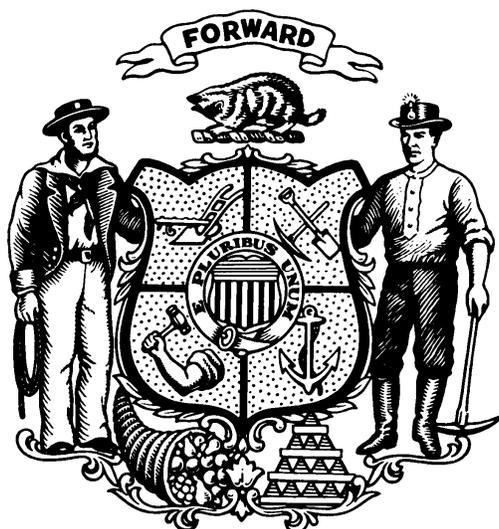


# WISCONSIN STATE COUNCIL ON ALCOHOL AND OTHER DRUG ABUSE



March 2, 2012  
MEETING

**Michael Waupoose**  
Chairperson Governor

**SCOTT WALKER**

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# **State Council on Alcohol and Other Drug Abuse (SCAODA)**

## **Strategic Plan Goals: July 2010 – June 2014**

### **PRIMARY OUTCOME GOAL AND MEASURE:**

The immediate primary outcome goal is to have Wisconsin no longer ranked in the top ten states for Alcohol and Other Drug Abuse (AODA) and problems related to AODA.

*SCAODA's primary outcome goal is in accord with the Wisconsin Department of Health Services' "Healthiest Wisconsin 2020 Plan" regarding unhealthy drinking and drug use that results in negative consequences. Its goals are also consistent with the HW2020 lifespan and equity objectives and the data-driven priorities established through the current "Wisconsin Epidemiological Profile on Alcohol and Other Drug Use, 2008.*

### **SCAODA GOALS:**

1. SCAODA with its committees
  - a. Effectively fulfill the statutory dictate to provide leadership and direction on AODA issues in Wisconsin
  - b. Is a highly recognized and respected body that serves as the voice to whom the Governor, legislators, local coalitions, and media turn for guidance on AODA issues
  - c. Develop and exhibit broad collaborative leadership and aligned action across multiple sectors to advance progress on SCAODA goals.
2. Wisconsin cultural norms change to people vehemently rejecting social acceptance of the AODA status quo and demand and support methods to transform the state's AODA problems into healthy behavioral outcomes.
3. There will be educated Wisconsin citizens regarding the negative fiscal, human and societal impacts of AODA in WI (e.g., risk and addiction, prevention, stigma, treatment and recovery, including the racial and gender disparities and inequities relative to these issues).
4. Wisconsin will have adequate, sustainable infrastructure and fiscal, systems, and human resources and capacity:
  - a. For effective prevention efforts across multiple target groups including the disproportionately affected
  - b. For effective outreach, and effective, accessible treatment and recovery services for all in need<sup>1</sup>.
5. SCAODA with its committees provide leadership to the Governor and Legislature and other public policy leaders to create equity by remedying historical, racial / ethnic and other systems bias in AODA systems, policies and practices that generate disparities and inequities toward any group of people.

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<sup>1</sup> Effective prevention, treatment and recovery services include: using science and research based knowledge, trauma informed, culturally competent, and use of practices that have promise to work.

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## **Tobacco-Free Environment**

American Family Insurance is a tobacco-free environment. We prohibit the use of tobacco products everywhere, by anyone, at all times.

- Use of tobacco products is prohibited in all interior and exterior spaces, including inside your vehicle while on company-property and in parking ramps and parking lots.
- We ask that you refrain from using tobacco products while using our facility.

Thank you for your cooperation. We welcome you and look forward to serving you!

**Meeting Coordinator – Please make sure the meeting participants are aware American Family is a Tobacco-Free Environment.**

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# **SCAODA 2012 Meeting Dates**

**American Family Insurance Conference Center  
6000 American Parkway  
Madison, WI 53783**

**All meetings will be from 9:30am to 3:30pm and will be in Room A3151**

**The meeting dates are:**

**March 2, 2012**

**June 8, 2012**

**September 7, 2012**

**December 14, 2012**

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State of Wisconsin

**State Council on Alcohol and Other Drug Abuse**

1 West Wilson Street, P.O. Box 7851  
Madison, Wisconsin 53707-7851

March 2, 2012

MEETING AGENDA

9:30 a.m. – 3:30 p.m.

American Family Insurance Conference Center

6000 American Parkway Madison, WI 53783 Building A Room A3151

American Family General Information: (608) 242-4100 ext. 31555 or ext. 30300

Please call Faith Boersma at (608)261-0652 or e-mail

[Faith.Boersma@wisconsin.gov](mailto:Faith.Boersma@wisconsin.gov) to advise if you or your designee will not attend the meeting.

- 9:30 a.m. I. Introductions / Welcome/Pledge of Allegiance/Announcement Noise Level / Agenda – Michael Waupoose
- 9:35 a.m. II. Review /Approval of December 9, 2011 Minutes – Michael Waupoose...pp.11-20
- 9: 45 a.m. III. Public Input (maximum 5 minutes per person)—Michael Waupoose
- 10:00 a. m IV. Treatment Alternatives and Diversion presentation—Ray Luick, Kit Van Stelle and Janae Goodrich...pp.35-41
- 10:30 a.m. V. Motivational Interviewing—Scott Caldwell...pp.43-53
- 11:00 a.m. VI. Combined Mental Health and Substance Abuse Needs Assessment Planning Sub—Committee—Joyce Allen...pp.55-56
- 11:10 VII. Update on Workforce Surveys—Mike Quirke...pp.57-58
- 11:40 a.m. VIII. Working Lunch
- 12:15 p.m. IX. State Agency Reports to SCAODA—Michael Waupoose
  - Pharmacy Examining Board - Charlotte Rasmussen
- 1:00 p.m. X. Committee Reports: SCAODA Goals

1. Provide Leadership	2. Change the Culture	3. Educate Citizens	4. Sustain Infrastructure	5. Address Disparities
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- Executive Committee Report—Michael Waupoose...pp.59-64

- Motion to Support Drunk Driving Reform Bill...p.59
- Planning & Funding—Joyce O’Donnell...pp.65-74
  - Motion to affirm/expand SBIRT...p.71
  - Motion to oppose Assembly Bill 464/Senate Bill 358...p.72
  - Motion to oppose Assembly Bill 547...p.73
  - Motion to create strategy to increase Legislative involvement on SCAODA...p.74
- Prevention Committee—Scott Stokes...pp.75-83
  - Motion to oppose Assembly Bill 464/Senate Bill 358...p.79
  - Update on Legislation on Product Stewardship
- Diversity Committee—Rebecca Wigg-Ninham...pp.85-90
- ITC—Norm Briggs and Roger Frings...pp.91-117
  - Update on Ad-hoc Committee on Access

- 2:00 p.m. XI. Agenda Items for June 8, 2012 meeting—Michael Waupoose
- 2:15 p.m. XII. Announcements—Joyce Allen
- 2:30 p.m. XIII. Adjourn—Michael Waupoose

**2012 Meeting Dates**

March 2, 2012

June 8, 2012

September 7, 2012

December 14, 2012



State of Wisconsin

**State Council on Alcohol and Other Drug Abuse**

1 West Wilson Street, P.O. Box 7851  
Madison, Wisconsin 53707-7851

**STATE COUNCIL ON ALCOHOL AND OTHER DRUG ABUSE  
MEETING MINUTES**

**December 9, 2011**

**9:30 a.m. – 3:30 p.m.**

**American Family Insurance Conference Center  
6000 American Parkway Madison, WI 53783  
Room A3141**

**Members Present:** Mark Seidl, Joyce O'Donnell, Mary Rasmussen, Sandy Hardie, Tina Virgil, Scott Stokes, Douglas Englebert, Duncan Shrout, Michael Waupoose, Rebecca Wigg-Ninham, Roger Frings, Kevin Moore, Dennis Baskin, Sonya Sidky, Norman Briggs.

**Members Excused:** Camille Solberg, Steve Fernan, Representative Sandy Pasch.

**Members Absent:**

**Ex-Officio Members Present:** Mark Mathwig, Kim Eithun-Harshner.

**Ex-Officio Member Excused:** Linda Preysz, Joann Stevens, Charlotte Rasmussen, Judith Hermann, Mike Wagner

**Ex-Officio Member Absent:** Ray Luick, Randall Glysch, Thomas Heffron.

**Staff:** Joyce Allen, Linda Harris, Melanie Foxcroft, Scott Caldwell, LeeAnn Cooper, Sue Gadacz, Lori Ludwig, Lou Oppor, Pat Cork, Gail Nahwahquaw, Tanya Bakker, Faith Boersma, Christy Niemuth, Elizabeth Hudson, Arlene Baker, and Bernestine Jeffers.

**Guests:** Francine Feinberg, Denise Johnson, Jill Kenehan-Krey, Sue Gudenkauf, Dr. Steven Dakai, Shel Gross, Judith Reed, Todd Campbell, Karen Kinsey, Dave McMaster, Sarah Melde (Gunderson-Lutheran in La Crosse), Staci McNatt (Wisconsin Recovery Community Organization--WIRCO), Paul Krupski (Health First Wisconsin), Paul Moberg, Jill Kenehan-Krey.

**I. Introductions—Michael Waupoose**

Michael Waupoose welcomed the group. Members, staff and guests introduced themselves. The group recited the Pledge of Allegiance. Mr. Waupoose reminded everyone to avoid talking amongst themselves during the meeting. It makes it difficult to hear and difficult for the

interpreters to follow. Mr. Waupoose then announced the newest citizen appointments and re-appointments to SCAODA by the Governor. They are: Norm Briggs, Sandy Hardie and Duncan ShROUT.

## II. Review/Approval of September 9, 2011 Minutes—Michael Waupoose

Mr. Waupoose asked for any changes, corrections or additions to the minutes. Hearing none, **Mark Seidl made a motion to approve the minutes of September 9, 2011. Sandy Hardie seconded the motion. The motion was approved unanimously.**

## III. Public Input—Michael Waupoose

IV. There were no requests from the public to address the Council.

## V. Trauma Informed Care presentation—Elizabeth Hudson

Elizabeth Hudson introduced herself as a consultant from the University of Wisconsin Department of Psychiatry, working in the Bureau of Prevention Treatment and Recovery for the last three and one-half years. She explained that the underpinnings of Trauma Informed Care (TIC) come from the “Adverse Child Experience” (ACE) research. She distributed two handouts, “What’s My ACE Score?” and “Adverse Childhood Experiences and Health & Well-Being over the Lifespan.” Ms. Hudson encouraged the group to go to the Center for Disease Control’s website (<http://www.cdc.gov/ace/findings.htm>) and follow the link to the ACE Study. Major findings are: “Almost two-thirds of our study participants reported at least one ACE, and more than one of five reported three or more ACE. The short- and long-term outcomes of these childhood exposures include a multitude of health and social problems.” Ms. Hudson reported correlations between ACE scores and problems such as IV drug use, sexually transmitted diseases, abortion, rape, use of hallucinogens, alcoholism, depression, suicide, chronic obstructive pulmonary disease, heart disease and liver disease. She reported that people with ACE scores are more likely to die earlier than people with no ACE scores. She continued that the research shows that ACE’s are very common and they predict health risks. TIC provides a philosophical shift from “What is wrong with you?” to “What happened to you?” Ms. Hudson played a video named “Still Face Baby”. The point of the video was to show that babies need empathetic responses for limbic development. It is a significant factor in prevention of the psychological and physical health problems listed above in order to endure life’s stresses as adults. Ms. Hudson conveyed that TIC is really an effort to change culture. It crosses boundaries, requires collaboration and consumer leadership. Wisconsin is the only state in the nation to designate TIC staff. She informed the group of her TIC activities. She is working to increase the number of TIC Champions statewide, modify assessment tools, hold statewide discussion, collect stories and data. Francine Feinberg reported that in women’s treatment TIC has been going on for years and years. The numbers of girls and women who experience violence are astonishing. She offered that violence effects the functioning of the brain. The executive functions are affected causing acting out, impulsiveness and a lack of a self concept. Kevin Moore indicated that DHS and DCF are involved in TIC efforts and that the First Lady has made TIC her priority and mission. Rebecca Wigg-Ninham asked about the relationship with the Tribes. Ms. Hudson responded that it has not been strategic. She has worked with

Menominee, Stockbridge Muncie and Bad River Tribes, but not systematically. TIC resonates deeply with tribal people. Norm Briggs felt that the substance abuse field hasn't engaged with this and asked Ms. Hudson if she would have any direction for the field. Ms. Hudson felt that engagement of consumers makes all the difference. Staci McNatt reported one reason that the mental health field uses TIC more than the substance abuse field does is that recovery coaching is more active in mental health field. Ms. Hudson added that the other reason is that AODA treatment comes from the disease model. TIC philosophy asks you to reconsider these assumptions. Mary Rasmussen reported that a reaction to "What happened to you," falls into the blame game. In other words, from the point of view of a substance use recovery, it allows one to avoid responsibility, for example, "It's because of..." In substance abuse recovery it is a forgone conclusion that something happened to you, the point is, what do you do now? Elizabeth Hudson felt that TIC looks at new explanations, better explanations, not excuses. Michael Waupoose added that the consumer movement actually began in the addiction community. The substance abuse community struggles with anonymity. It is a delicate balance, a double edged sword. Ms. Hudson concluded her presentation by providing the group with another handout, a schematic representation of the complexity involved with the integration of the TIC philosophy into existing systems, communities and cultures. Mr. Waupoose thanked Ms. Hudson for her presentation and the group responded with applause.

#### VI. Screening Brief Intervention and Referral to Treatment (SBIRT) presentation—Joyce Allen, Scott Caldwell and Dr. D. Paul Moberg.

Joyce Allen informed the group that there have been SBIRT presentations in the past, but since there are so many new people on the Council, it was important to bring them up to speed. Scott Caldwell will present on the SBIRT project and Dr. D. Paul Moberg, from the Population Health Institute, will present on the evaluation of the project. Ms. Allen continued that SBIRT is a part of the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL). SBIRT has been implemented in 31 healthcare clinics throughout the state. The model identifies people with risky or unhealthy use of substances. She then introduced Scott Caldwell, SBIRT Program Coordinator in the Bureau of Prevention Treatment and Recovery (BPTR). Mr. Caldwell explained that SBIRT is a program which, when delivered properly, each and every client with a positive screen would be referred to treatment or a brief intervention as needed. While most people are low risk drinkers, there are lots of folks with risky or problematic drinking who would benefit from a brief intervention. If they are determined to be dependent, they will be referred to treatment. After five years (of implementation in Wisconsin) 117,580 people have been screened; there has been 26,336 brief interventions. Four hundred ten (410) people have been referred to treatment or 1.5% of all SBIRT patients. Mr. Caldwell explained that the average nationally for referral to treatment is 1.3%. However, there have been difficulties in actually admitting all of these referrals into treatment. Part of the problem is that health educators weren't trained in how to get a referral going. Primary care seems disconnected from AODA treatment as a system. We are learning lessons from primary care. SBIRT can be implemented in diverse settings, such as hospital emergency rooms, crisis settings and pre-natal care coordination settings. There is interest in implementing SBIRT in middle schools. Why deliver SBIRT? Reasons are: to prevent hazardous use; AODA is the fourth leading cause of death in Wisconsin; there is a huge economic cost; and it works. A meta analysis of all alcohol treatment shows that brief interventions are very effective. It works in general health care and it works on

drugs as well as alcohol. SBIRT provides a bridge to treatment and is cost effective. It has been endorsed by many organizations.

Dr. Paul Moberg began his presentation of the evaluation of SBIRT. He provided a power point presentation based on an interim report. There are both process findings and outcomes. Of 166,647 eligible patients, approximately 113,647 received brief screens. Of those, two-thirds were negative for harmful or risky use, or one-third (37,335) were positive. Of all of the brief screens, 27% were binge drinkers, 8% were drug users, 7% were positive in admitting using alcohol or drugs more than they meant to, and 11% thought they should cut down on their drug or alcohol use. Of all of the positive screens, 81% admitted to binge drinking. Additional areas of screening include tobacco, nutrition, exercise, depression, weight and violence. Sixty-three percent of the positive brief screens received full screens. 80% of those were determined to be “at risk” (83%), “harmful” (7%) or “likely dependent” (10%). Dr. Moberg pointed out that while approximately 1800 were determined to be “likely dependent,” according to Scott Caldwell’s statistics only 410 were referred to treatment. What accounts for the differences? Dr. Moberg explained that some sought treatment within their own health care systems and they were not tracked in this study. Outcome data were collected from a 10% random sample of all patients with a positive screen and also consented to follow-up interviews. Follow-up interviews were conducted via telephone by trained evaluation staff. The following data represent the results from 538 interviews. There were changes seen across all age groups except those who were age 65 and over. Dr. Moberg reported a significant change overall with respect to binge drinking. Marijuana use also decreased significantly from 25% to 21%. Program feedback indicated that SBIRT helped change many areas and 65% were able to modify their lifestyles. Dr. Moberg answered a number of questions from the Council members. Duncan Shroul thanked Dr. Moberg indicating that SBIRT is a great program that should be promoted and commended as well as the Population Health Institute for the evaluation. Dr. Moberg thanked Mr. Shroul and informed the group that the WIPHL team is applying for other projects within the private sector to build SBIRT into insurance health plans and employee health plans. He also informed the group that there is a code in Medicaid to pay for health education but it has not been used much yet. He relayed that he may need help to obtain de-identified Medicaid data for patients who went through WIPHL. He would like to look at the cost offset. He indicated that he may need SCAODA’s support. That would be useful and helpful. Mr. Waupoose thanked Joyce Allen, Scott Caldwell and Dr. Moberg for their presentation.

## VII. State Agency Reports

Kim Eithun-Harshner from the Department of Children and Families (DCF) reported on a new initiative to improve the neuro-development of children through a home visiting program. The goals of the program are to the relationships between mothers and their children and improve maternal and child health. There are two federal grants funding the program, a formula grant and a development grant. In Wisconsin 15 and 5 tribes will be funded. The Women’s Treatment Coordinator from BPTR has been involved in planning as have representatives from mental health and Birth to 3 partners. Elizabeth Hudson from the TIC initiative has also been collaborating. Ms. Eithun-Harshner informed the group of another DCF initiative in the Western Region, the Regional Partnership Grant. This initiative works with Child Welfare and the Courts with parents with substance use disorders. Joyce O’Donnell asked about the amounts of the

grants. Ms. Eithun-Harshner reported that the formula grant is for \$1.6 million and the discretionary grant is for \$2.1 million.

Kevin Moore from DHS reported that Pat Cork has been appointed his back-up to SCAODA. He also reported that he met with the Executive Committee from SCAODA, Michael Waupoose, Duncan Shroul and Scott Stokes. He reported that he is interested in having the Child Abuse and Neglect Board come to brief SCAODA on its activities; that the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) has been submitted; and that he has been working with Representative Sandy Pasch and the Legislative Liaison to identify additional legislators to serve on SCAODA. Todd Campbell asked about the disbursement of the SAPTBG. Joyce Allen responded that at this time, there is a funding plan in place. Regarding new initiatives, there have been rumors of reductions. However, future discussion at the federal level will include the issue of treatment needs in relation to health insurance and how the block grant should be used for non-insurance fundable services. Kevin Moore added that if dollar amount changes occur, procurement amounts would change.

## VIII. Committee Reports

### Executive Committee—Michael Waupoose

Michael Waupoose reported that on October 28, 2011 the Executive Committee of SCAODA met to discuss AB63/SB44. These bills extend the period of time retailers may sell alcoholic beverages (from 6:00 am instead of from 8:00 am). The Executive Committee made and passed a motion to send the letter of opposition to the bills to the Governor, asking for his veto. A letter was sent to the Governor on 10-31-11.

The Executive Committee's actions were ratified by SCAODA on 12-9-11 with the membership voting in favor except for abstentions from Tina Virgil and Kevin Moore. A guest reported that the Governor signed the bill on December 8<sup>th</sup>.

Michael Waupoose asked the group if SCAODA should send letters to the County Executives. Kevin Moore suggested that it would be more efficient to send letters to the League of Municipalities. Duncan Shroul and Mark Seidl felt that was an excellent suggestion. Mr. Waupoose added that in Dane County, there is not to be any changes in current hours of sale.

### Diversity Committee—Sandy Hardie

Sandy Hardie reported that the Diversity Committee has discussed issues regarding the Minority Training Institute. Please see the minutes in the packet about the impact on counselors. Also, the Diversity Committee is having difficulty obtaining a quorum. There has been discussion regarding what actions to take to keep members. Perhaps members of the Diversity Committee should separate and each one sit on each of the other Committees. She reported that the Diversity Committee is looking for suggestions. If there are any, please email Ms. Hardie or Gail Nahwahquaw. Michael Waupoose encouraged people to participate on the Diversity Committee. There is lots of meaningful work to do.

ITC—Norman Briggs

Mr. Briggs referred the group to the minutes in the packet. ITC has a focus on particular populations, such as the treatment population of adolescents, children and youth and older adults. Treatment has come a long way in specialized services, including Trauma Informed Care. Dave Macmaster reported on the latest WINTIP statistics and referred the group to <http://www.tobaccorecovery.org/> for tobacco recovery resources. He thanked ITC for making tobacco cessation part of their strategic plan. He reported that next year funding to WINTIP will be cut 22%. He also wanted to thank SCAODA and state staff for their continuing support.

**Mr. Briggs made the following motion on behalf of both ITC and Planning and Funding:**

**To oppose AB 286 (Companion bill SB 207). This bill specifies that it is not employment discrimination because of conviction record for an employer to refuse to employ or to bar or terminate from employment an individual who has been convicted of a felony and who has not been pardoned for that felony, whether or not the circumstances of the felony substantially relate to the circumstances of the particular job. Duncan ShROUT seconded the motion.** Mr. Waupoose asked for discussion: Joyce O'Donnell pointed out that employers in Milwaukee have been impacted. Legislators there have in the past opposed this type of legislation. **Mr. Waupoose called for the vote. All were in favor except Kevin Moore and Tina Virgil who abstained. The motion passed.**

Planning and Funding—Joyce O'Donnell

Planning and Funding made the following motion:

**Whereas SCAODA's purpose is to inform Wisconsin citizens on AODA policy and issues, and whereas providers and funders struggle to provide adequate and sufficient AOD services, and whereas the direction of national health care reform is ambiguous, the Planning and Funding Committee motions that the Chair of SCAODA appoint an ad hoc committee to address the growing number of Wisconsin citizens and tribal members seeking and not able to access AOD treatment in Wisconsin. The Planning and Funding Committee recommends this ad hoc committee prepare a preliminary report by March, 2012 and a complete report by June 2012.**

Discussion: Norm Briggs pointed out that within the latest Substance Abuse Block Grant application there is a great deal of information on access to treatment services on a county by county basis. ITC looks at access for special populations. He felt that the Ad-hoc Committee should be attached to ITC. He asked for a little more form and structure to the issues. Mr. Waupoose asked Joyce O'Donnell about the intent of the motion. What was Planning and Funding looking at? What were they asking for a report on? Ms. O'Donnell responded that the availability of counselors was an issue. Mr. ShROUT added that as the Affordable Care Act is implemented there will be changes to block grant funding. There is a strong desire among citizens in Wisconsin (reporting through the Public Forums that P & F have hosted) to understand the impediments to access. What can SCAODA do to decrease the barriers to

treatment and increase access to screening? We need to look at the entire state. The role of SCAODA is to inform the general public on access, funding and to decrease barriers.

Mr. Waupoose suggested an Ad-hoc committee to identify barriers and problems of access; potential remedies; funding; insurance; travel—all these elements. Is this confirmed, he asked? Mr. ShROUT would like SCAODA to offer specific solutions to resolve them. We need to suggest solutions for the state. The issue is bigger than DHS, private clinics, insurance. People in Wisconsin have difficulty in accessing treatment. Regarding making this study part of ITC, Mr. ShROUT said, “fine.” He suggested ITC consulting with P & F. Michael Waupoose asked who should be on the Ad-hoc committee. Mr. ShROUT suggested that representatives from DHS should attend, one or two persons from P & F and meet telephonically.

Kevin Moore suggested adjusting the dates. There can be no preliminary report by March 2012, he suggested 2014. Drill down on those problems and difficulties. The scope is large, it may implode under the weight of the concerns. He was concerned that the report would hi-light what we already know. We already know the problem exists. Mr. ShROUT responded that we do not want to recreate existing data. There is a multiplicity of issues. We should offer solutions, not unsolvable problems. Mark Seidl suggested that interested members contact Michael Waupoose, but the numbers of people involved should be limited.

Duncan ShROUT recognized that the scope is broad. He suggested that we need assistance, perhaps from the Population Health Institute at UW. DHS could narrow down the issues. **Joyce O’Donnell added that the timeline is flexible. She added that she would delete the timeline of the motion with the consent of the Chair.** Michael Waupoose added that Ad-hocs are to exist for one year. Joyce O’Donnell suggested that ITC and P & F work together. Regarding the amendment to delete the timeline of the motion, **the group voted unanimously in favor of the amendment. Regarding the motion, all were in favor with Rebecca Wigg-Ninham abstaining.**

**Joyce O’Donnell made the following motion:**

**The Planning and Funding Committee recommends to Representatives Krusick and Ott a modification in the proposed legislation known as the Drunk Driver Reform Bill LRB 2144 in paragraph number 7 which recommends \$10 million of funding for this legislation be taken from current beer, wine, and liquor tax revenues. It is highly unlikely that any current revenue source will be allocated for this worthy legislation. The Planning and Funding Committee recommends that an alternate source of funding be created through an increase in Wisconsin’s beer tax on a barrel of beer. SCAODA is on record supporting legislation which would raise the beer tax from \$2 to \$10 a barrel. Based on current Wisconsin’s alcohol consumption patterns, an \$8 per barrel increase would raise an additional \$50 Million Dollars in annual revenue. Additionally, the SCAODA IDP Funding report approved by SCAODA in September 2011 also supports such a tax increase to fund treatment services for indigent Wisconsin citizens convicted of intoxicated driving for whom treatment is recommended.**

Joyce O'Donnell recognized that in order to increase funding for prevention and treatment services an increase on the alcohol tax is necessary. This is an opportunity for us to increase tax funding for additional needs for treatment dollars. **Duncan Shroul seconded the motion.** Discussion included the point from Kevin Moore that it extremely unlikely that the legislature would ever increase taxes. Duncan Shroul then made a motion to support LRB 2144 and instead of asking for increased taxes to support additional funding, ask legislators to consider other sources of funding. **The motion to change the motion to support LRB 2144 by removing increasing alcohol taxes to fund the bill and asking instead that the legislature consider other sources of funding passed with three abstaining, Tina Virgil, Kevin Moore, and Douglas Englebert. Duncan Shroul then made a motion that SCAODA support LRB 2144 and ask the legislature to consider other sources of funding for the bill. Joyce O'Donnell seconded the motion. The motion passed unanimously.**

**Joyce O'Donnell made the following motion: Planning and Funding opposes a multiple-tier reimbursement system based solely on educational status and recommends a grand fathering option where anyone with less than a Bachelor's degree, but a licensed counselor be given a period of time (10 years or until 2024) to complete their BA degree. Planning and Funding would ask that other SCAODA Committees weigh in on this proposal.**

Michael Waupoose asked for discussion. Kevin Moore asked that the motion be withdrawn. He referred to the survey of SACs and CSACs which will give the Department more information from which to make decisions. We need to see the numbers we're impacting. We need data and analysis. We need to continue the discussion with Medicaid and Health Care Access and Accountability. Joyce O'Donnell responded that this motion reflects a continuing concern of the Planning and Funding Committee. It is based on feedback from the public at our Public Forums. **She will withdraw the motion but asked the other Committee's to review this motion. Mr. Waupoose asked the other Committees to please address this issue.** He asked what a multiple tier reimbursement system was. Mr. Shroul replied that it means that someone with a bachelor's degree can be reimbursed at one level and someone with less education is reimbursed for the same service at a lower level. Joyce Allen informed the group that in general the current system reimburses Master's degreed persons at one level and a Ph. D. at another level. This practice is common throughout Medicaid. A multi-tier system already exists. Sue Gadacz then informed the group that the survey is being developed in conjunction with input from providers. Information will be collected from SACs and CSACs on race and ethnicity, age, rendering IDs, workplace data (private or MA certified clinic) and other information. She just obtained the address list from the Department of Safety and Professional Services. **Joyce O'Donnell then withdrew the motion.** She reiterated that the worry is who will get paid and who won't. Kevin Moore indicated that he appreciated that.

On other news, Joyce O'Donnell reports that liquor sampling includes up to 3 shots of liquor now and can be made available in gas stations. She sited Representative Kleefisch as responsible for the legislation. She also reported that regarding tobacco, there is a company converting tobacco into bio fuel as a substitute for gasoline.

Prevention—Scott Stokes

Mr. Stokes reported that Dorothy Cheney reported on the Controlled Substances Workgroup Report at the last meeting. The report is in the process of being finalized and published. This is the final year for SPF-SIG (Strategic Prevention Framework State Incentive Grant). There is a new Ad-hoc committee being developed within the Prevention Committee addressing the 911 Good Samaritan laws. Mr. Stokes indicated he would have a list of participants by the March meeting.

IX. Agenda Items for March 2, 2012 Meeting—Michael Waupoose

- Update on the Counselor Survey
- Update on the Ad-hoc on Access Committee
- Update on WINTIP
- Update on Prescription Monitoring Program by DSPS
- Report from Wisconsin Recovery Community Organization (WIRCO)

X. Announcements—Sue Gadacz

- Synar Report is available on-line at the Bureau's website
- There will be an IDP (Intoxicated Driver Program) Audit. Timeline is about a month and a half for data collection, and then the Audit Committee will discuss.
- The SABG is being audited by the Legislative Audit Bureau
- There will be a federal audit of the SABG this Spring
- There is a combined meeting today of the Executive Committees of SCAODA and the Wisconsin Council on Mental Health to begin the process of developing a plan for the 2013 combined block grant application submission.
- Joyce O'Donnell thanked and recognized Sue Gadacz and LeeAnn Cooper for their work in obtaining an IDP Audit.

XVII. Adjournment—Michael Waupoose

Mark Seidl motioned to adjourn. Sandy Hardie seconded the motion. The meeting adjourned. The next SCAODA meeting is scheduled for March 2, 2012 from 9:30 am to 3:30 pm in room A3151.

2012 SCAODA Meeting Dates:

March 2, 2012  
June 8, 2012,  
September 7, 2012  
December 14, 2012

DRAFT



State of Wisconsin

**State Council on Alcohol and Other Drug Abuse**

1 West Wilson Street, P.O. Box 7851  
Madison, Wisconsin 53707-7851

**STATE COUNCIL ON ALCOHOL AND OTHER DRUG ABUSE  
MEETING MINUTES**

**September 9, 2011**

**9:30 a.m. – 3:30 p.m.**

**American Family Insurance Conference Center  
6000 American Parkway Madison, WI 53783  
Room A3141**

**Members Present:** Mark Seidl, Joyce O'Donnell, Representative Sandy Pasch, Steve Fernan, Mary Rasmussen, Sandy Hardie, Tina Virgil representing Dave Spakowicz, Scott Stokes, Douglas Englebert, Duncan Shrout, Michael Waupoose, Rebecca Wigg-Ninham, Roger Frings, Kevin Moore, Dennis Baskin, Sonya Sidky.

**Members Excused:** Camille Solberg

**Members Absent:**

**Ex-Officio Members Present:** Ray Luick, Mark Mathwig, Linda Preysz, Mike Wagner, Randall Glysch, Joann Stevens and Thomas Heffron.

**Ex-Officio Member Excused:**

**Ex-Officio Member Absent:** Colleen Baird, Judith Hermann and Matt Vogel.

**Staff:** Linda Harris, Lila Schmidt, Leeann Cooper, Sue Gadacz, Lori Ludwig, Lou Oppor, Gail Nahwahquaw, Susan Endres, Tanya Bakker, Faith Boersma, Christy Niemuth, Jack Grotzky, and Bernestine Jeffers.

**Guests:** Francine Feinberg, Georgiana Wilton, Dorothy Chaney, Gail Kinney, Dr. Steven Dakai, Norm Briggs, Shel Gross, Sheila Weix, Manny Scarbrough, Dave McMaster, Tami Bahr, Nina Emerson, Georgiana Wilton, Kristi Obmascher, Robin LeCoanet, Raina Haralampopoulos, Paula Perin, Andrea Jacobson, Bill McCulley.

**I. Introductions—Mark Seidl**

Mark Seidl welcomed the group. Newcomers were introduced: Dennis Baskin from the Department of Corrections, Sonya Sidky from the Department of Transportation, Mike Wagner

from the Department of Revenue and Mark Mathwig from the Department of Veterans Affairs. The group recited the Pledge of Allegiance.

## II. Election of Officers—Joyce O’Donnell

Joyce O’Donnell asked the two candidates running for Chairperson to introduce themselves. Michael Waupoose informed the group that he is a manager with Gateway Recovery at University of Wisconsin Health Care. He has twenty-five years of management experience with non-profit and private substance use disorder treatment providers. He has chaired the Diversity Committee for the last four years and was also a member of the Intervention and Treatment Committee. He was a member of the Substance Abuse Advisory Council at the Department of Regulation and Licensing (now the Department of Safety and Professional Services). He reported that his strengths are in negotiation through conflict. He felt that it is important to hear all sides of an issue. As Chairperson of SCAODA he indicated that he would bring a strong commitment to the issues which would be in the best interest of the citizens of the state. Communities of color would be his special interest. Mark Seidl reported that he has been a member of the Wisconsin County Human Service Association (WCHSA) since 1974 and has chaired several committees during his tenure there. He is currently the Behavioral Health Manager at Kewaunee County Department of Human Services. He has been the Chairperson of SCAODA since 2008 and a member of SCAODA since 1994. As Chairperson of SCAODA he would represent the interest of the state of Wisconsin through his strong commitment to health and human services, having worked in the field for forty years. Joyce O’Donnell then asked staff to distribute ballots for voting. Staff (Lori Ludwig and Faith Boersma) distributed the ballots and then collected them. Nominating Committee member Rebecca Wigg-Ninham tabulated the votes, with assistance from staff. The ballots were then returned to Ms. O’Donnell who announced the final outcome. **Michael Waupoose was elected as Chairperson. Ms. O’Donnell asked for a motion to accept and approve the results of the election. Mark Seidl so moved; Kevin Moore seconded the motion and the vote of approval was unanimous.**

Duncan Shrout was introduced by Joyce O’Donnell who informed the group that Mr. Shrout would accept the position of Vice-Chairperson. Mr. Shrout introduced himself as having 30 years of experience in the field of substance abuse prevention. He has worked with legislators at the local, state and national level. Recently, he reported, he chaired the Intoxicated Driving Program Ad Hoc Committee on Funding. He has worked on many community coalitions and looks forward to working with Michael Waupoose. **Joyce O’Donnell asked if there were any more nominations for the Vice-Chairperson position from the floor. She asked three times. Hearing no other nominations, she cast a unanimous ballot for Duncan Shrout, which was seconded by Mark Seidl. There was unanimous consent and Duncan Shrout was elected Vice-Chairperson of SCAODA.**

Ms. O’Donnell introduced Scott Stokes, current Secretary of SCAODA indicating that he has agreed to accept appointment to SCAODA as Secretary for another year. Mr. Stokes introduced himself. He is Director of the AIDS Resource Center. He reported that it has been his honor to Chair the Prevention Committee. Joyce O’Donnell then asked if there were any nominations from the floor three times. **Hearing no other nominations, she cast a unanimous ballot for**

**Scott Stokes which was seconded by Dennis Baskin. There was unanimous consent and Scott Stokes was elected Secretary of SCAODA.**

Ms. O'Donnell then thanked Mark Seidl and recognized his commitment to SCAODA. Mark Seidl thanked Ms. O'Donnell and Rebecca Wigg-Ninham for their work on the Nominations Committee. Michael Waupoose then assumed his duties as Chairperson.

### III. Review/Approval of March 4<sup>th</sup> and June 10, 2011 Minutes—Michael Waupoose

Joyce O'Donnell motioned to approve the minutes of March 4, 2011 and the minutes of June 10, 2011. Representative Sandy Pasch seconded the motion. The minutes were approved without changes.

### IV. Public Input—Michael Waupoose

There were no requests from the public to address the Council.

### V. Women-Specific Treatment/FASD (Fetal Alcohol Spectrum Disorders) Awareness Day—Francine Feinberg, Norman Briggs, Georgiana Wilton, Bernestine Jeffers.

