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Notes

WORK GROUP ON RESEARCH

Washington, D.C.
July 11, 1983

Dick Penna (Chairman), American Pharmaceutical Association
Barry Brock, Roche Laboratories
Don Fletcher, Smith, Kline & French Laboratories
Maria Grassadonil, DuPont Pharmaceuticals
Ron Mole, Roche Laboratories
Barry Rhodes, Odyssey Resources, Inc.
Sal Rubino, Winthrop Laboratories
Al Russell, Drug Enforcement Administration
Bonnie Wilford, American Medical Association
Jim Williams, Pharmaceutical Manufacturers Association

I. *Goal of the research*

To provide a comparative evaluation of the effects of various methods of diversion control on the public health, drug distribution and consumption patterns, and study the comparative costs of those methods.

II. *Methods of diversion control currently in use in the states*

A. *Multiple prescription systems*
B. *Controlled substances boards*
C. *Drug scheduling at the state level more stringent than the federal schedules*
D. *Peer review/pressure--voluntary compliance activities*
E. *State-imposed controls on dispensing physicians*
F. *State-imposed limits on quantities of drugs dispensed*
G. *State-imposed limits on prescribing indications*
H. *Restrictions on drugs included in Medicaid formularies*
I. *Pharmacy audits*
J. *"Lock-in" of Medicaid patients to specified physicians and pharmacists*
K. *Drug Investigative Units (DIUs)*
L. *Voluntary reporting of suspicious purchases to state boards of pharmacy by drug manufacturers and distributors*

(A description of each of these methods, featuring a short narrative paragraph and an example of a state in which the method is used, will be prepared for the work group by Barry Rhodes. There was general agreement that this description, in and of itself, would be an original contribution of the body of knowledge on diversion control systems and thus ought to be widely disseminated.)

III. *Sources of data that may be useful in studying diversion control methods*

A. *Drug Abuse Warning Network (DAWN)*
B. *Automated Reports and Consolidated Orders System (ARCOS)*
C. *National Medical Care Survey (NMCS) of the National Center for Health Statistics*
D. *Medicaid Management Information Systems (MMIS)*
E. *Health Maintenance Organizations (HMOs)*
F. *Drug Distribution Data (DDD) surveys*
G. *Prescription Drug Survey (PDS)*
H. *Chain drugstores with common computer systems*
I. *Wholesalers' order data*
J. *National Disease and Therapeutic Index (NDTI)*
K. *Third-party payers (i.e., Blue Shield, private insurers)*
L. *IMS-America hospital audits (inpatient use)*
M. *Ad hoc surveys*

IV. *Diversion control methods that should be studied first*

A. *Multiple prescription systems*
B. *Peer review*
C. *DIUs*
D. *Controlled substances boards*

(These methods must be carefully distinguished and described in the research protocol.)

For each of these methods, the research should examine:

A. *Costs (including reals costs to practitioners, rather than only costs to the administering agency)*

B. *Changes in distribution and consumption patterns, including:*

(1) *Morbidity and mortality trends*

(2) *Transference phenomena (geographic, cross-schedule, and licit-to-illicit)*

(3) *Changes in the level of criminal activity (e.g., pharmacy thefts, burglaries)*

(4) *Price*

(A drug index will be prepared to facilitate this step)

C. *Attitudes of professionals, law enforcement officials, public*

V. *Sources of funding that might be available to finance the research*

A. *Federal government (HHS)*

B. *Professional associations (APhA, AMA, PMA, etc.)*

C. *Foundations (Johnson, etc.)*

(A mix of funding sources would be most desirable. Government funding would be least desirable. AMA can provide "seed money" to develop the protocol and begin the research.)

VI. *Next steps in designing the research studies*

A. *Odyssey Resources (Michael Baden, M.D./Barry Rhodes) will prepare a detailed research protocol for the studies described in point IV, above.*

B. *Odyssey will prepare an analysis of what the various data systems listed in point III, above, can be used to measure.*

C. *The draft protocol and analysis of data systems will be distributed to the work group members for careful study. The group will convene approximately four weeks after this information is distributed to (1) refine the research protocol, (2) determine which component studies should be undertaken first, and (3) identify specific sources of funding for the research.*

VII. *Other points of discussion*

A. *Jim Williams distributed an analysis of state adoption of the Uniform Controlled Substances Act.*

B. *Don Fletcher reported that a literature search had yielded only three reports on diversion control methods (see copies attached). Don will continue the search, using new topic entries.*

C. *Bonnie Wilford distributed samples of NMCS research reports to work group members in advance of the meeting and reported that staff of the National Center for Health Statistics are willing to (1) prepare special reports for the work group, and (2) consult with the work group in designing the survey instrument for the 1984 National Medical Care Survey.*

D. *Don Fletcher suggested that improved data on the magnitude of prescription drug diversion and abuse may be a beneficial by-product of the research to be undertaken.*

E. *Dick Penna, as Chairman of the work group, will report progress to the full Steering Committee at its July 21 meeting. Bonnie Wilford will send a summary report of that meeting to all members of the work group.*

BBW/mf
Atts.

cc: Nancy Cahill
Dan Lambert
Manny Steindler

National Association of State Alcohol and Drug Abuse Directors

NASADAD Annual Meeting

Sunday, June 5, 1983

4:00 - 6:00 p.m.
Registration — *La Concha Lobby*

6:00 - 8:00 p.m.
Board of Directors Meeting — *Salon Mirador*

Monday, June 6, 1983

8:00 a.m. - 5:00 p.m.
Registration — *La Concha Lobby*

Technical Session

8:30 - 9:00 a.m.
Welcome Address — *Regency Room*

The Honorable José Ramón Cordero Rodriquez, Esq., Secretary, Puerto Rico Addiction Control Services

9:00 - 9:30 a.m.
Presidential Address

Donald J. McConnell, NASADAD President and Connecticut Alcohol and Drug Abuse Commission Executive Director

9:30 - 9:45 a.m.
Break

9:45 a.m. - 12 Noon
Plenary Session — *Regency Room*

"The Federal Strategy and Related National Efforts in the Alcohol and Drug Field"

Thomas B. Kirkpatrick, Jr., Illinois, *Moderator*
Carlton Turner, ODAP
Diane Steed, NHTSA
Diana Tabler, ADAMHA
Loran Archer, NIAAA
William Pollin, NIDA
Bonnie Wilford, AMA
Mickey Skyring, Presidential Commission on Drunk Driving

12 Noon - 2:00 p.m.
Luncheon — *Salon Mirador*

Luncheon Speaker: The Honorable Carlos Romero Barceló, Governor of Puerto Rico

Awards Presentation:
Richard Ham, Nevada

Luncheon Panel

"The 98th Congress"

Kenneth Eaton, Michigan
Ripley Forbes, Staff Member, House Subcommittee on Health and the Environment

Tuesday — continued

6:30 - 8:00 p.m.
Evening Session — *Salon Mirador*

"Current Issues on Methadone"

Donald J. McConnell, Connecticut, *Moderator*
Barry Brown, NIDA
Chauncy Veatch, California
Thomas B. Kirkpatrick, Jr., Illinois
Richard Russo, New Jersey
John Gustafson, New York
John Callen, Puerto Rico

Wednesday, June 8, 1983

8:45 - 10:30 a.m.
Plenary Session — *Regency Room*

"Current Perspectives on Prevention"

Lorne A. Phillips, Kansas, *Moderator*
Elaine Johnson, NIDA
Michael Jacobson, Center for Science in the Public Interest
Judi Funkhouser, NIAAA
William J. McCord, South Carolina

10:30 - 10:45 a.m.
Break

10:45 a.m. - 12:30 p.m.
Plenary Session — *Regency Room*

"Prescription Drug Abuse: The Cooperative Use of Prevention, Treatment, Regulatory and Private Resources at the State Level"

Thomas B. Kirkpatrick, Jr., Illinois, *Moderator*
Barry Rhodes, Odyssey Resources
Ronald Wilson, Missouri
Richard Ham, Nevada
Larry Monson, Wisconsin

12:30 p.m.
Adjournment

12:45 - 3:30 p.m.
Board of Directors
Reorganization Meeting

NASADAD Staff

William Butynski
Nancy E. Record
Jo Lynn M. Yates

AGENDA ITEM III,
NASADAD

NASADAD

National Association of State Alcohol and Drug Abuse Directors

August 11, 1983

Dear

The Informal Steering Committee on Prescription Drug Abuse has identified the need for information on how the various States are approaching the misuse, abuse and diversion of prescription drugs. The subcommittee on legislation needs baseline data on the adoption of laws dealing with the problem. The PADS workgroup needs to know how best to implement the PADS model, considering that the administrative structure for diversion control differs from State to State.

