

LOUISIANA JUDGES & LAWYERS ASSISTANCE PROGRAM

PERFORMANCE AUDIT

**July 22-October 26, 2015
New Orleans, LA**

By

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INTRODUCTION

The Louisiana State Bar Association's Committee on Alcohol and Drug Abuse was first established in 1985 to provide confidential assistance to members of the Bar and their families who were experiencing problems with alcohol or drug abuse. In 1992, the Louisiana State Bar Association (LSBA) formed the Lawyers Assistance Program, Inc. (LAP) an LSBA-owned 501(c) (3) non-profit corporation designed to provide confidential, life-saving assistance to the profession and its family members.

The Board of Directors of the current Louisiana JLAP commissioned an independent performance audit of its Program to review and evaluate its current organizational structure and function. Program effectiveness, management, and utilization were assessed along with relapses, legal considerations, personnel issues, and public relations activities. A major area of inquiry was the program's sensitivity to confidentiality and public safety concerns. Fiscal responsibility and cost effectiveness was not addressed.

Like any first audit of any enterprise, especially one that has been in existence for 23 years, some areas needing attention are likely to be uncovered, and that indeed was the case herein. The auditors have attempted to present a road map that can be used to address areas that have not been previously examined, updated, or which require new impetus as part of the developmental process for the JLAP. These recommendations should not imply that not having addressed these issues previously constitutes error or neglect. This analysis may be simply the next step in the JLAP's evolution.

During an audit it is necessary to draw conclusions and make inferences based on incomplete information. The conclusions and recommendations in this report should be closely scrutinized by all parties before any action is taken. Furthermore they should be challenged by those whose experience, judgment, and proximity to the issue suggest otherwise.

DISCLAIMER: Nothing in this report is to be construed as constituting legal advice. Furthermore, inclusion of material from any of the auditors' former programs does not imply nor confer anything beyond illustrating some methods, among many, adopted by those programs. Inclusion of such forms in this audit implies no endorsement by those programs nor do they incur any obligation whatsoever.

Addressing the earmarked issues will take considerable time. Our recommendations have been separated into immediate, intermediate, and

later attention categories. Please understand that despite these issues, it is crystal clear that the JLAP has been responsibly and professionally managed for many years. The Executive Director has been diligent and skillful in performing his monitoring and recovery management functions. He has great passion and a firm commitment to facilitating the rehabilitation of its participants while discharging his responsibility to assist the Louisiana State Bar Association and the Supreme Court in protecting the public.

ABOUT THE AUDITORS

Hon. Sarah L. Krauss (ret.)

A NYC Judge who is the immediate Past Chair of the ABA Commission on Lawyers Assistance Programs, and is presently an Advisory Committee member to CoLAP and Chair of the CoLAP Judicial Assistance Initiative (JAI). She has participated in the evaluation of the SD, TX, and NJ LAPs.

Tish Vincent, MSW, JD

A Program Administrator of the Michigan Lawyers and Judges Assistance Program who has extensive experience working in an adult Psychiatry unit, an in-patient Addiction unit, in a Behavioral Medicine managed care company, and as a treating therapist for Physicians and Lawyers in Michigan's PHP and LAP. In addition, she is a trained Mediator and Lawyer in Health Law and Dispute Resolution.

Martha E. Brown, MD

An Addiction Psychiatrist and former Medical Director of the LA Physicians Health Program who is currently the Associate Medical Director of Florida's PHP. She is an Associate Professor in the Department of Psychiatry at the University of Florida College of Medicine.

Lynn Hankes, MD, FASAM

An Addiction Medicine Specialist who is the former Director of the Washington Physicians Health Program and a Past President of the Federation of State PHPs. He has been involved in 8 Physician Health Program performance audits in the past several years.

METHOD

The JLAP Executive Director provided multiple program documents for the Auditors' advance review. Such documents included but were not limited to:

- Articles and Bylaws
- Policies and Procedures
- 2013 Annual Report
- Department of Justice Settlement
- Sample Contracts
- Relapse Data
- Urine Drug Screening Policy
- Judicial Assistance Committee Report
- Affinity System Information
- ASAM Criteria
- Staff CVs
- Board of Directors Roster
- Evaluation and Treatment Standards

The on-site component of the audit was conducted in New Orleans, LA on July 22-24, 2015. The Auditors were bound in confidentiality by contract.

The Audit Team inspected the Mandeville office and met with the Clinical and Administrative Staff. The JLAP demographic data base was demonstrated. Additional documents and program forms were provided for our perusal.

Over 3 days, the auditors interviewed most of the following individuals in person:

- Chair, JLAP Operations Committee
- Deputy General Counsel- Louisiana Supreme Court
- Member of the LSBA Board of Governors
- Members of the JLAP Audit Sub-Committee
- Director of the Office of Disciplinary Counsel
- 4 Defense Bar JDs representing disgruntled JLAP clients
- President, Louisiana State Bar Association
- Executive Director, LA State Bar Association
- 2 current JLAP Clients without any complaints
- 1 current JLAP Client with many complaints
- Immediate Past President of the LSBA
- Character & Fitness Attorney-Louisiana Supreme Court Committee on Bar Admissions
- Chair of the Committee on Bar Admissions

- JLAP Client with complaints (by phone)
- Supreme Court Justice (by phone)

In addition, the Audit Team:

- Called 6 Addiction Treatment Centers used by JLAP
- Called 1 Center that does evaluations only
- Called 6 local Psychologist Evaluators
- Called Affinity Medical Review Officer
- Anonymously surveyed 10% of current clients
- Surveyed States with Conditional Bar Admissions
- Reviewed a letter from JLAP's Intervention Trainers
- Called the JLAP Staff multiple times after leaving New Orleans
- Conducted a conference call with LSC and COBA Attorneys
- Analyzed the LSC Rules relating to the JLAP

Lastly, the Audit Team conducted 9 conference calls to formulate this report courtesy of the Michigan Lawyers and Judges Assistance Program which provided the conference line gratis.

All those interviewed were most cooperative, responsive to all inquiries and provided additional info thereby adding to the thoroughness of the review. The JLAP Executive Director and his staff were consistently open to auditor perspectives, feedback, and suggestions.

This assessment is based upon information available to the auditors at this time, and assumes that accounts and data supplied were reliable. Subsequent disclosure of additional information could require reformulation and possibly revised findings and/or recommendations.

PROGRAM EFFECTIVENESS *

Total Number of Cases Monitored=209 (January 1, 2010 to present)

- Successful Completion: Almost without exception every client who signed a 5 year Chemical Dependency monitoring contract completed it
- Suicides: 0 while being monitored
- Suicides: 1 who left monitoring against advice
- Other Deaths: 0
- Currently being monitored: 101
- Penetration:

The generally accepted prevalence of chemical dependency in medical professionals is about 18 %. We are not aware of any data showing a significant difference in the legal profession. This is a lifetime prevalence, which, when divided by a 30-year practice span, yields a point-in-time prevalence of 0.6 %. National experience derived from the Federation of State Physician Health Programs is that effective Programs usually generate a 0.4 to 1.0 % penetration.

Total # of LSBA members: 22,000. Therefore, the LA LAPs's point-in-time penetrance is 0.46 %.

For comparison, here is a recent survey of 5 State PHPs:

- WA monitors 225 out of a base of 19,000 = 1.2%
- MS monitors 95 out of a base of 8,500 = 1.1%
- TN monitors 185 out of a base of 22,000 = 0.8%
- NY monitors 500 out of a base of 87,000 = 0.6%
- NC monitors 275 out of a base of 31,000 = 0.9%

*Efficiency is doing things right. Effectiveness is doing the right things!

RELAPSE ANALYSIS

Between 2010 and 2015, about 209 clients were monitored. There were 21 relapses in those 5+ years; therefore, the cumulative relapse rate is 10 %.
All 21 were reported to the ODC.

2010	0
2011	4
2012	3
2013	0
2014	11 *
2015	<u>3</u> to date
	21 total

* The marked increase in 2014 was likely due to new testing with EtG (Ethyl Glucuronate) which provided a wider window of detection.

Contract Year when detected

Year 1	7
Year 2	6
Year 3	3
Year 4	1
Year 5	<u>4</u> **
	21

**The uptick in year 5 has also been the experience of Physician Health Programs, hence their practice of increasing testing frequency in year 5.

By chemical

Alcohol	17
Drugs	3
Both	<u>1</u>
	21

How detected

0	Peer monitor
0	Case Managers
0	Report from law practice
0	From DUI
0	From the court
21	By Urine Drug Test

By type of law practice

This was not tracked.

Disposition of relapsers

21 All were referred for re-assessment; 10 refused the re-assessment (They are on the “left **Against Medical Advice** list”)

11 Completed the re-assessment

- 2 recommended for 30 day residential treatment
- 6 recommended for 45 day residential treatment
- 3 recommended for 90 day residential treatment (These 3 had never had any prior treatment)

The **LA JLAP** cumulative relapse rate is **10 %**. To compare this rate with the following national studies, a statistical extrapolation is required given that the Louisiana figure is for 5+ years compared to 11 and 7.2 years for the larger studies.

26% Washington Physicians Health Program (**WPHP**) study of 292 consecutive health care professionals followed for 11 years¹

22% Blueprint study of 904 physicians in **16 PHPs** followed for an average of 7.2 years²

The JLAP relapse rate of 10% is unrealistically low. We speculate that if more frequent urine drug tests were done, the rate would be higher, and very likely be similar to that in the above long term physician studies. However, the relapse rates in professionals are at least 50 to 75% lower than in the general non-professional population.

Also, this rate may be skewed to the low side because some individuals with already established recovery will have fewer relapses than those who are just entering treatment or who are brand new in recovery. It will be interesting to track any rate changes that might occur as a result of the new NCBE application questions.

1. Domino, K, Hornbein, T, Hanks, L, et al. Risk Factors For Relapse In Health Care Professionals With Substance Use Disorders. *JAMA*. 2005, 293: 1453-60

2. McLellan, AT, Skipper, GE, Campbell, M, DuPont, RI. Five Year Outcomes in a Cohort Study of Physicians Treated For Substance Use Disorders In The United States. *BMJ*. 2008: 2038

PROGRAM UTILIZATION

Statistics

No program statistics were kept prior to 2010. In the 5 year span between 2010 and 2015, the total cumulative yearly averages are as follows:

- Active new contacts 836*
- Evaluations 400
- New referrals per year 94
- Interventions since 2014 12

*Note: The JLAP filters a large number of calls for assistance with problems other than addiction or mental illness, such as marital discord, financial difficulties, stress, burnout, and compassion fatigue. Every presentation or *BAR Journal* article generates a new volley of these types of calls requesting information or assistance for relatives, friends and co-workers with these issues.