Bernestine Jeffers, the Women's Treatment Coordinator in the Bureau of Prevention Treatment and Recovery introduced herself, Francine Feinberg, Director of Meta House and Norm Briggs, Director of ARC Community Services. They distributed a handout and presented a power point entitled, "Women Specific Treatment/ FASD Awareness Day. They also distributed a brochure entitled "Women and Alcohol," and a Fact Sheet on Fetal Alcohol Spectrum Disorders (FASD). They encouraged the group to investigate SAMHSA's "TIP 51, Substance Abuse Treatment: Addressing the Specific Needs of Women." Francine Feinberg reported that substance use disorder treatment was originally developed for men. As a result, women did not do very well in treatment. Everything is different for women. Their experience is one of more emotional pain, depression, stress, trauma, psychological and physical distress. Women are very likely to have experienced childhood sex abuse or physical abuse. The prevalence of a history of sex abuse for women in treatment is about 95%. The families of origin of women substance abusers are more dysfunctional. Women are more likely to be poor, with fewer job opportunities, caring for children, caring for other family members, carrying multiple roles and juggling their lives without the support of a significant other. They are at greater risk for co-occurring disorders of mood, depression and anxiety, with much stronger negative self identities, more extreme stress and lack of coping skills. Women also have a different physiological response to alcohol and drugs. They have a higher mortality risk. They also risk alcohol exposed pregnancy. Partners and family members are more likely to abandon her. Men and women find different aspects of the treatment experience important. Evidence-based practices for women are based on relational models and family-centered treatment. Family-based services require maximum amounts of system coordination where case managers assume the responsibility for intensive coordination of care. Ms. Feinberg reported that six-month post discharge outcomes for family-centered treatment include: a 55-60% decrease in the number of women who reported using alcohol or drugs, decreases in arrest rates, increases in employment and vocational training, and birth outcomes that are better than average women. Outcomes for the eight Urban and Rural

programs are: reduced use/abstention among participants (69-87%), 64-88% are not arrested following discharge, and 55-74% are self-sufficient and productive. Bernestine Jeffers referred the group to the handout to note the interpersonal and systemic barriers to treatment. She then introduced Georgiana Wilton to report on the thirteenth annual FASD Awareness Day. Dr. Wilton stressed how important it is that women are served differently. She informed the group that Wisconsin leads the nation in binge drinking and alcohol use among women of child bearing age. She referred the group to SAMHSA's TIP 51, the FASD Fact Sheet and the Women and Alcohol brochure distributed as well as to the Governor's Proclamation (page 33 in the packet) proclaiming today, Friday September 9, 2011 as Fetal Alcohol Spectrum Disorders Awareness Day. Joyce O'Donnell noted that pregnant mothers' use of tobacco is also a detriment to their babies. Sue Gadacz shared that if and when the Affordable Care Act is implemented, SAMHSA's intent is to maintain the women's treatment set-aside. It is, therefore, the intent of the Bureau to continue this funding. Representative Pasch asked if anyone from SCAODA testified about the bill to increase penalties for W2 recipients testing positive for drugs (AB 172). There was a Public Hearing held. She encouraged the group to participate in relevant public hearings. Joann Stephens spoke to the importance of recognizing the role that trauma plays in women's treatment. She recommended that Elizabeth Hudson, Trauma Coordinator at the Bureau, provide an overview for the Council. Mr. Waupoose thanked the group of presenters for their report.

#### VI. Paula's Story—Nina Emerson

Nina Emerson, the Director of the Resource Center on Impaired Driving at the University of Wisconsin Law School, introduced "Paula's Story," a seven minute video on the personal journey of Paula, a multiple OWI offender, now in recovery. Ms. Emerson made the point that a person cannot be punished into getting better. People with addictions will not get better until they are treated. Paula, present for the discussion answered questions about her experience. Michael Waupoose thanked Paula for sharing her story.

#### VII. By-Laws Revisions Vote—Scott Stokes

Scott Stokes directed the group to pages 34-5 in their packets to review the proposed revisions to SCAODA By-Laws. He reported that at June's meeting there was general consensus for approval of the suggested revisions and that the proposed revisions had been distributed to SCAODA members for at least 30 days (as per By-Laws requirements for amending the By-Laws) for their consideration. **Mr. Stokes made a motion to approve the revised By-Laws pertaining to Committee Structure. Duncan Shroul seconded the motion. The motion was passed with unanimous consent.** Mr. Stokes reminded the group that the By-laws are intended to provide guidance. However, if issues come up, SCAODA can reconvene the By-Laws Committee. Mr. Waupoose explained that revisions are usually proposed at the June meeting.

#### VIII. Attendance—Scott Stokes

Mr. Stokes reported that at the June meeting, there wasn't a quorum present. Subsequently, a letter was sent out to members who have not attended meetings for awhile. Mr. Stokes received six responses and as a result, there is a quorum today. In the future, Mr. Stokes plans to pay

better attention and if individuals miss two meetings, a letter will be sent. Michael Waupoose reminded the group to consider participation beyond the four Council meetings per year. Consider joining one of the Committees—it is critical to the work of the Council.

#### IX. DHS Report on Process to Apply for Federal Grants—Kevin Moore

Kevin Moore noted that several items on the agenda are related to this topic (applying for federal grants). Mr. Moore reported that there are two different processes at the Secretary’s Office (DHS). 1) There are grant continuations—and most are continued, he reported. 2) There are also new grants which the Secretary reviews, for example, the Mental Health and Substance Abuse Block Grants. The Secretary focuses on what works and if we are duplicating services. Ultimately, the Secretary makes sure the grants fit into a bigger picture. Duncan ShROUT referred to articles in the Milwaukee Journal Sentinel and the Capitol Times, specifically the grants for SBIRT (Screening Brief Intervention and Referral to Treatment) through the Wisconsin Initiative to Promote Healthier Lifestyles (WIPHL). Mr. ShROUT felt that there can never be too much screening in this state. Mr. ShROUT agreed that duplication should be minimized. However, he emphasized that any AODA screening project should be a priority. Scott Stokes echoed Mr. ShROUT’s argument. Wisconsin passed on a \$600,000 prevention grant. He felt that passing on the grant was a mistake.

#### X. Controlled Substance Report—Dorothy Chaney

Dorothy Chaney began her report with its charge, to look at the scope and breadth of the issue of prescription and non-prescription drug abuse in Wisconsin, focusing upon legal opiates and illegal opiates, as well as other drugs of abuse. It was also charged with,

“... examining the prevalence and burden of use within Wisconsin and to determine if an adequate surveillance system exists. In addition, the Controlled Substances Workgroup (CSW) examined the role of community coalitions, substance abuse prevention and treatment providers, law enforcement and the judicial system, the medical community, schools, and legislative and state agencies in preventing drug abuse. The work group was also required to identify key educational messages that should be delivered to the health care community in the broad scope including; physicians, pharmacists and other key health care stakeholders, and to determine if there are preventive measures that can be employed when prescribing or dispensing drugs with a high potential for abuse. It was also required to examine key messages that should be delivered to the general population and specific subgroups (such as high risk populations) to help avoid abuse and its deadly consequences.”

Finally, the group recognized that while there is a link between prescription drug addiction and heroin addiction, there is an inherent challenge in addressing both legal and illicit drugs and producing a report on both would be extremely difficult. The group came to a consensus that for the purposes of the report, the scope would be limited to “Food and Drug Administration” (FDA) approved prescription medication. The CSW looked at reports from other sources such as SAMHSA and the Office of National Drug Control Policy and other states such as Maryland and Ohio. They looked at priority areas: fostering healthy youth; designing a prescription drug monitoring program; involving the health care community; addressing public policies and

governmental actions at the federal state and local level; and linking broad-based community anti-drug coalitions. They examined the breadth of the problem and made a number of recommendations. Some of the 28 recommendations in the report are:

- Mandate training for health care professionals
- Implement a broad-based community awareness campaign
- Engage and educate the health care community
- Establish secure convenient disposal of medications from households statewide
- Build bridges between law enforcement and community-based prevention efforts
- Create a statewide electronic surveillance system

Dorothy Chaney advised the group that if we implement these recommendations, we will see positive change. Substance abuse is a public health issue, not just a law enforcement issue. Kevin Moore asked how we could take the concepts in the report and implement them. Ms. Chaney recommended contacting experts in the area for plans. Include actionable and feasible priorities. As an example, in the area of drugged driving, she suggested that a pilot program designed to measure the extent of the problems could be set up. It is a realistic goal. Ms. Chaney then referred the group to page 52 of the report for funding considerations. Some of the recommendations presented in the report would become sustainable as a result of a policy enactment, others through re-distribution of current resources, while others would require new sustainable funding. The report estimates that funding in the amount of \$1.3 million would be needed annually to support the recommendations. The report itemizes the funding issues. Ms. Chaney indicated that the CSW felt that funding for these activities could be achieved through a two-cent surcharge on each prescription filled in the State of Wisconsin. Duncan Shrout commented that the report was both impressive and thorough. He pointed out that people are asked to drop-off their unused prescriptions at specific times in specific places. Dorothy Chaney reported that the Alliance for Wisconsin Youth North Woods Coalition (about 50 coalitions) is working on disposal. The DEA is changing its policies regarding semi-annual drop-off events. (Please see the DEA website for specific information about dates, times and places). There are a number of Wisconsin incinerators that could be used, however regulatory changes are needed. Michael Waupoose asked Dorothy Chaney how SCAODA could help. **At that point Scott Stokes made a motion on behalf of the Prevention Committee to accept the Controlled Substances Workgroup Report (with appropriate edits) and to present this report to the State Council on Alcohol and Other Drug Abuse at their September 9, 2011 meeting for full Council endorsement and dissemination. Joyce O'Donnell seconded the motion. Without further discussion the motion was passed unanimously.**

#### XI. State Agency Reports to SCAODA

Steve Fernan informed the group that in the past, he has reported on proposed funding changes for the Department of Public Instruction that were pending in the budget bill. In particular, he referenced the consolidation of several discretionary grants and how that money would be collapsed into one small amount that schools could compete for. The budget bill did pass and currently there is less than \$1 million for AODA prevention programming statewide that schools can apply for.

#### XII. Nominations for Citizen Appointments—Joyce O'Donnell

Joyce O'Donnell reported that she and Rebecca Wigg-Ninham met as the Nominating Committee to review the fourteen applications submitted for the three open citizen appointments to the State Council. After a lengthy and thorough review of each application their discussion narrowed the list of recommendations to five candidates. Final appointments will be made by the Governor's Office.. The candidates recommended were (in alphabetical order): Pamela Bean, Norman Briggs, Kathleen Falk, Sandy Hardie, and Duncan Shrout. **Mark Seidl made a motion to accept the recommendations of the Nominating Committee and forward the names to the Governor's Office. Joyce O'Donnell seconded the motion. Without further discussion the motion was put to the vote. There were all ayes except Duncan Shrout who abstained. The motion carried.**

### XIII. Committee Reports

#### Prevention—Scott Stokes

Mr. Stokes reported that the Controlled Substances Report was finalized and at the next meeting, the Prevention Committee is looking at next steps and the Good Samaritan laws. SPF-SIG is winding down, although a no-cost extension has been granted. The State Prevention conference was held in the Dells June 13-16. Over 400 people registered and the Prevention Committee hosted the SCAODA Public Forum. Mr. Stokes then introduced four motions on behalf of the Prevention Committee.

**1) The Prevention Committee motioned to support Senate Bill 159 also on behalf of the Planning and Funding Committee. This bill prohibits underage use of any alcohol at all on school property. Joyce O'Donnell seconded the motion. There were all ayes except Tina Virgil abstained.**

**2) The second motion was to send a letter to the Governor and the Secretary of DHS encouraging them to apply, accept and support all available federal funds for alcohol and other drug abuse prevention services. Duncan Shrout seconded the motion. Tina Virgil asked if federal matching funds were involved. Mr. Stokes indicated that some are, but not for the recent prevention grants. Douglas Englebert echoed the concern asking if any thought had been given to matching dollars and regulatory requirements. Scott Stokes asked for a friendly amendment. Linda Preysz suggested adding, "...prevention services that mirror Wisconsin objectives for a healthy environment." Duncan Shrout seconded the friendly amendment. Mr. Waupoose called for a vote on the amendment. There were all ayes except for Tina Virgil who abstained. The amendment passed.** Scott Stokes then read the complete motion. Discussion was initiated by Kevin Moore. He recognized that among the Committees' motions there were a series of motions regarding the DHS Secretary turning down federal grant opportunities. He wished to state his position. It is imperative that there is coordination at the state level with the federal level. How do the grants match up with mental health, substance abuse and Medicaid? Bringing in dollars must be part of an overall plan and not duplicative. For these reasons, Mr. Moore explained, he would be abstaining for DHS. **Mr. Waupoose called for the vote. All were "aye," except Mr. Moore and Ms. Virgil abstained. The motion passed.**

**3) Mr. Stokes read the following motion on behalf of the Prevention Committee: Motion requesting that SCAODA write a letter to Wisconsin's U.S. Congressional Leaders requesting they consider broadening eligible applicant criteria when the only eligible applicant is the state agencies. In these situations, state agencies should have first right-of-refusal, and if refused, other non-state agencies should be qualified to apply when state support or endorsement is withheld. Duncan ShROUT seconded the motion.** Mr. Waupoose called for discussion: Mr. ShROUT echoed Mr. Moore's argument. Sometimes there is a reason for state coordination. Linda Preysz added that while recognizing the intent of the motion, how do we address statewide implementation. Mr. Moore felt that coordination at the state level was imperative. Bringing in funds must be part of an overall plan and not duplicative. Mr. ShROUT suggested engaging in a dialogue with DHS on this subject and agreeing on how to go forward. Ms. Preysz thought that a definition of duplication would be helpful. **At that point, Mr. Stokes withdrew the motion and deferred to Duncan ShROUT who motioned on behalf of SCAODA that SCAODA and other appropriate parties, (DHS, DOC, DCF, DOT, DOJ, DPI) engage in a conversation to determine appropriate criteria for federal grant applications. Mark Seidl seconded the motion.** Mr. Moore pointed out that we have those opportunities four times a year (at the SCAODA meeting). **Mr. Waupoose called for the vote. All responded "aye," except Kevin Moore, Tina Virgil and Rebecca Wigg-Ninham who abstained.**

**4) Mr. Stokes deferred the last motion he had planned to make regarding federal agencies modifying criteria regarding eligible applicants.** Mr. Stokes will discuss this matter with the Prevention Committee scheduled to meet October 20, 2011.

Diversity Committee—Sandy Hardie

Sandy Hardie reported that discussion at the Diversity Committee has centered on engaging with the Bureau of Prevention Treatment and Recovery regarding Scope of Practice issues and to continue the conversation about the Minority Counselor Training Institute about how to promote obtaining diversity in counseling practitioners.

Intervention and Treatment Committee (ITC)—Norman Briggs

Mr. Norman Briggs referred the group to the minutes in the SCAODA information packet. The ITC has focused on women, children, youth and seniors. He then referred the group to the motions planned to be put forth by ITC.

- 1) The first motion planned to be introduced by ITC had to do with expressing concern about DHS decision to not support federal grant applications for SBIRT and SPF SIG planning grant. Mr. Briggs informed the group that ITC would not put this forward and would take a similar position (as Mr. Stokes decision to withdraw the Prevention Committee's last motion).**
- 2) Regarding the motion expressing concern about DHS decision to no longer support state sponsored conferences, Mr. Briggs decided to not put this motion forward, but would defer to the intention of creating a dialogue with DHS.**
- 3) Mr. Briggs read ITC's third motion: The Intervention and Treatment Committee recommends that SCAODA draft a letter to the leadership of the Senate and the Assembly expressing concern with the legislature's increasingly punitive approach (increased financial penalties and/or increased periods of incarceration) to addressing alcohol and**

**other substance use disorder related problems without acknowledgment of and support for addressing the addiction that is the root cause of the behavior. Joyce O'Donnell made the motion on behalf of ITC. Rebecca Wigg-Ninham seconded the motion.** Discussion: Mr. Briggs reminded everyone that substance use disorders are an illness. Not that there shouldn't be consequences, but legislation should address this as an illness. Mr. Moore felt that SCAODA needs to fill in its "legislator appointment" openings. SCAODA needs to bolster its accountability with the legislature. He expressed concern over the tone of the motion and suggested coming to an understanding with the Legislature, asking to fill the appointments and acknowledging that legislation dealing with substance abuse is a balancing act. He suggested building bridges. Mr. Waupoose suggested that the Bureau of Prevention Treatment and Recovery could help write the letter. **The letter could ask for legislative appointments to be made and make the point that legislation dealing with offenses committed by substance abusing and addicted offenders take on a more balanced approach. Mr. Briggs agreed and so moved. Rebecca Wigg-Ninham seconded and the vote was taken. All expressed "ayes" except Tina Virgil who abstained.**

Children Youth and Families (CYF) Sub-Committee—Susan Endres

Ms. Endres reported she would like to sponsor regional trainings on the evidence-based teen intervene program. There is a training scheduled in September at the Department of Juvenile Corrections in Milwaukee. Recent CYF discussions have included a Tribal presentation and discussion on four Juvenile Drug Treatment Courts. Other discussion items for the CYF Sub-Committee were: implementing a survey to identify youth that are ineligible for Medicaid; planning a conference on Opioids, tentatively scheduled for November 9<sup>th</sup> at Monona Terrace; and developing service codes for adolescent-specific counselors and adolescent-specific services.

WINTIP Update—Dave Macmaster

Mr. Macmaster acknowledged that two of the WINTIP Steering Committee members were present today at the SCAODA meeting, Susan Gadacz and Randall Glysch. WINTIP stands for the Wisconsin Nicotine Integration Treatment Project. He pointed out that over 4,300,000 people have died from tobacco related diseases in the decade since "9-11." In the last ten years, 78,000 of those deaths were in Wisconsin and 34,000 of the deaths were among people with substance use disorders. Mr. Macmaster reported that tobacco cessation programming has been integrated with addiction services in New York State. Mr. Macmaster distributed three documents. One was an Update for SCAODA. The document indicated that tobacco cessation training programs are currently being implemented in Wisconsin. WINTIP will be offering free trainings for AODA clinicians and managers. These trainings have been scheduled to be held in Eau Claire, Rhinelander and Sheboygan. A \$99 incentive will be offered to participants who agree to evaluation follow-up. There is a new free training on the Web scheduled for September 15<sup>th</sup> on the UW-CITRI and WINTIP websites. The Wisconsin Recovery Community Organization has accepted WINTIP's tobacco integration mission assuring that tobacco recovery will be included in their work.

Planning and Funding Committee—Joyce O'Donnell

Ms. O'Donnell introduced Duncan ShROUT who reported on the Intoxicated Driver Program (IDP) Funding Ad Hoc Committee's Final Report. Mr. ShROUT referred the group to page 89 of their information packets for a discussion on the other sources of funding counties use in order to supplement IDP revenue to pay for treatment costs of indigent IDP clients. Mr. ShROUT reported that the Planning and Funding Committee thinks that the Substance Abuse Block Grant should not be used to pay for treatment of IDP clients. They believe that the surcharge should pay for the program. Mr. ShROUT reported that the IDP-Funding Ad Hoc Committee discussed how to increase funding (see page 91 of the information packet). A beer tax and legislation were discussed. Mr. ShROUT thanked Leeann Cooper for her excellent staff work with the IDP-Funding Committee. On page 94 of the information packet, there is a spreadsheet identifying the amount of money needed to fully fund the program. **Mr. ShROUT made a motion that the Intoxicated Driver Program Funding Ad Hoc Committee Final Report be forwarded to SCAODA for approval, and he added, allow the work to move forward. Joyce O'Donnell seconded the motion.** Mark Seidl pointed out that the amount of county tax levy that goes in the IDP program each year is significant. He felt that counties couldn't keep doing that. The IDP funds available keep shrinking even if the need increases. **Mr. Waupoose called for the vote. All were aye and the motion passed.** Ms. O'Donnell thanked Duncan ShROUT for his work. Ms. O'Donnell then introduced the following motions:

**1) The Planning and Funding Committee motions to oppose AB 200.** This bill if enacted would increase the accessibility of wine on fairgrounds. **Duncan ShROUT seconded the motion. Without further discussion the group passed the motion with Tina Virgil and Kevin Moore abstaining.**

**2) Planning and Funding Committee motions to support AB 208 with the caveat that 100% of the fines over \$600 is designated to the Intoxicated Driver Supplemental Fund within the Department of Health Services.** **Duncan ShROUT seconded the motion.** Discussion: Mr. ShROUT indicated that the Planning and Funding Committee debated whether or not to support this bill but finally decided that if they didn't, it might appear as if SCAODA didn't care, or had no opinion on the matter. **Mr. Waupoose called for a vote. All were in favor and the motion passed with Tina Virgil abstaining.**

**3) Planning and Funding recommends that SCAODA create a plan of action to be implemented to address and remedy historical racial/ethnic disparities and inequities by increasing the number of minority counselors qualified and available to provide services under the Scopes of Practice requirements.** **Duncan ShROUT seconded the motion.** Kevin Moore asked the Committee to withdraw this motion. He indicated that the Bureau was working on this and that the Department is currently in the process of retooling where to go with this issue. The Bureau is in discussion with the Secretary about this. Mr. Moore asked the Committee to hold off on this until the Bureau was able to address the issues. **Joyce O'Donnell responded by withdrawing the motion. Duncan ShROUT seconded the withdrawal of the motion.** Ms. O'Donnell indicated that she would bring the issue back to the Planning and Funding Committee. She explained that the problem with the certification of minorities has been raised during several Public Forum facilitated by the Planning and Funding Committee. Members of the Committee are very concerned about the issue. However, out of respect for Mr. Moore's Office, Ms. O'Donnell agreed to withdraw the motion. Mr. Moore appreciated the gesture and indicated that the Committee can always bring this issue back but for the time being there are lots of things going on behind the scenes. **4) The next motion of the Planning and Funding Committee was to ask Department of Health Services Secretary Smith to**

**reconsider his decision not to seek federal funding for the Screening Brief Intervention and Referral to Treatment (SBIRT) program and the Strategic Prevention Framework State Prevention Enhancement Planning Grant (SPE).** Ms. O'Donnell indicated that out of concern she will hold back on introducing this motion. Mr. Moore expressed the hope that DMHSAS and SCAODA would be able to sit down and talk about this.

**5) Joyce O'Donnell motioned on behalf of the Planning and Funding Committee for SCAODA to support a ban on 190 proof Everclear. Duncan Shroul seconded the motion.**

Ms. O'Donnell explained that a mother of a young man who recently graduated from college approached her regarding her son's death. He drowned in the family's swimming pool after consuming Everclear, Red Bull and Gatorade. Lou Oppor reported that quite a few states and territories in Canada have banned the 190 proof Everclear. It is not uncommon to ban this under state law. Ms. O'Donnell stressed that this truly was a tragedy. Mr. Waupoose asked if there was a current bill dealing with this. Ms. O'Donnell indicated that no, there wasn't. However, the constituent was working with the legislator, Peggy Krusick. **Mr. Waupoose called for a vote. All responded "aye," with the exception of Tina Virgil who abstained. The motion passed.**

Ms. O'Donnell indicated that she wanted to announce that there will be a Public Forum at the Bureau Conference hosted by the Planning and Funding Committee on October 25<sup>th</sup>. The conference runs from October 25-26.

#### XIV. Substance Abuse Prevention and Treatment Block Grant (SAPTBG)—Sue Gadacz

Sue Gadacz announced that the Bureau is preparing the SAPTBG application for submission by October 1<sup>st</sup>. Wisconsin will be applying for \$27,949,837. We are preparing the "Planning" section now. The "Reporting/Fiscal" section is due December 1<sup>st</sup>. The "Planning Priorities" are available now. State staff will email them to the Council. Part of the Planning section includes assessing the strengths and needs of the service system. Subsequent years' plans would be developed in conjunction with the mental health block grant planning process for a combined application. Current priority populations will be maintained. At this moment, there are problems with the on-line electronic submission site. However, the information for citizen access to provide comment is listed on your agenda. <https://bgas.samhsa.gov/> Follow the link to "SAPT Submission Launch FY 2012"; Citizen login is: citizenwi; citizen password is: citizen. Comments can also be sent to Lori Ludwig: [lori.ludwig@wisconsin.gov](mailto:lori.ludwig@wisconsin.gov). Steve Fernan asked if there would still be the same requirements for prevention. Ms. Gadacz responded that all set-asides will be maintained: 20% for primary prevention; 10% for women's treatment services, and 5% for administration. Mark Seidl asked if there would still be funds going to Synar for tobacco prevention. Ms. Gadacz indicated that yes, there would be. Rebecca Wigg-Ninham asked about Tribal collaboration. Ms. Gadacz responded that the Tribal State Collaborative needs to be strengthened. There needs to be a strong mechanism to increase the dialogue with Native American Tribes. At this point, we haven't discussed the process beyond what currently exists. Ms. Wigg-Ninham suggested that the Diversity Committee or Planning and Funding should look at this in terms of developing a more equal relationship. There needs to be consensus and on-going dialogue. How do we develop lines of communication? Mr. Waupoose responded that we need to reach out to Tribal Government.

## XV. Agenda Items for December 9, 2011 Meeting—Michael Waupoose

- Update on SBIRT from Dr. Rich Brown
- Presentation on Trauma Informed Care (suggested by Joann Stephens)
- Update on workforce shortage/alcohol and drug treatment
- Drug Endangered Children Program (suggestion from Tina Virgil to bring together law enforcement and social workers about kids in drug homes)
- Alcohol and Tobacco Taxes—how much and where they go (suggestion from Dave Macmaster/ presentation on Beer Tax)

Mike Wagner indicated that tobacco taxes are ranked fourth among sources of revenue in Wisconsin. However, they are below projection. He can bring the information on alcohol taxes. Kevin Moore indicated that there are \$45 million in alcohol taxes and \$604 million in tobacco taxes.

- ITC and Prevention Committees—what is the intersection of the two when it comes to the treatment of pregnant women? (suggestion from Francine Feinberg)
- Adolescent Treatment (suggestion from Susan Endres)

## XVI. Announcements—Sue Gadacz

- Sue Gadacz announced that the IDP program enhancement RFPs are due on September 15<sup>th</sup>
- She also announced that the IVDU strategic outreach RFPs will be going out next week as will the women's specific RFPs. There is \$1.1 million for Milwaukee and \$2.4 million for the other counties.
- September is Recovery Month. Please see the Governor's Proclamation on page 105 of your packet. Also please see WAAODA.org; and FAVOR.org for more information. Also there is a Recovery Walk on September 10<sup>th</sup> in Milwaukee. September 17<sup>th</sup> there is a recovery event at Marshall Park in Madison.
- The Bureau Conference is October 25-26. The Public Forum is October 25<sup>th</sup> from 4:45 pm to 5:45 pm.
- The Crisis Conference is September 22-23 in the Dells.
- The Clinical Supervision Conference is November 1<sup>st</sup> in Ashland. ITC will sponsor the Public Forum there.

## XVII. Adjournment—Michael Waupoose

Mark Seidl motioned to adjourn. Duncan Shroul seconded the motion. The meeting adjourned. The next SCAODA meeting is scheduled for December 10, 2011 from 9:30 am to 3:30 pm in room A3151.

2011 SCAODA Meeting Dates:

~~March 4, 2011~~

~~June 10, 2011~~  
~~September 9, 2011~~  
December 9, 2011

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Treatment Alternatives and Diversion (TAD) Program:  
**Advancing Effective Diversion in Wisconsin**

*Advancing Fiscally Sound, Data-Driven Policies and Practices To  
Enhance Efficiencies in the Criminal Justice System  
and To Promote Public Safety*

*A Collaboration of  
The Wisconsin Office of Justice Assistance  
The Wisconsin Department of Corrections  
The Wisconsin Department of Health Services*

*Prepared by  
Kit R. Van Stelle and Janae Goodrich  
University of WI Population Health Institute  
March 2012*

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## Overview of Presentation

- Highlights from 2011 Evaluation Outcomes Report
- Cost-Benefit Analysis
- Recommendations For Improvement From the TAD Advisory Committee
- Next Steps

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## HIGHLIGHTS FROM 2011 EVALUATION REPORT

To access a copy of the full report:

<http://uwphi.uwohealth.wisc.edu/about/staff/van-stelle-kit.htm>

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## TAD Legislative Development

- In 2005, Wisconsin Act 25 (SECTION 90m. 16.964) authorized the WI Office of Justice Assistance to administer “grants to counties to enable them to establish and operate programs, including suspended and deferred prosecution programs and programs based on principles of restorative justice, that provide alternatives to prosecution and incarceration for criminal offenders who abuse alcohol or other drugs.”
  - 2005 WI Act 25 also required that OJA contract for evaluation of the TAD projects. OJA, DOC, and DHS have shared the cost of the required evaluation.

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## Continued TAD Legislative Support

- In 2011, the WI state budget included funding specifically for expanding and evaluating TAD to *“...provide an additional \$110,000 PR annually in justice information surcharge funding to provide additional resources for the treatment alternatives and diversion (TAD) program, including \$65,000 for program administration and \$45,000 for the evaluation of the program as required by state statute.”*
  - OJA, DOC, and DHS have agreed to supplement the \$45,000 designated for evaluation by continuing to share the costs of the expanded program evaluation.

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## TAD Sites in Wisconsin

- Adult Drug Treatment Courts**
  - Burnett County (in collaboration with the St. Croix tribe)
  - Washburn County
  - Wood County
  - Rock County
- Adult Diversion Models**
  - Milwaukee County (pre-charging diversion and deferred prosecution)
  - Washington County (diversion of operating while intoxicated and also offenders entering as an alternative to revocation of correctional supervision)
  - Dane County (pre-trial bail diversion in arraignment court)
  - Ashland and Bayfield Counties (bail diversion, deferred entry of judgement, and day reporting)



New in 2012

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## TAD Evaluation Components

- Participant Database:** To document characteristics of project admissions, services, and discharges; Each site uploads data monthly to PHI and receives feedback
- Process Evaluation:** Documentation of project implementation through review of project reports, review of annual site reapplications, annual meetings with site staff, ongoing communication with sites, and survey of evidence-based treatment practices
- Outcome Evaluation:** Criminal justice outcomes of TAD participants after program
  - CCAP: new charges and convictions
  - DOC: admission to WI state prison

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## TAD Admission and Completion

Admissions for Four-Year Period (2007-2010)	2,061
Treatment Courts	408
Diversion Projects	1,653

	Treatment Courts	Diversion Projects	Overall
	N = 322	N = 1,534	N = 1,856
Average Days in Project	297 days	157 days	182 days *
Graduation/Completion Rate	55%	66%	64%

\*difference significant at p<.05 or better

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## TAD Integration of Evidence-Based Practices

TAD projects incorporate a wide variety of evidence-based practices recommended for:

- Management of correctional populations,
- Substance abuse treatment,
- Case management,
- Criminal risk and needs assessment,
- Drug treatment courts, and
- Judicial processing and decision-making.

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## Effectiveness of TAD Model

### DOES TAD WORK?

Yes!

The results of the current evaluation reveal that the TAD program effectively diverts non-violent offenders with substance abuse treatment needs from incarceration and reduces criminal justice system costs. TAD projects have positive impacts on individual offenders, communities, and local service systems.

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## Criminal Justice Outcomes

### Does TAD Divert Offenders From Incarceration?

Yes!

A total of 135,118 incarceration days were averted by TAD projects during the first four years of operation (86,530 jail days and 48,588 prison days)

Treatment courts averted a total of 43,716 incarceration days and diversion projects averted 91,402 incarceration days

Treatment court graduates were averted from an average of 8 months of incarceration and diversion project completers were averted from an average of 3 months of incarceration

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### Does TAD Reduce Recidivism?

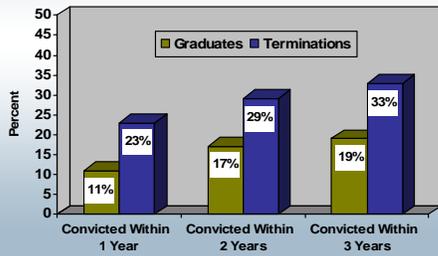
Yes!

- More than three-quarters of TAD participants (76%) are not convicted of a new crime after program participation
- Successful completion of TAD treatment reduces the likelihood of a new conviction after TAD  
11% of TAD graduates were convicted of a new offense within one year compared to 23% of those who were terminated from TAD projects

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### Conviction for a New Offense After Discharge

Offenders who complete TAD are significantly less likely than those terminated to be convicted of a new crime after program participation. Graduates are less likely than terminations to be convicted of a new offense within one year after TAD discharge (11% vs. 23%), within two years after discharge (17% vs. 29%), and within three years after discharge (19% vs. 33%).



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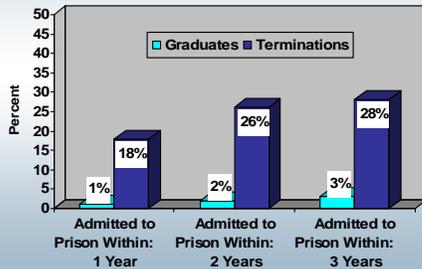
### Does TAD Reduce Recidivism? Yes!

- Offenders who complete TAD are nine times less likely to be admitted to state prison after program participation than those who do not complete TAD

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### Admission to State Prison After Discharge

TAD participation also successfully impacts subsequent state prison incarceration. Overall, 12% of TAD participants were admitted to prison after discharge -- 7% are admitted within one year, 11% are admitted within two years, and 12% are admitted within three years.



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### Outcomes for Alternative To Revocation (ATR) of Correctional Supervision

	Alternative to Revocation (ATR) Participants Completed 2007-2010						Overall (N = 181)
	Burnett (N = 22)	Washburn (N = 16)	Dane (N = 18)	Rock (N = 13)	Washington (N = 105)	Wood (N = 7)	
% ATR Discharges Completed	82%	75%	72%	15%	38%	57%	49%*

\* Difference significant at p<.05 or better. Milwaukee TAD does not admit ATRs.

- An average of 7 months of incarceration were averted for each ATR graduate compared to other (non-ATR) TAD completers who avoided an average of 3.6 months. The 89 ATRs who completed TAD during the first four years of the program were averted from a total of 18,936 incarceration days.
- TAD ATRs are convicted of new offenses after discharge (28%) at rates similar to that of other TAD offenders (24%).
- 27% of ATRs were admitted to prison after participating in TAD. Only 4% of ATRs who completed TAD were admitted to prison compared to nearly one-half (48%) of those who were terminated. In addition, none (0%) of the treatment court ATR graduates were incarcerated in state prison after completion.

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### Does TAD Save Money?

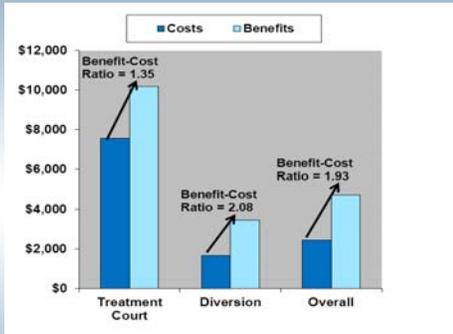
Yes!

Every \$1.00 invested in TAD yields benefits of \$1.93 to the criminal justice system through averted incarceration and reduced crime.

TAD treatment courts yield benefits of \$1.35 for every \$1.00 invested.

TAD diversion projects yield benefits of \$2.08 for every \$1.00 invested.

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The true net benefits of TAD are underestimated in the current analyses because broader benefits (i.e., employment, improved physical and mental health, etc.) could not be considered.

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### Selected TAD Advisory Committee Recommendations for Program Improvement

Based on both the evaluation results and current evidence-based practices, the TAD Advisory Committee developed recommendations for improvement of the TAD program.

In addition to the selected recommendations highlighted here, a comprehensive list of recommendations is available in the full evaluation report.

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### Selected TAD Advisory Committee Recommendations for Program Improvement

#### Modify Existing Statutes Related to TAD To...

- Allow projects to enroll persons with a prior charge/conviction that would currently exclude them from program eligibility, if the local project team and/or local advisory committee determine that the offender is otherwise appropriate.
- Expand the current limited scope of standards to include criminal justice EBP principles for correctional populations.

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## Selected TAD Advisory Committee Recommendations for Program Improvement

### Program Implementation

- Continue to promote and encourage local development of projects that utilize evidence-based practices to address local conditions and needs.
- Require projects to incorporate evidence-based practices (EBPs) recommended for correctional populations, substance abuse treatment, case management, criminal risk and needs assessment, drug treatment courts, and judicial processing/decision-making.
- TAD must implement treatment and case management strategies consistent with evidence-based practices, specifically prioritizing the assessed criminogenic needs of moderate and high risk offenders.