The American Medical Association has contracted with Odyssey Resources and NASADAD to conduct this survey to determine the various State legislative administrative frameworks for diversion control.

State Alcohol and Drug Abuse Directors are an important part of the Informal Steering Committee's efforts, through NASADAD's participation in the Committee itself, and the involvement of eight State Directors in various committee projects. It is therefore logical that NASADAD and its members are the best source of the information to be gathered by this survey.

The data collected from each State will be compiled and issued as a report. This report will not identify individual State responses. The finished report will be used by the Informal Steering Committee to ascertain the types of technical assistance that might help States with legislative and administrative activity to enhance diversion control. The final report also will be distributed through NASADAD to its members.

The information we are requesting in the survey is not currently available anywhere. We appreciate your support in helping to provide comprehensive information on State legislative and administrative diversion control mechanisms.

444 North Capitol Street, N.W. • Suite 530 • Washington, D.C. 20001 • (202) 783-6868

Please return the completed survey forms to me at the NASADAD office, 444 North Capitol Street, N.W., Suite 530, Washington, D.C. 20001 by not later than August 25, 1983.

Thank you for your help.

Sincerely,

William Butynski
Executive Director

INFORMAL STEERING COMMITTEE ON PRESCRIPTION DRUG ABUSE
NASADAD STATE DIVERSION CONTROL SURVEY

We recognize that the pressures of time and limited resources limit the quantity and complexity of the responses you can provide. Therefore, this survey has been divided into two sections; Core items (A-C), and optional items (D-J). It is our hope that all items can be completed. We appreciate your help.

STATE _____ NAME OF AGENCY _____

NAME OF RESPONDENT _____ TELEPHONE NUMBER OF RESPONDENT _____

In answering the following question please include the name of the agency, the name of the person in charge, their address and phone number.

INVENTORY OF STATE-LEVEL INTERVENTION RESOURCES

A. Which state agency is responsible for:

1. Licensing practioners?

a. Physicians (M.D.'s and D.O.'s) a. _____

b. Dentists/Dental Surgeons b. _____

c. Veterinarians c. _____

d. Podiatrists d. _____

e. Nurses e.

f. Pharmacists/pharmacies f.

2. Establishing controlled drug schedules and regulations?

3. Monitoring compliance with controlled drug regulations?

4. Investigating practitioner's prescribing habits?

5. Investigating pharmacies' dispensing records?

6. Initiating licensure actions? (Against practitioners as listed in A.1. a-f.)

7. Initiating criminal prosecutions at the state level?

8. Processing licensure applications?

B. Has your state adopted the Uniform Controlled Substances Act?

Yes No

C. Does your state require practitioners to use special multiple prescription blanks for certain controlled drugs?

Yes No

If yes, which schedules, classes or drugs? (The most general answer is acceptable.)

OPTIONAL ITEMS

D. Does your state impose more stringent restrictions for any drug or class of drugs than than imposed by federal law?

_____ Yes _____ No

If yes, briefly describe.

_____

_____

_____

E. Has your state adopted legislation specifically designed to prevent/control prescription drug diversion?

_____ Yes _____ No

If yes, list the title, reference number, and date of passage.

_____

_____

_____

F. 1. Does the Medicaid Management Information System (MMIS) in your state produce reports that identify:

a. Prescriptions written by practitioners? _____ Yes _____ No

b. Prescriptions filled by pharmacists? _____ Yes _____ No

c. Medications purchased by recipients? _____ Yes _____ No

2. Are appropriate state agencies permitted to use these reports for fraud or other criminal investigations?

_____ Yes _____ No

3. Does your state manage a primary provider/lock-in program for Medicaid?

_____ Yes _____ No

G. Is there a state agency that has the responsibility for interagency co-ordination of diversion control activities?

_____ Yes _____ No

If yes, please list the name of the agency, the name of the person in-charge, their address and phone number.

_____

_____

_____

_____

Please also list the names of the agencies involved in the co-ordinated effort.

_____

_____

_____

H. Does your state have the ability to limit, suspend or revoke prescribing and/or dispensing priviledges sperate from the license to practice?

_____ Yes _____ No

I. 1. In your state, can physicians dispense controlled substances?

_____ Yes _____ No

If yes, briefly describe any limitations (such as number of dosage units).

_____

_____

_____

2. In your state, can nurse practitioners prescribe controlled substances?

_____ Yes _____ No

If yes, briefly describe any limitations (such as schedules and/or classes of drugs, and number of dosage units).

_____

_____

_____

3. In your state can chiropracters

a. prescribe controlled substances? _____ Yes _____ No

b. dispense controlled substances? _____ Yes _____ No

If yes to either of these questions, briefly describe any limitations.

_____

_____

_____

4. In your state, can dentists dispense controlled substances?

_____ Yes _____ No

If yes, briefly describe any limitations.

_____

_____

_____

5. Other than Pharmacists, Veterinarians, Podiatrists and the practitioners listed in F. 1-4., can any other practitioners prescribe and/or dispense controlled substances?

_____ Yes _____ No

If yes, please identify the type of practitioner, whether they prescribe, dispense (or both), and any limitations.

_____

_____

_____

J. Is there a state agency that annually receives ARCOS data?

_____ Yes _____ No

If yes include the name of the agency, the name of the person in charge, their address and phone number.

_____

_____

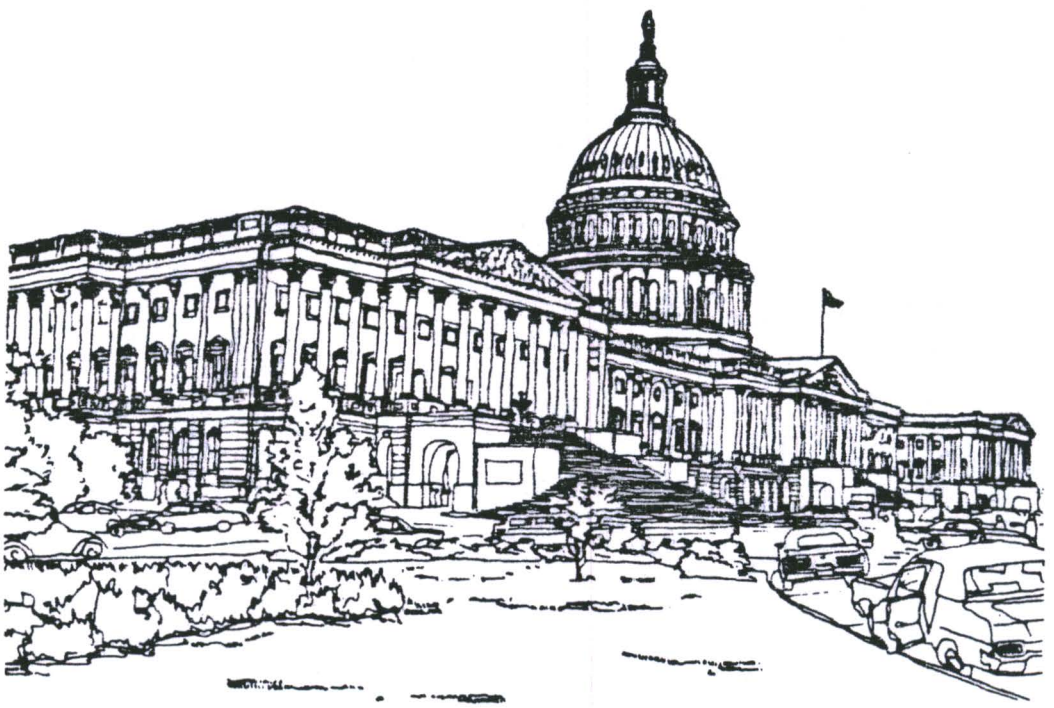
_____

P

BW

adpa

34th Annual Conference of the Alcohol and Drug Problems Association



August 28 – September 1, 1983
Hyatt Regency – Capitol Hill
Washington, D.C.

NATIONAL STRAGEGIES AGAINST PRESCRIPTION DRUG ABUSE

Plenary Session 9 - 10:30 Monday August 29
Barry Rhodes, Moderator

The following speakers will each make fifteen minute presentations on the designated topic, in the order listed.