Number in monitoring:

- 2011 115 }
- 2012 120 }yearly average 114
- 2013 107 }

Currently monitored-by type of contract

- 44% from COBA
- 41% from ODC
- 15% are Voluntary

Currently monitored-by problem

- 95% Chemical abuse/dependency
- 5% Psychiatric illness only

Referrals by type

- 25% Mandated (COBA or ODC)
- 75% Voluntary

Conversion rate of voluntary referrals

- 80 % Get an evaluation
- 66 % Go to treatment

Referral sources

- COBA
- ODC
- Law Firm
- Attorney
- Colleague
- Spouse
- Family
- Friend
- Physician
- Therapist
- JLAP Client
- SOLACE Program
- Self

CAUTION:

There are two types of LAPs (**See section on: *Lawyer Assistance Program Comparisons***). When comparing one LAP to another, one must first determine whether the LAP in question is an LCL model or a BB model. A LAP of one model must be compared to another LAP that operates on the same model. The Michigan LAP (BB) cannot be compared to the Oregon LAP (LCL). Michigan can be compared to Florida. Oregon can be compared to Pennsylvania. In the body of complaints presented to the audit team the Louisiana JLAP (BB) was compared to Texas (LCL). The legal professional who compared the two is critical of the Louisiana LAP. This is an unfair comparison.

EVALUATION & TREATMENT

- The JLAP clinical staff handles referrals by phone. The Staff may recommend an office evaluation by a local Psychologist or an in-depth 3 day evaluation at a facility. The Staff's decision is based on its clinical judgement of the current presenting problem and its complexity.
- If a 3 day in-depth evaluation is recommended, the potential participants are given the choice of at least 3 centers at which to obtain this evaluation. Those who disagree with the initial evaluation are offered the **option** of obtaining a **second opinion** at another JLAP-approved site. Less than 1 % of these individuals in the last 5 years have requested a second opinion.
- If the evaluation results in a Chemical Dependency diagnosis and treatment is recommended, they have the **option** of obtaining that treatment at an **alternate** JLAP-approved site. About 10 % of these individuals requested and were granted this option. They all sign a form acknowledging they have options for treatment locations prior to the evaluation process beginning. If they elect to remain at the evaluating center for treatment also, usually the cost of the evaluation is applied toward treatment costs.
- Of all evaluations recommended by the JLAP:
 - 80 % are done by local Psychiatrists and Psychologists
 - 20 % are done as an inpatient at treatment centers over 3 days
- Similarly if it is clear that an evaluation is not necessary and treatment is medically indicated, and the individual concurs, he or she is given the choice of centers at which to obtain such treatment.
- The Executive Director is very knowledgeable about evaluation and treatment resources throughout the entire country. He and his Clinical Director have made on-site inspections of each facility to which they makes referrals, and a visit to The Pavillon in NC is scheduled soon. Re-inspections will be conducted every 2 to 3 years because of frequent personnel shifts or ownership changes.
- The JLAP currently uses six residential Treatment Centers. The Audit Team has a list of these centers, most of which are approved also by Physician Health Programs. Eighty-five percent of JLAP participants cluster around two of these centers. This clustering

does not necessarily imply preferential consideration, but rather it is because of their geographic proximity.

- Doctorate level professionals, including Physicians and Lawyers, have special issues, and there are only a limited number of centers possessing the requisite therapeutic expertise to effectively deal with these needs.
- The Louisiana JLAP utilizes treatment centers* with certain critical components, including, but not limited to:
 - A full-time Physician-Medical Director who is:
 - An ASAM-Certified Addiction Medicine doctor, or a
 - Psychiatrist with Added Qualifications in Addiction Psychiatry, or a
 - Psychiatrist with Addiction expertise and has experience in physician-health
 - Credentialed &/or certified Counselors, some of whom are in substantial recovery themselves and who are unlikely to be intimidated by argumentative Lawyers
 - Acceptance of addiction as a primary disease
 - Insistence on total abstinence
 - Separation of alcoholic/addict patients from primary psychiatric patients
 - Psychiatry & Psychology Consultants
 - Internal Medicine Consultants
 - A strong family component
 - 12-Step orientation
 - A cohort-specific treatment track tailored to professionals in safety-sensitive occupations (See American Society of Addiction Medicine Treatment Criteria)

*All treatment centers are not equal. Some have enhanced capabilities in certain areas. The clinical team must match the participant to the appropriate facility for evaluation or treatment. This decision is based on sound clinical judgment after considering gender, age, sexual orientation, drug of choice, psychiatric co-morbidity, physical condition, family-of-origin issues, legal entanglements, and a host of other factors.

FINANCIALS

Review of the budget and financial statements is not within the purview of this performance audit; however, we note that:

- LAP's 5 year fees for monitoring and toxicology testing per participant are approximately:
 - \$ 3, 000 PHP fees
 - 5,250 Lab fees
 - \$8,250 TOTAL =\$1,650/year=\$137.50/month**

Compared to industry standards these fees are very reasonable.

- The current 07/01/15 to 06/30/16 fiscal budget is:
 - \$ 635,000 expenses
 - -500,000 revenue
 - \$ 135,000 deficit (revenue over expenses)

Apparently, this **deficit** is to be covered by tapping the previously accumulated prudent reserve fund.

- Funding sources include:
 - \$ 250,000 LSBA
 - 60,000 Supreme Court
 - 120,000 Tobacco settlement
 - 8,000 Donations
 - 2,000 Miscellaneous
 - 60,000 Monitoring fees
 - \$ 500,000

A financial audit is conducted yearly by Postlewaite & Netterville. The last audit contained some items requiring remedy and these have been implemented. They will be scrutinized in this year's examination which is in process at this writing.

PROGRAM MANAGEMENT

The Staff:

- Executive Director: Joseph E. “Buddy” Stockwell, III is a former Litigation Attorney and has been the full-time Director of the LA JLAP since October 1, 2010. His former law practice ultimately focused on Family Law where he worked closely with mental health professionals in difficult custody disputes. He is a member of the LSBA as well as its Committee on Alcohol and Drug Abuse. He has completed many credit hours of instruction in Addiction Studies and is a Certified Clinical Interventionist.
- Clinical Director: Leah Rosa has a Masters of Health Science (MHS) degree in Rehabilitation Counseling and is Board Certified through the American Psychotherapy Association, by the Commission on Rehabilitation Counseling, and by the National Board (NCC). She is a Louisiana Licensed Professional Counselor (LPC). She began her career working with NAMI (National Alliance for the Mentally Ill) and subsequently in several adolescent and adult out-patient and residential programs.
- Clinical Case Manager: Jennifer Gros has a Masters in Science (MS) degree in Rehabilitation Counseling and is a Louisiana Licensed Professional Counselor (LPC). She has experience working with both mentally ill and chemically dependent clients. In 2012 she received the Excellence in Treatment Award given by the Greater New Orleans Council on Alcohol and Drug Abuse.
- Clinical Case Manager: Jessica Duplantis also has a Masters of Health Science (MHS) degree in Rehabilitation Counseling as well as being certified nationally (CRC). Her experience is in both Chemical Dependency and Psychiatric rehabilitation in both out-patient and residential settings.
- Administrative Assistant: Angela Mortillaro is a recent addition to the Staff. She will manage business aspects of the office and serve as the receptionist as well.
- Certified Public Accountant: Kathy Hebert, CPA, has been hired as a part time Consultant to insure that all financial transactions have essential checks and balances. She is training the Administrative Assistant to assume these duties.

- The Staff appears firmly focused and displays professional demeanor. They interface well and harmony dominates the atmosphere. This operation is clearly a team effort. They are all content with the LSBA saving and benefit package.
- Program management has been very effective to date, however, current staffing levels will likely be stretched as higher enrollment occurs and more services are being demanded as the JLAP continues to evolve (**See section on: *Emerging Trends***).

The Affinity Data Base: This was not yet installed at the time of our office visit. However, the Physician Audit Team members are familiar with it. A full base includes:

- Alerts: missed monitoring, task reminders, missing reports, positive UDSs, missed assignments, etc.
 - Messages: to and from participants
 - Members: name, stage, etc.
 - Categories:
 - Intake
 - Intervention
 - Pending
 - Evaluation
 - In treatment
 - Standard monitoring
 - Senior monitoring
 - Discharged
 - Compliance-all tracking
 - Administrative-demographics, etc.
- The Staff has assembled its own double Excel sheet data collection system which will be merged with a partial Affinity Data Base to form a clinical case management data base.

Security:

- All computers are password protected and the Executive Director has all the passwords. All active files are now electronically stored. There is one locked file cabinet with old paper files soon to be transferred. Outer doors are locked nightly and there is no cleaning personnel with office access.

The Board of Directors:

- Is composed of 7 members, 4 of whom are nominated by the LSBA President, consisting of 3 nominees from the LSBA Leadership and 1 nominee from state and federal judges; and 3 of whom are nominated by the JLAP Operations Committee from lawyers with experience in substance abuse, mental health or gambling addiction, and all of whom shall be elected by the LSBA Board of Governors. The Board was initially staggered into 1, 2 and 3 year terms and thereafter elections are for 3 year terms. The Executive Director is a non-voting advisory member of the Board. Except for the judges, all members are practicing attorneys.

The Operations Committee:

- Is composed of 9 members, 3 of whom are state or federal judges, 1 of whom is nominated by of the Louisiana District Judges Association, 1 by the Louisiana City Judges Association, and 1 by the Louisiana Conference of Court of Appeals Judges; and 5 of whom are members of the LSBA Committee on Alcohol and Drug Abuse, nominated by the existing Operations Committee members, and all of whom are appointed by the JLAP Board. These Operations Committee members were initially staggered into 1, 2 and 3 year terms, and thereafter appointments are for 3 year terms. The JLAP Board shall appoint the Executive Director as the 9th member of the Operations Committee.

PUBLIC SAFETY

- From 2010 to 2015, 209 Lawyers were placed under a monitoring contract with the JLAP
- All of the above either have completed or are still under contract and in compliance with it
- Currently being monitored:
 - 44 % from COBA
 - 41 % from ODC
 - 15 % are Voluntary
- Voluntary clients are protected by La. R.S. 37:221, and absent a specific waiver of this confidentiality, the JLAP is prohibited from communicating with any external party
- Mandated clients referred by COBA or ODC by contract must waive confidentiality, and therefore the JLAP can report them under any of the following situations:
 - Relapse
 - Substantial contract non-compliance
 - Imminent danger to self or others
- All 21 relapses have been reported to ODC
- All relapses thus far have been detected by Urine Drug Screens. The average time from detecting a positive urine to reporting is about 2 business days and about 1 week for a PEth (blood) test.
- The JLAP Executive Director states unequivocally that **he is not aware of even a single instance of a client being harmed** by a JLAP participant while that Attorney is under a monitoring contract.