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## Selected TAD Advisory Committee Recommendations for Improvement

### State-Level Coordination and Training

- Continue to structure TAD as a multi-agency, collaborative effort among OJA, DOC, and DHS.
- The State of Wisconsin should coordinate and fund
  - (a) solutions to high volume and critical program functions such as drug testing and mental health services that are integral to all treatment and diversion projects and
  - (b) training for local and state community justice stakeholders on the latest evidence-based practices and treatment standards.

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## Selected TAD Advisory Committee Recommendations for Program Improvement

### Evaluation and Accountability

- Continue commitment to independent and comprehensive program evaluation through state and local agency partnerships.
- Direct the state agencies responsible for managing administrative data systems to provide evaluation data as part of a shared responsibility.
- Require a research-based process evaluation targeting critical components to ensure that the project is being delivered as designed.

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## Selected TAD Advisory Committee Recommendations for Improvement

### Specific to DOC

- Require that TAD projects serving offenders as an alternative to revocation (ATR) of correctional supervision develop a collaborative plan with DOC to coordinate proper case referrals, supervision, case management, and treatment for these offenders.

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## Conclusion

TAD projects have positive impacts on individual offenders, communities, and local service systems.

The evaluation results reveal that the TAD program effectively diverts non-violent offenders with substance abuse treatment needs from incarceration and reduces criminal justice system costs.

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## Next Steps

- Dissemination of 2011 Outcomes results
- Implementation at expansion sites
- Future evaluation activity and reports
- Collaboration with other coordinating efforts

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# Toward a Theory of Motivational Interviewing

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*The widely disseminated clinical method of motivational interviewing (MI) arose through a convergence of science and practice. Beyond a large base of clinical trials, advances have been made toward “looking under the hood” of MI to understand the underlying mechanisms by which it affects behavior change. Such specification of outcome-relevant aspects of practice is vital to theory development and can inform both treatment delivery and clinical training. An emergent theory of MI is proposed that emphasizes two specific active components: a relational component focused on empathy and the interpersonal spirit of MI, and a technical component involving the differential evocation and reinforcement of client change talk. A resulting causal chain model links therapist training, therapist and client responses during treatment sessions, and posttreatment outcomes.*

**Keywords:** motivational interviewing, psychotherapy, theory, client-centered, behavior change

**W**ithin psychological science, much emphasis has been given to what Reichenbach (1938) termed the *context of justification*. Behavioral scientists have prized the process of beginning from a theory, deriving empirical hypotheses, and subjecting these to experimental testing. Good science, Reichenbach maintained, involves a dialogue between this theory-testing process and the *context of discovery* whereby new ideas and theories emerge. Failure to confirm expectations is a particularly fruitful point of meeting between the scientific contexts of justification and discovery. Unexpected findings, if taken seriously, lead one back to the drawing board of discovery to develop a better theory for subsequent testing.

This article reviews the development of motivational interviewing (MI) and MI research over three decades. The method and research of MI arose from a series of unexplained outcomes and led to an emergent theory of the underlying mechanisms of this brief psychotherapy.

## The Origins of MI

### Therapist Effects

An unanticipated finding drew attention to the impact of interpersonal processes on behavior change. In preparing for a clinical trial of behavior therapy for problem drinking (Miller, Taylor, & West, 1980), Miller trained nine counselors both in techniques of behavioral self-control training (Miller & Muñoz, 2005) and in the client-centered skill of accurate empathy (Rogers, 1959). After initial certification

of the counselors, three supervisors observed them delivering the behavioral intervention with self-referred outpatients and independently rank ordered the extent to which the counselors had manifested empathic understanding while delivering behavior therapy. Therapist empathy during treatment predicted a surprising two thirds of the variance in client drinking six months later ( $r = .82, p < .0001$ ). Even 12 and 24 months after treatment, counselor empathy continued to account for one half ( $r = .71$ ) and one quarter ( $r = .51$ ) of the variance in behavioral outcomes, respectively (Miller & Baca, 1983). This effect of therapist style was far larger than differences among the behavioral interventions being compared. Valle (1981) similarly reported that alcoholism counselors' client-centered interpersonal functioning accounted for a substantial proportion of variance in the relapse rates of randomly assigned clients. Later studies likewise showed large differences in drug use outcomes depending on the counselor to whom clients had been randomly assigned (Luborsky, McLellan, Diguier, Woody, & Seligman; 1997; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; McLellan, Woody, Luborsky, & Goehl, 1988).

### A Clinical Style

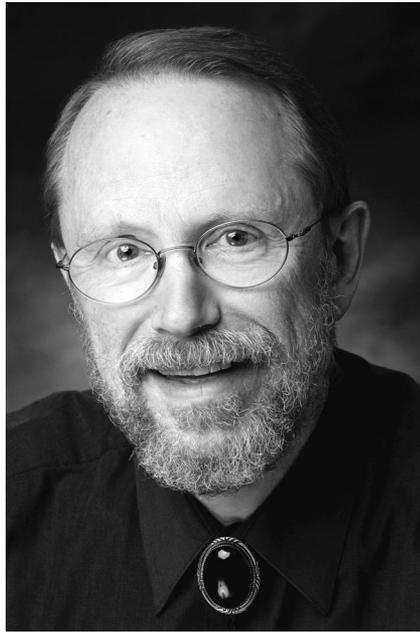
With these surprising findings, Miller went on sabbatical leave to Bergen, Norway. His original clinical description of MI (Miller, 1983) was an unanticipated product of interacting with a group of colleagues there. He had been invited to lecture on behavioral treatment for alcohol problems and also was asked to meet regularly with a group of young psychologists. This group asked him to demonstrate how he might respond to clients they were treating, and in the role-play process they frequently stopped him to ask why he had said what he did, where he was going, and what was guiding his thinking. Thus they caused him to verbalize what had previously been an implicit model guiding his clinical practice, a model that he had not been consciously

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This work was supported in part by Grant K05-AA00133 from the National Institute on Alcohol Abuse and Alcoholism, Grant 049533 from the Robert Wood Johnson Foundation, and Grant U10-DA01583 from the National Institute on Drug Abuse.

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**William R. Miller**

aware of and that differed from the behavior therapies on which he was lecturing.

From notes on this process, Miller wrote down a conceptual model and some clinical guidelines for MI. The model focused on responding differentially to client speech, within a generally empathic person-centered style. Special attention was focused on evoking and strengthening the client's own verbalized motivations for change. Counterchange arguments ("sustain talk," which was originally subsumed in MI within the concept of "resistance") represented the other side of the client's ambivalence, to which the counselor was to respond empathically, a clear contrast with the confrontational style of addiction counseling at the time (White & Miller, 2007). Pushing or arguing against resistance seemed particularly counterproductive in that it evoked further defense of the status quo. A guiding principle of MI was to have the client, rather than the counselor, voice the arguments for change.

In describing MI, Miller explored links between this conceptual approach and prior psychological theories. The change-promoting value of hearing oneself argue for change was linked to Festinger's (1957) formulation of cognitive dissonance and to Bem's (1967, 1972) reformulation of self-perception theory. Also relevant was Rogers's theory of the "necessary and sufficient" interpersonal conditions for fostering change (Rogers, 1959). The supportive atmosphere described by Rogers seemed an ideal, non-threatening context within which to explore clients' ambivalence and elicit their own reasons for change.

Miller mailed the manuscript to several colleagues, asking for comments. Among them was Ray Hodgson, then editor of the British journal *Behavioural Psychotherapy*, who persuaded him to publish a reduced version of the conceptual paper (Miller, 1983).

## Evaluating the Efficacy of MI

### **MI Plus Assessment Feedback: The Drinker's Check-Up**

Returning to New Mexico, Miller continued to develop what had emerged. Analysis of clinical trials pointed to six components that were often present in effective brief interventions (Bien, Miller, & Tonigan, 1993). These were summarized by the mnemonic acronym FRAMES: Feedback, emphasis on personal Responsibility, Advice, a Menu of options, an Empathic counseling style, and support for Self-efficacy. This led to the development of a "drinker's check-up" (DCU) to manifest these components (Miller & Sovereign, 1989). The DCU combined MI with personal feedback of assessment findings in relation to population or clinical norms. The DCU was expected to increase engagement in treatment for alcohol problems, in a manner similar to effects previously reported by Chafetz et al. (1962). A randomized trial, however, showed no effect of the DCU on treatment seeking relative to a waiting list control group (Miller, Sovereign, & Krege, 1988). Instead, the DCU group showed an abrupt decrease in their drinking, a change that was mirrored when the waiting list control group was subsequently given a DCU. This finding was replicated in another randomized trial (Miller, Benefield, & Tonigan, 1993). It appeared that the DCU alone induced significant change in problem drinking. This particular combination of MI with assessment feedback was later termed *motivational enhancement therapy* (MET) and developed into a manual-guided brief treatment (Miller, Zweben, DiClemente, & Rychtarik, 1992).

### **MI Added to Other Active Treatment**

The next three clinical trials evaluated MI as a prelude to treatment. In all three, clients entering substance abuse treatment programs were randomly assigned to receive or not receive a single MI session at the outset of treatment. In all three, clients receiving MI showed double the rate of total abstinence three to six months after inpatient (Brown & Miller, 1993) or outpatient treatment for adults (Bien, Miller, & Boroughs, 1993) or adolescents (Aubrey, 1998), relative to those receiving the same treatment programs without initial MI. MI also significantly increased retention (Aubrey, 1998) and motivation for change as judged by therapists unaware of group assignment (Brown & Miller, 1993).

### **New Terrain**

In 1989 Miller, on sabbatical in Australia, met Stephen Rollnick, who explained that MI was popular in addiction treatment in the United Kingdom and encouraged Miller to write more about MI. This led to their coauthoring the original MI book (Miller & Rollnick, 1991) elaborating the clinical method (Moyers, 2004). Rollnick proceeded to pioneer new applications of MI in health care (Rollnick, Mason, & Butler, 1999; Rollnick, Miller, & Butler, 2008).

More than 200 clinical trials of MI have been published, and efficacy reviews and meta-analyses (Burke,

Arkowitz, & Menchola, 2003; Dunn, Deroo, & Rivara, 2001; Erickson, Gerstle, & Feldstein, 2005; Hettema, Steele, & Miller, 2005; Rubak, Sandbaek, Lauritzen, & Christensen, 2005) have begun yielding positive trials for an array of target problems including cardiovascular rehabilitation, diabetes management, dietary change, hypertension, illicit drug use, infection risk reduction, management of chronic mental disorders, problem drinking, problem gambling, smoking, and concomitant mental and substance use disorders. Unexpectedly, the specific effect size was larger (Burke et al., 2003) and more enduring (Hettema et al., 2005) when MI was added to another active treatment, a somewhat counterintuitive finding in that one might expect larger effects when the competition is no treatment at all. This suggests a synergistic effect of MI with other treatment methods. Recent volumes have included broader applications of MI in behavior change (Miller & Rollnick, 2002), health care (Rollnick et al., 2008), and psychological services (Arkowitz, Westra, Miller, & Rollnick, 2008).

### **Multisite Trials**

The first multisite trial of MET was Project MATCH, a nine-site psychotherapy trial with 1,726 clients (Project MATCH Research Group, 1993). Outcomes through three years of follow-up were similar for a four-session MET and the two 12-session treatment methods with which it was compared, yielding a cost-effectiveness advantage for MET (Babor & Del Boca, 2003; Holder et al., 2000; Project MATCH Research Group, 1997, 1998a). Similar findings emerged from the three-site United Kingdom Alcohol Treatment Trial (UKATT) comparing MET with an eight-session family-involved behavior therapy (Copello et al., 2001; UKATT Research Team, 2005a, 2005b).

The Clinical Trials Network of the U.S. National Institute on Drug Abuse has undertaken six multisite trials of MI and MET compared with treatment-as-usual for drug problems and dependence (Carroll et al., 2002). MI-based interventions have been found to promote sustained reductions in alcohol use (Ball et al., 2007) and increased treatment retention (Carroll et al., 2006). Site by treatment interactions also appeared such that MET exerted a significant beneficial effect at some sites but not others (Ball et al., 2007; Winhusen et al., 2008).

### **Mixed Findings**

Not all trials have been positive. Null findings for MI have been reported, for example, with eating disorders (Treasure et al., 1998), drug abuse and dependence (Miller, Yahne, & Tonigan, 2003; Winhusen et al., 2008), smoking (Baker et al., 2006; Colby et al., 1998), and problem drinking (Kuchipudi, Hobein, Fleckinger, & Iber, 1990). Even within well-controlled multisite trials, MI has worked at some sites but not others (Ball et al., 2007; Winhusen et al., 2008). It is apparent that some clinicians are significantly more effective than others in delivering the same MI-based treatment (Project MATCH Research Group, 1998b), and of course even in positive trials a certain proportion of clients do not respond to MI.



**Gary S. Rose**

The efficacy of MI also can vary across populations. A meta-analysis found that the effect size of MI was doubled when the recipients were predominantly from minority populations, compared with White non-Hispanic Americans (Hettema et al., 2005). A retrospective analysis of Project MATCH data found that Native Americans responded differentially well to MET, compared with cognitive-behavioral or 12-step facilitation treatment (Villanueva, Tonigan, & Miller, 2007). Similarly, Clinical Trials Network studies found some evidence for differential benefit from MET among pregnant drug users from minority backgrounds (Winhusen et al., 2008).

Such variability in outcomes across and within studies suggests the need to understand when and how a treatment works and the conditions of delivery that may affect its efficacy. Discovering the mediators and moderators of efficacy requires opening the black box of treatment to examine linkages between processes of delivery and client outcomes, a form of research pioneered by Carl Rogers and his students (Truax & Carkhuff, 1967).

### **Evaluating Underlying Processes of MI**

An implicit causal chain originally hypothesized for MI was relatively straightforward (Miller, 1983). Behavior change would be promoted by causing clients to verbalize arguments for change (“change talk”; Miller & Rollnick, 2002). Conversely, evoking “sustain talk” would favor the behavioral status quo. This is a *technical* hypothesis regarding the efficacy of MI: that proficient use of the techniques of MI will increase clients’ in-session change talk and decrease their sustain talk, which in turn will predict behavior change.

A second factor expected from the outset to be important in MI efficacy was the client–counselor relationship and, more specifically, the therapeutic skill of empathic understanding (Gordon, 1970; Rogers, 1959; Truax & Carkhuff, 1967). Rogers (1959) hypothesized that accurate empathy, congruence, and positive regard are critical therapeutic conditions that create an atmosphere of safety and acceptance in which clients are freed to explore and change. These *relational* factors were predicted in themselves to promote positive change (Miller, 1983). As described above, studies preceding the introduction of MI supported a specific and strong relationship between therapist empathy and drinking outcomes (Miller et al., 1980; Valle, 1981).

These technical and relational components are not rival or incompatible hypotheses. Psychotherapy research has long postulated a combination of specific (technical) and general or nonspecific (relational) factors that influence outcome. Figure 1 illustrates a variety of pathways by which MI may facilitate behavior change. In the remainder of this article we explore current empirical evidence for the various links in this putative chain.

### Measuring MI Processes and Fidelity

Before we review MI process research, a brief explanation is in order regarding how therapist fidelity of delivery has been assessed. We know of no reliable and valid way to measure MI fidelity other than through the direct coding of practice samples. Clinicians’ self-reported proficiency in delivering MI has been found to be unrelated to actual practice proficiency ratings by skilled coders (Miller & Mount, 2001; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004), and it is the latter ratings that predict treatment outcome. Such ratings in turn require the training of coders to a standard of interrater reliability, which is itself a challenging process (Miller, Moyers, Arciniega, Ernst, & Forcehimes, 2005). The first process rating system for MI—the Motivational Interviewing Skill Code, or MISC—was developed by Miller and Mount (2001) and refined in subsequent clinical trials (Miller et al., 2004; Moyers, Martin, Catley, Harris, & Ahluwalia, 2003). The original MISC required three coding passes: one for global skill ratings, one for therapist and client behavior counts, and one for relative talk time. With experience, categories and

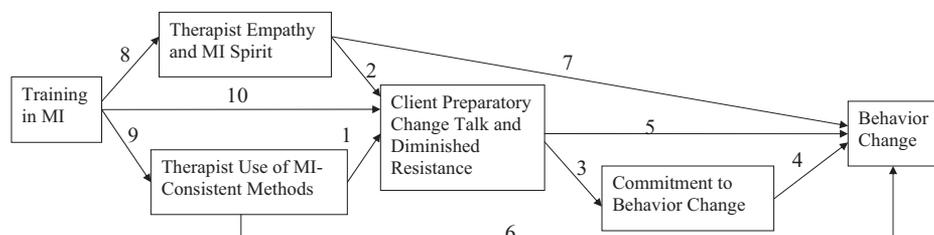
definitions were refined, unreliable or redundant codes eliminated, and distinctions sharpened, a process that resulted in the current MISC Version 2.1 (<http://casaa.unm.edu/download/misc.pdf>). In order to reduce time demands, a simplified MI Treatment Integrity (MITI) code was developed that focused only on therapist behavior (Moyers, Martin, Manuel, Hendrickson, & Miller, 2005). Subsequently, a variety of other MI coding systems have been developed and studied (Madson & Campbell, 2008). In a review of MI process research, Apodaca and Longabaugh (2009) concluded that MI is reliably differentiated from minimal/placebo control conditions, treatment-as-usual, and other active treatment conditions such as cognitive-behavior therapy, in rates of both MI-consistent and MI-inconsistent therapist responses.

### MI Influences Change Talk

For the technical hypothesis to be supported, it is first necessary to show that MI influences the predicted mediator of change (Baron & Kenny, 1986), which in this case is change talk, client utterances that favor the target behavior change. “Resistance” was initially conceptualized as the opposite of change talk, namely speech favoring the status quo (Miller & Rollnick, 1991). In Figure 1, this relationship between MI and client speech is reflected in Paths 1 and 2

In the first study to incorporate process measures of MI, clients receiving the DCU were randomly assigned to one of two styles of personal feedback (Miller et al., 1993). In one style, counselors sought to persuade clients of the need for change, confronting resistance as it arose. In the contrasting MI style, counselors focused on understanding client perspectives through reflective listening and on evoking clients’ own concerns. The same counselors delivered both interventions. Clients in the MI condition voiced about twice as much change talk and half as much resistance. This between-groups effect mirrored findings from Patterson and Forgatch (1985), who found that client resistance increased and decreased in step-function as clinicians shifted within sessions between directive and reflective counseling styles. These studies indicate that client change talk and resistance are highly responsive to counselor style.

**Figure 1**  
*Hypothesized Relationships Among Process and Outcome Variables in Motivational Interviewing (MI)*



Further evidence that MI influences client change talk emerged from psycholinguistic analysis of session tapes before and after clinicians had been trained in MI. Following MI counselor training, counselors' clients showed significantly higher frequency and strength of change talk, particularly when the MI training had been of the most intensive variety (Amrhein, Miller, Yahne, Knipsky, & Hochstein, 2004; Houck & Moyers, 2008; Miller et al., 2004;). Similar results were obtained following MI training intervention for community mental health workers (Schoener, Madeja, Henderson, Ondersma, & Janisse, 2006).

Moyers and colleagues (Moyers & Martin, 2006; Moyers et al., 2007) provided additional evidence for the link between MI and client change talk. Utilizing a sequential coding system of client and therapist utterances, they analyzed 38 randomly selected MET sessions from Project MATCH. Examining relationships of MI-consistent and MI-inconsistent therapist utterances with client change talk and resistance, they found strong support for the mediational hypothesis. Specifically, MI-consistent therapist responses tended to be followed by client change talk, whereas MI-inconsistent utterances were likely to be followed by sustain talk. There also appeared to be a synergy between therapist and client utterances in that MI elicits change talk, which then increases the probability of further MI-consistent therapist responses.

Taken together, these data provide strong support for Paths 1 and 2 in Figure 1. MI-consistent practice does significantly increase client change talk and decrease resistance.

### **Change Talk Predicts Behavior Change**

A second link in the chain is the relationship between client change talk and outcome (Paths 3, 4, and 5 in Figure 1). The prediction here is that behavior change will be directly related to clients' change talk during an MI session and inversely related to sustain talk.

Early support for this linkage came from analysis of DCU session tapes (Miller et al., 1993). The frequency of clients' in-session resistance strongly predicted their drinking outcomes at 6, 12, and 24 months; the more clients had resisted, the more they drank. No significant relationship was observed, however, between change talk frequency and outcome.

Next, Miller's team used the MISC to analyze the first 20 minutes of MI session tapes from a clinical trial of MI (Miller et al., 2003). Again, no relationship was found between change talk frequency and behavioral outcome—a problem for the causal chain.

Psycholinguist Paul Amrhein suggested an alternative classification scheme that was based on his analysis of the natural language with which people negotiate change and make commitments (Amrhein, 1992). Using the same clinical trial MI tapes, he differentiated change talk into linguistic subcategories reflecting various components of motivation for change: desire, ability, reasons, need, and commitment. Rather than recording the mere occurrence of these speech acts, he used an established taxonomy to rate

the strength of utterances favoring change (drug abstinence) or the status quo (continued drug use). His three years of work yielded valuable insights into processes of MI. One of the six linguistic categories directly and robustly predicted behavior change: strength of *commitment* language. The strength of expressed desire, ability, reasons, and need for change all reliably predicted the strength of commitment, but none of them directly predicted behavior change. In this sense, these seemed to be preparatory steps toward commitment. Furthermore, it was the *pattern* of commitment strength that predicted outcome: A positive slope of commitment strength across the MI session was associated with abstinence during the subsequent year, with the strongest prediction derived from client speech toward the end of the session (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). Why had we previously failed to detect this effect? In essence, we had been studying the wrong parameter (intercept instead of slope) for the wrong measure (frequency instead of strength) of the wrong variable (change talk instead of commitment) during the wrong part of the session (beginning instead of end).

The prognostic linkage of client commitment language to behavior change was replicated in subsequent research in which the treatment being studied was cognitive-behavior therapy for drug abuse (Aharonovich, Amrhein, Bisaga, Nunes, & Hasin, 2008). Mean commitment strength predicted drug-free urine samples, and a positive in-session slope of commitment strength predicted treatment retention. Further replication of Amrhein's findings was provided by Hodgins, Ching, and McEwen (2009) with problem gamblers. Commitment language specifically predicted 12-month gambling outcomes, whereas preparatory change talk (desire, ability, reasons, and need) did not. These studies offer support for the robustness of commitment as a construct predictive of client outcome, not only in MI but in behavioral treatment more generally.

The practical implication is that MI can elicit clients' statements of desire, ability, reasons, and need for change (Paths 1 and 2 in Figure 1), with an eye toward evoking increasingly strong commitment to change (Path 3). As commitment language emerges, behavior change is more likely to occur (Path 4). This process converges with cognitive psychology research on the importance of implementation intentions in promoting behavior change (Gollwitzer, 1999; Gollwitzer & Schaal, 1998). A foreshadowing of this pattern had been present in the early description of MI as occurring in two phases (Miller & Rollnick, 1991). In the first phase, the interviewer focuses on eliciting change talk to elicit intrinsic motivation for change. When sufficient motivation appears to be present, the interviewer transitions to a second phase of strengthening commitment to change, focusing on converting motivation into commitment to specific change goals and plans.

Recent research replicates the connection between client change talk and subsequent behavior change. Strang and McCambridge (2004) reported that therapist ratings of clients' "action-oriented" change talk correlated with postintervention reductions in cannabis use. Gaume, Gmel, and Daeppen (2008) analyzed (with MISC Version 2.0)

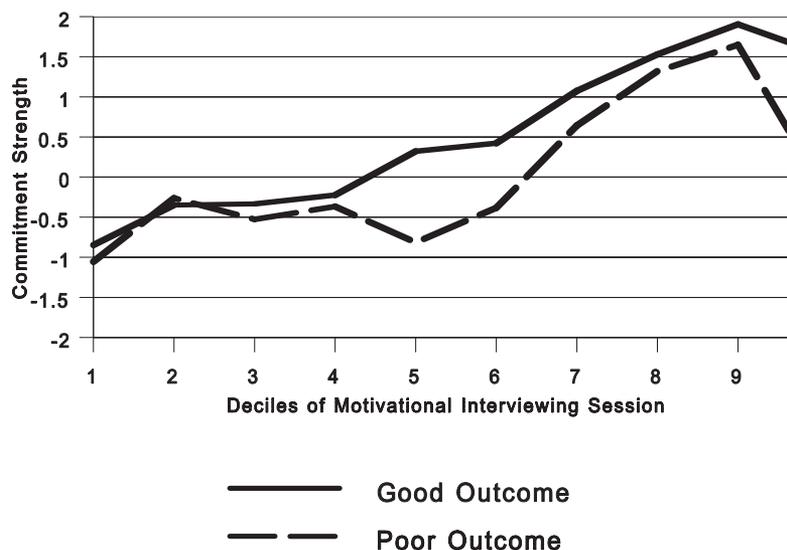
1,055 brief alcohol interventions in a hospital emergency department and found that client statements of ability (but not commitment) correlated with drinking rates 12 months later. Offering homeless adolescents a four-session adaptation of MI, Baer et al. (2008) reported that teens' sustain talk (e.g., "I really love getting high and, besides, I can keep it under control") predicted substance use at 30- and 90-day follow-up; conversely, verbalizing reasons for change predicted abstinence at follow-up. Moyers et al. (2007) investigated the relationship of client change talk to subsequent alcohol use across all three psychotherapy conditions delivered at the New Mexico site in Project MATCH. In all three therapies, frequency of change talk and sustain talk independently predicted drinking outcomes even after baseline variance in readiness to change and alcohol use were accounted for. In this study, change talk and sustain talk functioned not as opposite poles of a single dimension but rather as independent constructs that each contributed to drinking outcomes. Summarizing research on substance use disorders alone, Apodaca and Longabaugh (2009) found that client change talk exerted a small to medium effect on behavioral outcome.

Could psycholinguistic analyses also help us to understand what goes wrong when MI does not work? Failure analysis seeks to spin gold from the straw of null results. The data set that yielded Amrhein's above-described psycholinguistic findings came from a clinical trial that failed to show a main effect of MI when it was added to drug dependence treatment (Miller et al., 2003). As a first step, Amrhein utilized cluster analysis to differentiate treatment outcomes into four groups. Cluster 1 clients ("changers") entered treatment using illicit drugs on about 80% of days

but maintained high rates of abstinence throughout follow-up. Cluster 2 ("maintainers") showed similarly good outcomes but had begun treatment abstinent on 80% of days—already well on their way to change. Together, these two groups, with pleasing 12-month treatment outcomes, comprised 72% of those in the sample. Cluster 3 ("strugglers"; 17% of the sample) started treatment using drugs on 80% of days and averaged about half of their baseline rate during the subsequent year. The fourth group consisted of the 11% whose self-report of abstinence was contradicted by urine drug screens. Amrhein then proceeded to examine what clients in each of these groups had said during their MI session (Amrhein et al., 2003). The language patterns for changers and maintainers were quite similar: a steady increase over the course of the session in strength of commitment to drug abstinence. The principal difference was in their starting points. Changers (who had been using on 80% of days) began the session with strong commitment to continued drug use, whereas maintainers (who had been abstinent on 80% of days) began the session more ambivalently, committing neither to abstinence nor to continued use. Both ended the session expressing strong commitment to abstinence. The combined in-session speech patterns of these two good-outcome groups are shown in Figure 2.

In contrast, the speech patterns of the strugglers looked quite different and resembled the language pattern of the fourth group, who did not honestly report their drug use. When the session was divided into deciles, these groups showed an initial increase in commitment to change that reversed through Deciles 3–6. Commitment to abstinence then strengthened dramatically until Decile 9 but then fell back to zero (ambivalence) at Decile 10. The

**Figure 2**  
*Strength of Client Commitment Language to Drug Use (–) Versus Abstinence (+) During a Motivational Interviewing Session: Good Versus Poor Treatment Outcomes*



combined in-session speech patterns of these two poor-outcome groups are also shown in Figure 2. The good and poor outcome groups did not differ from each other significantly at baseline on drug use or on measures of pretreatment motivation for change. Yet the course of their MI sessions, as reflected in commitment language, was quite different, as were their drug use outcomes. What might account for the unusual jagged pattern of the less successful group in Figure 2, with distinct drops in client commitment at Deciles 3 and 10?

The single-session MET intervention was manual guided, with a structured sequence of steps to follow. The session began (Deciles 1 and 2) with open-ended MI, which elicited client change talk. Then the therapist presented personal feedback from the client's pretreatment assessment (roughly Deciles 3–6), after which the therapist returned to MI (Deciles 7–9). Finally, at the end of the session, the therapist developed a change plan with the client and asked for commitment. For the 72% of cases with good outcomes, this sequence flowed relatively smoothly, with steadily increasing strength of commitment to change. For those with poor outcomes, however, it appears that they were not ready, in some sense, to hear their feedback or to agree to a change plan. When the therapist nevertheless pushed ahead with these steps, the client's commitment level dropped. A skillful MI counselor attends and responds to such in-session fluctuations in change talk and resistance and would not press ahead with the agenda if the client was not coming along. The structured therapist manual that Miller had authored, however, required the therapist to complete these steps within a single session. The apparent result was that the therapist disregarded client resistance at these points and thus lost motivational momentum.

In sum, there is a growing body of research to support Paths 3–5, that the natural language utterances of clients do predict behavior change. Further insights are likely to emerge from such research as reliable MI coding systems are refined (Madson & Campbell, 2008).

### **MI Spirit and Outcome**

The relational hypothesis of MI's efficacy predicts a direct relationship between therapist style and client outcome (Path 7 in Figure 1). Rogers (1959) postulated that certain therapeutic conditions in themselves promote positive change. Accurate empathy appears to be a particularly good candidate (Miller et al., 1980; Najavits & Weiss, 1994; Valle, 1981).

Rollnick and Miller (1995) described an underlying spirit of MI as a crucial component of its efficacy. This spirit (a) is collaborative rather than authoritarian, (b) evokes the client's own motivation rather than trying to install it, and (c) honors the client's autonomy. Early evidence for the linkage of MI spirit with change talk and favorable outcome is found in the aforementioned study of Miller et al. (1993). Gaume et al. (2008) also reported a positive correlation between therapist empathy and 12-month drinking outcomes. Furthering this line of inquiry, Moyers, Miller, and Hendrickson (2005) completed pro-

cess analyses of a clinical trial of MI (Miller et al., 2004). As predicted by the relational hypothesis, clinician interpersonal skills correlated significantly with measures of client involvement. Similarly, two investigations with adult smokers obtained positive correlations among therapist skillfulness, client engagement in treatment (Boardman, Catley, Grobe, Little, & Ahluwalia, 2006), and intensity of the therapeutic interaction (Catley et al., 2006).

### **Training in MI**

A final link in the hypothesized chain illustrated in Figure 1 involves MI training. Ideally, training clinicians in MI should change practice behavior and improve their clients' outcomes. A fully integrated model, not yet demonstrated, would show that training shapes particular clinician responses, which in turn evoke specific in-session client responses that predict client outcomes.

Two early studies found that clinicians reported high satisfaction and significant self-perceived gains in proficiency after an MI workshop (Miller & Mount, 2001; Rubel, Sobell, & Miller, 2000). However, tape-recorded work samples before and after training reflected only modest changes in practice and no difference in clients' in-session response (e.g., change talk). In short, the workshop convinced clinicians that they had acquired MI skillfulness, but their actual practice did not change enough to make any difference to their clients (Miller & Mount, 2001).

This finding indicated that trainees need more than a one-time workshop to improve skillfulness in this complex method. Two common learning aids seemed good candidates for improving training: progressive individual feedback on performance and personal follow-up coaching. The individual and combined impact of these training aids was evaluated in a randomized trial with 140 clinicians (Miller et al., 2004). The design also included a control group given a manual (Miller & Rollnick, 2002) and training videotapes (Miller, Rollnick, & Moyers, 1998) for self-directed learning. Relative to pretraining work samples, clinicians in the self-directed learning group showed no improvement of skills in four-month postintervention practice samples. Feedback and coaching, both individually and combined, significantly improved clinician MI proficiency beyond the effects of a two-day training workshop. Improvements were demonstrated in global ratings of MI spirit and empathy (Path 8 in Figure 1) as well as in specific technical skills (Path 9). One would also hope that when clinicians learn and practice MI, their clients will show increased change talk (Path 10). In contrast to the workshop-only study (Miller & Mount, 2001), the clients of participants in this enhanced training did show significant increases in change talk and commitment language, which are in-session proxies of subsequent behavior change (Amrhein et al., 2003, 2004). These changes in clinician practice may also exert other effects on client outcomes, through or apart from the mediation of change talk (Paths 6 and 7). A practical challenge in training clinicians in MI, then, is to help them persist in behavior change past an initial workshop exposure that may erroneously convince them that they have already learned the method, a motiva-

tional challenge not unlike that of helping clients change lifestyle behaviors.

## Discussion

Though originally developed to address substance use disorders (Miller, 1983), MI has now been tested across a wide range of target behavior changes. It has been found to be effective both in reducing maladaptive behaviors (e.g., problem drinking, gambling, HIV risk behaviors) and in promoting adaptive health behavior change (e.g., exercise, diet, medication adherence). The clinical style and apparent mechanisms of change in MI thus seem to be related to generalizable processes of human behavior and not limited to specific target problems. As discussed above, the effectiveness of MI also appears to be amplified when it is added to other active treatment methods. It therefore shows promise as one clinical tool, to be integrated with other evidence-based methods, for use when client ambivalence and motivation appear to be obstacles to change.

Therapist style and practice can substantially improve or degrade client outcomes. This relation has been reflected in the variability of outcomes of MI across therapists, sites, and studies. Research on MI sheds light on some of the underlying processes that may be operative well beyond the specific method of MI. Moyers and colleagues (Moyers, Martin, et al., 2005; Moyers, Miller, & Hendrickson, 2005; Moyers & Martin, 2006; Moyers et al., 2007) have presented data indicating a complex relationship among therapist responses, client speech, and subsequent behavior change. Both the relational (MI spirit) and technical attributes of MI contribute to outcome as mediated by client change talk. Progress has been made toward constructing a causal chain that clarifies how MI affects behavior change. A large efficacy literature shows that MI can directly impact client outcomes (Paths 6 and 7 in Figure 1). Linkage has also been established between specific MI practice behavior and client change talk (Paths 1 and 2 in Figure 1), a hypothesized mediator of MI's impact on behavior change. The strength of preparatory change talk predicts subsequent strength of commitment (Path 3), both of which have been shown to predict client outcomes (Paths 4 and 5). Furthermore, training in MI has been shown to improve clinician performance on MI skills (Paths 8 and 9) that are themselves related to client outcome (Paths 6 and 7) and to directly increase change talk among clients of trained clinicians (Path 10). An independent review of MI process research found that MI implementation is discriminable by MI-consistent therapist behaviors, which in turn predict in-session client responses and postsession treatment outcomes in a manner consistent with the theory of MI stated here (Apodaca & Longabaugh, 2009, p. 712). An obvious next step is the evaluation of full mediation models integrating the multiple links in this chain (Baron & Kenny, 1986; Longabaugh & Wirtz, 2001).

Even so, causal chain analyses are but a first step in understanding how and why MI effects behavior change. If therapist empathy does enhance client change talk or otherwise improve client outcomes, *how* does it do so? If the elicitation of client change talk is reliably linked to com-

mitment and behavior change, *why* is that so? Is it literally the voicing of change talk that causes behavior change? Chanting aloud 100 times "I will change, I will change" seems unlikely to make it so. Instead, it is plausible that the processes of MI trigger covert events that are not directly observable but that result in both increased commitment language and subsequent behavior change. In this case, the observed commitment language is not itself a cause of change but represents a signal that the covert events are occurring and that change is likely to follow. If that is so, then the verbalization of commitment strength is not a necessary precondition for change. Often, we suspect, the tree falls in the internal forest and no one hears the sound of it.

What might such covert antecedent events be? Some possible descriptors are acceptance, readiness, or decision, with corresponding shifts in perception of self. A reasonable analogy is engagement. When a couple become engaged, they have reached a decision that they are ready (or at least preparing) to make a commitment to each other, which is accompanied by shifts in perception of themselves and their relationship. Engagement is often an emotionally charged, highly significant event, but is not in itself the act of commitment in the presence of witnesses. The public committing act of marriage follows from the private event of engagement. In American culture, at least, engagement does not typically involve binding legal documents. Most often it is a private event, the announcement of which is optional and may be formal or informal. There are some common outward and visible signs of engagement: a ring, statements made to others, focusing of intimacy on the betrothed. Yet none of these is in itself the act of engagement; they are simply reflections of the underlying event. So, too, readiness for change may emerge as a private, discrete shift that opens the door for public commitment.

