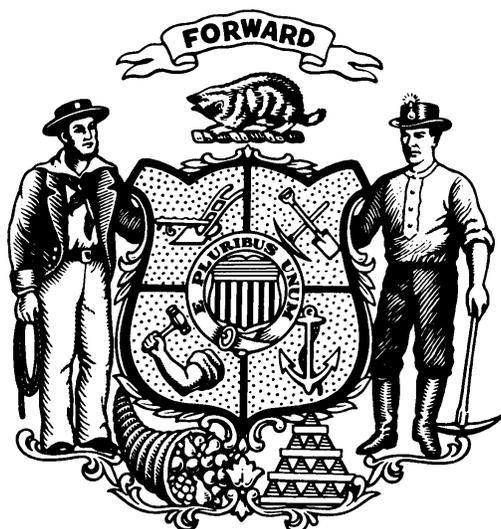


WISCONSIN STATE COUNCIL ON ALCOHOL AND OTHER DRUG ABUSE



March 5th, 2010
MEETING

Mark Seidl
Chairperson

JIM DOYLE
Governor

STATE COUNCIL ON ALCOHOL AND OTHER DRUG ABUSE

MISSION STATEMENT

To enhance the quality of life of Wisconsin citizens by preventing alcohol and other drug abuse and its consequences through prevention, treatment, recovery, and enforcement and control activities.

SCAODA FOUR-YEAR STRATEGIC PLAN GOALS 2006 – 2010

Adopted by SCAODA June 2, 2006

GOAL 1:

Support, promote and encourage the implementation of a system of substance abuse services that are evidence-based, gender and culturally competent, population specific, and ensure equal and barrier-free access.

GOAL 2:

Support the prevention and reduction of alcohol, tobacco, and other drug use and abuse through evidence-based practice with special emphasis on underage use.

GOAL 3:

Support and encourage recovery in communities by reducing stigma, discrimination, barriers and promoting healthy lifestyles.



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.

SCAODA 2010 Meeting Dates

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

March 5, 2010	9:30am to 3:30pm	Room A3151
June 11, 2010	9:30am to 3:30pm	Room A3151
September 10, 2010	9:30am to 3:30pm	Room A3151
December 10, 2010	9:30am to 3:30pm	Room A3151



Jim Doyle
Governor

Karen E. Timberlake
Secretary

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

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

Mark Seidl, WCHSA
Chairperson

Linda Mayfield
Vice-Chairperson

Scott Stokes
Secretary

March 5, 2010

MEETING AGENDA

9:30 a.m. – 3:30 p.m.

American Family Insurance Conference Center

6000 American Parkway Madison, WI 53783 Room A3141

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

Please call Lori Ludwig at (608)267-3783 or e-mail Lori.Ludwig@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 – Mark Seidl
- Cynthia Graham designee today for newest member, Matt Vogel, who will attend June 11th meeting representing University of Wisconsin System
- 9:35 a.m. II. Review /Approval of January 8, 2010 Minutes – Mark Seidl
- 9:40 a. m III. Public Input—Mark Seidl
- 9:55 a.m. IV. Alcohol Culture and Environment (ACE) Sub-Committee Report—Julia Sherman
- Motion to approve the ACE Report
- 10:25 a.m. V. Medical Marijuana—Senator Jon Erpenbach and Dr. Mike Miller
- 11:25 a.m. VI. Stretch Break
- 11:30 a. m VII. Follow-up Brighter Futures Initiative—Mark Campbell
- 11:50 a.m. VIII. SCAODA Appointment of Department of Children and Families—Mark Seidl
- Motion to Include Department of Children and Families as Ex-Officio Member
- 12:00 p.m. IX. Working Lunch
- 12:30 p.m. X. Committee Reports:
- Planning and Funding—Joyce O’Donnell
 - Motion to Oppose SB 368 & AB 554 (medical marijuana)
 - Prevention—Scott Stokes
 - Motion 1—To support AB 598 (snowmobile)
 - Motion 2—To oppose AB 335 (consumption at private colleges)
 - Motion 3—To oppose AB 390 (quadricycle)
 - Motion 4—To oppose SB 368 & AB 554 (medical marijuana)

- Motion 5—To support AB 227 (Pharmacy Board monitoring program)
 - YRBS Report—Gary Sumnicht
 - Diversity—Michael Waupoose
 - Motion to request Department Regulation and Licensing invite the AODA Advisory Committee to advise on Administrative Rule 7 Rewrite
 - Intervention and Treatment—Linda Preysz
- 1:30 p.m. XI. Update SCAODA 2010-2014 Four Year Strategic Planning –Joyce O’Donnell
- Planning & Funding 2010-2014 Priorities—Joyce O’Donnell
 - Prevention 2010-2014 Priorities—Scott Stokes
 - ITC 2010-2014 Priorities—Linda Preysz
 - Diversity 2010-2014 Priorities—Michael Waupoose
- 2:00 p.m. XII. Stretch Break
- 2:05 p.m. XIII. County Infra-Structure Study Update—Joyce Allen
- 2:30 p.m. XIV. Report on CSAT Conference—“Strategic Planning for Providers to Improve Business Practices”—Kate Johnson, Dr. Steven Dakai, Norm Briggs, Sheila Weix
- 2:45 p.m. XV. Report on Parity Legislation—Shel Gross
- 3:15 p.m. XVI. Agenda Items for June 11, 2010 meeting—Additional Items?—Mark Seidl
- 3:20 p.m. XVII. Announcements—Sue Gadacz
- April is Alcohol Awareness Month and Proclamation
 - Update OWI legislation signed into law
 - Adoption of 2010-2014 SCAODA Four Year Plan
 - By-Laws Review
 - WAAODA Public Forum
 - Possibly Discussion on standing agenda item, “Reports from Departmental Members or Designees”
- 3:30 p.m. XVIII. Adjourn—Mark Seidl



Jim Doyle
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

Linda Mayfield
Vice-Chairperson

Scott Stokes
Secretary

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

September 11, 2009

9:00 a.m. – 1:00 p.m.

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

Members Present: Mark Seidl, Joyce O'Donnell, Representative John Townsend, Sandy Hardie, Greg Phillips, Duncan Shroul, Michael Waupoose, Pamela Phillips, Blinda Beason, Minette Lawrence, Gary Sumnicht, John Easterday, Janet Nodorft, Scott Stokes, Renee Chyba, Coral Butson, Mary Rasmussen.

Members Excused: Douglas Englebert, Linda Preysz., Linda Mayfield

Members Absent: Eileen Mallow

Ex-Officio Members Present: Ray Luick

Ex-Officio Member Excused: Larry Kleinsteiber

Ex-Officio Member Absent: Thomas Heffron, Roger Johnson, Randall Glysch.

Staff: Sue Gadacz, Lori Ludwig, Kate Johnson, Jerry Livings, Gail Nahwahquaw, Lou Oppor, Susan Endres

Guests: Norm Briggs, Harold Gates, Dave Macmaster, Tami Bahr, Jill Kenehan-Krey, Sue Gudenkauf, Denise Johnson, Bill McCulley, Georgiana Wilton, Kristi Obmascher, Candace Peterson, Manny Scarbrough.

Introductions/Welcome/Agenda—Mark Seidl

Mark Seidl, called the meeting to order at 9:05 am. He welcomed the group and asked the group to introduce themselves. After introductions, Mr. Seidl reminded the group that sidebar conversations during the meeting were distracting and make it difficult for the interpreters to know which conversation to translate. He asked the group to maintain respect for the needs of the entire group by minimizing sidebar conversations. Following that announcement he asked the group for a moment of silence in memory of those lives lost on September 11, 2001, eight years ago to the date of the meeting. A moment of silence was observed. Joyce O'Donnell then requested that the group recite the Pledge of Allegiance as appropriate of the eighth anniversary of September 11, 2001. The Pledge was recited.

Review/Approval of Minutes—Mark Seidl

Mark Seidl asked for approval of the June 5, 2009 meeting minutes. **Representative John Townsend moved for approval of the minutes, Joyce O'Donnell seconded the motion. The motion passed unanimously without discussion.**

Public Input—Mark Seidl

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

Governor's Proclamation Fetal Alcohol Spectrum Disorder (FASD) Awareness Day—Georgiana Wilton

Prior to the presentation, Georgiana Wilton had distributed to each SCAODA participant a small cowbell from the FASD Regional Training Center commemorating FASD Awareness Day and an FASD Awareness Day fact sheet, "9-09-09: 09 Months of an Alcohol-Free Pregnancy." She then addressed the group informing them that every year on the ninth of September, FASD Awareness Day is celebrated around Wisconsin. On September 9th of this year, there was an event at Monona Terrace with Lieutenant Governor Lawton who presented Dr. Wilton with a Governor's Proclamation recognizing FASD Awareness Day. Mark Seidl then read to the group from the Proclamation which noted the problem of alcohol consumption by women of child bearing age in Wisconsin and the associated problems of FASDs. Dr. Wilton thanked John Easterday and Sue Gadacz for supporting the need for increased treatment capacity. She also announced that she had been awarded a Great Lakes FASD Regional Training Center grant and that there were brochures available at the back table. The brochure entitled, "Adapting Motivational Interviewing for Individuals with FASD and Other Cognitive Limitations" was an informational overview of a workshop to be held October 12, 2009. Another brochure held information on a Spring 2010 "FASD Training of Trainers Program." The third provided information on obtaining FASD training through the "Great Lakes FASD Regional Training Center" housed at the University of Wisconsin-Madison.

Elections—Joyce O'Donnell

Joyce O'Donnell reported that according to the By-Laws, as Vice-Chairperson of the Council, Linda Mayfield, convened the Nominating Committee and appointed Joyce O'Donnell Chairperson of the Nominating Committee. As it turned out, Ms. O'Donnell continued, all current officers were interested in being re-elected. Then, she asked for any additional nominations from the floor for Chairperson of SCAODA. She asked this three times. There were no other nominations. **Joyce O'Donnell then made a motion for a unanimous ballot for Mark Seidl for Chairperson of SCAODA. John Easterday seconded the motion. There was no further discussion and the motion passed unanimously.** She then asked for any additional nominations from the floor for Vice-Chair, three times. There were none. **Joyce O'Donnell then made a motion for a unanimous ballot for Linda Mayfield as Vice-Chairperson of SCAODA. Blinda Beason seconded the motion. There was no further discussion and the motion passed unanimously.** She then asked for any additional nominations from the floor for Secretary, three times. Hearing none, **Joyce O'Donnell made a motion for a unanimous ballot for Scott Stokes for Secretary of SCAODA. Greg Phillips seconded the motion. There was no further discussion and the motion passed unanimously.**

Budget Update—John Easterday

John Easterday distributed a document entitled “Substance Abuse Prevention and Treatment Block Grant Award Summary Funding Detail October 2008 to September 2010 One-time FFY 09 Increase \$1,398,801.” He explained that the funds represent more of a restoration to the 2003 funding level than an increase. He reviewed the planned use of the funds. First, the funds will be used to offset the SAPTBG structural deficit for SFY 09 and SFY 10 (\$841,291). Second, the funds will be used to backfill a DAPIS shortfall due to revenue reduction (\$106,139). Third, the funds will be used to restore funding for the “My Baby and Me” FFY 10 program (\$55,00). Fourth, the funds will be added to the “Consumer Advocacy” contract for FFY 10 RFP (\$16,775). Fifth, the funds will be used to purchase the services of a Tribal methadone counselor, training and clinical supervision (\$35,000). Sixth, the funds will offset the “Synar Program” increased costs (\$80,000). Seventh, the funds will go to the STAR-SI Quality Improvement continuation (\$133,598). Eighth, the funds will be used to contract data improvement for HSRS (\$18,000) and SAP-SIS (\$14,038). Ninth, the funds will sustain the “Parents Who Host Lose the Most” prevention campaign (\$88,960). Tenth, the funds will be used to partner with the Wisconsin County Human Services Association for psychiatric consulting services (\$10,000).

Screening Brief Intervention & Referral to Treatment (SBIRT)—Candace Peterson

Candace Peterson distributed a handout of her Power Point presentation. The Power Point presentation was used two days ago at an important meeting called the Thought Leaders meeting. It included medical providers, people from the insurance industry and other people who have collaborated on the SBIRT project. A summary of the conclusions drawn at this meeting was:

- “Risky drinking, drug use, and other unhealthy behaviors are prevalent, harmful and costly in Wisconsin.
- SBIRT and other behavioral screening elicit healthier behaviors, lower healthcare costs, superior outcomes and higher productivity.
- Services can be implemented with high patient satisfaction, efficiency, and profitability.
- Mandates and quality measures are coming.
- Let’s implement SBIRT and behavioral prevention now.”

SBIRT is a national program. In Wisconsin, SBIRT is supported by the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL). The focus is on alcohol and drugs. SBIRT is located in 19 health care clinics across the state. Screening is provided to all patients seen in a healthcare setting. Of all those seen by the SBIRT program, 6-7% would fall into the treatment category, that is, referred to treatment. Another 19% are considered risky, or problematic users who would fall into the brief intervention category. The 19% are responsible for more total harm than the 6-7%. Of all patients screened, then, 25-26% are considered high risk, risky or problematic users and receive either a brief intervention or a referral to treatment. In addition to the many SBIRT milestones at the national level, Wisconsin Medicaid will expand SBIRT coverage from pregnant women to all Badger Care Plus and Medicaid recipients beginning January 2010. The SBIRT model uses Bachelor degreed health educators and an established protocol including a software system that guides the health educator, collects clinical data, and generates reports. The total number of people screened in Wisconsin as of two weeks ago was 65,188. Ms. Peterson reported that of those people screened in Wisconsin, 68% had a negative screen and 32% had a positive screen. Of those who screened positive, 11,451 received brief interventions. In terms of their satisfaction with SBIRT, those who were surveyed agreed that the health educator had given them new ways of looking at their drinking or drug use; that they received help in accomplishing changes; that they are clearer about how to make changes; and that the ways they

are working towards those changes are correct. She reported that outcome measures of the number of drinking days for participants were substantially less at 6-months post intervention. She reported that continuation of SBIRT services depends on the sustainability of the service delivery model. Currently, project staff are concentrating on an effort to educate clinics on how to bill for SBIRT services and increasing the number of providers who will pay. The cost of the health educators can be sustainable. One of the challenges to SBIRT is that the healthcare clinic staff believes the focus should be broader and include smoking, diet/obesity and depression screening. Norm Briggs asked a question about those who were screened and referred to treatment. How many people who needed treatment, got treatment? Ms. Peterson responded that many of the same dynamics at play in clinics happens in health care settings; namely that 1) patients are not ready for services; 2) patients don't have resources to pay for services; and 3) the demand for services exceed the supply. SBIRT employs an "access" person on staff and there are some funds available to pay for treatment services. Michael Waupoose asked where SBIRT stands with the numbers of people screened and the number of clinics involved in terms of where it had anticipated it would be. Ms. Peterson responded that there are currently 19 clinics operating in Wisconsin; they had hoped for 25. However, they discovered that the clinics needed more funding than originally anticipated. In terms of the number of people, the goal was 88,000. SBIRT has screened over 65,000 with another year to go. Ms. Peterson felt that in terms of numbers of people seen, they were on track. Coral Butson remarked that she was at the event earlier in the week and a video was shown that was quite powerful. It is available at <http://www.WIPHL.org>. Ms. Peterson indicated that the video contains individuals talking about the impact of the SBIRT program. Mr. Waupoose asked about the issue concerning notice of consent to pregnant women and whether there had been any resolution. Ms. Peterson summarized by saying there were attorneys involved; things were complicated, but the attorneys drafted suggested language and shared it with clinical sites. The group thanked Ms. Peterson and Mr. Waupoose indicated that later in the meeting, the Diversity Committee would be making a motion of support for SBIRT.

Committee Reports

Prevention Committee: Scott Stokes reported that regarding SPF-SIG, three two-day training events on program implementation are being planned. Counties final plans are due September 15th. Approval will be determined by state staff. At the federal level, the carry-over request was approved. The ACE (Alcohol Culture and Environment) Sub-Committee will report on its activities during the December SCAODA meeting. The Prevention Committee is also establishing an ODA (Other Drugs of Abuse) Sub-Committee and will establish goals and objectives for that Sub-Committee at the next Prevention Committee meeting. Regarding the "Parents Who Host Lose the Most" campaign, last year 50 communities participated. There will be a report at the December SCAODA meeting on the Public Forum held during the Prevention Conference last June. About 20 people attended. Greg Phillips reported that one of the drugs the Department of Justice is seeing a major resurgence in is heroin. They are targeting users in Madison, Milwaukee and Racine. There have been numerous deaths. Mr. Stokes responded that heroin is on their list.

Diversity Committee:

Michael Waupoose reported that he met with the program manager from the Minority Counselor Training Institute (MCTI). The issue had come up at both the Wisconsin Association on Alcohol and Other Drug Abuse (WAAODA) Public Forum and the Tribal Public Forum that the MCTI was not working well for Native American people or Hispanic people. How can the MCTI reach into Tribal and Hispanic communities? The program manager will be attending Diversity

Committee meetings to help them be more successful with outreach. The Diversity Committee continues to monitor the impact of the Vendorship bill as well as the issue around the attempt to remove the requirement that AODA counselors need certification in AODA. Mr. Waupoose also reported that the Deaf/Deaf Blind/Hard of Hearing Sub-Committee disseminated a survey on SCAODA's website as well as the websites of WAADAC (Wisconsin Association of Alcohol and Drug Abuse Counselors), WADTPA (Wisconsin Alcohol and Drug Treatment Providers Association), and WAAODA —three professional organizations. Survey results will be summarized and reviewed at the December SCAODA meeting. Mr. Waupoose also reported on the issue of how to re-integrate a drug & alcohol counselor back into the workforce after relapse. It was difficult to find out information from the Department of Regulation and Licensing (DRL). The Impaired Professionals Program Coordinator from DRL will be attending the October Diversity Committee meeting. This is a critical piece for state folks to address. Mr. Waupoose reminded everyone that September is National Recovery Month and September 20th is National Addiction Counselors Day. Please recognize Addiction Counselors that you know for the phenomenal work that they do. **Mr. Waupoose then made a motion that SCAODA support and endorse SBIRT services. Gary Sunnicht seconded the motion.** John Easterday indicated that he was a huge supporter of SBIRT, but had a question about what kind of support Mr. Waupoose was looking for. Secretary Timberlake and the Medicaid program have already agreed to fund SBIRT services. Was it symbolic? Mr. Waupoose answered in the affirmative. Further discussion included a comment from Blinda Beason who felt that the SBIRT data presented is old. Further, she felt that there is interest in SBIRT participants aged 1 through 25. We need to look at what data each other is collecting. We need to talk about what we are seeing. Without further discussion, Mr. Waupoose repeated the motion. **The motion passed unanimously.**

Intervention and Treatment Committee:

Linda Preysz, Chairperson of the ITC Committee was not present but had asked Renee Chyba to report for the ITC Committee. Ms. Chyba reported that the Intoxicated Driver Program (IDP) Sub-Committee has been formed. It is comprised of representatives from the Wisconsin County Human Services Association (WCHSA) and IDP Coordinators and Assessors from the Department of Transportation (DOT). Also on the IDP Sub-Committee are representatives from law enforcement, the judiciary, University of Wisconsin Resource Center on Impaired Driving, IDP providers and insurance representatives. The kick-off meeting will be September 25th. In December the group will prioritize goals and objectives. Ms. Chyba reported that at the last meeting of the ITC Committee, state staff Cathy Swanson-Hayes presented an overview of older adults and their mental health and substance abuse issues. The definition of what age distinguishes an older adult varies. The age 60 and up suffices for the general population while Tribal peoples consider age 55 and older as "older adults." There are many unaddressed issues among this population. Co-occurring care (substance abuse and mental health) and funding are issues. The Intervention and Treatment Committee will discuss these issues further and incorporate this topic into the strategic plan. Ms. Chyba then asked Dave Macmaster to report on WINTIP. Mr. Macmaster reported that tobacco dollars are disappearing. The legislature passed clean air/smoke free legislation; increased taxes on tobacco to fund an increased demand for the quit line, and then cut tobacco dollars by 55%! WINTIP had been funded at \$100,000 and was cut back to \$75,000, and now only has a small amount left. WINTIP in Wisconsin was elevated to a National model; Wisconsin is one of four leading states. How can we advance WINTIP in 2010 with \$50,000, that is, if WINTIP gets \$50,000? WINTIP is poised to perish. The website is still up. Mr. Macmaster said that he didn't want to lose the momentum. He had been receiving funding through the Division of Public Health. He was hoping to receive some funding from the Bureau that addresses addictions. He asked for help from the Governor's

Office. Michael Waupoose reported that his clinic had a WINTIP presentation. However, he can no longer obtain resources through WINTIP to help clients quit and that is unfortunate. Ms. Chyba requested that the Planning and Funding Committee assist any way it can to support the WINTIP initiative.

Children, Youth and Family Sub-Committees: Tami Bahr reported that Project Fresh Light (PFL) is surveying adolescent treatment providers again. The last time they were surveyed was in 2005. Currently, they are finding a decrease in the number of providers for about 47,000 adolescents in need of treatment. It is important to promote adolescent services, Ms. Bahr pointed out because of the likelihood of suicide among this population. She indicated that PFL obtained additional funding to support training of service providers on evidence-based practices for adolescents with AODA treatment needs. Ms. Bahr continued that during the Bureau conference to be held in October (27-28), the second annual meeting of adolescent treatment providers will occur. They will be reviewing gaps in services and collecting data.

Planning and Funding Committee:

Joyce O'Donnell reported on the Planning and Funding Committee's meeting with Mark Seidl in August. Mr. Seidl reviewed the County Infra-Structure Study for them. There was a discussion about SCAODA's role: advocacy and/or advisory. Ms. O'Donnell believed the role of SCAODA was advocacy with advisory powers. Ms. O'Donnell also reported that the letter opposing SB 30 that was sent to Senator Jausch, was also forwarded to Senator Robson, over Mark Seidl's signature. She reported that Susan Endres, who had initially agreed to lead the Strategic Planning effort for the development of SCAODA's 2010-2014 Four Year Plan, withdrew due to conflicts with her work schedule. She has been replaced by Kristine Freundlich, an experienced planner with the Office of Policy Initiatives and Budget in the Department of Health Services. Ms. O'Donnell reported that she would like to have a police captain come in and present on the "Think" program. This is a prevention program for elementary or middle school students. It is going over very well in his community. Susan Endres has a copy. Ms. O'Donnell would like the opportunity for him to present a slide show. It's all about decision-making for the future. Mary Rasmussen asked if he has anything from NREPP. Ms. O'Donnell did not know.

Ms. O'Donnell made a motion that she would like to recognize the University of Wisconsin for having taken the position of declining alcohol and beer advertisements. They should be recognized and commended. Mary Rasmussen seconded the motion. Blinda Beason felt that they should specify Madison. Gary Sumnicht did not know about other campuses. Greg Phillips suggested that the motion should be tabled until we find out. Mark Seidl suggested that the assignment go to a staff member. Joyce O'Donnell was concerned about postponing the motion because there would be a 3-month delay. Gary Sumnicht agreed that he supports the motion, but we need to be accurate. John Easterday (who took over chairing the meeting for Mark Seidl who temporarily left the room) asked how would we go about confirming. Mr. Sumnicht suggested calling someone on the Committee. Mr. Sumnicht volunteered that he knew who to call, Larry Reuben at the System level. John Easterday suggested that the motion be tabled until the end of the meeting when Mr. Sumnicht would have had a chance to call Mr. Reuben. Ms. O'Donnell indicated that she didn't want to wait so long. Mary Rasmussen agreed that there's no reason to table it. With that, Mr. Easterday suggested a 10 minute break. Joyce O'Donnell indicated that she had completed her report.

Following the break, Gary Sumnicht reported that only the Madison campus has declined alcohol and beer advertising. Mark Seidl reported that there is a motion on the floor. The letter

will go to UW Madison only. **Without further discussion, the motion passed unanimously.** Greg Phillips wondered if this Committee should send a letter to the rest of the schools asking them to do the same. Mr. Sumnicht suggested that the others will probably go along. This will be a topic of discussion at the next meeting. It will probably happen anyway. Greg Phillips agreed and withdrew his suggestion. Ms. O'Donnell suggested that Mr. Sumnicht take the message to the group. He agreed that he would. Blinda Beason reported that during the next UW System meeting, all the alcohol and drug professionals will be brought together. She is sure that Larry Reuben will bring it up.

By-laws Review

As a member of the By-laws Workgroup, Scott Stokes explained that we should take the opportunity to look at the By-laws periodically, for a general review and bring forth any discussion. He then proceeded to review briefly each Article and section. He felt that the Committee Chairs should go through the By-laws with their Committees. Mark Seidl pointed out that if a voting member is not going to be present, their designee should be present. Norm Briggs asked about the status of any bill increasing SCAODA's membership. Sue Gadacz indicated that she has asked Rachel Currans-Sheehan to update the group. Representative Parisi was to introduce the bill before he left the Assembly. Mark Seidl reported that Representative Townsend is also open to the suggestion of introducing the legislation. There was a brief discussion about the Governor's Law Enforcement Crime Commission because statutorily, one of SCAODA's original 22-members should be from that Commission. However, there hadn't been a Governor's Law Enforcement Crime Commission to anyone's knowledge—at least for quite some time. Mr. Seidl suggested that prior to each meeting, a tally of members' attendance be undertaken to determine if a quorum were present. Since we're down to 18 members currently, 10 would be a quorum.

Proposed Procedural Changes

Mr. Seidl reported that SCAODA is bound by Open-Meetings Laws. Meetings have to be publicly noticed; and agenda items have to be set. As a procedural point—under the Open Meetings Law, additions to the agenda can be brought forth for the good of the order. If the subject is not on the agenda, a motion can not be entertained; there can be no discussion and no motion. We don't have the following agenda items, "Additions to the agenda" at the beginning of the meeting; or "For the good of the order" at the end of the meeting. Ms. O'Donnell continued that as such, motions can be brought up by Committees, for example today's Planning and Funding Committee report is an agenda item. Michael Waupoose asked if the "Motion Introduction Form" still needed completion. Mr. Seidl responded that if motions are brought forth at the time of the meeting, then "Motion Introduction Forms" are not necessary. If it is known ahead of time that a motion will be brought forth, then the form should be completed. Ms. Chyba posed a question. If a motion comes up (during the meeting), then, shouldn't there be time for us (as designees) to go back and discuss the matter with the appointed SCAODA member? Mr. Seidl suggested that in those circumstances, one should abstain. As a group, we need to keep moving forward on the agenda, so if you are uncomfortable voting, abstain.

The proposed meeting dates and times were presented to the group as follows:

March 5, 2010	9:30am to 3:30pm	Room A3151
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June 11, 2010	9:30am to 3:30pm	Room A3151
September 10, 2010	9:30am to 3:30pm	Room A3151
December 10, 2010	9:30am to 3:30pm	Room A3151

Joyce O’Donnell made a motion to adopt the dates and times as presented for 2010 meetings. Greg Phillips seconded the motion. Discussion elicited that all the meetings were on Fridays. The motion passed unanimously.

Legislative Update—Rachel Currans-Sheehan

Ms. Currans-Sheehan introduced herself as the Legislative Liaison for the Department of Health Services. She gave a general overview of the Legislature’s fall session. From September to March are when most of the legislation is brought forth.. The next 6 months are when major action occurs. The Budget Bill has been passed, including SBIRT funding, Medicaid rate reform, an additional 600 million dollars in savings and the smoke free tobacco bill. Also included was the Vendorship bill. After HFS 35, there was a push to ensure licensed mental health professionals could bill independently from a clinic setting. The bill goes into effect January 1, 2011. Regarding the OWI bills, the Governor and the Department are taking a back seat approach to see what the Legislature comes up with. Then, the Department will review the legislation. The importance of treatment dollars is a position that the Department will take. Ms. Currans-Sheehan then reviewed other bills the Department is involved with: pursuing nursing home Chapter 50 regulations; testing HIV requirements regarding written consent; and expedited partner therapy regarding STD’s and treatment. There is a federal push regarding information technology. Money is available to ensure health information exchange. The Department is applying for funds so providers can adopt e-health records. Other bills of interest to the Department include bills on nutrition/obesity; newborn screening; menu labeling; and seclusion and restraint. Those bills that have had public hearings will be voted on in September and October. Ms. Currans-Sheehan was not aware of any bill expanding SCAODA membership. She did indicate that Representative Sandy Pasch has expressed interest in being on SCAODA. She has a background in psychiatric nursing. She needs an official letter. She asked the group for any names they might bring forth and she would reach out to them. Joyce O’Donnell suggested Senator Sheila Harsdorf and Representative Staskunas, and asking Senator Carpenter who he would recommend for a replacement.

Agenda Items for December 9th Meeting

Regarding the item “Update on the County Infra-structure Study” John Easterday pointed out that the Division of Mental Health and Substance Abuse Services has contracted with The Management Group (TMG) to conduct a study of the funding and delivery of publically funded mental health and substance abuse services. December 3rd there will be a Summit in Stevens Point. Results of the study will be presented. All SCAODA members will be invited. Options and information will be presented. Then, the Department will turn to the stakeholders to give their recommendations for directions for any change. Each of the different pathways/models will be evaluated according to access, accountability and effectiveness.

Announcements—Sue Gadacz

Sue Gadacz announced that the Infra-Structure Study Summit is on December 3rd; The Wisconsin County Human Service Association (WCHSA) is on December 4th; and SCAODA is the following Wednesday, December 9th.

Regarding SCAODA sign-in; Ms. Gadacz asked that all present please document your attendance; it is needed for travel reimbursement. Visit the SCAODA website for the reimbursement form.

Ms. Gadacz pointed out that September is Recovery Month—visit WAAODA.org for activities.

Ms. Gadacz announced that the Bureau conference is October 27-28 in Appleton. John Easterday pointed out that there will be two national speakers: Rob Morrison and Robert Glover—health care reform will be a topic. The Public Forum will be from 4:45 p.m. to 5:45 p.m.

Ms. Gadacz announced that the Tribal Conference is October 28 and 29th. There is overlap with the Bureau conference. The Public Forum at the Tribal conference will be on the 28th from 3:00 p.m. to 4:30 p.m.

Dave Macmaster announced that there will be a Plenary session on WINTIP at the Bureau Conference.

Mark Seidl announced that he is arranging a meeting with John Easterday and Joyce Allen and the four Committee Chairpersons from SCAODA regarding the role of the State Council.

Adjournment: The meeting was adjourned. The next meeting is scheduled for December 9, 2009 at 9:00 am to 1:00 pm at American Family Insurance Conference Center, Room A3151.

SCAODA 2009 Meeting Dates

March 6, 2009	9:30 am	12:30 pm
June 5, 2009	9:30 am	3:30 pm
September 11, 2009	9:00 am	1:00 pm
December 9, 2009	9:00 am	1:00 pm



Jim Doyle
Governor

Karen E. Timberlake
Secretary

State of Wisconsin

State Council on Alcohol and Other Drug Abuse

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

Mark Seidl, WCHSA
Chairperson

Linda Mayfield
Vice-Chairperson

Scott Stokes
Secretary

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

~~December 09, 2009~~

January 8, 2010

9:00 a.m. – 1:00 p.m.

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

Members Present: Mark Seidl, Joyce O'Donnell, Representative John Townsend, Sandy Hardie, Greg Phillips, Duncan Shrouf, Michael Waupoose, Blinda Beason, Gary Sumnicht, John Easterday, Janet Nodorft, Scott Stokes, Coral Butson, Rebecca Wigg-Ninham,

Members Excused: Douglas Englebert, Linda Mayfield, Mary Rasmussen, Renee Chyba, Pamela Phillips,

Members Absent: Eileen Mallow

Ex-Officio Members Present: Linda Preysz, Larry Kleinsteiber

Ex-Officio Member Excused: Ray Luick

Ex-Officio Member Absent: Thomas Heffron, Roger Johnson, Randall Glysch, Colleen Baird or Jeff Scanlan.

Staff: Sue Gadacz, Lori Ludwig, Kate Johnson, Jerry Livings, Gail Nahwahquaw, Susan Endres, Kathy Thomas, Rachel Currans-Sheehan

Guests: Mark Campbell, Mike Bachhuber, Harold Gates, Dave Macmaster, Jill Kenehan-Krey, Jodi Lopez, Denise Johnson, Bill McCulley, Manny Scarbrough, Linda Pastor.

I. Introductions/Welcome/Agenda—Mark Seidl

At 9:15 A.M., due to weather difficulties, there was still not a quorum present. Kathy Thomas reported that SCAODA can still hold a meeting and ascertain "the opinion of the members." Mark Seidl called the meeting to order, thereafter. He introduced himself and asked the group to introduce themselves. Mr. Seidl welcomed Rebecca Wigg-Ninham, the newest member of SCAODA, representing the Governor's Law Enforcement Commission.

II. Review/Approval of Minutes—Mark Seidl

At 9:30 a.m. there wasn't a quorum. Approval of the minutes was held. Additional SCAODA members arrived by 9:45 and a quorum was achieved. Mr. Seidl asked for approval of the September 11, 2009 meeting minutes. **Joyce O'Donnell moved for approval of the minutes, Greg Phillips seconded the motion. The motion passed unanimously without discussion.**

III. Secretary Timberlake—Department Updates

John Easterday reported that unfortunately Secretary Timberlake was pulled in another direction this morning and was unable to attend. Dr. Easterday reported that Secretary Timberlake would attend either the March or June SCAODA meeting.

IV. Public Input/Synar Report Comments—Mark Seidl

There were no requests from the public to address the Council. Sue Gadacz reported that the public comment period for the Synar Report had closed because the report was due and submitted on December 30th, 2009. Tan Feiner, Coordinator for the Synar program, addressed the comments that she did receive, Ms Gadacz reported.

V. State Plan for Independent Living—Mike Bachhuber, Executive Director of Independent Living Council of Wisconsin

Mike Bachhuber was delayed by the weather, but was eventually able to attend and give a report. He distributed to the group a brochure titled "Independent Living: Centers, Coalition, Council of Wisconsin. Eight independent Living Centers' contact information were listed, as well as service and client information. The Independent Living Council, he reported is a Council appointed by the governor to work with disability groups and to promote independent living. His purpose in presenting to SCAODA is to gain input into the planning process and make SCAODA aware of its services. Broadly, the purpose of the Council is to promote consumer control, equal access, peer relationships and self-advocacy. The Independent Living Centers provide information, assistance and referral, skills training, advice, devices, whatever is needed. Services are for all ages and all disabilities. They are in the process of developing their next Plan to be finalized October 1, 2010. Traditionally, the Independent Living Council would address barriers, housing, long term care services, and access to employment. People with alcohol and drug abuse problems is a disability group the Independent Living Council and Centers try to serve. He wanted an opportunity to open dialogue with this group. Gail Nahwahquaw asked about the Independent Living Council's relationship with Independence First, an agency that needs funding for AA and NA deaf interpreting. Mr. Bachhuber indicated that the Independent Living Centers receive funding. Independence First is a provider. The Centers, he continued, try to include all disability groups, and will serve the deaf. They try to make services available in different formats and modalities. He mentioned CART, a real time transcription service. Ms Nahwahquaw asked if the Independent Living Council or Centers could fund Independence First. Mr. Bachhuber indicated that all the Centers provide referrals for interpreting services. He also reported that there are too few interpreters to meet the need; and too few funds to fund the interpreters. He indicated that the Independent Living Council would fund programs to develop more interpreters. In general, services required under the Americans with Disabilities Act are

covered. The Independent Living Council's role is to provide information to groups to make sure that happens. Manny Scarbrough asked for information from an individual's perspective. Mr. Bachhuber gave an example of a drunk driver facing eviction. A person from the Independent Living Center would be assigned to work with that person to identify the community resources available, such as treatment, the job center, homelessness prevention programs and counseling/skill training. Regarding the eviction issue, if there is a need for funding, a local church or service club may help. Mr. Bachhuber asked that if there were people present who provide direct service. If so, he would like to have their suggestions for issues to be included in their Plan. He stressed opening a dialog and working together. Sue Gadacz suggested that if we had a copy of the Independent Living Council's current Plan it would be helpful to distribute it to the Council and ask for feedback. Mr. Bachhuber agreed to e-mail the plan and the power point to state staff who could then distribute it. He continued that there are six areas in the current plan: Working with Department of Health Services (DHS) community services; Working with DHS Family Care; Transportation; Housing; Employment; and Emergency Management. Ms. O'Donnell asked if the Independent Living Council was involved in working with veterans. Mr. Bachhuber reported that they are getting more involved. There is a huge increase in disabled veterans in the last couple of years. The Independent Living Council and Centers are working with Vet Centers and continuing to develop their relationship.

VI. Report on CSAT Conference—"Strategic Planning for Providers to Improve Business Practices"—Kate Johnson, Dr. Steven Dakai, Norm Briggs, Sheila Weix

Mr. Seidl introduced Kate Johnson. Ms. Johnson reported that Norm Briggs was unable to attend today's meeting as was Dr. Steven Dakai. Ms. Johnson further reported that it was uncertain whether or not Ms. Sheila Weix would arrive, but at present she also was not in attendance. Ms. Johnson reported that the three individuals scheduled to report, that is, Dr. Dakai, Mr. Briggs, and Ms. Weix attended a CSAT (Center for Substance Abuse Treatment) conference with Ms. Johnson in October of 2009. Ms. Johnson reported that Dr. Dakai attended the conference to represent the tribal communities' interests, Mr. Briggs represented women's specific treatment interests and Ms. Weix represented the Wisconsin Alcohol and Drug Treatment Providers Association. Ms. Johnson reported that during the conference, attendees were updated on recent federal health legislation, for example, electronic health care records and health care packages currently being debated. Ms. Johnson reported that there was a need expressed by the attendees for on-going communication among state and federal staff and providers. Specifically, Ms. Johnson reported, was a request to make clear implications for tribal communities. Ms. Johnson felt that it was unfortunate that none of the attendees could make today's SCAODA meeting as they had much more information to report. She requested that this agenda item be brought forth to next March's meeting.

VII. Committee Reports

Diversity Committee:

Mr. Waupoose reported that the Deaf/Deaf Blind/Hard of Hearing survey results have been reviewed and interpreted by Denise Johnson. Next steps include posting the correct answers to the survey on the SCAODA website. Mr. Waupoose also reported that the agency that Denise

Johnson works for, Independence First, has exhausted its state funding for interpreters for AA and NA meetings. In 2009, Independence First provided interpreters for 152 meetings. Now, in 2010 they cannot provide any interpreters for these meetings. This issue is of critical importance and the Diversity Committee will continue to address it. Coral Butson asked if this issue was a result of state funds being exhausted in 2009, and whether the grant had been renewed. Denise Johnson reported that the grant is renewed however there is not enough money allocated for interpreter service. It will remain an ongoing issue. Michael Waupoose reported that he continues to hear a lack of support for tribal communities from the Minority Counselor Training Institute (MCTI). The meetings with the MCTI program manager went well but follow-up could be better. It has been disappointing the way things have gone and trust is being eroded. Duncan Shroul asked Mr. Waupoose if the Minority Counseling Training Institute is funded through the Substance Abuse Block Grant. Sue Gadacz responded that it was. Mr. Shroul asked why the MCTI hasn't been more responsive? Ms. Gadacz reported that they were given action steps when the Bureau staff met with them. They were told that if the steps were not followed the contract would be put out on bid. Ms. Gadacz continued that the Bureau was trying to have deliverables built into the contract. There was a discussion about the importance of trust when working with tribal communities. Mr. Waupoose suggested evaluating the relationship over the long term that is, looking for improvements over a three- year time period, rather than a one-year time period. Blinda Beason attested to the challenges of relationship building within the eleven tribal communities. It isn't something that can occur in short order, based on her experience. Mr. Waupoose also reported on the Impaired Professionals Program (IPP) and the issue of how to re-integrate a drug & alcohol counselor back into the workforce after relapse. The Diversity Committee had invited the IPP Coordinator (from the Department of Regulation and Licensing) to meetings with little success, and this is the same outcome as reported by counselors trying to learn about the IPP. Coral Butson indicated that she would follow-up on behalf of the Diversity Committee. Mr. Waupoose indicated that the Diversity Committee has a commitment to meet in other communities and felt that all SCAODA Committees should do the same. The last Diversity Committee meeting was held at the Fox Valley Technical College during a diversity class.