PUBLIC RELATIONS

- The JLAP submits an annual written report to the Louisiana State Bar Association Committee on Alcohol and Drug Abuse. The last one was at the end of 2013.
- The JLAP Executive Director is available for consultation with COBA, ODC, LSBA, CADA, and the Supreme Court when needed. JLAP provides expert testimony to the Louisiana Disciplinary Board (LDB) for the Supreme Court's consideration in disciplinary matters.
- JLAP's advocacy for its participants is *conditional*, that is, it is *contingent* upon contract compliance and stable recovery.
- JLAP's *Brochure* is widely disseminated and highlights:
 - The Disease Concept of Addiction
 - Symptoms and progression
 - A 10 question self-test
 - Confidentiality
- The JLAP Executive Director made 38 presentations in 2013 and 22 in 2014.
 - LSBA Board of Governors, Summer Schools, Ethics School, Free CLE Seminars, Disability Panel
 - Various Bar Associations
 - Law Schools
 - AFCCLA Seminars
 - A whole host of others
- Each year JLAP receives direct referrals from the SOLACE program through which the LSBA Foundations Community Action Committee reaches out in meaningful ways to the legal community. The Honorable Jay C. Zainey is a strong supporter of both the JLAP and its Executive Director. He has written a *BAR Journal* article describing his working relationship with JLAP.
- The JLAP Executive Director stays abreast of latest developments in the field. He and his Clinical Director have attended the following conferences:
 - Baton Rouge-American Psychiatric Association Seminar on its new Diagnostic and Statistical Manual of Mental Health Disorders, Fifth edition (DSM-5) wherein they learned of the new nomenclature for chemical dependency

- San Diego and Nashville-ABA National Conference on Lawyers Assistance Programs
 - Ft. Worth-Federation of State Physician Health Programs (FSPHP) annual meeting (2 JLAP Clinicians)
 - FL PRN Evaluator Training on Amelia Island, FL
- The JLAP Director is available for presentations on:
 - Alcoholism
 - Drug Addiction
 - Mental Illness
 - Intervention
 - JLAP IQ
 - Stress
 - Burnout
 - Compassion Fatigue
 - Other topics can be developed upon request

LEGAL

- The JLAP has never had a lawsuit filed against it
- When COBA or ODC refers a Lawyer to JLAP that individual must sign a consent allowing JLAP to communicate with the referring source. If COBA or ODC makes a post-referral inquiry to JLAP regarding disposition of the case, AND, that Lawyer has refused to execute such consent, JLAP is prohibited from communicating with the referral source. To do so would be violative of 42 CFR Part 2. Therefore, JLAP and referral sources should have a mutual understanding that if JLAP responds by effectively saying, “I cannot confirm or deny that (the individual in question) is or ever has had any interaction with JLAP,” that means that JLAP doesn’t have consent to discuss anything about that referral. In such an instance, it is the responsibility of the referring source to deal with that uncooperative Lawyer.
- Determine if 42 CFR Part 2 applies to the JLAP. It appears that being a 501(c)(3) non-profit corporation qualifies it as being “Federally Assisted” under this Regulation. If it does, then current consent forms need to be revised regarding possible attempted revocation of the original release.

The current consent forms which are incorporated into the Monitoring Agreements are not in compliance with 42 CFR Part 2. See specifics in section 2:31. Remove the consents from the Monitoring Agreements, and construct a separate “Consent to Disclosure of Health Care Information.”

DISCLAIMER: None of the above commentary is to be construed as constituting legal advice. **Consult your Attorney before** any action is taken on them.

EMERGING TRENDS

- Recent increased demand for more services has resulted in significant expansion beyond dealing with just chemically dependent and dually diagnosed individuals. Additional services often include:
 - Solitary mental illness
 - Behavioral health issues
 - Stress
 - Burnout
 - Anger management
 - Compulsive gambling
 - Other process addictions
 - Cognitive impairment
 - Medical conditions
- There are external forces impacting the operations of LAPs and PHPs:
 - Political assaults
 - Managed care restrictions
 - Accountability demands
 - Greater transparency (erosion of current confidentiality provisions)
 - Renewal of punitive sanctions rather than rehabilitative efforts (“they’re bad, not sick!”)
 - Cyclical assaults on AA’s effectiveness
 - Assaults on the treatment industry in general
 - Ignorance or misunderstanding about the disease concept, intervention, evaluation parameters, and treatment approaches.
 - Litigious Lawyers

RELATIONSHIPS

- JLAP's chief challenge is one of Public Relations
- There exists a perception that JLAP:
 - is an arm of, or extension of, ODC
 - is punitive
 - embraces a "one-size-fits-all" approach
 - has an Executive Director who is too rigid with a "marine-like" persona
- The extent of this perception cannot be accurately gauged, but to whatever extent it exists, it is indeed troublesome. Note the recent dissent by Judge Crichton:

09/11/2015 "See News Release 044 for any Concurrences and/or Dissents.
"SUPREME COURT OF LOUISIANA

NO. 2015-BA-1528

IN RE: COMMITTEE ON BAR ADMISSIONS CFN-1682

CRICHTON, J., concurs in part, dissents in part and assigns reasons:

I concur with the result in the per curiam opinion, but only insofar as petitioner is granted admission. In my view, despite petitioner's consent to the recovery agreement proposed by LAP, the appropriate result would be to grant petitioner admission without any conditions. Upon close examination of the record, including the unique circumstances presented, I believe that conditional admission is unduly harsh and the five-year probationary period, with its attendant burdensome testing requirements for the individual, is unwarranted. While we accord appropriate discretion to LAP recommendations, we are not necessarily bound to these recommendations, even if petitioner has indicated his or her consent. In all cases, the court should carefully scrutinize the severity of the punishment proposed in relation to the facts in the record before us. On these particular facts, I would grant petitioner's admission without any conditions.

- It is imperative that the Executive Director embark upon an intense educational effort to explain to COBA, ODC, the Supreme Court, and the rest of the LSBA that JLAP will endeavor to pursue tailored case management based upon that individual's current clinical presentation and the complexity of the case. Emphasis should be placed on how

Lawyers present special challenges in assessment and treatment, and clearly state the rationale underlying JLAP's clinical decisions. Lastly, special attention should be paid to the unique considerations attendant to dealing with individuals in safety-sensitive occupations.

- JLAP should promote its advocacy role in an attempt to entice voluntary clients to seek its assistance. Hopefully over time, voluntary clients will constitute more than the current 15% of JLAP's monitored population.

RECOMMENDATIONS-CLINICAL

1. Design a protocol for the management of COBA/ODC cases allowing for sufficient latitude to offer various levels of evaluation, treatment, and monitoring based upon thorough assessment of the current clinical situation rather than upon past conduct or a past medical condition.

The American Society of Addiction Medicine's Treatment criteria for persons in safety-sensitive occupations should be utilized, elaborating on the key qualities of this sub-population as well as the rationale for an initial multi-disciplinary evaluation and for profession-specific therapy in specialized treatment centers with qualified therapists. In formulating this protocol, incorporate, to the extent applicable to the legal profession, the:

- Federation of State Physician Health Programs Guidelines
- American Society of Addiction Medicine Public Policy Statements on impairment, appropriate evaluation and treatment, discrimination based on illness, and confidentiality
- ASAM's detailed position statements on impairment and length of monitoring

Implementation of the protocol should incorporate enough flexibility to reflect individualized care as opposed to a rigid one-size-fits-all approach.

2. There is no legal precedent in Louisiana, state or federal, that holds that a referral to AA (or any other 12 Step Program) is violative of any law. However, there are a handful of cases in other federal jurisdictions which state that in some circumstances mandating AA participation is violative of the Establishment Clause of the First Amendment of the US Constitution under current case law.

Therefore, it is recommended that JLAP does not MANDATE attendance at 12 Step type meetings. Instead, the best practices in national LAPs would suggest that recommendations to the various 12 Step Programs such as, AA, NA, Al-Anon, ACOA, ACA, can be RECOMMENDED in monitoring contracts but also reference to

“community support,” “mutual-help,” or “mutual support” meetings is appropriate for those candidates who may object to 12 step meeting attendance on religious grounds. JLAP participants who voice a legitimate 1st Amendment objection to AA as a religion should be given the choice of other alternative abstinence-based groups, such as SOS (Secular Organization for Sobriety), RR (Rational Recovery), or SMART (Self-Management And Recovery Training).

3. Establish a “Diagnostic Monitoring” category (contract) for:
 - so-called “gray zone” cases, e.g. “intermittent or episodic abuse”
 - treatment occurring years ago with no interval documented recovery
 - chemical dependency diagnosis made years ago with no interval documented recovery
 - treatment received at a non-JLAP approved center
 - alcohol/drug-related past conduct with no interval treatment or documented recovery

This contract should read “not to exceed 2 years with reassessment at the end of the first year.” These clients should have a peer monitor, and have the same urine drug screens (UDSs) as others, but NOT necessarily be required to attend any support groups.

4. Greatly expand local evaluator resources. Consider utilizing even out-of-state evaluators. It is not uncommon for a client to fly to another state, participate in a half-day evaluation, and return home the same night at less expense than a 3-day inpatient evaluation. The latter should be reserved for the more complex cases which are better assessed in an inpatient 24 hour setting. The JLAP clinical staff should conduct initial screening triage for further evaluations, possible treatment, and/or monitoring. The JLAP staff should NOT perform its own in-house full evaluations in order to avoid even the perception of a conflict-of-interest or accusations of any preconceived bias. Communicate to the evaluator any and all clinical data relevant to the current situation, and relay additional information as it becomes available. However, the JLAP should not share any of its diagnostic opinions that may color the evaluator’s subsequent judgment and the JLAP should abide by the evaluator’s opinion even if it disagrees with it.

5. Expand residential treatment resources. JLAP currently uses six acceptable residential treatment programs. Develop a protocol for centers to apply for JLAP approval, and develop assessment criteria including but not limited to:
 - Willingness and ability to conduct a forensic evaluation
 - Familiarity with JLAP operations
 - Significant experience with medical and legal professionals
 - Understanding of the unique attributes of professionals in safety-sensitive positions
 - Utilizing a multidisciplinary approach
 - Follows FSPHP guidelines for assessment and treatment as applicable to legal professionals.

Many state Physician Health Programs approve approximately 20 of these centers several of which are also approved by JLAP:

6. Presently JLAP does 14 UDSs per year;* add at least one PEth test. The frequency of testing should be commensurate with the severity of the illness and its current presentation.

Note: *Most PHPs test at least 36 times a year.

7. Create a “Clinical Advisory Committee” whose composition might include some of the following depending upon availability: an Addiction Psychiatrist, a regular Psychiatrist, or an Addiction Medicine Specialist; the JLAP Clinical Staff; and the JLAP Executive Director. This new Committee could meet regularly in person or as needed by phone to assist the JLAP Staff with the more complex cases.
8. Increase peer monitor training to twice a year incorporating concepts used in the Michigan LJAP. (**See section on: *Peer Monitoring Model***)
9. Insure that evaluators and treatment centers offer 2nd opinion diagnostic or alternative treatment centers to everyone by written documentation that is sent back to the JLAP.