There remain some interesting wrinkles to be ironed out in the fabric of MI, such as the role of disingenuous change talk. It was not the frequency or absolute level of commitment language (the intercept) that predicted behavior change so much as a pattern of increasing strength of commitment (positive slope) during a counseling session (Amrhein et al., 2003). Initial commitment level at the beginning of the MI session did not signal behavior change, and clients whose commitment strength did not increase during a session were less likely to be abstaining from drugs at follow-up. It follows that clients who enter a session already professing high commitment may not be the most likely to change. This in turn raises the issue of client honesty. People can offer dishonest change talk, signaling commitments that they have no intention of keeping. Amrhein's psycholinguistic coding system included attention to nonverbal cues (such as a slight shrug of the shoulders) that when accompanying commitment language signal significantly decreased likelihood of behavioral follow-through. Such subtle cues probably contribute to clinicians' impressions of client sincerity and motivation, which can in themselves be prognostic of behavior change outcomes (Dunn, Droesch, Johnston, & Rivara, 2004). It is noteworthy that clients who were subsequently dishonest

about abstinence showed the same pattern of in-session vacillating commitment as did those who reported continued drug use (Amrhein et al., 2003). The pattern of their in-session speech told the truth. Further study of the nature and patterning of client responses, as well as of the manner in which intentionality is coded and decoded in everyday conversations (Malle, 2004), may lead to more reliable markers of dissimulation and intentionality toward behavior change.

The relative contributions of the relational and technical components of MI also remain to be clarified. If therapists manifest a high relational level of accurate empathy and MI spirit, how much is efficacy further improved by adding the technical focus on eliciting change talk and commitment language? One randomized clinical trial (Sellman, Sullivan, Dore, Adamson, & MacEwan, 2001) studied this question with moderately severe problem drinkers, comparing the effects of nondirective counseling, simple feedback, and MET. The MET intervention yielded significantly greater reduction in heavy drinking than did nondirective counseling or a single feedback session, indicating a large effect associated with the technical attributes of MI. Karno and Longabaugh (2005) found an interaction between the client's anger and reactance and the clinician's interpersonal style; clients with high levels of anger and reactance did poorly with clinicians who demonstrated behaviors inconsistent with both the spirit and technique of MI. Thus, the answer to the relational versus technical contributions of MI may be a complicated one.

The opposite question—How much does MI spirit add to the technical components?—would seem more difficult to evaluate, in part because MI without this underlying spirit is no longer MI. One trial of MI techniques delivered in what appears to be a more authoritarian overall style (Kuchipudi et al., 1990) showed no effect on behavioral outcomes.

It is also likely that other factors will be discovered that play an important role in the processes and outcomes of MI. Clarification of these “active ingredients” could help to focus training on those components that are necessary and/or sufficient for the efficacy of MI and thereby to clarify what aspects can be modified (e.g., in cross-cultural adaptations of MI) without compromising its efficacy (Miller, Villanueva, Tonigan, & Cuzmar, 2007; Venner, Feldstein, & Tafoya, 2007).

## Summary

After three decades of research, motivational interviewing is a psychotherapeutic method that is evidence-based, relatively brief, specifiable, applicable across a wide variety of problem areas, complementary to other active treatment methods, and learnable by a broad range of helping professionals. A testable theory of its mechanisms of action is emerging, with measurable components that are both relational and technical. This theory may in turn clarify more general processes that affect outcomes in other psychotherapies (Aharonovich et al., 2008; Moyers et al., 2007).

## REFERENCES

- Aharonovich, E., Amrhein, P. C., Bisaga, A., Nunes, E. V., & Hasin, D. S. (2008). Cognition, commitment language, and behavioral change among cocaine-dependent patients. *Psychology of Addictive Behaviors, 22*, 557–562.
- Amrhein, P. C. (1992). The comprehension of quasi-performance verbs in verbal commitments: New evidence for componential theories of lexical meaning. *Journal of Memory and Language, 31*, 756–784.
- Amrhein, P. C., Miller, W. R., Yahne, C., Knupsky, A., & Hochstein, D. (2004). Strength of client commitment language improves with therapist training in motivational interviewing. *Alcoholism: Clinical and Experimental Research, 28*(5), 74A.
- Amrhein, P. C., Miller, W. R., Yahne, C. E., Palmer, M., & Fulcher, L. (2003). Client commitment language during motivational interviewing predicts drug use outcomes. *Journal of Consulting and Clinical Psychology, 71*, 862–878.
- Apodaca, T. R., & Longabaugh, R. (2009). Mechanisms of change in motivational interviewing: A review and preliminary evaluation of the evidence. *Addiction, 104*, 705–715.
- Arkowitz, H., Westra, H. A., Miller, W. R., & Rollnick, S. (Eds.). (2008). *Motivational interviewing in treating psychological problems*. New York: Guilford Press.
- Aubrey, L. L. (1998). *Motivational interviewing with adolescents presenting for outpatient substance abuse treatment*. Unpublished doctoral dissertation, University of New Mexico, Albuquerque.
- Babor, T. F., & Del Boca, F. K. (Eds.). (2003). *Treatment matching in alcoholism*. Cambridge, England: Cambridge University Press.
- Baer, J. S., Beadnell, B., Garrett, S. B., Hartzler, B., Wells, E. A., & Peterson, P. L. (2008). Adolescent change language within a brief motivational intervention and substance use outcomes. *Psychology of Addictive Behaviors, 22*, 570–575.
- Baker, A., Richmond, R., Haile, M., Lewin, T. J., Carr, V. J., Taylor, R. L., et al. (2006). A randomized controlled trial of a smoking cessation intervention among people with a psychotic disorder. *American Journal of Psychiatry, 163*, 1934–1942.
- Ball, S. A., Martino, S., Nich, C., Frankforter, T. L., Van Horn, D., Crits-Christoph, P., et al. (2007). Site matters: Multisite randomized trial of motivational enhancement therapy in community drug abuse clinics. *Journal of Consulting and Clinical Psychology, 75*, 556–567.
- Baron, R. M., & Kenny, D. A. (1986). The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*, 1173–1182.
- Bem, D. J. (1967). Self-perception: An alternative interpretation of cognitive dissonance phenomena. *Psychological Review, 74*, 183–200.
- Bem, D. J. (1972). Self-perception theory. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 6, pp. 1–62). New York: Academic Press.
- Bien, T. H., Miller, W. R., & Borouhgs, J. M. (1993). Motivational interviewing with alcohol outpatients. *Behavioural and Cognitive Psychotherapy, 21*, 347–356.
- Bien, T. H., Miller, W. R., & Tonigan, J. S. (1993). Brief interventions for alcohol problems: A review. *Addiction, 88*, 315–336.
- Boardman, T., Catley, D., Grobe, J., Little, T., & Ahluwalia, J. (2006). Using motivational interviewing with smokers: Do therapist behaviors relate to engagement and therapeutic alliance? *Journal of Substance Abuse Treatment, 31*, 329–339.
- Brown, J. M., & Miller, W. R. (1993). Impact of motivational interviewing on participation and outcome in residential alcoholism treatment. *Psychology of Addictive Behaviors, 7*, 211–218.
- Burke, B. L., Arkowitz, H., & Menchola, M. (2003). The efficacy of motivational interviewing: A meta-analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology, 71*, 843–861.
- Carroll, K. M., Ball, S. A., Nich, C., Martino, S., Frankforter, T. L., Farentinos, C., et al. (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence, 81*, 301–312.
- Carroll, K. M., Farentinos, C., Ball, S. A., Crits-Christoph, P., Libby, B., Morgenstern, J., et al. (2002). MET meets the real world: Design issues

- and clinical strategies in the Clinical Trials Network. *Journal of Substance Abuse Treatment*, 23, 73–80.
- Catley, D., Harris, K. J., Mayo, M. S., Hall, S., Okuyemi, K. S., Boardman, T., & Ahluwalia, J. (2006). Adherence to principles of motivational interviewing and client within-session behavior. *Behavioural and Cognitive Psychotherapy*, 34, 43–56.
- Chafetz, M. E., Blane, H. T., Abram, H. S., Golner, J. H., Hastie, E. L., & Meyers, W. (1962). Establishing treatment relations with alcoholics. *Journal of Nervous and Mental Disease*, 134, 395–409.
- Colby, S. M., Monti, P. M., Barnett, N. P., Rohsenow, D. J., Weissman, K., Spirito, A., et al. (1998). Brief motivational interviewing in a hospital setting for adolescent smoking: A preliminary study. *Journal of Consulting and Clinical Psychology*, 66, 574–578.
- Copello, A., Godfrey, C., Heather, N., Hodgson, R., Orford, J., Raistrick, D., et al. (2001). United Kingdom Alcohol Treatment Trial (UKATT): Hypotheses, design and methods. *Alcohol and Alcoholism*, 36, 11–21.
- Dunn, C., Deroo, L., & Rivara, F. P. (2001). The use of brief interventions adapted from motivational interviewing across behavioral domains: A systematic review. *Addiction*, 96, 1725–1742.
- Dunn, C., Droesch, R. M., Johnston, B. D., & Rivara, F. P. (2004). Motivational interviewing with injured adolescents in the emergency department: In-session predictors of change. *Behavioural and Cognitive Psychotherapy*, 32, 113–116.
- Erickson, S. J., Gerstle, M., & Feldstein, S. W. (2005). Brief interventions and motivational interviewing with children, adolescents, and their parents in pediatric health settings: A review. *Archives of Pediatrics and Adolescent Medicine*, 159, 1173–1180.
- Festinger, L. (1957). *A theory of cognitive dissonance*. Stanford, CA: Stanford University Press.
- Gaume, J., Gmel, G., & Daeppen, J.-B. (2008). Brief alcohol interventions: Do counsellors' and patients' communication characteristics predict change? *Alcohol and Alcoholism*, 43, 62–69.
- Gollwitzer, P. M. (1999). Implementation intentions: Simple effects of simple plans. *American Psychologist*, 54, 493–503.
- Gollwitzer, P. M., & Schaal, B. (1998). Metacognition in action: The importance of implementation intentions. *Personality and Social Psychology Review*, 2, 124–136.
- Gordon, T. (1970). *Parent effectiveness training*. New York: Wyden.
- Hettema, J., Steele, J., & Miller, W. R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology*, 1, 91–111.
- Hodgins, D. C., Ching, L. E., & McEwen, J. (2009). Strength of commitment language in motivational interviewing and gambling outcomes. *Psychology of Addictive Behaviors*, 23, 122–130.
- Holder, H. D., Cisler, R. A., Longabaugh, R., Stout, R. L., Treno, A. J., & Zweben, A. (2000). Alcoholism treatment and medical care costs from Project MATCH. *Addiction*, 95, 999–1013.
- Houck, J. M., & Moyers, T. B. (2008). *What you do matters: Therapist influence on client behavior during motivational interviewing sessions*. Paper presented at the International Addiction Summit, Melbourne, Australia.
- Karno, M. P., & Longabaugh, R. (2005). An examination of how therapist directiveness interacts with patient anger and reactance to predict alcohol use. *Journal of Studies on Alcohol*, 66, 825–832.
- Kuchipudi, V., Hobein, K., Fleckinger, A., & Iber, F. L. (1990). Failure of a 2-hour motivational intervention to alter recurrent drinking behavior in alcoholics with gastrointestinal disease. *Journal of Studies on Alcohol*, 51, 356–360.
- Longabaugh, R., & Wirtz, P. W. (Eds.). (2001). *Project MATCH hypotheses: Results and causal chain analyses* (Project MATCH Monograph Series, Vol. 8). Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.
- Luborsky, L., McLellan, A. T., Diguier, L., Woody, G., & Seligman, D. A. (1997). The psychotherapist matters: Comparison of outcomes across twenty-two therapists and seven patient samples. *Clinical Psychology: Science and Practice*, 4, 53–65.
- Luborsky, L., McLellan, A. T., Woody, G. E., O'Brien, C. P., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry*, 42, 602–611.
- Madson, M. B., & Campbell, T. C. (2008). Measures of fidelity in motivational enhancement: A systematic review. *Journal of Substance Abuse Treatment*, 31, 67–73.
- Malle, B. F. (2004). *How the mind explains behavior: Folk explanations, meaning, and social interaction*. Cambridge, MA: MIT Press.
- McLellan, A. T., Woody, G. E., Luborsky, L., & Goehl, L. (1988). Is the counselor an "active ingredient" in substance abuse rehabilitation? An examination of treatment success among four counselors. *Journal of Nervous and Mental Disease*, 176, 423–430.
- Miller, W. R. (1983). Motivational interviewing with problem drinkers. *Behavioural Psychotherapy*, 11, 147–172.
- Miller, W. R., & Baca, L. M. (1983). Two-year follow-up of bibliotherapy and therapist-directed controlled drinking training for problem drinkers. *Behavior Therapy*, 14, 441–448.
- Miller, W. R., Benefield, R. G., & Tonigan, J. S. (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology*, 61, 455–461.
- Miller, W. R., & Mount, K. A. (2001). A small study of training in motivational interviewing: Does one workshop change clinician and client behavior? *Behavioural and Cognitive Psychotherapy*, 29, 457–471.
- Miller, W. R., Moyers, T. B., Arciniega, L., Ernst, D., & Forcehimes, A. (2005). Training, supervision and quality monitoring of the COMBINE Study behavioral interventions. *Journal of Studies on Alcohol*, Supplement 15, 188–195.
- Miller, W. R., & Muñoz, R. F. (2005). *Controlling your drinking*. New York: Guilford Press.
- Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.
- Miller, W. R., Rollnick, S., & Moyers, T. B. (Director). (1998). *Motivational interviewing* [7-VHS videotape/DVD series]. Available from <http://casaa.unm.edu/download/mitrain98.pdf>
- Miller, W. R., & Sovereign, R. G. (1989). The check-up: A model for early intervention in addictive behaviors. In T. Løberg, W. R. Miller, P. E. Nathan, & G. A. Marlatt (Eds.), *Addictive behaviors: Prevention and early intervention* (pp. 219–231). Amsterdam: Swets & Zeitlinger.
- Miller, W. R., Sovereign, R. G., & Kreege, B. (1988). Motivational interviewing with problem drinkers: II. The Drinker's Check-up as a preventive intervention. *Behavioural Psychotherapy*, 16, 251–268.
- Miller, W. R., Taylor, C. A., & West, J. C. (1980). Focused versus broad spectrum behavior therapy for problem drinkers. *Journal of Consulting and Clinical Psychology*, 48, 590–601.
- Miller, W. R., Villanueva, M., Tonigan, J. S., & Cuzmar, I. (2007). Are special treatments needed for special populations? *Alcoholism Treatment Quarterly*, 25(4), 63–78.
- Miller, W. R., Yahne, C. E., Moyers, T. B., Martinez, J., & Pirritano, M. (2004). A randomized trial of methods to help clinicians learn motivational interviewing. *Journal of Consulting and Clinical Psychology*, 72, 1050–1062.
- Miller, W. R., Yahne, C. E., & Tonigan, J. S. (2003). Motivational interviewing in drug abuse services: A randomized trial. *Journal of Consulting and Clinical Psychology*, 71, 754–763.
- Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. C. (1992). *Motivational Enhancement Therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence* (Project MATCH Monograph Series, Vol. 2). Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.
- Moyers, T. B. (2004). History and happenstance: How motivational interviewing got its start. *Journal of Cognitive Psychotherapy: An International Quarterly*, 18, 291–298.
- Moyers, T. B., & Martin, T. (2006). Therapist influence on client language during motivational interviewing sessions: Support for a potential causal mechanism. *Journal of Substance Abuse Treatment*, 30, 245–251.
- Moyers, T. B., Martin, T., Catley, D., Harris, K. J., & Ahluwalia, J. S. (2003). Assessing the integrity of motivational interventions: Reliability of the Motivational Interviewing Skills Code. *Behavioural and Cognitive Psychotherapy*, 31, 177–184.
- Moyers, T. B., Martin, T., Christopher, P. J., Houck, J. M., Tonigan, J. S., & Amrhein, P. C. (2007). Client language as a mediator of motivational interviewing efficacy: Where is the evidence? *Alcoholism: Clinical and Experimental Research*, 31(Suppl. 3), 40–47.

- Moyers, T. B., Martin, T., Manuel, J. K., Hendrickson, S. M. L., & Miller, W. R. (2005). Assessing competence in the use of motivational interviewing. *Journal of Substance Abuse Treatment, 28*, 19–26.
- Moyers, T. B., Miller, W. R., & Hendrickson, S. M. L. (2005). How does motivational interviewing work? Therapist interpersonal skill predicts client involvement within motivational interviewing sessions. *Journal of Consulting and Clinical Psychology, 73*, 590–598.
- Najavits, L. M., & Weiss, R. D. (1994). Variations in therapist effectiveness in the treatment of patients with substance use disorders: An empirical review. *Addiction, 89*, 679–688.
- Patterson, G. R., & Forgatch, M. S. (1985). Therapist behavior as a determinant for client noncompliance: A paradox for the behavior modifier. *Journal of Consulting and Clinical Psychology, 53*, 846–851.
- Project MATCH Research Group. (1993). Project MATCH: Rationale and methods for a multisite clinical trial matching patients to alcoholism treatment. *Alcoholism: Clinical and Experimental Research, 17*, 1130–1145.
- Project MATCH Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol, 58*, 7–29.
- Project MATCH Research Group. (1998a). Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism: Clinical and Experimental Research, 22*, 1300–1311.
- Project MATCH Research Group. (1998b). Therapist effects in three treatments for alcohol problems. *Psychotherapy Research, 8*, 455–474.
- Reichenbach, H. (1938). *Experience and prediction*. Chicago: University of Chicago Press.
- Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: The study of a science. Vol. 3. Formulations of the person and the social context* (pp. 184–256). New York: McGraw-Hill.
- Rollnick, S., Mason, P., & Butler, C. (1999). *Health behavior change: A guide for practitioners*. New York: Churchill Livingstone.
- Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy, 23*, 325–334.
- Rollnick, S., Miller, W. R., & Butler, C. C. (2008). *Motivational interviewing in health care*. New York: Guilford Press.
- Rubak, S., Sandbaek, A., Lauritzen, T., & Christensen, B. (2005). Motivational interviewing: A systematic review and meta-analysis. *British Journal of General Practice, 55*, 305–312.
- Rubel, E. C., Sobell, L. C., & Miller, W. R. (2000). Do continuing education workshops improve participants' skills? Effects of a motivational interviewing workshop on substance abuse counselors' skills and knowledge. *The Behavior Therapist, 23*, 73–77, 90.
- Schoener, E. P., Madeja, C. L., Henderson, M. J., Ondersma, S. J., & Janisse, J. J. (2006). Effects of motivational interviewing training on mental health therapist behavior. *Drug and Alcohol Dependence, 82*, 269–275.
- Sellman, J. D., Sullivan, P. F., Dore, G. M., Adamson, S. J., & MacEwan, I. (2001). A randomized controlled trial of motivational enhancement therapy (MET) for mild to moderate alcohol dependence. *Journal of Studies on Alcohol, 62*, 389–396.
- Strang, J., & McCambridge, J. (2004). Can the practitioner correctly predict outcome in motivational interviewing? *Journal of Substance Abuse Treatment, 27*(1), 83.
- Treasure, J. L., Katzman, M., Schmidt, U., Troop, N., Todd, G., & deSilva, P. (1998). Engagement and outcome in the treatment of bulimia nervosa: First phase of a sequential design comparing motivational enhancement therapy and cognitive behavioural therapy. *Behaviour Research and Therapy, 37*, 405–418.
- Truax, C. B., & Carkhuff, R. R. (1967). *Toward effective counseling and psychotherapy*. Chicago: Aldine.
- UKATT Research Team. (2005a). Cost effectiveness of treatment for alcohol problems: Findings of the randomized UK Alcohol Treatment Trial (UKATT). *British Medical Journal, 331*, 544–548.
- UKATT Research Team. (2005b). Effectiveness of treatment for alcohol problems: Findings of the randomized UK Alcohol Treatment Trial (UKATT). *British Medical Journal, 331*, 541–544.
- Valle, S. K. (1981). Interpersonal functioning of alcoholism counselors and treatment outcome. *Journal of Studies on Alcohol, 42*, 783–790.
- Venner, K. L., Feldstein, S. W., & Tafoya, N. (2007). Helping clients feel welcome: Principles of adapting treatment cross culturally. *Alcoholism Treatment Quarterly, 25*, 11–30.
- Villanueva, M., Tonigan, J. S., & Miller, W. R. (2007). Response of Native American clients to three treatment methods for alcohol dependence. *Journal of Ethnicity in Substance Abuse, 6*(2), 41–48.
- White, W. L., & Miller, W. R. (2007). The use of confrontation in addiction treatment: History, science, and time for change. *Counselor, 8*(4), 12–30.
- Winhusen, T., Kropp, F., Babcock, D., Hague, D., Erickson, S. J., Renz, C., et al. (2008). Motivational enhancement therapy to improve treatment utilization and outcome in pregnant substance users. *Journal of Substance Abuse Treatment, 35*, 161–173.

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## Community Mental Health & Substance Abuse Prevention & Treatment Block Grant Needs Assessment

### What is a Needs Assessment?

- **Definition.** A systematic exploration of “*the way things are*” (and often why from a **needs analysis**) and “*the way things should be*” relative to the performance of the system of the mental health and substance abuse prevention, treatment and recovery supports.
- Needs assessments are used as a tool for program planning which uses available data and key informants to evaluate **various aspects of a system** in order to establish a hierarchy of needs thru priority setting and the establishment of goals and strategies to address those priority needs.
- The key identified system components or **framework for the needs assessment and data collection are:**
  1. **Population(s) Affected. Prevalence** of disorders, conditions or impacts of those disorders or conditions on the entire population of a service area, as well as prevalence estimates and impacts for special populations that may be inordinately affected. What is the **relative need** for services or supports across different populations, including **special or priority populations**, regions or communities?
  2. **Access to Prevention, Treatment and Supports.** Are people able to gain entry to services or supports? Do they receive the appropriate preventative, treatment or supportive services when (timeliness) and where (geographically available) they need it from a provider they can communicate with and trust? What percentage of the populations and special or priority populations actually are served by the public system (treated prevalence or penetration rates)?
  3. **Services.** What types of services are needed by the population in need and what is the necessary capacity of the system to meet the needs? What is the **capacity of the system** (including number of providers and workforce characteristics) to provide a culturally and linguistically appropriate mix of services to meet the needs and preferences of the populations affected. In addition, are the resources in the system appropriately aligned and cost effective (i.e. relative use of emergency room or hospital-based care compared to other community based care)?
  4. **Quality of Services, Supports or Treatment.** Are the services, supports or treatment of desired quality? Consider whether or not the services/supports/treatment/interventions provided:

- Effective – evidence-based or meet current practice standards?
  - Safe?
  - Consumer/Patient Centered?
  - Efficient?
  - Equitable?
5. **Outcomes.** What happened to the consumer and/or the system as a result of the interventions, services or supports? What is the impact of what is, and is not done to ameliorate the condition, disorder or problem? Outcomes to be measured will include what consumers believe are important to them and those important for the overall system.

### Steps of a Needs Assessment

1. **What is (current state)?** Identify current state of the system of mental health and substance abuse within Wisconsin. What does it look like now? What factors currently exist that might affect the way things are now (**barriers**)?
2. **What should it look like (future state)?** What is the ultimate **goal or vision** for the various aspects of the system that should be strived for? What is a reasonable or attainable vision/goal(s) to achieve within a specified time period? What do key stakeholders (i.e. consumers, advocates, counties, tribes, providers, state agencies, **SAMHSA's goals/vision statements**) think about what the goals/vision should be or to working towards (**environmental scan**)?
3. **What is the gap between what is and what it should look like (gap or needs analysis)?** What are the system strengths, needs and service gaps identified when comparing the future state to current state? What does **SAMHSA recommend as best practice** and how does Wisconsin measure up? Analyze the available data to determine the relative scope and intensity of the needs and gaps identified. This may involve looking at trends over time, looking at other states or the nation as a whole compared to Wisconsin; looking for possible differences and disparities in special populations or in certain geographic areas in the state. Identify needs/gaps where there are effective strategies to impact the need/problem. Review what the current environment holds as to opportunities and threats.
4. **Prioritization of Needs and/or Gaps.** Use the analysis from the gap analysis to rank order the needs and/or gaps identified. Consider key stakeholders' view of priorities, including SAMHSA's perspective on key priorities, representatives of special populations, consumers, providers, counties, Tribes (thru Tribal Consultation).
5. **Develop Plan of Action.** Develop a plan of action that includes a measurable goal and performance measures. Identify evidence-based or science-based strategies to address needs/gaps that are prioritized.

## Wisconsin Substance Abuse Counselor Survey, 2012

### Purpose

The Patient Protection and Affordable Care Act (PPACA) healthcare reforms anticipated in 2014 and beyond that emphasize Masters degreed substance abuse and mental health professionals necessitate the need for information about the education and credentials of Wisconsin substance abuse professionals. The Wisconsin 2012 substance abuse counselor survey data will identify gaps between PPACA-emphasized educational levels and current Wisconsin substance abuse professional education levels in order to:

- Inform the future direction of the Minority Counselor Training Institute
- Inform the plans of substance abuse education programs at vocational-technical colleges, four-year colleges, and graduate schools

While the Wisconsin Medicaid program currently includes SACs and CSACs without a Bachelor's degree as reimbursable under the HN modifier (Bachelors degree level), this position may need to be reviewed in light of the PPACA emphasis. Internal department discussions have also centered around possible lower Medicaid reimbursement rates if the counselor does not possess at least a Bachelors degree. Concerns have been raised among Wisconsin Counselors and other advocates about this multiple-tier reimbursement approach based solely upon education level. The survey information can be used in these discussions as well.

### Prior Survey

The last survey of this kind was taken in 1995 when there were about 1,340 Wisconsin substance abuse counselors. Seventy-nine percent (79%) returned completed surveys. The race distribution among Counselors was 91% White, 6% African American, 2% American Indian, and 1% Hispanic/Latino; 55% were female. The average annual wage was \$31,490. Fifty-four percent (54%) possessed a Medicaid provider number. The education levels in 1995 are in the following table:

Education Level, 1995 Substance Abuse Counselor Survey

High School, GED or less	29%
Associate degree	9%
Bachelors degree	22%
Masters degree	37%
Doctorate degree	3%

### 2011 Wisconsin Substance Abuse Counselor Education Program Survey

Another complimentary statewide survey was completed by the University of Wisconsin (Flo Hilliard, MSH) in 2011. Twenty-two (22) substance abuse counselor education programs at various technical colleges and universities across the state responded. This survey provides a very useful listing of education programs, their curriculum, minority student population, and their future viability.

### SAMHSA-facilitated Model Scopes of Practice and Career Ladder for Substance Use Disorder Counseling Report, February 2011

In 2011, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) released a report of a 2010 gathering of experts in the substance abuse field who developed counselor scope of practice recommendations. While the recommendations in the report do not necessarily reflect the views, opinions, or policies of SAMHSA, the report can serve as a guide for states as they develop or modify their own counseling practice levels, education, training, experience, clinical supervision standards and workforce development activities. In summary, the expert panel recommends five levels of counselors:

- Independent Clinical Substance Use Disorder Counselor/Supervisor 4 (at least a Masters degree; may practice independently; 4,000 hours supervised experience; may practice psychotherapy)
- Clinical Substance Use Disorder Counselor 3 (at least a Masters degree and under supervision of an Independent Clinical Substance Use Disorder Counselor/Supervisor 4; must practice in a licensed facility; 3,000 hours supervised experience; may practice psychotherapy)
- Substance Use Disorder Counselor 2 (at least a Bachelors degree and under supervision of at least a Clinical Substance Use Disorder Counselor; must practice in a licensed facility; 2,000 hours supervised experience; may practice psycho-educational counseling)
- Associate Substance Use Disorder Counselor 1 (at least an Associates degree under supervision of an Independent Clinical Substance Use Disorder Counselor/Supervisor 4; must practice in a licensed facility; 2,000 hours supervised experience; may practice psycho-educational counseling)
- Substance Use Disorder Technician (high school diploma or GED under the supervision of at least a Clinical Substance Use Disorder Counselor 3; must practice in a licensed facility; 1,500 hours supervised experience; may provide psycho-educational counseling under close supervision; 150 clock hours of substance use disorder education/training)

Scott Walker  
Governor



Michael Waupoose  
Chairperson

Duncan Shrout  
Vice-Chairperson

Scott Stokes  
Secretary

State of Wisconsin

**State Council on Alcohol and Other Drug Abuse**

1 West Wilson Street, P.O. Box 7851  
Madison, Wisconsin 53707-7851

February 21, 2012

Representative Peggy Krusick  
Room 128 North  
State Capitol  
P.O. Box 8952  
Madison, WI 53708

Representative Jim Ott  
Room 317 North  
State Capitol  
P.O. Box 8953  
Madison, WI 53708

Dear Representative Krusick and Representative Ott:

On behalf of the State Council on Alcohol and Other Drug Abuse, I am writing to offer our support and sponsorship of the "Drunk Driver Reform Bill LRB 2144".

The Executive Committee of the State Council on Alcohol and Other Drug Abuse met today to discuss the Council's support of this Bill. By unanimous vote, the Officers of the Council voted to support of this Bill as written.

The State Council on Alcohol and Other Drug Abuse remains concerned about inadequate funding for alcohol and other drug abuse prevention and treatment services. A separate letter will be forthcoming addressing these concerns.

If you have any questions, please do not hesitate to contact me. I can be reached at (608) 278-8200 or my email at: [Michael.Waupoose@UWMF.WISC.EDU](mailto:Michael.Waupoose@UWMF.WISC.EDU).

Sincerely,

A handwritten signature in cursive script that reads "Michael Waupoose".

Chairperson

Cc: Executive Committee  
Kevin Moore  
Kitty Rhoades



State of Wisconsin

**State Council on Alcohol and Other Drug Abuse**

1 West Wilson Street, P.O. Box 7851  
Madison, Wisconsin 53707-7851

**SCAODA Executive Committee Meeting**

**February 16, 2012**

**10:30 am – 11:30 pm**

**Conference Call  
Call In Information**

**Phone Number: (877) 810-9415**

**Access Code: 7998653**

**AGENDA**

- **Roll Call**
- **Introduction of Issue**

**Representative Peggy Krusick has inquired if SCAODA supports LRB–2144/2 (see Bill attached to December 9, 2011 SCAODA Meeting Packet found at: <http://scaoda.state.wi.us/docs/meetings/120911Binder3.pdf>. (page 87).**

**On December 9, 2011, SCAODA minutes reflect the following:**

**Joyce O'Donnell made the following motion:**

**The Planning and Funding Committee recommends to Representatives Krusick and Ott a modification in the proposed legislation known as the Drunk Driver Reform Bill LRB 2144 in paragraph number 7 which recommends \$10 million of funding for this legislation be taken from current beer, wine, and liquor tax revenues. It is highly unlikely that any current revenue source will be allocated for this worthy legislation. The Planning and Funding Committee recommends that an alternate source of funding be created through an increase in Wisconsin's beer tax on a barrel of beer. SCAODA is on record supporting legislation which would raise the beer tax from \$2 to \$10 a barrel. Based on current Wisconsin's alcohol consumption patterns, an \$8 per barrel increase would raise an additional \$50 Million Dollars in annual revenue. Additionally, the SCAODA IDP Funding report approved by SCAODA in September 2011 also supports such a tax increase to fund treatment services for indigent Wisconsin citizens convicted of intoxicated driving for whom treatment is recommended.**

Joyce O'Donnell recognized that in order to increase funding for prevention and treatment services an increase on the alcohol tax is necessary. This is an opportunity for us to increase tax funding for additional needs for treatment dollars. **Duncan Shroul seconded the motion.**

Discussion included the point from Kevin Moore that it extremely unlikely that the legislature would ever increase taxes. Duncan Shroul then made a motion to support LRB 2144 and instead of asking for increased taxes to support additional funding, ask legislators to consider other sources of funding. **The motion to change the motion to support LRB 2144 by removing increasing alcohol taxes to fund the bill and asking instead that the legislature consider other sources of funding passed with three abstaining, Tina Virgil, Kevin Moore, and Douglas Englebert. Duncan Shroul then made a motion that SCAODA support LRB 2144 and ask the legislature to consider other sources of funding for the bill. Joyce O'Donnell seconded the motion. The motion passed unanimously.**

- **Consideration of Motion to Support Drunk Driver Reform Bill as Written.**
- **Adjourn**



State of Wisconsin

**State Council on Alcohol and Other Drug Abuse**

1 West Wilson Street, P.O. Box 7851  
Madison, Wisconsin 53707-7851

**MINUTES**

**SCAODA Executive Committee Meeting**

**February 16, 2012**

**10:30 am – 11:30 pm**

**Conference Call**

- **Roll Call**

Chairperson Waupoose called the meeting to order and a roll call was taken.

The following members participated on the conference call: Michael Waupoose (Chairperson), Duncan Shrout (Vice-Chairperson), Scott Stokes (Secretary), Joyce O'Donnell (Chairperson, Planning and Funding Committee) and Louis Oppor (Staff).

- **Introduction of Issue**

Chairperson Waupoose stated he called this Executive Committee meeting together to address a request from Representative Peggy Krusick who has inquired about SCAODA's sponsorship of the Drunk Driver Reform Bill LRB 2144.

Louis Oppor provided the following background information:

Representative Peggy Krusick has inquired if SCAODA supports LRB-2144/2 (see Bill attached to December 9, 2011 SCAODA Meeting Packet found at: <http://scaoda.state.wi.us/docs/meetings/120911Binder3.pdf>. (Page 87).

On December 9, 2011, SCAODA minutes reflect the following:

Joyce O'Donnell made the following motion:

**The Planning and Funding Committee recommends to Representatives Krusick and Ott a modification in the proposed legislation known as the Drunk Driver Reform Bill LRB 2144 in paragraph number 7 which recommends \$10 million of funding for this legislation be taken from current beer, wine, and liquor tax revenues. It is highly unlikely that any current revenue source will be allocated for this worthy legislation. The Planning and Funding Committee recommends that an alternate source of funding**

**be created through an increase in Wisconsin's beer tax on a barrel of beer. SCAODA is on record supporting legislation which would raise the beer tax from \$2 to \$10 a barrel. Based on current Wisconsin's alcohol consumption patterns, an \$8 per barrel increase would raise an additional \$50 Million Dollars in annual revenue. Additionally, the SCAODA IDP Funding report approved by SCAODA in September 2011 also supports such a tax increase to fund treatment services for indigent Wisconsin citizens convicted of intoxicated driving for whom treatment is recommended.**

Joyce O'Donnell recognized that in order to increase funding for prevention and treatment services an increase on the alcohol tax is necessary. This is an opportunity for us to increase tax funding for additional needs for treatment dollars. Duncan Shroud seconded the motion.

Discussion included the point from Kevin Moore that it is extremely unlikely that the legislature would ever increase taxes. Duncan Shroud then made a motion to support LRB 2144 and instead of asking for increased taxes to support additional funding, ask legislators to consider other sources of funding. **The motion to change the motion to support LRB 2144 by removing increasing alcohol taxes to fund the bill and asking instead that the legislature consider other sources of funding passed with three abstaining, Tina Virgil, Kevin Moore, and Douglas Englebert. Duncan Shroud then made a motion that SCAODA support LRB 2144 and ask the legislature to consider other sources of funding for the bill. Joyce O'Donnell seconded the motion. The motion passed unanimously.**

From review of the Draft Minutes, it was unclear if SCAODA was in support of Representative Krusick's Bill or only approved the Bill if alternative sources of funding were sought.

**Duncan Shroud moved that a letter be sent to Representative Krusick and Ott indicating that SCAODA is in support of LRB 2144 and should be listed as a sponsor of the Bill. Motion was Seconded by Scott Stokes**

Discussion: Members wanted to make it clear that there was general agreement that the original action taken at the December 9, 2011 meeting was to support LRB 2144. A separate motion was made by Duncan Shroud requesting that the Legislature seek alternative funding. This was not to say that SCAODA would withdraw their support if alternative funding was not found. It was the intent that the Legislature seek additional funding for substance abuse prevention and treatment services through alternative funding sources. It was not the intent to oppose LRB 2144.

As Chairperson of the Planning and Funding Committee, Joyce O'Donnell indicated it was the intent of the Planning and Funding Committee to support LRB 2144. Ms. O'Donnell also stated she has discussed this with Representative Krusick and that Representative Krusick understands the need for additional funding for substance abuse prevention and treatment services.

**The motion passed unanimously among Executive Committee Members.**

State staff was directed to draft two letters to both Representative Krusick and Representative Ott. The first letter was to indicate that the Executive Committee met on February 16, 2012 and voted to support LRB 2144 as written. A second letter should also be drafted to both Legislators indicating support of LRB 2144 but also requesting that consideration be given to seek alternative funding for support of alcohol and other drug abuse prevention and treatment services.