Speaker	Topic
Joseph H. Deatsch, M.D. Medical Director River Region Human Services, Inc. 577 College Street Jacksonville, Fla. 32204	The Impact of Prescription Drug Abuse on Treatment Programs
David E. Joranson, M.S.W. Drug Abuse Program Policy Specalist, Bureau of Alcohol and Other Drug Abuse State of Wisconsin 1 West Wilson Madison, Wisconsin 53702	The Wisconsin Experience with Diversion Control and Its Impact on Treatment Programs
Karen Gillespie Project Director Pracon, Inc. 10390 Democracy Lane Fairfax, Virginia 22030	Building a National Strategy: An Historic Perspective
Bonnie B. Wilford Senior Research Associate Health and Human Behaviour Program American Medical Association 535 N. Dearborn Street Chicago, Illinois 60610	Activities of the AMA Informal Steering Committee on Prescription Drug Abuse

Barry Rhodes will then give a ten minute presentation which will give a brief overview of the workshops included in the track, and five minutes on the PADS Project. This will allow 15 minutes for questions and answers.

7. The Prescription Abuse Data Synthesis Model (PADS): Using Existing Data Systems to Control Diversion

Barry Rhodes, M.Ed.
Vice President for Development
Odyssey Resources, Inc.
817 Fairfield Avenue
Bridgeport, CT 06604

8. Prescription Drug Abuse Prevention Through Professional and Public Education

Bonnie B. Wilford,
Senior Research Associate
Health and Human Behaviour Program
American Medical Association
535 N. Dearborn Street
Chicago, Illinois 60610

9. Physican Victimization by Drug Addicts

W. Wayne Bohrer
Delbert D. Konnor, Pharm. M.S.
Office of Diversion Control
Drug Enforcement Administration
1405 I Street, N.W.
Washington, D.C. 20036

PRESCRIPTION DRUG ABUSE WORKSHOPS

All Presentations are Fifty Minutes

	Title of Presentation	Speaker
1.	The Clinical Implications of Prescription Drug Abuse on Treatment Programs	Joseph H. Deatsch, M.D. Medical Director River Region Human Services,Inc. 577 College Street Jacksonville, Fla. 32204
2.	Diversion Control and Its Relationship to the Drug Abuse Treatment System	David E. Joranson, M.S.W. Drug Abuse Program Policy Specalist Bureau of Alcohol and Other Drug Abuse State of Wisconsin 1 West Wilson Madison, Wisconsin 53702
3.	Approaches to State Legislation on Prescription Drug Abuse	Robert Angarola, Esq. Hyman and Phelps, P.C. 1120 G Street, N.W. Washington, D.C. 20005
4.	Prescription Drug Abuse Prevention: The Kansas Health Promotion Conference	Lorne A. Phillips, Ph. D. Commissioner Alcohol and Drug Abuse Services State of Kansas Biddle Building 2700 W. 6th Topeka, Kansas 66606
5.	Prescription Drug Abuse Control: The Wisconsin Approach and the Missouri Response	David E. Joransen, M.S.W. Drug Abuse Policy Specalist Bureau of Alcohol and Other Drug Abuse State of Wisconsin 1 West Wilson Madison, Wisconsin 53702 and Ronald Wilson, Director Division of Alcoholism and Drug Abuse State of Missouri 2002 Missouri Blvd P.O.Box 697 Jefferson City, Missouri 65101
6.	Prescription Drug Abuse Prevention: Pharmaceutical Industry Efforts	Karen S. Gillespie Project Director Pracon, Inc. 10390 Democracy Lane Fairfax, Virginia 22030

7. The Prescription Abuse Data Synthesis Model (PADS): Using Existing Data Systems to Control Diversion

Barry Rhodes, M.Ed.
Vice President for Development
Odyssey Resources, Inc.
817 Fairfield Avenue
Bridgeport, CT 06604

8. Prescription Drug Abuse Prevention Through Professional and Public Education

Bonnie B. Wilford,
Senior Research Associate
Health and Human Behaviour Program
American Medical Association
535 N. Dearborn Street
Chicago, Illinois 60610

9. Physican Victimization by Drug Addicts

W. Wayne Bohrer
Delbert D. Konnor, Pharm. M.S.
Office of Diversion Control
Drug Enforcement Administration
1405 I Street, N.W.
Washington, D.C. 20036

Q

TAB Q

ILLEGAL DRUG TRAFFICKING IN THE UNITED STATES

Special Governors' Work Session

February 27, 1983

Washington, D.C.

Sponsored By

The National Governors' Association

Committee on Criminal Justice and Public Protection

Governor Charles S. Robb, Chairman

NATIONAL CRIMINAL JUSTICE ASSOCIATION

444 North Capitol Street, N.W., Suite 305, Washington, D.C. 20001, (202) 347-4900

ACKNOWLEDGEMENT

The development and production of this special session on illegal drug trafficking in the United States was accomplished with the help of many and varied interests. It was the interest of the Southern Governors at their annual meeting in South Carolina, and a special meeting of Southern border Governors held in Tennessee and sponsored by Governors Graham of Florida and Alexander of Tennessee, that gave impetus to the National Governors' Association's illegal drug initiative. This initiative received tremendous support from the Administration, with their announcement of a comprehensive drug enforcement program inclusive of an effort to involve the nation's Governors in a cooperative venture to deal with the problem of illegal drugs.

The chairman of the NGA Committee on Criminal Justice and Public Protection, Governor Charles Robb of Virginia, convened an Ad Hoc Group of Governors' aides to work with the Administration and the Committee to flesh out the concept of the Governors' Project as proposed by the Administration, and to help develop this special work session on illegal drug trafficking. Special thanks go to the Ad Hoc Group, whose members are listed in this acknowledgement.

The Staff Advisory Council to the Committee on Criminal Justice and Public Protection, chaired by Franklin White, Secretary of Public Safety in Virginia, reviewed and commented on the special session format, and the Governors' Project report as developed by the Ad Hoc Group.

The Department of Justice worked closely with the NGA Committee staff in developing this special session. Attorney General William French Smith appointed Edward McNally to direct and coordinate the Governors' Project for the Department. Catherine Anderson, Special Assistant to the Attorney General, has been most helpful in facilitating meetings with DOJ officials and providing materials needed for the special session. Rudolph Giuliani, Associate Attorney General, and Jonathan Rose, Assistant Attorney General for Legal Policy, scheduled briefings and offered their support for this work session. And, a very special note of appreciation is due Robert Diegelman of the Office of Justice Assistance, Research and Statistics for his continued understanding and support of state and local initiatives to fight crime, especially illegal drug trafficking.

Finally, this work session represents the first major initiative orchestrated by the National Criminal Justice Association in its capacity as staff to the NGA Committee on Criminal Justice and Public Protection, which evolved out of a cooperative agreement between NCJA and NGA. R. Thomas Parker, Executive Vice President of NCJA, coordinated the Ad Hoc Group that developed and expanded the Governors' Project for a cooperative effort between Governors and the Administration in the fight against illegal drugs. The entire NCJA staff worked deligently in the production of this NGA work session on drugs.

NGA appreciates the participation of Attorney General William French Smith and Federal Bureau of Investigation Director William Webster in the special session on illegal drug trafficking in the United States.

Overall, we acknowledge all who helped in the development of this session.

Nolan E. Jones
Staff Director
Committee on Criminal Justice
and Public Protection

AD HOC DRUG WORKING GROUP

MEMBERS

Col. James P. Adams
Director
Texas Department of Public Safety

Major Russell Anderson
Director
Bureau of Criminal Investigation
Pennsylvania State Police

Mr. Jay Cochran
Director
Bureau of Criminal Investigations
Department of State Police
Commonwealth of Virginia

Mr. Matthew Crosson
Assistant District Attorney
County of New York

Mr. Robert Dempsey
Commissioner
Florida Department of
Law Enforcement

Mr. Bruce G. Dew
Director
South Carolina Division of
Public Safety Programs

Lt. Col. Justin Dintino
Executive Officer
Special Forces Division
Department of Law
and Public Safety
New Jersey State Police

Mr. Richard W. Friedman
Executive Director
Maryland Governor's Commission
on Law Enforcement and
Administration of Justice

Major Gary R. Grant
Assistant Chief of
Special Operations Bureau
Maryland State Police

Mr. Richard N. Harris
Director
Virginia Department of
Criminal Justice Services

Chief Steve C. Helsley
(President, State Drug Enforcement Alliance)
Bureau of Narcotics Enforcement
California Department of Justice

Ms. Judy Johnson
Executive Assistant
Office of the Governor
Richmond, Virginia

Mr. Bill Koch
Legal Counsel to the Governor
Office of the Governor
Nashville, Tennessee

Mr. Robert A. Melott
Deputy Secretary for Crime Control
Department of Crime Control
and Public Safety
State of North Carolina

Mr. Harold Miller
Chief of the Policy Analysis Division
Pennsylvania Governor's Office
of Policy and Planning

Mr. Andrew B. Kramer
Deputy Attorney General
Office of the Attorney General
Pennsylvania Bureau of
Narcotics Investigation

NGA DRUG POLICY INITIATIVE
BACKGROUND
CHRONOLOGICAL OUTLINE

The following is a chronological outline of developments regarding the drug issue.