10. For voluntary clients who do not complete their JLAP contract, track them to see if they are subsequently referred to the JLAP as an involuntary client.
11. Track relapses by:
- Type of law practice
 - Referral source
 - Type of treatment
 - Treatment provider
 - Return to work
12. Eventually expand your services to include stress, burnout, and behavioral issues, BUT do not do so until you are able to assign one Staff Clinician solely to this arena and until you have readily available a consulting Psychiatrist or Psychologist. Provide education to the ODC, COBA, LSBA, and the Supreme Court about the drastic differences in the underlying assumptions in managing chemical dependency vs. mental illness using Ms. Vincent's excellent treatise on this subject (**See section on: *Mental Illness & Addiction Differences***)

RECOMMENDATIONS -ADMINISTRATIVE

1. Clarify the scope and function of the Operations Committee and examine its composition. None of the members has any clinical expertise. This Committee has met only once or twice. Is it providing a valuable service to JLAP, or is it just another “Advisory-type” Committee with no meaningful purpose? Its role is unclear to the Audit Team.
2. Hire a Health Law Attorney to deal with recalcitrant lawyers and defense counsel.
3. Finalize the merger of the double Excel sheet data base with the partial Affinity data base.
4. Provide the JLAP Board Chair with all keys and computer passwords in case of Executive Director disability or death.
5. Implement adequate safeguards against employee theft, forgery, computer fraud, and insure that bank accounts are reconciled by someone not authorized to deposit or withdraw funds.
6. Hire an Administrative person to handle all aspects of the JLAP’s business affairs.
7. Consider adding to the Board of Directors a Physician with Addiction and/or Mental Illness expertise such as an Addiction Psychiatrist; a business person with fund-raising experience who might also be a member of another non-profit Board; an Academician from one of the Law Schools; and a non-Lawyer public member to ameliorate even the perception of the “fox (all Lawyers) guarding the henhouse.” Having a public member deflects criticism from citizen advocacy groups. Some PHP Boards also have a former PHP participant on its Board, that is, a Physician who has successfully completed the 5 year contract and who demonstrates substantial recovery. Ideally there should be a balance between recovering and non-recovering members of the Board.
8. The Board should perform all the usual and customary functions including but not limited to long-range strategic planning, developing a mission statement, a vision statement, a values list, goals and objectives, plus strategies and tactics. Other goals could include: instituting a standard Executive Director performance appraisal instrument, approving Policy and Procedure manual revisions, conducting periodic stakeholder surveys, and

developing a Board member self-appraisal. At each meeting, end with an Executive session dismissing the Executive Director and any other non-voting guests; do this whether or not there is any business to conduct at this private level. Effective Boards are governance oriented as opposed to just functioning in an oversight capacity.

RECOMMENDATIONS- MARKETING/EDUCATION/NETWORKING

1. Immediately contact Judge Ben Jones, Chair of the JAC, to encourage full funding of the proposed fall meeting, and request inclusion of an in-depth educational program by Buddy. Emphasize the importance of capitalizing on this moment to introduce the Judiciary to the concept of a joint Judges and Lawyers LAP. All resources, financial and otherwise, should be used to insure a high quality roll-out, perhaps supplementing the conference with outside experts from Addiction Medicine and/or Physician Health Programs.
2. Convene a forum, perhaps with an informal Liaison Committee, to meet with designated representatives from the Supreme Court, COBA, ODC, and the LSBA on a quarterly basis. Utilize this opportunity for education, ongoing communication, and conflict resolution. Topics could include:
 - Description of a flow chart from entry to discharge with all the stops in-between.
 - The concept of addiction as a brain disease
 - Relapse as a spectrum of activity, its causes, and disposition of cases
 - Dual-diagnosis cases
 - Evaluator and treatment center criteria (ASAM safety-sensitive information and FSPHP Guidelines)
3. Continue to support your Staff attending the annual CoLAP and FSPHP meetings. Each year encourage attendance by a couple of your Board and Operations Committee members as well.
4. Devote one hour at each Board of Directors meeting for education, e.g., presenting topics as in #2 above.
5. Have one Staff Clinician per year attend the Florida PRN evaluator training session that the Executive Director attended this year.
6. Continue the excellent *BAR Journal* articles. Try and get an article in every issue.
7. Do NOT publish your approved treatment provider list. Clients looking for an “easier, softer way” will be tempted to do an end-run and by-pass the LAP. Furthermore, center staffs change often and the quality of their health care changes as well. Lastly, all centers are not equal just because they are on

your approved list; some do better in certain areas than others. Treatment center recommendations should be individualized based on clinical considerations.

8. Consider modifying your annual seminar to include a two day session. Either before or after the first day session on ethics and professionalism, consider having an appreciation dinner for all JLAP volunteers such as peer monitors, Ops Committee, Clinical Advisory Committee (if established) and JLAP Board members. On day 2, follow with a “JLAP Reunion” for clients only. This meeting promotes camaraderie and mutual support. It eventually morphs into a mini-ILAA or mini-IDAA type meeting, and it is great “public relations” for the LAP. Utilize expert outside speakers. This weekend can also be used as one of the training sessions for peer monitors. Entice them to come by subsidizing their costs.

9. Encourage the LSBA to establish a 501(c)(3) “scholarship” fund for financially bereft Lawyers. Through this vehicle, provide no interest loans to pay for evaluations, UDSs, and, perhaps, part of their treatment costs. Establish criteria for granting such loans.

10. Market the Louisiana branch of the Association of Legal Administrators and the Paralegal section of the LSBA.

11. When appearing before first year law students, take along one of your recovering clients to tell his/her mini-story.

12. Conduct a truly anonymous client survey. (**See section on:** *Anonymous Client Survey*)

13. Other than at the annual seminar where CLEs are awarded for professionalism and ethics, do not conduct other joint educational sessions with ODC in order to avoid the perception that the JLAP is merely an arm of or an extension of that disciplinary body.

RECOMMENDATIONS-RELATIONSHIPS

CHANGES TO LANGUAGE AND RELATIONSHIPS

- In light of the Settlement Agreement between the United States of America and the Louisiana Supreme Court under the Americans with Disabilities Actⁱ the Louisiana Supreme Court Rules on Admission to the Bar and the section on Character and Fitness have been reviewed.
- A review of Conditional Admissions Rules in other jurisdictions has been conducted.
- The ABA Model Rule on Conditional Admission has been reviewed. This review has been conducted with an emphasis on best practices for addressing substance abuse and alcohol abuse of any individual who is an Applicant for Admission to the Louisiana State Judges and Lawyers Assistance Program, the Committee on Bar Admissions, and the Supreme Court was necessary.

Some of the recommendations will be focused on the effect that the change in the NCBE questions will have on future applicants. It is the understanding of the audit team that, in the future, because of the change in the NCBE application which occurred as a result of the settlement with the Louisiana Supreme Court, any actual diagnosis of either a mental health issue or a substance use/abuse disorder will place an applicant under extra scrutiny for admission ONLY if there is recent conduct related to the diagnosis. Historically this has not been the case. From the body of complaints presented to the audit team for their consideration it appears that some individuals have been sent to JLAP for the purpose of conditional admission based on conduct that occurred many years prior to their application. It also appears that individuals have been sent to JLAP based only on their admission of a history of a substance use disorder that was denoted as severe but that has been in full remission for years.

Bearing all this in mind, the audit team offers the Louisiana Lawyers Assistance Program, Louisiana State Bar Association, Supreme Court of Louisiana, and the Committee on Bar Admissions the following recommendations:

I. JLAP's Supportive Role for Impaired Attorneys/Applicants

Because the audit team is of the opinion that applicants to the Louisiana State Bar, as well as a number of these applicants' attorneys, have typically

viewed the Lawyers Assistance Program as a wing of discipline and as a probation department that is punitive and controlling, it is recommended that the Judges and Lawyers Assistance Program carve out and protect a relationship with Bar applicants and applicants for readmission that is separate from the Committee on Bar Admissions and the Office of Disciplinary Counsel. The recommendations on changes in the language of the rules governing both Conditional Admission and Discipline, as outlined below, and along with other recommendations in this report governing certain policies and procedures, will hopefully assist the JLAP in beginning to address this perception.

II. Changes in Rules Language for Conditional Admission

- A) Character and Fitness LASC Rule XVII §5 (E)¹⁶ reads: “Evidence of drug or alcohol misuse, abuse or dependency” - should read **“evidence of any substance use disorder”**.ⁱⁱ
- B) Character and Fitness LASC Rule XVII § 5 (F) the passage *[If the applicant is found to have engaged in conduct which at that time would have constituted grounds for an unfavorable recommendation, then the applicant must show by clear and convincing evidence that his or her character has been rehabilitated and that such conduct, inclination or instability is unlikely to recur in the future. The mere fact that there has been no repeat of any such conduct, instability or inclination shall not in and of itself be sufficient to constitute rehabilitation or proof of good moral character and fitness]* **should be changed to reflect that the standard of proof should be applied to conduct only, not to a diagnosis of a substance use disorder that is in full remission.**
- C) Character and Fitness LASC Rule XVII § 5 (M) (6) should read “If the Court approves the conditional admission, the conditionally admitted lawyer’s compliance with the terms of the consent agreement shall be supervised by a compliance monitor **assigned by the Office of Disciplinary Counsel. In cases involving substance use disorders or mental, physical or emotional disability the Judges and Lawyers Assistance Program will report compliance or noncompliance with the JLAP monitoring agreement to the Compliance officer assigned by the Office of Disciplinary Counsel.** Cooperation with the JLAP monitor is required and failure of the conditionally admitted lawyer to cooperate may be grounds for the revocation of the conditional admission.

III. Changes in Procedure for Conditional Admission

- A) It is recommended that the Committee on Bar Admissions utilize the service of investigators with a background in Criminal Justice who can investigate each applicant and identify those applicants who may need a higher level of scrutiny before being admitted to the Louisiana State Bar. The investigation of background and prior conduct by a bar applicant should not be within the responsibilities of JLAP staff.
- B) It is recommended that the Committee on Bar Admissions establish a pool of volunteer attorneys to sit on hearing panels to review those bar applicants that have been flagged by the investigators. The hearing panel will review the file provided by the applicant, the materials gathered by the investigator, and then meet with the applicant to determine from the face to face encounter whether this applicant meets criteria to be granted admission. During this process JLAP will provide evidence of the applicant's compliance or non-compliance with their monitoring agreement.
- C) For applicants who do not pass at the first level of hearings it should be made clear to the applicant that they have a right to an appeal to the Committee on Bar Admissions. If the applicant fails to be granted admission upon that appeal that there is a further right to appeal such determination to the Louisiana Supreme Court. Under no condition should an applicant's right to the appellate process be discouraged by JLAP staff, COBA Staff, or LSC staff.

IV. Disciplinary Rules

Disciplinary Rule LSAC XIX § 24 (E) (3) Reads at present:

3) If the lawyer was suffering under a physical or mental disability or infirmity at the time of suspension or disbarment, including alcohol or other drug abuse, the disability or infirmity has been removed. Where alcohol or other drug abuse was a causative factor in the lawyer's misconduct, the lawyer shall not be reinstated or readmitted unless:

- (a) the lawyer has pursued appropriate rehabilitative treatment;
- (b) the lawyer has abstained from the use of alcohol or other drugs for at least one year; and
- (c) the lawyer is likely to continue to abstain from alcohol or other drugs.

Recommended changes as follows:

3) If the lawyer was suffering under a physical or mental disability or infirmity at the time of suspension or disbarment, including alcohol or other drug abuse, the disability or infirmity has been **diagnosed, treated, and is in remission**. Where alcohol or other drug abuse was a causative factor in the lawyer's misconduct, the lawyer shall not be reinstated or readmitted unless:

(a) the lawyer has pursued **and complied with the treatment recommendations of the LA-JLAP and has complied with the conditions of the monitoring contract**

(b) the lawyer has **offered evidence of sustained abstinence from addictive substances or processes and/or has offered evidence of compliance with recommended healthcare regimen prescribed by provider(s) that meet LA-JLAP standards.**

(c) **A healthcare provider or team of providers that meet LA-JLAP standards who has been involved with the care of the lawyer indicates in writing that the applicant's prognosis is sufficiently good to predict that they will continue to manage any condition or disability effectively.**

Since the audit team's impression and experience of the Louisiana JLAP is that it conducts its work in both a professional and appropriate manner, and is dedicated to providing support and accountability to those attorneys and Bar applicants who need their services, we offer these recommended rule changes to also make it clear to the legal profession that it is not JLAP which controls who is admitted to the Bar with or without conditions, but that such authority lies firmly within the purview of the Louisiana Supreme Court with the recommendations of the Committee on Bar Admissions and the Office of Disciplinary Counsel which may or may not rely on the opinions and recommendations of the Louisiana Judges and Lawyers Assistance Program staff.