Intervention and Treatment Committee:

Linda Preysz, Chairperson of the ITC Committee reported that the Intoxicated Driver Program (IDP) Sub-Committee has been formed. Ms. Preysz reported that during their first meeting, they were dealing with what their strategic planning options were. They talked about identifying pre-offenders. They are in a data gathering phase. Ms. Preysz reported that the Children and Youth Sub-Committee is also in the process of gathering data. It appears that at present there are about two treatment providers per every 100 children (in need). Information is being gathered on what kind of treatment is available and where, as well as expertise and timeframes. Kate Johnson reported that the group was looking at motorized recreational vehicles, since they were not included in the consequences of OWI legislation. Ms. Preysz then asked Dave Macmaster to report on WINTIP (Wisconsin Nicotine Treatment Integration Program). Mr. Macmaster distributed two documents to the group: 1) "WiNTiP 2009 Achievements," and 2) WINTIP 2010 Integration Formula." He reported that in Wisconsin during 2009, 3500 people with substance abuse disorders died from nicotine disorders. He reported that people in substance

abuse treatment without referral to nicotine dependence treatment, will die faster from the nicotine disorder than from the substance for which they entered treatment. Mr. Macmaster also reported that he was able to attend and present at the Bureau's Conference in October. He indicated that 80% of the conference attendees reported that there is a willingness to address this problem. There are barriers, however. There has been no recognition that nicotine treatment should be a part of our practice. New York State has a policy that every substance abuse treatment program must be tobacco free and include treatment planning for tobacco withdrawal. They have developed a course with credit for substance abuse counselors that provides them with the skills and knowledge they need. That course is in the public domain and WINTIP is working to make it accessible to Wisconsin substance abuse counselors. Mr. Macmaster then reported that budget cuts in WINTIP have made it difficult to plan. However, the WINTIP Advisory Committee has agreed to continue. Ms. Preysz then reported that the Intervention and Treatment Committee has begun to look at developing its strategic plan for 2010-2014. She voiced continued support for WINTIP; a counselor-level focus; and inclusion of older adults as preliminary planning. She also reported that the Department of Workforce Development is hosting a Summit with the Department of Corrections in February for two days. The focus will be on the issues ex-offenders face including AOD issues. There will be an emphasis on collaboration with regional teams being formed. They are looking for community partners. The Annie Casey Foundation is providing financial support for the conference and a Coordinator. Please contact Linda Preysz for more information if you are interested. She also announced that the Mental Health Center of Dane County has teamed with United Way to present information for special needs kids and end of life decisions, including forming special needs trusts. The presentation will be January 20, 2010, at United Way at 6:30 p.m. Mr. Scarbrough asked Ms. Preysz that since she mentioned old individuals, is she planning to look at other disparities, are they looking at other groups? Ms. Preysz indicated in the affirmative. Diversity issues, she explained should not be after the fact. They should be part of the plan. Mr. Seidl questioned Ms. Preysz on the DWD Summit and indicated that it is critical that counties receive the information about the Summit. Ms. Preysz agreed to forward the information to Mr. Seidl.

Planning and Funding Committee:

Joyce O'Donnell reported on the Planning and Funding Committee first of three motions: the motion dealing with the Brighter Futures Program. **Ms. O'Donnell made a motion to support moving the Brighter futures Initiatives (BFI) program back to the Department of Health Services (DHS) from the Department of Children and Families (DCF) in order to bring administration of the program (BFI), including program funds and staff (1 FTE) under the Single State Agency (SSA) for Substance Abuse and Prevention Programming, thus significantly reducing the Maintenance of Effort (MOE) deficiency currently threatening the approval of the Substance Abuse Prevention and Treatment Block grant (SAPTBG) 2010 application. Greg Phillips seconded the motion.** The discussion was initiated by Sue Gadacz. She recognized Mark Campbell, Director of the Bureau of Safety and Well Being, Division of Safety and Permanence, in the DCF, attending today's meeting. Ms. Gadacz then explained that the DCF used to be a Division within the Department of Health and Family Services (DHFS). Brighter Futures was housed within the DHFS in the Division of Children and Families. In July of 2008, the DHFS split into two separate departments; the DHS and the DCF. The Brighter Futures Program, remained in the former Division, now Department of Children

and Families. Prior to the organizational split, both Divisions (Mental Health and Substance Abuse Services and Children and Families) counted General Purpose Revenue towards MOE. SAPTBG laws only allow the Division of Mental Health and Substance Abuse Services (DMHSAS) to claim the state funds flowing through DMHSAS. Because the state funds appropriated to BFI went to DCF, DMHSAS can no longer claim a little over \$800,000 of these GPR funds. For the last year and a half DMHSAS has tried to come up with a way to claim these funds towards the SAPTBG MOE. One problem is that all of state revenue is rolled into one big bundle, and it would be difficult to break out \$800,000 amount. However, there is support from both Departments to achieve resolution. A legislative fix has been considered, but it would not be addressed until the next biennium. DMHSAS has applied for an extraordinary economic conditions MOE waiver. There has been Division Administrator to Division Administrator communication, but still no resolution. Ms. Gadacz reported that Lou Oppor and she met with DCF recently. At the conclusion of that meeting, there was an agreement to ask accountants to determine how to manage the funds. Willingness exists, but there is still no resolution. Mark Campbell reported that DCF does not want to lose BFI. He continued that the accountants there (at DCF) say they can do the funds transfer without too much trouble. John Easterday reported that Wisconsin is not the only state with MOE difficulties. When the new SAMHSA Administrator (Pamela Hyde) begins her appointment, perhaps there will be a way for the MOE difficulties to be addressed nationally. Ms. Gadacz agreed that the problem is in regards to financing not programming. A 20% shortfall to the MOE for the SAPTBG is significant. Larry Kleinsteiber asked if the proposed action was necessary. Ms. O'Donnell expressed that because of the uncertainty of the situation, Planning and Funding does not want the issue lost. If things can work out the action would not be necessary. However 2012 is too late to wait for legislative action. Ms. Gadacz reported that the two Departments have agreed to work this out. There is also collaboration between the two Departments on other programs as well. Representative Townsend asked if DMHSAS was spending less money on the MOE. Ms. Gadacz responded that DMHSAS has to go by the federal definition. Now that the funds are going to DCF, DMHSAS cannot claim those dollars. Representative Townsend suggested that if legislative action is needed, DMHSAS should act quickly now. The legislative cycle is over in May. John Easterday responded that his preference would be to repair the situation administratively. There was a discussion about the status of the motion and whether it should be withdrawn, postponed or voted on. Ms. O'Donnell decided to withdraw the motion with the understanding that a letter of resolution be written and attached at the next SCAODA meeting. She felt that a 20% reduction to the SAPTBG MOE was a significant reduction resulting in a significant impact on the agency. A reduction of that sort would put funding for many substance abuse services in jeopardy. She also does not want to see this issue lost, especially if a piece of legislation is needed. **Mark Seidl agreed to the withdrawal of the motion with the understanding of the letter of resolution to be attached.**

The second motion introduced by Joyce O'Donnell on behalf of the Planning and Funding Committee was a motion that the maintenance of the 2008 funding level for tobacco prevention programming is crucial to the state at this time to support efforts to make Wisconsin a smoke-free state. Programs such as the quit line, WINTIP, and other tobacco prevention programs are negatively effected and are at risk due to planned reductions. Therefore, the Planning and Funding Committee moves to support the Division of Public Health in its efforts to obtain federal funds through the American Recovery and

Reinvestment Act (ARRA-stimulus funds), the Community Prevention and Wellness Initiative. Duncan Shroul seconded the motion. There was no further discussion. Mark Seidl called for a vote. All were in favor, with two abstaining. **The motion passed.**

The third motion introduced by Planning and Funding was a **motion to recommend SCAODA support AB 547.** Ms. O'Donnell reported that at a teleconference between the four Chairpersons of the SCAODA Committees, a discussion of this motion took place. She reported that there were concerns from the other Chairpersons that the legislation regarding first time offenders was too punitive. Ms. O'Donnell argued that the purpose of the bill was to strengthen the OWI legislation on first offenders. She felt that the authors of the bill, Senator Darling and Representatives Krusick and Ott, were known for the support of strong OWI legislation. Ms. O'Donnell felt that the Planning and Funding passed a motion in support of this bill and it was her responsibility to present it to the Council. **Duncan Shroul seconded the motion.** Discussion included comments from Linda Preysz and Michael Waupoose concerning the punitive nature of the bill, in that it requires jail time for first offense OWI when a family member may need to go to work to provide for their family instead of doing mandatory jail time. Consider for example a single parent who is poor. This bill would provide a significant burden and there is no allowance for release for critical functions. Ms. O'Donnell felt that the authors of this bill wanted to come in with strong stuff. Mr. Shroul pointed out that research has shown over and over that the first offense means that the offender has driven drunk 40-80 times prior to being arrested. What is our responsibility, Mr. Shroul asked, knowing that first offenders have done this many, many times before. Ms. Preysz indicated that the Intervention and Treatment Committee would say, prevention, intervention and outreach would have a bigger impact. Mr. Waupoose added that he believes that OWI offenders should have consequences. He also believes that jail would not be the remedy. Treatment and working with the offenders does offer a realistic solution. Consider the example of a poor single mom. Where would the children go? There are no exceptions to mandatory. Is it reasonable to say amendments would happen? That is a big if. Representative Townsend made two points: 1) Sometimes legislation is introduced to show constituents that they are effectively dealing with a problem. 2) Police officers have lots of latitude to arrest. If legislation says "mandatory jail time" there will be unintended consequences given this latitude. **The Chairman called for a vote. There were 3 ayes, 4 nays and 4 abstaining. The motion failed.**

Ms. O'Donnell made a final comment recognizing that the Journal Sentinel was recognized by the Department of Transportation with a special award. The journal Sentinel did a valuable service. Janet Nodorft recognized the series published through Gannet and the Appleton Post Crescent as good work, too.

Prevention Committee:

Kathy Thomas reported that Scott Stokes was unable to attend today due to weather and driving concerns. Ms. Thomas distributed a handout to the group titled, "January 8, 2010 Prevention Committee Updates." Ms. Thomas reported that prevention is taking on something new in Wisconsin. From the Public Forum held during the Prevention Conference, last June, "Wisconsin has the highest rates in the nation for current drinking among high school students; current underage drinking; current drinking among adults, binge drinking among adults, chronic,

heavy drinking among adults and oxycontin use in the past month. In the past, prevention efforts have focused on after school programs. However, the environment here in Wisconsin is unique. There was an example in the news this morning of a Mom who held a birthday party in West Bend for her teenage daughter and gave the kids champagne and Mike's hard lemonade. Ms. Thomas reported another example of the culture that promotes unhealthy alcohol use, a Judge in one Wisconsin community who throws out OWI cases from his Court and will not find the person guilty. It is clear that we need to change the culture in Wisconsin. In order to change the environment we need to change policies, knowledge and attitudes. She then talked about the things that the Prevention Committee is doing to change the environment in Wisconsin as it relates to unhealthy alcohol use.

1. The Prevention Committee has formed a Sub-Committee, the "Alcohol, Culture and Environment" (ACE) Sub-Committee. This Sub-Committee is comprised of members from the law enforcement community, health systems, judicial representatives, the Department of Transportation and the Division of Public Health. (from the handout), "They have recently completed their review of Wisconsin alcohol law and policies and (have) drafted a report to the State Council with over 50 recommendations to state and local policy makers on reducing unhealthy alcohol use. This report will be presented to the SPF SIG Prevention Committee at their January 21st meeting and then forwarded to the full State Council at their March 2010 meeting."

2. The SPF SIG Prevention Committee is establishing a new Sub-Committee titled "Other Drugs of Abuse." (from the handout), "This Sub-Committee will examine the prevalence of Wisconsin's prescription and opiate drug abuse and provide prevention recommendations to the full State Council on Alcohol and Other Drug Abuse." This Sub-Committee is seeking a Tribal representative and should be up and running in about one month.

3. "The Parents Who Host Lose the Most Campaign is getting underway for implementation April-June 2010." This environmental campaign originated from Ohio. It is a collaboration between DHS, DOT, DPI, DCF, UW Extension and UW. It focuses on parental responsibilities. About 100 communities implemented the Parents Who Host campaign last year. It was very successful.

4. "A Law Enforcement Meeting is being planned to take place in March 2010. Law Enforcement personnel from SPF SIG Communities will be invited to participate. Several Law Enforcement Personnel from across Wisconsin have been participating in the planning of this event...The purpose of the meeting is to provide information to law enforcement agencies working within SPF SIG grant areas." (from handout)

Gary Sumnicht added that it has been found that with "Parents Who Host" communities, law enforcement involvement makes the program much more effective. Kathy Thomas added that environmental strategies whether in large cities or smaller communities, changing the environment in Wisconsin is not easy when \$250,000 of beer is sold at one football game. Joyce O'Donnell commented that regarding changing the culture, the Planning and Funding Committee has been contacting the Milwaukee Brewers regarding the "Tavern of the Game," an activity that allows the name of a tavern to be drawn randomly for prizes including 40 tickets to the game. Ms. O'Donnell indicated that she would be advocating for a "Treatment Facility of

the Game.” She will continue that conversation. Linda Preysz announced that the Co-Chair of the Intoxicated Driver Program Sub-Committee is also on the ACE Committee for coordination.

VIII. Update County Infra-Structure Study—Mark Seidl

Mark Seidl asked John Easterday to report on the status of the County Infra-Structure Study. John Easterday agreed and provided the group with a website address to access information from the Summit held on December 4, 2009, including a finalized study. The website is:

<http://www.UWSP.edu/conted/conferences/MHSAsummit>

Mr. Easterday reported that in terms of follow-up from the Summit, the next step is a meeting with DHS Secretary Timberlake to identify what changes should be made in the system regarding funding for public mental health and substance abuse systems. The goal for the next phase or stage 2 is to put together recommendations for the next biennial budget. Mr. Easterday indicated that there will be a method for soliciting further input. They are discussing strategies such as soliciting input from stakeholders; expanding members on the steering committee; and holding forums across the state. Mr. Easterday reported that if requests are developed for DOA or others, that information would be necessary by April. Mr. Scarbrough asked if something would be going out from the DHS. Mr. Easterday referred him to the web site. He reported that a summary of the report would also be available. Mr. Easterday continued that the Summit was well attended; there were good and interesting discussions and reports from the break out sessions will be included in the summary.

IX. Public Forum Reports

Prevention Conference:

Kathy Thomas reported that there were four primary areas covered at the Prevention Conference Public Forum. Two areas discussed at today’s meeting were: 1. The Beer Tax. and 2. Prescription drugs of abuse by young people. At this point the group engaged in a discussion of the availability of data supporting the claim that young people are abusing prescription drugs. Much of the data available are anecdotal. Several SCAODA members and staff reported situations in individual counties of overdose or hospitalization. Disposal of prescription drugs is also an issue. Gary Sumnicht reported that the Youth Risk Behavioral Survey reported last year that prescription drug abuse is growing in Wisconsin. Greg Phillips reported that the level of purity in heroin used to be 2-4%. Now, the level of purity in heroin is 60-90% pure. He reported that youth are smoking it or nasally inhaling the drug rather than using needles. Ms. Thomas reminded the group that the “Other Drugs of Abuse” Sub-Committee is forming to gather statistics and write a report. She asked for those interested in being on that Sub-Committee to let herself, Lou Oppor or Sue Gadacz know.

Tribal Conference:

Michael Waupoose reported findings from the Tribal Public Forum during his Committee Report. He also reminded the group that the report is attached to the meeting packet.

Bureau Conference:

Joyce O'Donnell reported that the Bureau Conference was held in Appleton. The report from the Public Forum is in the meeting packet. Issues raised were funding for services, counselor accreditation and services for children. Ms. O'Donnell felt that it was a good Public Forum and thanked state staff Sue Gadacz, Kate Johnson, Joyce Allen and Lori Ludwig for attending and addressing questions.

X. Update SCAODA 2010-2014 Four Year Strategic Planning—Joyce O'Donnell

Joyce O'Donnell reported that the Strategic Planning Committee had its first meeting on November 20th. Genesis has been hosting the meetings. The next meeting is January 28, 2010 9:30 to 2:30. She referenced a document titled, "SCAODA Planning Formally Beginning November 2009, Objective Qualities and Givens" in the meeting packet. Sue Gadacz pointed out that the document reflects that the Committee's objective is "to have a meaningful effort with useful dialogue and the creation of an effective plan". Qualities of the plan agreed upon include: "Grounded in accurate knowledge, emergent public concerns, attuned to special populations, includes legislatively mandated requirements and that the plan be clear, concise, easily understood, can lead to meaningful measurement, is committee-friendly, and drives the work of the council and its committees." Givens of the process include thinking and work on AODA issues that are state-wide, crossing governmental departments, agencies, systems and acknowledgement that Wisconsin's problems with AODA issues exceed those of most states and acknowledgement of Healthiest Wisconsin 2020 emerging public health plan, among others.

XI. Access to Recovery III—John Easterday

John Easterday reported on the Division of Mental Health and Substance Abuse Service's (DMHSAS') history in securing federal grants from CSAT(Center for Substance Abuse Treatment) for Access to Recovery (ATR) I and II. Each were 3-year programs that were highly competitive. Currently there is an Access to Recovery III grant application to which DMHSAS is applying. He reported that both the Bush and Obama administrations have been supporters of ATR. The announcement regarding the grant application came out on January 4, 2010 and is due March 10, 2010. Dr. Easterday reported that the ATR application used to be through the Governor's Office, now the SSA (Single State Authority) or Tribes may apply. One issue being scrutinized for those states that have participated in earlier ATR projects is the mandatory follow-up of participants six-months following program participation. The project mandates that a certain set of information be collected at the beginning of and following program participation. The set of information is labeled "GPRA" and stands for Government Performance and Results Act. The "GPRA compliance rate" is the percentage of participants for whom prior to and 6-month following program participation datasets are complete. Wisconsin had a 65% GPRA compliance rate. Dr. Easterday reported that it will be tough to get ATR III because the federal staff are looking for those projects with an 80% or better GPRA compliance rate. He reported that while Wisconsin did better than most states, two or three other states achieved 80% GPRA compliance rates. The plan for ATR III is to focus on Milwaukee County, proposing to expand to counties in southeast Wisconsin. Waukesha and Ozaukee are interested. Dr. Easterday plans to send out letters outlining ATR III requirements to all the south east counties and solicit their interest. The number of grants being let out has increased over the years. For ATR I, only twelve grants were funded at about \$22 million dollars each. ATR II funded 20 grants with

approximately fourteen million dollars for all three years. ATR III will be for 30 or more communities at 2-4 million dollars each for four years. Each time the number of awards increases, the amount of money available decreases. Manny Scarbrough asked if nicotine dependence treatment is part of ATR. He reported that almost 100% of the people who drink also smoke. Duncan ShROUT reported that people seek services for alcohol problems even if they enter treatment for other drugs (cocaine mainly).

XII. Legislative Update—Rachel Currans-Sheehan

Ms. Currans-Sheehan introduced herself as the Legislative Liaison for the Department of Health Services. She will be updating the group on three pieces of legislation today:

1) Passage of the OWI (Operating While Intoxicated) legislation. Key components of the bill are that the 4th offense is now a felony; ignition interlock devices can now be court ordered for second offenders; it extends sentencing options to any county for certain second and third offenders such that the period of imprisonment for an OWI offense may be reduced if the violator successfully completes a period of probation that includes alcohol and other drug treatment; and a first offender will be charged with a misdemeanor if there is a child under 16 in the car. Ms. Currans-Sheehan reported that funding for the new provisions was a legislative compromise and additional fees will be assessed on offenders.

2) Introduction of the Medical Marijuana legislation. Ms. Currans-Sheehan reported that this is the third time this type of legislation has been introduced. It was introduced by Senator Erpenbach, and Representative Pocan. A Public Hearing was held. Basically, the Public Hearing took a look at what other states have done, the effects on DHS and fees for use. The bill would license compassion centers. The fiscal impact is a factor. The Department of Justice raised issues about enforcement. It was a long hearing with lots up for discussion. Basically those who support the bill are doing so through the compassion argument. We will have to wait and see what happens with this bill.

3) Mental Health Parity bill. The federal legislation held those employers with 51 or more employees responsible for mental health and substance abuse treatment services at the same level that their health plans provided for medical services. The Wisconsin bill is looking at those employers with less than 51 employees; and looking at parity provisions. Mental health and substance abuse services should be no more restrictive than medical surgical benefits. The bill doesn't effect the Medicaid program which already covers those services. Public hearings were held in November. Currently forums are being held across the state.

Ms. Currans-Sheehan advised the group that this spring they should expect to see the following: Because of the economy, legislative initiatives mostly on jobs; a legislative initiative to curb STDs through the health youth act legislation. This legislation would seek to expedite partner therapy through antibiotic prescriptions for sex partners without a Dr.'s visit; HIV statutes currently mandate written informed consent for testing. It has been found that written consents may be a barrier to testing. The bill would remove the written consent requirement and seek only verbal consent. It has been found that states who remove this barrier see an increase in testing; Badger Care Plus Basic insurance coverage for persons on the wait list for the Core plan

(childless adults). People on the wait list will be able to buy into health care access while waiting to access the Core plan.

Manny Scarbrough asked about an article in the Capitol Times on a health care bill. The article referenced physicians writing prescriptions for sex partners. Mr. Scarbrough asked if the bill addresses concerns that females are more at risk. He indicated that there were a disproportionate number of Latinos and African Americans who have contracted STDs. Ms. Currans-Sheehan responded that those two concerns were the impetus to the bill's creation. The bill will allow physicians who serve those populations to use this mechanism. She indicated that strategies are still being addressed. Mr. Scarbrough cautioned that it won't work unless you go to the women in the disparate populations—women, Latinos and Blacks. Ms. Currans-Sheehan pointed out that this is just a small sliver of the steps in Public Health to decrease STDs and increase healthy birth outcomes. This is one small intervention to help.

Representative Townsend initiated a discussion on Medical Marijuana. He felt that the Council should pay close attention to this bill because of major ramifications. He reported that 13 states have now passed medical marijuana laws. The bill that is currently in front of the legislature proposes that an individual can grow up to 12 plants. Individuals can receive medical marijuana through a physician's recommendation, not a prescription. It does not go through licensed pharmacists. Representative Townsend reported that he received information from a constituent physician, Darold A. Treffert, M.D., Fond du Lac, on this topic and asked the group if they would like to see the information. There was general agreement and Representative Townsend then asked Lori Ludwig to distribute the information. Representative Townsend thought that SCAODA should go on the record one way or another. Mark Seidl requested that medical marijuana be placed as an item on the agenda for SCAODA's March meeting. He felt that both sides of the issue should be presented. Joyce O'Donnell pointed out that SCAODA has dealt with this issue many times. Mr. Seidl felt that it was critical that as a group we take a position on the proposed legislation. SCAODA needs to hear both sides of the argument. Greg Phillips wanted to point out to the group that in his experience, growers of medical marijuana do not always use high grade plants; sometimes the medical marijuana is switched with Mexican for use. This is just one fact to be aware of. Also, he reported that there are 471 known carcinogens in marijuana, that medical marijuana results in five times the normal "high"; there are other avenues to receive the benefits of the drug; and there is a prescription drug, dronabinol, which contains the same active ingredient as marijuana.

Agenda Items for March 5th Meeting—Sue Gadacz

Sue Gadacz listed the following as possible agenda items for the March 5th meeting: 1) Report on the Strategic Planning Process; 2) ACE (Alcohol, Culture and the Environment Sub-Committee) Report, including an update of the YRBS data; 3) Brighter Futures—Update of flow of state funds; 4) WAAODA Conference (Dave Macmaster); 5) Healthy Wisconsin Plan update; 6) Including Department of Children and Families as Member (Mark Campbell).

Announcements—Sue Gadacz

Ms. Gadacz announced as a reminder, that the March 5th meeting is a full day meeting. Lunch will be provided. She also announced that the Alliance for Recovery Advocates (AFRA) grant is being let out from the Division of Mental Health and Substance Abuse Services. \$50,000 will be available to coordinate activities for Recovery Month and link to the national movement. The grant application will be issued January 26, 2010. Ms. Gadacz announced that the prevention and treatment portions of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) have been approved. We are just waiting for the approval of the Synar portion of the SAPTBG.

John Easterday reminded the group that the Department of Children and Families (DCF) used to be part of SCAODA (prior to the division of DHFS into DCF and DHS). Mr. Easterday asked what it would take to have DCF become a member of the Council.

Joyce O'Donnell asked if the message about SCAODA's three empty legislative appointments are being forwarded. John Easterday reported that discussions are underway.

Adjournment: Greg Phillips made a motion to adjourn the meeting. Michael Waupoose seconded the motion. The meeting was adjourned. The next meeting is scheduled for March 5, 2010 from 9:30 a.m. to 3:30 p.m. at American Family Insurance Conference Center, Room A3151.

SCAODA 2010 Meeting Dates

March 5, 2010	9:30 am - 3:30 pm
June 11, 2010	9:30 am - 3:30 pm
September 10, 2010	9:30 am - 3:30 pm
December 10, 2010	9:30 am - 3:30 pm

DRAFT

**Final Report of the Alcohol, Culture and Environment
Work Group
Prevention Committee
State Council on Alcohol and Other Drug Abuse**

From the Charge to the Alcohol, Culture and Environment Subcommittee:

The consequences and costs of alcohol misuse in Wisconsin are staggering and have created a diverse range of problems. Changing Wisconsin's culture of alcohol will require an equally diverse set of solutions including new policies and practices in all segments of the community, including local and state government.

The subcommittee will examine the state laws, local ordinances and related policies that regulate the sale and serving of alcohol to identify legal, cultural and financial barriers to alcohol policy reform. The subcommittee will also examine the role of Wisconsin's culture and history as it may impact current alcohol related problems.

Wisconsin's framework for alcohol policy was established fifty years before research demonstrated that public policy and community practices have the ability to prevent and reduce illegal, inappropriate and dangerous alcohol use without significant impact on moderate drinkers over age 21. Accordingly, the subcommittee will examine strategies and or options at the private, community, municipal and state levels in an effort to make alcohol less acceptable, available, attractive and affordable to vulnerable populations. Our goal is to reduce underage drinking, young adult binge drinking and alcohol-related vehicular crashes and death.

Members of the Alcohol, Culture and Environment Workgroup

Listed Alphabetically

Blinda Beason

Wisconsin Department of Transportation, Bureau of Traffic Safety

Lisa Berger

Helen Bader School of Social Welfare, University of Wisconsin – Milwaukee

Barry Busby

Winnebago County Coroner, Oshkosh

Nina Emerson

Resource Center on Impaired Driving, University of Wisconsin Law School

Greg Holding

Alderman of the 11th District City of Racine

Tracy Herlitzke

CESA #4, La Crosse County Medical Health Science Consortium

Barb Hermann

Manitowoc County Public Health Department

Alan Iverson

La Crosse Police Department

Francie McGuire-Winkler

Focus on Community, Racine

Julia Sherman (Chair)

Resource Center on Impaired Driving, University of Wisconsin Law School
(formerly with the Wisconsin Clearinghouse for Prevention Resources)

Annie Short

Northeast Wisconsin Area Health Education Center, Manitowoc

Christopher Wardlow

ThedaCare, Outagamie County Department of Health & Human
Services, Wisconsin Prevention Network

Professional affiliations are listed only for purposes of identification and do not indicate an organizational endorsement of the report or its recommendations.

Alcohol Use in Wisconsin

Alcohol has played an undeniable role in Wisconsin's history. Alcohol production was a factor in early economic growth while the temperance movement played a role in Wisconsin's early political history. In 1836, Wisconsin's territorial government authorized local alcohol licensure, presaging the current system of municipal licensure.¹ In the late 19th and early 20th century alcohol became a proxy issue for anti-immigrant sentiments and religious bias.² At one point, religious overtones in the alcohol debate led Archbishop Messmer of Milwaukee to ban prohibitionist sermons.³ After prohibition was repealed, Milwaukee became synonymous with beer and the brewing industry, an image reinforced through advertising and popular TV programs.

Over time, nostalgia became denial. Like other people in different cultures and countries, Wisconsinites considered the favored alcoholic beverage a cultural virtue and not alcohol.⁴ The fact that more adults in Wisconsin drink alcohol and consume more alcohol than adults in other states may have masked the increasing occurrence of alcohol abuse and misuse. Over time, alcohol outlets proliferated to double the national average of alcohol outlets per capita.⁵ Wisconsin's rate of disorderly conduct arrests grew to five times the national average during the same period while similar arrest rates in other states were falling.⁶

Since 2000, Wisconsin has experienced among the highest rates in the nation of the following⁷:

- Binge drinking among adults
- Chronic heavy drinking among adults
- Underage drinking
- Underage binge drinking
- Self-reported drinking before driving

As a result, Wisconsin's alcohol-related law enforcement, medical and similar costs have soared. Even more concerning, the number of people who need but do not receive alcohol treatment has soared, especially among youth. In 2007, Wisconsin had an estimated 126,000 young people aged 12-25 in need of treatment for their alcohol dependence did not receive care.⁸

Wisconsin's alcohol environment has evolved over many years. The result of Wisconsin's alcohol policies and practices were not intentionally malicious but instead were the result of unintentional consequences of community growth, isolated municipal control and the increasing influence of the alcohol and hospitality industry.

Fortunately, the experience of other states and nations suggests communities and institutions have the ability to reverse this situation. Change will take time and resources. Wisconsin's alcohol culture (also called the alcohol environment)

can be improved through the sustained effort among all segments of the community. In the long run, even difficult changes will be more cost-effective than the extraordinary amounts Wisconsin currently expends on alcohol related health care, emergency services, and treatment. Failure to create change will cripple the state's economic growth, limit our children's future and dishonor the efforts of earlier generations to build a strong and prosperous state.

This report is one step on the path towards a healthier, more prosperous Wisconsin. Subsequent groups should consider continued efforts to improve the alcohol environment, encourage employer efforts to support employees, provide treatment for the alcohol dependent and build communities which support recovery.

Final Report of the Alcohol, Culture and Environment Work Group

Introduction

For nine months, the Alcohol, Culture and Environment (ACE) work group of the Wisconsin State Council on Alcohol and Other Drug Abuse Prevention Committee has examined the elements contributing to what many call the state's culture of alcohol or alcohol environment. While there is a widespread perception that the culture of alcohol contributes to injury, death and disease – there is no consensus in regards to how the alcohol culture developed or the factors that contributed to its development.

The ACE work group focused on the aspects of our alcohol environment that can be changed to exert a positive impact on Wisconsin's culture. To that end, ACE examined the public, organizational, and community policies and practices that could be changed to possibly improve the alcohol environment.

The problems associated with Wisconsin's culture of alcohol have been widely reported and discussed in the media, while a vision of a healthy alcohol environment in Wisconsin has remained unclear. Therefore, we offer this broad vision of a healthy, vibrant Wisconsin with a balanced alcohol environment:

- All Wisconsin residents have the right to a family, community and working life protected from injury, harm and other negative consequences of alcohol misuse.
- All of Wisconsin's children have the right to grow up in an environment protected from the negative consequences of alcohol use, including overexposure to alcohol advertising.
- Wisconsin's residents have the right to complete, accurate and impartial information on the effects and consequences of alcohol use and misuse beginning at a very early age.
- Wisconsin residents who choose not to consume alcohol, for any reason, have the right to have their decision supported without judgment or pressure to consume alcohol.
- All Wisconsin residents experiencing the effects of dangerous drinking or alcohol abuse should have access to treatment and care.⁹

Wisconsin's alcohol environment has evolved over time, community by community. Wisconsin residents are largely unaware of the significant power communities have over their alcohol environment. Since alcohol is regulated and controlled locally, changes must occur incrementally in each community. Local alcohol control gives individual citizens a significant amount of responsibility for control of the local alcohol environment.

Wisconsin's elected and appointed officials have the responsibility and authority to regulate the community alcohol environment, but often lack the information and support needed to understand the legal and municipal issues of alcohol policy. Elected and local officials need an ongoing independent source of information and training on alcohol policy with the tools for municipalities to create a moderate alcohol environment and police protocols that remediate alcohol related problems economically and without disruption to the community at large.

There is no single cause or remedy for Wisconsin's alcohol-related problems. Action by both the Wisconsin Legislature and municipal government is needed to successfully make the changes that will improve the state's alcohol environment. The 49 unanimous recommendations included in this report begin with legislative support for actions which enable municipalities and communities to create a positive alcohol environment. Recommendations are categorized by the organization responsible for implementing the recommendation. Every level of government and community institution has a role in reforming our culture of alcohol.

Recommendations Requiring Legislative or State Action:

The Wisconsin Legislature should approve action promoting public health and safety, through an improved alcohol environment. Legislative action is recommended to restore local authority and policies that have been eroded over time. Also, licensure fees must be restored to a level needed to support the local regulatory responsibilities.

1. Wisconsin statutes should be amended to allow sobriety checkpoints.
2. Municipalities should be given the authority to ban the sale of specific alcohol products within their communities.
3. Municipalities should be given the authority to limit operator's licenses to individuals within the municipality age 21 or older.
4. The 21 Minimum Legal Drinking Age (MLDA) has effectively reduced youth access to alcohol and traffic fatalities among young adults. This effective public policy should not be repealed or amended.
5. Wisconsin's statutes should be amended to prohibit parents, guardians and spouses over age 21 from purchasing alcohol in Class B establishments for their underage children or wards, while allowing parents and guardians to provide alcohol to their own children within the privacy of their home.

6. The ACE work group recognizes the important role the drunken driving (OWI) laws play in shaping public attitude and behavior. The degree of societal tolerance is reflected in the laws that prohibit and punish drunk driving. The ACE work group recommends the following revisions to the current legal structure:

In 1997, Wisconsin Act 237 established January 1, 1989 as the date from which all alcohol related offenses are counted for purposes of determining offender status under Wis. Stat. § 343.307 and appropriate penalty exposure under § 346.65.

In 2009, after experiencing the effects of having a 20-year look-back period, Wisconsin enacted 2007 Wis. Act 111. This Act created three new felony classifications to differentiate among the burgeoning number of repeat OWI offenders.¹⁰

- The look-back period for counting purposes under § 343.307 shall be narrowed to a ten-year window from the time of the current offense. DMV records shall continue to reflect all convictions, revocations and suspensions as of January 1, 1989.
- The look-back period in felony cases of homicide by intoxicated use under § 940.09 and great bodily harm by intoxicated use under § 940.25 shall remain January 1, 1989.
- OWI Offenses under § 346.63(1) shall be punishable under § 346.65(2)(am) as follows:
 - First offense will be a misdemeanor subject to a fine of not less than \$500 nor more than \$1,000.¹¹ Not less than 48 hours in jail nor more than 6 months.
 - Second offense will be subject to a fine of not less than \$1,000 nor more than \$2,400, and imprisonment for not less than 30 days nor more than 1 year in the county jail.¹²
 - Third offense will be a felony violation, subject to a fine of not less than \$1,000 and imprisonment for not less than 1 year nor more than 10 years in prison.
 - Incarcerated felony offenders shall have access to evidence-based AODA treatment prior to release and shall have an aftercare plan in place for extended supervision.
- “Code Red” will be implemented as a condition of release (bond or bail) for all OWI offenders. An offender is required to report to the designated agency twice a day, every day, and provide an alcohol-free breath test sample.
- Homicide by intoxicated use under § 940.09 is a Class D felony *unless* a person has one or more prior convictions, suspensions, or revocations, as counted under s. 343.307(2), which makes the offense a Class C felony.

- A Class D felony is subject to a fine not to exceed \$100,000 or imprisonment not to exceed 25 years, or both. A Class C felony is subject to a fine not to exceed \$100,000 or imprisonment not to exceed 40 years, or both.
 - For homicide by intoxicated use cases only, a Class D felony will be subject to a fine not less than \$1,750 nor more than \$100,000 or imprisonment not less than 12.5 years nor more than 25 years, or both.
 - For homicide by intoxicated use cases only, a Class C felony will be subject to a fine not less than \$2,000 nor more than \$100,000 or imprisonment not less than 20 years nor more than 40 years, or both.
 - Injury (great bodily harm) by intoxicated use under § 940.25 is a Class F felony subject to a fine not to exceed \$25,000 or imprisonment not to exceed 12 years and 6 months, or both.
 - For great bodily harm by intoxicated use cases only, a Class F felony shall be subject to a fine not less than \$1,000 nor more than \$25,000 or imprisonment not less than 6 years and 3 months nor more than 12 years and 6 months, or both.
7. Current police protocols for absolute sobriety requirements for underage drivers may be resulting in under enforcement of this important measure. ACE recommends creation and support for a procedure that handles absolute sobriety violations differently than under the current status quo. We recommend absolute sobriety violations with blood alcohol less than .08 be entered on the citation and the youth released to a responsible adult, without the transport and processing required of an adult charged with OWI. This method preserves severity and corresponding penalties of this offense, maintains public safety and allows law enforcement to process the violation and quickly return to duty.
 8. Wisconsin statutes should be amended to require all individuals who pour, serve or mix alcohol to take responsible beverage server (RBS) classes regardless of individual licensure.
 9. The Department of Revenue should require that the following content be included in online classes for Responsible Beverage Servers:
 - Photos or videos of role playing servers refusing to serve intoxicated individuals, underage individuals or pregnant women.
 - Information about gender differences in metabolizing alcohol
 - Information on the effect of alcohol on the fetus, particularly brain development, during pregnancy.
 10. Managers' training approved for use in Wisconsin should require a higher level of responsibility than beverage server training; specifically, how to supervise serving staff to receive a managers' license.

11. Wisconsin statutes should be amended to require licensed operators to be age 21 or older.
12. Wisconsin statutes should be amended to increase the allowable fee of Temporary Class "B" *picnic* licenses to \$25 or more.
13. Wisconsin Statutes Section 85.55 should be amended to expand the number of alternative patron/customer transportation programs eligible for funding collected from the OWI surcharge.
14. The Wisconsin Law Enforcement Standards Board should create law enforcement and certification standards for a new category, Alcohol Compliance and Education officers, with the required curriculum including information on Wisconsin's alcohol related problems and alcohol protocols that have been determined to be effective.
15. Wisconsin's occupational tax rates on alcohol (commonly called alcohol excise taxes) should be increased to the national average for each category of alcohol beverage and indexed to the Consumer Price Index with increased revenues earmarked for alcohol related enforcement, adjudication, treatment and evidence based prevention activities.
16. Administrative or legislative action should be taken to increase the alcohol occupational taxes to an amount equal to Wisconsin's minimum mark-up if the required level of mark-up is repealed or reduced.
17. Wisconsin should double the minimum and maximum amounts municipalities may charge for alcohol licenses (from \$50 - \$500 to \$100 - \$1000) and increase Class B Permit fees to \$100 minimum and \$200 maximum.
18. Administrative or legislative action should be taken to assure that underage drinking offenses enumerated in 125.07 (4) (b) are treated sequentially, without regard to location. This should include offenses incurred across jurisdictions and out-of-state beginning with the first offense until age 21.
19. Wisconsin, through the Department of Health Services or another designated agency, should undertake a long-term media campaign outlining adult responsibilities and liability exposure that may occur as a result of purchasing, providing or pouring alcohol for underage individuals other than their own child or spouse. This campaign could be conducted in coordination with Parents Who Host Lose the Most: Don't Be a Party to Teenage Drinking statewide effort or similar efforts to reduce youth access to alcohol which has shown great promise.
20. Wisconsin should establish a statewide goal of 80% licensed retail compliance with minimum legal drinking age laws and support local alcohol

age compliance checks. State support should come in the form of coordinated federal and state funding streams for law enforcement overtime, equipment purchases and civilian support services. These services should include training, recruiting youths, media and data analysis, in anticipation of Federal action linking state compliance rates and federal block grant funds.¹³

21. Wisconsin statutes should be amended to extend s.125.075 to cover any underage person who is provided alcohol and then suffers great bodily harm or death due to that consumption, closing the current gap in state law. (Underage person is substituted for "minor" and is defined in 125.02(20m) as a person who has not attained the legal drinking age.)