- July 28, 1982 – The Southern Governors' Association meeting placed illegal drug trafficking as a priority issue and called for a special meeting among the southern states.

- August 8, 1982 – Governor Clements of Texas discussed the drug abuse problem before the Governors at their annual meeting in Oklahoma. NGA approved the policy entitled "Controlling Illegal Traffic in Narcotics."

- August 15-30, 1982 – A survey of Committee Governors identified drug trafficking, prison overcrowding and sentencing as priority problems.

- September 15, 1982 – The Southern Governors met in Tennessee on the drug trafficking problem. A policy outline was developed.

- October 2, 1982 – The President announced his comprehensive drug program on his weekly radio program.

- October 5, 1982 – The President officially released his comprehensive program to combat drug abuse and trafficking.

- October 14, 1982 – The Department of Justice released its fact sheet on the President's initiative to combat drug trafficking and organized crime – the law enforcement section of the comprehensive program. The Governors' Project was announced in this package.

- November 12, 1982 – Governor Robb initiated the Ad Hoc Drug Working Group (NGA/NCJA) and discussed the Committee agenda with the NGA Executive Committee in Park City, Utah.

- November 18, 1982 – Ad Hoc Drug Working Group met to define the Governors' Project referred to on October 14, 1982.

- December 13, 1982 – The Staff Advisory Council met and approved the Ad Hoc recommendations for the Governors' Project.

- January 6, 1983 – Governor Robb met with Attorney General William French Smith to discuss the Governors' Project.

- January 13, 1983 – The NGA/NCJA Ad Hoc Drug Working Group met to further refine the drug policy recommendations as developed by Governor Bob Graham's staff. The first federal/state drug enforcement operations meeting was held at the Department of Justice.

- February 27, 1983 – NGA work session on the Illegal Drug Problem in America.

- February 28, 1983 – The Committee recommended and approved drug policy.

- March 1, 1983 – NGA approved new drug policy.

Strategies for Drug Control Efforts

In July 1982, at the Annual Meeting of the Southern Governors' Association in Hilton Head, South Carolina, the southern governors agreed that international drug trafficking has become an issue of major regional concern. Governor Lamar Alexander of Tennessee and Governor Bob Graham of Florida invited governors and state law enforcement officials to a special meeting in Nashville, Tennessee to discuss strategies for handling drug trafficking problems. The results of that meeting, held in September 1982, were eight policy recommendations for states to enhance drug control efforts. These recommendations subsequently received unanimous concurrence from all participating states.

On October 14, 1982, President Reagan announced his national initiatives to combat drug smuggling and organized crime. These initiatives are consistent with the recommendations developed by the governors in Nashville.

An ad hoc staff group of the National Governors' Association (NGA) met in Washington, D.C. on November 18, 1982, to define the role of the *Governors' Project* included in the President's initiatives. The group also agreed to work with staff of Governor Bob Graham of Florida to prepare an implementation strategy for the eight policy recommendations approved by the southern states. On January 13, 1983, Commissioner Robert Dempsey of the Florida Department of Law Enforcement presented an implementation strategy to the ad hoc committee for their review and comment. The southern governors wish to express their appreciation to the members of this committee for their willingness to work on this endeavor.

Upon adoption of the implementation strategy by the NGA, a steering committee should be appointed immediately to oversee and ensure implementation. This steering committee should submit an annual report to the NGA on progress related to these initiatives.

Both the President's and the governors' recommendations indicate that it is imperative that implementation of drug strategies be closely coordinated among the states and at the federal level.

Executive Summary

The following is a plan for implementing recommendations for drug control that was drafted by an ad hoc group from the NGA in January 1983. The following eight items were identified as needed for better drug control in the United States:

1. **Increased educational efforts**, including the establishment of blue ribbon commissions in each state and a federally-sponsored national education program;
2. **Intensified eradication and interdiction, i.e., military/naval assistance to state and local governments**, focusing on the destruction of drugs at their source, foreign or domestic, and on an increased military commitment to the interdiction of drugs being imported by air or sea;
3. **National reaction**, encouraging the continuation of the Bush Task Force and the twelve regional task forces;
4. **Centralized information and intelligence data base**, combining and coordinating data from local, state, multi-state and federal sources;
5. **Concerted street enforcement activity**, urging stronger support for local law enforcement agencies' drug control personnel and equipment;
6. **Standard legislation**, to be developed in each state and through a national committee formed for this purpose;
7. **Greater prosecutorial commitment**, with the same priority given to drug cases as to other priority areas; and
8. **Coordination of efforts of local agencies**, enabling agencies to pool information and resources for maximum effort.

Each recommendation is accompanied by specific suggestions about actions governors might take or support. There is also a comment on the fiscal impact of each recommendation and ways in which this might be minimized.

A list of presidential initiatives that were not among those developed by the NGA, but which nevertheless deserve gubernatorial support, is included at the end of this document.

The Governors' Issues

1 Need for Increased Educational Efforts

The problem of drug abuse in our society is related to so many factors that it cannot be successfully addressed by any single discipline. A consistent exchange of information and ideas among the various disciplines that can affect consumer demand does not exist. The ultimate long-term success of drug control efforts is not possible without a marriage of these disciplines, supported by an educated and involved public.

Recommendation

Each state should consider the establishment of a Blue Ribbon Statewide Drug Education Commission involving leaders from the public and private sectors. This Commission should consist of high-level representatives from a cross section of disciplines including law enforcement, prosecution, judicial, educational, medical, legislative and citizen/parent/young people groups.

Implementation Strategy

- ☐ Each governor should consider appointing representatives from a cross section of the public and private sectors to a Statewide Drug Education Commission. It is imperative that the membership comprising this Commission be committed to and aggressive toward accomplishing the goals established by this recommendation. The Commission should direct efforts toward:
  - *Private Industry:* Providing crime-specific information, identifying industry prevention programs and funding sources, and integrating mutual industry/citizen/enforcement activities.
  - *Public Awareness and Concern:* Coordinate and organize citizens' groups and programs; develop citizens' prevention program models; develop media campaigns' "technology transfers"; and integration with civic and church groups, industry, education and enforcement. The Commission should consider the "Texas War on Drugs" program, which has established itself as a model in this area.
  - *Public School Education:* Assist the Department of Education in developing and presenting more relevant, positive and proactive curricula in law-related education.
  - *Law Enforcement, Community Organizations and Neighborhood Coordination:* Provide training to law enforcement personnel in order to promote more effective integration of enforcement agencies with community educational activities. Existing crime prevention and other local networks should be recognized and used.
- ☐ Governors should urge that a national effort, adequately staffed, be undertaken to develop program models and information services for the individual states.
- ☐ Governors should urge that the federal government develop and implement a national education program. In this regard, the President has recommended that emphasis be placed on training of state and local law enforcement personnel. Governors should be encouraged to support this initiative.

Fiscal Impact

The fiscal impact of educational efforts can be minimized by turning to the private sector for executive resources, fund raising activities and creative talent. Membership on the Blue Ribbon Commissions would be voluntary. States could also save resoures by promoting drug education through existing citizen networks, such as those addressing crime prevention.