- **Adjourn**

**At 10:50, a motion was made by Duncan Shroul to adjourn. Motion was seconded by Scott Stokes. The motion passed unanimously.**



State of Wisconsin

**State Council on Alcohol and Other Drug Abuse**

1 West Wilson Street, P.O. Box 7851  
Madison, Wisconsin 53707-7851

**STATE COUNCIL ON ALCOHOL & OTHER DRUG ABUSE**

Planning and Funding Committee Meeting Minutes

Friday November 18, 2011 9:30 A.M. – 2:30 P.M.

ARC CENTER FOR WOMEN & CHILDREN

1409 EMIL STREET, MADISON

608 283-6426

**MEMBERS PRESENT:** Joyce O'Donnell, Duncan Shrout, Tom Fuchs, Sally Tess, Norman Briggs and Todd Campbell,

**EXCUSED:** Karen Kinsey, Ken Wagner, Manny Scarbrough and Bill McCulley.

**STAFF:** Lori Ludwig

I. Call to Order – Joyce O'Donnell:

Joyce O'Donnell called the meeting to order at 9:30 A.M.

II. Review /Approval of October 21, 2011 Committee Minutes—Joyce O'Donnell

**Sally Tess made a motion to approve the minutes of October 21, 2011. Duncan Shrout seconded the motion. The motion passed unanimously.**

III. Planning and Funding Meeting Dates for 2012

The following dates were chosen for meeting dates in 2012:

- January 20<sup>th</sup>
- February 17<sup>th</sup>
- April 20<sup>th</sup>
- May 18<sup>th</sup>
- July 20<sup>th</sup>
- August 17<sup>th</sup>
- October 19<sup>th</sup>
- November 16<sup>th</sup>

IV. SCAODA Appointments—Joyce O'Donnell

Joyce O'Donnell announced that the following persons have been appointed or reappointed to SCAODA as citizen members: Duncan Shrout, Sandy Hardie, and Norman Briggs. Joyce

O'Donnell informed that group that letters have been sent out to those candidates who were not appointed, suggesting that they join one of SCAODA's Committees.

#### V. Public Forum at the Bureau Conference—Joyce O'Donnell

Lori Ludwig reported that the main theme from the persons attending the Public Forum at the Bureau Conference was a lack of AOD treatment and supportive services, eg., residential treatment, housing, out-patient treatment and recovery services. Todd Campbell pointed out that the lack of AODA services for Tribal members was also raised as a severe need among native people living on the reservations. There was a resulting discussion among P & F members about how to best respond to these needs. The following motion was made by Duncan Shrout: **Whereas SCAODA's purpose is to inform Wisconsin citizens on AODA policy and issues, and whereas providers and funders struggle to provide adequate and sufficient AOD services, and whereas the direction of national health care reform is ambiguous, the Planning and Funding Committee motions that the Chair of SCAODA appoint an ad hoc committee to address the growing number of Wisconsin citizens and tribal members seeking and not able to access AOD treatment in Wisconsin. The Planning and Funding Committee recommends this ad hoc committee prepare a preliminary report by March, 2012 and a complete report by June 2012. Tom Fuchs seconded the motion. The motion passed unanimously.**

#### VI. Drunk Driving Reform Bill—Joyce O'Donnell

A summary of a Drunk Driving Reform bill (not yet introduced or assigned a number) from the office of Representative Peggy Krusick and in collaboration with Representative Jim Ott, was distributed. Ms. O'Donnell explained that this would be an opportunity for the Planning and Funding Committee to have input into the bill. Tom Fuchs indicated that he objected to the bill's provision that a new fund would be established and allocated to District attorneys, public defenders, circuit courts and counties to pay the costs for prosecuting first-offense OWI cases and to the DHS Intoxicated Driver Program for first time OWI offenders. He felt there needs to be a mechanism to fund significant treatment for people assessed by an AOD counselor. Sally Tess expressed the concern about the bill's provision that "Jail means jail," that is, the summary indicated that for OWI offenses that carry a mandatory minimum sentence, offenders would be required to serve at least that mandatory minimum in jail. She reported that the Department of Corrections already sees people on supervision for their first, second or third DUI. **Duncan Shrout made the following motion: The Planning and Funding Committee recommends to Representatives Krusick and Ott a modification in the proposed legislation known as the Drunk Driver Reform Bill LRB 2144 in paragraph number 7 which recommends \$10 million of funding for this legislation be taken from current beer, wine, and liquor tax revenues. It is highly unlikely that any current revenue source will be allocated for this worthy legislation. The Planning and Funding Committee recommends that an alternate source of funding be created through an increase in Wisconsin's beer tax on a barrel of beer. SCAODA is on record supporting legislation which would raise the beer tax from \$2 to \$10 a barrel. Based on current Wisconsin's alcohol consumption patterns, an \$8 per barrel increase would raise an additional \$50 million dollars in annual revenue. Additionally, the SCAODA IDP Funding report approved by SCAODA in September 2011**

**also supports such a tax increase to fund treatment services for indigent Wisconsin citizens convicted of intoxicated driving for whom treatment is recommended. Tom Fuchs seconded the motion and the motion passed unanimously.**

#### VII. Follow-up on Legislative Motions—Joyce O’Donnell and Lori Ludwig

Lori Ludwig and Ms. O’Donnell updated the group on the status of several bills that were of interest to the Planning and Funding Committee as follows:

- AB 63 (Companion SB44)—Meeting of Executive Committee. These bills extend the period of time retailers may sell alcoholic beverages (from 6:00 a.m. instead of from 8:00 a.m.). Motion to send letter of opposition to the bills to the Governor, asking for his veto, passed unanimously. Letter sent 10-31-11. Ms O’Donnell reported that that Assembly passed the bill on a voice vote.
- AB 200 (Companion SB 155)—This bill authorizes a winery to make retail sales and provide taste samples of wine on fairgrounds, under the “Class B” license issued to the fair association, if the wine is purchased from a wholesaler. SCAODA passed motion to oppose on 9-9-11. Letter sent 10-8-11. As of 11-10-11 bill passed Assembly, is still in Committee in the Senate.
- AB 208 (Companion bill SB 154)—This bill removes upper limits for fines and prison sentences for OWI offenders. SCAODA passed motion to support with caveat 9-9-11. Letter sent 10-8-11. Still in Committee in both houses.
- SB 159—This bill prohibits an underage person from being on school premises with any detectable alcohol concentration in his or her blood or breath, regardless of whether the underage person is accompanied by his or her parent, guardian, or spouse who has attained drinking age. SCAODA passed motion to support 9-9-11. Prevention Committee to send letter. Passed in Senate 10-25-11.
- AB 286 (Companion Bill SB 207). This bill specifies that it is not employment discrimination because of conviction record for an employer to refuse to employ or to bar or terminate from employment an individual who has been convicted of a felony and who has not been pardoned for that felony, whether or not the circumstances of the felony substantially relate to the circumstances of the particular job. This bill has passed out of Committee in the Senate; it is still in Committee in the Assembly. P & Funding passed a motion to oppose on 10-21-11. Motion Introduction Form for SCAODA meeting on December 9, 2011.

#### VIII. Workforce Issues/Scopes of Practice—Sue Gadacz

Sue Gadacz, Substance Abuse Section Chief, reported via telephone per the request of the Planning and Funding Committee regarding pending workforce issues resulting from the “Scopes of Practice” anticipated substance abuse counselor requirements and issues related to the Minority Counselor Training Institute (MCTI). Points that she made included:

- MCTI was not preparing students to draw down on Medicaid as it was.
- The need is to align counselor requirements with Medicaid reimbursement.
- Two-phase survey is underway to ascertain what the education institutions are doing in this regard and educational qualifications of current workforce.

- DHS Secretary Smith has requested from Department of Safety and Professional Services (formerly Department of Regulation and Licensing) Secretary Ross a list of current certified substance abuse counselors and clinical substance abuse counselors' addresses for the purpose of surveying demographic and educational qualifications information from them.
- There will be an additional \$100,000 added to the minority training effort resulting from an early 2012 competitive grant for a total of \$383,000.
- The Bureau will analyze the results and identify areas in the state to concentrate efforts to develop the workforce.
- Regarding existing counselors, the survey analysis should determine the impact of the alignment of certification requirements and Medicaid reimbursement. As discussed internally so far, if a counselor has a rendering ID, they will still be reimbursed but at a lower rate if they are without a bachelors degree.

Mr. Tom Fuchs registered his concern for 15 year veterans who under the rule would be drawing down less than BA's. These veterans are CSACs and supervisors. There will be a huge impact on every single provider. Mr. Duncan ShROUT asked about people of color. Will this have a chilling aspect to them? He felt that the Planning and Funding Committee should make some recommendations about grand-fathering. **Duncan ShROUT made the following motion: Planning and Funding opposes a multiple-tier reimbursement system based solely on educational status and recommends a grand fathering option where anyone with less than a Bachelor's degree, but a licensed counselor be given a period of time (10 years or until 2024) to complete their BA degree. Planning and Funding would ask that other SCAODA Committees weigh in on this proposal. Tom Fuchs seconded the motion. The motion passed unanimously.**

#### IX. Committee Reports—Group

Joyce O'Donnell brought the group's attention to the Milwaukee Journal Sentinel article, "Cuts to Medicaid Hurts the Poor." Duncan ShROUT commented that he is unhappy with the disenfranchisement of a large segment of people from health care. He expressed concern about this. People who need substance abuse and mental health care are no longer eligible for services. Ms. O'Donnell plans to express that this is a real concern. Mr. ShROUT felt that this is a matter of significant concern for the Council. He felt that an effective strategy would be to modestly increase taxes on citizens of Wisconsin. This would be a worthy gesture to help people in these circumstances. Ms. O'Donnell pointed out that the cuts are affecting the elderly and children, too.

Ms. O'Donnell also reported that she attended a Trauma Training conference featuring Dr. Stephanie Covington. She indicated that it was a good conference and that there were several different definitions of evidence based programs/practices.

Lori Ludwig updated the group on plans to coordinate SCAODA and the Mental Health Councils' input and oversight of the 2013 Combined Mental Health and Substance Abuse Block Grant needs assessment and applications. The Executive Committees from the two Councils will initially meet following the December 9, 2011 SCAODA meeting.

Mr. Shroul expressed discouragement about a bill to provide health care for life for police and fire fighters and their families who were injured in the line of duty and can't work which did not pass. This would effect about 10-15 families per year.

X. Agenda for Next Meeting—Joyce O'Donnell

Items suggested for the next meeting included the future of health care financing, the Scopes of Practice, new legislation and collaborating with the Mental Health Council. Lori Ludwig agreed to send out a reminder about a week prior to the meeting, asking for agenda items.

XI. Adjourn—Joyce O'Donnell

The meeting was adjourned at 2:30 p.m. The next meeting is listed below:

PLANNING AND FUNDING COMMITTEE MEETING  
January 20, 2012  
9:30 A.M. – 2:30 P.M.  
ARC CENTER FOR WOMEN & CHILDREN  
1409 EMIL STREET  
MADISON, WI  
608/283-6426

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## SCAODA Motion Introduction

<p>Committee Introducing Motion: Planning and Funding</p>
<p>Motion: That the Council affirm the value of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) project and agree to a closer examination of its implementation. The Committee requests that this be done in consort with the Intervention and Treatment Committee, and within this year 2012 that three members of each Committee meet with Scott Caldwell, Rich Brown, and/or Paul Moberg to develop recommendations to improve SBIRT outcomes and to locate sources of funding for sustainability of the project. Tom Fuchs, Pamela Bean, and Duncan Shroul will represent Planning and Funding on this project.</p>
<p>Related SCAODA Goal: Goal #4 - Wisconsin will have adequate, sustainable infrastructure and fiscal, systems, and human resources and capacity:</p> <ol style="list-style-type: none"><li>For effective prevention efforts across multiple target groups including the disproportionately affected.</li><li>For effective outreach, and effective, accessible treatment and recovery services for all in need.</li></ol>
<p>Background: SBIRT is a part of the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) and has been implemented in thirty-one healthcare clinics throughout the state. The model identifies people with risky or unhealthy use of substances; when delivered properly, each and every client with a positive screen would be referred to treatment or a brief intervention as needed. After five years of implementation in Wisconsin, 117,580 people have been screened, with 26,336 brief interventions and 410 referrals to treatment (or 1.5%, 0.2% above the national average of 1.3%). The Committee recognizes the positive impact of this project, and would like to explore expansion into other effective settings and investigate resources available to ensure continued sustainability.</p> <ul style="list-style-type: none"><li>Positive impact: Expand SBIRT project to additional settings, increase sustainability, and improve outcomes.</li><li>Potential Opposition: SBIRT outcomes not focused on referral to treatment, rather as a screening tool. Difficulty creating buy-in with primary care. Difficulty locating funding sources for health educators.</li></ul>
<p>Rationale for Supporting Motion: AODA is the fourth-leading cause of death in Wisconsin. A meta-analysis of all alcohol treatment shows that brief interventions are very effective. SBIRT provides a cost-effective bridge to treatment. However, efforts to expand the SBIRT program to the other settings and create sustainability are imperative to its continued success.</p>

## SCAODA Motion Introduction

Committee Introducing Motion: Planning and Funding
Motion: Oppose Assembly Bill 464/Senate Bill 358
Related SCAODA Goal: Goal #5 - SCAODA with its committees provide leadership to the Governor and Legislature and other public policy leaders to create equity by remedying historical, racial / ethnic and other systems bias in AODA systems, policies and practices that generate disparities and inequities toward any group of people.
<p>Background: Under current law an under-aged person may not: enter/attempt to enter, falsely represent his/her age, and procure/attempt to procure, or possess/consume alcohol on licensed premises unless accompanied by a parent, guardian, or spouse who has attained the legal drinking age. A person who commits an underage violation is subject to various penalties, including a forfeiture ranging in amount from \$250 to \$1,000. This bill provides alcohol beverages licensees with a private right of action against persons who engage in conduct that constitutes an underage violation. Under the bill, a licensee may bring a civil action against such an underage person and, if judgment is entered in favor of the licensee, the court must award to the licensee damages in the amount of \$1,000, plus costs and reasonable attorney fees. However, if the underage person is less than 18 years of age and not emancipated, the licensee brings the action against the parent or legal guardian of the underage person instead. The licensee has the burden of proving that the underage person's conduct constituted an underage violation, but the action may be brought regardless of whether the underage person received a citation for, or was convicted of, the violation.</p> <ul style="list-style-type: none"><li>• Positive impact: Opposition of the bill challenges the right of taverns to profit from the provision of alcohol to underage persons. It also protects children, from being penalized once with a citation and forfeiture, and a second time with a civil lawsuit and damages.</li><li>• Potential Opposition: This bill could be interpreted as a further deterrent to underage drinking through stiffer penalties.</li></ul>
Rationale for Supporting Motion: AB 464 is self-serving to the tavern league, allowing taverns to profit from provision of alcohol to underage persons. It also places children attempting to/purchasing alcohol in double jeopardy.

## SCAODA Motion Introduction

Committee Introducing Motion: Planning and Funding
Motion: Oppose Assembly Bill 547
Related SCAODA Goal: Goal #4 - Wisconsin will have adequate, sustainable infrastructure and fiscal, systems, and human resources and capacity: b. For effective outreach, and effective, accessible treatment and recovery services for all in need.
Background: Current law prohibits an individual licensed as a marriage and family therapist, social worker, or professional counselor by the Marriage and Family Therapy, Professional Counseling, and Social Work Examining Board from using the titles "alcohol and drug counselor" or "chemical dependency counselor" unless the individual is also certified through a separate certification process established by DSPS. This bill eliminates that prohibition. <ul style="list-style-type: none"><li>• Positive impact: Opposition of this bill would keep intact existing regulations and oversight of Substance Abuse Counseling training requirements for MSW's and prevent providers who are inadequately trained to attempt to provide specialized treatment that may be ineffective and of poor quality.</li><li>• Potential Opposition: Passage of this bill would increase availability of the Substance Abuse Counselor workforce.</li></ul>
Rationale for Supporting Motion: The State has an ethical responsibility to its citizens to provide oversight of Substance Abuse Counselor Licensure in order to protect the residents of Wisconsin by ensuring compliance with education and training requirements necessary to provide the most safe and effective treatment and recovery services for all in need.

## SCAODA Motion Introduction

Committee Introducing Motion: Planning and Funding
Motion: That the Executive Committee create a strategy that involves SCAODA's development of an approach to increase representation of Legislators on SCAODA
Related SCAODA Goal: Goal #1 SCAODA with its committees: a. Effectively fulfill the statutory dictate to provide leadership and direction on AODA issues in Wisconsin b. Is a highly recognized and respected body that serves as the voice to whom the Governor, legislators, local coalitions, and media turn for guidance on AODA issues c. Develop and exhibit broad collaborative leadership and aligned action across multiple sectors to advance progress on SCAODA goals.
Background: Statutorily, the Governor (or designee) and four additional members of the Legislature are required to sit on SCAODA; however, in recent years membership has waned. Currently, the Governor's designee and one Legislator are actively involved with the Council. The Council has recently sent letters to the Legislature requesting additional participation of its members. <ul style="list-style-type: none"><li>• Positive impact: Will enable SCAODA to more effectively provide advisory leadership to the Legislature and the Governor on AODA issues</li><li>• Potential Opposition: None known</li></ul>
Rationale for Supporting Motion: The Planning and Funding Committee recognizes the importance of the active involvement of the Legislature in the leadership and advisory role of the Council. It is critical to the mission of the Council that they recruit and retain the participation of Legislative members.



State of Wisconsin

**State Council on Alcohol and Other Drug Abuse**

1 West Wilson Street, P.O. Box 7851  
Madison, Wisconsin 53707-7851

**Prevention Committee Meeting**

**October 20, 2011**

**9:30 a.m. – 1:30 p.m.**

**Wisconsin State Patrol Deforest Post**

**911 W. North Street**

**Deforest, WI 53532**

**Members Present:** Scott Stokes, Rick Peterson, Chris Wardlow, Emanuel Scarborough, Carol Wright, Ken Wagner, Francie McGuire Winkler, Julia Sherman, Judie Hermann, Lee Wipfli, Nancy Kendall.

**Others Present:** Louis Oppor, Arlene Baker, Christy Niemuth

**Call to Order, Welcome/Introduction & Approval of Minutes**

The meeting was called to order at 9:34 a.m. Scott Stokes (Chairman) welcomed those in attendance and asked members and guests to introduce themselves. Minutes from the 8/23/2011 Prevention Committee Meeting were reviewed. McGuire-Winkler moved to approve the minutes, seconded by Peterson. Minutes were approved with edits.

**State Council on Alcohol and Other Drug Abuse Meeting Update**

SCAODA met in September and elected new officers: Michael Waupoose -Chair, Duncan Shrout- Vice Chair, Scot Stokes -Treasurer. Update on Motions: Planning and Funding, ITC and Prevention Committees had similar motions to write a letter to Secretary Dennis Smith to reconsider seeking federal funding. Kevin Moore, Executive Assistant to Secretary Smith, attended the SCAODA meeting and committed to work with SCAODA on future opportunities. The motion was withdrawn by the Committees. The Prevention Committee members discussed this issue and decided not to forward another motion at this time.

There was an agreement that SCAODA would write a letter to Kevin Moore and Secretary Smith thanking them for their cooperation and willingness to work with SCAODA in the future. The "Thank You" letter would include some education on prevention and treatment. Scott Stokes agreed to discuss this with other Chairs and work on a draft of the letter.

**Legislative Summary**

SCAODA has sent letters in support or opposition regarding the bills that have been reviewed by the Prevention Committee and other Committees.

Assembly Bill 290 was reviewed. Under this bill, a person is not required to hold a license or permit to manufacture wine or beer at a business primarily engaged in selling supplies and equipment for use by home brewers or home winemakers, or to taste the wine or beer at this business, if the wine or beer is not sold or offered for sale. A person is also not required to hold a license or permit to manufacture wine or beer for educational purposes, or to taste the wine or beer at the place of manufacture, if the wine or beer is not sold or offered for sale. A person who manufactures wine or beer under these circumstances is also not required to pay an occupational tax. The bill also specifies that a person who manufactures wine or beer at his or her home, farm, or place of residence for consumption by the person or his or her family and guests, and who receives no compensation, is not required to pay an occupational tax on the wine or beer regardless of where it is consumed. No action was taken by the Prevention Committee.

Assembly Bill 63 was also reviewed. This bill changes the morning closing hours for Class “A” and “Class A” retailers from 8:00 a.m. to 6:00 a.m., so that a Class “A” retailer may sell beer from 6:00 a.m. until midnight unless the municipality in which it is located establishes more restrictive closing hours, and a “Class A” retailer may sell intoxicating liquor from 6:00 a.m. until 9:00 p.m. Julia Sherman reported that the Grocers Association was in support of this Bill. Ms. Sherman also stated that individual communities could retain current local hours through city ordinance. The Prevention Committee took no action on this Bill.

Senate Bill 159 was also reviewed. Under current law, a person who has not attained the legal drinking age of 21 years (underage person), and who is not accompanied by his or her parent, guardian, or spouse who has attained the legal drinking age, may not knowingly possess or consume alcohol beverages. An underage person who violates this prohibition is subject to various possible penalties depending on the circumstances, including a minimum forfeiture of \$100 and a maximum forfeiture of \$1,000.

Current law also prohibits a person of any age from possessing or consuming alcohol beverages on premises owned, rented, or under the control of a public, parochial, private, or tribal elementary school, middle school, or high school (school premises), unless written permission is obtained from the school administrator and this permission is consistent with applicable laws, ordinances, and school board policies. A person who violates this prohibition is subject to a forfeiture of not more than \$200, except that an underage person who possesses or consumes alcohol beverages on school premises is subject to the penalties identified above.

The Prevention Committee would like to offer an alternative to expulsion/suspension to schools that provides in school assessments for those children. This bill would put underage offenders through the municipal court system, so an opportunity for assessment may exist. Sherman reported that the bill would go to the spring Assembly if it passes the Senate this fall.

*Sherman made a motion to ask SCAODA to send a letter to the legislature in support of Senate Bill 159 and it was seconded by McGuire-Winkler. Motion passed.*

### **SPF SIG Updates**

With the state SPF SIG is in its final year, a no-cost extension was awarded for the grant, ending Sept. 29, 2012. FFY 2012 grant money will be used for close-out, evaluation and sustainability activities and may also be used to continue strategies as funding permits. SAMHSA had wanted

to use prevention dollars for a behavioral health model. The U.S. Senate has said they will not support this; they do not want substance abuse prevention dollars to be spent on strategies that are not primary substance abuse prevention services. The Senate also maintained the SAPTBG at last year's funding level.

### **Epidemiological Profile**

The prevention Committee serves as the advisory committee for the SPF SIG grant. Every two years the state Epidemiological Workgroup has produced a state Epidemiological Profile which will be published again in July of 2012. The Epidemiological Workgroup began meeting to discuss additions to the report. In the past, there was no risk factors section. The five primary individual risk factors for substance abuse in SAMHSA's behavioral health model include: childhood victimization, anxiety disorders, PTSD, depression, and parental substance abuse. Oppor provided a handout on these risk factors. The subcommittee discussed whether to include data on these risk factors in the epidemiological profile for 2012. Some points of discussion were:

- How useful would this data be locally?
- Is there research that shows one or two of the risk factors correlate more than others with youth substance use?
- Parental substance use stands out as highly related to youth use.
- Are there different risk factors for different races/ethnicities?
- How could the report incorporate one or two individual risk factors by race/ethnicity?
- Which risk factors have more readily accessible data?
- How to present the data so that it is as actionable as possible.

Oppor introduced data from the Department of Revenue on alcohol outlet density as a community risk factor. Research shows a high correlation between alcohol motor vehicle injuries and death and alcohol outlet density. The subcommittee agreed that the data on alcohol outlet density at a county level should be included in the next epidemiological report, with a footnote reminder that licenses are issued by the municipality and not the county.

Discussion included:

- Concern for counties where density is clustered into extremely high concentration areas.
- How to identify "tourist" areas.
- Provide focus on the larger issue of the national average (1,500 people per license) vs. Wisconsin where the "best" county has 605 people per license.
- Epidemiological workgroup should look into municipalities or counties nationally that are similar in economics, population and tourism to compare outlet densities.
- Geo mapping would be interesting.

### **Tribal Update**

GLITC has completed their five-year SPF SIG grant, but will use unspent money through a no-cost extension until May 31, 2012 for evaluation. They also have money left to provide three sites a mini grant through a competitive process for strictly environmental strategy work. They are in the process of getting these approved with SAMHSA. GLITC also received a Strategic Prevention Enhancement (SPE) Grant. The grant may prove challenging in the tribal structure as it was developed for states entities. Oppor and Sherman will be members of the GLITC policy consortium, holding its first meeting in November. Part of the grant will look at coordination of

services incorporating more behavioral health promotion. GLITC received a community transformation planning grant through a competitive process. The first year of this grant, will support 10 communities.

### **SAPT BG Update**

This year, the SAPT BG application became a three-year application and has been completed and approved by the secretary of DHS. Currently, a distribution of SAPTBG dollars throughout the state will continue as in the past. However, by 2014 the Affordable Healthcare Act will likely have an impact on reductions in treatment funding from the SAPTBG, at which point statutory changes will be needed in order to change how the prevention dollars are allocated to counties and tribes. Note: In the future, SAMHSA continues to move toward combining the mental health and substance abuse applications together.

### **Good Samaritan Law**

The work of the Controlled Substances Workgroup has concluded. Stokes wants to form an Ad-Hoc Committee to research and make recommendations to SCAODA members regarding the appropriateness of the 911 Good Samaritan law. Prevention Committee members were asked to contact Scott Stokes if they had interest in being a part of that Ad-Hoc committee.

### **Report on Life of an Athlete Program**

Short was not able to attend. Report reserved for another meeting.

### **Departmental/Agency/Member Updates**

**DPI:** AODA grants will be reviewed and awarded in the near future. There is \$700,000 available and 90 districts are allowed to apply.

**DCF:** Home visitation funds are available to the state. Needs assessment must be conducted. Eighteen at-risk communities have been identified and will be able to apply for funding. Five counties are presently receiving funding. DCF has applied and received a \$3.2 million, five year grant to fund home visiting through GLITC and other counties. Hermann will keep the committee updated on the evaluation of these grants.

**WCH:** WCH was 1 of 24 states that received a Community Transformation Implementation Grant. The first year, the grant is \$ 4.7 mil, with hopes of the same in the following four years. The funding is for working on chronic disease issues, such as tobacco, obesity, high blood pressure, cholesterol levels etc. The focus is on rural areas since Milwaukee County applied separately for their own grant.

**Others:** Waukesha is offering RBS training on November 10, 2011 for servers that have received a citation. By attending the training, the citation will be dropped. Waukesha will participate in the prescription drug mail back program. In the City of Racine, a social host ordinance is close to passing along with the Racine's Public Safety and Licensing Committee to close nuisance bars. The coalition has bought prescription drug drop boxes for several communities.

### **Adjourn**

Stokes adjourned the meeting at 12:35 p.m.

Next meeting date: December 15, 2011 at the Deforest State patrol Headquarters.

## SCAODA Motion Introduction

Committee Introducing: Prevention Committee
Motion: Motion to oppose Assembly Bill 464 and companion Senate Bill 358.
Related SCAODA Goal: Wisconsin cultural norms change to people vehemently rejecting social acceptance of the AODA status quo and demand and support methods to transform the state's AODA problems into healthy behavioral outcomes.
Background: This bill provides alcohol beverages licensees with a private right of action against persons who engage in conduct that constitutes an underage violation. Under the bill, a licensee may bring a civil action against such an underage person and, if judgment is entered in favor of the licensee, the court must award to the licensee damages in the amount of \$1,000, plus costs and reasonable attorney fees. However, if the underage person is less than 18 years of age and not emancipated, the licensee brings the action against the parent or legal guardian of the underage person instead. The licensee has the burden of proving that the underage person's conduct constituted an underage violation, but the action may be brought regardless of whether the underage person received a citation for, or was convicted of, the violation.
Rational for Opposing: <ul style="list-style-type: none"><li>• AB 464 (and SB 358) will end alcohol age compliance checks in Wisconsin: The proposal does not create any exception for youth operating under police supervision. Any youth that attempts to purchase alcohol is subject to a civil action, regardless of police supervision or support. In other words, this bill allows a bar or retailer to sue an underage youth decoy in small claims court for participating in an alcohol age compliance check operation.</li><li>• There is no right to an alcohol license in Wisconsin. Retailers have a responsibility to train and supervise staff to take steps to effectively enforce the minimum legal drinking age laws. This bill reverses responsibility and allows retailers to recover TWICE (\$1,000) the cost of a state citation for serving an underage drinker (\$500) 125.07(1)(b)(a).</li><li>• Under this proposal, a bar or store owner can operate without regard to customer or community safety and simply use the underage customers he has admitted and served as an ATM creating his financial safety net.</li></ul>

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2011 - 2012 LEGISLATURE  
**2011 ASSEMBLY BILL 464**

January 9, 2012 - Introduced by Representatives JACQUE, BIES, KLEEFISCH, A. OTT, PRIDEMORE, SPANBAUER and WYNN, cosponsored by Senators GALLOWAY, KEDZIE and HOLPERIN. Referred to Committee on Judiciary and Ethics.

**AN ACT** *to create* 125.07 (4) (f) of the statutes; **relating to:** alcohol beverages violations by underage persons on licensed premises.

***Analysis by the Legislative Reference Bureau***

Under current law, with limited exceptions, a person who has not attained the legal drinking age of 21 years may not: 1) procure or attempt to procure alcohol beverages from an alcohol beverages licensee or permittee; 2) possess or consume alcohol beverages on premises for which an alcohol beverages license has been issued (licensed premises), unless accompanied by a parent, guardian, or spouse who has attained the legal drinking age; 3) enter, knowingly attempt to enter, or be on licensed premises unless authorized by statute to do so; or 4) falsely represent his or her age for the purpose of receiving alcohol beverages from an alcohol beverages licensee or permittee (underage violation). A person who commits an underage violation is subject to various penalties, including a forfeiture ranging in amount from \$250 to \$1,000 depending on the number of prior underage violations the person has committed.

This bill provides alcohol beverages licensees with a private right of action against persons who engage in conduct that constitutes an underage violation. Under the bill, a licensee may bring a civil action against such an underage person and, if judgment is entered in favor of the licensee, the court must award to the licensee damages in the amount of \$1,000, plus costs and reasonable attorney fees. However, if the underage person is less than 18 years of age and not emancipated, the licensee brings the action against the parent or legal guardian of the underage person instead. The licensee has the burden of proving that the underage person's conduct constituted an underage violation, but the action may be brought regardless of whether the underage person received a citation for, or was convicted of, the violation. Before a licensee may bring an action, the licensee must provide notice of its intent to bring an action and the notice must include a demand for the monetary relief that would be available if the action were brought.

***The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:***

**SECTION 1.** 125.07 (4) (f) of the statutes is created to read:

2 125.07 **(4)** (f) 1. Except as provided in subd. 2., and subject to subd. 3., if an 3underage person engages in conduct that violates par. (a) on the premises of a 4licensee, the licensee may bring a civil action against the underage person. If 5judgment is entered in favor of the licensee, the court shall award to the licensee 6damages in the amount of \$1,000 and, notwithstanding s. 814.04 (1), the costs of the 7action, including reasonable attorney fees. A licensee may bring an action under this 8paragraph regardless of whether the underage person has been convicted of, or 9received a citation for, the violation

of par. (a), but the licensee has the burden of 10proving, by a preponderance of the evidence, that the underage person's conduct was 11in violation of par. (a).

12 2. If the underage person who engages in conduct that violates par. (a) on the 13licensee's premises is less than 18 years of age and is not an emancipated minor, the 14licensee may bring the civil action against the underage person's parent, as defined 15in s. 46.56 (1) (j).

16 3. A licensee may not bring a civil action under this paragraph unless the 17licensee has first provided notice to the underage person or the underage person's 18parent, as applicable, of the licensee's intent to bring the action. The notice shall be 19mailed to the last-known address of the underage person or underage person's

1parent, as applicable, at least 15 days prior to filing the action and shall include a 2demand or the relief described in subd. 1. The department may, by rule, prescribe 3a form for this notice.

#### **4SECTION 2. Initial applicability.**

5 (1) This act first applies to violations of section 125.07 (4) (a) of the statutes 6committed on the effective date of this subsection.

7 **(END)**

### **2011 - 2012 LEGISLATURE ASSEMBLY AMENDMENT 1, TO 2011 ASSEMBLY BILL 464**

February 2, 2012 - Offered by Representative JACQUE.

1 At the locations indicated, amend the bill as follows:

2**1.** Page 2, line 1: before that line insert:

3" **SECTION 1c.** 125.07 (3) (a) 15. of the statutes is created to read:

4 125.07 **(3)** (a) 15. An underage person employed by or assisting a law 5enforcement agency in carrying out enforcement activities to determine compliance 6with, or investigate potential violations of, the provisions of this section.

7**SECTION 1g.** 125.07 (4) (bg) of the statutes is created to read:

8 125.07 **(4)** (bg) Paragraphs (a) and (b) do not apply to an underage person 9employed by or assisting a law enforcement agency in carrying out enforcement 10activities to determine compliance with, or investigate potential violations of, the 11provisions of this section."

12**2.** Page 2, line 1: delete " **SECTION 1**" and substitute "**SECTION 1m**".

### **2011 - 2012 LEGISLATURE ASSEMBLY AMENDMENT 2, TO 2011 ASSEMBLY BILL 464**

February 2, 2012 - Offered by Representative JACQUE.

1 At the locations indicated, amend the bill as follows:

2**1.** Page 2, line 2: delete "subd. 3." and substitute "subds. 3. and 4.".

3**2.** Page 3, line 3: after that line insert:

4"4. A licensee may not bring a civil action under this paragraph if the licensee 5has been convicted of, or received a citation for or been charged with, a violation of

6sub. (1) or (3) related to the same incident, occurrence, or conduct giving rise to the  
7underage person's violation of par. (a), unless the licensee is entitled to a defense 8under  
sub. (6). A licensee that asserts a defense under sub. (6) has the burden of 9proving the  
defense by a preponderance of the evidence.".

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Scott Walker  
Governor

Mark Seidl, WCHSA  
Chairperson

State of Wisconsin

**State Council on Alcohol and Other Drug Abuse**

1 West Wilson Street, P.O. Box 7851  
Madison, Wisconsin 53707-7851

Scott Stokes  
Secretary

**Diversity Committee Meeting  
Thursday July 7, 2011 (Approved)  
1PM-3:00PM  
DHS, 1 W. Wilson St., 950B  
Madison, WI 53703**

**Attendees:**

1. Michael Waupoose
2. Gail Kinney-Teleconference
3. Steve Dakai-Teleconference
4. Denise Johnson
5. Sandy Hardie-Teleconference
6. Interpreters X2

**Excused Absent:**

1. Angela Rivera
2. Jerry Kaye

**Unexcused Absent**

1. Angela McAlister

**State Staff:**

Gail M. Nahwahquaw

**Diversity Committee Meeting Minutes:**

I. Call to Order:

Meeting was called to order at 1:07PM. Members reviewed the May minutes. Minutes approved as written.

II. SCAODA Update:

Cultural Competency Presentation

Gail K. gave a phenomenally awesome Cultural and Linguistically Appropriate Services (CLAS) standards presentation. By observation the SCAODA members were receptive to the information though did not ask many questions. Gail K. wasn't sure how to read the audience they didn't seem to be as engaged by her experience. Gail K. this was a very different experience than teaching and guiding discussion with students. Michael-I think the presentation was delivered exceptionally well and I believe it caused the SCAODA members to think about CLAS by a different perspective because Gail K. was

the presenter. Members are familiar with cultural competency presentation being offered by people of color. Gail N.-Having Gail K. make the presentation and she using the example of applying “labels” to herself offered this information in a manner not often considered by most. I think it certainly caused the group to think about how this information applies to them.

#### Public Comment Discussion:

Mark S. offered some clarification on the Public Comment protocol for SCAODA meetings. During SCAODA meetings those choosing to offer public comment will need to sign-in. Each person signing –in will be allowed 5 minutes for comment. SCAODA council members are not allowed to engage, questioning or making comments with those offering public comment. Michael-The discussion during the 4 Chairs meeting that the Public Comment protocol changes are reactionary to the Public Comment given regarding the Intoxicated Drivers Program Subcommittee. Michael offered during the 4-Chairs meeting that if this was to be the protocol moving forward than the SCAODA needs to apply them consistently even when the comments are positive reflection on SCAODA. Denise-regarding the 5 minute rule, if a group like the IDP subcommittee come in, do all members get five minutes or is one person selected to represent the group? Michael-Anyone who chooses to offer public comment will need to sign-in first, those who sign-in will be allowed up to five minutes of time during the Public Comment period.