Recommendations Requiring Municipal Action

The primary responsibility for alcohol licensure and control falls on local governments in Wisconsin. Municipalities can improve the alcohol environment through adoption and implementation of evidence based practices. ACE recommends these specific changes in municipal policy that are proven to reduce alcohol misuse:

1. The sale of alcohol and gasoline at the same location is incompatible and continues to pose a serious threat to the public safety. Municipalities should cease to issue and, when appropriate, revoke or decline to renew alcohol licenses to establishments that sell gasoline.
2. Municipalities should adopt procedural guidelines and policies to govern all local deliberations and decisions on whether to issue, renew or revoke licenses to sell or serve alcohol. (See example in Appendix 1)
3. Municipalities should consider using detailed license conditions, appended to pending alcohol licenses and renewals, to address specific concerns about the operation of the establishment and neighborhood concerns such as traffic, noise or sidewalk congestion. (See example in Appendix 2)
4. Municipalities should regulate alcohol tasting in Class A establishments. The scope of regulations should include:
 - Cordoned, attended sampling area
 - Requiring ID check limiting sampling to age 21 and older.
 - Locating the sampling area away from child-oriented products
 - Require alcohol advertising for tastings to be at least 36 inches off the floor
 - Presence of licensed operator within the sampling area

5. Municipalities should adopt an ordinance establishing significant forfeitures for adults who provide a safe haven for underage drinking, pour or provide alcohol for 3 or more nonrelated youth on their property (See example in Appendix 3).
6. Law enforcement agencies should establish ongoing liaison with the owners and managers of rental property to prevent party or nuisance houses. These individuals should also establish a protocol for securing and dispersing unruly gatherings and evicting tenants in violation of the lease as a result of alcohol related problems.
7. Municipalities individually, or as part of a multi-jurisdictional task force, should operate well publicized saturation patrols to discourage drunk driving.
8. Municipalities should append the following conditions to all Class “B” Temporary [picnic] licenses (beer gardens, festivals, etc.) to reduce alcohol related injuries, disturbances and prevent underage drinking:
 - Create secure perimeter around the licensed area with a double fence (with a minimum 7 foot gap), a single entrance and photo ID check
 - Use wrist bands and hand stamps in rotating patterns to identify customers age 21 and older for alcohol purchase
 - Require a BAC not greater than 0.04 and ban alcohol consumption while serving and mandate that alcohol RBS or local RBS alternative training be completed by all servers
 - Mandate a minimum of one licensed bartender (operator) on site whenever alcohol is sold or served
 - Allow only 12 oz (or smaller) clear or opaque cups with sale limited to two cups per purchase
 - Stop serving alcohol one hour before closing the area
 - Require vendors to offer food or allow food purchased from vendors into the licensed area
 - Nonalcoholic drinks be priced less than alcohol beverages
 - No one under age 21 will be served alcohol even when accompanied by a parent, guardian or spouse of legal drinking age

If additional security is required, municipalities may consider the following:

 - Search all bags and backpacks of individuals entering the licensed alcohol area for alcohol and other contraband.
 - Toilet facilities shall be available within the secure perimeter.
9. Municipalities should limit alcohol advertising to prevent youth overexposure to alcohol advertising. Municipalities should consider:

- A ban on alcohol advertising within 500 ft. of a school, church or park¹⁴
 - Banning single serving alcohol products where possible
 - Banning alcohol advertising on public property
 - Limiting alcohol banners over streets
 - Establishing rules for tastings
 - Limiting the portion of a window that can be covered in advertising viewable from the exterior
 - Raising alcohol displays to above 36" from the floor¹⁵
10. Municipalities should adopt ordinances prohibiting those who sell or serve alcohol from drinking while on duty or having a BAC above a 0.04 while working, commonly called sober server ordinances.
 11. Municipalities should adopt ordinances banning the use of beer bongs and similar devices in addition to competitions and games designed to force the rapid consumption of alcohol in licensed establishments.
 12. Municipalities should establish ongoing, comprehensive alcohol age compliance checks for both on and off premises licensees with citations issued to vendors and/or employees for noncompliance.
 13. Municipalities should adopt ordinances placing significant restrictions on the sale of alcohol at public events including:
 - Prohibiting alcohol sales at youth events and youth oriented events such as interscholastic sports or children's entertainment
 - Mandated on or off-duty officers retained for security, wrist bands and hand stamp to confirm security and the diligent monitoring for intoxicated/ incapacitated persons
 - Non-alcohol beverages that cost less than alcohol
 - Fenced and gated alcohol serving and consumption area with seating
 - Limiting the number of alcohol beverages one individual may purchase at a time
 - Schedule saturation patrols to coincide with the anticipated conclusion time of the event
 14. Municipalities should prohibit consumption-based drink specials such as time limited pricing, specials which increase drink volume without increasing the price and all-you-can-drink flat fee specials.
 15. Municipalities should adopt beer keg registration ordinances as an effective tool to apprehend adults who provide alcohol to underage youth and to deter such purchases in the future. (See example in Appendix 4).

Recommendations Implemented by Educators or Educational Institutions

Wisconsin's public and private schools, colleges and universities are the heart of Wisconsin's communities and key to future economic growth. These recommendations recognize the unique leadership role of educators. Broad-based community involvement in school efforts to reduce alcohol abuse by youth and young adults will create stronger, engaged communities and schools.

1. Youth participation in co-curricular activities is a privilege, not a right. Wisconsin educators and youth would benefit from the adoption and consistent enforcement of a single statewide Code of Conduct for co-curricular activities. Each school district has the right to restrict participation in co-curricular activities for rule violations across conferences with the goal of a statewide, consistently enforced code.
2. Violations of a student or athletic code of conduct should be entered into the student's permanent record. Disciplinary actions should carry over between academic sessions and observed by all public and private schools.
3. Schools should be strongly encouraged to conduct the Youth Risk Behavior Survey (YRBS) to provide an accurate local measure of youth alcohol and other drug use.
4. Wisconsin school principals, athletic directors, and guidance counselors, should be required to attend Drug Impairment Training for Educational Professionals (DITEP) every three years and become familiar with local referral networks.
5. Both public and private schools should implement long-term evidence-based practices and programs to prevent and reduce underage drinking. These efforts should be renewed through scheduled booster sessions and reinforce the communities overall prevention goals. Schools should work with the community to ensure the necessary services are in place so that students in need of alcohol related services can be referred to the appropriate provider.¹⁶
6. Schools should provide parents with information on the hazards of underage drinking and alcohol initiation as part of parenting education sessions, helping parents define their own guidelines for alcohol use and prevention of misuse.
7. Wisconsin's colleges, universities and the municipalities where they are located should take steps to create an environment that discourages underage and high risk drinking. This should include adopting the policies and practices endorsed by the Task Force on College Drinking of the

National Advisory Council of the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

We further recommend that measurable standards documenting the implementation of the NIAAA recommendations be a measure of performance for campus leaders.

Recommendations for Community Groups and Organizations

The practices and policies of community groups are barometers of community norms. In some cases, an organization's long-standing alcohol policies unintentionally contribute to community alcohol problems even as these groups dedicate themselves to community improvement. When civic groups and faith communities review and adopt policies to discourage alcohol misuse, they improve the quality of community life and make a significant contribution to improving Wisconsin's alcohol culture.

1. Wisconsin's civic and service groups should support the efforts of community coalitions working to improve alcohol environment to make the community a more desirable place to live, work and do business. Further, service and civic groups should adopt and implement policies and practices that reduce underage drinking and excessive drinking leading to intoxication.
2. Civic groups should demonstrate responsible alcohol policy and practices by adopting the following guidelines for their own alcohol sales, including:
 - Alcohol must not be served to anyone under age 21, without exception, at group events.
 - Alcohol must not be sold at youth oriented events.
 - When alcohol is sold as part of fundraising events, groups should voluntarily adopt the recommended serving conditions for Temporary Class "B" picnic licenses.
3. While each religious tradition must define its own ministry of prevention, we recommend the following for serious consideration and implementation:

Local faith communities should adopt alcohol policies meeting the same standards recommended for Class "B" Temporary permits:

- Create secure perimeter around the licensed area with a double fence (with a minimum 7 foot gap), a single entrance and photo ID check.
- Use wrist bands and hand stamps in rotating patterns to identify age 21 and older customers for alcohol purchase.

- Require a BAC less than or equal to 0.04 and ban alcohol consumption while serving and require alcohol RBS or local RBS alternative training required for all servers.
- Mandate a minimum of one licensed bartender (operator) on site whenever alcohol is sold or served.
- Allow only 12 oz (or smaller) clear or opaque cups with sale limited to two cups per purchase.
- Stop serving alcohol one hour before closing the area.
- Require vendors to offer food or allow food purchased from vendors into the licensed area.
- Nonalcoholic drinks must cost less than alcohol beverages.
- No one under age 21 should be served alcohol
- Other than as part of a religious service, require all groups, including private events held by parishioners on church property, to abide by rules for alcohol service including:
 - Adult monitoring of the alcohol supply at the event.
 - Alcohol should not be given to underage persons by caterers or other serving staff.
 - ID check should be required by service staff to everyone appearing to be age 30 or less.
- Provide parents with information on the hazards of underage drinking and alcohol initiation as part of parenting education sessions, helping parents define their own guidelines for alcohol use and prevention of misuse.
- Each congregation or faith community should support interfaith and community efforts to reduce youth access to alcohol and young adult binge drinking through community coalitions and campus-community coalitions.
- Prohibit adults from consuming alcohol while supervising or sponsored chaperoning youth events or consuming alcohol prior to attending the event.
- Establish and publicize a policy of respect and simple acceptance for those who request non-alcoholic beverages; providing nonalcoholic beverages at all events for those who choose not to consume alcohol for any reason.

If additional security is required, community groups and organizations may consider the following:

- Search all bags and backpacks of individuals entering the licensed alcohol area for alcohol and other contraband.
- Toilet facilities shall be available within the secure perimeter.

Recommendations for Employers

Individual alcohol use is influenced by employers' expectations as well as the community alcohol environment.¹⁷ Alcohol related problems impact worker productivity, workplace safety and, health care costs. The complex legal and health implications of the workplace alcohol environment suggest a need for alcohol policy and workplace work group composed of employers and employee representatives charged with developing private and public sector policies and practices.

1. While implementing Smoke-Free Wisconsin 2010 requirements, we recommend employers evaluate or reevaluate their workplace alcohol environment. Employers should consider whether official policy, sanctioned activities or common practice creates an environment that condones or contributes to alcohol misuse or exerts pressure to drink on those who wish to abstain from alcohol use for any reason. We make this recommendation to all employers regardless of whether drug-free workplace laws or regulations apply.
2. Wisconsin's employers can support a productive workforce, lower the social and financial burden of alcohol misuse and guide the development of an educated and productive workforce by:
 - Asking supervisors to model appropriate alcohol use.
 - Prohibit serving alcohol to anyone under the age of 21 at company events and provide a variety of nonalcoholic beverage choices.
 - Amend company personnel policies to suggest respect for those who chose not to drink alcohol for any reason.
 - Adopt policy requiring absolute sobriety for employees during business hours.
 - Include Screening, Briefing Intervention and Referral to Treatment (SBIRT) in employee health packages.¹⁸
 - Provide SBIRT screening through on-site medical staff or as part of regular screening for a wide range of conditions.
 - Provide follow-up services as part of the employee assistance program for alcohol abuse to reduce the likelihood of relapse.
3. We recommend the Wisconsin State Council on Alcohol and Other Drug Abuse convene a workgroup including different categories of manufacturing and service sector employers, organized labor, workplace safety experts, labor lawyers and industrial health care professionals. This group should review policies and practices that impact the workplace alcohol environment including the use of portable breathe testing equipment. For example, all stakeholder groups may want to consider the use of portable breath testing equipment in similar ways to urine drug screens for illicit drugs of abuse (e.g., random alcohol breath tests among all employees.

The members of the ACE workgroup are grateful for the many municipalities, law enforcement agencies, community coalitions, and individuals who provided copies of public and private policies intended to reduce alcohol related harms in their communities. The following examples are provided to foster community discussion and do not represent the full range of potential options.

Appendix 1: City of Fitchburg Policy Guidelines for Alcohol Beverage Licenses

Appendix 2: License Condition Adopted by the City of Racine

Appendix 3: Social Host Ordinance Adopted by City of Manitowoc

Appendix 4: La Crosse Keg Registration Ordinance.

Appendix 1

CITY OF FITCHBURG POLICY GUIDELINES ALCOHOL BEVERAGE LICENSES

Intent. As it is the responsibility of the Public Safety & Human Services Committee (“Committee”) of the Fitchburg Common Council to screen applications for alcohol beverage licenses within the City of Fitchburg under the licensing authority granted by Chapter 125 of the Wisconsin Statutes and Chapter 11 of the Fitchburg Ordinances, the Committee adopts the following guidelines in order to specify the reasons for denying, non-renewing or revoking an alcohol beverage license. If a decision is made to deny, revoke, suspend or non-renew a license, the committee is required to provide that person with a written reason for the denial. These guidelines are adopted to meet that requirement.

Please note: If the Police Department recommends denial, revocation, suspension, or nonrenewal of a license, both that person and the employer are notified in writing of the recommendation and are provided the opportunity to meet with the Public Safety and Human Services Committee to discuss the denial. If the Public Safety and Human Services Committee denies, revokes, suspends or does not renew a license, both that person and the employer will be notified, in writing, of the denial and the guideline that was used as reason for denial.

The following guidelines are established by the Committee to provide a framework for which persons are eligible for issuance of an alcohol beverage license (*i.e.* grounds for denial) and a framework for suspension, revocation or non-renewal. **There is broad discretion retained on behalf of the Committee to consider each case on an individual basis. Deviation from the guidelines may be allowed if mitigating circumstances exist, which may include, but are not limited to, the particular circumstances documented or the length of time that has expired since the offense.**

Since alcohol beverage license holders must act in cooperation with law enforcement to enforce the alcohol beverage laws, drunk driving laws, and assist with minimizing disturbances of the peace and maintaining the safety of the community, individuals with a past history of negative or uncooperative contacts with police agencies should be scrutinized; provided, however, that the Committee shall not discriminate against such applicants based on a prior arrest or conviction record, pursuant to Wis. Stat. §§ 111.321, 111.322, 111.335 and 125.12(1)(b), unless said arrest or conviction record substantially relates to the circumstances of the particular licensed activity.

It is with these goals in mind, as well, that these guidelines are adopted. For purposes of these guidelines, an “alcohol beverage license,” “license” or “permit” constitutes a retail license or an operators license. Additionally, the

definition of “person” shall be as defined in Chapter 11 of the Fitchburg Ordinances. Therefore, these guidelines also apply to corporations, limited liability companies, agents, and partnerships. A corporation or limited liability company with an arrest or conviction record may be issued a license if the corporation or limited liability company has terminated its relationship with all the individuals whose actions directly contributed to the conviction [Sec. 125.04(5)(C)].

Furthermore, to the extent Wis. Stat. Ch. 125 or Fitchburg Ordinances provide additional grounds for denial, suspension, revocation or non-renewal, the Committee may also rely on such provisions.

The Committee will only deny renewal of, suspend or revoke a current alcohol beverage license under these guidelines, or other justification provided by law, if the person committed an offense substantially related to the licensed activity within the license year period immediately preceding the year for which the person is seeking renewal or within the license year period in which suspension or revocation is sought, unless the police chief demonstrates that previous offenses were not considered in the approval of the current license. In the event the person is considered for non-renewal, suspension or revocation as the result of such an offense, the Committee shall consider all offenses, regardless of when they occurred, to determine application of these guidelines.

Additionally, with respect to a non-natural person, such person’s license may be revoked, suspended or non-renewed in the event a new officer, director, member, or manager, is named and such person does not qualify under these guidelines; with the exception that a corporation or limited liability company may retain its license if it terminates its relationship with all the individuals whose actions directly contributed to the conviction. With respect to successor agents, see Wis. Stat. § 125.04(6). Notwithstanding the above, the following violations may not be used as grounds for suspension, revocation or non-renewal of an existing license:

1. Furnishing alcohol beverages to underage persons unless the licensee has committed two (2) violations within a one (1) year period), or 2. Violations punishable under Wis. Stat. § 945.03(2m), 945.04(2m) or 945.05(1m) (relating to commercial gambling and gambling devices).

A copy of these guidelines shall be provided to each person who applies for a license.

GUIDELINES

Guideline 1. Provided the offense is **substantially related to the circumstances of the licensed activity**, any person who has been convicted of

any felony, unless duly pardoned, does not qualify for an alcohol beverage license. (To the extent the other guidelines reference a specific offense, this guideline shall apply if the offense constitutes a felony.)

Guideline 2. Provided the offense is **substantially related to the circumstances of the licensed activity**, any person who has been convicted of, released from incarceration in a State or Federal Prison System, or a county jail for, or released from parole or probation status, or has a current charge pending, for two (2) or more offenses, **arising out of separate incidents**, within the last ten (10) years in the following subcategories, does not qualify for an alcohol beverage license:

- (a) Violent crimes against the person of another, including but not limited to homicide, aggravated battery, sexual assault, injury by negligent use of a weapon, injury by negligent use of a vehicle, or injury by intoxicated use of a vehicle.
- (b) Crimes involving cooperation (or lack thereof) with law enforcement officials, including but not limited to, obstructing a police officer, resisting arrest, bribery of public officers or employees, misconduct in public office, bomb scares, or acts or threats of terrorism.
- (c) Manufacturing, distributing, delivering a controlled substance or a controlled substance analog; possessing with intent to manufacture, distribute or deliver, a controlled substance or a controlled substance analog.

Guideline 3. Provided the offense is **substantially related to the circumstances of the licensed activity**, any person who has been convicted of, released from incarceration in a State or Federal Prison System, or a county jail for, or released from parole or probation status, or has a current charge pending, for two (2) or more offenses, **arising out of separate incidents**, within the last three (3) years in the following subcategories, does not qualify for an alcohol beverage license:

- (a) Disorderly conduct, criminal damage to property, solicitation of prostitution or other prostitution related offenses, wherein the offense involves an incident at a place that is, or should have been licensed under Wis. Stat. Ch. 125.
- (b) Alcohol beverage offenses (under Wis. Stat. Ch. 125 or Fitchburg Ordinance Ch. 11 - excluding administrative violations such as “failure to post license under glass”) **(furnishing alcohol beverages to underage persons shall not be used as grounds for suspension, revocation, or non-renewal of an existing license unless the licensee has committed two (2) violations within a one (1) year period).**
- (c) Perjury or false swearing, wherein the offense involves an incident at a place that is, or should have been licensed under Wis. Stat. Ch. 125.
- (d) Possessing a controlled substance, controlled substance analog or drug paraphernalia.
- (e) Operating a motor vehicle while under the influence of intoxicants or drugs.
- (f) Operating a motor vehicle with a BAC in excess of .08% by weight.

- (g) Open intoxicants in public places or in a motor vehicle.

Guideline 4. Provided the offenses are **substantially related to the circumstances of the licensed activity**, any person who is an habitual law offender does not qualify for an alcohol beverage license. To constitute an habitual law offender there need not have been a trial or conviction for each or any offense. What is required is that the offenses were committed, that the law has been violated, and that the fact of such violations can be shown. *See Smith v. City of Oak Creek*, 139 Wis. 2d 788 (1987). For purposes of these guidelines, an habitual offender includes, but is not limited to a person who has committed:

- (a) Two (2) or more offenses, each a separate incident, within the immediately preceding six (6) months.
- (b) Three (3) or more offenses, each a separate incident, within the immediately preceding two (2) years.
- (c) Six (6) or more offenses, each a separate incident, within the preceding ten (10) years.

In the case of a person applying for, or possessing, a retail license, an habitual law offender, or habitually troublesome license holder, shall include, but not be limited to persons who have accumulated more than 100 points, in at least two (2) separate incidents, in the immediately preceding year for violations set forth under 11.15(4) of the Fitchburg Ordinances.

Guideline 5. In addition to the other provisions under these guidelines, pursuant to Wis. Stat § 125.12, a person's alcohol beverage license may be denied, non-renewed, suspended or revoked if the person:

- (a) Keeps or maintains a disorderly or riotous, indecent or improper house.
- (b) Sold or has given away alcohol beverages to known habitual drunkards.
- (c) Does not possess the qualifications under Chapter 11 of Fitchburg Ordinances to hold a license.

Guideline 6. Any person who materially falsifies an application for an alcohol beverage license will not be eligible to re-apply for an alcohol beverage license for a period of six (6) months from the **date of denial** of such application. The Committee may waive the provisions of this paragraph, allow the applicant to submit a corrected application, with the appropriate fee, and grant an alcohol beverage license to the person, if it appears to the Committee that any falsifications on the application were the result of inadvertence, excusable neglect, or mistake.

Severability. If any section, subsection, sentence or phrase of this Policy is for any reason held to be invalid or unconstitutional by reason of a decision of any court of competent jurisdiction, such decision shall not affect the validity of any other section, subsection, sentence, clause or phrase.

Conflict. Any conflict between Wis. Stat. Ch. 125, Fitchburg Ordinance Ch. 11 and this policy shall be decided on the order of precedence which shall be the order listed in this sentence.

This policy will go into effect on the 25th day of November , 2003.

Appendix 2 License Conditions Adopted by the City of Racine

CONDITIONAL USE AGREEMENT

WHEREAS, Constantin Tousis, agent for TTDH, Inc., d/b/a Better Day BP desires to acquire a "Class B" fermented malt beverage and intoxicating liquor license for 2100 Douglas Avenue, Racine, Wisconsin; and

WHEREAS, the Public Safety and Licensing Committee has concerns regarding the factors set out in § 125.12(3m), Wisconsin Statutes, for the public health, safety and welfare of the neighborhood where Better Day BP is located.

NOW, THEREFORE, it is agreed by and between Constantin Tousis and the Public Safety and Licensing Committee, as follows:

- I. The Public Safety and Licensing Committee will recommend to the Common Council that Constantin Tousis be issued a "Class B" fermented malt beverage and intoxicating liquor license, on the following conditions:
 - (a) That neither Constantin Tousis nor any officer, agent, official or employee of TTDH, Inc. d/b/a Better Day BP will sell any single containers (i.e., individual cans or bottles) of fermented malt beverages to any customer at any time in the convenience store area, and will only sell individual mixed drinks and/or individual bottles of beer and/or individual glasses or bottles of wine to customers seated in the restaurant area of said premises.
 - (b) That no packaged intoxicating liquors will be sold for on or off-site consumption.
2. Any violation of the conditions set out above shall be grounds for revocation and/or nonrenewal.

Appendix 3 Manitowoc Social Host Ordinance

ORDINANCE

An Ordinance to create Section 14.07 of the City of Manitowoc Municipal Code regulating underage possession and consumption of alcohol at private residences located in the City of Manitowoc.

The Mayor and Common Council of the City of Manitowoc do ordain as follows:

Section 1. Section 14.07 is created to read as follows:

“(1) Purpose and Findings. The Common Council of the City of Manitowoc intends to discourage underage possession and consumption of alcohol, even if done within the confines of a private residence, and intends to hold persons civilly responsible who host events or gatherings where persons under 21 years of age possess or consume alcohol regardless of whether the person hosting the event or gathering supplied the alcohol. The Common Council of the City of Manitowoc finds:

- (a) Events and gatherings held on private or public property where alcohol is possessed or consumed by persons under the age of twenty-one are harmful to those persons and constitute a potential threat to public health requiring prevention or abatement.
- (b) Prohibiting underage consumption acts to protect underage persons, as well as the general public, from injuries related to alcohol consumption, such as alcohol overdose or alcohol related traffic collisions.
- (c) Alcohol is an addictive drug which, if used irresponsibly, could have drastic effects on those who use it as well as those who are affected by the actions of an irresponsible user.

- (d) Often, events or gatherings involving underage possession and consumption occur outside the presence of parents. However, there are times when the parent(s) is/are present and condone the activity, and in some circumstances, provide the alcohol.
- (e) A deterrent effect will be created by holding a person responsible for hosting an event or gathering where underage possession or consumption occurs.

(2) Definitions. For purposes of this chapter, the following terms have the following meanings:

(a) Alcohol. “Alcohol” means ethyl alcohol, hydrated oxide of ethyl, or spirits of wine, whiskey, rum, brandy, gin or any other distilled spirits including dilutions and mixtures thereof from whatever source or by whatever process produced.

(b) Alcoholic Beverage. “Alcoholic beverage” means alcohol, spirits, liquor, wine, beer and every liquid or solid containing alcohol, spirits, wine or beer, and which contains one-half of one percent or more of alcohol by volume and which is fit for beverage purposes either alone or when diluted, mixed or combined with other substances.

(c) Event or Gathering. “Event or gathering” means any group of three or more persons who have assembled or gathered together for a social occasion or other activity.

(d) Host or Allow. “Host” or “allow” means to aid, conduct, entertain, organize, supervise, control or permit a gathering or event.

(e) Parent. “Parent” means any person having legal custody of a juvenile:

- (1) As natural, adoptive parent or step-parent;
- (2) As a legal guardian; or

(3) As a person to whom legal custody has been given by order of the Court.

(f) Residence, Premises or Public or Private Property. “Residence”, “premises”, or “public or private property” means any home, yard, farm, field, land, apartment, condominium, hotel or motel room or other dwelling unit, or a hall or meeting room, park or any other place of assembly, whether occupied on a temporary or permanent basis, whether occupied as a dwelling or specifically for a party or other social function, and whether owned, leased, rented or used with or without permission or compensation.

(g) Underage Person. “Underage person” is any individual under twenty-one (21) years of age.

(h) Present. Being at hand or in attendance.

(i) In Control. The power to direct, manage, oversee and/or restrict the affairs, business or assets of a person or entity.

Section 2. Prohibited Acts. It is unlawful for any person(s) to: host or allow an event or gathering at any residence, premises or on any other private or public property where alcohol or alcoholic beverages are present when the person knows that an underage person will or does (i) consume any alcohol or alcoholic beverage; or (ii) possess any alcohol or alcoholic beverage with the intent to consume it; and the person fails to take reasonable steps to prevent possession or consumption by the underage person(s).

(a) A person is responsible for violating (A) above if the person intentionally aids, advises, hires, counsels or conspires with or otherwise procures another to commit the prohibited act.

(b) A person who hosts an event or gathering does not have to be present at the event or gathering to be responsible.

Section 3. Exceptions. This chapter does not apply to conduct solely between an underage person and his or her parents while the parent is present and in control of the underage person.

(a) This chapter does not apply to legally protected religious observances.

(b) This chapter does not apply to situations where underage persons are lawfully in possession of alcohol or alcoholic beverages during the course and scope of employment.

Section 4. Penalties. A person who violates any provision of this ordinance is subject to a forfeiture of not less than \$1,000 nor more than \$5,000, together with the costs of prosecution. A person who is in default of payment is subject to imprisonment in the county jail until the forfeiture and costs are paid.”

Section 5. This Ordinance shall take effect the day after publication.

This instrument drafted by Kathleen M. McDaniel
Assistant City Attorney

Appendix 4 La Crosse Beer Keg Registration Ordinance

KEG REGISTRATION.

(1) Definitions. For the purpose of this subsection the following definitions shall apply:

- (a) “Keg” means any container capable of holding four gallons or more of beer, which is designed to dispense fermented malt beverages (beer) directly from the container for purposes of consumption.
- (b) “Registration-seal” means any document, stamped declaration, seal, decal, sticker or device approved by the City Police Department, which is designed to be affixed to kegs, and which displays a registration number and such other information as may be prescribed by the City Police Department.

(2) Registration-Seal Requirement. No retail licensee of fermented malt beverages may sell fermented malt beverages in a keg without having registered the sale, on a form provided for by the city Police Department, and affixing a registration seal on the keg at the time of the sale.

(3) Registration–Declaration. The registration-declaration shall contain the following:

- (a) Require the purchaser of fermented malt beverages to sign a declaration and receipt for the keg or other container in substantially the form provided for in Paragraph (3)(c) of this ordinance.
- (b) Require the purchaser to provide two pieces of identification.
- (c) Require the purchaser to sign a statement on the declaration that:
 - (i) The purchaser is of legal age to purchase, possess, or use fermented malt beverages.
 - (ii) The purchaser will not allow any person, under the age of twenty-one (21) years, unless authorized by State law, to consume the beverage.

- (iii) The purchaser will not remove, obliterate, or allow to be removed or obliterated, the identification required under this ordinance to be affixed to the container.
- (d) Require the purchaser to provide their name and address.
- (e) Such other information as may be required by the City Police Department.

(4) Keg Return-Procedure to be followed by Licensee. When a registered keg is returned to the licensee, the registration seal shall be removed or obliterated and note of such action shall be made on the registration records of the licensee.

(5) Seizure or forfeiture of keg. If a person is in possession of a keg used for or containing beer in violation of this ordinance, then the keg and its contents shall be subject to seizure by the City of La Crosse Police Department.

(6) Responsibility to Maintain Records. All licensees of fermented malt beverages shall maintain a complete and accurate record of all registration forms and other documentation of the sale of kegs at the place of business selling kegs for a period of not less than two (2) years. Such records regarding keg sales shall be open to inspection by the City Police Department at reasonable times.

(7) Limitation on Number of Kegs and Gallons of fermented Malt beverages.

- (a) No licensee shall sell to any person or any address where consumed more than the number of kegs that exceed 31 gallons of fermented malt beverages within a forty-eight (48) hour period, which kegs may contain 15.5 gallons of fermented malt beverages for a total of 31 gallons of fermented malt beverages.
- (b) This prohibition limiting the number of kegs for a total of 31 gallons per address or location shall also apply to each address or location or those addresses that are simultaneously provided for a single event if said addresses are contiguous to each other with respect to the consumption of fermented malt beverages in containers totaling more than 31 gallons. Such occupants or owners of those addresses and locations shall be subject to the penalties for violating this ordinance.

(8) Administration of Keg Registration. The City Police Department, by its Chief of Police, or his or her designee, shall provide for the implementation of this ordinance, which is intended to prevent the misuse of alcohol consumption, as well as provide for orderly, compatible, livable neighborhoods.

(9) That a minimum \$50 deposit is required for each keg, which will be returned to purchaser upon return of the keg.

(10) Kegs seized by the City of La Crosse Police Department in violation of this ordinance must be registered. Unregistered kegs shall be subject to a forfeiture of not less than \$1,000 plus penalty and costs. (The ordinance shall take effect November 1, 2005, after its passage and publication.) (3rd Am. Ord. #4287 created 9/8/05)

¹ Strong, Moses McCure. History of the Territory of Wisconsin from 1836-1849. (Madison, Democrat Printing Co, 1885), p.231.

² Current, R., The History of Wisconsin, Volume 2, (Madison Wisconsin State Historical Society, 1976).

³ "Messmer Held Church Aloof from Dry War Milwaukee Sentinel ; August 14, 1930. Accessed December 30, 2009.

⁴ Edwards, Anderson, Babor et. al. Alcohol Policy and the Public Good., (New York, Oxford University Press 1995).

⁵ Rommel, R. Wisconsin is famous for outgoing spirit, but getting home can be deadly. Wasted in Wisconsin, Milwaukee Journal Sentinel, October 1' 2008..

⁶ Jovaag, Amanda. Impact of Alcohol and Illicit Drug Use in Wisconsin (Madison University of Wisconsin Population Health Institute. School of Medicine and Public Health, 2007.

⁷ Jovaag, Amanda. Impact of Alcohol and Illicit Drug Use in Wisconsin, (University of Wisconsin Population Health Institute. School of Medicine and Public Health), 2007.

⁸ Department of Health and Social Services Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, 2007 State Estimates,. Accessed December 30, 2009

⁹ Modeled upon the Ethical Principles and Goals of the European Charter on Alcohol, adopted December 1995.

¹⁰ Fifth and Sixth OWI = Class H felony: fine not to exceed \$10,000, imprisonment not to exceed 6 years or both.

Seventh, Eighth and Ninth = Class G felony: fine not to exceed \$25,000, imprisonment not to exceed 10 years or both.

Tenth and subsequent = Class F felony: fine not to exceed \$25,000, imprisonment not to exceed 12 years & 6 months or both. Effective April 2, 2008.

¹¹ This is an increase from the current second offense penalties of a fine not more than \$350 nor more than \$1,100 and imprisonment for not less than 5 days nor more than 6 months.

¹² This increases the forfeiture amount from not less than \$150 nor more than \$300.

¹³ National Research Council and Institute of Medicine (2004) Reducing Underage Drinking: A collective Responsibility. Committee on Developing a Strategy to Reduce and Prevent Underage Drinking, Richard, J. Bonnie and Mary Ellen O'Connell.

¹⁴ Distilled Spirits Council of the United States Code of Professional Responsibility, http://www.discus.org/pdf/61332_DISCUS.pdf and Beer Institute Advertising and Marketing Code, 2006 <http://www.beerinstitute.org/BeerInstitute/files/ccLibraryFiles/Filename/00000000384/2006ADCODE.pdf>

¹⁵ «Point-of-Purchase Alcohol Marketing and Promotion by Store Type --- United States, 2000—2001»Morbidity and Mortality Weekly Report, April 11, 2003 52(14); 310-313.

¹⁶ National Research Council and Institute of Medicine (2004) Reducing Underage Drinking: A Collective Responsibility. Committee on Developing a Strategy to Reduce and Prevent Underage Drinking, Richard, J. Bonnie and Mary Ellen O'Connell, editors.

17. The George Washington University Medical Center. Workplace Screening and Brief Intervention: "What Employers Can and Should Do About Excessive Alcohol Use". Ensuring Solutions to Alcohol Problems. March 2008.

18 Roman, P., Blum T., «The Workplace and Alcohol Problem Prevention», National Institute on Alcohol Abuse and Alcoholism.. Accessed October 20, 2009.

18. Roman, P., Blum T., «The Workplace and Alcohol Problem Prevention», National Institute on Alcohol Abuse and Alcoholism.. Accessed October 20 , 2009

SCAODA Motion Introduction

Committee Introducing Motion: Prevention
Motion: To endorse the Alcohol Culture and Environment final report and send it to SCAODA For approval and distribution.
Related SCAODA GOAL: Support the prevention and reduction of alcohol, tobacco, and other drug use and abuse through evidence-based practice with special emphasis on underage use.
<p>Background: The consequences and costs of alcohol misuse in Wisconsin are staggering and have created a diverse range of problems. Changing Wisconsin's culture of alcohol abuse will require an equally diverse set of solutions including new policies and practices in all segments of the community, including local and state government.</p> <p>The Alcohol, Culture and Environment Subcommittee of the Prevention Committee examined state laws, local ordinances and related policies that regulate the sale and serving of alcohol to identify legal, cultural and financial barriers to alcohol policy reform. The subcommittee also examined the role of Wisconsin's culture and history as it may impact current alcohol related problems.</p> <p>Wisconsin's framework for alcohol policy was established fifty years before research demonstrated that public policy and community practices have the ability to prevent and reduce illegal, inappropriate and dangerous alcohol use without significant impact on moderate drinkers over age 21. Accordingly, the subcommittee examined strategies/options at the private, community, municipal and state levels in an effort to make alcohol less acceptable, available, attractive and affordable to vulnerable populations. The goal of this report is to reduce underage drinking, young adult binge drinking and alcohol- related vehicular injuries and fatalities.</p>
Rationale for Supporting Motion: The Alcohol Culture and Environment final report is a collection of specific policy recommendations that could have an impact on Wisconsin's alcohol abuse culture.

"For the longest time, our political opponents were older Americans who were not familiar with marijuana and had lived through the 'Reefer Madness' mentality and they considered marijuana a very dangerous drug," said Keith Stroup, the founder and lawyer of NORML, a marijuana advocacy group.

"Now, whether they resume the habit of smoking or whether they simply understand that it's no big deal and that it shouldn't be a crime, in large numbers they're on our side of the issue."

Each night, 66-year-old Stroup says he sits down to the evening news, pours himself a glass of wine and rolls a joint. He's used the drug since he was a freshman at Georgetown, but many older adults are revisiting marijuana after years away.

"The kids are grown, they're out of school, you've got time on your hands and frankly it's a time when you can really enjoy marijuana," Stroup said. "Food tastes better, music sounds better, sex is more enjoyable."

The drug is credited with relieving many problems of aging: aches and pains, glaucoma, macular degeneration, and so on. Patients in 14 states enjoy medical marijuana laws, but those elsewhere buy or grow the drug illegally to ease their conditions.

Among them is Perry Parks, 67, of Rockingham, N.C., a retired Army pilot who suffered crippling pain from degenerative disc disease and arthritis. He had tried all sorts of drugs, from Vioxx to epidural steroids, but found little success. About two years ago he turned to marijuana, which he first had tried in college, and was amazed how well it worked for the pain.

"I realized I could get by without the narcotics," Parks said, referring to prescription painkillers. "I am essentially pain free."

But there's also the risk that health problems already faced by older people can be exacerbated by regular marijuana use.

Older users could be at risk for falls if they become dizzy, smoking it increases the risk of heart disease and it can cause cognitive impairment, said Dr. William Dale, chief of geriatrics and palliative medicine at the University of Chicago Medical Center.

He said he'd caution against using it even if a patient cites benefits.

"There are other better ways to achieve the same effects," he said.

Pete Delany, director of applied studies at the Substance Abuse and Mental Health Services Administration, said boomers' drug use defied stereotypes, but is important to address.

"When you think about people who are 50 and older you don't generally think of them as using illicit drugs – the occasional Hunter Thompson or the kind of hippie dippie guy that gets a lot of press maybe," he said. "As a nation, it's important to us to say, 'It's not just young people using drugs it's older people using drugs.'"

In conversations, older marijuana users often say they smoke in less social settings than when they were younger, frequently preferring to enjoy the drug privately. They say the quality (and price) of the drug has increased substantially since their youth and they aren't as paranoid about using it.

Dennis Day, a 61-year-old attorney in Columbus, Ohio, said when he used to get high, he wore dark glasses to disguise his red eyes, feared talking to people on the street and worried about encountering police. With age, he says, any drawbacks to the drug have disappeared.

"My eyes no longer turn red, I no longer get the munchies," Day said. "The primary drawbacks to me now are legal."

Siegel bucks the trend as someone who was well into her 50s before she tried pot for the first time. She can muster only one frustration with the drug.

"I never learned how to roll a joint," she said. "It's just a big nuisance. It's much easier to fill a pipe."

latimes.com/news/local/la-me-medical-marijuana18-2010feb18,0,1023346.story

latimes.com

UC studies find promise in medical marijuana

As an \$8.7-million state research effort comes to an end, investigators report that cannabis can significantly relieve neuropathic pain and reduce muscle spasms in MS patients. More research is urged.

By John Hoeffel

February 18, 2010

With an innovative but little-known state program to study medical marijuana about to run out of money, researchers and political supporters said Wednesday the results show promise.

"It should take all the mystery out of whether it works. We've got the results," said former state Sen. John Vasconcellos, who led the effort to create the 10-year-old Center for Medicinal Cannabis Research.

The center has nearly spent its \$8.7-million allocation, sponsoring 14 studies at UC campuses, including the first clinical trials of smoked marijuana in the United States in more than two decades.

Much of the research is still underway or under review, but five studies have been published in scientific journals. Four showed that cannabis can significantly relieve neuropathic pain and one found that vaporizers are an effective way to use marijuana. Another study, submitted for publication, found that marijuana can reduce muscle spasms in multiple sclerosis patients.

Dr. Igor Grant, a neuropsychiatrist at UC San Diego who is the center's director, called the pain studies "pretty convincing" and urged the federal government to pay for additional clinical studies.

With the state stuck in a daunting budget crisis, even the center's advocates do not expect more support. "There is no state money at this time, unfortunately," said state Sen. Mark Leno (D-San Francisco).

Since the center opened in 2000, medical marijuana use has spread rapidly in California, driven largely by doctors' willingness to recommend it for a wide range of ailments. But little research has been done on its effectiveness, in part because researchers must win approval from federal agencies, including the Drug Enforcement Administration.

Grant said federal officials did not try to thwart the research, but noted that approval typically took 18 months. "We basically did a lot of the work for investigators in terms of jumping through the hoops," he said.

The unusual scientific program, approved by the Legislature in 1999, was the result of

negotiations between Vasconcellos and former Atty. Gen. Dan Lungren. The two were vigorous adversaries in the contentious debate over the 1996 initiative that approved the use of medical marijuana.

Lungren, now a Republican congressman from Gold River, argued that Californians were moving ahead without the research needed to show whether marijuana was useful as a medicine. "I said at that time, if we had scientific evidence, we ought to be guided by scientific evidence," he said.

"I was shrewd enough to pick up on Lungren's 'Let's do research,' " Vasconcellos said. Lungren said he was shrewd enough to accept.

Lungren said the results are helpful, but underscore that medical marijuana should be more tightly controlled and used only where it has been proven effective.

The center funded a range of research, including six studies of whether marijuana reduces neuropathic pain, which is caused by a damaged or abnormally functioning nervous system. A UC San Francisco study of patients with HIV-related pain found that 52% of those who smoked marijuana experienced significant relief.

"I think that clearly cannabis has benefits," said Dr. Donald I. Abrams, a San Francisco oncologist who led that study. "This substance has been a medicine for 2,700 years; it only hasn't been a medicine for 70."

Abrams doubts that the research will alter the debate over marijuana. "Science has not been driving this train for a long time now. I think it's all politics," he said.

Grant was more optimistic: "We have a different administration, and they are looking at the science basis of many things."

He said the research shows marijuana should no longer be classified as a Schedule I drug. "It is not a drug without value," he said.

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Board Backs Legalizing Medical Marijuana In Iowa

POSTED: 1:00 pm CST February 17, 2010
 UPDATED: 8:21 am CST February 18, 2010

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DES MOINES, Iowa -- The Iowa pharmacy board took the state a step closer to legalizing marijuana for medical use, but the issue still faces a huge obstacle in the Iowa Legislature.



The recommendation could eventually lead to doctors in Iowa being able to prescribe marijuana to some patients.

In a small Des Moines conference room, months of heated debate came down to a single discussion: should marijuana be reclassified as an addictive, but useful drug, or should it remain illegal?

"I tend to look at public health in the bigger scope than just the person using it," said board member Ann Diehl.

"It's not public health really. It's a small portion of the people that are wanting to use the marijuana for medical purposes," said pharmacist Vernon Benjamin.