2 Need for Intensified Eradication and Interdiction: Military/Naval Assistance to State and Local Governments

The federal government has exclusive responsibility for coordinating interdiction of drug shipments from foreign countries and assisting those countries in the eradication of drugs at the source. As a result of intensive lobbying, three significant developments have occurred over the past year that have had a positive impact on eradication and interdiction efforts: (1) relaxation of the *Posse Comitatus* doctrine, allowing the military to provide assistance to civilian law enforcement agencies; (2) the removal of the Percy Amendment to the Foreign Assistance Act, which prohibited foreign governments from receiving assistance from the U.S. government if herbicides were used to control illicit drugs; and (3) the recent efforts made by the national administration to support eradication efforts in foreign countries.

Recommendation

The federal government should adopt, as its top drug control priority, the eradication of illicit drugs in source countries and the interdiction of drugs leaving those countries.

The United States should continue encouraging foreign governments to employ eradication methods, including herbicidal applications, and should continue to absorb or contribute to the costs of some of the more critical programs in significant source countries. In addition, the military forces of the United States should be called upon to make a *major* commitment to increase their level of support in the interdiction effort.

Implementation Strategy

- Governors should consider adopting a resolution to Congress and the President to urge the federal government:
  - to keep as one of its top drug control priority programs the eradication of drugs at source countries and to continue to provide adequate funding in subsequent years.
  - to develop improved eradication techniques.
  - to continue to contribute to the cost of these control efforts.
  - to continue to encourage other countries to utilize eradication methods.
- Keeping in mind the tremendous increase of domestically grown marijuana and clandestine manufacture of dangerous drugs, governors should support eradication efforts and the development and application of innovative measures within their states to combat these activities.
- Governors should urge the national administration to expand the role of the military forces of the United States in air and sea interdiction efforts. This increased role should include all regions of the country.
- Governors should encourage their state and local law enforcement agencies to work closely with and seek assistance from the military forces of the United States and develop plans with military forces to coordinate efforts against drug trafficking.
- Governors should encourage their respective congressional delegations to provide sufficient funding to the military to offset the costs involved in participating in civilian drug control efforts.
- The governors should consider having the National Guard and all other appropriate resources work with state and local law enforcement agencies in drug interdiction and eradication programs.

Fiscal Impact

States implementing eradication efforts will experience costs. Cooperation with federal eradication efforts is encouraged to minimize those expenditures. Costs may also be associated with National Guard activities aimed at assisting state drug law enforcement. These costs can be minimized, or possibly eliminated, by conducting National Guard drug enforcement activities in conjunction with regular Guard training exercises.

3 Need for A National Reaction

Over the past decade, numerous states have been hurt by the growing drug problem. These states have taken independent steps to combat the problem; however, their resource limitations and geographic restrictions have hindered the states' effectiveness. The federal government, realizing the national ramifications of the drug problem, has conducted several significant operations that have lessened these restrictions and limitations, such as the recent Bush Task Force in South Florida and the creation of twelve regional task forces.

Recommendation

The federal government should be encouraged to maintain on a permanent basis the federal resources associated with the original Bush Task Force and twelve new task forces.

Implementation Strategy

- Each governor should urge his/her respective congressional delegation to maintain and continue support of the original Bush Task Force and the twelve new regional drug task forces.
- The governors should urge that top White House and justice officials meet twice yearly with selected governors from the NGA to discuss policy issues of mutual interest related to drug trafficking.
- Governors should support the Presidential Commission on Organized Crime, which will be in operation for three years. Membership of this commission should include a representative of the NGA.
- Governors should request the Department of Justice to include state representatives having policy-making or operational responsibilities in drug enforcement on the internal group responsible for administering the regional task forces. Further, that these representatives have appropriate decision-making status in the group within parameters of state-related responsibilities. Further, that each governor should appoint a state drug enforcement coordinator to meet with the lead administrator of the respective task force on a specific periodic basis.
- The governors should communicate with their respective state and local law enforcement officials to actively support the President's initiative.
- Governors should consider actively soliciting public support of these initiatives through speeches, media and other public information resources.
- Governors should, through their respective legislatures, ensure that adequate resources are available for states to coordinate effectively with and complement the federal task force efforts.

Fiscal Impact

Each state must analyze its investments to ensure that it is taking a balanced approach to drug law enforcement. A state's investment priorities should reflect the seriousness of the drug problem in that state.

4 Need for A Centralized Information and Intelligence Data Base

Law enforcement agencies involved in drug control have historically been hampered by lack of accessible and assessable intelligence information relating to illegal trafficking. A centralized system to receive, analyze and disseminate information among state and local law enforcement agencies must exist if proactive, non-duplicative and significant targeting efforts are to occur. Such a system must interact with similar systems in other states and with the federal government.

Recommendation

Each state must establish a centralized drug-related intelligence system. To be effective, the individual systems must ensure input from and response to local enforcement agencies and should interact consistently with appropriate state and multi-state systems and the Drug Enforcement Administration's El Paso Intelligence Center (EPIC).

Implementation Strategy

- ☐ Governors should direct their primary state drug enforcement agency to begin the development of a statewide drug-related intelligence system, with analysis and targeting capabilities. These systems should be joined with the other appropriate state, multi-state and federal intelligence systems.
  - States that possess such systems should share concepts, ideas and technologies with other states.
  - States should ensure that these systems provide the information to all local law enforcement agencies within their respective states.
  - The individual states should ensure that their systems are linked with appropriate systems in other states, as well as with multi-state and federal intelligence systems.
- ☐ Governors should recommend that their appropriate law enforcement agencies develop a mandatory drug statistics reporting system relevant to the measurement of the drug problem and the impact of enforcement efforts.

Fiscal Impact

Costs associated with establishing or enhancing state intelligence systems will vary from state to state. Purchasing a new computerized system, including both hardware and software, is an expensive process. Where computer systems are already in place, such as in those states where responsibility for collecting UCR data is at the state level, costs may be limited to developing necessary software. Some personnel enhancements may also be necessary.

5 Need for Concerted Street Enforcement Activity

Local law enforcement agencies must provide the immediate response to a variety of community demands for crime control. It is difficult for those agencies to dedicate already strained resources to proactive drug prevention and enforcement problems. However, the real direct and indirect drug-related crimes must be dealt with constantly as a part of the required law enforcement response to the community. This response is as adamantly demanded as are responses to violent crime areas.

Recommendation

Governors and legislators of the various states should apply maximum support and effort toward increasing resources (personnel and equipment) of local law enforcement agencies.

Implementation Strategy

- ☐ Governors should consider alternative funding options, such as private sources (foundations, etc.) or via legislative mechanisms such as fine and forfeiture allocations specifically earmarked for drug control enforcement programs.
- ☐ Governors should promote adequate federal and state support of local law enforcement agencies. Because the drug problem is one of national scope, federal resources are needed to support critical or extraordinary state and local enforcement efforts. Governors should also stress to local leaders their support for the allocation of needed resources to conduct drug enforcement programs, joint operations and cooperative efforts.

Fiscal Impact

State government statistical systems must provide governors with adequate assessments of local drug trafficking problems. Resource support will vary from state to state depending upon the magnitude of the problem, i.e., border state, source state, major distribution point, etc. Governors should assess existing investments to ensure they are addressing the problem as a priority matter. In particular, border states must dedicate a portion of available new resources to the priority problems of drug trafficking and distribution.

6 Need for Standard Legislation

There is great disparity among the states' drug laws. There is evidence that smuggling organizations have taken advantage of some states' deficiencies in legal recourse and probabilities of detection, apprehension and prosecution.

Recommendation

Each state should establish a legislative committee of prosecutive, enforcement, judicial and legislative members to examine and develop a comprehensive system of model and uniform laws dealing with the drug problem. The state bar associations and law schools should be included in this effort. This committee can be a separate entity, or a part of an existing statewide drug activity.