#### Annual Report:

Michael gave a committee annual report. Gail N. prepared a written report that she will get out to the Diversity Committee.

#### By-Laws:

There was some discussion about by-laws language changes. Gail N.-SCAODA was not able to vote on anything because there wasn’t a quorum. There was a teleconference meeting set for the following Tuesday to vote on the motions specifically, but quorum wasn’t reached in that meeting either. So the guidance (Bureau?) was to have action on motions go back to committees. Regarding the Diversity motion to reconvene the Substance Abuse Counselor Advisory committee, Gail N. prepared a letter to Department of Regulation and Licensing (DRL) Secretary Ross. A draft was sent to Michael who offered small edits there was also an internal review with edit suggestions. Gail N.-Will follow-up on the status of the letter and make sure it gets sent out under Michael’s signature. During Michael’s meeting with Sue G. she commented that there was action being taken by DRL to reconvene the Substance Abuse Counselor Advisory committee already. Gail K. has not received any information about a pending meeting.

Elections for SCAODA Officers will take place at the September meeting.

### III. Diversity Workplan

The committee needs to develop a workplan based on the 2010-2014 Strategic Plan goals. Gail K.-Goal 1, bullets 1 and 3 can be enhanced easily by hyper-linking resource sites like the Georgetown University; Cultural Competency site. This site offers abundant

resources; assessment tools, steps and directions on use of the tools, articles and much more. Make the cultural competency definition and CLAS standards more prominently posted on the SCAODA webpage and list the Diversity Committee as advocates for the information. Michael will set a meeting with Harold Gates to get his input. When Harold was an active Diversity committee member he always offered key resource information either by suggested readings or websites resources.

Bullet #2 Mechanism for making known agency's commitment to culturally competent services. Sandy-One way might be to send letters to treatment providers to inform them of this listing. We as the Diversity Committee will need to be clear about the list and expectations. "I have concern about how the Diversity Committee will manage this piece." Gail K. this can be a voluntary act. Who's to say an agency is culturally competent? Another suggestion is to have agencies share what's worked in the self-assessment process. Michael-An agency can list which assessment tool they used and share where they stand in the development of quality improvement. Also Diversity will need to clarify what Goal 1, bullet #2 looks like; listing of tools, process, expectations etc.

Goal #4, Michael-Is it beneficial to get an update from Angela about the Minority Counselor Training Institute (MCTI)? Gail N.-informed Diversity that WAAODA's MCTI was only funded thru the end of June 2011. As of right now MCTI does not have a contract with the Bureau. Angela has submitted a list of MCTI participants, advocating for a contract extension to help these participants to complete their training for substance abuse counselor certification, we are currently negotiating this request. Steven D.-Empathetic but Angela didn't offer much action around the concern from tribal communities to be more inclusive of their needs. Since there wasn't much follow-up on the concern its hard to be supportive. Sandy-What does the future hold for recruiting ethnically diverse into the field of substance abuse counseling? Michael-I'm concerned that an unintended result of this action will be that less people will have access to substance abuse counselor training. MCTI had curriculum in place and offered programming for counselor certification. Denise-Will WAAODA still be an agency? Yes, this just affects the MCTI program. WAAODA collects membership dues so should remain solvent based on that revenue. Steve D-I'm interested in knowing the racial demographics of the members requesting an extension to complete their training. Gail N.-A majority of the members listed are from Milwaukee, the southeast region or Madison. Michael- I'm not certain how the Diversity Committee works on this issue. Steve-Diversity will have a role in this issue, just uncertain about how. Michael-To date much of the effort in support of growing the substance abuse counselor field in ethnic minority communities has been by offering recommendations to Angela and the MCTI. Now that it's no longer contracted to provide this service how does Diversity proceed to affect change on this issue? Michael-I don't hear a clear goal about where "we're" (the state?) going with the future of training for minority counselors. Gail N. the funds directed toward the MCTI will remain targeted toward training for ethnic minority participants. Michael-What is the federal guidance around this directive, is there a specific set-aside for training needs of ethnic minorities? Gail N. I don't believe there is specific federal guidance on this issue, the state has prioritized this need for Wisconsin

and has allocated ~\$280,000 to the initiative. Sandy-It will be helpful to hear the states goal around this issue. Gail N.- Right now we in the bureau are in data gathering mode. Trying to get a better understanding of the training capacity from technical colleges and universities and learn from SACs and CSACs their highest education attained and interest in returning to school for bachelors degrees.

Michael-Invite Sue G. to the next Diversity Committee meeting to learn more about workforce goals. Gail N. will make the invitation. Continue to have “Workplan” as a standing agenda item. Areas for consideration for the workplan development will include; webpage design, resources list, agencies/programs listed as culturally competent and minority counselor’s training.

IV. Diversity Webpage:

Michael is asking committee members to review the SCAODA, Diversity Webpage and offer up suggestions for changes. This was covered in the Diversity workplan discussion as well. One suggestion is to get a counter on the page. The webmaster has access to the number of hits a page receives it’s just a matter of featuring the counter on the webpage directly.

V. Scope of Practice:

Michael met with Sue G. a few weeks ago to understand the Bureau’s perspective on SAMHSA’s Scope of Practice recommendations. Michael-What I got out of the meeting is 1. The Bureau/State supports SAMHSA’s Scope of Practice recommendations. Sue G. Believe this is the appropriate direction for the state and its citizen especially considering Healthcare Reform. 2. If people (profession) doesn’t agree or feel this is the right direction for Wisconsin it’s not the Bureau’s responsibility to be a champion for the profession. For instance with the Vendorship Bill, the state and the National Association of Social Workers (NASW)-Wisconsin did not agree. NASW chose to advocate support of what they feel is in the best interest for the profession. The state is not going to change this focus or slow these efforts. Steve D.-So Sue G’s. comment at the WAAODA Conference Public Forum that no one will get left behind is not a true statement based on this information. Michael-I don’t agree there is a place for everyone on the Scope of Practice who is practicing today. If I am a non-degreed substance abuse counselor practicing in this profession today, in 2014 I can still be in the profession but my practice may change based on practice requirements. Gail K.-In public forum or by public comment the state never offered that it is supporting SAMHSA’s Scope of Practice recommendations. The message was always that the state is required to make these changes. Michael-Sue G. feels she has delivered the message that the state supports SAMHSA’s recommended changes around the Scope of Practice issue. There is a disconnect between Sue’s message and what people in the field are hearing or understanding. The message will need to be refined. Gail K.-People in the field have questions. A conversation about this issue with the stakeholders has not occurred because of the way the state has delivered their message. Sandy-This will change my life dramatically. It’s frustrating that there isn’t the recognition of the importance to have conversation even if it’s heated. The issues can get voiced and we can move toward

some good dialogue if we could just allow the conversations to happen. Gail K.- Agencies are learning how the scope of practice issue may affect them, but have not been allowed to add to the conversation. Michael-What will the dialogue with the state look like, what are the questions that need to be asked? How did this process unfold? Sandy- There should be a specific forum at the Bureau Conference on this issue specifically. Invite treatment agency staff and allow questions to be submitted to the state prior to the conference so they have time to prepare. Stakeholders need the opportunity to ask how and why. If the forum is a breakout session at the Bureau Conference than preparation will need to happen. Explain how people will not be left behind, people need to know what this means. The state needs to help dispel the misinformation, and potentially help allay fears. Sandy-I've worked in this field for 27 years working next to people with master level education who can't do the work of substance abuse counseling. Gail K.- Reimbursement and billable service has been brought into the discussion as a reason for the changes. The state has the power to set the rules by which reimbursement is made. The implication has been made that the state doesn't have a choice but to move in this direction. This is frustrating to hear. Steve-I can accept that the state is not a champion for the profession, but it does have a responsibility to help develop the treatment services system that is in the best interest of the citizens and this issue should be included. Michael-I agree with how everyone is feeling. Most are feeling they have been railroaded by this issue. What are other possible solutions, I've heard a suggestion for a forum at the Bureau Conference, I've heard the suggestion for stakeholder meetings across the state. Steve-The Department had a perfect opportunity to present the issue at the Tribal Consultation meeting a few weeks ago, to solicit feedback about how this will affect the tribes. Michael-I may have misunderstood, but during my meeting with Sue G. I thought she said that WAAODA, WADTPA and WAADAC are on board with the state's direction on this issue. Steve-As of right now the WAADAC Board of Directors are not endorsing these recommended changes at this time. Gail K-Historically the discussion about whether people with less than a bachelor's degree can get reimbursed for services. There have been two arms of support; the bachelors level and the anybody who is licensed level. The anyone who is licensed arm allows for those at the lowest level of licensure to move thru a career ladder and get reimbursed. Sandy-We need to get to a point where good information and dialogue occur. There's a video called the Good Leader that demonstrates good leadership skills. When a leader's vision is shared workers mourn for what was. Ultimately people want to feel they had an opportunity to be heard.

Other suggestions include; the need for factsheets to be developed, with basic explanations, projections about what the counseling field will look like in 2014, direct mailing to the certified counselors statewide, creating a blog forum for discussion. Gail K.-the letter included in the survey that was sent to colleges had some of this information. *The Patient Protection Affordability Care Act will be fully implemented in 2014. There are new requirements of licensure from SAMHSA that will generate changes in the certification requirements and RL 160-168. The Bureau is committed to meet the demand.* The survey questions are about the ability to offer a degreed program and articulating to a higher degree. These are strong statements and Gail K. sent a "reply all" message indicating that none of this is mandated.

Michael-the suggestions seem very doable. Stakeholder meetings occurred across the state when the Wisconsin Certification Board's role was transitioning to the DRL. All agree that Diversity should play a role in helping to develop the language for the factsheets. One potential means to reach counselors is via the internet and WAAODA's membership list. Gail K. suggests if the state is truly interested in knowing what counselors think about this whole issue than continue, if not than don't insult people either. Does anyone know if WAAODA, WADTPA or WAADAC are doing anything about this? Gail K. received an email response from WADTPA assuring these changes are not going to happen. Some have asked NAADAC, and leadership at NAADAC say yes these changes are coming and "we will require it." Michael-The agency where I work is a member of WADTPA and I'm a member of WAADAC and I've not heard opposition to this action from either organization. Gail K. referenced a string email about NAADAC listing SAMHSA/HRSA requires addiction counselors to have master's level education and there is no such requirement. So people don't understand. The state's credibility is lost because it doesn't own their choice. During the WAADAC meeting in May there wasn't much discussion around the issue because it was presented as a federal requirement to change. Gail K.-Stakeholders don't know where and how to speak out, [because of] how it was communicated is not accurate. Gail K. certification is a state decision, Medicaid reimbursement is a state decision, the federal government doesn't make the requirements.

Denise-the email about LBGT data elements survey why are these being added and not deaf, deaf blind and hard of hearing? Michael-this is national data requirements and it's an opportunity to voice opinion on the recommendations to start collecting this data.

Meeting Adjourned at 3:05PM.



State of Wisconsin

**State Council on Alcohol and Other Drug Abuse**

1 West Wilson Street, P.O. Box 7851

Madison, Wisconsin 53707-7851

**INTERVENTION AND TREATMENT COMMITTEE (ITC) MEETING**

**Tuesday, November 8, 2011**

**10:00am – 2:30pm**

Department of Corrections

3099 E. Washington Ave.

Room 1M-H

Madison, WI

**MINUTES**

**Present:** Roger Frings, Norm Briggs, Dan Nowak, Staci McNatt, Nina Emerson, Dave Macmaster & Sheila Weix (by phone)

Lila Schmidt & Susan Endres - staff

**Absent:** Tami Bahr, Andrea Jacobson, Shel Gross, Sheri Graber, Francine Feinberg

**Welcome, Introductions, and Review of Minutes** – Norm Briggs and Roger Frings

Norm brought the meeting to order at 10:10 with introductions. Minutes from the August meeting were reviewed and approved as written. Minutes from the October meeting were reviewed and approved with the following revisions to page 3 of the minutes:

(First paragraph second line) change “is advocating” to “will be advocating”

(First paragraph, third line) add “several years ago” to the end of sentence

(First paragraph, sixth line) delete the words “essentially a consumer and not” so the sentence will state The Wisconsin Association of Alcohol and Drug Abuse Counselors is a provider organization

(First paragraph, eighteenth line) change “is essentially used” to “is on occasion used” to balance the budget

(Second paragraph, third sentence) remove “Families United Against Death by Tobacco” from sentence

**Children, Youth and Families Subcommittee Update** – Susan Endres

Susan is reporting for Tami who is unable to attend. The minutes for the last two CYF meetings are in need of review and will be given to Lila upon completion for distribution to ITC and inclusion in the December SCAODA packet.

Kenya Bright has been invited but unconfirmed for the December CYF meeting to talk about the Bureau’s work on healthcare reforms related to youth and health homes for corrections and the foster care initiative. There will be a person coming from the Department of Justice to talk about collaboration around their drug endangered children, which was identified in Milwaukee as a

way of continuing to support and look at the use of opiates for youth. Also on the agenda will be review of the strategic plan and developing back ups for Tami and Susan due to increasingly busy schedules. Tami is now in the role of Assistant Director at Connections, which has been serving more kids with the Basics model.

Sometime in February, Susan will be working with Tanya Bakker on a point in time study with the Methadone Clinics around the State. They will ask for information on clients for a one week period to obtain information on when they began using opiates. Susan wants to be able to show that Wisconsin is similar to the National report which says that kids begin using at age 14. Youth are appearing at the Methadone clinics around age 18 or 19. Sheila offered to gather this information for the clients in their clinic as well.

The Opiate adhoc committee is continuing to work with the Recovery Foundation on planning the summit. West Boyd from Harvard is still on board. The Payer/Provider group will be doing more planning in December, with another meeting in January. There had been some delay as the involved HMO's were resolving issues with the state. They are interested however in developing adolescent treatment and recovery services.

From her role with the Bureau, Susan reported on updates from the Teen Intervene model that she has been working on for four years. The model can be done with a variety of professionals who know how to engage with kids. At the first training session, combined with NIATx, three programs were implemented. One with schools for athletic code violations, one with a new business line and the third incorporated it into their regular ongoing work. The second training which followed a year later invited folks to do a second round of NIATx with Ken Winters and Teen Intervene. Waukesha was described as a county that has made great strides in using that model and will be adopting Teen Intervene as a way of doing business in their county. They have been able to address how they communicate with one another, the use of motivational interviewing, and streamlining their system of referral. They were also connected with Chestnut to learn to be a trainer of trainers.

The third round of training will be starting after Thanksgiving and taking place for two days beginning in Shawano, followed by Manitowoc, Milwaukee and the Beloit area. These places were identified in the gap analysis as areas that don't have resources for kids. The trainings are filling up fast. Milwaukee already has a waitlist and half of the 50 individuals signed up there are from the Milwaukee Bureau of Child Welfare which is the perfect place to get intervention going. Roger suggested looking at the bigger picture and inviting the area legislators to the event to show them the good work that is being done. As they are not always aware of all the activities going on, Roger felt this would be a chance for them to see first hand how important it is. Roger agreed to provide Susan with advice on how to proceed. Susan noted the significance of this effort, as they are not only providing the training but are using the NIATx principle of coaching. Following the training, folks will have the opportunity to participate in 6 months of coaching calls with Ken Winters, Susan and some of the experts from the earlier trainings to assist them in implementation and provide peer support. This is a big step in increasing treatment capacity in Wisconsin and in doing early intervention. Participants will also be given their county code to use the GAIN short screen. The information obtained in the questions is put into treatment language and gives direction for substance abuse, mental health or co-occurring referrals. Susan

will also be bringing the NIAAA (National Institute on Alcohol and Alcoholism) brief two question screening tool which was basically made for physicians but is also being seen in schools and with others.

Susan reported that all of these efforts are creating and showing the capacity building that needs to be done for treatment which includes the HMO's partnership on the subcommittee along with the expertise that is being developed and nurtured around the state. Waukesha is learning ACRA, Dane is learning In Home Treatment and Connections is learning DBT. Susan states that if we don't have a special certification or program area for the state to administer for adolescent substance abuse treatment then it is very challenging to get consistent training. Universities want to know that they will have a pool of people that need this and know what the requirements will be. Currently it is all seen as good practice but there is nothing specific in DHS 75 that is specific to adolescents. Through a grass roots approach there is good progress being made, but more needs to be done to develop the infrastructure needed for adolescent substance abuse treatment.

NASAD has started an Adolescent Youth Committee that Susan will be participating in for Wisconsin. She has had the opportunity to speak to 30 other states about what WI is doing and will continue to meet with the group on a monthly basis. Susan identifies the need to have a national protocol through health care reform to draw attention to early adolescent substance abuse treatment.

#### **WiNTiP Updates– Dave Macmaster**

Mac distributed a WiNTiP update (November 8, 2011) and began with announcing that the long awaited videos for integrating tobacco into addiction programs are now available. The videos were developed by New York State and will be available for free on both the WiNTiP and CETRI websites. One video is designed for clinicians and another for clients. They are a major teaching aid and educational resource that provide good information, patient activities and include information on the issue and nicotine replacement medication by Dr. Kipnus, Medical Director, at New York State's single state agency, Office of Alcohol and Substance Abuse Services (OASAS).

AODA Reorganization Update – Mac is on the Board of Directors as the Marketing and Outreach Coordinator for both the Wisconsin Recovery Community Organization (WIRCO) and the new Substance Use Practitioners for Recovery (SUPAR), the reorganization concept of the Wisconsin Association of Alcohol and Drug Abuse Counselors (WAADAC). SUPAR will be presented to WAADAC's Board on November 18<sup>th</sup>. The website is already up and the contents are being worked on by Joe Kuehn. Efforts are underway to put together the communication infrastructure of FaceBook, Twitter, List Serve and anything else. The idea is for anybody who works in the addiction field to have a support organization to address their issues. The hope is to pick up some of the things that the WI Certification Board did in connecting people together. Planning for future trainings is still premature. Getting the membership started has been a primary focus. There will be a minimal membership fee, maybe around \$50. Folks will also have the option of access to the WAADAC membership which is more comprehensive and have access to the national work that is going on there. The hope is that one of the elements of the

reorganization will be to provide better advocacy for the treatment provider's trade association. The intent is to work closely with Norman and others so there is a more united voice with the same mission. WiNTiP is involved with all of this because all these associations have endorsed the WiNTiP resolution to encourage policy to lead to the integration of evidence based nicotine treatment into our AODA and Mental Health services.

Susan mentioned that the annual workforce survey that the Certification Board used to do in combination with the identification of needs was very helpful in developing a training plan at the State. Mac noted that WAADAC membership is around 115 counselors out of a possible 1200 to 2000 individuals who have a license, not to mention the social workers who have the qualifications. There are a lot of people out there though there is not a clear handle yet on who they are. It will take some time, including obtaining 501c3 status because WAADAC is part of NAADAC and does not have an individual forum right now. Mac is very encouraged by all this and sees his board as enthusiastic and supportive.

Mac distributed posters from the WiNTiP advertising campaign. CETRI folks decided that they wanted to help with the adaptations of the WiNTiP posters and there was a full page ad in a nursing magazine with one of the posters. WiNTiP received feedback from WIRCO that a woman in one of the ads looked too healthy to be a smoker. Mac passed this observation onto the designers of the ad who decided to continue on with it. The committee also suggested that the individuals featured in future ads represent a broader cultural spectrum of the community. WiNTiP has purchased a banner to go on the websites of WAAODA, WAADAC, and WIRCO, which takes you the address for [helpusquit.org](http://helpusquit.org), which has all resources available through the university folks.

This year WiNTiP had a deliverable to provide training for clinicians in mental health and substance abuse. There were 3 clinician trainings completed this year, with the last one in Eau Claire to around 43 individuals. The goal of the trainings is that no matter what type of setting a person is in that they are able to do something with tobacco, which at a minimum may be an assessment with a referral to the quit line. There is also a fax to quit system, where the person at the agency arranges a convenient time for the quit line staff to call the patient instead of relying on the patient to make the call. This sets them up with an active intervention and gives a resource to the counselor who doesn't know what to do because their program isn't set up to treat nicotine dependence. As part of the training, folks are given access to a lecture model that Mac developed at the St. Claire Center and the Tobacco Awareness group model for exploring the relationship people have with tobacco. There are also sample treatment plans and assessment forms and CETRI folks discuss the free technical assistance they provide for evidence based nicotine treatment.

Sheila and Mac are scheduled to do the last training this year, on Wed (11/16) for managers and administrators. The message is that this won't work unless we change the existing tobacco culture to a tobacco free culture. Providing smoke free environments just moves the tobacco use outside or results in folks sneaking tobacco or contraband in. There is evidence that this can be done successfully by looking at the 90% compliance in New York State where they have been obligated to do this for the past three years. The training offered this year is also addressing the barriers of "this is not in my scope of practice, I don't want to do it, I can't do it". 92% of

clinicians say they are willing to do it if provided the training. When those who had participated in this year's training were asked whether they had ever assessed for nicotine dependence and put it on the treatment plan the answer was zero. The hope is that the training will facilitate assessment for nicotine dependence, record it as 305.10 and have a plan for addressing it. As clinicians receive training on this, they can become role models for others. The future challenge is finding a way for it to become standard state practice.

Mac is also finishing up with his outreach and promoting the free 24 hour on line nicotine addiction treatment training available to clinicians and others. He also plans to convene a WiNTiP advisory meeting in December to share some new video material that has been developed. WiNTiP is interested in attracting some new members from the Cancer, Heart and Medical Society to the advisory committee.

Sheila commented about their experience up north with integrating nicotine dependence into treatment. St. Joseph's has been doing this since 2002 and it works. For those with co-occurring disorders, it actually requires less medication for their other diagnosis because there are changes in the metabolism when you take away the nicotine. Her experience was that counselors really don't struggle much with this if you frame it as to how this is any different than addressing marijuana. It has more to do with the point of view of the provider; which is really the main focus of the training. Providers already have the skill set, they just need to look at it differently. Sheila also shared the importance of looking at the whole person; which is what is behind health care reform and medical homes. Assessing nicotine use is part of looking at the whole person, asking them about quitting and providing resources is just a standard of good care. It is well supported in the literature and a part of what is happening in health care reform.

Norm raised the issue that some medical directors have a good reason for not supporting this because they use cigarettes in their behavior modification approach; especially in working with persons with severe and persistent mental illness. Sheila responded that all programs do this whether they admit it or not. Smoke breaks are taken away from patients or extra or extended smoke breaks are given when programs are short staffed. It really requires a change in the culture of the program. If you want to motivate a patient, one could use a patient centered motivational approach to find out what is important to that patient and work with it from that point of view.

### **ITC Public Forum Report – Sheila Weix and Lila Schmidt**

The public forum took place at the 2<sup>nd</sup> Annual Northern Wisconsin Substance Abuse Counseling Conference in Ashland. The forum was held over the lunch hour with approximately 30 individuals present with 23 persons signing the roster. The fact that it was held during regular conference hours rather than as an after hour's option appeared to increase participation. ITC members felt that this may be something for other SCAODA committees to consider when scheduling future public forums. Sheila reported that the individuals participating in the forum had concerns, but were very open to dialogue. She began the forum explaining the role of SCAODA and the need for their input and encouraged folks to be active in other ways such as WAADAC. The agenda included asking for feedback in five specific areas ITC had identified, as well as opening it up for any other issues.

### Integrating Peer Support Services into Treatment

Was viewed positively by providers and seen as a way to take some of the pressure off of providers. Someone raised the question as to whether the scopes of practice was behind the development of peer support services as a way to provide a role for non degreed recovering staff now working in the field. Sheila spent time discussing the value of developing recovery support services from the client and provider perspective. There was also interest in how agencies could get the lists of persons who are certified peer specialists as a resource for filling positions or possibly for training. Overall there seemed to be a lack of clarity around peer specialists and recovery coaches in terms of roles, how this is all going to work, who will provide the training, will they be reimbursable, etc. Hurdles around HIPPA and confidentiality were identified especially for small agencies. The need for regional assistance was identified as something that would be helpful.

### Accessing methadone/suboxone/subutex treatment

Some prejudice regarding the use of medications like suboxone was identified. Providers in that area don't have a lot of experience in working with medication assisted treatment and therefore haven't seen first hand the benefits for clients. Some have only heard the stories about the difficulty of withdrawal from medications like suboxone. There are very few prescribers available in that area. Someone in Ashland mentioned that they only have two prescribers and folks need to travel long distances for medication access. Transportation problems and communication problems between the prescriber and treatment provider often make it a set up for failure. General practitioners are not interested in taking on these clients who aren't seen as fitting in well with other patients in the primary health care settings.

Folks were also interested in getting more data on the prevalence of prescription drug use in the state. The Wisconsin Prescription Drug Recommendation report completed by SCAODA's Controlled Substance work group was sent electronically to participants following the conference. Someone brought up the idea of having physicians conduct a substance abuse screening before prescribing medication with a high abuse potential. Discrepancies of MA coverage for methadone as well as not being able to bill for persons coming to WI from Michigan was also raised.

### Scopes of Practice Changes

Concerns regarding the workforce shortage were expressed, as was the need for a strong force to address this issue. Though folks recognized that these proposed changes are federally driven they wanted to know who at the State was taking a leadership role with this. Susan Gadacz was the person identified for the state. We discussed the workforce issue as a priority on a number of SCAODA's committees.

The need to look at the Educational structure was also identified with better coordination there, so that college graduates will be able to get the 360 hours of training required without going through an associate program. The difficulty of rural areas in attracting qualified staff was expressed as a unique issue in those communities. We shared information on the two surveys that are being done right now to gather information to guide us in a course of action (one to the Tech colleges and Universities and the other to the providers).

### Treatment Courts

Folks expressed interest in knowing how to go about getting a treatment court started, so ideas were shared about primary stakeholders and how to start the discussion. Information was shared on websites where folks could get more information about treatment courts, including a list of treatment courts within the State. Particular mention was made about the development of Veterans Courts and interest in that area. There was a very positive view of the treatment court model and its effectiveness.

#### Nicotine Treatment Integration

Integrating nicotine addiction was seen as a good opportunity to stop the use while continuing to build motivation for cessation. Someone talked about a physician in their area who was regularly asking patients about smoking, discussing a quit date and asking about it at subsequent contacts. Folks were glad that it is a reimbursable service. Sheila shared the experience at St. Joseph's with the integration of nicotine treatment and promoting a tobacco free culture. There was a lot of interest in this area and folks saw it positively. WiNTiP, Quit Line and CETRI were given as resources.

#### Other

- Concern was expressed with proposed legislation allowing employers to refuse to hire or terminate individuals with felony convictions. Where are the incentives for people to do well? Strong feeling that this is punishment after the punishment for the crime is completed.
- A couple social workers from the Adult Correctional Institutions discussed the inability within DOC to provide effective training for the community correction agents. They talked about the training and specialized case loads for persons with chronic mental illness but that there wasn't anything comparable for addressing folks with substance use disorders. Social workers are given a pay increase for completion of training, which is not the case for PO's. They also felt that DOC should require all their contracted treatment programs be certified.
- Someone expressed concern with the abuse of K2 and the status of making it illegal. Folks at the forum shared that such legislation has been passed.
- Interest in knowing how many legislators are participating in SCAODA and underscoring the importance of this participation.
- Northern communities are dealing with different issues. OWI fatalities were experienced as a different type of trauma for rural communities. Everyone knows everyone so it hits closer to home. There is a perception that there is a higher incidence of drunk driving based on population size with significant impact and losses. Alongside this, there is also a desensitization occurring as people become resigned to this as the reality.

#### **Treatment Access and Wait time Updates – Roger Frings**

Roger contacted the Chief in the Accident and Health section of the Bureau of Market and Regulation to find out about complaints received for mental health and substance abuse in terms of wait times, services, etc. He found that nothing is really categorized in that great of detail. Starting in January 2010, with mental health parity, there was a citation field created in complaints categorized as mental health issues which would include substance abuse information as well. Included were mental health, co-insurance and providers regarding access issues. Since January 2010 there have been a total of 13 complaints. It is likely that folks are not even aware that this option exists. There were suggestions to include the 1 800 number on client rights

documents and appropriate websites. The complaint form is available electronically on the OCI website; however complaints may also be made by phone or mail. It is available for any consumers who are having problems with insurance including MA and HMO's. As a follow up to this, Roger is going to work with his complaints section to see if they can categorize the complaints beyond the general category of mental health. The process after receiving a complaint is to complete a review, that includes contacting the provider or what ever party is involved to ask for a response from them, review the law and then as a regulatory agency make an order to correct the problem. This can include penalties and/or fines. Though providers need to go through their Medicaid Regional folks to resolve the issue, there is no reason the consumer can't contact OCI directly. The toll free number is 1-800-236-8517 and the local Madison number is 608-266-3585.

### **ITC Goals for the Aging Population – Norm Briggs and Roger Frings**

Jane Raymond provided a presentation in August to ITC on older populations and substance use disorders. The older population remains a priority of our strategic plan but without form. It was clarified that older populations include individuals 50 years old and older. Sheila shared information from a TEDS June 2010 publication report which compared data from 1992-2008 showing that the proportion of admissions for older adults reporting alcohol abuse had decreased from 84.6% to 59.9%. The proportion reporting primary heroin abuse doubled and those reporting multiple substance abuses nearly tripled from 13.7% to 39.7%. Older admissions who initiated use of their primary substance within the past five years were more likely to have started with prescription pain relievers as their primary substance. Many of the baby boomers who are now in their sixties never gave up their drugs. Norm also shared that Dane County reported that the 60 and older population is the second largest heroin user group in the county.

Susan suggested that Sharon Beall with Long Term Support may be a good resource as someone who is knowledgeable and passionate in this area. She has a good handle on what others are experiencing across the state and may be helpful as an ITC committee member. The committee discussed the reality that individuals 50 and older with substance abuse and nicotine abuse tend to also have co-occurring medical issues. These folks often present with multiple diagnosis. The impact of substance abuse is such a significant piece when you are coordinating care in someone's home or working with their physician on medical issues; yet the tools available to these folks are quite limited. There are also the attitudes that exist that these folks are older and can do what they want to do. Just getting folks to ask about substance use is a major step. This population is an ideal population for the medical home model, where you have the medical and addiction services come together.

Norm raised an issue identified by Sheila at a previous meeting about the discrimination that is experienced in the hospital setting where folks are being screened out of nursing home or assisted living facilities if they have a substance use disorder. Jane Raymond had actually recommended at that time that this issue be raised with the Division of Quality Assurance. Norm thinks that this may an issue that ITC can get started with and suggested inviting someone from DQA to an ITC meeting for discussion. Sheila reports that these individuals remain in the high cost hospital setting even though they don't have medical necessity while they search for someplace that will take them. A related issue is the difficulty of finding outpatient treatment with someone that accepts Medicare and can provide the service. If we are going to be screening

people in a primary care setting before they need to be hospitalized this is a big issue especially given that this is a growing population. The group agreed to proceed with this issue and invite someone from DQA to ITC for discussion.

Norm informed the group of the Poisoning Overdose Task Force in Dane County, which was formed to address the heroin problem and suggested that ITC keep aware of their activities. Also identified was the issue of older individuals selling their prescribed pain medications for profit and the concern with the large doses of pain medications that doctors seem so willing to prescribe without any follow up by the prescriber. Many people are just not aware of this as an issue. Norm shared information about a small group of high school students that were former users under an effort identified as “Team Real” that go into staff meetings at hospitals and clinics to talk about what is going on in the street. Judy Reed who has a PhD in Education and is principle at an alternative school has put this program together. Norm will be meeting with her and recommend that she connect with the CYF committee and possibly do a presentation at an upcoming SCAODA meeting.

The group also discussed the reality that there are individuals who have a very legitimate need of pain medication to manage pain and that the focus can not just be placed on physicians. The need for patient and public education are important elements. Often access for kids comes directly from the parents/grandparents medicine cabinets.

Dan offered to send an inquiry to the Associate Director of ARCW, who does the needle exchange program to find out if persons age 50 and older are increasing their access to the needle exchange in Milwaukee and across the state.

#### **SCAODA and ITC Strategic Planning – Norm Briggs and Roger Frings**

Due to time constraints this item was tabled for the January meeting.

#### **Presentation on WIRCO – Staci McNatt**

The Wisconsin Recovery Community Organization (WIRCO) was a project Staci spearheaded in her role as the Alliance for Recovery Advocates (AFRA) Coordinator which is a program of WAAODA. There was AFRA grant money set aside to do some advocacy initiatives which included planning and holding a recovery community event and supporting and increasing these types of events across the State during September Recovery month. Staci created a project called Bridging the Gap where she connected with key individuals around the State from different communities to do an analysis of what were the strengths and weaknesses as far as treatment and support services. She asked these individuals to bring others to the table including stake holders, families and those in recovery. What was realized from this project was the disconnect between folks at the table who didn’t always know that each other existed. Staci then began researching what other states were doing and found recovery community organizations, including the Connecticut Community Addiction Recovery (CCAR) Organization which is the largest in the country and is well respected by SAMHSA and Faces and Voices of Recovery. The idea to create such an organization in Wisconsin was supported by Pat Taylor of Faces and Voices of Recovery, WAAODA with AFRA and DHS. Through combined funding, a six month project was created to hold monthly meetings with volunteers from around the state, representing different disciplines with the guidance of CCAR. A decision was made to become a stand alone

organization and over this six month process (Jan – June 2011), the name WIRCO was identified along with a board of directors, bi-laws, mission/vision statement, and an overview of the strategic goals and plans. WIRCO is all volunteer based, which should work well in Wisconsin which is ranked 13<sup>th</sup> in the nation for the number of volunteers based on the size of the population.

Staci shared that she has been conducting research on the differentiation between recovery coaches, peer specialists, peer recovery support specialists, counselors and sponsors and is currently putting this information into a grid format that she will make available on the WIRCO website.

A Recovery Community organization is the conduit of a Recovery Oriented System of CARE (ROSC) model, helping connect the pieces of treatment and the recovery community together for the entire State population. In addition to substance abuse issues, there is the recognition of environmental and personal barriers and obstacles that prevent individuals from continuing on their path to recovery. WIRCO organizes and conducts prevention, treatment and recovery focused advocacy which includes educating legislators to make better legislative decisions. WIRCO goals are to eliminate stigma and discrimination, provide community education and outreach, promote recovery support services, and mobilize the resources both within and outside the recovery community (housing, child care, employment services, relapse prevention, case management, service linkages, peer mentoring and coaching, etc). The value in the ROSC is to view the person in a holistic way, spiritually, physically and mentally.

Some of the recovery support services that a recovery community organization typically provides are telephone recovery support and recovery coaching. Telephone recovery support consists of volunteer peers who receive formal training, who make scheduled calls (mini-check ups) to see how the person is doing. Information from these calls is logged into a data base which captures information on the date of the call, the number of attempts to reach the person, whether the call was completed and information about any other types of support they are using, are they frequenting AA, NA or faith based organizations, are they in recovery, have they relapsed since last contact, what resource referrals were made and any general comments, so that when the next person calls there is a history to go from. These calls are made to persons who are coming out of treatment or an incarceration setting or anyone who is looking for this type of support. All participants agree to voluntarily participate and sign waivers regarding liability of the volunteer peers. The volunteer hours are also logged into a central data base, so the volunteers get credit for what they do in terms of recognition, community service or experience on a resume or job application. 2010 data available from CCAR documented 1218 new participants in their telephone recovery support service. Volunteers made 27,000 outbound calls and 6800 conversations occurred. From a sample of 483 individuals who received calls for twelve weeks, 58 self reported they were no longer in recovery and 42 reported later they were back in recovery.

The Recovery Coaching model is also from CCAR. Folks in these roles help to remove personal and environmental obstacles and barriers to recovery, provide peer support, and function as a personal guide and mentor. They must have 5 years of recovery and abstinence and be able to model a healthy lifestyle. They must complete a five day intensive, comprehensive training,

which is currently being adapted to a three day online or one day onsite training for professional staff or staff that will be located at a treatment center. They focus on personal strengths and provide resource referrals both in and outside the recovery community and provide relapse prevention. They assist with recovery enhancement and recovery plans and detect whether there is a need for crisis intervention. They are also a community liaison and advocate. The core competencies of the training include: science of addiction and recovery, the recovery process and stages of recovery, recovery plan development, recovery promoting supports, ethical practice and confidentiality, boundaries and self care, cultural sensitivity and practice with cultural competency, trauma and its impact on addiction and recovery, community resources, and motivational interviewing. There is also interest in providing wellness support groups for recovery coaches.