The six-member board made up mostly of pharmacists was unanimous in recommending that Iowa lawmakers reclassify marijuana as a Schedule II drug in recognition of its medicinal benefits. The recommendation does not impact current Iowa law, which bans the use of marijuana for medical or other purposes.

A Schedule II drug means that the state recognizes the drug's medicinal benefits, but also a potential for abuse.

The board originally rejected the idea out of hand, but a judge ordered the board to take a closer look.

"We're absolutely ecstatic, obviously," said supporter Jimmy Morrison. "Putting it into Schedule Two says that it has accepted medical value in the United States, which is a huge, huge step."

The vote moves the debate up to the Legislature.

"It's elevating the discussion and that's probably a good thing," said House Majority Leader Kevin McCarthy.

The board is recommending that the Legislature convene a task force or study committee for the purpose of making recommendations back to the full Legislature regarding the

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SURVEY

Should Iowa lawmakers make marijuana available to Iowans for medical uses?

- Yes make it legal
- No don't
- I don't know

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administration of a medical marijuana program.

It's too late in this legislative session to restart the debate, but House leaders said the pharmacy board's recommendation may drive them to spend the summer researching their options.

"We will have a committee that would meet periodically with experts, with people from the pharmacy board, with doctors to see if there is bipartisan consensus to do something in this regard," McCarthy said.

He said if there is a bipartisan consensus, Iowans could expect a vote in about a year.

The board's action makes it the first in the nation to take such a stance on marijuana. There are now 14 states in which medical marijuana is legal.

Previous Stories:

- February 16, 2010: [Poll: Iowans Back Medicinal Marijuana](#)
- November 5, 2009: [Medical Marijuana Hearings Wrap Up](#)
- August 19, 2009: [Iowans Speak Out On Medical Marijuana](#)
- July 21, 2009: [Have Opinion On Medical Marijuana, Board Wants To Hear It](#)
- June 2, 2009: [Iowa Board Rules On Medical Marijuana](#)
- April 25, 2009: [Med Marijuana In Iowa's Future?](#)
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Wisconsin Medical Society

Your Doctor. Your Health.

TO: Senate Committee on Health, Health Insurance, Privacy Property Tax Relief, and Revenue
Assembly Committee on Public Health

FROM: Michael Miller, MD

DATE: December 15, 2009

RE: Opposition to Senate Bill 368/Assembly Bill 554

“It’s pretty hard to say that a doctor actually thinks marijuana would be helpful and the doctor can’t prescribe it, whereas [he] could prescribe morphine,” said Governor Jim Doyle. “We prescribe much more dangerous drugs.” (*Washington Post*, October 25, 2009, page 4B)

These are the kinds of things you hear said in the debate about ‘medical marijuana’:

- Why wouldn’t you want to be compassionate?
- Why wouldn’t you want to make available something that works for people who need it?
- This stuff really isn’t harmful.

Public policy changes addressing marijuana use have been called the “medical marijuana issue” based on the premise that marijuana should be allowed to be a “medicine” that people can use, with or without a doctor’s prescription. The basic assumptions behind “medical marijuana” initiatives are that marijuana is an **acceptably safe** and a **reasonably effective** product to relieve human suffering. Everyone wants to relieve human suffering – especially professionals such as physicians and nurses. “Medical marijuana” advocates add a layer of emotion by saying that their opponents want to prevent people in misery from being able to relieve their misery. Some states have approved “medical marijuana” not through a legislative process, but through a ballot initiative process – a referendum of the general citizenry. Whenever there is a legislative process, hearings are held and patients are brought forth to describe their misery and to make emotional pleas for relief. I’ve attended these hearings before – anyone who would say anything against “medical marijuana” is made to feel guilty for doing so, especially in front of sincere people who may be confined to wheelchairs or otherwise clearly impaired by a health condition.

But these are the facts:

Marijuana is illegal to possess, use, manufacture (grow), distribute, or sell. A major exception to this illegal status has arisen through various state “medical marijuana” policies.

Virtually all marijuana consumed by both persons with addiction to cannabis, ‘recreational users’ of cannabis, and ‘medical marijuana patients’, is consumed via smoking: a vegetable product is combusted. Combustion volatilizes chemicals that can then be inhaled, and produces a range of other combustion products, including particulates and carcinogens and carbon monoxide and other gasses and heat, which produces its own damage to the respiratory tree when combustibles are inhaled. ‘Recreational users’ and others can ingest marijuana (e.g., in baked goods such as brownies), but most of them don’t eat it, they smoke it.

Truly medicinal cannabis is the legal product, pharmaceutical tetra-hydro-cannabinol (THC). The FDA-approved product, which is the subject of safe manufacture and distribution, is a capsule with the trade name Marinol®. This is a capsule of THC taken by patients by mouth.

Marijuana “works” because of its major active ingredient, THC. THC works on the brain because the brain contains naturally occurring receptors to chemicals called cannabinoids. The human nervous system contains two well-known receptors for THC and some other compounds – the CB1 and the CB2 cannabinoid receptors. The brain also makes naturally occurring compounds that act on these receptors. Scientists in laboratories can also develop novel chemical compounds that turn on these receptors (cannabinoid agonists) and chemical compounds that turn off these receptors (cannabinoid antagonists).

The naturally occurring *cannabis sativa* plant contains a wide range of cannabinoids and other chemicals.

Pharmaceutical grade THC is already available and legal in the United States through a prescription medication called Marinol® that is taken in an oral capsule. Marinol® works. It is FDA-approved based on usual FDA processes that investigate both efficacy and safety for pharmaceuticals. It appears in federal Controlled Substances schedules.

Cannabinoids have been alleged to be effective for a wide range of medical conditions. But Marinol®, pure THC, does not “work” for every condition that marijuana is alleged to be a “medicine” for. The only three indications for Marinol® that have withstood the scrutiny of the FDA drug approval process, are nausea in certain patients, low appetite/low weight in certain patients, and elevated intra-ocular pressure in certain patients.

Marinol® is considered a ‘dangerous drug’ by the US agency formerly known as the Bureau of Narcotics and Dangerous Drugs (the predecessor agency to the DEA). Marinol® appears under Schedule II of the schedules created by the Controlled Substances Act. The definition of a Schedule II drug is a “drug or other substance [which] has a high potential for abuse; [which] has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions” and a drug or other substance for which “abuse of the drug or other substances may lead to severe psychological or physical dependence.” This scheduling is because THC is a dangerous drug. THC is addictive. There’s no debate about this, no controversy – no controversy within the fields of medicine and science.

[The whole topic of the addictive nature of marijuana is something of a side track argument I can certainly answer questions about, but would rather not focus on. The few points about it that I can make are that addiction is actually not about drugs but is about brains; the brains of persons with addiction are different than the brains of persons without addiction; addiction is a result of an interaction of genetic and environmental and socio-cultural factors just as much as it is dependent on the chemical properties of certain addictive drugs. Most people can use addictive drugs without developing problems, and the vast majority of people who smoke marijuana can do so without developing addiction. But this doesn’t mean that there are not persons with vulnerabilities to addiction who will develop addiction, including loss of control over substance use, continued compulsive use despite adverse consequences, preoccupation, a detriment in education, occupational, or family functioning, and even a disabling addiction to cannabis. Just because the majority of drinkers and the majority of pot smokers can engage in these behaviors “recreationally” and not become addicted to the substance, doesn’t mean that the substance itself is not associated with addiction.

How often do cannabis users develop cannabis dependence? The 2008 National Survey on Drug Use and Health of the U.S. Department of Health and Human Services shows that past-year use rates for marijuana and hashish for persons aged 12 and older are 10.1 percent, and that the 12-month prevalence rate for cannabis dependence (according to the criteria in the DSM-IV [new footnote]) in the same age segment is 1.1 percent.

The prevalence rate for cannabis dependence is higher than for any other single illicit drug or drug class. **The rate of cannabis dependence among users of cannabis is 10.4 percent**; per this analysis, cannabis is ‘twice as addictive’ as ethanol (where 5.3 percent of users meet diagnostic criteria for alcohol dependence). These rates are comparable to the rates of substance dependence among users of prescription stimulants, prescription sedatives, and prescription opioids. As is the case for other classes of drugs, cannabis dependence is more likely to occur in individuals with co-morbid psychiatric conditions.]

But back to my main points:

THC is effective, but its effects are limited. And there’s a very important point to be made here. One can hear experts talk about the difference between the CB1 receptor and the CB2 receptor, how the CB1 receptor is related to the psychoactive effects of THC and its ability to produce hallucinations, delusions, euphoria, a reduction of anxiety, etc.; and how the CB2 receptor is involved in the peripheral nervous system in inflammatory processes and is the receptor involved in cannabinoids working as analgesics. But it’s important to know that the pain-relieving potential of THC is the equivalent of about 30 mg of codeine – nothing more. The idea that someone with severe pain, unresponsive to other analgesics at high doses, will get significant pain relief if marijuana is approved as a “medicine” for analgesia, simply doesn’t stand up to any scientific scrutiny. It is an effective analgesic, but it is a relatively weak analgesic. It can work for minor pain. But there are many safe and effective alternatives for minor pain. It is not a “big gun” to be taken out when all of the things fail – because it’s not that potent of an analgesic.

Marijuana definitely has anxiety-reducing effects when taken at low doses by experienced users. The therapeutic effects for many patients, I’m certain, are “non-specific,” deriving from the psychoactive effects on anxiety in experienced users, and not due to some specific pharmacological effect on pain, spasticity, nausea, etc. We have very safe and effective alternatives for pain, spasticity, nausea, and anxiety.

Next, we get to the issue of harm. Other than its psychoactive effects and its potential to produce addiction, marijuana is indeed relatively – I emphasize relatively – harmless. Most “inexperienced users” develop dysphoria when they use marijuana – they just don’t like the feeling, the impairments in concentration and coordination that it causes, and so doses people take are limited, except in heavy regular users. But THC is not really that toxic of a compound. What is toxic is smoking – smoking marijuana, tobacco, or any other drug. I would like to emphasize that smoking is an unsafe drug delivery system and there is no reason to approve it for any drug. Smoke marijuana is dangerous, because of the smoke.

Because of this, pharmaceutical companies have been developing non-smoked routes of administration for potentially therapeutic cannabinoids. Beyond the oral capsule (Marinol®, which is pure THC) there are nasal sprays and patches and just a variety of safe drug delivery devices that do not involve smoking. It’s very important to note that the pharmaceutical researchers are looking at other psychoactive compounds in the marijuana plant that can be therapeutic, besides THC itself: newer agents under development sometimes contain a variety of cannabinoids other than THC, in specific mixtures. In England there are companies with big greenhouses that genetically select marijuana plants for a certain percentage of one cannabinoid versus another, trying to maximize the beneficial effects and minimize the negative effects including, unpleasant psychoactive effects.

Research on cannabinoids found in the marijuana plant, and able to be synthesized in a chemistry laboratory, is ongoing and important. There certainly is the promise of therapeutics to come from medications that work on the CB1 and CB2 cannabinoid receptors in the brain. I think in the next 10 years we will see fascinating developments of treatments for a wide range of health conditions including obesity, using chemicals that work on the CB1 or CB2 receptor. But these will not be smoked marijuana.

The Wisconsin Medical Society has policy that supports research on cannabinoids and the development of safe and effective medications, and the American Medical Association recently revised its policies with the aim of facilitating such research, including the development of safe delivery systems for THC and other cannabinoids.

The Wisconsin Medical Society does not support smoking as a delivery device for THC, other cannabinoids, or any compound considered to be “therapeutic.”

Finally, let’s get down to the technical ideas here. Would a physician prescribe “medical marijuana”? If so, how would the physician write the prescription? What is the dose? How does one know the dose of the “therapeutic agent” in a joint? Would this all be laboratory grade marijuana where the percentage of different cannabinoids would be well known? The marijuana buyers clubs in California aren’t this way at all – it’s almost a free market, almost complete legalization, where just a whole range of connoisseur-level euphoricants are available in different humors available for sale. And then there are some liability issues. The adverse effects of cannabinoids on coordination, reaction time, alertness, and therefore operation of a motor vehicle, are well known. Let’s say a physician writes a prescription for “medical marijuana,” let’s say the patient gets into a car crash. What’s the liability for the physician? Did the physician prescribe an unsafe amount of drug – akin to several handfuls of Valium®, for the person who would be driving?

The Medical/Scientific Committee of the National Council on Alcoholism and Other Drug Dependencies has adopted a statement on “Medical Marijuana,” stating that NCADD “is not in favor of wholesale, broad availability of smoked marijuana; if it is for legal medical use, it should be in same context of how other dangerous drugs are prescribed including warnings, labeling, appropriate forms of dispensing, scheduled and monitored and administered in same way as other drugs under FDA oversight.”

So the problems are many. One is knowing the dose that the patient is using and that the doctor is “prescribing.” The other is smoke as a delivery vehicle – one of the most important issues here. And the other is efficacy.

I sincerely believe that P.T. Barnum and W.C. Fields would be delighted to watch what’s happening in America with regard to the topic of so-called “medical marijuana.” The extent to which people are being fooled is just dramatic. The original premises are very understandable – who would want to see anyone suffer unnecessarily? But the leaps that are taken between a suffering human being and the legal authorization for someone to smoke marijuana to relieve their ills, is just a wild leap. All the benefits can be obtained without passing this legislation. Wisconsin joining the ranks of other states that approve the use of ‘joints’ as ‘medicine’ would be a boon to marijuana growers, marijuana sellers, and marijuana users. We need the researchers to give us better products that involve cannabinoids and other chemicals that act on cannabinoid receptors. But smoked marijuana is not the path to Nirvana from a public policy standpoint. It is wrong for Wisconsin.

Thank you for your attention.



Wisconsin Medical Society

Your Doctor. Your Health.

Wisconsin Medical Society and American Medical Association Policies: Marijuana

Society Policy:

ALT-001

Medical Marijuana:

1. The Wisconsin Medical Society (Society) recommends that adequate and well-controlled studies of smoked marijuana be conducted in patients who have serious conditions for which pre-clinical, anecdotal or controlled evidence suggests possible efficacy including AIDS wasting syndrome, severe acute or delayed emesis induced by chemotherapy, multiple sclerosis, spinal cord injury, dystonia and neuropathic pain, and that marijuana be retained in Schedule I of the Controlled Substances Act pending the outcome of such studies. Smoked marijuana should not be used for therapeutic reasons without scientific data regarding its safety and efficacy for specific indications.
2. The Society urges the National Institutes of Health (NIH) to implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research into the medical utility of marijuana. This effort should include
 - a. Disseminating specific information for researchers on the development of safeguards for marijuana clinical research protocols and the development of a model of informed consent on marijuana for institutional review board evaluation.
 - b. Sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of marijuana for clinical research purposes.
 - c. Confirming that marijuana of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the Drug Enforcement Agency who are conducting bona fide clinical research studies that receive Food and Drug Administration approval, regardless of whether or not the NIH is the primary source of grant support.
3. The Society believes that the NIH should use its resources and influence to support the development of a smoke-free inhaled delivery system for marijuana or delta-9-tetrahydrocannabinol (THC) to reduce the health hazards associated with the combustion and inhalation of marijuana.
4. The Society does not support reinstatement of the Single Patient Investigational New Drug program for smoked marijuana at this time, because the program would likely be unable to meet the needs of individual patients in a timely fashion due to procurement difficulties associated with regulatory oversight and because this approach will not provide the scientific data needed to guide the public debate on the utility of medical marijuana.
5. The Society believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. (HOD, 0405)

AMA Policy:

Medical Marijuana

(1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.

(2) Our AMA urges that marijuana's status as a federal Schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.

(New HOD Policy)

(3) Our AMA urges the National Institutes of Health (NIH) to implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research into the medical utility of marijuana. This effort should include: a) disseminating specific information for researchers on the development of safeguards for marijuana clinical research protocols and the development of a model informed consent on marijuana for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of marijuana for clinical research purposes; c) confirming that marijuana of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the Drug Enforcement Agency who are conducting bona fide clinical research studies that receive Food and Drug Administration approval, regardless of whether or not the NIH is the primary source of grant support.

(4) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. (CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01)



ASAM

American Society of Addiction Medicine

Public Policy Statement on Marijuana

Marijuana is a mood-altering drug capable of producing dependency. Its chief active ingredient is delta-9-Tetrahydrocannabinol, but there are many other ingredients.

Marijuana has been shown to have adverse effects on memory and learning, on perception, behavior and functioning, and on pregnancy. Because of the widespread use of this drug, its effects on mind and body, and the increasing potency of available supplies,

ASAM strongly recommends:

1. **Education about drugs, beginning in the earliest grades of elementary school and continuing through university level. Drug education should contain scientifically accurate information on the dangers and harmful effects of marijuana, and on the disease of marijuana dependence.**
2. **Health and human service professionals should be educated about marijuana and marijuana dependence as a required part of their curriculum.**
3. **Persons suffering from alcoholism and other drug dependencies should be educated about the need for abstinence from marijuana and its role in precipitating relapse, even if their original drug of choice is other than marijuana. Treatment programs providing addictions treatment for chemically dependent patients should include tests for cannabinoids with other drug test panels and consider test results when designing treatment plans.**
4. **Marijuana dependent persons, like other drug dependent people, should be offered treatment rather than punishment for their illness. Treatment of marijuana dependence should be part of the plan for rehabilitation of any person convicted of a drug-related offense, including driving under the influence of alcohol and/or drugs, who is found to be marijuana dependent.**
5. **Medical uses of pharmaceutical delta-9-Tetrahydrocannabinol (such as Marinol™) for the treatment of illnesses associated with wasting, such as AIDS, the treatment of emesis associated with chemotherapy, or for other indications should be carefully controlled. Smoking marijuana is dangerous to the health of any user, and produces health risks of passive smoke akin to risks of exposure to passive tobacco smoking. Inhaled smoke is a suboptimal delivery method for any agent**

intended to be health-promoting in any way. ASAM supports continued evidence-based research into alternative delivery systems of cannabinoid applications.

- 6. Research on marijuana, including both basic science and applied clinical studies, should receive increased funding and appropriate access to marijuana for study. The mechanisms of action of marijuana, its effect on the human body, its addictive properties, and any appropriate medical applications should be investigated, and the results made known for clinical and policy applications. In addition, ASAM strongly encourages research related to the potential and actual effects of marijuana-related public policy.**
- 7. Physicians should be free to discuss the risks and benefits of medical use of marijuana, as they are free to discuss any other health-related matters. Recognized scientific researchers following established research protocols should be free to conduct research on marijuana and pharmaceutical cannabinoids.**

Adopted by ASAM Board of Directors April 1987; revised April 1997, October 1997, July 1998, December 2000 and May 2006.

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American Society of Addiction Medicine

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REPORT 3 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-09)
Use of Cannabis for Medicinal Purposes
(Resolutions 910, I-08; 921, I-08; and 229, A-09)
(Reference Committee K)

EXECUTIVE SUMMARY

Objective. This report: (1) provides a brief historical perspective on the use of cannabis as medicine; (2) examines the current federal and state-based legal envelope relevant to the medical use of cannabis; (3) provides a brief overview of our current understanding of the pharmacology and physiology of the endocannabinoid system; (4) reviews clinical trials on the relative safety and efficacy of smoked cannabis and botanical-based products; and (5) places this information in perspective with respect to the current drug regulatory framework.

Data Sources. English-language reports on studies using human subjects were selected from a PubMed search of the literature from 2000 to August 2009 using the MeSH terms “marijuana” “cannabis,” and tetrahydrocannabinol,” or “cannabinoids,” in combination with “drug effects,” “therapeutic use,” “administration & dosage,” “smoking,” “metabolism,” “physiology,” “adverse effects,” and “pharmacology.” Additionally the terms “abuse/epidemiology,” and “receptors, cannabinoid” in combination with “agonists,” or “antagonists & inhibitors” as well as “endocannabinoids,” in combination with “pharmacology,” “physiology,” or “metabolism” were used. Additional articles were identified by manual review of the references cited in these publications. Web sites of the Food and Drug Administration, Drug Enforcement Administration, National Institute on Drug Abuse, Marijuana Policy Project, ProCon.org, and the International Association for Cannabis as Medicine also were searched for relevant resources.

Results. The cannabis sativa plant contains more than 60 unique structurally related chemicals (phytocannabinoids). Thirteen states have enacted laws to remove state-level criminal penalties for possessing marijuana for qualifying patients, however the federal government refuses to recognize that the cannabis plant has an accepted medical benefit. Despite the public controversy, less than 20 small randomized controlled trials of short duration involving ~300 patients have been conducted over the last 35 years on smoked cannabis. Many others have been conducted on FDA-approved oral preparations of THC and synthetic analogues, and more recently on botanical extracts of cannabis. Federal court cases have upheld the privileges of doctor-patient discussions on the use of cannabis for medicinal purposes but also preserved the right of the federal government to prosecute patients using cannabis for medicinal purposes. Efforts to reschedule marijuana from Schedule I of the Controlled Substances Act have been unsuccessful to date. Disagreements persist about the long term consequences of marijuana use for medicinal purposes.

Conclusions. Results of short term controlled trials indicate that smoked cannabis reduces neuropathic pain, improves appetite and caloric intake especially in patients with reduced muscle mass, and may relieve spasticity and pain in patients with multiple sclerosis. However, the patchwork of state-based systems that have been established for “medical marijuana” is woefully inadequate in establishing even rudimentary safeguards that normally would be applied to the appropriate clinical use of psychoactive substances. The future of cannabinoid-based medicine lies in the rapidly evolving field of botanical drug substance development, as well as the design of molecules that target various aspects of the endocannabinoid system. To the extent that rescheduling marijuana out of Schedule I will benefit this effort, such a move can be supported.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-I-09

Subject: Use of Cannabis for Medicinal Purposes

Presented by: C. Alvin Head, MD, Chair

Referred to: Reference Committee K
(Peter C. Amadio, MD, Chair)

1 This report responds to three resolutions related to the use of marijuana for medicinal purposes.

2
3 Resolution 910 (I-08), submitted by the Medical Student Section and referred to the Board of
4 Trustees (BOT), asked:

5
6 That our American Medical Association (AMA) support reclassification of marijuana’s status
7 as a Schedule I controlled substance into a more appropriate schedule.

8
9 Resolution 921 (I-08), submitted by the Washington Delegation and referred to the BOT, asked:

10
11 That our AMA support reclassification of marijuana’s status from a Schedule I controlled
12 substance to a more appropriate schedule; and

13
14 That our AMA support efforts to cease criminal prosecution and other enforcement actions
15 against physicians and patients acting in accordance with states’ medical marijuana laws.

16
17 Resolution 229 (A-09), submitted by the New York Delegation and referred to the BOT, asked:

18
19 That our AMA offer assistance in seeking clear, indisputable confirmation from the federal
20 government that physicians who follow the proposed New York State legislation if passed and
21 regulation when subsequently developed will not be prosecuted for allegedly failing to follow
22 the Presidential order still in place making it illegal for a physician to prescribe or even advise
23 a patient to use marijuana for medical purposes; and

24
25 That our AMA seek a reversal of the Executive Order itself that makes it illegal for a physician
26 to prescribe or advise medical marijuana.

27
28 The Council has issued two previous reports on “Medical Marijuana” in 1997 and 2001.^{1,2} The first
29 report is the basis for the current AMA policy on medical marijuana (Policy H-95.992, AMA
30 Policy Database (Appendix A)) and was developed largely in response to emerging state initiatives
31 designed to facilitate the medical use of marijuana. The second report in 2001 reviewed legal,
32 regulatory, and scientific developments on this topic that had transpired since the first report. As of
33 2001, the Council had concluded that sufficient evidence existed to support further research on the
34 potential use of marijuana:

Action of the AMA House of Delegates at the 2009 Interim Meeting: Council on Science and
Public Health Report 3 Recommendations Adopted as Amended and Remainder of Report Filed.

- 1 • In HIV-infected patients with cachexia, neuropathy, or chronic pain, or who are suffering
2 adverse effects from medication, such as nausea, vomiting, and peripheral neuropathy, that
3 impede compliance with antiretroviral therapy;
- 4 • In patients undergoing chemotherapy, especially those being treated for mucositis, nausea, and
5 anorexia, and those patients who do not obtain adequate relief from either acute or delayed
6 emetic episodes from standard therapy;
- 7 • To potentiate the analgesic effects of opioids and to reduce their emetic effects in the treatment
8 of postoperative, traumatic, or cancer pain;
- 9 • In patients suffering from spasticity or pain due to spinal cord injury, or neuropathic or central
10 pain syndromes; and
- 11 • In patients with chronic pain and insomnia.

12
13 In 2001, the AMA House of Delegates reaffirmed that marijuana should be retained in Schedule I
14 of the Controlled Substances Act pending the outcome of further controlled studies.

15
16 The Institute of Medicine (IOM) published a comprehensive report in 1999 commissioned by the
17 Office of National Drug Control Policy, entitled “Marijuana and Medicine: Assessing the Science
18 Base.”³ The findings in this report (see Appendix B) generally agreed with the Council’s
19 assessment of the evidence on the potential medical utility of synthetic and plant-derived
20 cannabinoids. The IOM report also concurred with the Council that further research on the medical
21 utility of marijuana and individual cannabinoids was warranted and that resources should be
22 devoted to developing alternative, smoke-free delivery systems. The IOM further noted:

23
24 “because marijuana is a crude THC delivery system that also delivers harmful substances,
25 smoked marijuana should generally not be recommended for medical use. Nonetheless,
26 marijuana is widely used by certain patient groups, which raises both safety and efficacy
27 issues. If there is any future for marijuana as a medicine, it lies in its isolated components, the
28 cannabinoids and their synthetic derivatives. Isolated cannabinoids will provide more reliable
29 effects than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana
30 would not be to develop marijuana as a licensed drug but rather to serve as a first step toward
31 the development of nonsmoked rapid-onset cannabinoid delivery systems.”

32
33 Accordingly, the IOM report supported the availability of a compassionate-use protocol as an
34 interim measure whereby the clinical use of medical cannabis would be allowed for symptom relief
35 in seriously ill patients in limited and locally implemented peer-reviewed treatment trials. Recently
36 the American College of Physicians (ACP) issued a policy statement on medical marijuana
37 (Appendix C).⁴ Like the AMA, the ACP supports approaches to conduct rigorous scientific
38 evaluation of the potential therapeutic benefits of marijuana, and development of non-smoked
39 forms. Additionally, ACP urged federal review of marijuana’s status as a Schedule I substance to
40 determine if it should be reclassified, and strongly supported exemption from federal criminal
41 prosecutions, civil liability, or professional sanctions for physicians who issue recommendations
42 for medical marijuana in accordance with state law, as well as protection from criminal or civil
43 penalties for patients under such circumstances.

44
45 In light of the foregoing discussion, this report evaluates the merits of Resolutions 910 (I-08), 921
46 (I-08) and 229 (A-09). In so doing, the Council: (1) provides a brief historical perspective on the
47 use of cannabis as medicine; (2) examines the current federal and state-based legal envelope
48 relevant to the medical use of cannabis; (3) provides a brief overview of our current understanding
49 of the pharmacology and physiology of endogenous cannabinoid receptors and substances
50 (endocannabinoids); (4) reviews the more recent clinical trial evidence on the relative safety and

1 efficacy of smoked cannabis and other cannabis-based products; and (5) places this information in
2 perspective with respect to the current drug regulatory framework, and the rights and
3 responsibilities of physicians to provide optimal care for their patients. In many places the term
4 “cannabis” is used. Marijuana is a slang term for the dried flowers and bracts of the cannabis plant.
5 In cases where the term “marihuana” or “marijuana” is used in the statute, policy statement or other
6 legal way, such terms are retained.

7 8 METHODS

9
10 English-language reports on studies using human subjects were selected from a PubMed search of
11 the literature from 2000 to August 2009 using the MeSH terms “marijuana” “cannabis,” and
12 tetrahydrocannabinol,” or “cannabinoids,” in combination with “drug effects,” “therapeutic use,”
13 “administration & dosage,” “smoking,” “metabolism,” “physiology,” “adverse effects,” and
14 “pharmacology.” Additionally the terms “abuse/epidemiology,” and “receptors, cannabinoid” in
15 combination with “agonists,” or “antagonists & inhibitors” as well as “endocannabinoids,” in
16 combination with “pharmacology,” “physiology,” or “metabolism” were used. Additional articles
17 were identified by manual review of the references cited in these publications. Web sites of the
18 Food and Drug Administration, Drug Enforcement Administration, National Institute on Drug
19 Abuse, Marijuana Policy Project, ProCon.org, and the International Association for Cannabis as
20 Medicine also were searched for relevant resources.

21 22 BACKGROUND

23
24 Cannabis is one of the oldest psychotropic drugs in human history. Originating from central Asia,
25 and then spreading to China and India, the first modern description of its pharmacological
26 properties was provided by an Irish physician (William O’Shaughnessy) in 1839.⁵ First listed in
27 the United States Dispensary in 1854, cannabis was promoted for a variety of conditions based on
28 its putative analgesic, sedative, anti-inflammatory, antispasmodic, anti-asthmatic, and
29 anticonvulsant properties.^{1,6,7} Many cannabis-containing oral extracts and tinctures were
30 subsequently manufactured. Interest in the medical use of cannabis waned somewhat in the late
31 nineteenth and early twentieth centuries with the advent of opiates, barbiturates, chloral hydrate,
32 and aspirin and the widespread availability of hypodermic syringes for injection of water-soluble
33 compounds. Nevertheless, cannabis remained available in the British Pharmacopoeia in extract
34 and tincture form until 1971.

35
36 The U.S. government and popular media began condemning the use of smoked cannabis in the
37 1930s, linking its use to homicidal mania. The Marihuana Tax Act of 1937 introduced the first
38 federal restrictions on marijuana. This federal law required industrial or medical users to register
39 and pay a tax on marijuana of \$1/ounce. Individuals using marijuana for recreational or other
40 purposes were required to pay a tax of \$100/ounce. A combination of the paperwork required of
41 physicians who wished to use the drug in their practice, and regulations later imposed by the
42 Federal Bureau of Narcotics designed to prevent diversion, quickly dampened enthusiasm for
43 pursuing medical applications of cannabis.

44
45 At the time, the AMA was virtually alone in opposing passage of the Marihuana Tax Act. The
46 AMA believed that objective data were lacking on the harmful effects of marijuana, and that
47 passage of the Act would impede future investigations into its potential medical uses.⁸ The AMA’s
48 Committee on Legislative Activities recommended that marijuana’s status as a medicinal agent be
49 maintained.⁹ Nevertheless, secondary to governmental pressures, marijuana was removed from the
50 U.S. Pharmacopoeia in 1942, thus losing its remaining mantle of therapeutic legitimacy.

1 In 1964, delta-9-tetrahydrocannabinol (hereafter referred to as THC) was identified as the primary
2 psychoactive cannabinoid in *Cannabis sativa* (see below) and successfully synthesized.¹⁰ The
3 1960s witnessed a resurgence in the recreational use of smoked cannabis, and the ability of
4 cannabis to relieve certain disease symptoms was “rediscovered.” Thereafter the recreational and
5 “medical” forms of smoked cannabis became merged. This contrasts with the path of medicinal
6 opioid development and the recreational use of smoked botanical opium, which became clearly
7 distinct.

8
9 Receptors in the brain and periphery that bind THC (cannabinoid receptors) were discovered in the
10 early 1990s, and the identification of endogenous compounds that act at cannabinoid receptors
11 (endocannabinoids) soon followed. The last decade has seen an explosion in research about the
12 “endocannabinoid system” (see below). Information gleaned from these investigations has shed
13 light on the pharmacologic activity of phytocannabinoids, and created opportunities for the
14 development of pharmaceuticals interacting with this system.

15 16 CANNABINOIDS AND THE ENDOCANNABINOID SYSTEM

17
18 *Cannabis Sativa*. The plant contains over 400 chemical compounds.¹¹ The main psychoactive
19 substance is generally believed to be THC, but more than 60 other cannabinoids (C₂₁-containing
20 compounds) have been identified in the plant (phytocannabinoids) and pyrolysis products.¹⁰⁻¹²
21 Cannabinoids are chemical compounds that are unique to the cannabis plant. Delta-8-THC is
22 similar in potency to THC, but is present in only small concentrations.¹³ Cannabinol and
23 cannabidiol are the other major cannabinoids present. The former is slightly psychoactive, but not
24 in the amounts delivered by smoking marijuana.¹³ Cannabidiol is not psychoactive and has
25 distinctive properties (see below). The average content of THC in cannabis plants is highly
26 variable depending on the strain, climate, soil and growing conditions, and handling after harvest.¹⁴
27 THC is a resinous weak acid, pK_a = 10.6, with a very high lipid solubility and very low aqueous
28 solubility.¹⁵ It binds to glass, diffuses into plastic, and is photo labile and susceptible to heat, acid,
29 and oxidation; these characteristics have served as barriers to the development of traditional
30 pharmaceutical dosage forms. The (-) enantiomer is up to 100 times more potent than the (+)
31 enantiomer depending on the pharmacological test.¹⁶

32 33 ENDOCANNABINOIDS

34 35 *Cannabinoid Receptors*

36
37 Two types of cannabinoid receptors (CB1 and CB2) have been clearly identified and both are
38 members of the superfamily of G-protein-coupled receptors. The CB1 receptor, first cloned in
39 1990, is mainly expressed in the brain and spinal cord.¹⁷ Distribution is heterogeneous with the
40 highest densities present in the basal ganglia, hippocampus, and cerebellum, with comparatively
41 fewer receptors in the brainstem.^{18,19} CB1 receptors are among the most abundant G-protein
42 coupled receptors in the brain.²⁰ By coupling predominately to inhibitory G proteins, CB1 receptors
43 inhibit certain inwardly directed calcium channels, activate outwardly directed potassium channels,
44 and activate various mitogen-activated protein (MAP) kinases.²¹ The latter may play a role in the
45 modulation of synaptic plasticity, cell migration, and neurite remodeling. CB1 receptors are
46 located on the terminals of central and peripheral neurons. Generally, their activation inhibits the
47 ongoing release of a number of different excitatory and inhibitory transmitters, or hyperpolarizes
48 neurons, which also inhibits activity.²¹

49
50 The CB2 receptor, first cloned in 1993 is predominantly expressed in cells of the immune and
51 hematopoietic systems but also is present in nonparenchymal cells of the liver, endocrine pancreas,

1 and bone.²² Some CB2 receptors also are functionally expressed in the CNS, notably on microglial
2 cells.^{23,24} CB2 receptor activation alters the release of cytokines from immune cells and participates
3 in the regulation immune function.²⁰ CB2 agonists generally suppress the functions of these cells.
4 CB2 modulates immune cell migration both within and outside the central nervous system^{25,26}

5 6 *Endocannabinoids*

7
8 In parallel with the discovery of cannabinoid receptors, endogenous substances that bind and
9 activate these receptors were identified (endocannabinoids). The two best characterized are
10 arachidonoyl ethanoamide (AEA or anandamide) and 2-arachidonoylglycerol (2-AG), although
11 other putative endocannabinoids also have been identified. In contrast to conventional
12 neurotransmitters, endocannabinoids are not stored in synaptic vesicles, but are produced on
13 demand via cleavage of membrane lipid precursors and then released after *de novo* synthesis.^{27,28}
14 Once formed in response to presynaptic depolarization, endocannabinoids function as “retrograde”
15 messengers, diffusing back across the synapse and signaling the presynaptic (upstream) neuron to
16 decrease neurotransmitter release and/or activity. These effects have been implicated in the
17 modulation of both short- and long term synaptic plasticity, events which are integral to the
18 remodeling of synaptic networks in the CNS, as well as fundamental processes such as learning
19 and memory.

20
21 Termination of the action of AEA and 2-AG is accomplished by re-uptake into the neuron and
22 subsequent enzymatic degradation. These transport proteins and degradative enzymes represent
23 other targets for manipulating the endocannabinoid system.

24
25 AEA primarily activates CB1 receptors, and also stimulates TRPV1 receptors.²⁹ The latter is an
26 important component of pain signaling pathways. AEA is a partial or full agonist at CB1 receptors,
27 depending on the species, tissue, and biological response being examined.²⁹ Partial agonists are
28 capable of binding to a receptor, but do not cause maximal activation. Pharmacologically, they can
29 function as agonists or antagonists, depending on the dose, and endogenous activity of the
30 biological system they are interacting with. This fact complicates the interpretation of
31 endocannabinoid effects that have been observed in animal models, as well as findings which may
32 be relevant to phytocannabinoids such as THC. Although AEA binds to CB2 receptors, it has a
33 low efficacy, and may act primarily as an antagonist.²⁹ 2-AG has approximately equivalent activity
34 at CB1 and CB2 receptors, is much more abundant than AEA in the brain, and is believed to act
35 primarily as an agonist at cannabinoid receptors.³⁰ Other putative endocannabinoids also tend to be
36 considerably more active as CB1 receptor agonists.³¹ Additionally, other receptor systems appear
37 to respond to endocannabinoids.^{31,32}

38
39 THC is also a partial agonist at the CB1 and CB2 receptors. Cannabidiol displays anti-oxidant
40 activity, is a TRPV1 agonist like AEA, and inhibits the uptake and metabolism of AEA. It has low
41 efficacy for CB1 and CB2 receptors.

42
43 Taken together, the endocannabinoid system is widely dispersed and it modulates the activity of
44 several prominent neurotransmitters, immune regulating cells, and other tissue and organs.
45 Accordingly, endocannabinoids likely play a role in the regulation of a wide variety of functions
46 and disease states. Some of the most prominent include appetite regulation, peripheral energy
47 metabolism, obesity and associated metabolic abnormalities, pain and inflammation,
48 gastrointestinal motility and secretion, central nervous system disorders,
49 neurotoxicity/neuroinflammation/neuroprotection, and certain mental disorders, including
50 substance misuse.³²⁻³⁸

1 STATE MEDICAL CANNABIS LAWS

2
 3 Thirteen states (Alaska, California, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New
 4 Mexico, Oregon, Rhode Island, Vermont, and Washington) have enacted laws since 1996 which
 5 remove state-level criminal penalties for qualifying patients (with physician recommendations or
 6 certifications) for cultivation, possession, and use of cannabis.³⁹ Most of these measures were
 7 adopted by ballot initiative, but some have been passed by state legislatures. Typically, these laws
 8 identify a number of “qualifying conditions.” In California vagaries such as the presence of a
 9 “debilitating condition” or “chronic ailment” or any *other illness for which marijuana provides*
 10 *relief* are introduced. Most state laws provide a specific allowance for cannabis possession, and a
 11 few require/maintain registries or offer certification cards which may assist patients if they are
 12 confronted by police officers.

13
 14 Two other state laws address medical marijuana to a lesser extent. Maryland’s law does not create
 15 a medical marijuana program but protects patients from jail time for possession of marijuana if they
 16 can prove in court that their use of marijuana was a medical necessity; the maximum penalty is a
 17 \$100 fine. Arizona allows physicians to prescribe marijuana, but such a system is not in place
 18 since federal law prohibits physicians from prescribing Schedule I substances. At least 13 other
 19 states have pending legislation or ballot measures to legalize medical marijuana.⁴⁰

20
 21 The number of patients who use cannabis in states that have removed state-level penalties and
 22 permit medical use is not clearly established. According to one compilation, approximately 7,000
 23 physicians have authorized the use of cannabis for at least 400,000 patients.⁴¹

24
 25 FEDERAL POLICIES

26
 27 *Controlled Substances Act*

28
 29 As recreational drug use proliferated during the 1960s, legislative concern led to passage of the
 30 Comprehensive Drug Abuse Prevention and Control Act of 1970 (commonly referred to as the
 31 Controlled Substances Act). This Act classifies certain psychoactive drugs into 5 categories, or
 32 schedules that impose varying restrictions on access to the drugs under direction of the DEA.

33
 34 A drug is placed in Schedule I if (1) it has a high potential for abuse; (2) it has no currently
 35 accepted medical use in treatment in the United States; and (3) there is a lack of accepted safety for
 36 use of the drug under medical supervision. In contrast, Schedule II criteria are that the drug (1) has
 37 a high potential for abuse; (2) has a currently accepted medical use in treatment in the United States
 38 or a currently accepted medical use with severe restrictions; and (3) abuse of the drug may lead to
 39 severe psychological or physical dependence.