It will take time for this reputation to change. It is recommended that the above changes be adopted to place an obvious boundary between the mission of COBA and the JLAP and a similar obvious boundary between ODC and the LAP.

ADDITIONAL CHANGES TO LANGUAGE AND RELATIONSHIPS

- Enhance direct communication with all clients, especially when making any changes such as the new protocol for the Affinity website client progress reports. Issue clear instructions verbally and utilize Affinity literature to warn clients about dilute urines and other false positives. Provide each client with a list of alcohol-containing foods and liquids, including so-called “non-alcohol” beer and wine, as well as personal care products such as hand sanitizers or denture rinses. Clients should be warned to “read all labels.”
- Endeavor to explain the rationale for any new policies. Enhance confidentiality by double screening the primary and copied recipients of any emails.
- The Executive Director is generally known as a strict “trust but verify” guy, and he is viewed very favorably in general, e.g., “He saved my life.” He is also highly regarded in the “LAP world.” The Audit Team Leader was recently in West Virginia lecturing at an addiction conference, and the LAP Director there stated that his program was about to be dissolved, but Buddy Stockwell’s *BAR Journal* article saved it and the WV LAP program was subsequently funded. However, the Executive Director’s communication style is perceived in some quarters as being “dictatorial,” “rigid,” “aggressive,” “adamant” and the like. We suggest that he implement measures to ameliorate this perception.
- The JLAP Board should endeavor to solidify all current and potential JLAP funding sources in order to establish stable sources of revenue.

ⁱ*Settlement Agreement Between the United States of America and the Louisiana Supreme Court Under the Americans with Disabilities Act*, signed August 13, 2014.

ⁱⁱ*Alcohol Use Disorder: A Comparison Between DSM-IV and DSM-5*. National Institute on Alcohol Abuse and Alcoholism. July, 2015.

<http://pubs.niaaa.nih.gov/publications/dsmfactsheet/dsmfact.pdf>

IMPLEMENTATION TIMELINE

IMMEDIATE ATTENTION:

1. CLINICAL

- a. Design Case Management protocol
- b. Reword all monitoring contracts
- c. Establish a Diagnostic Monitoring contract
- d. Expand Evaluator resources

2. ADMINISTRATIVE

- a. Clarify scope and function of the Operations Committee
- b. Finalize merger of Excel and Affinity data bases
- c. Hire an Administrative person

3. MARKETING-EDUCATION-NETWORKING

- a. Encourage full funding for JAC fall meeting
- b. Convene a regular educational forum for COBA, ODC, the Supreme Court, and the LSBA
- c. Continue to Support Staff education
- d. Establish an educational session for each JLAP Board of Directors meeting

4. RELATIONSHIPS

- a. Petition the Supreme Court to change its Rules governing Conditional Admissions and Discipline

IMPLEMENTATION TIMELINE

INTERMEDIATE ATTENTION:

1. CLINICAL

- a. Expand Residential Treatment resources
- b. Add a PEth test
- c. Establish a Clinical Advisory Committee
- d. Increase Peer Monitor Training to twice a year

2. ADMINISTRATIVE

- a. Implement adequate safeguards for all financial transactions
- b. Hire a Health Law Attorney
- c. Provide JLAP Board Chair with security access

3. MARKETING-EDUCATION-NETWORKING

- a. Consider modifying the annual seminar
- b. Conduct a truly anonymous client survey
- c. Minimize any joint ODC/JLAP educational events
- d. Strive for a monthly *BAR Journal* article
- e. Do not publish an approved treatment provider list

4. RELATIONSHIPS

- a. Enhance client communications

IMPLEMENTATION TIMELINE

LATER ATTENTION:

1. CLINICAL

- a. Insure 2nd opinions and alternate treatment sites are offered and documented in writing
- b. Monitor any subsequent conversion of voluntary clients to an involuntary participant
- c. Increase parameters for tracking relapses
- d. Expand clinical services

2. ADMINISTRATIVE

- a. Consider additions to the Board of Directors
- b. Review Board of Directors operations

3. MARKETING-EDUCATION-NETWORKING

- a. Solicit a former JLAP client to participate in Law student educational events
- b. Send one Clinical Staff member to the FL PRN Evaluator Training
- c. Market the Louisiana Branch of the Association of Legal Administrators and the Paralegal Section of the LSBA
- d. Encourage LSBA to establish a “scholarship” fund

4. RELATIONSHIPS

- a. Board promotion of stable funding

CONCLUSIONS

The LA JLAP entered the Lawyers Assistance arena back in 1992. The combined support of the LSBA, an enthusiastic volunteer JLAP Board, and strong leaders established a firm foundation for the program.

Its existence is widely known throughout the state as evidenced by 836 calls for assistance in the last 5 years. It has facilitated 400 referrals in that same period. It launched a vast marketing, education, and networking campaign. It has demonstrated skill in persuading 80% of voluntary clients to get an evaluation and 66 % of them to go to treatment. Its penetration is commensurate with that seen in Physician Health Programs, and its relapse rate, perhaps spuriously low, is nevertheless striking. Urine Drug Screening is the major method of relapse detection. Most importantly, there is no known case of client harm perpetrated by an Attorney while under JLAP monitoring.

Strong leadership is provided by Buddy Stockwell who is dedicated, sincere, and resolute in his convictions. He has a supportive clinically competent staff that functions harmoniously and efficiently with mutual respect in a cordial office atmosphere. After navigating some difficult transition waters, he has made significant changes from the former LAP model.

In transitioning from the previous LAP, the current Executive Director has introduced a new paradigm in which he strives to emulate the Physician Health Program (PHP) model. This is commendable in so far as PHP research, published in major peer-reviewed medical journals, clearly demonstrates the highest recovery rates with only 1 case of patient harm, a prescription error, among 904 medical professionals from 16 PHPs followed for 7.2 years.

However, the implementation of this new approach may have been a bit overzealous leading to a perceived, as well as sometimes real, inflexible case management style. This style is perhaps catalyzed by the existence of considerable ambiguity surrounding monitoring expectations and unclear boundaries between the JLAP and LSBA/COBA/LSC. We hope that the implementation of the recommendations made by the Audit Team for the future procedures and policies of JLAP and LSBA/COBA/LSC resolves this situation, so that in handling future monitoring cases, COBA, ODC, and LSC are viewed as the monitoring **authority** and the JLAP as the monitoring **entity**.

Two additional challenges exist: 1) Assimilation of Judges into the system, and 2) a mounting demand for additional clinical services. Both will require

an enormous educational effort. The current landscape reveals a legal community concerned about the stress experienced by Lawyers as they cope with numerous changes in their professions. While the prevalence of chemical dependency in Lawyers remains unchanged, mental illness, stress, disruptive behavior, and boundary issues will continue to be pressing problems. In meeting future challenges, the LA JLAP should be very selective in choosing pathways that will not dilute its core activity or erode its credibility.

SUMMARY

The LA JLAP has effectively facilitated the rehabilitation of its participants while simultaneously protecting the public. Its Board, Executive Director, and Staff are dedicated and committed to lofty ideals. The program has a clear legislative mandate, qualified immunity, and support from the legal community as evidenced by its high number of referrals.

While certain areas requiring attention have been noted, the JLAP's overall operation unequivocally qualifies it as a top tier program. The recommendations contained herein hopefully address concerns that naturally result from inevitable growth.

The JLAP Board of Directors is to be commended for commissioning this audit which is one of only several ever done in the entire nation! It is our sincere hope that this analysis will be construed merely as a guidepost to assist the JLAP in its quest to reach its next level of excellence. JLAP is dedicated to improving the quality of legal care for the people of Louisiana by striving to assure healthy legal professionals. Many Louisiana legal professionals have benefited from the JLAP with resultant solid recovery, safer practices, and usefully whole lives.

Lynn Hankes, MD

Lynn Hankes, MD
(Electronically signed)

Sarah L. Krause

Hon. Sarah L. Krause (ret.)
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Tish Vincent, MSW, JD

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Martha E. Brown, MD

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LOCAL OR IN-STATE EVALUATOR SURVEY

1. How many referrals have you had from the LA LAP? **5-10**
2. Over what period of time? **1-2 years**
3. How long do these evaluations typically take? **2 hours**
4. Of those you have evaluated, how many:
 - Resulted in a firm diagnosis? **1**
 - Resulted in no diagnosis? **8**
 - Resulted in a “gray zone” uncertain diagnosis, e.g. “episodic or intermittent abuse?” **1**
5. Of those with a firm diagnosis, how many challenged the diagnosis and requested a second opinion? **0**
6. Of those with a firm chemical dependency diagnosis, how many did you recommend?
 - For in-patient treatment? **0**
 - For out-patient treatment? **1**
7. Of those with an uncertain diagnosis, how many did you recommend?
 - For further in-depth (3-4 day in-patient) evaluation? **0**
 - For “diagnostic monitoring” **0**
 - For “watchful waiting” without any monitoring **1**
8. What’s the typical cost for your standard evaluation? **\$450.00**
9. How did you communicate your findings to the LAP?
 - Verbally by phone?
 - In writing? **X**
 - Both?
10. Did any client refuse or withdraw consent prohibiting you from speaking to the LAP? **No**

11. What percent of the time did the LAP disagree with your findings? **0**
12. Did the LAP ever exercise “undue influence” over you to change your findings? **No**
13. Do other LAPs refer to you? **No**
14. Does the LA Physicians Health Program refer to you? **No**
15. How did the LA LAP learn about you as a potential referral source?
Leah Rosa is a colleague
16. Do you utilize a lie detector in your evaluations? **No**
17. Were any of those you evaluated also treated by you? **No**
18. If so, were they given the option of treatment elsewhere? If yes, was this offer documented in writing? **NA**
19. Does your evaluation focus on conduct that indicates a current medical problem? **Yes**
20. Has the LA LAP exerted any pressure on you to find a person needs treatment presently for a condition that responded to treatment previously and that is not causing any problems? **No**
21. If your evaluators found that a person with Alcohol Use Disorder, Severe, 303.90, in Full Remission, who has been in Full Remission for 5 years, do they recommend a 90-day in-patient treatment? If so, please provide the clinical rationale for such a recommendation. **No**

SUMMARY-This is a Mandeville Psychologist. Comments are self-explanatory. We could not connect with the other 5 local evaluators.

TREATMENT CENTER SURVEY (3 Centers: A, B, & C)

1. How many referrals have you had from the LA LAP? Over what period of time?

A-13/1 year

B-8/5 years

C-10/2 years

2. What percent were sent to you for an in-depth (several-day) evaluation?
What is your cost for this evaluation?

A-76%

B-75%

C-35%

A-\$3-5K

B-\$3-5K

C-\$3-5K

3. What percent were sent you for treatment without your evaluation?

A-24%

B-25%

C-65%

4. Of those you evaluated, what percent:

- Resulted in a firm diagnosis? **A-90%** **B-85%** **C-90%**
- Resulted in no diagnosis? **A-10%** **B-0%** **C-0%**
- Resulted in a “gray zone” uncertain diagnosis, e.g., “episodic or intermittent abuse?” **A-0%** **B-15%** **C-15%**

5. Of those with a firm diagnosis:

- What percent challenged the diagnosis and requested a second opinion? **15/10/15% (Challenged, but did not request a 2nd opinion)**

6. Of those with a firm diagnosis, what percent did you recommend for:

- For in-patient treatment? **A-50%** **B-85%** **C-50%**
- For out-patient treatment? **A-50%** **B-15%** **C-50%**

7. Of those recommended for in-patient treatment, what per cent remained at your facility for that treatment?

A-66%

B=85%

C-20%

8. What percent challenged the treatment recommendation, and requested another evaluation?

A-?