Implementation Strategy

- ☐ The Governors should consider the establishment of a committee operating within their respective states to examine existing legislation and determine that state's needs.
- ☐ A National Committee should be created, reporting to the NGA Committee on Criminal Justice and Public Protection. This committee will develop a comprehensive system of model and uniform laws dealing with the drug issue and will disseminate the model drug legislative package back to the respective states for their consideration.
- ☐ The Governors should see that the federal government assign appropriate representatives to this National Committee to promote uniformity of state and federal laws and serve as a mechanism to transmit states' concerns to the federal legislative process.
- ☐ The National Committee should consider at least the following items for the model legislative package:
  - *Racketeer-Influenced and Corrupt Organizations Act (RICO):* providing for the prosecution of entire criminal organizations and civil forfeiture of real and personal property used in the course of, or acquired with the proceeds of, their criminal activities.
  - *Drug Trafficking Laws:* providing appropriate sentences for drug violators and a graduating scale of penalties commensurate with the seriousness of the violation, and permitting consideration of foreign felony drug convictions in sentencing drug law violators.
  - *Wiretaps:* providing for court-authorized interception of telephonic communications between drug law violators.
  - *Mutual Aid:* providing for definitions of interjurisdictional authorities, liabilities, agreements and resource exchanges within and among the various states.
  - *Mandatory Reporting of Currency Transactions:* requiring financial institutions' reporting of certain transactions to the states. The statute of limitations must provide sufficient time to allow full use of complex law enforcement techniques before arrest.
  - *Conspiracy Provisions:* providing for charging those who direct or participate in drug smuggling ventures to be sentenced as principals.
  - *Mandatory Reporting of Drug Statistics:* to a central entity both within the states and at the federal level to reduce duplicate reporting and to establish a valid data base for problem assessment and resource allocation.
  - *Contraband and Asset Forfeiture Reform:* with application of fines and forfeitures being applied directly to law enforcement programs, i.e., through trust funds.
  - *State Department of Revenue Files Access:* providing for access, with appropriate safeguards, by law enforcement agencies.
  - *Witness and Victim Protection:* providing authority and funding required and making it an offense with significant punishment to annoy or injure a witness or victim involved in the criminal justice process.
  - *Bail Reform:* to more certainly immobilize drug traffickers with less judicial discretion, i.e., where smugglers are known to travel internationally or where violence is predictable.
- ☐ Governors should urge that the Congress remove restrictions, with appropriate safeguards, that prevent the Internal Revenue Service from sharing intelligence regarding criminal activities with state and local authorities.
- ☐ The President has asked the Congress to continue its efforts to seek passage of essential criminal law reforms. The specific laws mentioned were bail reform, forfeiture of assets, sentencing reform and amendments to the exclusionary rule. The governors should consider supporting the President's initiative in seeking passage of these essential reforms and ensure that these issues are coordinated with similar state legislation reform efforts.

Fiscal Impact

There are minimal state costs associated with this activity.

7 Need for Greater Prosecutorial Commitment

Prosecutors are hindered by heavy court dockets and broad responsibilities that make it difficult for them to dedicate resources to the prosecution of major drug smuggling operations. Alternative approaches to drug prosecution and better coordination among circuits dealing with multi-jurisdictional organizations are needed. Prosecutors should take steps to expedite drug enforcement cases, as has been done successfully in cases involving career criminals. Additional resources are needed for prosecution of highly financed and well-defended drug organizations.

Recommendations

Governors of the various states are urged to encourage prosecutors to include drug cases as a part of their jurisdiction's priority prosecution/career criminal programs.

Governors should develop programs that will attract and retain competent prosecuting attorneys.

Implementation Strategy

- Governors should seek strong commitments from their respective legislatures to ensure that prosecutive offices are given the necessary support to recruit and retain qualified prosecutors for specific assignment to drug cases.
- Governors should urge that state prosecutive officials coordinate with federal task forces and U.S. Attorneys to minimize duplicative efforts and maximize the impact of prosecutive efforts. This effort should include the newly established Law Enforcement Coordinating Committees (LECC) and other recognized processes created to provide mutual federal, state and local assistance.
- Governors should encourage state and local prosecutors to assume leadership in the development and coordination of priority drug investigative efforts and priority prosecution strategies, and urge implementation of special judicial processes that guarantee fair and speedy adjudication of major drug cases.

Fiscal Impact

Direct state jurisdiction over prosecution responsibilities vary from state to state. Where career criminal programs have been implemented throughout the state, major drug cases should be handled on the same expedited basis as a way of establishing priorities and minimizing expenditures associated with prosecution. This effort should include development and implementation of procedures for handling prosecution of both career criminal and major drug trafficking cases on a priority basis. Where prosecution is a shared responsibility of the state and local governments, all levels should work together to expedite the prosecution of career criminals and drug trafficking cases. Most costs associated with a new emphasis on the prosecution of drug cases will be for personnel.

8 Need for Coordination of Efforts of Local Agencies

There is generally no mechanism to provide for local/state agencies to pool their resources and work together on common drug targets. Equipped with the necessary legislation, agencies can draft contractual agreements to effect "joint force operations" or "mutual aid pacts" to expand resource and jurisdictional abilities to attack drug operatives.

Recommendation

The various states should consider development of necessary legislation to develop a "mutual aid system", whereby law enforcement agencies can contractually join together and pool their knowledge, resources and skills toward investigatively attacking drug smuggling networks.

Implementation Strategy

- The Governors should consider, as referenced in the legislative reform section, the development of "mutual aid" legislation to ensure that the law enforcement agencies within and among the various states can contractually join together to effect joint force operations.
- The Governors should ensure that the lead state law enforcement agency coordinates with local law enforcement agencies so that their operational concerns and initiatives are effectively coordinated with federal task force efforts.

Fiscal Impact

Development of "mutual aid" systems will require a dedication of time by existing personnel and minimal support resources.

Additional Presidential Initiatives

In addition to the recommendations made by the President that have been included in the previous discussions, the following presidential initiatives are also worthy of strong support by the NGA.

- The President has called for a Cabinet-level Committee on Organized Crime, chaired by the Attorney General, to review and coordinate all federal efforts against organized crime.
- The President has requested that the Attorney General prepare an annual report to the American people to report on progress and needs in the drug fight.
- The President has requested that additional prison and jail space be provided to meet the need caused by the creation of the twelve task forces.
- The President recommends that emphasis be placed on training of state and local law enforcement personnel.

R

Meeting of July 21, 1983

PARTICIPATING ORGANIZATIONS

Alcohol and Drug Problems Association of North America
American Academy of Family Physicians
American Dental Association
American Medical Association
American Nurses Association
American Pharmaceutical Association
American Podiatry Association
American Society of Hospital Pharmacists
American Veterinary Medical Association
Career Teachers in Alcohol and Drug Abuse
National Association of Boards of Pharmacy
National Association of State Alcohol and Drug Abuse Directors
National Governors' Association
National Institute on Drug Abuse
Pharmaceutical Manufacturers Association
U.S. Drug Enforcement Administration
U.S. Food and Drug Administration
White House Drug Abuse Policy Office
World Health Organization

MAJOR GOALS OF THE COMMITTEE

- Foster the development of problem identification and resolution activities through cooperative, interdisciplinary programs at the state level.
- Develop methods to identify substandard prescribers and dispensers, to assess the cause of their problems, and to institute appropriate remedial measures.
- Promote better prescribing and dispensing practices on the part of all practitioners.
- Educate patients and the public in the proper use of prescription drugs.
- Engage the support of all concerned professional and governmental organizations for cooperative programs to achieve these goals.

INFORMAL STEERING COMMITTEE ON PRESCRIPTION DRUG ABUSE

Program Objectives: 7/82 - 12/83

1. Continue to coordinate activities and exchange information through the Informal Steering Committee on Prescription Drug Abuse.

2. Support the model interdisciplinary conferences scheduled in five states in 1982 and use the knowledge gained in those conferences to encourage the development of 10 additional state or regional conference in 1983.

3. As a key result of each state or regional conference, support the establishment of an interdisciplinary task force in each state to coordinate ongoing problem identification, goal-setting, planning and action.

4. Establish a financial clearinghouse function to match the resource needs of state and regional conferences and other programs with sources of available funding.

5. Develop and field-test methods of longitudinal instruction in prescribing for use in residency training programs.

6. Develop a data integration and analysis model for use by states in identifying the nature, magnitude, locus and source of prescription drug abuse and diversion activities. Offer this model, with the technical assistance needed to implement it, to the appropriate agencies in each state.

7. Study legislative issues, such as peer review and immunity, that affect regulation, enforcement and remediation activities with prescribers and dispensers. Draft model legislation to meet any identified needs.

8. Explore the feasibility of establishing a national clearinghouse for use by state authorities in exchanging information about practitioners whose licenses have been suspended or revoked.

9. Perform (or encourage a qualified outside group to perform) a carefully controlled study of the effects of multiple-copy prescription systems on the level of drug diversion and the quality of patient care.

10. Maximize professional and public awareness of the problems of prescription drug misuse, abuse and diversion, as well as possible solutions.