40
 41 Marijuana and tetrahydrocannabinols naturally contained in the cannabis plant (as well as synthetic
 42 equivalents and derivatives with similar activity) are assigned by statute to Schedule I, along with
 43 many other drugs such as heroin, lysergic acid diethylamide (LSD), mescaline and other
 44 hallucinogenic amphetamine derivatives, methaqualone, and illicit fentanyl derivatives. Certain
 45 other psychoactive botanical substances (e.g., peyote, psilocybin) also are in Schedule I. With
 46 regard to the placement of marijuana in Schedule I, the following definition is applied:

47
 48 The term "marihuana" means all parts of the plant *Cannabis sativa* , whether growing or not;
 49 the seeds thereof; the resin extracted from any part of such plant; and every compound,
 50 manufacture, salt, derivative, mixture, or preparation of such plant, its seeds or resin. Such term
 51 does not include the mature stalks of such plant, fiber produced from such stalks, oil or cake

1 made from the seeds of such plant, any other compound, manufacture, salt, derivative,
 2 mixture, or preparation of such mature stalks (except the resin extracted there from), fiber, oil,
 3 or cake, or the sterilized seed of such plant which is incapable of germination (21 U.S.C. 802).
 4

5 Some botanical products that serve as raw materials (i.e., coca leaves; raw opium, opium poppy
 6 and poppy straw) for controlled substances are themselves placed in Schedule II. These raw
 7 materials are imported into the U.S. from other countries under international treaty and convention.
 8 FDA-approved pharmaceutical preparations containing THC are in Schedule III, whereas a
 9 synthetic analogue (nabilone) is in Schedule II. Schedule III criteria are that the drug (1) has less
 10 potential for abuse than drugs or other substances in schedules I and II; (2) has a currently accepted
 11 medical use in treatment in the United States; and (3) abuse of the drug or other substance may lead
 12 to moderate or low physical dependence or high psychological dependence.
 13

14 *Federal Court Cases Relevant to Medical Marijuana*

15
 16 Three prominent federal court cases evolved out of California’s 1996 passage of its medical
 17 marijuana ballot initiative (Proposition 215).
 18

19 *Conant v. Walters (2002)*. After California passed its medical marijuana regulation in 1996, Barry
 20 R. McCaffrey, Director of the Office of National Drug Control Policy (ONDCP) issued a statement
 21 entitled “The Administration’s Response to the Passage of California Proposition 215 and Arizona
 22 Proposition 200.” This statement threatened physicians who recommended marijuana with the loss
 23 of their license to prescribe controlled substances and the ability to participate in Medicaid and
 24 Medicare. Physicians and patients filed a class action lawsuit, claiming a constitutional free-speech
 25 right, in the context of a doctor-patient relationship. In *Conant v. Walters* the United States Court
 26 of Appeals in a permanent injunction recognized that physicians have a constitutionally-protected
 27 right to discuss the use of marijuana as a treatment option with their patients and to make oral or
 28 written recommendations for medical marijuana (the AMA had already endorsed this view).⁴²
 29 However, the court cautioned that physicians could exceed the scope of this constitutional
 30 protection if they conspire with, or aid and abet, their patients in obtaining medical marijuana. The
 31 U.S. Supreme Court denied the appeal.
 32

33 *USA v. Oakland Cannabis Buyer’s Cooperative (OCBC) and Jeffrey Jones (2001)*. A medical
 34 cannabis buyer’s cooperative was established in Oakland (Oakland Cannabis Buyer’s Cooperative).
 35 Its proprietor (Jeffrey Jones) distributed marijuana based on the theory that the cooperative could
 36 operate as each patient’s “caregiver” and use a medical necessity defense. The U.S. government
 37 disagreed and the Department of Justice filed a civil suit in January 1998 to close six medical
 38 marijuana distribution centers in northern California. Ultimately, the case went to the U.S.
 39 Supreme Court which ruled unanimously that a medical necessity exception for marijuana was at
 40 odds with the terms of the Controlled Substances Act (i.e., the CSA classified marijuana as lacking
 41 a recognized medical benefit).⁴³
 42

43 *Gonzales v. Raich (2005)*. In response to DEA agents’ destruction of their cannabis plants, two
 44 patients and caregivers in California brought suit. They argued that applying the CSA to a situation
 45 in which cannabis was being grown and used locally for medicinal purposes (and not being sold)
 46 exceeded the federal government’s constitutional authority under the Commerce Clause, which
 47 allows federal regulation of interstate commerce. The U.S. Supreme Court eventually ruled that
 48 Congress’s power to regulate commerce “extends to purely local activities” that are “part of an
 49 economic class of activities that have a substantial effect on interstate commerce.”⁴⁴ While not
 50 invalidating state medical marijuana laws, this ruling preserved the ability of the DEA to enforce
 51 the CSA against medical marijuana patients and their caregivers.

1 Another relevant case is the *County of San Diego v. State of California* (2009) in which the U.S.
2 Supreme Court denied an appeal by the County of San Diego allowing a lower court's ruling to
3 stand which held that federal law does not preempt California's medical marijuana law. The
4 County had argued that it did not have to comply with the state-mandate to implement an
5 identification card program for patients based on federal preemption.

6
7 Accordingly, states can create medical marijuana laws protecting patients and caregivers from
8 prosecution under their own state-level controlled substance laws, but federal agents can still
9 investigate, arrest, and prosecute medical marijuana patients, caregivers, and physicians (if they
10 willfully aid and abet) in such states.

11 12 RESCHEDULING

13 14 *Efforts to Remove Marijuana from Schedule I*

15
16 Advocates of decriminalizing marijuana have attempted to have it removed from Schedule I ever
17 since its original placement. A petition was first filed in 1972 by the National Organization for the
18 Reform of Marijuana Laws (NORML) to the Bureau of Narcotics and Dangerous Drugs seeking to
19 reschedule marijuana to Schedule II. After this petition was denied and public hearings were not
20 conducted, NORML filed suit in 1974 against the Bureau and in 1975 against its successor, the
21 DEA. After further legal maneuvering, the petition was eventually sent back to the DEA for
22 consideration in 1980 by the U.S. Court of Appeals for the District of Columbia. Eventually,
23 public hearings were held over a 2-year period from 1986 to 1988, at which time the DEA
24 Administrator once again rejected the position of NORML (now joined by the Alliance for
25 Cannabis Therapeutics [ACT], the Drug Policy Foundation, and the Physicians Association for
26 AIDS Care, among others) despite recommendations to the contrary by the DEA administrative
27 law judge in the case which called for reclassification of marijuana to Schedule II. The latter
28 parties petitioned the District Court for review of this order; after once again remanding the case in
29 1991, the District Court denied the petition for review on February 18, 1994. Subsequent
30 rescheduling petitions also have been rejected.

31
32 Although the petition for review was denied, it led to a revised formulation by the DEA for
33 determining whether a drug has a "currently accepted medical use." The 5-part test for fulfilling the
34 accepted medical use criteria of Schedule II is now comprised of the following:

- 35
36
- the drug's chemistry must be known and reproducible;
 - there must be adequate safety studies;
 - there must be adequate and well-controlled studies proving efficacy;
 - the drug must be accepted by qualified experts; and
 - the scientific evidence must be widely available.
- 37
38
39
40
41

42 A drug must meet all 5 criteria to be considered for rescheduling by the DEA.

43
44 Even if marijuana were rescheduled under current law it could not be marketed or medically
45 available for general prescription use unless it was reviewed and approved by FDA under the
46 Federal Food, Drug, and Cosmetic Act (FFDCA) (see below). Conceivably, a physician may be
47 able to write a prescription for an individual patient with the cooperation of a compounding
48 pharmacist with a schedule II license. However, the FDA treats compounded products as "new
49 drugs" subject to all the requirements of the FFDCA if pharmacists attempt to compound large
50 quantities of medication.

1 Congress or the Executive branch (through regulatory procedures authorized by the CSA) could
2 reschedule marijuana. Over the last decade various federal amendments (e.g., Hinchey-
3 Rohrabacher) have been submitted that would prevent the Justice Department from using
4 appropriated funds to interfere with the implementation of medical cannabis laws, and bills have
5 been introduced that would reschedule marijuana and/or prevent provisions of the CSA and
6 FFDCa from restricting activities in states that have adopted medical marijuana programs. These
7 have all been defeated to date, but others are pending.

8
9 “Executive Order”

10
11 Resolution 229 (A-09) makes reference to a “Presidential/Executive” order. To the Council’s
12 knowledge no such order exists. As previously mentioned, in 1996, the Director of ONDCP issued
13 a statement that threatened physicians with loss of certain privileges. However, this was not an
14 Executive Order, but rather a compilation of strategies developed by several federal agencies. It
15 never had the force of an Executive Order, and is nonetheless moot because of the permanent
16 injunction issued against implementation of this strategy in *Conant v. Walters*.

17
18 During the 2008 Presidential campaign, then-Senator Obama pledged to avoid the use of federal
19 resources in cracking down on medical marijuana activities in states where medical marijuana laws
20 were in place. This view has since been reiterated by the Attorney General in press briefings,
21 although DEA raids on a medical marijuana dispensaries in California have occurred in the same
22 time frame. Resolution 229 (A-09) was prompted by pending medical marijuana legislation in the
23 state of New York, and perhaps a provision authored by Congressman Maurice Hinchey (D-NY)
24 that seeks to clarify the Obama administration’s medical marijuana enforcement policy. The
25 Hinchey provision was included in the report accompanying the Commerce, Justice, Science and
26 related Agencies appropriation bill for fiscal year 2010. The provision (referring to the Department
27 of Justice) reads:

28
29 “There have been conflicting public reports about the Department’s enforcement of medical
30 marijuana policies. Within 60 days of enactment, the Department shall provide to the
31 Committee clarification of the Department’s policy regarding enforcement of federal laws and
32 use of federal resources against individuals involved in medical marijuana activities.”

33
34 CONDUCTING CLINICAL RESEARCH ON SCHEDULE I VS SCHEDULE II COMPOUNDS

35
36 Researchers who propose to conduct investigations in humans on Schedule I drugs must obtain
37 FDA review of the protocol and fulfill the FDA’s Investigational New Drug (IND) requirements
38 for safety. They also must submit the protocol to the DEA as part of the process to obtain a valid
39 registration for a Schedule I substance. When DEA receives the Schedule I research application,
40 they forward it to another division within FDA for scientific review as part of their decision-
41 making process. Investigators conducting research with a Schedule I substance must submit a
42 protocol for each study involving each Schedule I substance to obtain approval to conduct that
43 research. If a new protocol for a research study, even with the same substance is devised, the DEA
44 registration must be amended by submitting the new protocol for review to the DEA. This is a
45 requirement under the CSA and is separate from the FFDCa requirements for submitting INDs for
46 human studies to the FDA, whereby FDA assesses whether the study design is safe.

47
48 Investigators seeking to do human research on Schedule II substances must still procure FDA
49 safety review of the protocol and apply for a Schedule II registration with the DEA. Once granted,
50 this Schedule II license is sufficient for all future studies on that substance.

1 The only legal federal source of marijuana is grown under the auspices of the National Institute on
2 Drug Abuse (NIDA), and prior to 1999 only NIH-funded studies on marijuana could qualify for
3 access to the NIDA supply. In May 1999, the Department of Health and Human Services
4 announced a new guidance on procedures for the provision of marijuana for medical purposes on a
5 cost-reimbursable basis.⁴⁵ For protocols submitted by non-NIH funded sources, institutional peer
6 review and IRB approval precede the submission, after which the scientific merits of each protocol
7 are evaluated through a Public Health Service interdisciplinary review process. This guidance
8 created an avenue for externally funded investigators to acquire marijuana for research purposes,
9 but retains additional review and approval steps that are not required of other traditional IND-
10 sponsors.

11
12 In an effort to promote research on medical cannabis, California's State Assembly appropriated \$3
13 million to establish a university-based Center for Medicinal Cannabis Research, to be administered
14 jointly by the University of California's San Diego and San Francisco campuses.⁴⁶ Subsequently,
15 many of the randomized controlled trials on smoked cannabis have been supported by this
16 program. The cannabis used in such studies is obtained from NIDA in accordance with the
17 procedures outlined above.

18 19 BOTANICALS AS DRUG PRODUCTS

20
21 Many drugs have been derived from plants, and the *National Formulary* and *U.S. Pharmacopoeia*
22 formerly contained numerous botanical agents. Interest in the use of such agents waned with
23 advances in the understanding of physiologic, biochemical, and cellular functioning.
24 Pharmaceutical development evolved with a focus on identifying specific cellular targets
25 (receptors) amenable to drug intervention, although plants may provide the starting material for
26 certain products. The 1994 passage of the Dietary Supplement and Health Education Act fostered
27 a return to the public's use of botanical products in the form of "dietary supplements." Such
28 products are regulated as foods, and are not subject to FDA approval for safety and efficacy. They
29 can use so called "structure and function" claims but cannot claim to be useful in the treatment of a
30 disease or condition. In order to make a disease-based claim, the product must go through the FDA
31 drug approval process.

32
33 In 2004, the FDA issued a *Guidance for Industry Botanical Drug Products* monograph.⁴⁷ This
34 document provides the pathway by which botanical agents can be approved as prescription drugs.
35 The crude botanical substance can become a "botanical drug substance" through processes of
36 extraction, blending, addition of excipients, formulation, and packaging in a defined manner.
37 Particular attention is devoted to product composition because botanicals are complex mixtures of
38 chemical/structural components. Similar to conventional products, a botanical drug substance must
39 undergo animal toxicity studies, and demonstrate its safety and efficacy in randomized, double-
40 blind, placebo-controlled trials. Additional pharmacologic and toxicologic studies are required if a
41 non-oral route (e.g., inhalation) of administration is contemplated. If the substance is intended to
42 treat chronic conditions, 6 to 12 months in long-term safety extension studies is considered
43 sufficient.

44
45 An example of a drug that is seeking FDA approval through this pathway is an extract prepared
46 from two different breeds of cannabis that have been genetically developed to produce either high
47 quantities of THC or cannabidiol. Chemovars of cannabis were selected via Mendelian genetics to
48 express one predominant phytocannabinoid. Cloned plants undergo extraction to produce botanical
49 drug substances that contain predominately THC or cannabidiol, or an approximate 1:1
50 combination of the two. The final product is a botanical extract (Nabiximols) comprising an
51 oromucosal spray that delivers 2.7 mg of THC and 2.5 mg of cannabidiol per spray. Patients self-

1 titrate their overall dose and pattern of dosing according to their response and tolerance of the
2 medicine. This botanical drug substance is approved in Canada (Sativex®) for the symptomatic
3 relief of neuropathic pain in patients with multiple sclerosis, and as an adjunctive analgesic to
4 opioids in patients with advanced cancer pain.⁴⁸⁻⁵⁰ Nabiximols is progressing through the FDA
5 pathway for botanical drug substance approval as a treatment for patients with advanced cancer
6 whose pain has not been adequately relieved by optimized treatment with opioid medications.

7
8 Other cannabinoid based botanical drug substances have been developed in other countries (e.g.,
9 Cannador®), and several are in development in the U.S. with various modes of action (botanical
10 extracts; CB receptor agonists or antagonists; inhibitors of endocannabinoid uptake or
11 degradation). Cannador® is an extract delivered in an oral dosage form containing primarily 2.5
12 mg THC and 1 mg cannabidiol. It has demonstrated benefit in randomized controlled trials
13 involving patients with multiple sclerosis experiencing pain due to spasm, and in decreasing post-
14 operative pain.^{51,52} The development of pharmaceutical grade cannabis-based extracts with proven
15 medical benefits provides further evidence on the therapeutic potential of components of the
16 cannabis plant.

17 18 SMOKED CANNABIS STUDIES

19
20 Currently cannabinoids are “available” in three different categories:⁴¹ FDA approved oral
21 preparations of THC (Dronabinol; Marinol®) and a synthetic analogue (Nabilone; Cesament®);
22 *Cannabis sativa* extracts (e.g., Nabiximols [Sativex®], [Cannador®]) not currently approved in the
23 U.S.; and crude botanical sources made available under state laws. Since 2001, systematic reviews
24 have been conducted on smoked cannabis and other cannabinoids (mostly oral THC and botanical
25 extracts).⁵³⁻⁵⁶ The following discussion focuses on randomized, placebo-controlled human trials
26 that have evaluated smoked cannabis. Table 1 summarizes the characteristics and findings of such
27 trials.

28 29 *Randomized Trials on Smoked Cannabis*

30
31 Cancer chemotherapy. Three randomized, double-blind, controlled trials involving a total of 43
32 patients have evaluated the efficacy of smoked cannabis to alleviate nausea and vomiting
33 accompanying cancer chemotherapy; one directly compared smoked cannabis with oral THC but
34 was never published in a peer reviewed journal.⁵⁷⁻⁵⁹ These trials revealed a modest antiemetic
35 effect of smoked cannabis greater than placebo.

36
37 Several research/treatment studies were conducted by state departments of health during the late
38 1970s and early to mid-1980s under protocols approved by the FDA. These open label studies
39 involved patients who had responded inadequately to other antiemetics. In such patients, smoked
40 cannabis was reported to be comparable to or more effective than oral THC, and considerably more
41 effective than prochlorperazine or other previous antiemetics in reducing nausea and emesis.
42 Results of these studies generally were based on patients’ and/or physicians’ subjective ratings.
43 These programs were noted in the 1997 Council report and another independent review that was
44 published in 2001.⁵⁶ Smoked cannabis (as well as THC and other synthetic cannabinoids) is more
45 effective than older antiemetic drugs (neuroleptics) and placebo.⁵³ All of these trials in cancer
46 patients were conducted before the advent of 5-HT₃ and neurokinin-1 receptor antagonists.
47 Smoked cannabis has been compared with the 5-HT₃ receptor antagonist ondansetron in an
48 experimental emesis model. This randomized double-blind included 13 healthy volunteers who
49 received syrup of ipecac.⁶⁰ Smoked cannabis significantly reduced ratings of queasiness and
50 slightly reduced the vomiting induced by the syrup compared with placebo. Ondansetron
51 completely eliminated episodes of vomiting.

1 Appetite stimulation. Three randomized, placebo-controlled trials involving a total of 97 HIV+
2 adult patients have compared the effects of smoked cannabis with oral THC or dronabinol; two
3 used a “within subjects” design. Generally, the effects of smoked cannabis (2% or 3.9% THC)
4 were comparable to oral cannabinoids in increasing caloric intake and triggering weight gain,
5 although the dose of oral THC was substantially higher than normally recommended.⁶¹⁻⁶³ HIV viral
6 load and the pharmacokinetics of concurrent protease inhibitors were unaffected over a three week
7 period.⁶¹

8
9 Pain Management. Two randomized, double-blind, placebo-controlled trials involving a total of
10 89 patients with HIV-associated peripheral neuropathy, and one (n = 38) involving an experimental
11 pain model (capsaicin) have been reported.^{64,65} The latter was a randomized, double-blind,
12 placebo-controlled crossover trial in 15 healthy volunteers examining the effects of cannabis
13 cigarettes (2%, 4%, or 8%) on pain and cutaneous hyperalgesia induced by intradermal capsaicin.⁶⁵
14 The medium dose exhibited delayed analgesia, significantly inhibiting capsaicin-induced pain at 45
15 minutes after drug exposure; the low dose was ineffective, and the high dose increased capsaicin-
16 induced pain at 45 minutes. Smoked cannabis did not significantly affect acute painful heat, cold,
17 and mechanical thresholds.⁶⁴

18
19 In patients with HIV-associated neuropathic pain, cannabis cigarettes of varying concentration and
20 number consumed over a 5-day period significantly reduced pain intensity. Approximately half of
21 patients experienced more than a 30% reduction, which is a standard benchmark for efficacy.
22 Analysis of the number-needed-to-treat also compared favorably with historic values associated
23 with other drugs used to treat neuropathic pain.^{66,67}

24
25 Generally, side effects typically attributable to THC (anxiety, sedation, confusion, dizziness,
26 fatigue, tachycardia, dry mouth) were noticeable in these studies but were tolerable and not
27 considered dose-limiting. The use of higher potency cigarettes was more likely to be associated
28 with drug-related cognitive decline on psychological testing.

29
30 The overall evaluation of the clinical effects of smoked cannabis in stimulating appetite and
31 relieving neuropathic pain (and to a certain degree, nausea) correlates with patterns of use reported
32 in surveys of HIV+ patients. In this population, cannabis use also has been associated with
33 adherence to antiretroviral therapy in patients who experience nausea, and for the self management
34 of HIV-associated peripheral neuropathy.^{68,69} In one consecutive series, 23% of HIV+ patients
35 reported smoking cannabis in the prior 30 days to improve appetite or relieve pain, but also to
36 relieve anxiety or depression or “increase pleasure” which are characteristics of substance misuse
37 or recreational use.⁷⁰ Another survey found a similar percentage of HIV-positive patients (27%)
38 used cannabis to improve appetite, relieve nausea and pain, and for anxiety and depression. Nearly
39 half of these users reported memory deterioration.⁷¹

40
41 Multiple Sclerosis and Spasticity. Surveys reveal that 36% to 68% of patients with multiple
42 sclerosis have experimented with smoked cannabis for symptom relief, and approximately 15% are
43 continuing users.^{72,73} Two randomized, double-blind, placebo-controlled trials involving a total of
44 40 patients have been reported in patients with multiple sclerosis and spasticity.^{74,75} In a pilot study
45 involving 10 patients who smoked one cannabis cigarette of low potency (1.54% THC) some
46 patients reported subjective improvements, but exhibited impairment of posture and balance.⁷⁴
47 When higher potency cannabis cigarettes were used for three days, reduced scores for pain (50%)
48 and spasticity (30%) were observed, along with some cognitive impairment, dizziness, and fatigue;
49 the majority of these patients had prior experience smoking cannabis.⁷⁵

1 Glaucoma. In one randomized, double-blind, placebo-controlled crossover study of 18 adults with
 2 glaucoma, smoking one cannabis cigarette (2% THC) caused a significant reduction in intraocular
 3 pressure, along with alterations in sensory perception, tachycardia/palpitations, and postural
 4 hypotension.⁷⁶

6 ADVERSE EFFECTS OF SMOKED CANNABIS

7
 8 Determining the adverse effects of smoked cannabis used as medicine is problematic since only
 9 short-term controlled trials have been conducted. Most research on the harmful consequences of
 10 cannabis use has been conducted in simulated laboratory environments and in individuals who use
 11 cannabis for nonmedical purposes. One independent health assessment of four of the remaining
 12 seven patients obtaining cannabis cigarettes through the federal government's Compassionate Use
 13 Treatment IND (see Council report from 1997),¹ showed no demonstrable adverse outcomes
 14 related to their chronic medicinal cannabis use. Some of cannabis' adverse effects differ in
 15 experienced versus inexperienced users, and it is not clear to what extent the adverse effects
 16 reported in recreational users are applicable to those who use cannabis for the self-management of
 17 disease or symptoms. Most data on adverse effects has come from observational population-based
 18 cohort studies of recreational cannabis users, an unknown portion of whom may be using the
 19 substance for medicinal purposes. Adverse reactions observed in short-term randomized, placebo-
 20 controlled trials of smoked cannabis to date are mostly mild without substantial impairment. A
 21 systematic review of the safety studies on medical cannabinoids published over the last 40 years
 22 (not including studies on smoked cannabis) found that short term use was associated with a number
 23 of adverse events, but less than 4% were considered serious.⁷⁷

24 *Nonmedical Use*

25
 26
 27 Nonmedical use of marijuana continues to be problematic in society. Approximately one third of
 28 all Americans over 12 years of age have tried marijuana, usually experimenting first during
 29 adolescence.⁴ According to the most recent NSDUH Survey, marijuana continues to be the most
 30 commonly used illicit drug (14.4 million past month users).⁷⁸ Among persons aged 12 or older, the
 31 rate of past month marijuana use in 2007 (5.8 percent) was similar to the rate in 2006 (6.0 percent).
 32 The prevalence of past month marijuana use among adolescents (i.e., youths aged 12 to 17)
 33 generally decreased from 2002 (8.2 percent) to 2005 (6.8 percent), and then remained constant
 34 between 2005 and 2007. Adolescents who perceived great risk from smoking marijuana once a
 35 month were much less likely to have used marijuana in the past month than those who perceived
 36 moderate to no risk (1.4 vs. 9.5 percent). The specific illicit drugs that had the highest levels of
 37 past year dependence or abuse in 2007 were marijuana (3.9 million), followed by pain relievers
 38 (1.7 million) and cocaine (1.6 million). It is not clear how any of these trends have been influenced
 39 by the medical cannabis debate.

40
 41 Acutely, smoked cannabis increases heart rate, and blood pressure may decrease on standing.
 42 Cannabis intoxication is associated with impairment of short-term memory, attention, motor skills,
 43 reaction time, and the organization and integration of complex information.¹ Although dependent
 44 on the setting, smoked cannabis can cause relaxation and enhance mood. However, some
 45 individuals experience acute anxiety or panic reactions, confusion, dysphoria, paranoia, and
 46 psychotic symptoms (e.g., delusions, hallucinations).¹

Substance Dependence

Chronic cannabis use is associated with development of tolerance to some effects and the appearance of withdrawal symptoms (restlessness, irritability, mild agitation, insomnia, sleep disturbances, nausea, cramping) with the onset of abstinence. Depending on the measures and age group studied, 4% to 9% of cannabis users fulfill diagnostic criteria for substance dependence. Although some cannabis users develop dependence, they are considerably less likely to do so than users of alcohol and nicotine, and withdrawal symptoms are less severe.^{4,79,80} Like other drugs, dependence is more likely to occur in individuals with co-morbid psychiatric conditions.

Whether or not cannabis is a “gateway” drug to other substance misuse is controversial and whether the medical availability of cannabis would increase drug abuse is not known. Analysis of trends in emergency room visits for marijuana do not support the view that state authorization for medical cannabis use leads to increased signals of substance misuse.⁸¹ The IOM concluded that marijuana use is not the cause or even the most serious predictor of serious substance use disorders.⁴ A systematic review of longitudinal studies on the use of cannabis concluded its use was consistently associated with reduced educational achievement and the use of other drugs, but not other measures of psychosocial harm.⁸²

Cognitive Deficits and Mental Health

Other concerns about long-term cannabis use include cognitive effects, and its intersection with mental disorders. Acute intoxication with cannabis causes marked changes in subjective mental status, brain functioning, and neuropsychological performance. A meta-analysis conducted in 2003 found evidence of subtle impairments in the ability to learn and remember new information in chronic cannabis smokers, but no general persistent neuropsychological deficits.⁸³ Neuropsychological deficits and differences in brain functioning are most consistently observed among frequent, heavy users.⁸⁴

A recent systematic review on cannabis use and the risk of psychotic or affective mental health outcomes renewed the debate about the potential role of smoked cannabis as a cause or sequelae of mental disorders.⁸⁵ Whether cannabis use contributes to mental disorders, is used for self-management of mental disorders, or the mental disorder itself lends to cannabis use is not clear. The recent discontinuation of clinical trials on a CB1 receptor antagonist because of suicidal ideation indicates some involvement of endocannabinoids in the regulation of mood.

Respiratory Illness and Cancer

Like tobacco, chronic cannabis smoking is associated with markers of lung damage and increased symptoms of chronic bronchitis.⁸⁶⁻⁸⁸ However, results of a population-based case control study of cannabis smokers found no evidence of increased risk for lung cancer or other cancers affecting the oral cavity and airway.⁸⁹ Another population-based case-control study of marijuana use and head and neck squamous cell carcinoma (HNSCC) concluded that moderate marijuana use is associated with reduced risk of HNSCC.⁹⁰ Furthermore, although smoking cannabis and tobacco may synergistically increase the risk of respiratory symptoms and COPD, smoking only cannabis is not associated with an increased risk of developing COPD.⁹¹ One recent study suggests that use of smoked cannabis is associated with an increased risk for testicular cancers.⁹²

The use of a vaporizing device may mitigate some of these symptoms. Cannabis vaporization is a technique aimed at suppressing the formation of irritating respiratory toxins by heating cannabis to a temperature where active cannabinoids are volatilized, but below the point of combustion where

1 smoke and associated toxins form. The use of a vaporizer is associated with higher plasma THC
 2 concentrations than smoking marijuana cigarettes, little if any carbon monoxide production, and
 3 significantly fewer triggered respiratory symptoms.^{93,94}

4
 5 *Immunosuppression*

6
 7 Cannabinoids exert immunosuppressive and anti-inflammatory effects.⁹⁵⁻⁹⁷ Plant-derived and
 8 synthetic cannabinoids exert antiproliferative effects on a wide spectrum of human tumor cell lines
 9 in culture, although mitogenic responses also have been observed.^{98,99} Apoptosis, inhibition of
 10 proliferation, suppression of cytokine and chemokine product and induction of T regulatory cells
 11 have been identified. CB2 receptors are associated with activated microglia in the CNS.¹⁰⁰
 12 Clearly endocannabinoids are immune modulators, but how they regulate various elements of the
 13 human immune response is unclear, and how exogenous cannabinoids may interact with these
 14 processes also is not established. Short-term use of smoked cannabis did not affect viral load in
 15 HIV-positive patients and also is associated with adherence to therapy and reduced viral loads in
 16 patients with hepatitis C infections.^{61,101}

17
 18 **SUMMARY AND CONCLUSION**

19
 20 Despite more than 30 years of clinical research, only a small number of randomized, controlled
 21 trials have been conducted on smoked cannabis. These trials were short term and involved a total
 22 of ~300 patients. Results of these trials indicate smoked cannabis reduces neuropathic pain,
 23 improves appetite and caloric intake especially in patients with reduced muscle mass, and may
 24 relieve spasticity and pain in patients with multiple sclerosis. Substantially better alternatives than
 25 smoked cannabis are available to treat patients with glaucoma or chemotherapy-induced nausea
 26 and vomiting. Smoked cannabis has not been subject to any sort of rigorous study in any other
 27 indication. Results obtained from oral cannabinoid products (including botanical extracts) are not
 28 directly applicable to smoked cannabis for a number of reasons including substantial differences in
 29 constituents, pharmacokinetics of active ingredients, and active metabolite patterns. However,
 30 development of botanical extracts as prescription medications lends further credence to the
 31 therapeutic potential of components of the cannabis plant.

32
 33 There is a contrast between the relatively small number of patients who have been studied over the
 34 past 30 years in controlled clinical trials involving smoked cannabis and survey data from patients
 35 with chronic pain, multiple sclerosis, and amyotrophic lateral sclerosis that indicates a significant
 36 use of cannabis for self management. Additionally, surveys of patients with HIV or hepatitis C
 37 infection suggest that smoked cannabis is used to relieve a constellation of symptoms (pain,
 38 nausea, appetite suppression, sleep disorders) and as a source of palliation from antiviral
 39 medication side effects.

40
 41 Marijuana is the most common illicit drug used by the nation's youth and young adults. However,
 42 the fact that cannabis is prone to nonmedical use does not obviate its potential for medical product
 43 development. Many legal pharmaceutical products that are used for pain relief, palliation, and
 44 sleep induction have more serious acute toxicities than marijuana, including death. Witness the
 45 evolving series of steps that the FDA has taken in recent months to address the inappropriate use
 46 and diversion of certain long-acting Schedule II opioid drugs. However, the patchwork of state-
 47 based systems that have been established for "medical marijuana" is woefully inadequate in
 48 establishing even rudimentary safeguards that normally would be applied to the appropriate clinical
 49 use of psychoactive substances. Recent documentaries have noted the ease with which individuals
 50 can "qualify" for access to cannabis products in certain parts of California.

1 The AMA supports the concept of drug approval by scientific and regulatory review to establish
2 safety and efficacy, combined with appropriate standards for identity, strength, quality, purity,
3 packaging, and labeling, rather than by ballot initiative or state legislative action. The future of
4 cannabinoid-based medicine lies in the rapidly evolving field of botanical drug substance
5 development, as well as the design of molecules that target various aspects of the endocannabinoid
6 system. To the extent that rescheduling marijuana out of Schedule I will benefit this effort, such a
7 move can be supported. In the meantime, physicians who comply with their ethical obligations to
8 “first do no harm” and to “relieve pain and suffering” should be protected in their endeavors,
9 including advising and counseling their patients on the use of cannabis for therapeutic purposes.

10
11 **RECOMMENDATION**

12
13 The Council on Science and Public Health recommends that Policy H-95.952 be amended by
14 insertion and deletion to read as follows:

15
16 H-95.952 Medical Marijuana

- 17
18 (1) Our American Medical Association (AMA) calls for further adequate and well-controlled
19 studies of marijuana and related cannabinoids in patients who have serious conditions for
20 which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the
21 application of such results to the understanding and treatment of disease.
22
23 (2) ~~Our AMA recommends that marijuana be retained in Schedule I of the Controlled~~
24 ~~Substances Act pending the outcome of such studies. Our AMA urges that marijuana’s~~
25 status as a federal Schedule I controlled substance be reviewed with the goal of facilitating
26 the conduct of clinical research and development of cannabinoid-based medicines, and
27 alternate delivery methods. This should not be viewed as an endorsement of state-based
28 medical cannabis programs, the legalization of marijuana, or that scientific evidence on the
29 therapeutic use of cannabis meets the current standards for a prescription drug product.
30 (New HOD Policy)
31
32 (3) Our AMA urges the National Institutes of Health (NIH) to implement administrative
33 procedures to facilitate grant applications and the conduct of well-designed clinical
34 research into the medical utility of marijuana. This effort should include: a) disseminating
35 specific information for researchers on the development of safeguards for marijuana
36 clinical research protocols and the development of a model informed consent on marijuana
37 for institutional review board evaluation; b) sufficient funding to support such clinical
38 research and access for qualified investigators to adequate supplies of marijuana for
39 clinical research purposes; c) confirming that marijuana of various and consistent strengths
40 and/or placebo will be supplied by the National Institute on Drug Abuse to investigators
41 registered with the Drug Enforcement Agency who are conducting bona fide clinical
42 research studies that receive Food and Drug Administration approval, regardless of
43 whether or not the NIH is the primary source of grant support.
44
45 (4) ~~Our AMA believes that the NIH should use its resources and influence to support the~~
46 ~~development of a smoke free inhaled delivery system for marijuana or delta 9~~
47 ~~tetrahydrocannabinol (THC) to reduce the health hazards associated with the combustion~~
48 ~~and inhalation of marijuana.~~
49
50 (5) (4) Our AMA believes that effective patient care requires the free and unfettered exchange
51 of information on treatment alternatives and that discussion of these alternatives between

1 physicians and patients should not subject either party to criminal sanctions. (CSA Rep. 10,
2 I-97; Modified: CSA Rep. 6, A-01)

Fiscal Note: Less than \$500

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APPENDIX A

AMA Policy On Medical Marijuana

H-95.952 Medical Marijuana

(1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. (2) Our AMA recommends that marijuana be retained in Schedule I of the Controlled Substances Act pending the outcome of such studies. (3) Our AMA urges the National Institutes of Health (NIH) to implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research into the medical utility of marijuana. This effort should include: a) disseminating specific information for researchers on the development of safeguards for marijuana clinical research protocols and the development of a model informed consent on marijuana for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of marijuana for clinical research purposes; c) confirming that marijuana of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the Drug Enforcement Agency who are conducting bona fide clinical research studies that receive Food and Drug Administration approval, regardless of whether or not the NIH is the primary source of grant support. (4) Our AMA believes that the NIH should use its resources and influence to support the development of a smoke-free inhaled delivery system for marijuana or delta-9-tetrahydrocannabinol (THC) to reduce the health hazards associated with the combustion and inhalation of marijuana. (5) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. (CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01)

APPENDIX B

Institute of Medicine

Marijuana and Medicine: Assessing the Science Base

RECOMMENDATION 1: Research should continue into the physiological effects of synthetic and plant-derived cannabinoids and the natural function of cannabinoids found in the body. Because different cannabinoids appear to have different effects, cannabinoids research should include, but not be restricted to, effects attributable to THC alone.

Scientific data indicate the potential therapeutic value of cannabinoid drugs for pain relief, control of nausea and vomiting, and appetite stimulation. This value would be enhanced by a rapid onset of drug effect. (See Recommendation #2)

RECOMMENDATION 2: Clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems.

RECOMMENDATION 3: Psychological effects of cannabinoids such as anxiety reduction and sedation, which can influence medical benefits, should be evaluated in clinical trials.

The psychological effects of cannabinoids are probably important determinants of their potential therapeutic value. They can influence symptoms indirectly which could create false impressions of the drug effect or be beneficial as a form of adjunctive therapy.

RECOMMENDATION 4: Studies to define the individual health risks of smoking marijuana should be conducted, particularly among populations in which marijuana use is prevalent.

Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory diseases, but the data that could conclusively establish or refute this suspected link have not been collected.

RECOMMENDATION 5: Clinical trials of marijuana use for medical purposes should be conducted under the following limited circumstances: trials should involve only short-term marijuana use (less than six months), should be conducted in patients with conditions for which there is reasonable expectation of efficacy, should be approved by institutional review boards, and should collect data about efficacy.

Because marijuana is a crude THC delivery system that also delivers harmful substances, smoked marijuana should generally not be recommended for medical use. Nonetheless, marijuana is widely used by certain patient groups, which raises both safety and efficacy issues. If there is any future for marijuana as a medicine, it lies in its isolated components, the cannabinoids and their synthetic derivatives. Isolated cannabinoids will provide more reliable effects than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug but rather to serve as a first step toward the development of nonsmoked rapid-onset cannabinoid delivery systems.

RECOMMENDATION 6: Short-term use of smoked marijuana (less than six months) for patients with debilitating symptoms (such as intractable pain or vomiting) must meet the following conditions:

- failure of all approved medications to provide relief has been documented,
- the symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs,
- such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness, and
- involves an oversight strategy comparable to an institutional review board process that could provide guidance within 24 hours of a submission by a physician to provide marijuana to a patient for a specified use.

Appendix C

American College of Physicians Position Statement

Position 1: ACP supports programs and funding for rigorous scientific evaluation of the potential therapeutic benefits of medical marijuana and the publication of such findings.

- Position 1a: ACP supports increased research for conditions where the efficacy of marijuana has been established to determine optimal dosage and route of delivery.
- Position 1b: Medical marijuana research should not only focus on determining drug efficacy and safety but also on determining efficacy in comparison with other available treatments.

Position 2: ACP encourages the use of nonsmoked forms of THC that have proven therapeutic value.

Position 3: ACP supports the current process for obtaining federal research-grade cannabis.

Position 4: ACP urges an evidence-based review of marijuana's status as a Schedule I controlled substance to determine whether it should be reclassified to a different schedule. This review should consider the scientific findings regarding marijuana's safety and efficacy in some clinical conditions as well as evidence on the health risks associated with marijuana consumption, particularly in its crude smoked form.

Position 5: ACP strongly supports exemption from federal criminal prosecution; civil liability; or professional sanctioning, such as loss of licensure or credentialing, for physicians who prescribe or dispense medical marijuana in accordance with state law. Similarly, ACP strongly urges protection from criminal or civil penalties for patients who use medical marijuana as permitted under state laws.

Table 1. Randomized, Placebo-Controlled Trials of Smoked Cannabis					
Study	n	Design	Product and dosage	Efficacy	Adverse Effects
<i>Antiemetic effects in patients receiving cancer chemotherapy</i>					
Chang et al ⁵⁷	15 patients with osteogenic sarcoma undergoing high dose methotrexate chemotherapy (median age 24 years)	R, DB, CR, PC	Oral THC 10 mg/m ² 5 times daily or smoked cannabis (1.93% THC) cigarette substituted if vomiting occurred	Oral THC alone or the combination of oral and smoked cannabis had an antiemetic effect > placebo. THC reduced the number of retching and vomiting episodes, the degree and duration of nausea, and the volume of emesis. Clinical responses appeared to correlate with plasma THC values. Smoked THC yielded plasma concentrations more than 5 ng/mL on 70% of occasions compared with 44% of the time with oral THC.	Sedation in 80% of patients, most of whom had prior experience with smoked cannabis
Chang et al ⁵⁸	8 patients with various tumors undergoing adjuvant therapy with doxorubicin and cyclophosphamide (median age 41 years)	R, DB, CR, PC	Oral THC 10 mg/m ² 5 times daily or smoked cannabis (1.93% THC) cigarette substituted if vomiting occurred	No antiemetic effect. Seven of eight patients inexperienced in the use of cannabis.	Mood alteration and episodes of tachycardia
Levitt et al ⁵⁹	20 patients with various tumors	R, DB, CR, PC	One cannabis cigarette + placebo oral THC x 4; oral THC 15 mg + placebo cannabis cigarette x 4	Treatments were effective in only in 25% of patients; 35% preferred oral THC; 20% preferred smoked cannabis; 45% had nor preference.	Seven individuals exhibited distortions of time perception or hallucinations; four that had received THC; two with cannabis, and one with both
<i>Appetite stimulation</i>					
Abrams et al ⁶¹	67 adults with HIV infection	R, DB for oral THC or P, PL	One to three cannabis cigarettes/day (3.95% THC) or oral THC 2.5 mg tid for 21 days	Smoked cannabis and oral THC equivalent on weight gain and superior to placebo; viral load and pharmacokinetics of protease inhibitors unaffected	Generally well tolerated; one cannabis recipient discontinued due to emergence of neuropsychiatric symptoms; two oral THC recipients dropped out due to side effects (paranoia; headache)

Haney et al ⁶²	30 HIV+ experienced cannabis smokers, half with less than 90% ideal body mass	R, DB, PC	Dronabinol zero to 30 mg or cannabis cigarettes zero to 3.9% THC), administered in eight 7 hour sessions over three to four weeks	Cannabis and dronabinol significantly increased caloric intake in the low body mass group	Few adverse effects reports, except intolerance of high (30 mg) dronabinol dose
Haney et al ⁶³	10 HIV+ experienced cannabis smokers	R, DB, PC	Dronabinol 5 or 10 mg, or cannabis cigarettes 2% or 3.9% THC each four times daily for four days	Cannabis and dronabinol increased caloric intake in a dose dependent fashion, and body weight at the highest doses	Relative absence of cognitive impairment. Improved mood and objective and subjective sleep measures.
<i>Pain Management/Analgesia</i>					
Abrams et al ⁶⁶	55 patients with HIV-associated neuropathic pain	R, DB, PC, PL	Up to three cannabis (3.95% THC) cigarettes daily for 5 days	Smoked cannabis relieved chronic neuropathic pain (34% reduction), and more than 50% of patients experienced at least a 30% reduction in pain intensity. Smoked cannabis also reduced experimentally induced hyperalgesia	All patients had prior cannabis smoking experience. Anxiety, sedation, disorientation, confusion, and dizziness occurred more often in cannabis recipients, but were rated as between “none” and mild.
Ellis et al ⁶⁷	34 adult patients with HIV-associated neuropathic pain	R, DB, CR, PC	Cannabis cigarettes of varying THC concentration (1-8%) administered 4 times daily for 5 days	46% more patients achieved at least a 30% reduction in pain relief with cannabis vs placebo	All patients were taking additional analgesics. Concentration difficulties, fatigue, sedation, dry mouth, tachycardia more frequent but not dose limiting. Two dropouts for “psychosis” and “cough”
Wilsey et al ⁶⁴	38 adult patients experienced cannabis smokers with central and peripheral neuropathic pain	R, DB, CR, PC	Cannabis cigarettes zero, 3.5% or 7% THC administered in graded puffs over 2 hours	Smoked cannabis reduced pain intensity at 4 hours compared with placebo; no difference was noted between the 2 doses. No effects observed on evoked pain responses. Most patients had complex regional pain syndrome.	Cannabis recipients were more likely to report subjective and psychoactive drug effects including impairment and sedation. General cognitive decline on psychological testing.

