.

Transportation

Methamphetamine is transported to Maine from the southwestern United States in automobiles, commercial airlines, trucks, and by package delivery and mail services. In a major-

ity of the investigations in Aroostook County, methamphetamine was transported to Maine in express mail packages.

Distribution

Methamphetamine distribution in Maine occurs in several ways. Outlaw motorcycle gangs (OMGs), migrant workers, and addicts who have become dealers distribute methamphetamine in the state. The MDEA Task Forces in Augusta, Lyman, and Portland (Cumberland County) report methamphetamine use at raves held in their jurisdictions. The MDEA Task Forces in Augusta

and Bangor report methamphetamine distribution by members of the Saracens and Hells Angels OMGs. The DEA in Portland reports that some Mexican migrant workers who come to Maine to harvest blueberries maintain connections to methamphetamine producers located in the southwestern United States and arrange shipments to local dealers.

Outlook

- Overall availability and use of cocaine will remain stable possibly with a decrease in the use of powdered cocaine balanced by growth in crack cocaine use. Cocaine may be surpassed by heroin as the primary drug threat in the state.
- Heroin abuse will continue to increase in Maine. Younger users who snort the higher purity heroin rather than inject it will fuel the increase. Increasing availability will continue to be a problem because arrested addicts-turned-dealers are replaced quickly by other addicts subsidizing their own heroin habits.
- Demand for marijuana will continue to grow. Fifty-nine percent of twelfth graders in Maine have tried marijuana at least once. This first-hand knowledge of marijuana is reinforced by the trend in society to downplay the illicit and harmful nature of marijuana.
- The increase in OxyContin abuse will continue. The MDEA FY1999 Annual Report clearly describes the strain on resources this problem perpetuates. Prioritizing limited resources to address the cocaine and heroin problems will continue to limit the resources available to combat the diversion of prescription drugs. The latest treatment admissions data show OxyContin and other opiate abuse—excluding heroin—is rising sharply.
- Abuse of LSD will likely grow somewhat as raves continue to expand in Maine.
- MDMA abuse currently is limited, but as the marketing of raves and rave clubs expands northward from Boston, there is potential for an escalating problem in Maine.
- Methamphetamine abuse will continue at a low level due to a lack of demand and reduced availability.

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Sources

State and Regional Sources

Bangor Daily News

Bangor (Maine) Police Department

Maine Department of Education

Maine Department of Public Safety

Maine Drug Enforcement Agency

Maine Task Force on Substance Abuse

Maine Department of Human Services

 Bureau of Health

 Office of Data, Research and Vital Statistics

Maine Department of Mental Health, Mental Retardation, and Substance Abuse Services

 Office of Substance Abuse

Portland Press Herald

National and International Sources

Associated Press

U.S. Department of Health and Human Services

 National Institutes of Health

 National Institute on Drug Abuse

U.S. Department of Justice

 Drug Enforcement Administration

 Federal Bureau of Investigation

 U.S. Attorney's Office

 Maine

U.S. Department of the Treasury

 Financial Crimes Enforcement Network

 U.S. Customs Service

Other Sources

Boston Phoenix

Boston (Massachusetts) Police Department

California Border Alliance Group

Hartford (Connecticut) Police Department

Lawrence (Massachusetts) Police Department

Lowell (Massachusetts) Police Department

Springfield (Massachusetts) Police Department

Worcester (Massachusetts) Police Department

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