B-15%

C-?

9. What percent agreed with the treatment recommendation, but requested treatment at some other facility?

A-34%

B-15%

C-Unknown

10. What percent of LAP referrals were offered access to a second opinion or treatment elsewhere? **All 3 100%**
11. Were these offers documented? **A-Yes B-Yes C-No**
12. What was your average length-of-stay for an LAP client?
A-80 days B-30 days C-90 days
13. What was the average cost for this LOS? **\$28K/20K/30K**
14. What percent of LAP patients stayed for 90 days?
A-91% B-10% C-85%
15. What is your cost for this 90-day track? **\$28K/42/30K**
16. Have you provided any LA LAP clients with a “charity” or “scholarship” treatment?
A-No B-Yes C-Yes
17. What percent of LAP clients complete their entire treatment track?
A-100% B-50% C-100%
18. What percent left AMA (Against Medical Advice)?
A-0% B-15% C-0%
19. Do you have a Professional Treatment Track? **All 3 yes**
20. If so, what other professionals do you treat? **All-many**
21. What other individuals in safety sensitive positions do you treat?
All-pilots & medical professionals
22. Prior to discharge, what percent of your patients, before discharge, participated in a discharge planning session conducted by your team in conjunction with Buddy Stockwell &/or his clinical staff?
A-100% B-100% C-75%

23. What percent of the time did the LAP disagree either with your diagnosis or treatment recommendations? **Only 1 case from all 3 centers.**

24. Did the LA LAP ever exercise undue influence in either your diagnostic opinion or with your treatment recommendation? **All 3 centers-No**

25. Has the LA LAP exerted any pressure on you to find that a person needs treatment presently for a condition that responded to treatment previously that is not causing any current problems? **All 3 centers-No**

26. Have you had any problems with Buddy Stockwell or his Staff? **All 3 centers-No; however 1 had a problem with Bill Leary**

27. Have you had any problems dealing with the Attorney-patient such as relapse while in treatment, disruptive behavior, boundary violations, or threatened lawsuits?

A-a few argue

B-No

C-a few

28. Do you receive referrals from other LAPs? If so, which states?

A-Yes

B-Unsure

C-No

29. Do you utilize a lie detector in either the evaluation or during treatment?

A-No

B-No

C-Yes

30. Do your evaluations focus on conduct that indicates a current medical condition?

A-Yes

B-Yes

C-Yes

31. If your evaluation finds that a person with Alcohol Use Disorder, Severe, 303.90, in Full Remission, who has been in Full Remission for 5 years, do they recommend a 90-day in-patient treatment? If so, please furnish the clinical rationale for such a recommendation.

A-No

B-No

C-No

SUMMARY

The 5 treatment centers used by JLAP were surveyed. Two of them had only 1 or 2 referrals for evaluations, but no treatment. One of the remaining three treatment centers was used primarily only for a 30 day treatment program.

For the remaining other two treatment centers, an intensive 3-day in-patient evaluation costs \$3,000-5,000. Twenty-five percent of potential clients did not require an evaluation and were sent directly to inpatient treatment. Most evaluations resulted in a firm diagnosis which was challenged in only 15% of the cases and there were no requests for a 2nd diagnostic opinion. These two centers recommended in and out-patient treatment equally at 50% of the time, contrary to allegations that all clients automatically get inpatient treatment.

Of those recommended for inpatient treatment, two-thirds or more stayed at the same facility. All were offered a 2nd opinion or an alternate treatment site, and a third chose to go to another JLAP approved treatment center. However, most stayed for 90 days at a \$30,000 cost (which is reasonable by industry standards for a professional treatment track). All patients completed treatment.

JLAP disagreed in only one case with the treatment center's diagnosis, but they did not exercise any undue influence on the treatment center. One treatment center had a problem with the past Executive Director, but none complained about the current Executive Director.

We surveyed another facility which does evaluations only and does not offer treatment. It had 8 JLAP referrals in the past year. Evaluations take 3-4 days in an out-patient office setting and typically cost \$6,500. Seven were diagnosed with addiction and one with only mental illness. One client had been diagnosed elsewhere and sought a 2nd opinion here. After the evaluation center concurred with the original evaluation, the client requested yet a third opinion and was referred elsewhere for that. This was a dual-diagnosis patient with significant personality traits. Of the 7 clients this facility evaluated, they recommended inpatient treatment for 3, out-patient treatment for 1, and no treatment for 3 who were in stable recovery. JLAP disagreed with 1 diagnosis, but did not exercise any undue pressure. This facility receives referrals from the TN and KY LAPs, as well as from the Florida, Ohio, and Tennessee PHPs. The Medical Director at this facility states that JLAP's Executive Director is "deeply concerned" and "passionate" about his client's recovery. This Doctor rated the Louisiana JLAP and his own State's LAP as the nations "top two."

CONDITIONAL ADMISSIONS SURVEY

In order to assess whether the Louisiana Conditional Admission Rules were being applied in a manner consistent with a national perspective, twelve (12) state rules were reviewed (Florida, Indiana, Maine, Minnesota, Missouri, Montana, Nebraska, North Dakota, South Dakota, Tennessee, Texas, and Wisconsin) and contact was made with the LAP Directors of seven of those states (Florida, Indiana, Maine, Montana, Tennessee, Texas, and Wisconsin) to conduct a telephone interview regarding the practices and procedures in the use of the Conditional Admission Rules.*

In a number of states the contract length rule is similar to Louisiana's statutory rules in that most states do have a "five year" contract rule but the language in those rules usually contain the phrase "not to exceed" five years.* in two states-“not to exceed two years”

1) Length of Contracts

- A) Statutory Five Year Contracts-**Florida** (can be 1 to 5 years, nothing typical); **Indiana** (typically 2-3 years); **Tennessee** (Typically 3 years); **Wisconsin** (typically 2- 3 years)
- B) Statutory Two Year Contracts-**Texas** (typically 1-2 years); **Minnesota** (not monitored by LAP)

2) Assessments/Evaluations –

A) Types of Assessment/Evaluations

- (i) In house assessments-**Indiana**, for recent treatment candidates, **Tennessee**, for person already in treatment-50% of cases
- (ii) Out-patient Evaluation-**Indiana**, for cases with no recent treatment/evaluation; **Tennessee**, 50% of cases; **Wisconsin**, 100%; **Maine**-
- (iii) No Assessments by LAP; **Florida and Texas**-Bar Examiners conduct the assessments/evaluations**

B) Costs of Assessment/Evaluations

- Florida**-Bar Examiners handle the assessment/evaluation
- Indiana**-\$300
- Maine**-100% hearings before BE
- Tennessee**-\$300-\$600
- Texas**-Bar Examiners conduct the assessment/evaluations
- Wisconsin**-\$400.00 (out-patient substance abuse; \$2,500.00 (outpatient but interdisciplinary w/ psych eval.)

3) DRUG Testing Costs

Florida-\$60.00 per urine testing, more for EtG

Indiana-\$50.00 for urine screen; \$70 for EtG and only used if there are at least two dilutes or positive screens

Maine-

Tennessee-Random \$60-70.00 for urine; if dilute, \$110-130 for hair

Texas-Could not obtain statistics replied “confidential”

Wisconsin-\$65.00 per urine screen, after 1 year, then hair and nail 4X per year at \$225.00 per test.

4) Hearings

Florida-85% of CA cases have an informal hearing before BE; 10-15% get CA license w/o a hearing; rare to get a Supreme Court hearing re: CA license issues

Maine-

Indiana-Hearings are rare, but Board of Law Examiners will call in candidate to question

Tennessee-30% have hearings related to CA but not to dispute conditions

Texas-Could not obtain statistics

Wisconsin-BE does not keep these statistics but if a challenge is made to CA and the BE decides to deny admission, then 95% request and get a hearing on the denial.

5) Percentage of LAP caseload

Florida-30%

Indiana-30%

Maine-<5%

Tennessee-40%

Texas-Unable to obtain statistic

Wisconsin-40%

6) Additional Considerations

None of the states reviewed had exactly the same procedures as any other state. The LAPs in Indiana, Wisconsin and Tennessee take a proactive approach, i.e., they do the assessment/evaluations and then send a recommendation to the Bar Examiners office regarding the types of conditions and the length of contract that they think is appropriate.

Florida, Maine, Montana and Texas LAPs do not send recommendations. While Maine, Montana and Florida will monitor the CA attorneys after the conditions have been set by the bar examiners, Texas has a hybrid system wherein the Texas LAP trains and picks the monitors, but does not do any supervision or follow up with the monitors, the BE office handles that aspect. While all the states' statutes provide for hearing at various levels of the procedure, the most utilized is at the Board of Examiners level when the candidate is being reviewed for CA and conditions are set. Appeals to the Supreme Courts of the states for a second review of conditions are rare.

It appears that the costs of the urine testing are quite similar across the states, but procedures for additional testing have a wide variation in application. The most used as a follow up test should a urine screen result in a dilute is the EtG. Indiana states it has never followed up with hair and nail testing, while Wisconsin uses such testing as the primary testing after the first year (4X per year for second year of the contract).

Costs of Monitoring have some variation from as low as \$25.00 for CA (Indiana) to \$75.00 (Florida-with an initial payment upon entering CA monitoring of \$250.00).

*Nebraska, North Dakota and South Dakota statutes did not contain specific language about duration of the monitoring contract and there is no functioning professionally staffed LAP in these states. Minnesota rules provides that the monitoring is "not to exceed two years" but the LAP does not monitor in Minnesota so was not contacted for an interview. Texas has a two year rule but LAP does not monitor the cases directly. Montana had so few cases and no clear statistical information was obtained so not included in the analysis.

** Texas Bar Examiners office replied to most question as "not answered because of Confidentiality Rules-Texas Gov't Code 82.003(c)"

ANONYMOUS CLIENT SURVEY (11 respondents)

1. Date of your LA LAP contract_____.

2009-**2**

2010-**2**

2011-**0**

2012-**3**

2013-**3**

2014-**1**

2015-**0**

2. Who referred you to the LAP?

a. ODC (Office of Disciplinary Council)? **3**

b. COBA (Committee on Bar Admissions)? **3**

c. Voluntary self-referral? **4**

d. Other? **(A Counselor) 1**

3. Did the LAP refer you for an evaluation? **No-4**

a. to a Local Psychologist/Therapist? **Yes-6**

b. for an in-depth in-patient evaluation? **Yes-1**

4. How long was the evaluation? What was the cost?

Few hours-5

3 days-2

Can't remember-4

Cost range-\$75 to \$400

5. Did the evaluation result in a firm diagnosis?

Yes-7, N/A=4

If so, what was the diagnosis?

a. Alcoholism **5**

b. Drug Addiction **1**

c. Both **0**

d. Other mental illness **1**

e. Chemical dependency **0**

& mental illness

f. A behavioral disorder? **0**

6. Did you agree with the evaluator's diagnosis?

Yes-5, No-2

If no, were you offered the opportunity for a 2nd opinion (evaluation)?