The model is delivered in a non clinical setting so people are freer to speak with their peer. There is recognition that there are several pathways to recovery and that not everyone fits into the 12 step model. The recovery coaches provide hope, optimism and healthy living, and function as a safety net for individuals and families. The model can be done anywhere in the state regardless of area or sub population. Developing recovery coaching over the phone for harder to reach populations has also been discussed.

WIRCO is closer to launching its website but wants to make sure there is enough information available to bring folks back again. The concept of recovery is more than just substance abuse but also includes things like tobacco and gambling. Though this is all in the early stages of development there is a model to follow with CCAR. There has been a great deal of outreach with agencies and organizations across the State about these services and trying to get money to provide these recovery services. The goal eventually is to open recovery support centers which are created from within the community. They are spearheaded by individuals who bring in volunteers from their community. WIRCO is looking at doing a few pilot projects.

Staci mentioned Communities against Violence which targets ex-offenders. There is a program beginning in Madison and one being started in Milwaukee. In Madison there are 10 individuals that were identified for the program who will have the community involved to assist them in addressing the barriers and obstacles they face upon returning to their community. Their involvement begins with a panel of law enforcement individuals standing before them who state that they will not tolerate or accept violence or crimes committed by them and outline the consequences if another crime is committed. This is followed by the community representatives also stating that they will not tolerate further violence or crimes by them while adding that they are there to support them and provide services to address the issues they face returning to the community. They express their interest in them becoming a positively contributing member of society. The ex offenders are shown a video of persons who have gone through these programs in other states and are doing well. Family members are also able to say something if they wish and other community folks are there from other counties who are interested in setting up this type of program. At the end of the orientation the community partners are available to meet with the participants about their services and resources.

Sheila shared that the CCAR model started with 90 volunteers in 2005 providing 3450 hours of services which increased to 276 volunteers providing 13,000 hours of service in 2008. This is a

model that can grow over time and one that is able to continue with volunteers if grant money is cut. The recovery movement in mental health grew out of the domination by psychiatrists and other professionals where the consumers of those services were without a voice. Addiction services became medicalized out of AA and the recovering community where there was more of a consumer directed approach. So when talking about co-occurring disorders of mental health and substance abuse this is on the shallow end of mental health problems since folks with the peer support services are those with persistent mental illness as opposed to mood disorders like someone with cocaine dependence and depression. WIRCO is planning on following the CCAR model which has shown in places like the Texas Drug Court Program to have decreased depression, anxiety, suicides attempts and concentration and memory problems for those persons having access to recovery support services. Health Care Reform is also requiring the inclusion of recovery support services and Staci is getting calls everyday from organizations/programs who are interested putting some money away to have WIRCO provide these services.

Sheila added that the addiction recovery movement has many long time honored principles which include that you can't keep it unless you give it away. There is support for people volunteering to do this and it is a win win for volunteers in helping others move into recovery. Mac believes it takes away some of the difficulty in finding a place to give it away without dealing with the anonymity of AA, folks are able to identify as a volunteer. Similarly WIRCO provides a tool to educate the general public and legislators on the true issues and the real problems by putting a face and voice with it. One project started is creating documentary's based on video tapes and interviews from individuals in treatment, family members and others.

Nina also suggested contacting similarly situated organizations like Wisconsin Lawyers Assistance Program (WISLAP), which is statewide program which serves the legal community. Mac shared that the WIRCO Board of Directors have an assignment to provide 5 helpful links from areas that would be useful to consumers by their next Board meeting. Staci asks that folks send ideas on any resources they would like to see on the WIRCO website to her email.

## **Legislation/Miscellaneous Updates/Future Agenda – Norm Briggs and Roger Frings**

### SCAODA Committee Appointments

Norm announced his appointment as one of three open positions on SCAODA. The other two are Duncan Shroul and Sandy Harding.

### AB 286 and SB 207

This is a proposed change in the legislation to allow employers to discriminate against persons with a felony conviction(s) regardless of its connection to the employment. Planning and Funding has paid attention to this and it is appropriate for ITC to take a stand on as well. Mac made a motion for Norm and Roger on behalf of ITC to communicate with Planning and Funding for a joint motion to oppose the legislation at the December SCAODA meeting. The motion was seconded by Staci and voted unanimously in support by the committee.

Discussion – AB 286 has been voted out of committee but has not gone to the floor. SB 207 has not yet gotten out of committee. It is recommended that the Council express that this legislation

is counter productive. It provides another barrier to people becoming productive members of society and actually promotes further crime. It is contradictory to getting people to work. Neena mentioned sending a letter similar to the one that Michael Waupoose sent to Governor Walker on behalf of SCAODA asking him to not sign the bill that was passed in both houses allowing alcohol to be sold at 6am instead of 8am. Mac commented that we need to become better organized with others who have a stake in things like this to have a united and strong voice like the Tavern League had on the earlier alcohol sales; especially in regard to major public health matters. The committee was not aware of anyone who testified in opposition to AB 286. The need to mobilize the affected communities and the right players is important when ever possible. Roger clarified that legislative updates are sent to SCAODA and its committee members through DHS staff and that anyone can subscribe to get email alerts on legislative updates as well. We know who are allies are, so we need to pool our resources to work on these issues together rather than a simple letter from SCAODA. We need to put faces with these organizations, especially faces within the legislators districts. In reality employers can let folks go for any number of reasons since employment is at will. If individuals are terminated, employers don't have to pay unemployment. States like Massachusetts have passed legislation that doesn't allow employers to have the box on applications that asks about convictions and other states are attempting to pass similar laws.

The link to sign up for legislative email alerts is below. You will have to enter key words under the subject matter to receive notification in your areas of interest.

<http://notify.legis.wisconsin.gov/>

#### Status Report on the State Association Consolidation

There is an interest on the part of a number of folks to get an active, vibrant association of professionals in addiction treatment services to the point where we not only get legislative notifications but have a lobbyist or a contact within the state house to let us know when things are being discussed. The effort is moving forward with a contracted consultant in organizational development and design.

#### Minority Training Project Update

We are aware that there will be an RFP going out for this project which will fit into the counselor scopes of practice. Folks are still waiting to see how persons who are in recovery in the field without a degree will fit into this.

#### Ad hoc work group on Women's Treatment Core Values

The bureau has a plan to look at the core values as they relate to proposals going out. They did not get revised in time to include with the current RFP's but there is a plan to continue working on the revisions. It was suggested that ITC have some representation on that and both Norm and Francine Feinberg have been involved with that.

#### Future Items

- Health Insurance Exchange Updates

- Health Care Act development – come up with a list of things we would like to know about for the things we expect are going to happen.
- Strategic Planning – move up on January’s agenda.

### **Adjourn**

The meeting was adjourned by Norm.

### **Next meetings and dates:**

1. ITC  
January 10, 2011; 10:00 am – 2:30 pm. Department of Corrections, Madison
2. Children, Youth and Families Treatment Subcommittee  
December 2, 2011; 9:00am – 4:00pm.  
Connections Counseling, Madison
3. SCAODA  
December 8, 2011 9:30 am – 3:30 pm; American Family Insurance Conference Center, Madison. For more information, visit the SCAODA web site at:  
<http://www.scaoda.state.wi.us/meetings/index.htm>



State of Wisconsin

**State Council on Alcohol and Other Drug Abuse**

1 West Wilson Street, P.O. Box 7851  
Madison, Wisconsin 53707-7851

**INTERVENTION AND TREATMENT COMMITTEE (ITC) MEETING**

**Tuesday, January 10, 2012**

**10:00am – 2:30pm**

Department of Corrections

3099 E. Washington Ave.

Room 1M-H

Madison, WI

**MINUTES**

**Present:** Roger Frings, Norm Briggs, Tami Bahr, Dave Macmaster, Dan Nowak, Staci McNatt, Shel Gross, Sheri Graber, Francine Feinberg & Sheila Weix and Steve Dakai (by phone)  
Lila Schmidt & Susan Endres - staff

**Absent:** Nina Emerson, Andrea Jacobson,

**Welcome, Introductions, and Review of Minutes** – Norm Briggs and Roger Frings

Roger brought the meeting to order at 10:10 with introductions. Minutes from the November meeting were reviewed and approved with recommendations to delete the sentence on the second line of page 12 regarding the mental health model for recovery coaches and add Mac to the list of members in attendance. There were two areas identified from the minutes for further follow up. One was whether there has been any outreach to the Governors wife on substance abuse issues with discussion on possible next steps. The other is on how we will be coordinating, and collaborating if not integrating peer specialists and recovery coaches. Some states have integrated these and have one process for coaching for mental health and/or substance abuse disorders.

**December SCAODA Meeting Motion Update** – Norm Briggs and Roger Frings

The joint motion with ITC and Planning and Funding to oppose AB 286 (Companion bill SB 207) was passed at the December SCAODA meeting. This bill specifies that it is not employment discrimination because of conviction record for an employer to refuse to employ or to bar or terminate from employment an individual who has been convicted of a felony and who has not been pardoned for that felony, whether or not the circumstances of the felony substantially relate to the circumstances of the particular job. Though there was a bill passed last year related to employment at schools, this law would apply to any type of employment.

Shel shared that he has been working with others on this bill and did a number of legislative visits this past week in the Senate for companion bill (SB 207). It was not until the end of the year when AB 286 got reported out of committee and the Senate bill had been in the rules

committee that schedules bills to the floor that it looked like there would be some action. Because it didn't seem likely to stop the bill in the Assembly because of the majority party there, efforts were focused on with the Senate where the word was that there were a number of republican senators that had concerns about the bill. With a focus on the senators with more moderate history like Ellis, Olson, Harsdorf and Schultz, they did get some confirmation but didn't get any commitments on anything. Contact from constituents to their legislators was identified as very important. The goal is to keep the bill from being scheduled and if there are enough people in the caucus that don't want to vote for it than it probably won't be brought up for a vote. Shel encouraged folks to have contact with legislators or with the business community.

There are some concerns that this bill won't provide the kind of lawsuit protections to businesses because if they fire someone under this bill and don't fire someone else with a criminal conviction, they could still be potentially subject to a law suit. There is also concern regarding the employment for persons coming out of the criminal justice system. The District Attorney in Milwaukee is opposed to the bill, believing it is bad for public safety because if people can't get jobs they will be more likely to commit crimes. Some senators worry about how it will affect folks in their districts. Additional concerns have been raised by the Fatherhood Initiative as working against their goals and from religious leaders who raise the issue of forgiveness, questioning at what point we stop punishing people for their crime. Sheri also commented on how the bill goes against our efforts of decriminalizing addiction and raises the potential impact on the work force especially as it relates to the large number of individuals with OWI felony convictions at all levels of employment including politically held positions. The bill is believed to have come out of a lawsuit against Walmart, where somebody had been fired with a criminal history of sexual misconduct without any problems on the job. In looking at their work space, Walmart thought that there were places where he could potentially be a safety risk and fired him. The employee successfully sued and the case is now under appeal.

There was another motion introduced at the December SCAODA committee by the Planning and Funding committee to form an adhoc work group to identify specific areas of need for treatment. Norm has been asked to chair this group and addressed this issue later on in the agenda.

### **Children, Youth and Families Subcommittee Update – Tami Bahr**

Tami did a recap of 2011 activities. The committee decided to take things on the road in 2011 and held six meetings across the state. Tami reported that it was great to see the locations that providers work in and hear from people in the region about things they were working on. The committee met in December for updates and will be meeting in January for strategic planning. The group did decide to continue with on the road meetings but will be paring it down to four different regions in the state for 2012.

Susan reviewed the presentations done in 2011, which were all identified at the beginning of the year and matched to their strategic plan. The last meeting in Milwaukee focused on collaborative relationships with Medicaid, insurance and billing for Medicaid for adolescent substance abuse treatment with providers. In Fond Du Lac it was on suicide prevention and substance abuse issues as that community had survived numerous suicide completions the

previous year. In Dunn County the group learned about the integration of resources and screening going on there, where they are building resources into the POSIT screen so that resources would show up after completing the screening. There was also a focus on the four juvenile drug courts, which will include the committee hosting a future meeting of the four drug court programs to meet one another. In Stevens Point the focus was on closing the treatment gap because Stevens Point does not have an identified adolescent substance abuse treatment provider since the funding had been cut for a position that worked with youth in the juvenile justice system. The meeting provided the beginnings of a working relationship between the county and the hospital that runs outpatient services. There was also a presentation on the Recovery Oriented Systems of Care (ROSC). In Madison folks heard about a couple of peer support services going on there. Thanks to Faith Boersma at DHS, all of the CYF presentations are available through a link on the SCAODA website.

For 2012 there is a plan to have the payers and providers committee look at what would be needed for a recovery community support initiative with involvement of the HMO's and Medicaid. Michael Mercado will be taking the lead on this and the hope is that there will be a work plan developed by the next ITC meeting. The adhoc opiate group did have a symposium planned for last Fall which was put on hold when the sponsorship from DHS or DOJ became an issue. It looks like the Recovery Foundation may be able to provide sponsorship for 2012. Susan identified the need of early treatment for kids in middle and high school who are beginning to use prescription drugs but are not coming to treatment until they are out of the formal education system as a 2012 priority. She hopes the subcommittee will continue to beat the drum on the importance of early treatment, prior to age 18 given the significant ramifications of the effects of drug abuse on the young brain.

Tami reported on the upcoming symposium through Safer Communities scheduled for Jan 30<sup>th</sup> to address the opiate overdoses in Dane County. The Administration pulled together the Safer Communities organization by using a model that taps into a wide range of individuals that have any kind of touch with opiates and prescription drugs, such as healthcare doctors, paramedics, firefighters, police, harm reduction and treatment. Tami is interested in seeing how this goes and whether it is possible to do something like this on a statewide basis. The event takes place at the American Family Campus on the East side with registration through the Safe Communities website for a cost of \$15. Norm was interested in knowing how widespread the problem of opiates and prescription drugs are in Wisconsin or whether it is occurring in only certain parts of the state. Tami reported that it is about halfway up the state but is a growing problem. The media has reported overdoses across the entire state and providers like Kimeko Hagen in the Appleton area are reporting a greater prevalence. Dan also mentioned the dramatic increase in Naloxone saves in 2011 being reported by Jimmy Reinke. Susan suggested connecting with the Prevention Committee's Controlled Substance work group to see if there are some linkages we could make with them in this area.

Tami announced that Jill Gamoth will be joining her as the CYF co-chair, where they will alternate in attendance at ITC. Jill plans to attend her first ITC meeting in person but may later participate by phone as she is located in Menominee. At the January CYF meeting, Tami will be sharing information about the front end collections work that Connections has been doing and sharing the positive results of asking folks to pay their co-pays. This work has also morphed into

the development of policy and procedures for no shows, late or cancelled appointments and discharge notices for failure to pay fees, which is accompanied by finding other treatment resources.

Outside of CYF, Susan reported on her work at DHS.

- Four Teen Intervene Trainings that occurred in December (Shawano, Milwaukee, Manitowoc and Rockford). Over 100 individuals attended, including folks from the county, treatment providers, and schools, with implementation in each place. This training will be followed by a LinkedIn project and ongoing network for six months with Dr. Ken Winters.
- Evidence based practice initiative with DOC and juvenile corrections, where they are paying for EBP's of Teen Intervene, Multi-Dimensional Family Therapy (MDFT) and Celebrating Families through their purchase of service contracts.
- Formatting the Project Fresh Light website to get that up and running and exploring a twitter account that could promote projects occurring across the state.
- Participation in a two day meeting on the development of parent peer specialists in Wisconsin that will be inclusive of substance abuse. It will be based on a model where there are core competencies for both mental health and substance abuse. NASADAD has just sent out a survey to the substance abuse folks to see what is going on in other states on that.
- Susan is a part of NASADAD's one year focus on adolescent substance abuse treatment which will be developing protocols at the national level.
- She has also been able to attend a meeting about the initiation of health homes for kids in foster care and wonders whether CYF or ITC would like to invite the people from the Department of Children and Families involved to the table for discussion. Since substance abuse is not included as a diagnostic level like mental health is in Medicaid it doesn't always rise up to the level it needs to.

Tami reported on some trends that have occurred this past year. She reports growing concern with the cutting of more adolescent services which means people are using longer before getting into treatment making it more difficult to treat. She mentioned the closing of the sober high school in Waukesha, noting that two years ago there were three sober high schools and now there is one. The Milwaukee/Waukesha area has also seen closing of some of their intensive outpatient programs. Rosecrance out of Rockford reports their difficulty placing kids back into the community with adolescent substance abuse treatment providers.

In contrast, Susan pointed out examples of positive things happening for adolescent services. Jim Webb, who is in the Northeastern part of the state, has been very successful in maintaining and growing adolescent treatment. He has been able to continue to grow three adolescent outpatient clinics in Rhinelander, Eagle River and Minocqua and is in the final stage of certification and opening a transitional residential level of care in the Appleton area. Though he started with state funding he has been able to get the HMO's on board. Susan also discussed the misperception regarding recovery schools not having enough kids in them to justify their costs. The reason they don't have kids in them is because of the enrollment rules that apply to alternative schools. If the decision for enrollment needs to be made by February, how can someone identify in advance that a kid is going to get into trouble. The Horizon Recovery

School in Madison has successfully developed a relationship with the Madison Public schools to be able to get kids from their schools. In Waukesha County, even though Aurora closed its intensive outpatient program, the county is working with Chestnut Health Services to develop intensive outpatient using ACRA and is filling the service gap. Susan is hopeful that the Project Fresh Light website will provide a forum to report on the positive developments occurring so folks just don't hear about the negative. It may also be timely for the state to conduct another survey on adolescent treatment services. Tami mentioned a new collaborative NIATX opportunity called "It's a new year, you need a new payer" for providers who want to expand their insurance network. Applications are being taken at this time.

Mac wonders about the impact that the discontinuation of the drug free schools and the money that went into the schools for prevention and intervention is having. Susan shared that there is no longer a consistent level of expertise among persons in the school system in working with kids and families on substance abuse issues like there had been five years ago. Staci mentions that student guidance counselors/social workers are dealing with increased student case loads, going from 200 up to 500 or more. Shawano County as an example is looking at the GAIN and Teen Intervene as part of their response to the intervention framework, which is one of the strategies that DPI is using as well. In Waukesha there are people who are picking up some of the slack with Evidence Based Practices but with the loss of the recovery school on the other end of the continuum. Scott Caldwell is receiving numerous requests to do motivational interviewing training. Susan reported that one of the things they stress in their Teen Intervene trainings is to develop relationships with the local treatment providers. Sometimes all you need is to find someone in the community who has an interest in working with kids and many times that's all there is. Since there isn't an adolescent program code within DHS 75 and there isn't an adolescent treatment specialty within our certification process it is hard to get the universities to do specialty training and it's hard to get agencies to invest in a specialty without having the infrastructure.

Sheri reported on an article she saw in an Arthritis Today magazine on adolescent substance abuse and the damage it does to the adolescent brain, noting that we are targeting grandparents as intervention specialists. There are a large number of grandparents raising children of parents who are absent, incarcerated or still using. Many children are falling through the cracks because there is no one that knows what's going on. At the community clinic where she works they are unable to treat kids for substance abuse but can for other reasons and when they identify a substance abuse issue they have no place to send them. They are finding that the number of young people between the ages of 18-20 who are coming in with prescription overdose and abuse particularly with opiates has tripled over the past year. Connections which already have a large population of opiate abusers are getting more calls from people with medical assistance which is causing a problem with their doc coverage.

Steve mentioned seeing a recent article about a pharmaceutical company in San Diego that is manufacturing and distributing an opiate based vicodin to pharmacies that is ten times more powerful than the standard vicodin out there now. He also mentioned from a tribal perspective that there is a work group working with DHS on the establishment of a residential facility for native youth in WI. Currently these youth are going to the Keystone program in South Dakota, which prohibits family work as the young adult is making positive change.

### **WiNTiP Updates– Dave Macmaster**

Mac distributed a WiNTiP update (January 10, 2012) and reminded folks that WiNTiP is part of the strategic plan for both ITC and the Tobacco Control Prevention Program. WiNTiP received funding for 2012 with approximately \$42,000 from the Division of Public Health Tobacco Prevention and Control Program which is administered through the University Center for Tobacco Research and Intervention and coordinated by a steering committee. An additional \$5000 is from the Bureau on Prevention, Treatment and Recovery.

Part of WiNTiP's work is connected with the State Associations that have adopted WiNTiP's resolution to encourage policies that lead to the integration of tobacco into our services; including WIRCO and WAADAC and the development of SUPAR/WAADAC; which has been working on the development of a website and a mailing in early February to counselors with information on the new association and a survey. The current goal is to expand membership and fill the gap that occurred when the WI certification board was disband, so folks working in the field can have a stronger voice. WiNTiP is a stakeholder in all of this and WADPTA is involved in a similar process of reorganization and increasing its membership.

In 2011, trainings were completed for mental health and substance abuse clinicians and managers followed by a survey to find out what folks are doing with the training they received. WiNTiP received positive feedback on the trainings and designed manuals as a part of the comprehensive training. Now WiNTiP has partnered with WADPTA to provide \$1000 mini grants to individual practitioners or agencies that have an idea to introduce tobacco into their services. The grants would provide the seed money for implementation and the winning grant would get an additional \$250. WiNTiP wants to identify champions and early adapters to help move the implementation forward into the scopes of practice. The WiNTiP formula is buy in + training + resources = implementation. WiNTiP has achieved buy in, has begun the training and with minimal resources has developed allies and built credibility at the local, state and national level.

The next webinar will be presented on January 25<sup>th</sup> by Eric Heligenstein on "Tobacco Cessation for Persons with Mental Health and Addictive Disorders: Administrative and Policy Solutions". The webinar will be taped and made available on line on the WiNTiP and CTRI websites. There is also a new website ([www.helpusquit.org](http://www.helpusquit.org)) through CTRI which will have all the information/materials on mental health and substance abuse. The website also includes posters that can be downloaded, including two new posters have been created specific to African American women and pregnant women. The New York State videos designed for both clinicians and clients are now available for download for Wisconsin providers at the following links.

<http://www.oasas.ny.gov/tobacco/training/video-staff.cfm>

<http://www.oasas.ny.gov/tobacco/traing/video-client.cfm>

The videos were tested out in the clinician trainings and found to be very helpful. Tony Kline who is Mac's New York State colleague and a pioneer in this area is featured in both of the videos.

WiNTiP has also produced new manuals which are available on line for download. Since WiNTiP has an obligation to provide training, the manuals provide information on how to provide lectures, tobacco awareness groups, treatment plan samples, assessment tools/resources and supplemental readings. Since Mac is not as involved with mental health systems as he is

with substance abuse, WiNTiP developed an advertising campaign that includes the posters with the help us quit website link aimed at nurses, psychologists and social workers through their trade journals. In addition there were three one day trainings completed for mental health clinicians. WiNTiP has also done presentations at both the WI Psychological Association and National Association of Social Workers conferences. WI is the only state that is approaching both substance abuse and mental health in tandem.

William White, author of “Slaying the Dragon”, has become a WiNTiP supporter and has finished two research based articles, one for clinicians and the other for clients that will be available for download on the WiNTiP website. These are wonderful resources, since folks are always asking about the research. In addition Mac has also connected with the Smoking Cessation Leadership Network in San Francisco and will be going to Kansas City in August for the National Tobacco Health Conference and may be presenting some WiNTiP information there. Mac has also been designated as the liaison between the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and the Association for Treatment Tobacco Use and Dependence (ATTUD) for finding ways to connect on the integration into substance abuse and mental health. ATTUD has developed a position paper in relation to WiNTiP which will be on the website. The next steering committee is scheduled for January 11, where more work will be done on the mini grants and website development.

Norm brought up the editorial in the WI State Journal looking at the issue of the amount of money that the state takes in on tobacco taxes in comparison to the amount spent on prevention and cessation. Mac shared that WI brings in \$800 million a year in tobacco revenue with the money going into the general funds while the budget for the one program designed to do tobacco harm reduction is reduced by 66%. These cuts have resulted in the decimation of the tobacco control group.

### **SCAODA and ITC Strategic Planning – Norm Briggs and Roger Frings**

Norm reviewed the five identified goals for SCAODA, which raised a question about how successful SCAODA is in meeting its first goal of providing leadership and direction to the legislature and the governor’s office on AODA policy in Wisconsin. There were concerns noted that we have no legislative input at any of our meetings and only on occasion do we have a representative from the Governor’s office. There was some disappointment expressed about our lack of impact on public health policy. Norm mentioned that there is currently an initiative to get the legislative positions filled as we only have one legislator named at this time, who has only attended one meeting. Roger expressed that it is difficult to measure our success in this area since it is ever changing and dependent on the make up of the legislature and who is in charge in the Governor’s office. Francine identified that it depends on how you define success and it may be a matter of opinion; particularly in regard to measuring if there is a cultural change. Roger stated that it’s important to remember that SCAODA is an advisory council and that the legislature is not bound by anything that SCAODA does or recommends. He recommended that if we as a committee of the council don’t feel that the method we are using now to provide advice to the legislature and governor is as effective as we would like it to be, we need to look back at what we are utilizing in lobbying activities and seek a different approach that may have better outcomes. We need to be flexible in how we approach them and make our

pitch while remembering that as the pendulum swings there will be times when we will have good reception and times when we will not. Shel shared that a few years back a group from the mental health council talked with a number of legislators about why they hadn't been getting much traction on their issues. They received a consistent response that the legislators weren't hearing from their constituents about it. This was the case even with a number of other organizations associated with the council such as NAMI and other consumer groups sending out things as well. He believes the same reality holds true on the substance abuse side. Mac expressed that it sends the message that they don't care about our recommendations unless they hear from folks in their community, even though we are the most invested, informed, and experienced. Because the committee doesn't vote, we may need to do advocacy in the areas in which we live and work so that the message is delivered from the voting members of the community.

Mac suggested the idea of having a delegation from SCAODA with key council members that could meet with the legislators on the council and the Governor's representative about advancing one or two ideas in a different way rather than sending a letter or a petition that doesn't go anywhere. Sheri talked about the group from WAADAC that goes to Washington knocking on doors and meeting with people.

Susan reminded folks not to forget the influence that SCAODA and its committees has on getting things done at the State level, like the adolescent services gap analysis that would otherwise have not been accomplished. Tami also identified the networking that takes place and the value from the information that SCAODA and its committees are able to bring together. She brought up the changes that occurred at the UW Madison in regard to their drinking policy, which now requires that students with an underage drinking ticket participate in an evidence based program. Tami also thought that they may need to provide more direction to their committee on the kind of actions they could take in their local communities.

The process of addressing ITC's strategic plan began with identifying the current areas on the plan. These included: women services, workforce development, connection with mental health, substance abuse with the elderly, WiNTiP, CYF, IDP, health care reform and parity and outreach. Norm expressed his desire that we develop some very specific objectives that we can accomplish in a year on areas that we think are most important so we can come back to the full council with our accomplishments. The group then proceeded to identify which areas they wanted to include in the plan. Identified priorities included the following:

- IDP- with interest in getting changes made to the current regulations.
- Women services- there are a number of things that still need to occur.
- Continuation of the CYF subcommittee - particularly to take a look at the number of agencies that may have gone out of business since the last gap analysis.
- Elderly Population - they are an underserved group and we need to know who services them.
- Tracking health care reform and parity
- WiNTiP - needs to remain until we have implemented tobacco integration into the system and it is a standard scope of practice.
- Workforce development

The connection with mental health, system of services and outreach were all seen as core elements that need to be included in all of the areas rather than being identified as a stand alone area. There was some discussion about the inclusion of gambling however since the debate continues about whether it will remain with mental health or become a part of substance abuse, folks thought it may fit best fold in under the area of workforce development. After more discussion on the impact of gambling on licensing and credentialing and the possibility of a special co-occurring disorder certification process, Norm suggested we place the gambling issue as a parking lot issue at this time in our discussion. Shel also raised two other areas that have come up in discussions that may also fit it under workforce development (education of community correction agents and recovery coaches and peer support specialists). Mac thought that we should include the Public Health Council as part of our outreach since they are a similar group to SCAODA.

In terms of process, Norm suggested that we go through each area one by one and identify the objectives, tasks and measurements both short and long term. The recommendation was to begin by looking at the things that have been accomplished and then deciding where we will go from here.

Women's treatment - In terms of identifying access and challenges to services, Norm talked about the survey that was completed three years ago by a couple of interns at ARC who contacted agencies around the state through the treatment provider directory to find out details on what they were providing specific to women's treatment. Examples of the kind of information they found included that corrections pays for the majority of those services and that there was one child care slot for every 20 women. Norm offered to bring the information of that survey to the next ITC meeting and begin to flesh out information for our planning of action steps. We also have information that we received from Bernestine Jeffers' presentation to ITC on service gaps and needs to review as well. Francine also thinks there may be other issues we have not yet identified that we will want to include such as access to treatment for pregnant women who are on methadone or suboxone medications. Mac and Sheri both stressed the need to indicate things that we have completed such as these surveys even though we may continue to do further work in these areas.

Integration of Nicotine - Mac identified all the promotion and training that has been done through WiNTiP and is documented in the activity reports. They also have a list of programs which have had representation at the trainings and have made commitments to address this issue.

Senior Populations – Began process of identifying challenges related to access to services through Jane Raymond's presentation to ITC. This was followed up with the planning of MI training through Scott Caldwell from DMHSAS to protective services and elder abuse worker staff. Sharon Beall from the office of Elder Affairs was also contacted by Norm with an invitation to join ITC. A connection was made with Juan Flores, Bureau Director of Long Term Care, to report future concerns that arise related to seniors being screened out of nursing home or assisted living facilities who have a diagnosed substance abuse disorder.

Children Youth and Families – Completed a gap analysis a number of years ago to see where adolescent substance abuse is available in the state. The regional meetings of CYF have also provided a forum to obtain and disseminate information across the state on adolescents.

In terms of moving forward, Francine identified three areas of interest for greater collaboration. 1) state issued family centered treatment grants which include the treatment of children with their mothers. As an example she wasn't aware of the Celebrating Families model. 2) Not just looking at adolescents but birth outcomes for women who are pregnant and using. 3) 80% of child welfare families have substance abuse problems and they aren't always identified and referred for treatment. The focus is often on the child, but since that child is going back to the family how does that piece get integrated. Shel also noted the importance of the tie into the mental health piece and inquired about the connection with the CYF committee of the Mental Health Council. In addition, Susan also identified the Children Come First committee chaired by Marie and the importance of collaboration between the three groups. The idea of occasional joint meetings or having representatives from each group participating on the other committees was identified as useful. WI is below the national norm for identifying the substance abuse needs of the parents of children in the CPS system. The need to collaborate with the Department of Children and Families was seen as very important and timely in having an ally like Sinikka Santala available to work with on these issues. Francine agreed to see what she could find out about the advisory council for the child welfare system for the next meeting.

Intoxicated Driver Program – Steve identified two issues for the IDP program. 1) lack of uniformity in providing services and 2) racial and ethnic barriers that exist in referrals and providing services. Steve suggested having meetings with the tribes to hear about their experiences with the IDP program as a way to verify the issues. It was also suggested that LeeAnn Cooper attend ITC to update the committee on her work plan as she has been a part of the state Tribal collaboration group and has two working groups which focus on policy and best practices. Steve believes that there is a general lack of training on different cultural norms as it relates to the IDP screening, which is not just limited to the tribes that needs to be addressed. Shel also raised the concerns that our committee has had regarding growing punitive responses within the legislators and the need for a more balanced approach. Steve discussed the reality regarding the lack of uniformity on the credentials and training of persons who complete the IDP assessments. Some staff are AODA certified and others have no background in substance abuse which has resulted in some off the wall recommendations for treatment and a lot of information being lost in the assessment process itself. Norm recommended that we invite LeeAnn Cooper to our next meeting for an update on her work and review the recommendations of the former ITC IDP subcommittee chaired by Andrea and Nina.

Health care reform and parity – Steve brought up including SAMHSA's new definition of recovery. Shel identified four areas: 1) lack of consistency with private insurers reimbursement for the transitional treatment services 2) medical homes as a health care initiative, maybe looking at an interface with DCF 3) essential benefits as part of health care reform which is the proposal on the table from SAMHSA at this time and 4) health care exchanges. Steve also thought we may want to include recovery coaches as well.

Norm asked for volunteers to take responsibility for doing a draft layout of one of the areas of the revised strategic plan for our next ITC meeting on February 14. Tami and Susan will do CYF, Mac- WiNTiP, Steve-IDP, Shel-Health Care Reform and Parity, Norm and Francine-Women's treatment and Sheil-Senior Populations.

### **Insurance Update – Roger Frings**

The office of the Commissioner of Insurance (OCI) and DHS have been asked by the executive branch to suspend their activity on health insurance exchange development pending further guidance. Along with that there has been some discussion, but with no final decision, on returning some of the federal grant money that was received to help develop the exchanges, pending decisions by the Supreme Court which are expected by May or June. There have been a number of staff who have been working primarily on getting background information and a couple of staff that have been working directly on grants such as the rate review grant and the early innovator's grant. That activity is now on hold.

There was legislation introduced some time ago in the form of AB 210 which passed the assembly but shortly after reaching the senate, the chairman of the senate insurance committee made the statement that it was dead and not going anywhere. That legislation was technical in nature and let them do the bar bones minimum to set up our exchanges and be in compliance with the federal law. It has been made very clear that they do not want us to do that. There is concern that depending on what happens with the court decision, as to whether the state will have enough time to set up anything once the decision is made.

Each state is unique in this regard depending on the political make up of their state. Francine raised the issue of needing to know where the state is at in regard to essential benefits for substance abuse and mental health. She mentioned a meeting with Secretary Smith where he stated that the state's intent was to ask for a waiver for substance abuse and mental health. The feds are still dictating that these are essential benefits but haven't said what the benefit needs to be. Francine was not sure what Wisconsin would be seeking a waiver for. Shel noted the importance of having the OCI involved in discussions on this such as having their representation on the mental health infrastructure committee work group chaired by Pat Cork, as the private sector has a direct impact on what happens in the public sector.

### **Establishment of Adhoc Work Group to review Statewide Gaps in Service – Norm Briggs**

At the December SCAODA meeting a motion proposed by Planning and Funding was passed for the SCAODA chair to appoint an adhoc committee to address the growing number of citizens and tribal members seeking and not able to access substance abuse treatment in Wisconsin. The positive impact on the motion stated that SCAODA will have an understanding and have the specific evidence as to the degree of the problem and specific recommended remedies. The Planning and Funding committee recommended that this committee prepare a preliminary report by March 2012 and a complete report by June 2012. Michael Waupoose asked Norm to chair the committee. Norm shared that members of the Planning and Funding Committee were hearing reports from people not being able to access or benefit from substance abuse treatment in their communities. Francine noted that the issue of benefiting from treatment is whole different issue than access as these are folks who are receiving treatment but not getting what they need.

Norm wonders what information folks want that isn't already defined in the Substance Abuse Block grant application. He referenced the section of the Block grant called "Unmet service needs and critical gaps in Wisconsin's substance abuse prevention and treatment system" and the section on the States planning priorities to address the gaps. Norm is not sure what generated this, but would like ITC to agree to serve as the adhoc committee.

Shel brought up the joint meeting of the Planning and Funding committee with the Adult Quality committee of the Mental Health Council to talk about the treatment needs and help establish a joint planning process for the combined block grant application. Shel shared that it is not the intent of the joint block grant planning group to do any additional studies but to look at the information that is already out there such as info from Public Health, Healthy WI 20/20, the Bureau, etc. Shel wonders if that work is the same as what this adhoc committee is charged with doing. Perhaps this could be rolled in together rather than having two separate groups doing the same thing.

Francine raises the issue of people seeking treatment but unable to gain access as different from prevalence. Not everyone with a need is interested in seeking services. Sheila states that both types of information is available through SAMHSA and can be accessed by State. Susan brought up the logic model that was used for the development of the UPC which is being used to match the needs with the service delivery system. We don't always have the type of treatment available to match the need. Tami mentions that we have also gotten away from maintaining waiting lists for treatment which have been a source of information as well. Francine identified the issue of truncated care, where people get into treatment but then its gets cut short due to limited funding.

Norm asks that the committee members take a look at the material on the unmet service needs and critical gaps paper and the planning steps paper and develop any questions or comments by the next ITC meeting. This information is available on the website under the substance abuse block grant.