<i>Multiple sclerosis</i>					
Greenberg et al ⁷⁵	10 adult patients with multiple sclerosis and spasticity	R, DB, PC	One cannabis cigarette (1.54% THC) smoked over 10 minutes	Subjective feeling of clinical improvement in some patients	Impairment of posture and balance as measured by dynamic posturography
Cory-Bloom et al ⁷⁴	30 adult patients with multiple sclerosis and spasticity	R, DB, CR, PC	One cannabis cigarette (3.95%) daily for 3 days	Reduced pain (~50%) and spasticity (~30%) scores.	Cognitive impairment; dizziness; fatigue, "too high." 80% had prior cannabis use
<i>Glaucoma</i>					
Merritt et al ⁷⁶	18 adults with glaucoma (ages 28-71)	R, DB, CR, PC	One cannabis cigarette containing 2% THC	Significant reduction in intraocular pressure	Alteration in sensory perception (100%); tachycardia and palpitations (44%), postural hypotension (28%)

R = randomized; DB = double-blind; CR = crossover trials, PL = parallel group study; PC = placebo-controlled



Jim Doyle
Governor

State of Wisconsin

Mark Seidl, WCHSA
Chairperson

Linda Mayfield
Vice-Chairperson

State Council on Alcohol and Other Drug Abuse

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

Scott Stokes
Secretary

STATE COUNCIL ON ALCOHOL & OTHER DRUG ABUSE
Planning and Funding Committee Meeting Minutes
November 20, 2009
Genesis Enterprise Center
Madison, WI

MEMBERS PRESENT: Joyce O'Donnell, Duncan Shroul, Sally Tess, Manny Scarbrough, Tom Fuchs, Karen Kinsey

EXCUSED: Norm Briggs, Bill McCulley

GUESTS: Kris Freundlich

STAFF: Lori Ludwig

I. Call to Order – Joyce O'Donnell: Joyce O'Donnell called the meeting to order at 9:35 A.M.

II. Review of October 23, 2009 Meeting Minutes – Joyce O'Donnell: **Tom Fuchs motioned to approve the minutes of October 23, 2009. Sally Tess seconded the motion. The minutes were approved without modification.**

III. Public Forum Report—Bureau Conference October 27, 2009—Joyce O'Donnell: Ms. O'Donnell reviewed the report. Seventeen people signed in at the Public Forum representing County human service personnel, treatment providers, the Addiction Resource Council, and included a psychologist, a newly appointed SCAODA member, a representative of the Wisconsin Division of Quality Assurance, a representative of SCAODA's Diversity Committee and a student. The major issues addressed were: 1) Reduction in funding for deaf and hard of hearing services. Because of the reduction in the funds for deaf and hard of hearing services, there is a lack of funding to pay for interpreter services. 2) Counselor credentialing. It is difficult to locate a licensed substance abuse counselor. Concerns were raised in terms of meeting the current caseload as well as future declines. One participant suggested that instead of licensing both substance abuse and mental health counselors separately, credentialing should be for behavioral health, so one person could do both mental health and substance abuse counseling. 3) Children's services—two participants were concerned about the lack of adolescent services around the state. 4) Funding—there have been years and years of flat funding for treatment services or worse, cuts at both the County and State levels. Something has to change. Providers are serving fewer clients.) Shortage of funding for the Intoxicated driver Program. **Tom Fuchs made a motion to approve the report. Sally Tess seconded the motion.** Prior to a vote for approval, Mr. Fuchs expressed the importance of representing these ideas during the planning session (for the SCAODA 2010-2014 Four-Year Plan). He felt that we need to address these issues as a state.

Ms. Tess asked if the issue of credentialing should be referred to the Wisconsin Department of Regulation and Licensing. Lori Ludwig brought up the issue of credentialing in the Vendorship bill. Mr. Fuchs explained that clinicians with no background in alcohol and other drug abuse (AODA) can now bill Medicaid for substance abuse (not dependency) treatment. Ms. Tess wondered how the Wisconsin Department of Corrections would be affected. Manny Scarbrough informed the group that as a Drug Court Treatment Program case-manager, he sees those that are addicted, and those that are abusing. Ms. Ludwig brought up the related problem with schools of higher education lacking AODA curricula. She reported that letters went out to schools in the University of Wisconsin System in July of 2008 under Linda Mayfield's signature. Mr. Scarbrough reported that the issue of credentialing was also raised at the WAAODA conference in 2007. Mr. Fuchs asked Duncan Shrouf to address what we should be doing in relation to this issue: Mr. Shrouf responded that everyone knows that there is not sufficient funding for treatment—but that doesn't mean we should stop trying to get more money. Coalitions have the most traction, he suggested that coalitions need to be represented at the Public Forums. He continued that we need more congruence with people who have "a dog in this fight," (Bill Clinton). While the focus of the Public Forum was on treatment, we need a greater congruence of people in the field. How do we increase funding, he asked? Answering his own question, he indicated, through taxes and user fees. When the legislators back off, we don't support it. Unless we pay attention and do something, nothing will happen. If increases in the beer tax were law, then we could fund prevention and treatment. Community leaders should insist on increasing the beer tax even if it never happens, the more pressure brought to bear will remind legislators of the issue. Mr. Fuchs indicated that he sits on a faith based community action group. That group wonders where the leadership is? Where is SCAODA? The discussion turned to limitations of SCAODA, WAAODA, WADPTA, and WAADAC. Community Anti-Drug Coalitions of America (CADCA) was discussed as a potential leader in the field. Returning to the motion on the floor, approving the Public Forum report, **Ms. O'Donnell asked for a vote and without further discussion the motion passed unanimously.**

IV. Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Fiscal Summary—Lori Ludwig: As requested at the last meeting, Lori Ludwig provided the group with a budget summary including the amount of funding for counties, contracts and any other dispersal of funds; any changes in allocations from the previous year; and any long term concerns. Ms. Ludwig referred the group to several documents in their meeting packets. The first was a document titled, "Expenditures by Type of Recipient, 2010 SAPT Application (2007 data)." The document provided totals for Block Grant funds and state funds provided to 1) Contracted Providers 2) County Human Service or Community Service Departments 3) Other State Agencies 4) Statewide programs 5) Tribes. This document summarized how much of the Block Grant went where. The next few documents were provided in an attempt to acquaint the Planning and Funding Committee with a change in state funds allocations and a resulting long term concern. The first document regarding a change in state funds allocations and a resulting long term concern was a chart taken from the SAPTBG 2010 application, titled, "SSA (MOE TABLE I)," translation: Single State Agency Maintenance of Effort Table I." The next document included two charts, one lists the last five fiscal years of state funding for programs under the SSA with BFI and the other lists the last five fiscal years of state funding for programs under the SSA without BFI. The annual decrease in state funds was provided in both dollar amounts and percent differences. It was titled, "Single State Agency (SSA) Maintenance of Effort (MOE) Program Revenue (PR) and General Purpose Revenue (GPR). Ms. Ludwig explained that SAMHSA (Substance Abuse and Mental Health Services Administration) requires that states meet a certain level of funding of substance abuse services—and that the level (determined by taking the average of the previous two years state expenditures) be maintained. If the level declines, then states must prove either Material Compliance or apply for Economic

Hardship. If they cannot prove Material Compliance or Economic Hardship, then, there is a dollar for dollar decrease in the Block Grant allocation. Ms. Ludwig explained that Wisconsin has been deficient in its MOE for the last 4 years. Last year, Wisconsin was able to show Material Compliance, but would not be able to do so this year. We would be able to demonstrate Economic Hardship, however, according to SAMHSA's standards (loss of state revenue and increase in unemployment). The Economic Hardship letter was sent last week. Examination of why Wisconsin has been deficient in its MOE shows that it is a combination of things: 1) due to the loss of state revenue, reductions in state revenues going to fund various substance abuse prevention and treatment programs; 2) a one-time increase in funding for the Intoxicated Driver Program (IDP) in 2005, thereby raising the average for dollars spent or the level the MOE has to meet or exceed, and 3) the loss of the Brighter Futures Initiative (BFI) prevention program resulting from the division of the Department of Health and Family Services (DHFS) into the Department of Health Services (DHS) and the Department of Children and Families (DCF). BFI was housed within DCF, but all other substance abuse prevention and treatment programs were maintained in DHS. Only funds expended under the Single State Agency's (SSA) authority (in Wisconsin the SSA is the Division of Mental Health and Substance Abuse Services or DMHSAS within DHS) could be counted towards the MOE. With that explanation **Duncan Shroul motioned to support DHS in its efforts to move BFI back to DHS, thus restoring state funds expended under the SSA, and resulting in a reduction of the MOE deficiency. Tom Fuchs seconded the motion.** Discussion: Mr. Scarbrough asked what advantage the DCF would have in keeping BFI? Mr. Shroul indicated that DCF may have some reluctance to give this up. Mr. Scarbrough cautioned to be ready for some push back from DCF. Ms. O'Donnell then asked for a vote. **The motion passed unanimously.** Ms. O'Donnell indicated that she and Ms. Ludwig would work on the Motion Introduction Form.

V. Follow-up on Planning and Funding Motions—Lori Ludwig:

- Motion Introduction Form re: Motion regarding loss of tobacco funds. Ms. Ludwig reported that the Division of Public Health is applying for federal stimulus funds to possibly replace tobacco funds cut from a number of smoking prevention programs, including WiNTiP, the Quit Line and Synar compliance checks. The Planning and Funding motion at last month's meeting talked about condemning the process that resulted in these cuts to tobacco prevention programs. Our task today is to complete the "Motion Introduction Form" for the SCAODA meeting on December 9th. Ms. Ludwig suggested that a more productive motion might be to express concern over the loss of tobacco funding and support DPH in its efforts to secure stimulus funds. Joyce O'Donnell agreed to work with Ms. Ludwig on the selection of the related SCAODA goal. She pointed out that the rationale behind the motion was that cuts in tobacco funding have negatively impacted WiNTiP, Wisconsin-Wins (Synar) compliance checks, the tobacco quit line and other tobacco prevention programs. **Tom Fuchs moved to support maintaining funding levels for tobacco prevention programming as crucial to the state at this time when Wisconsin is transitioning to a smoke-free state; and support DPH in its efforts to obtain federal funding through the stimulus funds. Duncan Shroul seconded the motion. The motion passed unanimously.**
- Motion Introduction Form re: supporting AB 547: Ms. O'Donnell reported that the Planning and Funding Committee passed a motion to support AB 547 during the October meeting. She asked Ms. Ludwig to work with her over the phone to complete the "Motion Introduction Form."

VI. 2010 Meeting Dates for Planning and Funding Committee—Joyce O'Donnell: Ms. O'Donnell indicated that due to time constraints, this agenda item would be skipped.

VII. Items of Interest—Joyce O’Donnell

- Follow-Up on “Tavern of the Game”—Joyce O’Donnell: Ms. O’Donnell reported that she contacted the Brewers and spoke with Chris Barlow from the Brewers’ Public Relations Department. She asked him how they selected the Tavern of the Game. Mr. Barlow indicated that Tavern of the Game was a Miller Beer promotion and that names are drawn out of a hat. He suggested that Ms. O’Donnell contact Tyler Barns, Vice-President of Communications and e-mail him some questions. Mr. Fuchs felt that they need to have a “Treatment Provider of the Game.”
- Up-coming Conferences—Infra-Structure Study Summit on December 3, 2009, Stevens Point. Duncan Shroul indicated that he will be attending.

VIII. Adjourn: The next meeting is: Friday, January 15, 2010 from 9:30 a.m. to 2:30 p.m.

PLANNING AND FUNDING COMMITTEE MEETING

January 15, 2010

9:30 A.M. – 2:30 P.M.

ARC CENTER FOR WOMEN & CHILDREN

1409 EMIL STREET

MADISON, WI

608/283-6426

DRAFT



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State Council on Alcohol and Other Drug Abuse

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

Linda Mayfield
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Scott Stokes
Secretary

STATE COUNCIL ON ALCOHOL & OTHER DRUG ABUSE
Planning and Funding Committee Meeting Minutes
January 15, 2010
ARC Center for Women and Children
Madison, WI

MEMBERS PRESENT: Joyce O'Donnell, Duncan Shroul, Sally Tess, Manny Scarbrough,
Tom Fuchs, Karen Kinsey

EXCUSED: Norm Briggs, Bill McCulley

GUESTS:

STAFF: Lori Ludwig

I. Call to Order – Joyce O'Donnell:

Joyce O'Donnell called the meeting to order at 9:35 A.M.

II. Review of November 20, 2009 Meeting Minutes – Joyce O'Donnell

Duncan Shroul motioned to approve the minutes of November 20, 2009. Tom Fuchs seconded the motion. The minutes were approved without modification.

III. 2010 Meeting Dates for Planning and Funding Committee—Joyce O'Donnell

Ms. O'Donnell led the group through planning the dates for Planning and Funding meetings in 2010. The following are the dates chosen: February 26th, April 16th, May 14th, July 16th, October 15th, November 19th.

IV. Medical Marijuana bills—SB 368 AB 554—Joyce O'Donnell

A SCAODA member, Douglas Englebert of the Controlled Substance Board, asked staff to ask Committees to review the medical marijuana bills currently introduced into the Legislature. Ms. O'Donnell opened the discussion by expressing her opinion that marijuana is an illegal drug. Therefore, she reasoned the Legislature would need to legalize marijuana prior to approving a medical use. Duncan Shroul countered that according to the bill, marijuana can be made available through a physician recommendation. Because marijuana is a Schedule I drug, it cannot be prescribed. Ms. O'Donnell clarified that SCAODA wants a recommendation from Planning and Funding Committee. Duncan Shroul reviewed for the group three recent research articles that he was able to find concerning the topic. Two were authored by Peter J. Cohen and

Page 117 of 203

published in the Journal of Pain & Palliative Care Pharmacotherapy, Vol. 23 (1), 2009. The titles were, "Medical Marijuana: The Conflict Between Scientific Evidence and Political Ideology. Part One of Two and Part Two of Two. The third article, "Medicinal use of cannabis in the United States: Historical perspectives, current trends, and future directions," Aggarwal, Sunil K., PhD, et. al, Journal of Opioid Management 5:3, May/June 2009, he distributed for the Committee's and SCAODA's Chair, Mark Seidl, use only. If, Mr. Shroul cautioned, Mr. Seidl decides to distribute the article to others, permission from the authors must be obtained. Mr. Shroul summarized for the group that the Peter J Cohen articles conclude that there is not a sufficient body of knowledge available to argue one way or another. The US Departments of Justice and Health and Human Services have refused to re-schedule marijuana to do research. That is the problem. The article contends that there appears to be efficacy for certain conditions in smoked marijuana compared to marinol which appears to be not as effective for some conditions. The conclusion of the Cohen articles, according to Mr. Shroul, are that there is no reason why marijuana should not be researched as a medicine, if the Schedule were changed, then there could be research which would lead to the medicine being made available by prescription. No responsible researcher will get funding until marijuana is placed on Schedules 2,3,4 or 5. In the last 10 years there has been a big increase in private research on medical marijuana, but it has been paid for privately. Karen Kinsey commented that as regards medical marijuana, there is lots of cultural bias against this, law enforcement is against this and people have strong feelings about this. Mr. Shroul pointed out that regarding the Treffert letter, distributed by Representative Townsend and included in the Planning and Funding packet, the stance is against allowing the use of medical marijuana in Wisconsin. The Controlled Substances Board is also against it. Tom Fuchs pointed out that the issue is international. Our position should be that we cannot take a stand without further research. We cannot make a choice except to support the federal government moving marijuana to schedule 2. Mr. Fuchs was concerned that there is always the concern of the marijuana being diverted for non-medical use. Mr. Shroul predicted that SCAODA would oppose the bill, but because the federal government's refusal to move marijuana off schedule 1 for research, there are those with serious and persistent pain going without a potential effective treatment. If marijuana were rescheduled it could be made available by prescription. What is the difference between that and other prescription drugs being diverted for non-medical use. Mr. Fuchs agreed. Marijuana is certainly less dangerous than oxycontin. Karen Kinsey felt that current policies cause damage to adolescents and young adults who are going to prison. She felt that the increased use of Ritalin among our children and adolescents have led to the misuse of prescribed drugs like oxycontin. That is what does a lot of damage. Manny Scarbrough agreed that current policies do a great deal of damage to the legal and health status of our young. Unless we change our ways, he argued, we will adapt as an organism. What statement should we make? **Tom Fuchs made a motion to oppose the use of medical marijuana and therefore oppose Wisconsin bills SB 368 and AB 554. Duncan Shroul seconded the motion.** During discussion, Ms. O'Donnell felt that the group should consider putting in front of the motion some of the valid points raised during the discussion as a rationale. Mr. Scarbrough agreed and suggested adding an amendment to recommend marijuana be changed from schedule 1 to schedule 2. Rationale is as follows:

1. There is not a sufficient body of knowledge available to argue one way or another on the efficacy of medical marijuana.

2. The US Departments of Justice and Health and Human Services have refused to re-schedule marijuana from Schedule 1 to Schedule 2, 3, 4, or 5 in order to conduct research into the efficacy of medical marijuana.

3. Securing valid research results would provide scientific evidence about actual effects on use and dispensing of medical marijuana.

4. Planning and Funding Committee supports the federal government moving marijuana to Schedule 2, 3, 4, or 5 in order to facilitate scientific research.

Further discussion brought forth concerns about the process for SCAODA to take a position, given the possibility of differing Committees positions. The discussion also raised the concern that marijuana is held to a higher standard because of cultural differences. There are disparities in terms of ethnicity regarding who is arrested and who isn't for using or possessing marijuana. For example, a possession charge in Shorewood results in a municipal ticket while in Milwaukee the DA will pursue a charge. Mr. Shrout suggested that the State Council needs to say to the state legislators—we need to change this. Ms. Kinsey felt that the Planning and Funding Committee was jumping the gun and that evidence will be presented at the March SCAODA meeting. Mr. Shrout felt that Mr. Seidl, SCAODA Chairperson, prefers that motions come from Committees so people can be aware of the information ahead of time. Ms. O'Donnell felt that the State Council has a responsibility to support or oppose legislation. She felt that there has been enough information presented to take a stand. Mr. Shrout pointed out that it has been publicized that if the medical marijuana bill makes it through the Legislature, the Governor will sign it. With that a vote was taken. **All in favor consisted of all but one. The motion passed.** Mr. Scarbrough felt that since SCAODA can ask the Governor to do certain things he **would like to make a motion that the Council go on record to alleviate disparities in arrest, charging and sentencing decisions among Wisconsin citizens and illegal drug use in Wisconsin.** Mr. Shrout **seconded the motion.** Discussion included the concern that because judges like individual discretion in cases, if SCAODA supports a certain policy, an unintended consequence could be even more punitive measures. Mr. Scarbrough pointed out that where the rubber meets the road is local ordinances. There was concern expressed if SCAODA starts making recommendations that concern local ordinances. Mr. Shrout indicated that the point is, who repairs the current problem, the community, the Legislature or SCAODA? Mr. Scarbrough suggested we look at the data. Ms. Ludwig pointed out that the data exists. Pam Oliver, a researcher at UW-Madison has completed a comprehensive study. Mr. Scarbrough felt that Planning and Funding Committee could charge the Council with putting this together. Mr. Fuchs expressed support for Mr. Scarbrough's position but felt that this topic should be moved to the next agenda item, Planning and Funding Goals and Objectives for 2010-2014. Planning and Funding also had looked at moving 17-Year olds out of the adult Court system. Ms. Tess agreed to obtain the Pam Oliver data. She indicated that there were issues that DOC raised with the Pam Oliver data. **Mr. Scarbrough agreed and withdrew his motion.**

V. SCAODA 2010-2014 Four Year Plan—Group:

A. Discussion Synopsis of November 20th meeting—Lori Ludwig reviewed the document resulting from the November 20th strategic planning meeting, titled, “SCAODA—Planning Committee—Flip Chart Synthesis from 11-20-09.” Ms. Kinsey reported that she thought Kris Freundlich well-captured the discussion.

B. Planning and Funding Goals and Objectives for 2010-2014—Group—Mr. Scarbrough brought up the strategy of **sobriety check points**. Mr. Shrout suggested that the research says it is not helpful. Ms. Tess agreed, indicating there was substantial cost involved with sobriety check points and fewer results. Mr. Shrout felt there is nothing wrong with it as a statement, though. Ms. Kinsey indicated that she liked the idea of sobriety checkpoints. Mr. Shrout pointed out that sobriety check points are a marketing issue. They say to a community, “We want to check on the citizenry.” West Allis implements sobriety check points. In 2008, about 500 people were caught (for alcohol/drug violations) through sobriety checkpoints. About half were residents. It is a statement. West Allis catches about one-third of alcohol/drug violators this way. Ms. Tess indicated that sobriety checkpoints have withstood a Court challenge, they are constitutional.

Ms. Kinsey felt that the Planning and Funding Committee has a responsibility for fiscal oversight of 1) state agencies expenditures in the area of alcohol and other drug abuse programs; as well as 2) the Division of Mental Health and Substance Abuse Services' budget, including the Block Grant expenditures. This responsibility derives from SCAODA's enabling legislation, for the purpose of **developing recommendations on state AODA programs prior to passage of the biennial budget**. In the past, the Planning and Funding Committee would draft letters requesting agencies' planned budgets pertaining to expenditures on alcohol and other drug abuse programs for analysis, and then ask a representative from the agencies to come in to a Planning and Funding Committee meeting for feedback. The Chairs from the other SCAODA Committees would be there, too. **The objective would be to give SCAODA advice on how the programs should be implemented or changed**. Agencies' programs reviewed in the past were: the Department of Children and Families, the Department of Public Instruction, the Department of Corrections, the Department of Transportation, and the Department of Health Services, including the Division of Mental Health and Substance Abuse Services. Mr. Scarbrough pointed out that the process became clumsy because it is difficult to tell other agencies what to do, and the feedback sessions sometimes occurred after the budget was already adopted. Mr. Shrout asked what is the best way to look at our influence? What is our role? What is an effective utilization of our time? Ms. Kinsey reported that the most impact was on the Division of Mental Health and Substance Abuse Services. Ms. Kinsey asked how the Planning and Funding Committee members see themselves? Mr. Shrout responded that he felt their role was not that significant anymore. Bringing people in used to be influential, and he was not so sure that was still true. Ms. Kinsey felt that people should be brought in. She felt that the highest decision-makers possible should be brought in. She wants the people running mental health and substance abuse to come in to discuss what is going on, **to protect and encourage funding where there are issues**. In this regard, she is especially interested in being involved with the Division's Infra-Structure Study recommendations. She requested that John Easterday be invited to discuss recommendations and their effect on the budget and to give an update on Phase 2 of the study/process. Mr. Fuchs suggested that perhaps Planning and Funding should have as its next objective **working with treatment organizations to prepare for the future**.

Continuing on, Ms. Kinsey felt that the earlier discussion of the Planning and Funding Committee's intention regarding **racial disparities among drug offenders in the criminal justice system** fits nicely with the drafted "SCAODA Synthesis, SCAODA GOALS: "...C...to have WI exhibit collaborative broad-scale leadership and aligned action across multiple sectors to:...b) have adequate, sustainable resources for effective prevention efforts across multiple target groups including the disproportionately affected," and "c) have adequate, sustainable resources and ongoing capacity for effective outreach, and accessible treatment and recovery services for all in need." Or, alternately, it fits under the general area of "Effective Laws and Policies," "b) Attain strong leadership from the Governor and Legislature and other leaders to realize laws that provide adequate and sustainable resources for...prevention and outreach across multiple target groups including the disproportionately affected". **The goal would be to resolve disparity between arrest, conviction and sentencing rates for drug offenses of citizens of color and majority citizens**.

Goal number 3 would be from the legislative mandates, to review newly introduced legislation and prepare considered opinion.

- **Objective: To increase the Beer Tax**
- **Objective: Not taking underage children into bars—SCAODA legislators could introduce**

- **Objective: To develop State Alcohol policies that supplant local ordinances**

Goal number 4 would be to identify pertinent items.

- **Seventeen-year-olds out of adult court**
- **Increase in abuse of prescription drugs**
- **Fetal Alcohol Spectrum disorders**
 - **Funding**
 - **Resources**
 - **Education**
- **Underage Drinking**
- **Adults binge drinking**
- **Trauma Informed Care**

VI. Report Four Chairs Teleconference, December 4, 2009—Joyce O'Donnell: Ms. O'Donnell reported that Lou Oppor arranged for a discussion between the Chairpersons of the four SCAODA Committees prior to the meeting. Planning and Funding motions were discussed. Michael Waupoose and Linda Preysz decided that they would not support Planning and Funding's motion to support AB547. Ms. O'Donnell indicated that she would introduce the motion anyway. Mr. Shrout recognized Ms. O'Donnell for her leadership qualities and ability to articulate the issues. All were appreciative of Ms. O'Donnell's work and thanked her.

VII. Committee Reports:

Tom Fuchs requested that the website for the Infra-Structure study be sent out. He noted two system issues: 1) Treatment dollars are going into managed care and 2) the 51 system is built upon County responsibility. He reported that some counties are unwilling to do 3-party petitions or holds. Ms. O'Donnell asked what the role of the Governor would be in this. Mr. Fuchs indicated he didn't know, counties are refusing to participate. Ms. Tess added that if a person is under the supervision of the Department of Corrections, and the County won't pay for their treatment, then they stay in jail. Mr. Fuchs indicated that money should be our number one priority. He continued that we need to get the beer tax passed, we need to get the alcohol tax passed and have the resources sent to treatment and prevention. He suggested that we could tie resources to the prevalence of need.

VIII. Adjourn: The next meeting is: Friday, February 26, 2010 from 9:30 a.m. to 2:30 p.m.

PLANNING AND FUNDING COMMITTEE MEETING

February 26, 2010

9:30 A.M. – 2:30 P.M.

ARC CENTER FOR WOMEN & CHILDREN

1409 EMIL STREET

MADISON, WI

608/283-6426

SCAODA Motion Introduction

Committee Introducing Motion: Planning and Funding
Motion: To oppose Wisconsin bills SB 368 and AB 554 which prohibit the arrest or prosecution of a qualifying patient who acquires, possesses, cultivates, transports, or uses marijuana to alleviate the symptoms or effects of his or her debilitating medical condition or treatment.
Related SCAODA Goal: Goal 1--Support, promote and encourage the implementation of a system of substance abuse services that are evidence-based....
<p>Background: The US Departments of Justice and Health and Human Services have refused to re-schedule marijuana to do medical research. That is the problem. A review of the available research literature contends that there appears to be efficacy for certain conditions in smoked marijuana compared to marinol which appears to be not as effective for some conditions. There is no reason why marijuana should not be researched as a medicine. If the Schedule were changed, then there could be medical research which would lead to the medicine being made available by prescription. No responsible researcher will get funding until marijuana is placed on Schedules 2,3,4 or 5.</p> <ul style="list-style-type: none">• Positive impact: Medical marijuana will not get diverted for non-medical use.• Potential Opposition: People who could benefit through reduced suffering will not be able to use marijuana legally.
<p>Rationale for Supporting Motion: There is not a sufficient body of knowledge available to argue one way or another on the efficacy of medical marijuana.</p> <ol style="list-style-type: none">2. The US Departments of Justice and Health and Human Services have refused to re-schedule marijuana from Schedule 1 to Schedule 2, 3, 4, or 5 in order to conduct research into the efficacy of medical marijuana.3. Securing valid research results would provide scientific evidence about actual effects on use and dispensing of medical marijuana.4. Planning and Funding Committee supports the federal government moving marijuana to Schedule 2, 3, 4, or 5 in order to facilitate scientific research.



State of Wisconsin

State Council on Alcohol and Other Drug Abuse

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

**Strategic Prevention Framework State Incentive Grant/Prevention Committee
Meeting**

September 17, 2009

9:30 am – 3:00 pm

Pinney Branch Library Meeting Room

204 Cottage Grove Rd.

Madison, WI 53716

Meeting Minutes

Members Present: Scott Stokes (Chairperson), Kathleen Marty, Carol Wright, Doug Merrill, Rick Peterson, Julia Sherman, Gary Sunnicht, Chris Wardlow, Racquel Bell, Alan Iverson, Lee Wipfli

Members Excused: Blinda Beason, Claude Gilmore, Gerald Huber, Ronda Koplke, Jane Larson, Francie McGuire Winkler, Kathryn Wolf, Emanuel Scarbrough

Members Absent: Phil Collins, Tonia Gray, Tracy Herlitzke,

Staff: Louis Oppor, Kathy Thomas

Guests: Robin Lecoanet

Welcome and Introduction

Scott Stokes called the meeting to order at 9:40 am and welcomed members. Mr. Stokes welcomed new members Racquel Bell, Alan Iverson and Ms. Lee Wipfli. Other Committee members introduced themselves.

Approval of Notes

There was a unanimous decision to adopt the meeting notes of July 23, 2009.

Legislative Updates

Julia Sherman provided an overview of Assembly Bill 283 which makes a number of changes relating to operating a vehicle under the influence of an intoxicant; Assembly Bill 390 which allows individuals to consume alcohol on a commercial quadricycle; Senate Bill 30/Assembly Bill 106 which under this Bill, an underage person accompanied

by a parent, guardian, or spouse who has attained the legal drinking age may possess, consume, or be provided alcohol beverages on licensed premises only if the underage person is at least 18 years of age. Ms. Sherman also indicated Assembly Bill 287, increasing the tax rate for the tax on fermented malt beverages from \$2 per barrel to \$10 per barrel will have a public hearing on October 13, 2009 at the State Capitol.

Julia Sherman moved and was seconded by Rick Peterson to oppose Assembly Bill 283. The motion was passed unanimously by the Committee. The Committee felt passage of this Bill would:

- Add to Wisconsin's unhealthy drinking culture,
- Increase availability,
- Promote attractiveness of unhealthy alcohol consumption, and
- Further normalizes public drinking and intoxication.

Alcohol, Culture and Environment (ACE) Sub-committee Report

Ms. Julia Sherman, Chairwoman of the ACE Sub-committee indicated the ACE Sub-committee has been studying Wisconsin's alcohol environment with a focus on availability and acceptability. Ms. Sherman indicated the Sub-Committee will be finalizing their work and preparing a report prior to the next Prevention Committee meeting and would be prepared to review the report and recommendations at the next Prevention Committee meeting.

Other Drugs of Abuse Sub-committee Development

Mr. Scott Stokes reviewed the list of organizations he would like to invite to participate in a new Other Drugs of Abuse Sub-Committee that included:

- A Prevention Committee representative,
- A Medical Assistance representative,
- A Drug Enforcement representative,
- A Pharmacy Board representative,
- An Epidemiologist,
- A Law Enforcement representative,
- A Tribal representative,
- A Wisconsin County Human Service Association representative, and
- A Methadone Clinic representative.

Mr. Stokes asked for recommendations from the Prevention Committee of either specific individuals who may be contacted to fill these positions or recommendations of other organizations that may be important to the purpose of this Committee. Committee members offered the following suggestions:

- A representative of Drug Endangered Children,
- A representative of a local law enforcement agency that has developed a drug drop off site and protocol,
- A representative of the Department of Agriculture representing the Clean Sweep Program,

- David Spocowitz (sp?) – Drug Enforcement Administration
- Bradley Dunlap – Special Agent DCI, WI Dept. of Justice, Lake Winnebago Area Metropolitan Enforcement Group
- Drug Task Force Member from Vilas/Oneida Counties (Recommended by Carol Wright)
- A representative from Impact (Milwaukee) representing the 211 group. Duncan Shroud is the Director of Impact.
- David Reimer – MATTE Project
- Dr. Pamela Bean (recommended by Julia Sherman)

Department Updates

Department of Public Instruction – Mr. Gary Sumnicht indicated that the Safe and Drug Free Schools Federal State Grant Program funding will be eliminated from the 2010 Federal Budget Bill. Senator Feingold may try to support putting some of the dollars back in. Mr. Chris Wardlow indicated that the Safe and Drug Free Schools and Communities Act supported 72% of school based prevention funds. Ms. Kathryn Thomas indicated the elimination of these dollars would have a great impact upon the state not only for schools but for projects funded under the Governor’s portion including funding to the Wisconsin Clearinghouse for Prevention Resources, Tribal prevention program funding, funding for runaway programs. Mr. Wardlow stated that people could go to CADCA.org to register its impact upon the State.

Mr. Wardlow was also concerned about the elimination of Safe and Drug Free Schools and Communities Act funding for Wisconsin Clearinghouse services. Because the Wisconsin Clearinghouse played a vital role in the training and education of Wisconsin’s Prevention Specialists, it may be necessary for the Prevention Committee to establish a Workforce Development Sub-Committee to examine prevention workforce needs and develop recommendations to improve statewide capacity. Mr. Wardlow indicated he would be willing to Chair such a Sub-Committee. Mr. Louis Oppor indicated that the full State Council on Alcohol and Other Drug Abuse was concerned about workforce development and may be considering a new Committee to study issues related to the treatment workforce and perhaps prevention should also be a part of this study. Mr. Wardlow was also concerned about the continuation of the State Prevention Conference as the Wisconsin Clearinghouse played a critical role in the development and implementation of this annual conference. Mr. Wardlow indicated that if the Wisconsin Clearinghouse was not longer able to coordinate this effort, perhaps the Wisconsin Association of Alcohol and Other Drug Abuse may be interested in providing a prevention tract at its annual conference.

Mr. Sumnicht went on to state that the Department’s prevention programs supported by General Purpose Revenue would be cut by 10% .

Mr. Sumnicht also indicated that the Youth Risk Behavior Survey (YRBS) results were now being collected and analyzed. A report should be issued early 2010. The Online YRBS can also be accessed for free by school districts.

Department of Health Services – Mr. Louis Oppor indicated that the Department of Health Services is working in cooperation with four other Departments and agencies to implement the *Parents Who Host Lose the Most: Don't be a Party to Teenage Drinking* Campaign. Other partner agencies include the Department of Public Instruction, Department of Transportation, the Department of Health Services, the Wisconsin Clearinghouse for Prevention Resources and the Wisconsin Alcohol, Tobacco and Other Drug Abuse Education Network. Implementation of this effort will occur in April – June 2010. The Campaign will include community and law enforcement participation, distribution of CARD grants to law enforcement through the Department of Transportation, training for community coalitions, distribution of campaign materials to local applying coalitions, distribution of campaign billboards and a Governor's Proclamation. A resource web-link has been established at: <http://sites.google.com/site/parentswhohostawi/tools-you-can-use>. Mr. Oppor also indicated that all written and electronic materials have been developed for use at any time, not just limited to prom and graduation.

Ms. Kathryn Thomas reported on the Strategic Prevention Framework State Incentive Grant. Ms. Thomas indicated that all project implementation plans have been submitted and have been reviewed. She indicated that many projects were still in a state of limited community readiness. As a result, many of the implementation plans reflected strategies for community awareness and education concerning the consequences of alcohol abuse. Implementation will begin at the 20 SPF SIG sites in October 2009 although a couple of projects will need to submit revisions to their plans before they can be approved. Ms. Thomas also indicated a need for law enforcement training and was hopeful this would take place in early 2010. In addition, she also recognized a need for Parent Network training and she would look more closely at this in the coming months with hopes to have training developed in early 2010.

Mr. Oppor indicated the Healthy Wisconsin 2020 planning was under way and it is expected that a revised plan should be available in February 2010 outlining outcomes for substance abuse prevention and treatment.

Mr. Oppor reported on the Alliance for Wisconsin Youth activities and indicated there are now over 210 local Alliance Coalitions. The Alliance for Wisconsin Youth Regional Centers are meeting at least twice a year with their coalitions and providing them with State and Federal updates regarding evidence based prevention strategies. Local coalitions are also providing feedback to the State regarding local needs.

Mr. Oppor also reported there are now 29 Drug Free Community grantees in Wisconsin. Many of these coalitions are also a part of the Alliance for Wisconsin Youth coalitions.

Department of Justice – Although no Committee member was in attendance to provide an update from the Department of Justice, Mr. Alan Iverson is interested in establishing an Alcohol Compliance Education Certificate through the Department of Justice Training and Standards Bureau.

Public Forum

Scott Stokes provided a written report to the Prevention Committee regarding testimony received at the State Prevention Conference during the State Council on Alcohol and Other Drug Abuse Public Forum. Upon review, the Prevention Committee asked that the report be forwarded to SCAODA.

SCAODA Strategic Plan

No action taken at this meeting.

Other

At a future meeting, several Committee members expressed an interest in reviewing how new technology could be used to enhance the capacity of the prevention field.

Adjourn

The meeting was adjourned at 3:00 pm.

SCAODA Motion Introduction

Committee Introducing Motion: Prevention

Motion: To support points 3 and 4 in the legislative summary of AB 598, section 3 of the legislative summary raises the age of absolute sobriety on a snowmobile from any under 19 to anyone under 21. Section 4 increases the penalties for operating a snowmobile under the influence if the snowmobile is operated with a passenger under 16 years of age. <http://www.legis.state.wi.us/2009/data/AB-598.pdf>

Related SCAODA GOAL: Goal 2: Support the prevention and reduction of alcohol, tobacco, and other drug use and abuse through evidence-based practice with special emphasis on underage use.

Background: This bill makes the following changes relating to the regulation of snowmobile operation in this state:

1. Current law prohibits a person from operating a snowmobile in this state unless the snowmobile is covered by a public use or private use registration issued by the Department of Natural Resources (DNR) or is exempt from registration. A person who owns a snowmobile is generally exempt from snowmobile registration requirements in this state if the snowmobile is covered by a valid registration in another state or country. A public use registration is valid for two years and a private use registration is valid until ownership of the snowmobile is transferred.

This bill eliminates the two-year registration period for a public use registration and provides that a public use registration is valid until ownership of the snowmobile is transferred. The bill also lowers the public use registration fee from \$30 to \$15.

2. Under current law, a person who owns a snowmobile that is not registered in this state or is exempt from registration must display a trail use sticker issued by DNR on the snowmobile. The fee for this sticker is \$35. This bill requires all snowmobiles to display a trail use sticker, regardless of whether the snowmobile is registered in this state. The bill provides that the fee for a trail use sticker issued for a snowmobile that is registered in this state is \$14.25 if the snowmobile is owned by a snowmobile club member and \$34.25 if the owner does not belong to a snowmobile club.

3. Current law requires absolute sobriety for any person operating a snowmobile who is under the age of 19. This bill increases this age so that the absolute sobriety requirement applies to anyone under the age of 21.

4. The bill imposes increased penalties for operating a snowmobile under the influence of an intoxicant or with alcohol concentrations above specified levels if the snowmobile is operated with a passenger under 16 years of age.

5. Current law prohibits a person from operating a snowmobile at night at a rate of speed exceeding 55 miles per hour. Current law sunsets this provision on July 1, 2010. This bill repeals the sunset.

6. Under current law, DNR provides funding from the snowmobile account in the conservation fund for snowmobile regulation purposes including aids to counties for activities such as snowmobile trail development and maintenance and law enforcement. Currently, these activities are funded by snowmobile fees and by moneys transferred from the transportation fund to the conservation fund. The amount of this transfer equals the estimated snowmobile gas tax formula.