Yes-2

7. If Yes, did you obtain a 2nd evaluation? **No-2**

8. What was the evaluator's recommendation?

a. out-patient treatment? **3**

b. in-patient treatment? **4**

c. engage with a Therapist?

d. monitoring only with no treatment? **4**

e. no further monitoring or treatment?

f. Other?

9. Did you agree with the evaluator's recommendation?

Yes-7, No-1, N/A-3

If no, were you offered the opportunity to get a 2nd recommendation?

Yes-1

10. If Yes, did you obtain a 2nd recommendation? **No-1**

11. If either out-patient or in-patient chemical dependency treatment was recommended, did the evaluator:

a. refer you to a specific out or in-patient treatment program? **Yes-4, No-1, N/A-1**

b. send you back to the LAP for its treatment program recommendation?

12. If you received out-patient treatment:

a. Where? **Local Facility-2, Pine Grove-1**

b. Duration? **Can't remember**

c. Cost? **Can't remember**

13. If you received in-patient treatment;

a. Where? **Palmetto-2, Pine Grove-2**

b. Duration? **90 days-3, 100 days-1**

c. Cost? **\$20,000, \$25,000, \$30,000, Free (local)**

14. Were you allowed to participate in your discharge planning?

Yes-3, No-3, N/A-1

15. Did the LAP attempt to influence either the evaluation or treatment in any way? If so, how?

No-07, N/A-02

16. Was your LAP contract thoroughly explained to you?

Yes-09, No-02

17. Did you understand what would trigger a report on you to your referral source?

Yes-8, N/A-2, N/A-1

18. What is the length of your contract?

5 years-8, 6 years-1, N/A-1, unsure-1

19. Was the Urine Drug Screening procedure thoroughly explained to you?

Yes-10, No-1

20. Were you instructed verbally in writing or by Affinity Lab written materials about dilute urines and other false positives?

Yes-7, No-2, N/A-2

21. On a scale of 1 (low) to 5 (high) rate the LAP on:

a. telephone courtesy	1/2/3-0 votes, 4-5 votes, 5-6 votes
b. timeliness of response	1/2/3-0 votes, 4-4 votes, 5-7 votes
c. confidentiality	1-1 vote, 2-0 votes, 3-2 votes, 4-2 votes, 5-6 votes
d. cost	1-0 votes, 2-2 votes, 3-4 votes, 4-2 votes, 5-3 votes

22. On a scale of 1 (low) to 5 (high), rate the LAP Staff:

a. professional demeanor	1/2/3-0 votes, 4-3 votes, 5-8 votes
b. professional competence	1/2-0 votes, 3-1 vote, 4-3 votes, 5-6 votes
c. responsiveness	1/2-0 votes, 3-1 vote, 4-4 votes, 5-5 votes

23. Have you ever experienced the exercise of unbridled authority by the LAP Staff? If so, explain.

Yes-1 (“treated like a school boy”), No-10

24. Were your interactions with Buddy Stockwell helpful?

a. Yes	11
b. No	0
c. N/A	0

25. Has your participation in the LA LAP has resulted in improvement in your overall wellbeing?

- a. Yes **9**
- b. No **1**
- c. Uncertain **1**

26. Would you recommend the LAP to a colleague?

- a. Yes **9 (2 already have referred to JLAP)**
- b. No **1**
- c. Uncertain **1**

27. If no, why not?

“One size fits all bureaucracy”

28. How has the LAP been of most assistance to you?

Structure-3
Support-1
Treatment recommendation-2
Accountability-2
Monitoring-2
Referral to AA-0

29. How has the LAP been of least assistance to you?

Too rigid, too long, inconvenient UDSs, too costly-1

30. If you could wave a magic wand and change just one thing about the LAP what would it be?

Tailored approach
Larger urine drug screen window
Increase seminar to twice a year
Fix dilute urine problem
Better information for law students
Better confidentiality
Treat clients with dignity

Other Comments? **Peer monitors are excellent**

SUMMARY

This was truly an anonymous survey of 10 % of currently monitored clients. The results were consistent with the data initially provided by the Executive Director. Most potential clients were referred locally and not to a distant 3-day in-patient intensive evaluation. Four of the 11 evaluations resulted in no

diagnosis. Most clients agreed with both the evaluator's diagnosis and treatment recommendations. All were offered 2nd opinions or alternative treatment sites, but none availed themselves of these options. In-patient stays were all 90 days at an average cost of \$25,000 which is very reasonable by industry standards for professional treatment tracks. No one reported JLAP exercising undue influence on either the evaluation or treatment. All reported receiving adequate explanations about the contract, reporting triggers, and the UDS system. All contracts but one were 5 years duration. The JLAP program and especially the Staff received very high marks except for cost and confidentiality. There was only 1 complaint about JLAP exercising unbridled authority. Buddy Stockwell was rated by all 11 clients as conducting helpful interactions, 9 out of 11 said JLAP had improved the quality of their lives, and 9 of the 11 stated they would refer colleagues to the program (2 already had made referrals). The comments about most and least program assistance and suggested remedies are self-explanatory.

Based on this sample, overall it appears that the JLAP program is beneficial and that it's Executive Director and Staff have performed in an exemplary manner.

MENTAL ILLNESS & ADDICTION DIFFERENCES

MENTAL ILLNESS

Historically in the United States mental illness has been treated by a system of behavioral medicine providers who operate in the medical model. In the medical model “the physician focuses on the defect, or dysfunction, within the patient, using a problem solving approach.”ⁱ Within this framework mental illness is seen as treatable. The psychiatrist is the captain of the treatment team, assisted by psychiatric nurses, psychiatric social workers, and paraprofessional staff where there is an inpatient hospitalization.

The treatment of mental illness, personality disorders, and emotional illness operates on a “mental illness set of assumptions.” The assumptions identified by this writer with twenty nine years of experience working in this model are:

- The patient wants to get better, or their family wants them to get better.
- The patient is the most important source of information.
- Collateral contacts are kept to a minimum.
- Therapeutic interventions will eventually lead to symptomatic relief.
- If the patient has a severe major mental illness it is expected that they will be managed by CMH or their families on an outpatient basis and have revolving door psychiatric admissions to treat their symptoms when they are extreme.

The changes in the delivery of mental health services have been dramatic over the past twenty years. Medical care has transformed in every treatment area. With the advent of Community Mental Health Centers length of hospitalizations began to decrease. Now chronically ill individuals are managed on an outpatient basis as much as possible. Insurance coverage for psychiatric hospitalizations has consistently decreased. Behavioral medicine treatment teams work more on an outpatient basis. With challenging cases they work in multidisciplinary treatment teams.

In the treatment of mental illness the individual’s autonomy is respected. They have the right to make their own decisions. Sometimes they need a guardian ad litem appointed to help them see what is in their best interest. If they are a danger to them self or others a psychiatrist can petition the court for an involuntary admission for the purpose of diagnosis, stabilization and to coerce them into needed treatment.

SUBSTANCE USE DISORDERS

Historically structured substance use disorder treatment programs are rooted in the twelve step recovery movement and in the encounter groups popular in the 1970s and 1980s. The model for most addiction treatment centers is the Minnesota Model. This model “was highly structured and included detoxification, psychological evaluation, general and individualized treatment tracks, group meetings, lectures, and counseling as well as referral to medical, psychiatric, and social services as needed. . . . This model included a strong twelve step orientation.”ⁱⁱ

The treatment of addictions operates on an “addiction intervention set of assumptions”. This set of assumptions is rooted in the knowledge that an addicted brain needs to believe it is functional when there is much evidence to others that it is in deep and serious trouble.ⁱⁱⁱ However an individual addictions therapist approaches the person who has come to them for counseling it is likely that treatment provider will operate under this set of assumptions:

- The patient is in denial.
- The patient is not a reliable source of information; therefore others in their life must be consulted, family, employers, or the law.
- Abstinence from the drug of choice and all other psychoactive substances is a prerequisite and ongoing condition of remaining in treatment.
- Strong and artful confrontation is needed therapeutically every step of the way.
- Para professionals who have dealt with their own addiction and are in strong recovery are often the most effective at reaching the newly recovering addict.
- Community support is absolutely necessary for the recovering addict. Ideally this community support is provided best by involvement in a twelve step group.
- There is a “window of opportunity” for treatment and if action is not taken quickly that window will slam shut and the person will be lost to their addiction.
- The addiction has impacted the individual and those who love them equally. Intervention with the family and encouragement of the family members to attend their own twelve step recovery group (Al-Anon) is the best practice.

EVALUATIONS

Assessments are conducted differently in the mental illness model than in the substance use disorder treatment model. Much of the same information is gathered but it is gathered through a different lens. It is customary for a

mental health assessment to allow a narrative presentation in response to supportive questions.

In a substance use disorder assessment a more direct method of questioning is used. It is necessary to ask specific questions about the use of all addictive substances, the age of first use, the pattern of use over the life span, the highest amount used, and the last date of use. Substance use disorder assessors are aware that if they do not ask directive questions about these matters the information will not be provided.

A thorough assessment of an individual needs to include a mental health assessment and a substance use disorder assessment. Many clinicians from various professions are properly educated, trained, licensed and credentialed to provide comprehensive assessments.

BEHAVIORAL MEDICINE PROVIDERS

The healthcare industry has a long history of educating, training, and credentialing providers. Individuals who wish to pursue a career in the healthcare industry choose an accredited graduate training program, complete their studies, seek entrance to an accredited clinical training program, complete that program, sit for qualifying examinations, obtain a license in their state and maintain that license through continuing education and recertification. Specialty training programs and certificates are available that allow providers to distinguish themselves as having expertise in certain areas.

Providers who are properly credentialed to practice independently can get on insurance panels and be paid by health insurance companies. Health insurance companies only panel properly licensed and credentialed providers. At the present time psychiatrists, psychiatric nurse practitioners, PhD/PsyD clinical psychologists, and clinical MSWs are considered independent practitioners. In some parts of the country LPCs (Licensed Professional Counselors) are attaining the same status.

Other Masters level clinicians are credentialed to practice but only under the auspices of a PhD clinician or in a licensed program. These laws vary from state to state so it is imperative that the Mental Health Code for the state be consulted to discover the pertinent laws.

In addition to professional graduate education, training, and licensure most states in the nation offer specialty certifications for drug and alcohol counselors. These programs require a professional graduate degree, a certain number of supervised hours of practice, continuing education and

commitment to the Code of Ethics of the credentialing body. In Louisiana the Louisiana Association of Substance Abuse Counselors & Trainers offers a number of such credentials.

Evaluations can be conducted by a properly educated, trained and credentialed healthcare provider who is recognized by the state as an independent practitioner or working in a licensed program. For example, an individual with an MSW who has worked treating individuals with mental and addictive illnesses, is licensed, and credentialed to practice independently and holds the state approved addictions certificate would be capable of conducting a comprehensive assessment that could determine all diagnoses and also determine prognosis and whether the person has engaged in sufficient treatment to state definitively that they are capable of responsibly managing any condition with which they are diagnosed. Such a clinician can provide an evaluation that meets all the pertinent criteria clinically and do so at a lower cost than a multidisciplinary evaluation team. Transportation can be provided by a Chevrolet or a Rolls Royce, but it is transportation either way.