#### **Legislation/Miscellaneous Updates/Future Agenda – Norm Briggs and Roger Frings** AB 405

This is a proposed change in the legislation to make a fourth OWI offense a felony regardless of the amount of time that has elapsed since the last offense. It would also eliminate the option of a reduced period of imprisonment based upon completing a period of probation that includes alcohol and other drug treatment. This bill once again seems to underscore the imbalance between punishment and treatment and would not allow judges any discretionary sentencing options regarding treatment. Sheri said that it is inconsistent with the earned release program that now operates in the prison for OWI 5<sup>th</sup> and greater offenders. This bill is likely attempting to address concerns of public safety but fails to take in account the potential impact of substance abuse treatment. It also reflects a lack of understanding about the chronic relapsing nature of addiction and the reality that it often takes multiple episodes of treatment to achieve sustainable recovery. It also fails to recognize the significance of effective treatment matching or give consideration to residential treatment options as an alternative to more expensive incarceration. Sheri feels we may want to draft language in opposition that is based on unintended consequences if this bill is passed. This bill is still in committee and given that it is a democratic bill it is very unlikely that it will move forward.

The group discussed the options of drafting a written motion or contacting Senator Carpenter and Representative Berceau to gather information on their intent with the proposed bill and possibly provide them some education on addiction. The contact would be sure to make clear that this is not a SCAODA or ITC position but more fact finding. Norm agreed to email the SCAODA

executive staff about ITC's interest in making this type of contact and will let Sheri know their response, so she and any others who are interested can proceed with making a contact.

#### Needle Exchange Update

Dan reported on his inquiry to the ARCW's needle exchange program regarding those persons age 50 and older. The information he received is that despite the increased use of opiates, they have not seen an increase in the number of needle exchanges for this particular group.

#### ITC Public Forum

The ITC Public forum is scheduled for June 12, 2012 at UW Stout in Menominee. It will take place at the National Rural Institute on Alcohol and Drug Abuse Annual conference. The forum is scheduled within the regular programming from 10:30-noon.

#### **Adjourn**

The meeting was adjourned by Roger.

#### **Next meetings and dates:**

1. ITC  
February 14, 2011; 10:00 am – 2:30 pm. Department of Corrections, Madison
2. Children, Youth and Families Treatment Subcommittee  
January 27, 2011; 9:00am – 4:00pm.  
Connections Counseling, Madison
3. SCAODA  
March 2, 2012; 9:30 am – 3:30 pm; American Family Insurance Conference Center, Madison. For more information, visit the SCAODA web site at:  
<http://www.scaoda.state.wi.us/meetings/index.htm>

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**BY-LAWS  
of the  
State of Wisconsin  
State Council on Alcohol and Other Drug Abuse  
As Approved  
June 6, 2008  
Amended 9-10-10**

*<please note: lines underlined below are taken directly from statute.>*

**ARTICLE I**

**Purpose and Responsibilities**

**Section 1. Authority**

The council is created in the office of the governor pursuant to sec. 14.017 (2), Wis. Stats. Its responsibilities are specified under sec. 14.24, Wis. Stats.

**Section 2. Purpose**

The purpose of the state council on alcohol and other drug abuse is to enhance the quality of life of Wisconsin citizens by preventing alcohol, tobacco and other drug abuse and its consequences through prevention, treatment, recovery, and enforcement and control activities by:

- a. Supporting, promoting and encouraging the implementation of a system of alcohol, tobacco and other drug abuse services that are evidence-based, gender and culturally competent, population specific, and that ensure equal and barrier-free access;
- b. Supporting the prevention and reduction of alcohol, tobacco, and other drug use and abuse through evidence-based practice with a special emphasis on underage use; and
- c. Supporting and encouraging recovery in communities by reducing discrimination, barriers and promoting healthy lifestyles.

**Section 3. Responsibilities**

The state council on alcohol and other drug abuse shall:

- a. Provide leadership and coordination regarding alcohol and other drug abuse issues confronting the state.
- b. Meet at least once every 3 months.
- c. By June 30, 1994, and by June 30 every 4 years thereafter, develop a comprehensive state plan for alcohol and other drug abuse programs. The state plan shall include all of the following:
  - i. Goals, for the time period covered by the plan, for the state alcohol and other drug abuse services system.
  - ii. To achieve the goals in [par. \(a\)](#), a delineation of objectives, which the council shall review annually and, if necessary, revise.
  - iii. An analysis of how currently existing alcohol and other drug abuse programs will further the goals and objectives of the state plan and which programs should be created, revised or eliminated to achieve the goals and objectives of the state plan.
- d. Each biennium, after introduction into the legislature but prior to passage of the biennial state budget bill, review and make recommendations to the governor, the legislature and state agencies, as defined in [s. 20.001 \(1\)](#), regarding the plans, budgets and operations of all state alcohol and other drug abuse programs.
- e. Provide the legislature with a considered opinion under [s. 13.098](#).
- f. Coordinate and review efforts and expenditures by state agencies to prevent and control alcohol and other drug abuse and make recommendations to the agencies that are consistent with policy priorities established in the state plan developed under [sub. \(3\)](#).

- g. Clarify responsibility among state agencies for various alcohol and other drug abuse prevention and control programs, and direct cooperation between state agencies.
- h. Each biennium, select alcohol and other drug abuse programs to be evaluated for their effectiveness, direct agencies to complete the evaluations, review and comment on the proposed evaluations and analyze the results for incorporation into new or improved alcohol and other drug abuse programming.
- i. Publicize the problems associated with abuse of alcohol and other drugs and the efforts to prevent and control the abuse.
- j. Issue reports to educate people about the dangers of alcohol, tobacco and other drug abuse.
- k. The council also recommends legislation, and provides input on state alcohol, tobacco and other drug abuse budget initiatives.
- l. Form committees and sub-committees for consideration of policies or programs, including but not limited to, legislation, funding and standards of care, for persons of all ages to address alcohol, tobacco and other drug abuse problems.

## **ARTICLE II**

### **Membership**

#### **Section 1. Authority**

Membership is in accordance with section 14.017(2), Wis. Stats.

#### **Section 2. Members**

- 2.1** The 22-member council includes six members with a professional, research or personal interest in alcohol, tobacco and other drug abuse problems, appointed for four-year terms, and one of them must be a consumer representing the public. It was created by chapter 384, laws of 1969, as the drug abuse control commission. Chapter 219, laws of 1971, changed its name to the council on drug abuse and placed the council in the executive office. It was renamed the council

on alcohol and other drug abuse by chapter 370, laws of 1975, and the state council on alcohol and other drug abuse by chapter 221, laws of 1979. In 1993, Act 210 created the state council on alcohol and other drug abuse, incorporating the citizen's council on alcohol and other drug abuse, and expanding the state council and other drug abuse's membership and duties. The state council on alcohol and other drug abuse's appointments, composition and duties are prescribed in sections 15.09 (1)(a), 14.017 (2), and 14.24 of the statutes, respectively.

The council strives to have statewide geographic representation, which includes urban and rural populated areas, to have representation from varied stakeholder groups, and shall be a diverse group with respect to age, race, religion, color, sex, national origin or ancestry, disability or association with a person with a disability, arrest or conviction record, sexual orientation, marital status or pregnancy, political belief, or affiliation, or military participation.

**2.2** There is created in the office of the governor a state council on alcohol and other drug abuse consisting of the governor, the attorney general, the state superintendent of public instruction, the secretary of health services, the commissioner of insurance, the secretary of corrections, the secretary of transportation and the chairperson of the pharmacy examining board, or their designees; a representative of the controlled substances board; a representative of any governor's committee or commission created under [subch. I](#) of ch. 14 to study law enforcement issues; 6 members, one of whom is a consumer representing the public at large, with demonstrated professional, research or personal interest in alcohol and other drug abuse problems, appointed for 4-year terms; a representative of an organization or agency which is a direct provider of services to alcoholics and other drug abusers; a member of the Wisconsin County Human Service Association, Inc., who is nominated by that association; and 2 members of each house of the legislature, representing the majority party and the minority party in each house, chosen as are the members of standing committees in their respective houses. [Section 15.09](#) applies to the council.

### **2.3 Selection of Members**

From Wis. Stats. 15.09 (1)(a); Unless otherwise provided by law, the governor shall appoint the members of councils for terms prescribed by law. Except as provided in [par. \(b\)](#), fixed terms shall expire on July

1 and shall, if the term is for an even number of years, expire in an odd-numbered year.

## **2.4 Ex-Officio Members**

- a. Ex-officio members may be appointed by a majority vote of the council to serve on the council, special task forces, technical subcommittees and standing committees. Other agencies may be included but the following agencies shall be represented through ex-officio membership: The Wisconsin Departments of: Revenue, Work Force Development, Regulation and Licensing, Veteran Affairs and Children and Families, and the Office of Justice Assistance, the Wisconsin Technical Colleges System and the University of Wisconsin System.
- b. Ex-officio members of the council may participate in the discussions of the council, special task forces, technical subcommittees, and standing committees except that the chairperson may limit their participation as necessary to allow full participation by appointed members of the council subject to the appeal of the ruling of the chairperson.
- c. Ex-officio members will serve four-year terms.
- d. An ex-officio member shall be allowed to sit with the council and participate in discussions of agenda items, but shall not be allowed to vote on any matter coming before the council or any committee of the council, or to make any motion regarding any matter before the council.
- e. An ex-officio member may not be elected as an officer of the council.
- f. An ex-officio member shall observe all rules, regulations and policies applicable to statutory members of the council, and any other conditions, restrictions or requirements established or directed by vote of a majority of the statutory members of the council

## **2.5 Selection of Officers**

Unless otherwise provided by law, at its first meeting in each year the council shall elect a chairperson, vice-chairperson and secretary from among its members. Any officer may be reelected for successive terms. For any council created under the general authority of s. 15.04 (1) (c), the constitutional officer or secretary heading the department or the chief executive officer of the independent agency in which such council is created shall designate an employee of the department or independent agency to serve as secretary of the council and to be a voting member thereof.

## **2.6 Terms of Voting Members**

- a. Voting members shall remain on the council until the effective date of their resignation, term limit or removal by the governor, or until their successors are named and appointed by the governor.
- b. Letter of resignation shall be sent to the governor and council chairperson.
- c. Each voting member or designee of the council is entitled to one vote.

## **2.7 Code of Ethics**

All members of the council are bound by the codes of ethics for public officials, Chapter 19, Wis. Stats., except that they are not required to file a statement of economic interest. Ex-officio members are not required to file an oath of office. As soon as reasonably possible after appointment or commencement of a conflicting interest and before voting on any grant, members shall reveal any actual or potential conflict of interest. Chapter 19.46 of Wisconsin State Statutes states that no state public official may take any official action substantially affecting a matter in which the official, a member of his or her immediate family, or an organization with which the official is associated has a substantial financial interest or use his or her office or position in a way that produces or assists in the production of a substantial benefit, direct or indirect, for the official, one or more members of the official's immediate family either separately or together, or an organization with which the official is associated.

## **2.8 Nondiscrimination**

The council will not discriminate because of age, race, religion, color, sex, national origin or ancestry, disability or association with a person with a disability, arrest or conviction record, sexual orientation, marital status or pregnancy, political belief, or affiliation, or military participation.

## **2.9 Nomination Process for Appointed Members and Officers**

As per Article II, Section 2.1, the governor is required to appoint six citizen members. In addition, the council elects the chairperson, vice-chairperson and secretary, annually. The council will follow this process when making recommendations to the governor concerning appointments and nominating a slate of officers:

- a. The council, along with the office of the governor and department staff, will monitor when council terms will expire. It will also monitor the composition of the council with respect to the factors specified in Article II, Section 2.1.
- b. The vice-chairperson of the council shall convene a nominating committee and appoint a chairperson of that committee as needed to coordinate the process for all appointments to the council as outlined in Article II, Section 2 and annually put forth a slate of officers as identified in Article II Sections 3.1, 3.2 and 3.3. The Council Chairperson may ask for nominations from the floor to bring forth nominations in addition to the slate of officers brought forth by the nominating committee. The nominating committee shall make recommendations to the council regarding nominations and appointments prior to the September council meeting and have such other duties as assigned by the council.
- c. The nominating committee of the council, with support of bureau staff, will publicize upcoming vacancies, ensuring that publicity includes interested and underrepresented groups, including alcohol, tobacco and other drug abuse agencies, alcohol, tobacco and other drug abuse stakeholder groups, consumers, and providers. Publicity materials will clearly state that council appointments are made by the governor. Materials will also state that the governor normally considers the council's recommendations in making council appointments.

- d. While any person may apply directly to the governor according to the procedures of that office, all applicants will be asked to provide application materials to the council as well. Bureau staff will make contact with the office of the governor as necessary to keep the committee informed regarding applicants, including those that may have failed to inform the committee of their application.
- e. Applicants shall provide a letter of interest or cover letter, along with a resume and any other materials requested by the office of the governor. The nominating committee, in consultation with department staff, may request additional materials. The nominating committee, with support of bureau staff, will collect application materials from nominees, including nominees applying directly to the governor. The nominating committee or staff will acknowledge each application, advising the applicant regarding any missing materials requested by the nominating committee. The nominating committee or staff will review each application to ensure that all required nomination papers have been completed.
- f. The nominating committee may establish questions to identify barriers to attendance and other factors related to ability to perform the function of a member of the state council on alcohol and other drug abuse and to identify any accommodations necessary to overcome potential barriers to full participation by applicants. The nominating committee may interview applicants or designate members and/or staff to call applicants. Each applicant shall be asked the standard questions established by the committee.
- g. The nominating committee shall report to the full council regarding its review of application materials and interviews. The report shall include the full roster of applicants as well as the committee's recommendations for appointment.
- h. The council shall promptly act upon the report of the nominating committee. Council action shall be in the form of its recommendation to the governor. Department staff shall convey the council's recommendation to the office of the governor.

## **2.10 Removal from Office**

The Governor may remove appointed members from the council. The council may recommend removal but the Governor makes the final decision regarding removal.

## **Section 3. Officers**

### **3.1 Chairperson**

The chairperson is the presiding officer and is responsible for carrying out the council's business including that motions passed be acted upon in an orderly and expeditious manner and assuring that the rights of the members are recognized. The chairperson may appoint a designee to preside at a meeting if the vice-chairperson is unable to preside in their absence. The chairperson is also responsible for organizing the work of the council through its committee structure, scheduling council meetings and setting the agenda. The chairperson may serve as an ex-officio member of each council committee. The chairperson shall represent the positions of the council before the legislature, governor and other public and private organizations, unless such responsibilities are specifically delegated to others by the council or chairperson. The agenda is the responsibility of the chairperson, who may consult with the executive committee or other council members as necessary.

### **3.2 Vice-Chairperson**

The vice-chairperson shall preside in the absence of the chairperson and shall automatically succeed to the chair should it become vacant through resignation or removal of the chairperson until a new chairperson is elected. The vice-chairperson shall also serve as the council representative on the governor's committee for people with disabilities (GCPD). If unable to attend GCPD meetings, the vice-chairperson's designee shall represent the council.

### **3.3 Secretary**

The secretary is a member of the executive Committee as per Article IV, Section 5. The secretary is also responsible for carrying out the functions related to attendance requirements as per Article III, Section 6.

### **3.4 Past Chairperson**

The immediate past chairperson shall serve as a member of the council until expiration of their appointed term, and may serve as an ex-officio member during the term of her or his successor if the term of office as member of the council has expired.

### **3.5 Vacancies**

In the event a vacancy occurs among the Officers (Chairperson, Vice-Chairperson, or Secretary) of the State Council on Alcohol and Other Drug Abuse, the following procedure should be followed: In the event of a vacancy of the Chairperson, the Vice-Chairperson assumes the responsibility of Chairperson until such time as new Officers are elected according to the procedures outlined in the By-Laws. In the event of a vacancy of the Vice-Chairperson, the Secretary assumes the responsibility of the Vice-Chairperson until such time as new Officers are elected according to the procedures outlined in the By-Laws. In the event of a vacancy of the Secretary, the Chairperson shall appoint a replacement from the statutory membership until such time as new Officers are elected according to the procedures outlined in the By-Laws.

## **ARTICLE III**

### **Council Meetings**

#### **Section 1. Council Year**

The council year shall begin at the same time as the state fiscal year, July 1.

#### **Section 2. Meetings**

##### **2.1 Regular and special meetings**

Regular meetings shall be held at least four times per year at dates and times to be determined by the council. Special meetings may be called by the chairperson or shall be called by the chairperson upon the written request of three members of the council.

##### **2.3 Notice of meetings**

The council chairperson shall give a minimum of seven days written notice for all council meetings. An agenda shall accompany all meeting notices. Public notice shall be given in advance of all meetings as required by Wisconsin's Open Meetings Law. If a meeting date is changed, sufficient notice shall be given to the public.

### **2.3 Quorum**

A simple majority (51%) of the membership qualified to vote shall constitute a quorum to transact business.

### **Section 3. Public Participation**

Consistent with the Wisconsin Open Meetings law, meetings are open and accessible to the public.

### **Section 4. Conduct of Meetings**

- 4.1** Meetings shall be conducted in accordance with the latest revision of Robert's Rules of Order, unless they are contrary to council by-laws or federal or state statutes, policies or procedures.

### **Section 5. Agendas**

- 5.1** Agendas shall include approval of minutes from prior meetings, any action items recommended by a committee, an opportunity for public comment, and other appropriate matters.
- 5.2** Requests for items to be included on the agenda shall be submitted to the chairperson two weeks prior to the meeting.

### **Section 6. Attendance Requirements**

- 6.1** All council members are expected to attend all meetings of the council. Attendance means presence in the room for more than half of the meeting.
- 6.2** Council members who are sick, hospitalized or who have some other important reason for not attending should notify the secretary or the secretary's designee at least a week before the meeting. If that is not possible, notice should be given as soon as possible.

- 6.3** Any member of the council who has two unexcused absences from meetings within any twelve month period will be contacted by the secretary of the council to discuss the reasons for absence and whether the member will be able to continue serving. Appointed members who do not believe that they can continue should tender their resignation in writing to the secretary of the council. Any resignations will be announced to the council and forwarded to the appointing authority.
- 6.4** At any time the secretary of the council, after consultation with the appointed member, believes that a member will not be able to fulfill the duties of membership, he or she should bring the matter to the chairperson. When the chairperson confirms that recommendation, he or she shall place the matter on the next council agenda. The chairperson shall ensure that the member at issue is given notice that the council will consider a recommendation to the appointing authority regarding the membership. When the council, after the member at issue is given the opportunity to be heard, agrees with the recommendation, it shall recommend to the appointing authority that the member be removed from the council and a replacement appointed to fulfill the member's term.
- 6.5** If a statutory member or their designee are absent from two meetings within a year, they will be contacted by the secretary of the council to discuss the reasons for absence and whether the member will be able to continue serving. In the event that a statutory member believes they are unable to continue, the secretary of the council shall inform the council chairperson and upon confirmation the chairperson will provide written notice to the governor of the need for an alternate or replacement.

## **Section 7. Staff Services**

The division of mental health and substance abuse services shall provide staff services. Staff services shall include: record of attendance and prepare minutes of meetings; prepare draft agendas; arrange meeting rooms; prepare correspondence for signature of the chairperson; offer information and assistance to council committees; analyze pending legislation and current policy and program issues; prepare special reports, and other materials pertinent to council business.

## **Section 8. Reimbursement of Council and Committee Members**

According to Section 15.09 of Wisconsin Statutes: Members of a council shall not be compensated for their services, but, except as otherwise provided in this subsection, members of councils created by statute shall be reimbursed for their actual and necessary expenses incurred in the performance of their duties, such reimbursement in the case of an elective or appointive officer or employee of this state who represents an agency as a member of a council to be paid by the agency which pays his or her salary.

## ARTICLE IV

### Committees

#### Section 1. Committee Structure

- 1.1 There shall be an executive committee as provided below. The executive committee is a standing committee of the council.
- 1.2 The council may establish other standing committees and subcommittees as necessary or convenient to conduct its business. Of the standing committees established by the state council on alcohol and other drug abuse, at least one shall have a focus on issues related to the prevention of alcohol, tobacco and other drug abuse, at least one shall have a focus on issues related to cultural diversity, at least one shall have a focus on issues related to interdepartmental coordination, at least one shall have a focus on issues related to the intervention and treatment of alcohol, tobacco and other drug abuse, and at least one shall have a focus on issues related to the planning and funding of alcohol and other drug abuse services. Subcommittees are a subset of a standing committee. Subcommittees are standing committees, which by another name is a permanent committee. Standing committees meet on a regular or irregular basis dependent upon their enabling act, and retain any power or oversight claims originally given them until subsequent official actions of the council (changes to law or by-laws) disbands the committee. Of the standing subcommittees established by the state council on alcohol and other drug abuse, at least one shall have a focus on children youth and families and is a subcommittee of the intervention and treatment committee, at least one shall have a focus on the Americans with Disabilities Act (ADA) for deaf, deafblind and hard of hearing and is a subcommittee of the cultural diversity committee, at least one shall have a focus on cultural competency and is a subcommittee of the

cultural diversity committee, and at least one shall have a focus on epidemiology and is a subcommittee of the prevention committee.

Ad-hoc committees are established to accomplish a particular task and are to be temporary, with the charge being well-defined and linked to SCAODA's strategic plan, not to exceed duration of twelve calendar months. Ad-hoc committees are formed by standing committee chairs. Ad-hoc committees must report their progress at the meeting of their standing committee. Ad-hoc committees can be granted extensions by the standing committee chair.

It is the intent of this section that:

- There should be periodic review of the structure and progress of the work of the committees, subcommittees and ad-hoc committees.
- If the officers have concerns about the work of the standing committees, subcommittees or ad-hoc committees, they could convene an executive committee meeting to discuss options, "for the good of the order."
- The intent of this group is to recommend that ad-hoc committees be time-limited (recommend one year) and the committee chair determines if the work should go forward beyond the original charge.
- The charge should be well-defined and linked to SCAODA's strategic plan.
- The committee chairs should be primarily responsible for creating and disbanding ad-hoc groups.
- The committee chairs should be responsible for monitoring the work and duration of the work in coordination with SCAODA.

**1.3** Committees may determine their own schedules subject to direction from the full council.

## **Section 2. Composition of Committees**

**2.1** Council committees may include members of the public as well as council members.

**2.2** The council chairperson may appoint a chairperson who must be a member of the council, for each committee. The council chairperson,

with the advice of the committee chairperson may appoint other committee members.

- 2.3** Committees may designate subcommittees including ad hoc committees, as necessary or convenient subject to limitation by the full council.
- 2.4** A council member shall not chair more than one committee.
- 2.5** A committee chairperson's term shall not exceed the length of their appointment or four years whichever comes first. With the majority vote of the council, a chairperson may be reappointed.

### **Section 3. Requirements for all Committees**

- 3.1** A motion or resolution creating a committee shall designate the mission and duties of the committee. The council may also specify considerations for the chairperson to follow in appointing committee chairpersons and members and such other matters as appropriate.
- 3.2** All committee members are expected to attend all meetings of the committee. Attendance means presence in the room for more than half of the meeting.
- 3.3** Any committee may authorize participation by telephone conference or similar medium that allows for simultaneous communication between members as permitted by law.
- 3.4** Committee members who are sick, hospitalized or who have some other important reason for not attending should notify the chairperson or the chairperson's designee at least a week before the meeting. If that is not possible, notice should be given as soon as possible.
- 3.5** Any committee member who has two unexcused absences within a twelve month period will be contacted by the committee chairperson to discuss the reasons for absence and whether the member will be able to continue serving. Members who do not believe that they can continue should tender their resignation in writing to the committee chairperson. Any resignations will be announced to the council chairperson and to the committee.
- 3.6** The committee chairperson may remove committee members, other than executive committee members, after notice of proposed removal

to and an opportunity to be heard by the member consistently with this process.

#### **Section 4. Requirements for Committee Chairpersons**

The chairperson of each committee is responsible for:

- a. Ensuring that the by-laws and every applicable directive of the council are followed by the committee as indicated in Chapters 15.09, 14.017 and 14.24 of Wisconsin Statutes;
- b. Ensuring that recommendations of the committee are conveyed to the full council;
- c. Submitting meeting minutes in the approved format to the council; and
- d. Coordinating work with other committees where items could be of mutual interest.

#### **Section 5. Executive Committee**

**5.1** The executive committee shall be comprised of at least three members, including the council chairperson, vice-chairperson and secretary. The immediate past chairperson of the council may also be invited by the council chairperson to be a member of the executive committee.

**5.2** The executive committee will have the following responsibilities:

- a. Provide policy direction to and periodically evaluate the performance of the council and its activities relating to direction from the division of mental health and substance abuse services.
- b. Meet at the request of the chairperson as needed;
- c. Provide for an annual review of the by-laws;
- d. Act on behalf of the council when a rapid response is required, provided that any such action is reported to the council at its next meeting for discussion and ratification; and
- e. Other duties designated by the council.

### **5.3 Rapid Response**

The executive committee may act on behalf of the full council only under the following circumstances:

- a. When specifically authorized by the council;
- b. When action is needed to implement a position already taken by the council;
- c. Except when limited by the council, the executive committee may act upon the recommendation of a committee, other than the executive committee, if such action is necessary before a council meeting may reasonably be convened, provided that if more than one committee has made differing recommendations concerning the subject, the executive committee may not act except to request further study of the subject; or
- d. Except when limited by the council, the executive committee, by unanimous consent, may take such other action as it deems necessary before a council meeting may reasonably be convened.

## **ARTICLE V**

### **Amendments**

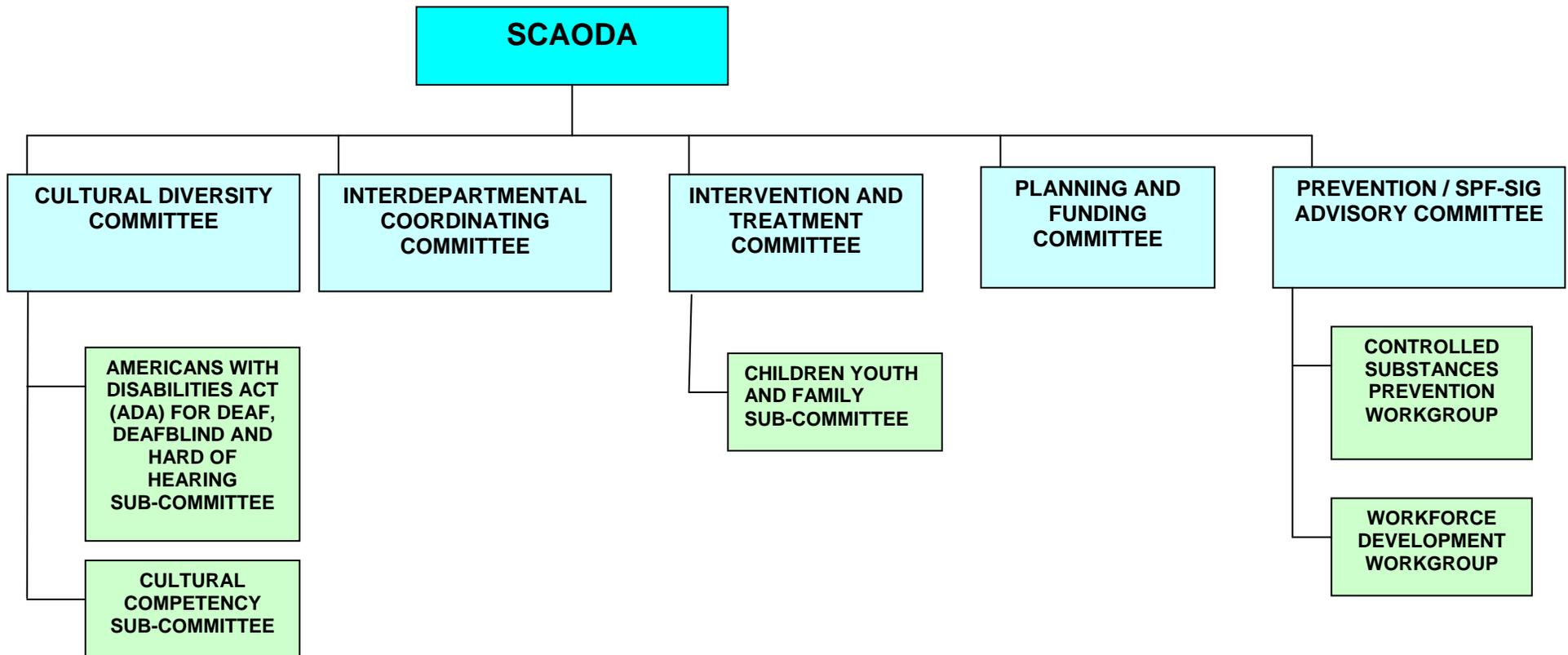
The by-laws may be amended, or new by-laws adopted, after thirty days written notice to council members by a two-thirds vote of the full council membership present at a regularly scheduled meeting.

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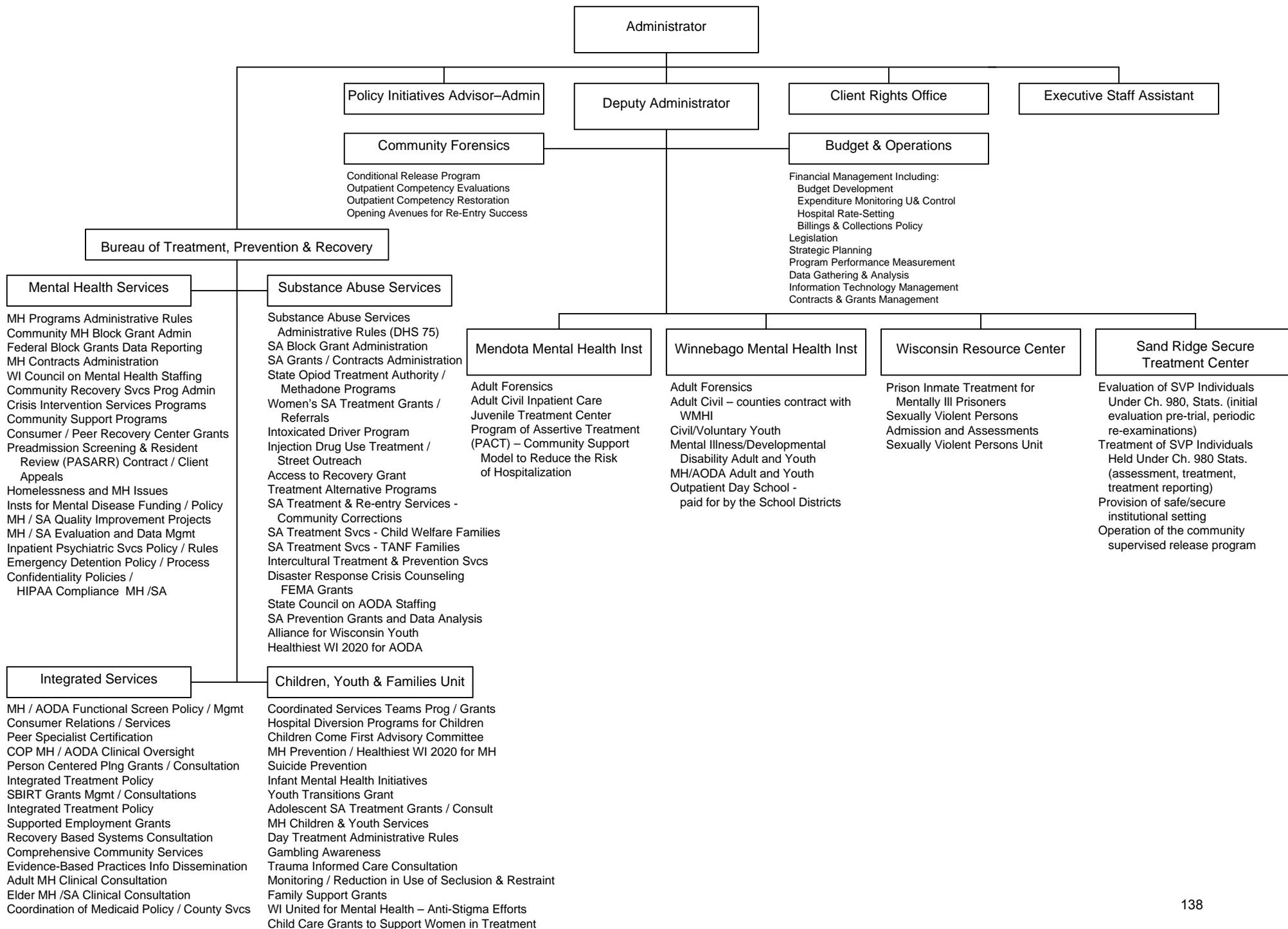
# SCAODA Organization Chart

October 2011

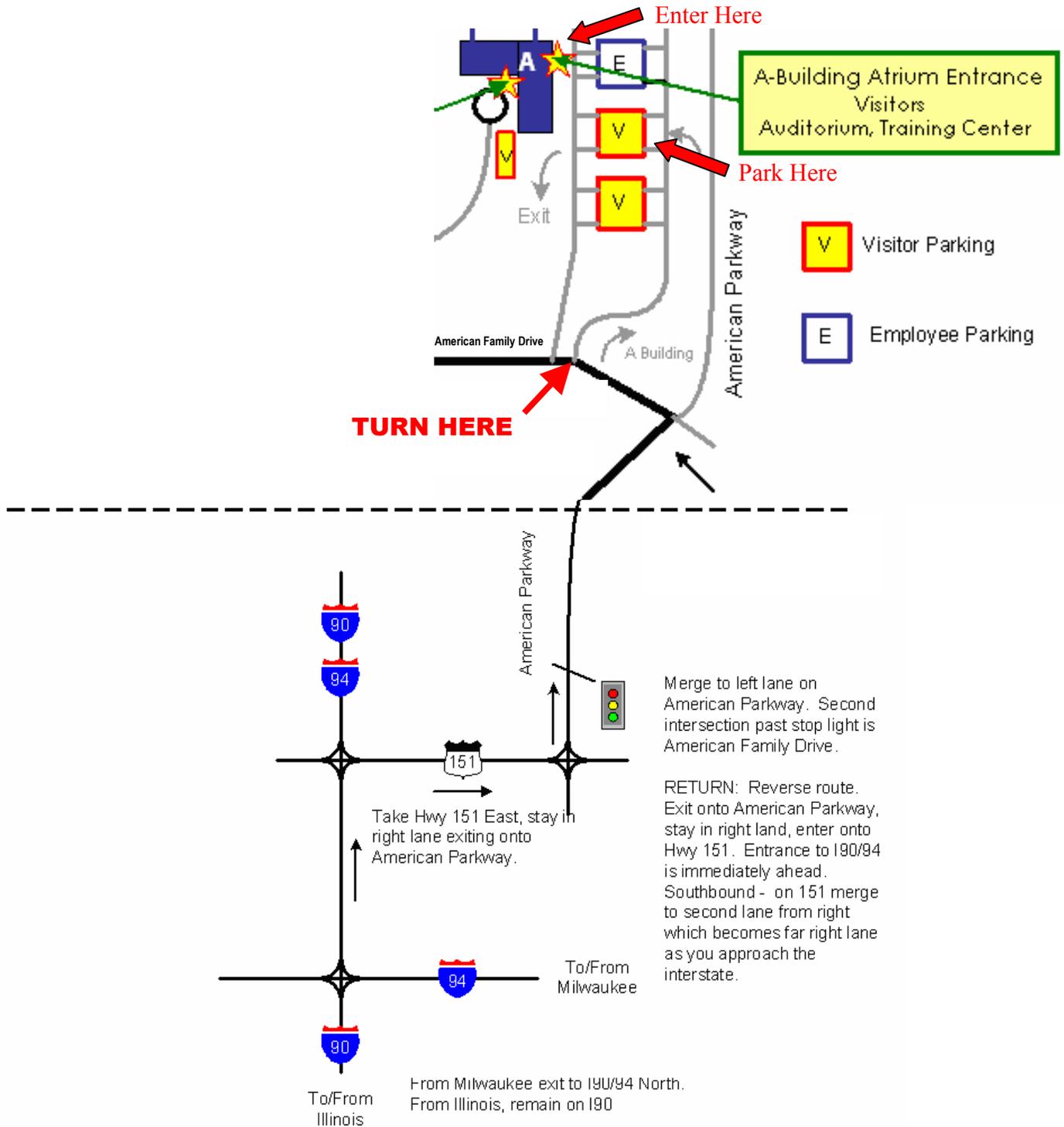
1. Cultural Diversity Committee
  - a. Americans with Disabilities Act (ADA) For Deaf, Deafblind and Hard of Hearing Sub-Committee
  - b. Cultural Competency Sub-Committee
2. Interdepartmental Coordinating Committee
3. Intervention and Treatment Committee
  - a. Children Youth and Family Sub-Committee
4. Planning and Funding Committee
5. Prevention / SPF-SIG Advisory Committee
  - a. Controlled Substances Prevention Workgroup
  - b. Workforce Development Workgroup



**Functions**



# Directions to American Family's Training Center and Auditorium



**Highway Directions to AF-NHQ Campus**