Project of the
National Institute on Drug Abuse
in conjunction with the
National Board of Medical Examiners®

Modular Examinations in Drug Abuse and Alcoholism

Information Brochure

The Task Force on Drug Abuse and Alcoholism, formed in 1976 and funded by the National Institute on Drug Abuse (NIDA), is constituted of medical educators from various specialty areas, most of whom are career teachers in drug abuse and alcoholism. The primary concerns of the task force are the quality and availability of examination materials in the area of drug abuse and alcoholism. In this regard, the task force and the National Board of Medical Examiners have developed a series of Modular Examinations in Drug Abuse and Alcoholism.

Funding in support of this project has been provided by the National Institute on Drug Abuse – Alcohol, Drug Abuse and Mental Health Administration – U.S. Department of Health and Human Services under Contract 271-76-4417 and Grant 1-T15-DA07230-01.

Contents

The Modular Examinations in Drug Abuse and Alcoholism are offered through the National Board of Medical Examiners for use by medical schools, residency training programs, hospital in-house training programs, medical specialty or allied health organizations, and other groups interested in education and evaluation of health professionals in the area of drug abuse and alcoholism. Because of the funding provided by NIDA for this project, it is currently possible to make these examination materials available to most organizations and institutions at no charge.

The modules, as described below, have an educational and an evaluative function, thereby making them valuable for use as mid-course evaluation instruments to identify areas for further instruction and as end-of-course evaluation instruments to assess knowledge gained as a result of instruction. The modules may be administered as single units or in series, depending upon the needs of the administering organization.

In addition, the Emory University School of Medicine currently offers continuing medical education credit for use of one of these examinations as self-assessment. Further information on this program is given on page 16 of this brochure.

DESCRIPTION OF MODULES

Each module consists of two books: a test book and a referenced answer book. The test book is comprised of one or more patient management problems (PMPs) and multiple-choice questions (MCQs) that are generally related to the topic introduced in the PMP. The referenced answer book (Syllabus) corresponds to the items in the test book and gives a rationale for the correct answer, an explanation of why the alternate choices were incorrect, and one or more reference sources to which the examinee may refer for further study. The modules are, therefore, appropriate as evaluation instruments and educational materials.

The eight modules currently available vary in length and required administration time:

> Five modules contain one or two patient management problems (each totalling approximately 75 PMP options) and approximately 100 multiple-choice questions. The average time required to work through one of these modules is approximately 1-1/2 to 1-3/4 hours.
>
> Three modules contain one patient management problem (each totalling approximately 40 PMP options) and approximately 40 multiple-choice questions. The average time required to work through one of these modules is approximately 45 minutes to 1 hour.

General topics covered by these eight modules include methadone maintenance, polydrug abuse, abuse of various individual drugs (amphetamines, PCP, marijuana, sedatives), and various clinical problems involving alcoholism.

PATIENT MANAGEMENT PROBLEMS (PMPs)

Patient management problems (PMPs) present medical problems in a manner resembling actual clinical encounters. Each PMP opens with a description of a clinical problem (the stem), which is designed to guide the examinee toward selection of an appropriate differential diagnosis. Following the stem there are several decision points (Problem S-1, Problem S-2, etc.) for which options are offered in random order concerning history, physical examination, diagnostic studies, or management. Each decision point is introduced by a lead-in that may offer additional information and/or ask a question regarding the options offered.

At each decision point, some of the options offered regarding procedure or management are appropriate and others are not. To the right of each option is a blank rectangular area that contains a latent image of the feedback for that option. When choosing an option, the examinee develops the feedback by rubbing the corresponding blank rectangular area lightly with an accompanying special felt-tip pen. The feedback may report answers to questions, results of procedures, or may simply indicate that a diagnostic or therapeutic procedure was scheduled, ordered, or performed. Feedback will not generally indicate whether the choice is correct or incorrect, and there will be no indication as to how many of the options at a decision point should be chosen (the number can vary from none to all). The score for the PMP will be determined by the number of correct choices made – that is, selection of appropriate options and rejection of inappropriate options.

A sample PMP follows.

Patient S

A 32-year-old man visits the emergency room because he has just vomited some blood. This is the first time the patient has experienced such an episode. On questioning, he states that he has had a feeling of epigastric emptiness for several weeks, but he has not had any significant physical illness, operations, or injuries. He is currently under the care of a psychoanalyst who is treating him for depression and marital problems. At this moment, the patient is complaining of weakness.

Problem S-1

With the understanding that a thorough history will be recorded, to which of the following points should particular attention be given in the immediate care of the patient?

1. Past episodes of fainting
2. Past episodes of weakness
3. Any recent weight loss
4. Any drug intake
5. Melena
6. Relief of epigastric symptoms with eating

Problem S-2

With the understanding that a thorough physical examination will be performed, to which of the following points should particular attention be given at this time in the assessment and management of this patient?

7. Examination of pupil size

8. Palpation of the abdomen

9. Complete neurologic examination

10. Observation for excessive perspiration

11. Blood pressure supine and sitting

12. Observation of gait

Problem S-3

Which of the following laboratory and diagnostic studies are now appropriate?

13. Screening the urine for drugs of abuse

14. Hematocrit

15. Blood alcohol concentration

16. Stool test for occult blood

17. SGOT

18. An upper GI series

19. Blood for crossmatch

Problem S-4

Appropriate further management and therapy at this time should include:

20. With patient's permission, consult with psychoanalyst concerning referral to alcoholism/drug abuse treatment center

21. Recommend a bland diet

22. Prescribe a tricyclic antidepressant

23. Recommend 5 to 6 small meals daily

24. Admit to hospital for further evaluation

This brief PMP is shorter than those encountered in the examination modules. The average length of the one or more PMPs contained in any module totals approximately 40 or 75 options (depending on the module chosen), compared with the sample of 24 options.

In the sample PMP above, the correct responses are 1, 2, 3, 4, 5, 6, 8, 10, 11, 13, 14, 15, 17, 19, 20 and 24. Responses 7, 9, 12, 16, 18, 21, 22, and 23 have no direct relationship to this case or are not appropriate at the particular stage of diagnosis or management at which it appears. Only those options directly applicable to the case at the diagnostic/management stage involved should be uncovered.

The feedback that would appear upon selecting and uncovering each of the boxes in the sample, both correct and incorrect, is as follows:

(* indicates end of feedback)

1. None *

2. None *

3. Hasn't noticed any *

4. Drinks martinis at lunch and dinner; has a nightcap before retiring. Occasionally takes pills to keep going or get to sleep. *

5. None noted *

6. Relief noted at times *

7. Normal pupils *

8. Mild epigastric tenderness *

9. None *

10. Patient's skin is pale and moist *

11. 110/70 supine; 90/60 sitting *

12. Gait normal, though slightly unsteady *

13. Specimen sent to laboratory *

14. Hematocrit 33% *

15. 0.03% *

16. Positive *

17. 80 units/ml (Normal: 10-40) *

18. Unsatisfactory visualization *

19. Done *

20. Done *

21. Ordered *

22. Ordered *

23. Recommended *

24. Admission arranged *

Multiple-Choice Questions (MCQs)

Multiple-choice questions included in the modules are of the following types: (1) One Best Answer – Single Item; (2) One Best Answer – Matching Sets; (3) Multiple True-False Items. A machine-scorable answer sheet is included with each test book for use by the examinee in marking answers. Descriptions and samples of each of the above item types are included below. A sample answer sheet and the answer key for all sample MCQs are included on page 14.

One Best Answer – Single Item

This is the traditional, most frequently used multiple-choice format. It consists of a statement or question followed by four or five options. In these examinations, the options in this item type are always lettered (i.e., A, B, C, D, E). The examinee is required to select the best answer to the question. Options other than the single best (correct) answer may be partially correct, but there is only one best answer to this item type.

Sample Items (Questions 1-2)

1. The rate of metabolism of ethanol by the body

   (A) is constant at all blood concentrations
   (B) is constant until the threshold for the dehydrogenase system is reached and thereafter increases with increasing blood concentrations
   (C) increases until the dehydrogenase system is saturated and then remains constant
   (D) increases steadily with increasing blood concentrations
   (E) decreases with increasing blood concentrations

2. A screening of the urine of patients in a methadone maintenance program should be sensitive to detection of each of the following EXCEPT

   (A) alcohol
   (B) barbiturates
   (C) cocaine
   (D) LSD
   (E) morphine

One Best Answer – Matching Sets

This item type usually consists of a list of entities (e.g., diseases, laboratory data) followed by several phrases or statements. As in the one best answer–single item type, there is one best answer. Options other than the correct answer may be partially correct. Examinees may also encounter pictorial materials (e.g., graphs, labeled photographs) that comprise the list of entities.