The estimated snowmobile gas tax formula amount is based on an estimate of the amount of excise tax paid on gasoline by operators of all snowmobiles registered in this state. This bill bases the estimated snowmobile gas tax formula on an estimate of the excise tax paid on gasoline by operators of registered snowmobiles in this state who are issued a trail use sticker.

7. This bill provides additional funding from the snowmobile account in the conservation fund in fiscal years 2010–11 to 2012–13 for alcohol education programs for snowmobilers, for law enforcement, and for the development and maintenance of state trails.

Rationale for Supporting Motion: Section 3 brings snowmobiles into line with motorized vehicles regarding zero tolerance for underage drivers. Increasing the penalties for operating a snowmobile under the influence if the snowmobile is operated with a passenger under 16 years of age, should help serve as a deterrent from operating snowmobiles while intoxicated.

SCAODA Motion Introduction

Committee Introducing Motion: Prevention
Motion: To oppose Assembly Bill 335, which allows private colleges and universities to establish an area to sell alcohol without a permit. http://www.legis.state.wi.us/2009/data/AB-335.pdf
Related SCAODA GOAL: Goal 2: Support the prevention and reduction of alcohol, tobacco, and other drug use and abuse through evidence-based practice with special emphasis on underage use.
Background: Under current law, an owner, lessee, or person in charge of a public place may not permit the consumption of alcohol beverages on the premises of the public place unless the person has an appropriate retail license or permit. Certain exceptions exist, including for county buildings and parks, athletic fields and stadiums, school buildings, churches, state fair parks, and clubs. This bill creates an additional exception for the campuses of private colleges at the place and time an event sponsored by the private college is being held.
Rationale for Supporting Motion: This bill is in conflict with current law and preempts local alcohol control, and increases the number of alcohol outlets.

SCAODA Motion Introduction

Committee Introducing Motion: Prevention
Motion: to oppose Assembly Bill 390, which allows passengers on quadricycles to drink alcohol. http://www.legis.state.wi.us/2009/data/AB-390.pdf
Related SCAODA GOAL : Goal 2: Support the prevention and reduction of alcohol, tobacco, and other drug use and abuse through evidence-based practice with special emphasis on underage use.
<p>Background: Under current law, an owner or other person in charge of a public place may not permit the consumption of alcohol beverages at that place unless a retail alcohol beverages license has been issued for the place. There are various exceptions to this prohibition, including for county parks, athletic fields and stadiums, school buildings, and churches. This bill adds an exception for commercial quadricycles.</p> <p>Also under current law, municipalities may impose regulations related to alcohol beverages that are not in conflict with state law. This bill specifies that no such regulation may prohibit the possession or consumption of alcohol beverages by passengers on a commercial quadricycle.</p> <p>The bill prohibits the driver of a commercial quadricycle from consuming alcohol while the commercial quadricycle is occupied by passengers and from driving a commercial quadricycle with an alcohol concentration of 0.08 or more. A driver that violates either of these prohibitions may be required to forfeit not less than \$20 nor more than \$40 for the first offense and not less than \$50 nor more than \$100 for the second or subsequent conviction within a year.</p> <p>The bill defines a “commercial quadricycle” as a vehicle with fully operative pedals for propulsion entirely by human power, that has four wheels and is operated in a manner similar to a bicycle, that is equipped with at least 12 seats for passengers, that is designed to be occupied by a driver and by passengers providing pedal power to the drive train of the vehicle, and that is used for commercial purposes.</p>
Rationale for Supporting Motion: This bill would promote accessibility to alcohol, would preempt local alcohol control, and would cause traffic safety issues.

SCAODA Motion Introduction

Committee Introducing Motion: Prevention
Motion: Motion to oppose Assembly Bill 554 which would legalize medical marijuana.
Related SCAODA GOAL: Goal 2: Support the prevention and reduction of alcohol, tobacco, and other drug use and abuse through evidence-based practice with special emphasis on underage use. http://www.legis.state.wi.us/2009/data/AB-554.pdf
<p>Background: <i>Current prohibitions and penalties</i></p> <p>Current law prohibits the manufacture, distribution, and delivery of marijuana (also known as tetrahydrocannabinols) and the possession of marijuana with intent to manufacture, distribute, or deliver it. Penalties for violating these prohibitions depend on the amount of marijuana involved. If the crime involves 200 grams or less or four or fewer marijuana plants, the person is guilty of a felony and may be fined up to \$10,000, sentenced to a term of imprisonment of up to three years and six months, or both. If the crime involves more than 200 grams but not more than 1,000 grams, or more than four plants but not more than 20 plants, the person is guilty of a felony and may be fined up to \$10,000, sentenced to a term of imprisonment of up to six years, or both. If the crime involves more than 1,000 grams but not more than 2,500 grams, or more than 20 plants but not more than 50 plants, the person is guilty of a felony and may be fined up to \$25,000, sentenced to a term of imprisonment of up to ten years, or both. If the crime involves more than 2,500 grams but not more than 10,000 grams, or more than 50 plants but not more than 200 plants, the person is guilty of a felony and may be fined up to \$25,000, sentenced to a term of imprisonment of up to 12 years and 6 months, or both. If the crime involves more than 10,000 grams or more than 200 plants, the person is guilty of a felony and may be fined up to \$50,000, sentenced to a term of imprisonment of up to 15 years, or both. Current law also prohibits a person from possessing or attempting to possess marijuana. A person who violates this prohibition and who has no prior drug convictions is guilty of a misdemeanor and may be fined not more than \$1,000, sentenced to the county jail for up to six months, or both. For a second or subsequent offense, a person is guilty of a Class I felony. Current law also contains certain prohibitions regarding drug paraphernalia, which includes equipment, products, and materials used to produce, distribute, and use controlled substances, including marijuana. Under current law, a person who uses drug paraphernalia or who possesses it with the primary intent to produce, distribute, or use a controlled substance, other than methamphetamine, unlawfully is guilty of a misdemeanor and may be fined not more than \$500, imprisoned for not more than 30 days, or both. A person who delivers drug paraphernalia, possesses it with intent to deliver it, or manufactures it with intent to deliver it, knowing that it will be primarily used to produce, distribute, or use a controlled substance, other than methamphetamine, unlawfully may be fined not more than \$1,000, imprisoned for not more than 90 days, or both.</p> <p><i>Medical necessity defense and immunity from arrest and prosecution</i></p> <p>This bill establishes a medical necessity defense to marijuana-related prosecutions and forfeiture actions. A person having or undergoing a debilitating medical condition or treatment (qualifying patient) may invoke this defense. A debilitating medical condition or treatment means any of the following: 1) cancer, glaucoma, AIDS, a positive HIV test,</p>

Crohn's disease, a Hepatitis C virus infection, Alzheimer's disease, Amyotrophic Lateral Sclerosis, nail patella syndrome, Ehlers–Danlos Syndrome, post–traumatic stress disorder, or the treatment of these conditions; 2) a chronic or debilitating disease or medical condition, or the treatment of such a disease or condition, that causes wasting away, severe pain, severe nausea, seizures, or severe and persistent muscle spasms; or 3) any other medical condition or treatment for a medical condition designated as a debilitating medical condition or treatment in rules promulgated by the Department of Health Services (DHS). A qualifying patient may invoke this defense if he or she acquires, possesses, cultivates, transports, or uses marijuana to alleviate the symptoms or effects of his or her debilitating medical condition or treatment, but only if no more than the maximum authorized amount of marijuana (that is, 12 marijuana plants and three ounces — approximately 85 grams — of marijuana leaves or flowers) is involved. If a person has obtained a valid registry identification card from DHS or a valid out–of–state registry identification card (see *Registry and distribution centers for medical users of marijuana* below) or has a written certification from his or her physician documenting that the person has or is undergoing a debilitating medical condition or treatment and that the potential benefits to the person of using marijuana outweigh the health risks involved, the person is presumed to have this defense if no more than the maximum authorized amount of marijuana is involved. The bill also prohibits the arrest or prosecution of a qualifying patient who acquires, possesses, cultivates, transports, or uses marijuana to alleviate the symptoms or effects of his or her debilitating medical condition or treatment if the person possesses a valid registry identification card, a valid out–of–state registry identification card, or a written certification. This prohibition, however, applies only if no more than the maximum authorized amount of marijuana is involved. In addition, the bill prohibits the arrest or prosecution of or the imposition of any penalty on a physician who provides a written certification to a person in good faith. The defense provided under the bill and the prohibition on arrest and prosecution contained in the bill do not apply if the person possesses or attempts to possess marijuana and if: 1) while under the influence of marijuana, the person drives or operates a motor vehicle; 2) while under the influence of marijuana, the person operates heavy machinery or engages in any other conduct that endangers the health or well–being of another person; or 3) the person smokes marijuana on a bus, at his or her workplace, on school premises, in an adult or juvenile correctional facility or jail, at a public park, beach, or recreation center, or at a youth center. In addition, if the putative qualifying patient is under 18 years of age, the defense provided under the bill and the prohibition on arrest and prosecution contained in the bill apply only if the person's parent, guardian, or legal custodian agrees to serve as a primary caregiver for the person. The bill defines a primary caregiver as a person who is at least 18 years old and who has agreed to be responsible for managing a qualifying patient's medical use of marijuana. The defense provided under the bill and the prohibition on arrest and prosecution contained in the bill apply also to a primary caregiver for any qualifying patient, if the primary caregiver acquires, possesses, cultivates, transfers, or transports marijuana to facilitate the qualifying patient's medical use of it. The defense and the prohibition apply to the primary caregiver only if it is not practicable for the qualifying patient to acquire, possess, cultivate, or transport marijuana independently or if the qualifying patient is under 18. The defense and the prohibition apply also to offenses

involving drug paraphernalia if the qualifying patient uses the drug paraphernalia for the medical use of marijuana.

Registry and distribution centers for medical users of marijuana

The bill requires DHS to establish a registry for medical users of marijuana. Under the bill, a person claiming to be a qualifying patient may apply for a registry identification card by submitting to DHS a signed application, accompanied by a written certification and a registration fee of not more than \$150. DHS must verify the information and issue the person a registry identification card. A qualifying patient and one of his or her primary caregivers may also jointly apply for a registry identification card for the primary caregiver. DHS may not disclose that it has issued to a person a registry identification card, or information from an application for one, except to a law enforcement agency for the purpose of verifying that a person possesses a valid registry identification card. A registry identification card is valid for one year, unless revoked sooner by DHS based on a change of circumstances, and may be renewed. This bill also requires DHS to promulgate a rule listing any state, district, commonwealth, territory, or insular possession thereof that allows the medical use of marijuana by a visiting qualifying patient or allows a person to assist with a visiting qualifying patient's medical use of marijuana. Under this bill, documents issued by these entities identifying a person as a qualifying patient, primary caregiver, or equivalent are treated the same as registry identification cards issued by DHS. The bill requires DHS to license and regulate nonprofit corporations, known as compassion centers, that distribute or deliver marijuana or drug paraphernalia or possess or manufacture marijuana or drug paraphernalia with the intent to deliver or distribute to facilitate the medical use of marijuana. This bill prohibits compassion centers from being located less than 500 feet from a school, prohibits a compassion center from distributing to a qualifying patient more than a maximum amount of marijuana, and prohibits an organization from possessing a quantity that exceeds, by an amount determined by DHS, the total maximum amount of marijuana of all of the qualifying patients it serves. An applicant for a license must pay an initial application fee of \$250, and a compassion center must pay an annual fee of \$5,000.

Effect on federal law

This bill changes state law regarding marijuana. It does not affect federal law, which generally prohibits persons from manufacturing, delivering, or possessing marijuana and applies to both intrastate and interstate violations. Because this bill creates a new crime or revises a penalty for an existing crime, the Joint Review Committee on Criminal Penalties may be requested to prepare a report concerning the proposed penalty and the costs or savings that are likely to result if the bill is enacted. For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

Rationale for Supporting Motion: The bill would be nearly impossible to enforce, would increase access to marijuana and doesn't comply with federal regulation.

SCAODA Motion Introduction

Committee Introducing Motion: Prevention
Motion: To support Assembly Bill 227, which would require pharmacies to create a registry for schedule 2 and 3 drugs. http://www.legis.state.wi.us/2009/data/AB-227.pdf
Related SCAODA GOAL: Goal 2: Support the prevention and reduction of alcohol, tobacco, and other drug use and abuse through evidence-based practice with special emphasis on underage use.
<p>Background: This bill directs the Pharmacy Examining Board (board) to establish by rule a program for monitoring the dispensing of certain drugs (generally, controlled substances that current law permits certain licensed practitioners to prescribe). The program must do all of the following: 1) require a pharmacist, physician, advanced practice nurse, dentist, or optometrist to generate an electronic record documenting each dispensing of a covered prescription and to deliver the record to the board, unless the prescription is administered directly to a patient; 2) identify data elements to be contained in such a record; 3) specify to whom and under what circumstances such a record may be disclosed; 4) specify a format and a deadline for delivery of such a record to the board; and 5) specify a penalty for a failure to comply with program requirements.</p> <p>The bill requires the Department of Regulation and Licensing to apply for certain federal grants to establish and operate the program. If the department fails to obtain federal funding before January 1, 2015, the bill is void.</p>
Rationale for Supporting Motion: Prescription drug abuse is growing at an alarming rate and a prescription drug registry would help cut down on prescription drug abuse.

“Parents Who Host” Billboard Image

E.P.O. - Images must be provided by client in specified format per art requirements. Color match proof will be provided at later date by printer.

**PARENTS
WHO HOST
LOSE
THE MOSTTM**



**DON'T BE
A PARTY TO
TEENAGE
DRINKING.**

It's against the law.

A joint project of WisDOT, DHS, DPI, CESA/WATODEN and The Wisconsin Clearinghouse for Prevention Resources. A project of the Drug Free Action Alliance.



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SCAODA Motion Introduction

Committee Introducing Motion: Diversity Committee
Motion: oMotion to request Department Regulation and Licensing invite the AODA Advisory Committee to advise on Administrative Rule 7 Rewrite
Related SCAODA Goal: Goal 3: Support and encourage recovery in communities by reducing discrimination, barriers and promoting healthy lifestyles
Background: DRL-Impaired Professional Program Coordinator monitors incident of Impaired Professional both self report and other. DRL staff reductions have affected the timely response to IPP follow-up which may have bearing on a persons counseling credentials. <ul style="list-style-type: none">• Positive impact: The rewrite will include informed feedback by substance abuse counselors.• Potential Opposition: DRLs anticipated timeline for Admin. Rule 7 is delayed based on advisory committee feedback.
Rationale for Supporting Motion: The Administrative Rule are written with an appropriately informed advisory committee with specific counseling strategies that help meet the needs of an impaired professional with substance abuse counseling needs.

INTERVENTION AND TREATMENT COMMITTEE (ITC) MEETING
Tuesday, November 10, 2009
10:30 am- 2:30 pm
Madison, WI

MINUTES

Present: Linda Preysz, Dan Nowak, Dave Macmaster, Norman Briggs, Renee Chyba, Andrea Jacobson, Tami Bahr (phone), Kate Johnson - staff

Absent: Michael Waupoose

Welcome, Introductions and Review of Minutes

The Committee welcomed Andrea Jacobson who works at the Mental Health Center of Dane County and is serving as one of the co-chairs for the Intoxicated Driver Program (IDP) Subcommittee; Nina Emerson from the UW Resource Center on Impaired Driving is the other co-chair.

Minutes were reviewed. Mac requested two changes to the attendees to the October meeting and reference to the WiNTiP Advisory Council. Minutes were approved with changes.

Children, Youth and Families Subcommittee Update

Susan Endres conducted a gap analysis examining adolescent AODA treatment resources for 13 to 19 year olds. She compared the number of treatment slots available to the number of adolescents needing treatment. The largest ratio of providers in any area of Wisconsin is 2.0 per 100 adolescents in need. The map of treatment providers and supporting information can be found on the Project Fresh Light web site at: <http://www.projectfreshlight.org> under the Knowledge Corner link.

Members discussed the possible implications of the data, historical trends with adolescent treatment providers closing, and the difference between need and demand for services for adolescents.

Other developments with adolescent treatment services include the expansion of brief interventions with teens through Teen Intervene, increased work with NIATx program improvement processes, and printing of the Adolescent Treatment Standards. Project Fresh Light is also working to increase engagement and coordination with families through regional dinners with families.

At the next meeting, the subcommittee is having someone from the SBIRT (Screening, Brief Intervention and Referral to Treatment) program to talk about adolescent services and care. They are going to discuss coordinating services more with primary health care providers and set goals for 2010. Of specific concern is the increase in heroin overdoses, deaths, and trends; a speaker will address this issue at the upcoming meeting, as well.

WiNTiP Update – Dave Macmaster

Mac provided an update about WiNTiP activities, including a copy of their new poster. WiNTiP held discussions with their Advisory Group and Steering Group to develop their 2010 plan based upon a \$50,000 grant supported by the Division of Public Health. The goals for 2010 include: outreach and recruitment through statewide associations (WADTPA, etc), increased lobbying with the legislature, development of new materials including training and web resources, attendance at conferences, design training of trainer models, identify funding, and many other activities.

Recently, WiNTiP staff presented at the Bureau of Mental Health and Substance Abuse conference and provided a variety of information about their initiative, including video posters. A planning survey was distributed at conference to get feedback from clinicians in both mental health and substance abuse. Researchers at the CTRI (The Center for Tobacco Research and Intervention) are going to take the information and put it into posters and other educational information.

Mac presented a draft resolution that he is taking to the Planning and Funding Committee and ITC. Committee members discussed the document, and Norm made a motion to change the conclusion of resolution to read, "The WINTIP program be included in the SCAODA strategic plan on an ongoing basis until the nicotine dependence integration process..." The motion approved unanimously. Mac will provide a year-end report at the December SCAODA meeting.

Intoxicated Driver Program Subcommittee Update – Andrea Jacobson

Andrea Jacobson presented an update about Intoxicated Driver Program (IDP) subcommittee. They are still looking for members representing law enforcement, Mothers Against Drunk Driving (MADD), the Tavern League, and a representative from Milwaukee.

The first two subcommittee meetings included reviewing the subcommittee charge, brainstorming about tasks, and discussing membership. At the second meeting, Janet Nodorft guided members through a strategic planning process. This resulted in a draft framework for the subcommittee to addressing issues of 1st OWI, 2nd, multiple offenders, and education, prevention, and treatment for all of those groups.

The group is proceeding with trying to figure out where to start working to address the different levels of OWIs and how to prevent clients from reoffending. Andrea views part of the subcommittee's work to be the identification of gaps in IDP program and services, which includes the distinction between alcohol consumption and addiction.

Members had a discussion of IDP and Drivers Safety Plan (DSP) development process. Members discussed that solutions need to be tailored to rural/urban, cultural influences, county, population, gender-specific issues, and other drugs of abuse. Committee members discussed reporting out on activities at upcoming meetings with report on strategic plan in early spring.

Information related to traffic crashes in Wisconsin can be found at the following Department of Transportation web site: <http://www.dot.wisconsin.gov/safety/motorist/crashfacts>

Forms related to IDP assessments and DSPs can be found on the Department of Transportation web site at: <http://www.dot.wisconsin.gov/forms/index.htm> under the Driver Licensing section.

Workforce Survey

Norm suggested that Anna Helena Skinrud may have some solutions/ideas through Prairielands Addictions Technology Transfer Center (PATTC). Part of their role is to gather data and transfer that information into the substance abuse workforce. A suggestion was made to have Anna Helena addressing the aging of the professionals in the addiction field. PATTC may have an instrument or process for gathering this information. A question was raised as to what will be done with the information once we get it.

The following steps will be taken about this issue:

1. Kate will contact Anna Helena to find out about the resources they can provide for workforce development, including:
 - Survey to determine gaps in workforce, i.e. determining need vs. demand
 - Aging of workforce, what is the estimated loss of workforce and need for recruitment
 - Estimated number of new staff coming into the field vs. number leaving
2. Mac will follow up with the Wisconsin Clearinghouse to see if they have any AODA-specific workforce data.
3. Kate will follow up to see if the state data systems have any information.

Kate will also follow up to see if agencies submit waitlist numbers.

Strategic Planning

The Planning and Funding Committee is hosting a strategic planning meeting for SCAODA with the four committee chairs and the leadership committee. The following items were discussed as strategic planning items for ITC:

Past goals/planning:

1. WINTIP
2. Gender-specific treatment
3. Outreach
4. Workforce development – education and training levels

Current suggestions:

1. WINTIP
2. Increased funding for addiction service
Contract funding levels have remained static over many years. When additional funds are available, new agencies or initiatives receive funds rather than providing additional funds to existing agencies that have proven outcomes. ITC should develop outcome-based goals/processes jointly with P and F.
3. Advocate for legislative representation, participation
4. Outreach and education, possibly include development of an Information Committee
5. Address the role of recovery

Next meetings and dates:

1. ITC - January
Department of Corrections, Madison
2. Children, Youth and Families Treatment Subcommittee
2nd Thursday of the month (ongoing by teleconference).
3. IDP Subcommittee
November 6, 2009; 9:30 am – 12:00 pm
4. SCAODA
December 9, 2009; 9:00 am – 1:00 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>

INTERVENTION AND TREATMENT COMMITTEE (ITC) MEETING

Tuesday, January 12, 2010

10:30 am- 2:00 pm

Madison, WI

MINUTES

Present: Dave Macmaster, Renee Chyba, Norman Briggs, Tami Bahr, Dan Nowak, Linda Preysz, Andrea Jacobson, Kate Johnson – staff

Absent: Michael Waupoose

Welcome, Introductions, and Review of Minutes

The meeting called to order at 10:40 am. Changes were recommended to the November meeting minutes; minutes approved with recommended changes. Renee asked if minutes from the spring and summer of 2008 were available; Kate will check with Bureau staff to locate them.

Children, Youth and Families Subcommittee Update

Tami provided an update about the Children, Youth, and Families Subcommittee including subcommittee strategic planning, scheduling and coordination, and other activities. The Subcommittee now has a consumer who is helping with committee coordination, particularly recording and distributing minutes. The next subcommittee meeting will be held by conference call on January 21st.

At the last meeting, subcommittee members discussed strategic planning goals. Some of the goals and activities for 2010 include the following:

- Distributing the adolescent treatment framework.
- Hosting the 3rd annual adolescent treatment meeting at the Bureau conference in the fall.
- Disseminating information and resources.
- Identifying gaps in the system and service provision.
- Focusing on opiate addiction and treatment services.
- Increasing outreach to parents and families across the state.

Treatment agencies are noticing an increase in adolescents and young adults using prescription drugs and heroin; Tami has seen adolescents as young as 14-15 years old in treatment for prescription drug and heroin use. Regarding family engagement, Susan Endres received grant funding to host appreciation dinners for families across the state. Families will be invited to come and celebrate their efforts.

The February subcommittee meeting scheduled for February 12th will feature guest speakers and is open to anyone wanting to attend. The meeting will begin with presenters at 10:00 am, including a consumer, Dr. Wright from Rosencrance adolescent AODA treatment facility, and a staff from Connections Counseling, and the afternoon will be spent discussing the presentations. Skye from Connections Counseling will be discussing laws relating to reporting of overdoses. Some prosecutors are using the “Len Bias law” to potentially criminally charge individuals who report people experiencing overdoses if the reporter is aware of or participating in illegal activity. Other states, particularly New Mexico, provide individuals who report overdoses immunity from certain prosecution, also known as the “Good Samaritan law.”

Another recent activity of the subcommittee included Susan partnering with Wisconsin Family Ties to update the adolescent treatment directory, which is now completed. Susan is planning to conduct follow

up calls to get more specific information from the providers about treatment services for adolescents. Committee members suggested the following questions:

1. What services are available for teens with opiate addiction? Do they or are they allowed to use suboxone? Randy Brown at the University of Wisconsin – Madison was suggested as a good resource for additional information.
2. Why have agencies closed? Where are clients being sent? Sally Sybil was recommended as a contact person in LaCrosse. WADTPA members were also mentioned as good resources, such as Tom Fuchs at Libertas.

The Wisconsin Initiative to Promote Healthy Living (WIPHL) conducted a pilot using SBIRT (Screening, Brief Intervention and Referral to Treatment) techniques with adolescents at St. Joseph’s Hospital. The data from the pilot is included below.

- 149 brief screens conducted
- 122 screens were negative.
- 25 screens were positive when the full screen was applied.
- 2 brief screens were positive but clients refused the full screen.
- 14 Clients with positive screens agreed to follow up contacts.

A number of agencies across the state are being trained in Teen Intervene, a provider brief intervention using motivational interviewing.

WiNTiP Update

Mac provided an overview of WiNTiP’s plans for 2010, a summary of activities from 2009, and a summary report from the December 2009 Advisory Group meeting. WiNTiP’s goals in 2010 include continued outreach statewide, expanding training resources, and identifying continued funding. They are working to provide basic materials and “how-to’s” (i.e. cheat sheet) for providers to easily incorporate nicotine addiction treatment into their existing services. WiNTiP will be doing web casts to disseminate information including pharmacology, mental health, and other topics for social workers and other non-AODA certified professionals. The connection to the University of Wisconsin Center for Tobacco Research and Intervention (CTRI) will benefit WiNTiP’s distribution of resources. WiNTiP also plans to continue presentations at meetings and conferences, conduct outreach to gain legislative support, and provide materials online for each access and utilization.

WINTIP is also looking at development of ongoing training for continuing staff and new staff (considering agency turnover). New York State has well-developed resources that are free; staff can take online courses for credit at no charge. Mac stated that tobacco and nicotine are included as accepted topics for addiction continuing education with the Department of Regulation and Licensing.

Mac also provided a summary of results from a survey distributed at the Bureau of Prevention, Treatment and Recovery conference in the fall of 2009. Committee members discussed the results; Mac highlighted the actual prevalence of clients who use nicotine. WiNTiP is getting to the point of having resources to help clients and providers address the high rate of nicotine use among clients. In addition to WiNTiP’s resources, Nicotine Anonymous hosts online meetings; clients can now participate in multiple meetings per week rather than just a couple per month.

Intoxicated Driver Program Subcommittee Update – Andrea Jacobson

Andrea provided an update about the work of the Intoxicated Driver Program (IDP) subcommittee. At the December IDP meeting, a topic for motorized recreational vehicles (MRV) was added to the planning grid. In most counties, the courts don’t want to intervene or accept any information about these cases. The subcommittee thought that this issue should be included in IDP discussions and subsequent

strategies, as it may also impact treatment and intervention for impaired drivers of licensed motorized vehicles.

The subcommittee developed a flow chart of the IDP program for those subcommittee members who are only involved with a part of the system and would appreciate a larger picture of the entire process. Nina Emerson also presented a summary of the legal history at the December meeting.

There was discussion about the financial burden for IDP being transferred more and more to clients. Some counties have seen an increase in the number of clients put into noncompliance, possibly due to financial obligations. Andrea presented data about the number of clients who had their license revoked for non-compliance with the assessment interview; the committee discussed the possible reasons and implications of this data. This information can help the subcommittee examine where to direct interventions for the biggest impact. There is a concern that the revocations due to noncompliance with assessment may increase with WI Act 100, which includes increased surcharge fees and requirement of ignition interlock devices (IIDs) for first offenses with a BAC over 0.15, all second offenses, and blood test refusals.

ITC committee members reviewed the handouts and discussed the IDP process. There was a recommendation to address or include law enforcement issues on the grid. There was discussion about ways to get clients to pay the assessment fee, for example collecting the IDP assessment fees court, provide grants for payment up-front, and others.

Workforce Survey

Last fall, Norm participated in a focus group with the National Addiction Technology Transfer Center (ATTC), which was gathering input about a national workforce survey they plan to conduct in 2011. The focus group discussed which agencies would get surveyed – public, private, state-certified, etc. Focus group participants emphasized the need to develop questions that will be easy to answer so that staff will complete it. He also shared a workforce survey conducted by Connecticut with the assistance of their regional ATTC. ITC members thought that the survey gathered some useful information but were uncertain if it was a representative sample since only 61 surveys were received. While the questions on the Connecticut survey may not be exactly what this committee wants to know for Wisconsin, it will be a good starting point for discussion. This issue will be forwarded to the February ITC meeting agenda.

SCAODA and ITC Strategic Planning

Planning and Funding is organizing the strategic planning process for the next SCAODA four-year plan. The first meeting was held on November 20th and the next meeting is scheduled for Jan. 28th. There will be several facilitated discussions to inform the strategic plan. One of the primary outcome goals discussed at the first meeting is not to be ranked first nationally in negative alcohol-related indicators. Secondary goals include: to provide leadership and coordination for AODA issues in Wisconsin with Governor, Legislature, and other organizations; to change the culture related to AODA issues in Wisconsin; and to provide leadership and action regarding AODA issues including prevention, outreach, treatment, and recovery.

ITC members recommended that input into SCAODA's goals and initiatives be expanded beyond SCAODA to statewide organizations such as WAAODA and WADTPA.

Legislative Update

At the SCAODA meeting in January, the council discussed AB 547, which increases penalties for OWI offenses. ITC objected to 30 day mandatory jail time for a first OWI offense due to the cost of incarceration on the law enforcement system and for individuals. Planning and Funding supported the

legislation because their perspective is that that SCAODA should support any changes to strengthen OWI laws. Three Council members voted to support the legislation and three members voted against support; Mark Seidl voted against supporting the legislation to break the tie.

The committee discussed that SCAODA should not support any legislation just because it has to do with AODA issues; any feedback and votes about legislation should be based upon specific criteria, evidence-based practices, and thorough discussion.

Other items and next meeting planning

Agenda items for the February meeting will include SCAODA strategic planning, brief subcommittee updates, and continued discussion about the workforce survey if time allows.

Next meetings and dates:

1. ITC
February 9, 2010, 10:30 am – 2:30 pm at the Department of Corrections, Madison
2. Children, Youth and Families Treatment Subcommittee
Thursday, January 21, 2010 (teleconference); Friday, February 12th, 10:00 am at Connections Counseling
3. IDP Subcommittee
Friday, January 15, 2010, 9:30 am – 12:00 pm at the Department of Workforce Development; Friday, February 5, 2010, 9:30 am – 12:00 pm at the Department of Workforce Development
4. SCAODA
March 5, 2010, 9:30 am – 3:30 pm at the American Family Insurance Conference Center, Madison. For more information, visit the SCAODA web site at:
<http://www.scaoda.state.wi.us/meetings/index.htm>

INTOXICATED DRIVER PROGRAM SUBCOMMITTEE MEETING MINUTES

Intervention and Treatment Committee

November 6, 2009

9:30 am – 12:00 pm

Department of Workforce Development

201 E. Washington Avenue

1st Floor, Room F105

Madison, WI 53703

DRAFT

Members present:

Linda Preysz, Janet Nodorft, Stephanie White Eagle, Sue Pastor, Nina Emerson, Randy Thiel, Perry Ackeret, Gregg Miller, Andrea Jacobson, Cheri Wotnoske, Deborah Newsome, Kate Johnson - staff

Members participating by phone:

Gena Jarr, Margaret Parsons

Welcome and Introductions

Linda started the meeting at 9:30 am with introduction of the co-chairs Nina Emerson and Andrea Jacobson. Janet Nodorft will be assisting the co-chairs with strategic planning.

Member updates

Subcommittee members introduced themselves, explained their job role and function, and provided updates about IDP activities within their agency. The subcommittee welcomed Susan Pastor from the University of Wisconsin Student Health Services, Gena Jarr from the Department of Corrections, Division of Community Corrections, and Randy Thiel from the Department of Public Instruction, as new members.

Review of Minutes

Members requested corrections to the following names in the minutes: Wotnoske, Jacobson, and White Eagle. Minutes were approved with corrections.

Membership

Members reviewed the Membership list and discussed recommendations for additional members. Perry will contact a Tavern League representative from his local area to see if someone might be interested. It was also recommended and supported to solicit an offender to get a client's perspective of the IDP in Wisconsin. This could be accomplished by having a client join the committee or to gather information from clients to share with the committee. Deb, Andrea, and other members offered to discuss this with clients. Refer to the IDP Subcommittee link on the State Council on Alcohol and Other Drug Abuse (SCAODA) for the membership list.

<http://www.scaoda.state.wi.us/committeetraventionandtreatment/intoxdriver.htm>

Strategic Planning process

Members discussed various aspects of intoxicated driving in Wisconsin and avenues or targets for intervention. A chart was developed that captures the committee's tentative activities and action steps. This chart is included below.

	Education	Prevention	Treatment
Pre-arrest	Think of options <u>prior</u> to drinking and driving. Educate about total costs of an OWI. Make sure <u>all</u> communities have options. Increase perceptions of <u>getting caught</u> .	Include/conduct outreach to DPI/youth/underage in prevention efforts. Promote knowledge of activities that can be done during leisure time other than drinking.	IDP credentials required in WI (don't need to be certified).
1 st offense/conviction	How do we: <ul style="list-style-type: none"> - Equip offenders with tools * identify high risk behaviors (consider age, stressors, marital status, gender, and other factors) - financial/non-financial impact - experience direct from multiple OWI offenders Timeframe arrest to conviction	More options for offenders. Distribute info so offenders know of high risk especially within the community.	Lack of LE and consequences <u>not</u> enforced.
2 nd + offenses/conviction	Gather consumer input. Gather and analyze current research and studies related to multiple OWI offenders. Determine what programs are being utilized and their results. Research practices in other states.	Advocate for legislative and state laws to impact prevention. Impact inconsistent interpretation and enforcement of state laws by judges (advocate for consistency). Advocate for increased enforcement by law enforcement professionals. Identify loopholes in state law, policies, and practices.	Advocate for increased enforcement by law enforcement professionals. Identify underlying issues for multiple offenders (i.e. lack of treatment resources, etc.). In rural areas, may be in treatment for 1 st OWI. Offender knows he/she can get away with multiple offenses.

Next steps

The subcommittee discussed future meeting dates, and Fridays seem to work well for most subcommittee members. Linda will send out an online request for available dates through Doodle.

INTOXICATED DRIVER PROGRAM SUBCOMMITTEE MEETING

Intervention and Treatment Committee

December 17, 2009

9:30 am – 12:00 pm

Department of Workforce Development

201 East Washington Avenue,

4th Floor, Room H403

Madison, WI 53703

MINUTES

Members Present

Nina Emerson, Andrea Jacobson, Margaret Parsons, Gregg Miller, Sandy Hardie, Lynn Pink, Kate Johnson – staff

Members participating by phone

Vana Steffen, Tom Saari, Stephanie White Eagle, Perry Ackert

Welcome/introductions

Andrea and Nina introduced themselves as Co-Chairs of the subcommittee. Members welcomed new member Lynn Pink from the Office of the Commissioner of Insurance.

Review meeting minutes

Minutes from the November 6th meeting were approved without edits or corrections.

Recap of November 24 meeting

In late November, Nina, Andrea, Janet, and Linda met to discuss coordination of the committee. Three issues arose during this discussion including: 1) the processing of intoxicated operation of motorized recreational vehicles cases, 2) creation of a flow chart outlining the Operating While Intoxicated (OWI) assessment and driver's safety plan process, and 3) information gathering about OWI policies and practices in other states.

The primary challenges discussed relating to clients who operate motorized recreational vehicles (MRVs) while intoxicated included their attendance at assessment and attendance and completion of treatment. There are not the same consequences for OWIs with MRVs as there are for OWIs with motor vehicles; the Department of Transportation (DOT) does not get involved or take action with MRV cases because a driver's license is not involved.

Tom Saari from Winnebago County said they have tried to address the issue of compliance with drivers safety plans (DSP) for OWIs with MRV by drafting an agreement with the district attorney to consider enforcement if a client does not attend their assessment or follow through with treatment; however this intervention is not used very often. Other counties reported problems with clients not reporting or following through with recommendation for OWIs with MRVs. Members discussed the multiple aspects of the problem and difficulty in tracking and engaging clients.

Members recommended adding this issue to the grid as another category, considering its relationship to the operation of motorized vehicles. The Wisconsin Department of Natural Resources' web site posts blood alcohol content (BAC) levels of recreational vehicle accidents including snowmobiles, ATVs, boats. Tom recommended that this issue also be forwarded and addressed by the larger Intervention and Treatment Committee (ITC).

Next steps from this discussion include:

1. Nina will conduct research with DNR re: education and implications related to OWI and MRV.
2. Perry will email the counties in his region to find out more about how they proceed with MRV cases.

In addition, at the last meeting a question was raised about data regarding the number of people who don't schedule or attend their assessment for an OWI offense with a motor vehicle. Andrea connected with DOT staff who are in the process of compiling county-specific data from across the state to report the number of clients who never schedule their assessment.

Andrea developed a flow chart so all members have an understanding of the IDP process, can identify gaps in the process, and make recommendations to the existing process. Members made suggestions to the chart, which Andrea captured. Margaret shared the chart with her staff, and they thought it would be helpful for consumers. Gregg also plans to incorporate the chart into the Intoxicated Driver Program – Approved Training (IDP-AT).

The subcommittee co-chairs also thought it would be helpful to contact other states to gain information about their procedures and policies related to OWI offenses. Andrea located a national directory and recommended that, in early 2010, the subcommittee contact other states to gather information. There were a number of suggestions of states that have achieved progress in the past couple of years with OWI issues - Arizona, Minnesota, and Iowa have seen changes to their OWI rates in the past few years. Perry is aware of a web site that has a compilation of states' OWI laws and policies, and Andrea has a listing of state AODA contacts that may be helpful.

Discussion continued about the utilization of electronic monitoring devices. All of the counties participating in this meeting have electronic monitoring available but vary in how they monitor alcohol and drug consumption with electronic monitoring alone and in utilization of the SCRAM (Secure Continuous Remote Alcohol Monitor). Probation and parole agencies order these monitoring devices. It was recommended that the subcommittee become educated about alternatives to incarceration that utilize technology – including aspects of SCRAM, electronic monitoring, IIDs, at-home detection devices, etc.

A suggestion was also made to gather data regarding other procedures related to IDP across the state, including the number of counties that are imposing immediate jail time and the number of counties requiring victim impact panels.

Grid Logic Model for Strategic Planning Process

As mentioned above, a recommendation was made to add a category to the planning grid to include MRVs. This information was incorporated into the plan.

History of IDP including statute/rules

Nina developed the “History of the Intoxicated Driver (IDP)” document and reviewed it with subcommittee members. There was much discussion among members about the history of the Intoxicated Driver Program, laws, and policies. The legislative findings that resulted in the creation of WI Chapter 20, which created the current IDP, were an important part of the research and creation of the IDP legislation. Prior to the development of the IDP program, an offender went to a Driver Improvement Analyst (DOT personnel) for an assessment and this information impacted sentencing. The 1982 law made assessments a requirement and removed its impact or influence on sentencing; the change disconnected the relationship between sentencing, results of assessment, and completion of education or treatment. The changes in 1982 also allowed DOT to connect licensing status to conviction.

Some suggestions were made to the document, including the addition of references to Trans 107 and DHS 75, which also impact the IDP.

One specific aspect of the legislative summary that was highlighted and discussed was the evaluation of OWI programs included at the end of the document. It stated that clients who complete treatment have a much lower recidivism rate but also noted that only about half of OWI clients complete treatment. Capturing the drop-off in OWI client continuation could significantly impact in recidivism. Committee members expressed an interest in looking at how clients are engaged and encouraged to continue in treatment.

Subcommittee members briefly discussed the proposed legislative package of OWI changes. In the proposed legislative package, ignition interlock devices (IIDs) are required for all 2nd offenders and 1st offenders over 0.15 BAC. DOT is responsible for tracking the installation and use of IIDs.

Next steps and meeting dates

The following topics or items were suggested for future meetings:

- Utilizing other states best practices
- Having a first offender speaker

The next IDP Subcommittee meetings will be held on Friday, January 15th and Friday, February 5th from 9:30 am – 12:00 pm.

INTOXICATED DRIVER PROGRAM SUBCOMMITTEE MEETING

Intervention and Treatment Committee

January 15, 2010

9:30 am – 12:00 pm

Madison, WI 53703

MINUTES - DRAFT

Present: Margaret Parsons, Sandy Hardie, Sue Pastor, Lynn Pink, Gregg Miller, Janet Nodorft, Stephanie White Eagle, Deb Newsome, Andrea Jacobson, Nina Emerson, Kate Johnson – staff

Participating by phone: Perry Ackeret, Gena Jarr, Joe Bodo, Diane Wagner, Tom Saari

Welcome/introductions

The meeting was called to order at 9:30 am.

Review meeting minutes

The December meeting minutes were approved with one edit.