Sample Items (Questions 3-5)

(A) Barbiturate withdrawal
(B) Delirium tremens
(C) Both
(D) Neither

3. Hallucinations

4. Paroxysmal atrial tachycardia

5. Low serum concentration of magnesium

Sample Items (Questions 6-7)

(A) Aspirin
(B) Acetaminophen
(C) Codeine sulfate
(D) Ergotamine tartrate
(E) Ethanol

6. Metabolic acidosis

7. Constipation

Multiple True-False Items

This item type consists of a statement or question followed by four numbered options. The examinee is required to determine whether each of the options is correct or incorrect. Responses are recorded according to a pattern of responses that permits five combinations of responses. The examinee must mark only one answer on the answer sheet, according to the code contained in the following directions to examinees that appears at the beginning of the section containing this item type:

> DIRECTIONS: For each of the questions or incomplete statements below, ONE or MORE of the answers or completions given is correct. On the answer sheet fill in the circle containing
>
> A if only *1, 2, and 3* are correct,
> B if only *1 and 3* are correct,
> C if only *2 and 4* are correct,
> D if only *4* is correct,
> E if all are correct.

At the top of each subsequent page containing this item type, the following summary of response patterns will appear:

DIRECTIONS SUMMARIZED

A	B	C	D	E
1, 2, 3 only	1, 3 only	2, 4 only	4 only	All are correct

Sample Items (Questions 8-9)

8. Of the following substances, those that are displaced from opiate binding sites by narcotic antagonists include

   (1) codeine
   (2) endorphins
   (3) enkephalins
   (4) propoxyphene

9. Chronic polydrug abusers typically

   (1) respond well to treatment in therapeutic communities
   (2) prefer sedative or hypnotic medications
   (3) use drugs primarily for recreational purposes
   (4) show significant psychiatric impairment

Answer Sheet for Sample Multiple-Choice Items

1 Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ

2 Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ

3 Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ

4 Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ

5 Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ

6 Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ

7 Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ

8 Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ

9 Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ

Answer Key for Sample Multiple-Choice Items

1. C	4. D	7. C
2. D	5. B	8. E
3. C	6. A	9. C

Currently available modules contain approximately 40-100 multiple-choice questions, depending on the module chosen.

Administrative Information and Procedure for Ordering Modules

Organizations or institutions wishing to administer a module to an examinee group should complete the enclosed *Order Form for the Modular Examinations in Drug Abuse and Alcoholism* and send it to reach the NBME at least five weeks in advance of the desired test date. If multiple administrations are planned, a separate order form should be submitted for each anticipated test date (for additional order forms, see page 16 of this brochure). The NBME will contact the requestor with further information on the specific content of individual modules in order to ascertain which of the modules are appropriate for the requestor's use.

In most instances, the funding provided by NIDA makes it possible to provide these examination materials to appropriate organizations and institutions at no charge. There are, however, limited quantities of these materials available. If additional quantities must be printed or if unusual shipping or other costs are involved in an order, there may be a charge to the organization or institution requesting the materials. If the requested materials cannot be furnished without charge, the requestor will be advised by the NBME as promptly as possible before processing the order for materials.

The NBME will make arrangements to ship the test materials to the requesting organization/institution approximately three weeks prior to the test date. A *Proctor's Manual*, which supplies information needed for administration of the examinations, will be included with each shipment. Other arrangements relating to the administration of the examinations (such as testing site, scheduling, etc.) as well as the actual administration of the examinations are the responsibility of the requesting organization/institution.

Use of these examination materials may be made only for the purposes and under the circumstances outlined in this brochure, and any unauthorized reproduction or use is prohibited. Test books must be returned to the NBME after completion of the test administration. Information needed for this and other procedures is also contained in the *Proctor's Manual.*

Requests from individuals for use of modules for self-assessment should be directed to Emory University School of Medicine as outlined on page 16 of this brochure.

Score Report Information

The National Board of Medical Examiners will provide scoring and score report services to users of the modular examinations. To facilitate this process, machine-scorable answer sheets are supplied to each examinee with the test book. Program or course directors are asked to return all test materials to the National Board of Medical Examiners for scoring.

The NBME will produce a performance report for each examinee that indicates, in addition to the percent correct score, the response that was chosen by that examinee for each PMP and MCQ item. These performance reports can then be used with the answer book, either by the individual examinee or by the program/course director as a group exercise, to identify areas of strengths and weaknesses for guiding further study. Performance reports are usually mailed to an identified program/course director within three weeks of return receipt of the test material.

Additionally, an alphabetic roster of examinees will be provided to the program/course director. This roster lists a separate percent correct score for each examinee for the PMP and MCQ sections, as well as the mean score for the group.

For groups of 20 or more examinees, the NBME will also provide an item-by-item analysis showing the percentage of examinees that selected each possible response for a particular item and a frequency distribution that shows the number of examinees and the percentage of the examinee group at each score level. For groups of less than 20 examinees, it may be possible to combine data from several administrations of a given module to accomplish these analyses at a later date.

Once performance data for each module has been accumulated from several administrations nationwide, the NBME will also make available normative tables so that a comparison can be made between an individual's or a group's performance and the performance of other examinees who have taken the same module.

Source for Further Information

Requests from organizations or institutions for further information, additional order forms, and/or confidential review copies of any or all modules of this examination program are encouraged, and should be directed to:

Melanie Valente
National Board of Medical Examiners
3930 Chestnut Street
Philadelphia, Pennsylvania 19104

Telephone: (215) 349-6400

Continuing Medical Education Credit

At present, one of the modules can be taken for continuing medical education credit. As an organization accredited for continuing medical education, the Emory University School of Medicine designates that this continuing education activity meets the criteria for 5 credit hours in Category I of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as directed. Details of this offering can be obtained by contacting:

John B. Griffin, Jr., M.D.
Emory University School of Medicine
Department of Psychiatry – Room 116-A
1256 Briarcliff Road, N.E.
Atlanta, Georgia 30306

Telephone: (404) 894-5869

THE MODULAR EXAMINATIONS IN DRUG ABUSE AND ALCOHOLISM

Provided by the Task Force on Drug Abuse and Alcoholism and the National Board of Medical Examiners®, with funding from the NIDA.

(Please refer to the MODULAR EXAMINATIONS IN DRUG ABUSE AND ALCOHOLISM INFORMATION BROCHURE for a full description of this program.)

SECTION A – REQUEST FOR TEST ADMINISTRATION

If you wish to use these examinations for testing purposes, please complete all the administrative information requested and return this form as directed in Section C below. This form should reach the NBME five weeks before the test date.

1. Test Date: _____ 2. Total # of Examinees: _____
3. Identity of Examinee Group: _____
(e.g., 3rd yr. medical students, physician's assistants, etc.)
4. # of Referenced Answer Books to be provided: _____
5. Desired emphasis of Modular Examination: ☐ Drug Abuse ☐ Alcoholism
6. Shipment Address for Test Materials:
(Do NOT use P.O. box)

_____
Name
_____
Title
_____
Department or Administrative Office
_____
Institution/Organization
_____
Street Address
_____
City State Zip Code
Telephone: _____

Mailing Address for Score Reports and Review Copies:

_____
Name
_____
Title
_____
Department or Administrative Office
_____
Institution/Organization
_____
Street Address
_____
City State Zip Code
Telephone: _____

7. I wish to review a copy of the modular examination to be provided prior to this test date: ☐

SECTION B – REQUEST FOR REVIEW COPY

This section should be completed if you wish to receive a review copy of a modular examination for informational purposes only. This form should also be returned as directed in Section C below.

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Institution/Organization
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Street Address
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City State Zip Code
Telephone: _____

SECTION C – INSTRUCTIONS FOR RETURN OF THIS FORM

Return two copies of this form to: Melanie Valente, National Board of Medical Examiners, 3930 Chestnut Street, Philadelphia, PA 19104. Retain one copy for your files. After receipt of this form by the NBME, you will be contacted regarding the specific content of the five available modules. If you anticipate any changes in the information you have provided on this form, please contact Melanie Valente at (215) 349-6400.

SIGNATURE: _____ TITLE: _____ DATE: _____

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Brochure prepared by the
National Board of Medical Examiners
Philadelphia, Pennsylvania

March 1983