Subcommittee updates and continued review of Strategic Planning grid

Andrea introduced and reviewed the “Revocations for Non-Compliance for Assessment Interview” data spreadsheet. This document shows the number of people who were placed into noncompliance due to not scheduling or attending their assessment interview after being convicted of an OWI. Andrea will also get conviction rates from DOT so that the subcommittee can compare and analyze the results. Subcommittee members also suggested gathering the following information in order to get a better understanding of where clients drop off in the OWI process:

1. The number of people in noncompliance for not completing their DSP.
2. The number of people who complete the entire process.
3. The number of clients who are placed in noncompliance between the assessment and completion of the DSP.
4. The percentage of clients who were placed in noncompliance and the reason.

Subcommittee members discussed the variety of reasons for noncompliance and that this data doesn't break out first offenders, multiple offenders, those who may get their assessment in the next year, etc. This information will be examined more in depth at a future meeting. Stephanie clarified that county numbers do include tribal members; tribal members convicted of an OWI must go through the assessment process with the county and then may receive treatment from the tribe or other agency.

There was also some discussion about assessment fees and the establishment of rate amounts. Andrea will break the noncompliance information down by assessment fee to see if noncompliance rates differ by expense of assessment fee. Gregg suggested also including unemployment rates by county since these variables may also affect the amount that counties establish for their assessment rate.

Assessment rates are posted on the Department of Health Services' (DHS) Intoxicated Driver Program web site at: <http://dhs.wisconsin.gov/substabuse/idp> County or provider updates to this listing should be sent to Kate.

Andrea attended the Intervention and Treatment Committee (ITC) meeting on Tuesday, January 12th and shared this data and other subcommittee updates. ITC members were glad to hear that the subcommittee

has included motorized recreational vehicles (MRV) in its scope. IDP issues were also discussed at the full State Council on Alcohol and Other Drug Abuse (SCAODA) meeting on January 8th, and SCAODA members requested an update about the work of the subcommittee at the June meeting. Considering the noncompliance numbers and fees that could be paid by those clients, ITC members suggested that the subcommittee examine different ways to collect surcharge fees through other options – the court, for example.

At the ITC meeting, Linda Preysz, the ITC Chair, shared the SCAODA strategic planning summary from the initial strategic planning meeting held November 20, 2009. She asked IDP to select a couple of goals to present at the March SCAODA meeting. At the February meeting, IDP members will discuss goals for the subcommittee to share with ITC and SCAODA. Please refer to the Qualities and Givens document dated 11-04-09 and the SCAODA Planning Meeting Flip Chart Synthesis dated 12-15-09 for additional information. These documents are in draft form and will be revised as the process continues.

The issue of law enforcement requiring an OWI assessment as a requirement of Huber privileges was raised. Joe Bodo stated that Sawyer County doesn't require assessments as a part of granting Huber privileges. Not all counties require this; Joe explained that the administrator determines whether or not an assessment is required. Perry will ask the Assessors Association in his region to see how many counties out of the 22 agencies in his group require the assessment as a part of Huber privileges.

The subcommittee moved on to review the strategic planning grid. Subcommittee members discussed public campaign and awareness efforts. Diane recommended gathering information about all of the different prevention services (such as Safe Ride and 1-800-taxi-cab) to find out what is being offered across the state. Janet stated that the National Highway Traffic Safety Administration (NHTSA) requires states to run a public campaign. The State Department of Transportation (DOT) has information about Safe Ride, Labor Day OWI enforcement, and other campaign efforts as a part of the NHSTA requirement. She offered to get a complete listing of services connected or related to DOT. Gena suggested that it would be helpful to add columns for the requirements and sanctions for each level of offense to the grid.

Describe the strategic planning process for each category

Janet led the group in a discussion of the education, prevention, and treatment categories of the strategic planning grid. Notes from this discussion are included on the grid.

Diane suggested it might be easier for people on the phone to follow discussion notes if we used a web-based program (such as webinex) or video conferencing. The Subcommittee chairs will look into option for more inclusion and participation for members participating in the meeting remotely.

Review of revised “History of IDP” document

Nina reviewed the revisions she made to the “History of the Intoxicated Driver Program (IDP)” document, which now includes references to Ch. 193, Laws of 1977; DHS 62; and TRANS 106 and 107.

Legislative update

Nina provided a brief overview of WI Act 100, the OWI legislation which is effective July 1, 2010. The main provisions in the bill include:

- The 0.08 - 0.99 loophole was eliminated. Any person arrested with a BAC of 0.08 or higher will be required to participate in an assessment and pay all associated fees and fines.
- Any county may offer a reduced minimum period of imprisonment for the successful completion of a probation period that includes alcohol and other drug treatment. This was previously designated as a pilot program in only Winnebago County.
- If a person is arrested for a first offense OWI with a minor under 16 years old in the car, the offense will be charged as a misdemeanor.
- Ignition Interlock Devices (IIDs) are required for first offenders with a BAC over 0.15, all second offenders, and chemical test refusals.
- A fourth OWI offense within five years will be charged as a felony.

SB 406 related to regulation, licensing, and operation of snowmobiles, including an increase in OWI penalties, will be discussed at the February 5th meeting.

Discussion of next steps for review of data from other states

Time did not allow for discussion of this item.

Planning for February 5th meeting

Suggested agenda items include:

- SB 406
- Motorized Recreational Vehicles (MRV)
- Strategic planning goals for SCAODA process
- Other suggested items included: funding and DACC (Drug Abuse Correctional Center)

Future meeting dates will be solicited using the Doodle scheduling tool; meeting dates will be scheduled into the spring. There was also a request to email the most updated membership list with the next meeting notice.

The meeting adjourned at 12:07 pm.

DOC DATE: 2-8-10

This document dated 2-8-10 attempts to reflect the work of the strategic planning group from their 11-20-09 meeting and the further input at the January 28, 2010 meeting to outline four-year strategic directions for SCAODA. The ultimate intent is to produce a current, concise and focused, high-level strategic directions document that provides priority focus areas for SCAODA and guides direction for the work of the SCAODA working committees.

WISCONSIN STATE COUNCIL OF ALCOHOL AND OTHER DRUG ABUSE (SCAODA) STRATEGIC PLAN: July 2010 – June 2014

PRIMARY OUTCOME GOAL AND MEASURE:

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

SCAODA GOALS:

1. SCAODA with its committees a) effectively fulfill the statutory dictate to provide leadership and direction on AODA issues in Wisconsin b) are 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 collaborative broad-scale leadership and aligned action across multiple sectors to advance progress on SCAODA goals.
2. Wisconsin cultural norms change in that people vehemently reject social acceptance of the AODA status quo and demand and support methods to transform the state's AODA problems into healthy behavioral outcomes.
3. Wisconsin has an educated citizenry regarding the negative fiscal, human and societal impacts of AODA in WI, risk and addiction, prevention, stigma, treatment and recovery, including the disparities and inequities relative to these issues.
4. Wisconsin has 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 ¹

¹ 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

5. SCAODA with its committees provide direction to and attain strong value system leadership from the Governor and Legislature and other 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.

STRATEGIC OBJECTIVES:

1) VIABILITY AND VISIBILITY OF THE COUNCIL

- a) Generate ongoing strong and effective communication and relationship with the Governor including face-to-face meetings at least bi-annually
- b) Regularly produce and / or widely disseminate meaningful and timely information on AODA impacts and critical ongoing or emerging issues through the media and partners to both targeted and broad public audiences.
- c) Prepare recommendations for development of legislation, and advise on pending legislation including the state budget based on information provided by relevant state agencies.
- d) Collaborate with key partners and stakeholders to examine issues and align action toward a common vision and strategic directions

2) EFFECTIVE LAWS AND POLICIES

- a) Attain strong leadership from the Governor and Legislature for the SCAODA goals
 - o Ensure that the Governor and legislature fully understands the EPI study and the serious economic, community, and individual / family consequences if the SCAODA goals are not achieved
- b) Attain strong leadership from the Governor and Legislature and other leaders to realize laws and policies that provide adequate and sustainable capacity and resources for:
 - o effective AODA prevention, outreach, treatment and recovery strategies to all in need across multiple target groups including the disproportionately affected
 - o building sufficient AODA capacity among systems for effective reciprocity and assurance of effective prevention, intervention and services
 - o a diverse AODA workforce that is culturally competent, qualified, and capable
 - o addressing bias in systems, policies and practices that generate inequities toward any group of people.
 - o AODA parity / comprehensive coverage of services
 - o enforcement of existing AODA laws

CAPACITY OBJECTIVE:

3) EFFECTIVE COUNCIL OPERATIONS

- a) Council and committee meetings are conducted effectively and address defined meeting objectives. They provide a forum for fruitful dialogue and action toward achievement of the Council's goals.
- b) Council and committee members value "leadership" and receive orientation / training appropriate to serve effectively in carrying out their role and responsibilities.
- c) Council and committees establish the right structure, plans and activities to best fulfill the strategic directions of the Council.
- d) Council and its committee membership is full, active and provides an appropriate mix of representation
- e) Council and its committees function in alignment with shared strategic direction and effective communication
- f) Council and its committee members advance the directions and work of SCAODA within their own professional fields and networks to expand statewide collaboration, coordination and capacity

STATE COUNCIL ON ALCOHOL & OTHER DRUG ABUSE
Planning and Funding Committee Priorities for SCAODA 2010-2014 Plan

Related to SCAODA Goal #1: To fulfill statutory dictates to provide leadership and direction on AODA issues in Wisconsin.

Planning and Funding Goal I. 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.¹

Objective I.1. Provide SCAODA with recommendations on how the plans, budgets and operations of all state alcohol and other drug abuse programs should be implemented or changed.

Planning and Funding Goal II. When legislation that relates to alcohol and other drug abuse policies, programs or services is introduced or offered in the legislature, SCAODA will...provide considered opinion of the effect and desirability as a matter of public policy of the legislation.

Objective II.1 Review and analyze AODA related bills as they are introduced into the legislature.

Objective II.2 Support legislation that increases a tax on beer and/or alcohol and directs resources to treatment and prevention.

Objective II.3 Support legislation that prevents adults from taking underage children into bars.

Related to SCAODA Goal #4: Wisconsin has adequate sustainable infrastructure, fiscal systems and human resources for effective prevention, treatment and recovery services for all in need.

Planning and Funding Goal III. To protect and encourage funding where there are issues.

Planning and Funding Goal IV. To educate providers and potential providers regarding changes in funding systems and structures.

Objective IV. 1 Participate in the Division of Mental Health and Substance Abuse Services' Infrastructure Study regarding public funding for mental health and substance abuse services.

¹ Hyper link:

[http://nxt.legis.state.wi.us/nxt/gateway.dll?f=xhitlist&xhitlist_x=Advanced&xhitlist_vpc=first&xhitlist_xsl=querylink.xsl&xhitlist_sel=title;path;content-type;home-title&xhitlist_d=%7bstats%7d&xhitlist_q=%5bfield%20folio-destination-name:'20.001\(1\)'%5d&xhitlist_md=target-id=0-0-0-3423](http://nxt.legis.state.wi.us/nxt/gateway.dll?f=xhitlist&xhitlist_x=Advanced&xhitlist_vpc=first&xhitlist_xsl=querylink.xsl&xhitlist_sel=title;path;content-type;home-title&xhitlist_d=%7bstats%7d&xhitlist_q=%5bfield%20folio-destination-name:'20.001(1)'%5d&xhitlist_md=target-id=0-0-0-3423)

Related to SCAODA Goal #5: To create equity within the AODA system by remedying historical, racial/ethnic disparities and inequities toward any group of people.

Planning and Funding Goal V. To resolve that the Council go on record to alleviate racial and ethnic disparities among drug offenders arrest, charging and sentencing rates in Wisconsin.

Planning and Funding Goal VI. Identify pertinent issues.—How does this relate to the overall 2010-2014 Plan?

Strategic Objective 1.b, “Regularly produce and or widely disseminate meaningful and timely information on AODA impacts and critical ongoing or emerging issues through the media and partners to both targeted and broad public audiences. Is that what P & F wants to do?”

Or, under the enabling legislation WI s. 14.24(9) “Publicize the problems associated with the abuse of alcohol and other drugs and the efforts to prevent and control the abuse.”

Other?

Seventeen-year-olds out of adult court—AB 732

Increase in abuse of prescription drugs

Fetal Alcohol Spectrum disorders

Underage Drinking

Adults binge drinking

Trauma Informed Care

Parking Lot: sobriety check points; To develop state alcohol policies that supplant local ordinances.

Strategic Priorities
Prevention/Strategic Prevention Framework State Incentive Grant (SPF SIG) Advisory
Committee
State Council on Alcohol and Other Drug Abuse (SCAODA)

Goal: 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, (By-laws of the State of Wisconsin State Council on Alcohol and Other Drug Abuse, June 6, 2008).

Strategic Priority: Advance best policies and practices.

- Identify key policies and practices.
- Develop a definition/description of a healthy, safe, sober Wisconsin.
- Recommend resources to advance the work and effectiveness of local coalitions.
- Develop and implement a mass social marketing plan using the internet and media partners to disseminate critical data, information, resources, and updates to key audiences.

Strategic Priority: Engage and collaborate with stakeholders at all levels who have an impact or influence on alcohol, tobacco and other drug abuse.

- Use epidemiological data and other valid sources; develop impact data/information sheets and white papers for SCAODA to disseminate to the Governor, legislators, community leaders, etc.
- Strengthen existing and develop new collaborative opportunities.
- Identify existing groups with which we currently collaborate and identify groups with which we want to collaborate.
- Develop and implement collaborative initiatives with identified groups.

Strategic Priority: Develop and strengthen the capacity of the Prevention/SPF SIG Advisory Committee.

- Improve Committee operations and effectiveness.
- Explore and enhance membership and participation of the Committee.
- Provide opportunities to enhance the knowledge and skills of Committee members to educate others.
- Keep apprised of similar initiatives in the State.
- Explore funding opportunities.



WISCONSIN LEGISLATIVE COUNCIL ACT MEMO

2009 Wisconsin Act 100
[2009 Senate Bill 66]

**Operating a Motor Vehicle While
Intoxicated**

2009 Wisconsin Act 100 makes a number of significant changes in the laws relating to operating a motor vehicle while under the influence of an intoxicant (hereafter, “OWI-related offense”). Major changes in Act 100 (with a general effective date of July 1, 2010) include:

- Making a first OWI-related offense a criminal offense if a child younger than 16 years of age is present in the vehicle at the time of the offense.
- Requiring the installation of ignition interlock devices (IIDs) for all repeat drunk drivers and for first offense drunk drivers with an alcohol concentration of 0.15 or more.
- Making a 4th OWI-related offense a felony, instead of a misdemeanor (current law), if that 4th offense occurs within five years of a prior OWI-related offense.
- Establishing minimum terms of imprisonment for 4th offense felony and 5th and subsequent OWI-related offenses.
- Permitting any county, at its option, to develop and use a program (currently permitted in Winnebago County) providing a sentencing option that allows the period of imprisonment of an OWI-related violator to be reduced if the violator successfully completes a period of probation that includes alcohol and drug treatment.
- Funding the various changes in Act 100 through general purpose revenues (GPR), increased criminal court processing fees and reinstatement of license fees, and a new IID surcharge.

The following table, prepared by Don Salm, Senior Staff Attorney, Legislative Council, based on a chart originally prepared by Jon Dyck, Fiscal Analyst, and Jere Bauer, Program

This memo provides a brief description of the Act. For more detailed information, consult the text of the law and related legislative documents at the Legislature’s Web site at: <http://www.legis.state.wi.us/>.

Supervisor, Legislative Fiscal Bureau, dated October 6, 2009, compares the provisions in current law with provisions in 2009 Act 100.

COMPARISON OF PROVISIONS IN CURRENT LAW WITH PROVISIONS IN 2009 WISCONSIN ACT 100

Fines, Jail Terms, and License Sanctions

	<i>Current Law</i>	<i>2009 Wisconsin Act 100</i>
First Offense OWI (with minor passenger)	\$300 to \$600 forfeiture (civil offense—forfeiture is doubled if minor passenger).	\$350 to \$1,100 fine; 5 days to 6 months term of imprisonment (criminal offense).
Third Offense OWI	\$600 to \$2,000 fine; 30 days to 1 year term of imprisonment.	Increases minimum term of imprisonment to 45 days.
Fourth Offense OWI	\$600 to \$2,000 fine; 60 days to 1 year term of imprisonment (misdemeanor offense).	For offenders with a prior offense within previous 5 years: \$600 to \$10,000 fine; 6 months to 6 years term of imprisonment (Class H felony--3 years prison and 3 years of extended supervision). For all other 4 th offense offenders: no change to current law.
OWI causing injury (basic OWI and commercial motor vehicle with BAC of 0.04 to 0.08)	\$300 to \$2,000 fine; 30 days to 1 year term of imprisonment (misdemeanor offense); fines and jail term doubled if there was a minor in the vehicle.	For persons with a prior OWI conviction(s): Up to \$2,000 fine; up to 6 years term of imprisonment (Class H felony); fines and prison term doubled if there was a minor in the vehicle. For other offenders (no prior offense): same as current law.
Absolute sobriety violation	Forfeiture of \$400.	For offenders where there was a minor in the vehicle: fine of \$400 (criminal offense). For other offenders: same as current law.
Revocation time periods		Extends the period of license revocation for an OWI offender by the number of days court sentences offender to jail or prison.
Occupational License Waiting Period	<u>2 OWI-related offenses</u> , a waiting period of 60 days; <u>3 or more OWI-related offenses</u> , 90 days; <u>2 or more OWI-related offenses within 5 years</u> , one year waiting period.	If 2 or more OWI-related offenses, waiting period of 45 days applicable to all.

Probation and General Sentencing Provisions

	<i>Current Law</i>	<i>2009 Wisconsin Act 100</i>
Minimum confinement period for multiple OWI offenders	48-consecutive-hour period (for all criminal OWI offenses).	For 7 th , 8 th , and 9 th offense: 3 years. For 10 th offense: 4 years. All other offenders: no change to current law.

	<i>Current Law</i>	<i>2009 Wisconsin Act 100</i>
Probation for OWI offenders	Probation allowed for 4 th offense OWI, not less than 6 months nor more than 2 years; probation not allowed for 2 nd or 3 rd offense.	Probation allowed for 2 nd and 3 rd offense OWI, in addition to 4 th offense OWI. Maximum probation period for 4 th offense OWI increased to three years.
Pre-sentence release and stay of sentence execution for OWI offenders	Pre-sentence release and stay of execution (up to 60 days) allowed for OWI offenders.	Pre-sentence release and stay of execution prohibited for 3 rd and subsequent offense until after the minimum period of confinement is served. There are exceptions if court finds legal cause to delay the execution of sentence or if court places person on probation.
Alternative sentencing options	In Winnebago County, 2 nd and 3 rd OWI offenders who complete probationary period that includes alcohol and other drug treatment are eligible for alternative sentencing with reduced minimum and maximum terms.	Extends Winnebago sentencing <u>option</u> to any county with a program similar to the Winnebago program. Increases the minimum sentence for a 3 rd offense participant from 10 days to 14 days. Sentencing option available for 4 th OWI offenders, with a minimum sentence of 29 days for participants.
Department of Corrections (DOC): Probation, Supervision, Assessment and Treatment for 2 nd and 3 rd OWI Offenders		Requires the DOC to provide probation supervision, assessment, treatment, and other community treatment options for 2 nd and 3 rd OWI offenders with no waiting list.

Ignition Interlock Device (IID) Provisions

	<i>Current Law</i>	<i>2009 Wisconsin Act 100</i>
General provisions	IID order allowed for 2 nd or subsequent OWI offense and required (unless seizure or immobilization ordered instead) for a 2 nd or subsequent offense committed within 5 years.	IID order mandatory for all repeat OWI offenses and for a first OWI offense with a blood alcohol level of 0.15 and above; seizure and immobilization options eliminated.
Time periods	IID restriction ordered for not less than one year nor more than maximum license revocation period for the offense; time period begins when IID restriction ordered by court.	IID restriction ordered for not less than one year nor more than maximum license revocation period for the offense, except if the maximum revocation period is less than one year, IID restriction is one year. Time period begins when first license is issued instead of when order is issued. Time period for vehicle installation order is eliminated. Court may order vehicle installation of IID immediately upon issuance of the order.
IID surcharge	No provision.	All OWI offenders for which IID ordered must pay a \$50 IID surcharge. Counties retain the \$50 surcharge; surcharge is placed after current law surcharges in priority of collection.

	<i>Current Law</i>	<i>2009 Wisconsin Act 100</i>
Provisions for low income offenders	All offenders liable for the full cost of installation and maintenance of the device.	Offenders with a household income at or below 150% of the poverty line pay 50% of the cost of installation and maintenance. Other offenders, full cost. DOT may not approve IID provider for business in the state if the provider does not agree to allow qualifying individuals to a payment structure equal to 50% of the full installation and maintenance cost for other offenders.
Occupational license provisions related to IIDs	No provision.	No occupational license may be issued to a person subject to an IID order unless the person submits proof that IID surcharge has been paid and that IID has been installed on every vehicle owned or registered in whole or in part by the offender. An exception is provided for a vehicle or vehicles excluded from the IID order by a judge for reasons of financial hardship.
Enforcement and penalty provisions	Forfeiture of \$150 to \$600 for removing, disconnecting, tampering with, or otherwise circumventing the operation of an IID.	Adds failure to install an IID, as ordered, as a violation; imposes criminal fine of \$150 to \$600, 6 months imprisonment, or both for violation; IID order period extended by 6 months for violation.
Prohibited alcohol concentration	0.08 prohibited alcohol concentration, 0.02 for person with three OWI offenses; no special provision for offenders subject to an IID order.	Adds 0.02 prohibited alcohol concentration for persons subject to an IID order.
Huber Law—Proof of Compliance with IID	Huber Law allows person sentenced to county jail or confined in county jail as a sanction while the person is on extended supervision to leave jail for certain purposes (e.g., work, school, community service, treatment or counseling).	Requires OWI offender for whom judge approves Huber Law participation to submit, within 2 weeks of sentencing date, proof of compliance with order to install IID on his or her vehicles. If fail to submit proof, person may not be released under Huber Law.

Other Provisions

	<i>Current Law</i>	<i>2009 Wisconsin Act 100</i>
Surcharges and other sanctions for OWI offenders with a blood alcohol level of between 0.08 and 0.10	Penalty surcharges, including OWI driver improvement surcharge are not levied for first-time OWI convictions if the offender had a blood alcohol concentration of between 0.08 and 0.10; no alcohol assessment required for such offenders.	Eliminates special surcharge and alcohol assessment exemptions for these offenders (the so-called “Loophole”).
Criminal Processing Fee	Upon conviction, criminal offender pays \$20 processing fee to clerk of court. 50% retained by county, 50% to the general fund	Increases processing fee to \$163 . County forwards 93.87% of fees it collects for deposit into general fund and retains 6.13% for use by county.

	<i>Current Law</i>	<i>2009 Wisconsin Act 100</i>
Additional Fee for Reinstatement of License	Person whose license is suspended or revoked must pay \$60 fee to reinstate license once period of suspension or revocation is over.	Requires, in addition to current \$60 reinstatement fee, person revoked for OWI to pay \$140 additional reinstatement fee (total of \$200). Funds from additional fee deposited in the general fund.
Appropriation for state costs		DOT: no provision. <u>Increased Appropriation:</u> District Attorneys, Director of State Courts, DOC, Department of Justice, and Office of State Public Defender: Joint Committee on Finance supplemental appropriation increased by \$8.8 million in 2010-11; DOA required to submit request under s. 13.10 on behalf of the agencies, above, to allocate funding.
DOC Appropriation for Community Probation Supervision and Funding Monitoring Center and Enhanced Treatment		Creates an appropriation for DOC to provide community probation supervision, to staff and fund a monitoring center, and to fund enhanced community treatment for 2 nd and 3 rd OWI offenders. \$6,600,000 are appropriated for this purpose in FY 2010-11. Protects these funds from the lapse requirements under 2007 Wisconsin Act 20 and 2009 Wisconsin Act 2 (as affected by 2009 Wisconsin Act 28).
Initial Applicability		Applies to OWI-related violations or refusals that occur on or after the effective date, but does not preclude counting of other OWI-related convictions, suspensions or revocations as prior convictions, suspensions, or revocations for purposes of administrative action by DOT, sentencing by a court, or revocation or suspension of operating privilege.
General Effective Date		July 1, 2010.

Effective date: The general effective date of 2009 Wisconsin Act 100 is July 1, 2010.

Prepared by: Don Salm, Senior Staff Attorney

January 5, 2010 (Revised
January 8, 2010)

DLS:jal

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

<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.

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, (ad hoc committees, workgroups and task forces) 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. These committees may make recommendations to the council and perform such other duties as designated by the council. These committees may not act on behalf of the council except when given such authority with respect to a specific matter and within specific limitations designated by the full council.
- 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 and vice-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 other officers and subcommittees including ad hoc committees, workgroups or task forces, 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

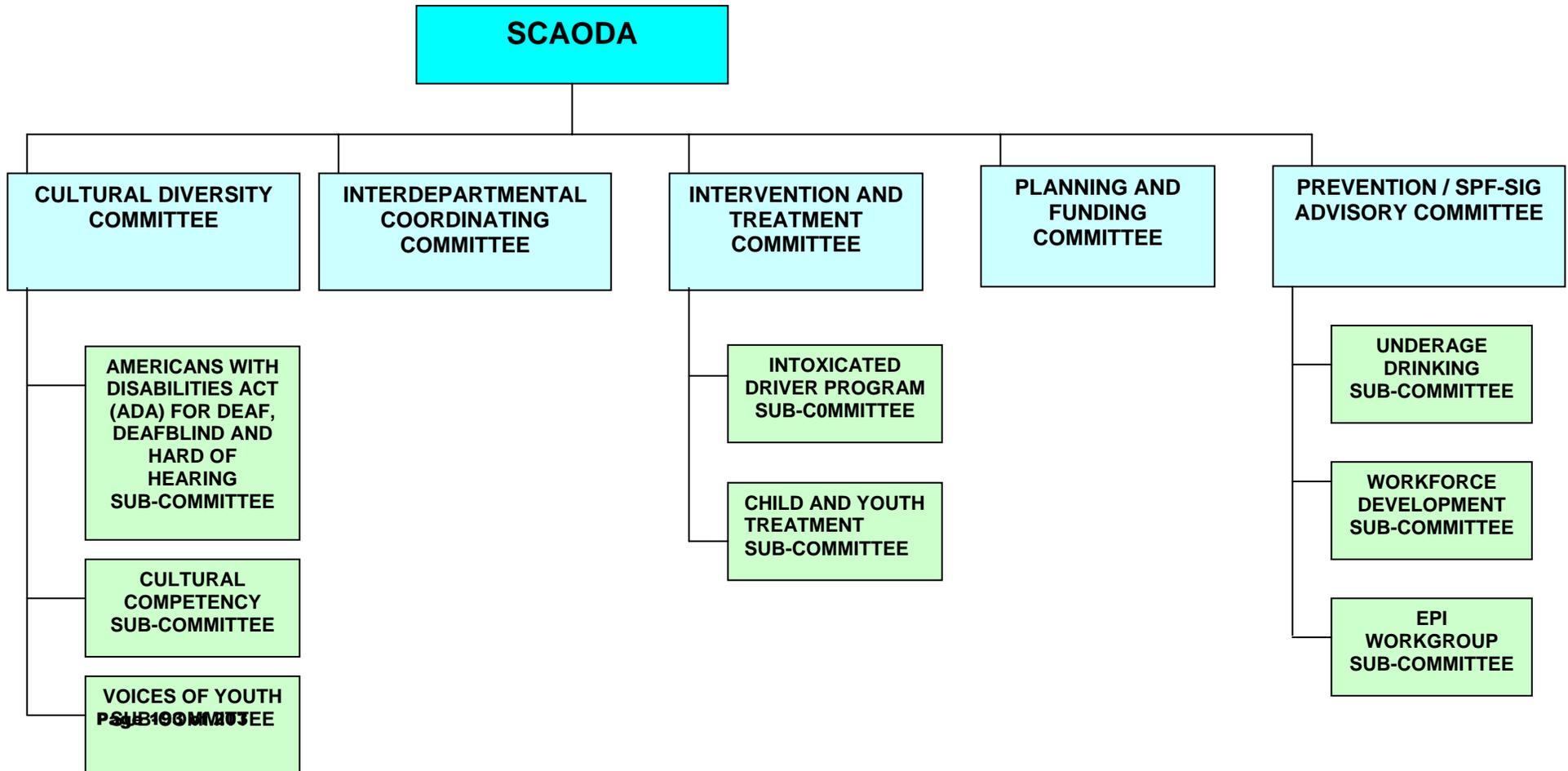
Amendments

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.

SCAODA Organization Chart

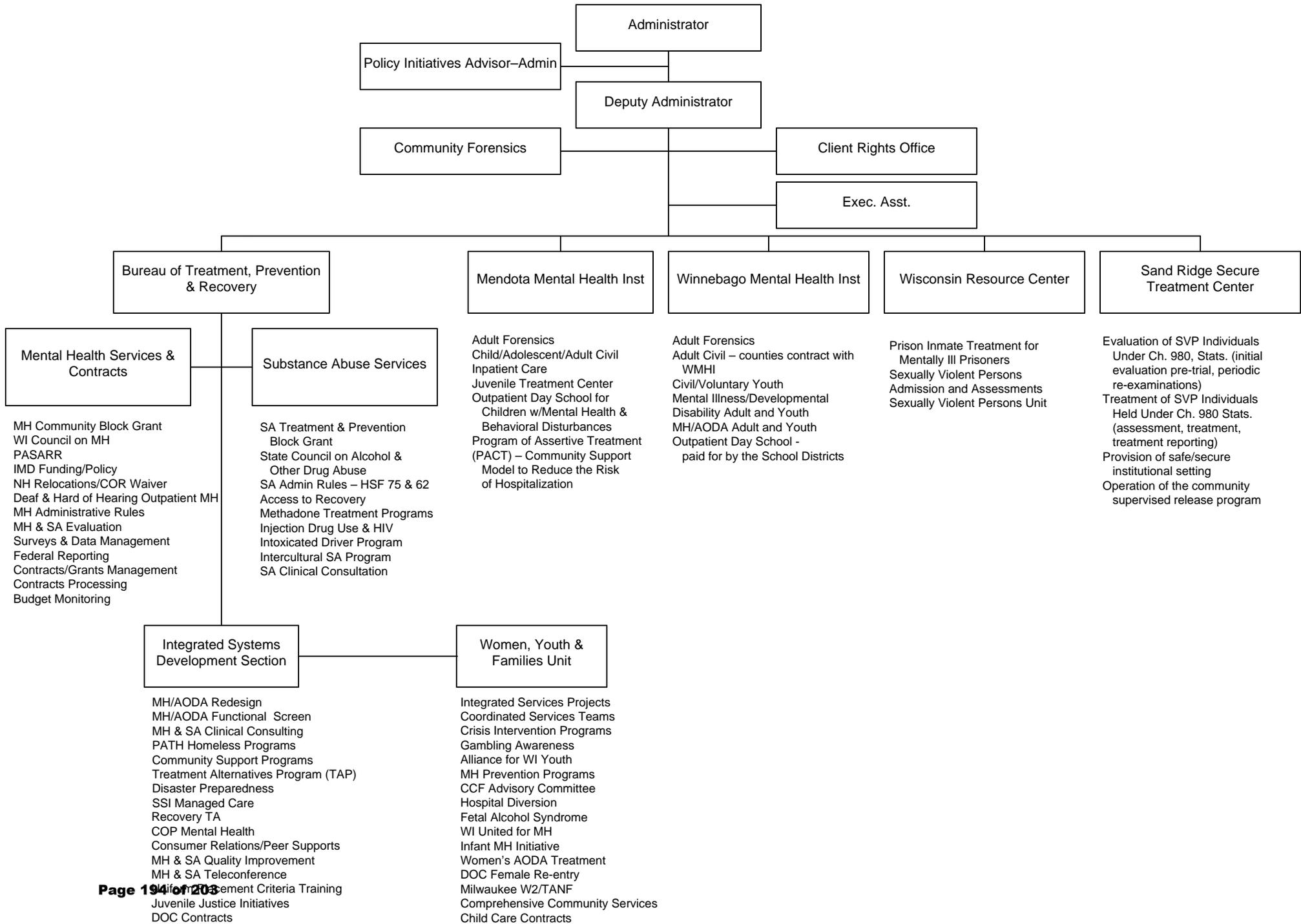
March 4, 2008

1. Cultural Diversity Committee
 - a. Americans with Disabilities Act (ADA) For Deaf, Deafblind and Hard of Hearing Sub-Committee
 - b. Cultural Competency Sub-Committee
 - c. Voices of Youth Sub-Committee
2. Interdepartmental Coordinating Committee
3. Intervention and Treatment Committee
 - a. Intoxicated Driver Program Sub-Committee
 - b. Child and Youth Treatment Sub-Committee
4. Planning and Funding Committee
5. Prevention / SPF-SIG Advisory Committee
 - a. Underage Drinking Sub-Committee
 - b. Workforce Development Sub-Committee
 - c. EPI Workgroup Sub-Committee



Department of Health Services
Division of Mental Health and Substance Abuse Services
Functions

August 2008



**Membership of the State Council on Alcohol and Other Drug Abuse, (SCAODA)
1 W. Wilson St., Room 434 Madison, WI 53702 (608) 266-3977**

STATUTORY MEMBERS *

	Key	Statutory Members	Member	Designee	Term
1		The Governor	Jim Doyle	Coral Butson	NA
2		The Attorney General	J. B. Van Hollen	Michael Myszewski <i>or</i> Gregory Phillips	NA
3		The State Superintendent of Public Instruction	Tony Evers	Gary Sumnicht	NA
4		The Secretary of Health Services	Karen Timberlake	Alternate: John Easterday	NA
5		The Commissioner of Insurance	Sean Dilweg	Eileen Mallow	NA
6		The Secretary of Corrections	Rick Raemisch	Renee Chyba	NA
7		The Secretary of Transportation	Frank Busalacchi	David Collins <i>or</i> Blinda Beason <i>or</i> Janet Nordorft	NA
8		the chairperson of the pharmacy examining board	Dr. Pamela Phillips		NA
9		A representative of the controlled substances board	Douglas Englebert		NA
10		Governor's Law Enforcement and Crime Commission	Rebecca Wigg-Ninham appointed 9-10-09.		A term to expire serving at the pleasure of the Governor.
11	C G	Citizen Member	Duncan Shrout appointed 10-20-08.		Term to expire July 1, 2011.
12	C G	Citizen Member	Sandy Hardie appointed 5-7-04 re-appointed 9-4-09.		Term to expire July 1, 2011.
13	C G	Citizen Member	Mary Rasmussen appointed 9-16-05; re-appointed 9-4-09.		Term to expire July 1, 2013.
14	C G	Citizen Member	Scott Stokes appointed 7-28-05; re-appointed 9-4-09		Term to expire July 1, 2013
15	C G	Citizen Member	Joyce O'Donnell appointed 6-13-94; re-appointed 9-4-09.		Term to expire July 1, 2013.
16	C G	Citizen Member	Linda Mayfield appointed 6-3-04; re-appointed 9-4-09		Term to expire July 1, 2011.
17	P	Provider of services	Michael Waupoose appointed 5-5-04		A term to expire serving at the pleasure of the Governor.
18		A member of the Wisconsin county human service association, inc.	Mark Seidl		Appointment determined by WCHSA

	Key	Statutory Members	Member	Designee	Term
19	R m	State Representative Minority Party	John Townsend	Minette Lawrence	Chosen as are members of standing committees in their respective houses.
20	D M	State Representative Majority Party	Vacant		Chosen as are members of standing committees in their respective houses.
21	R m	State Senator Minority Party	Vacant		Chosen as are members of standing committees in their respective houses.
22	D M	State Senator Majority Party	Vacant		Chosen as are members of standing committees in their respective houses.

M = Majority Party
m = Minority Party
R = Republican
D = Democrat
C = Citizen Member
P = Provider
G = Serves at the Pleasure of the Governor

Statutory Members are either appointed by the Governor, or in the case of legislative members, appointed by their respective leaders. Statutory members vote, and serve voluntarily as advisors to the Governor.

EX OFFICIO MEMBERS * (Non-Voting Members)

	Ex Officio Members	Member	Designee
1	University of Wisconsin System	Matt Vogel	
2	Secretary, Department Of Revenue	Roger Ervin	Roger Johnson
3	Secretary, Department Of Workforce Development	Roberta Gassman	Linda Preysz
4	Secretary, Department Of Regulation And Licensing	Celia Jackson	
5	Wisconsin Technical College System	Thomas Heffron	
6	Department Of Veterans Affairs	Larry Kleinsteiber	
7	Office Of Justice Assistance	David Steingraber	Ray Luick
8	Liaison to the Mental Health Council	Vacant	
9	Liaison to the Developmental Disabilities Council	Vacant	
10	Division of Public Health	Randall Glysch	

* Ex Officio members, not appointed by the Governor, are non-voting, and voluntarily serve the State Council.

The State Council consists of 22 statutory members and ten Ex Officio members and has five standing committees:

1. Cultural Diversity Committee
2. Interdepartmental Coordinating Committee
3. Intervention and Treatment Committee
4. Planning and Funding Committee
5. Prevention / SPF-SIG Advisory Committee

Updated: June 15, 2009

SCAODA Staff

Updated November 3rd, 2008

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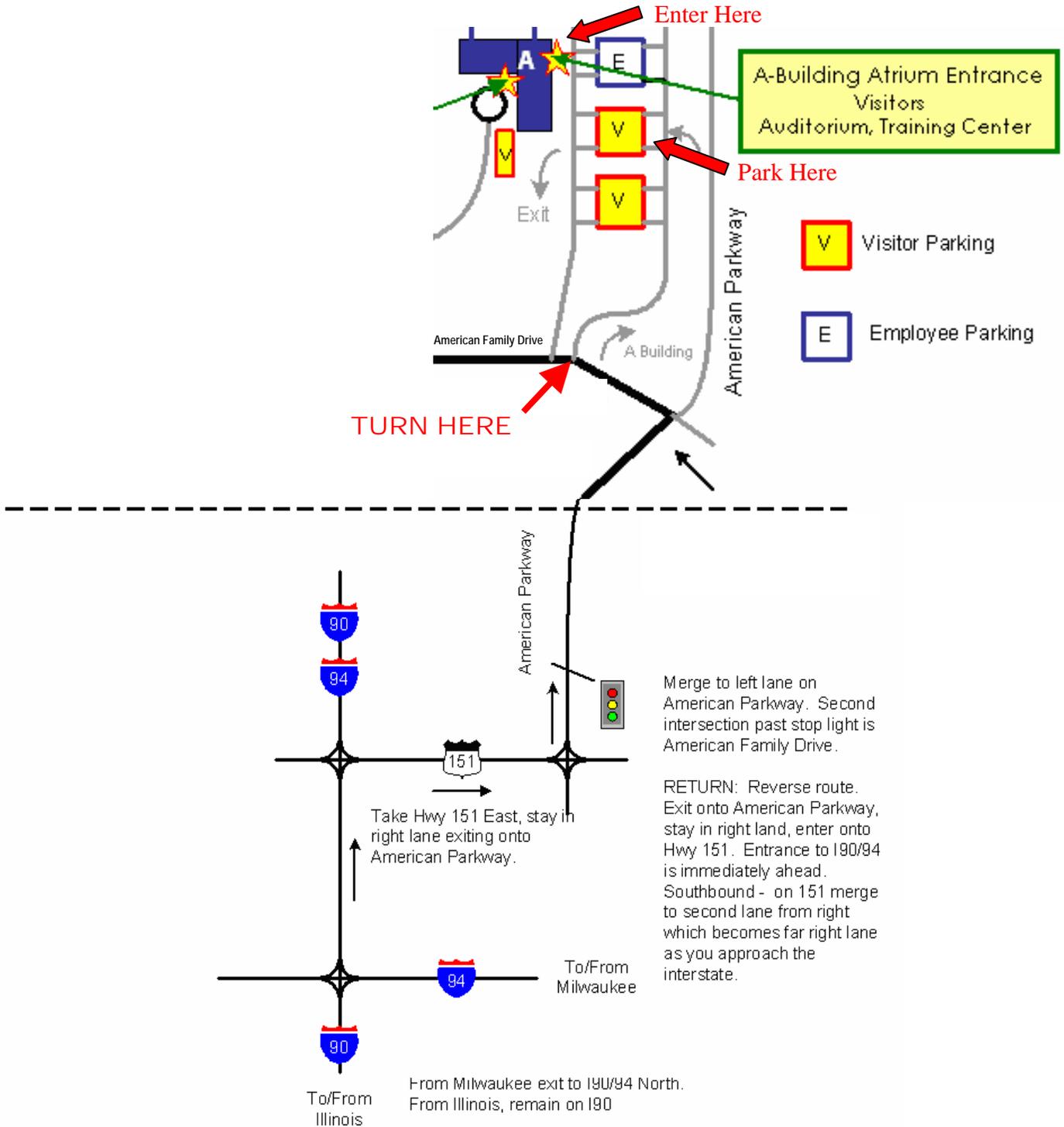
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