SAFETY SENSITIVE PROFESSIONS

Clinical work with highly educated professionals is challenging because it is common for the professional to resist the challenges of treatment utilizing their considerable knowledge and specific skills. Many highly trained behavioral medicine providers are not capable of intervening with professionals who have progressed to impairment.

Professional licensing bodies have a duty to the public to license professionals who are fit to practice. Safety Sensitive Professional Programs exist to serve the dual goals of protecting the public from impaired professionals, and offering accountability and support to impaired professionals. There is often a dynamic conflict between these goals. Staff in a physicians health program or a lawyers assistance program deals with this conflict often.

The extra challenges of intervening with impaired professionals and the conflict between the goals of protecting the public and helping an ill professional to heal require PHPs and LAPs to be discriminating in the providers they select. The providers must have all the appropriate education and training described above and a track record for working effectively with this special population.

CAVEAT

Individuals in monitoring contracts with a PHP or LAP are a captive audience of sorts. If they wish to gain and retain their license they must comply with treatment recommendations. Behavioral medicine providers live in a time of diminishing incomes and challenges to their business model. There are financial motivations that providers and treatment centers have. Just as PHPs and LAPs must have heightened perceptual abilities to evaluate impaired professionals, they must have heightened scrutiny of treatment providers and treatment facilities. Staff and expertise wax and wane in behavioral medicine. LAP staff is in the unique position of maintaining awareness of this reality. The ultimate decision about the best treatment providers and treatment facilities needs to remain in the hands of professional LAP staff.

CONDUCT OR STATUS

The Americans with Disabilities Act prohibits a licensing body from subjecting an applicant to a higher level of scrutiny based on a disability, or status alone. A diagnosis of mental or addictive illness is construed as status by the ADA. For a licensing body to have the right to require that an applicant submit to a comprehensive evaluation, prove that they are not symptomatic with their diagnosis, and submit to monitoring for a prolonged period of time there must be conduct that indicates the individual is remiss in managing their condition.

The Department of Justice has insisted that applicants with a mental illness must be evaluated and monitored by a psychiatrist. The only monitoring they can be subjected to is case management to hold them accountable for following through with the psychiatrist's recommendations. Their records must be kept with all privacy protections provided by HIPAA and 42 C.F.R. The DOJ has been very clear that no applicant can be subjected to greater scrutiny based on status alone.

For applicants with a history of addictive illness it can be predicted that the DOJ will take a similar tack in time. When an applicant presents with questionable conduct five to ten years prior to applying to the bar, can demonstrate intervention, treatment and recovery then any demand for intense and expensive evaluation, a demand to prove recovery, and a prolonged period of monitoring is based on status (diagnosis) and not on conduct. For conduct to be a pertinent focus of investigation it needs to be caused by a condition that is present, chronic, and permanent. The other possibility that would warrant greater scrutiny would be if the applicant lied

about prior conduct and it was discovered in a Character and Fitness investigation. The misrepresentation would be seen as conduct sufficient to doubt the veracity of other evidence offered to prove recovery.

ⁱ *Definition of the Medical Model*. The Free Dictionary. Farflex. <http://medical-dictionary.thefreedictionary.com/medical+model>

ⁱⁱ *Treatment of Adolescents with Substance Use Disorders*. Treatment Improvement Protocol Series, No. 32. Center for Substance Abuse Treatment. SAMSHA, Rockville, MD. 1999.

ⁱⁱⁱ I often hear the statement, “All alcoholics and drug addicts are liars.” When I go out to teach graduate students and medical students about the treatment of addictions I phrase it differently. I ask them to have compassion for the person whose brain has a faulty reward system. I ask them to understand that the only way the person who is addicted can make their way in the world is by tricking themselves into believing they are alright when there is much evidence that they are not. Our job is to help them understand that and to help them stop. Vincent, T. Countless lectures to graduate students, medical students, and training therapists. 1993 to present.

PEER MONITORING MODEL

State Bar of Michigan Lawyers and Judges Assistance Program Attorney Recovery Network/Attorney Monitor Member Information

Recovery Network Member

The Lawyers & Judges Assistance Program (LJAP), Attorney Recovery Network, is an informal group of volunteer attorneys from throughout the state of Michigan. We enlist the help of individuals from this group in the event we make contact with an attorney who is in need of support in his or her endeavor to negotiate the early stages of recovery from substance use and/or mental health disorders.

Criteria for Recovery Network Member

- 2 years sober
- 2 year in remission from mental health issues
- Volunteers may also help people who need short-term support regarding general wellness issues.

Attorney Monitor

We also enlist the help of those in the recovery network to serve as “attorney monitors”. Distinct from the recovery network, these individuals will assist us in working with attorneys who have been referred by the discipline system (Attorney Grievance Commission/Attorney Discipline Board). After determination is made as to the underlying issues related to their discipline status we would interface with discipline and monitor the attorneys’ efforts at recovery.

What Are The Prerequisite Qualifications For Serving as a Monitor?

It is crucial that the monitors be and act beyond reproach. The Recovery Monitoring Program's credibility depends upon the monitors knowing their duties and executing those duties faithfully. Volunteers, therefore, should

meet certain threshold qualifications and be specially trained to serve as monitors.

In order to be qualified to serve as a monitor under the Recovery Monitoring Program, one should be approved by and recommended by LJAP. He or she should also possess the following minimum qualifications:

- If the monitor is a lawyer, he or she should be licensed and in good standing for the last five years and with no disciplinary sanctions for at least the last two years;
- He or she should exhibit an understanding of the duties of a monitor and should indicate the willingness to perform those duties, especially with regard to the reporting requirements;
- He or she should complete the monitor training course; and if the monitor is recovering from an addiction, other compulsive disorder, or an emotional or mental illness, he or she should be required to demonstrate at least two years of continuous recovery from such condition.

What Should The Monitor Training Curriculum Include?

Each monitor should complete an approved training course. At a minimum, this training should include the following topics:

Orientation as to how the Recovery Monitoring Program works;

The purpose and benefits of monitoring; the standard conditions to be monitored; an overview of discipline and admissions;

An introduction to impairments, including the basics of the various addictions, other compulsive disorders and mental and emotional impairments; the dynamics of enabling; the recovery process; and the dynamics of relapse;

The mechanics of monitoring, including the use of program forms, reporting requirements, and drug screen procedures.

Please fill out the attached form if you are interested in becoming one of our Network Recovery/Attorney Monitor Members. Please check which one you are interested in.

Thank you!

WHAT AN ATTORNEY MONITOR DOES

An attorney monitor's *only* role is to supervise the monitored attorney in accordance with the monitoring contract and report to the monitoring authority as to whether the monitored attorney is or is not in compliance. It is not the monitor's role to serve as a counselor, sponsor, or treatment provider for the monitored attorney.

To better understand this role, it is helpful to consider what a monitor *must do*, what a monitor *should do*, what a monitor *can do*, and what a monitor *cannot do*.

The attorney monitoring contract provides all of the particulars about what is required of the monitored attorney. Those same requirements provide a road map to the attorney monitor about expectations and responsibilities.

What a monitor must do:

- Meet face to face with the monitored attorney as frequently as the contract provides
- Timely file all reports with the Lawyers and Judges Assistance Program staff
- Report all incidents of contractual non-compliance as required
- Maintain confidentiality

What a monitor should do:

- Be clear with the monitored attorney about the monitor's expectations
- Be consistent with expectations, consequences, and reporting
- Inform the monitored attorney when the monitor is attending the same 12-Step meeting

What a monitor can do:

- When necessary, approve a telephone contact in lieu of an in-person contact
- If concerned about the monitored attorney's abstinence and the contract mandates random drug screens, require the monitored attorney to submit to random drug screens

What a monitor cannot do:

- Act as the 12-Step recovery program sponsor for the monitored attorney
- Be responsible for the monitored attorney's recovery or compliance
- Enable the monitored attorney to continue in self-defeating behavior
- Represent the monitored attorney in any capacity
- Profit from the monitoring relationship in any way

QUALIFICATIONS FOR SERVING AS A MONITOR

It is crucial that the monitors be and act beyond reproach. The Recovery Monitoring Program's credibility depends upon the monitors knowing their duties and executing those duties faithfully. Volunteers, therefore, should meet certain threshold qualifications and be specially trained to serve as monitors.

In order to be qualified to serve as a monitor, he or she should possess the following minimum qualifications:

- Licensed with the State Bar of Michigan and having no disciplinary sanctions during the past two years
- Exhibit an understanding of the duties of a monitor and should indicate the willingness to perform those duties, especially with regard to the reporting requirements
- Complete the monitor training course
- If the monitor is recovering from an addiction, or other compulsive disorder, or an emotional or mental illness, have at least two years of continuous uninterrupted recovery

MONITORING TRAINING CURRICULUM

Each monitor should complete an approved training course. At a minimum, this training should include the following topics:

- Orientation as to how the Recovery Monitoring Program works
- The purpose and benefits of monitoring; the standard conditions to be monitored

- An introduction to impairments, including the basics of the various addictions other compulsive disorders, and mental and emotional impairments, depression, and how these may play a role in addiction and recovery will be explored as well; the dynamics of enabling; the recovery process; and the dynamics of relapse
- The mechanics of monitoring, including the use of program forms, reporting requirements, and drug screen procedures; and a detailed overview of what a monitor must, should, can, and should not do

APPOINTING MONITORS TO PARTICULAR CASES

To optimize the effectiveness of any Recovery Monitoring Program, every effort will be made to appropriately “match” the monitors with the monitored lawyers. In making this case-by-case determination, the following criteria will be considered whenever possible:

- **Gender**
- **Subject Matter of Law Practice**
- **Age**
- **Recovery**

To the extent possible, an effort will be made to match the gender, area of practice, age, and nature of addiction. Beyond a belief that an alignment of gender, area of practice, and age will promote easier communication, a monitor with a strong foundation in recovery and a drug(s) of choice in common with the monitored attorney is more likely to readily recognize signs of denial and relapse in the monitored attorney.

In appointing monitors, each case should be closely scrutinized for potential conflicts. Any past, current, or probable future relationship with a monitored lawyer that would interfere with the ability of the monitor to honestly and ethically perform his or her duties should disqualify a monitor from serving in that particular case. This could include past or current representation of the monitored attorney; past, current, or potential representation of any opposing parties in any legal matter; or past or current business or personal relationship.

MONITOR REPORTING/EFFECT OF REPORTS

Monitors should file the following written reports:

- Monthly reports as to whether the monitored attorney has complied with each of the monitored conditions
- Non-compliance reports immediately upon discovering an incident of non-compliance by the monitored attorney

Sample forms for each of these reports will be provided.

While all incidents of non-compliance on the part of the monitored attorney should be reported, not every incident of non-compliance will justify discontinuation of the monitoring arrangement. It is not the responsibility of the attorney monitor to determine what sanction or consequence will be imposed as a result of any instance of non-compliance. Whenever non-compliance is reported, the attorney monitor should consult with the Lawyers and Judges Assistance staff about what steps should be taken, if any, beyond the reporting of non-compliance to the monitoring authority.

Some incidents may only require the imposition of a one-time intervention; e.g., attendance at an extra recovery program meeting per week for one month. Some may require additional conditions to be adhered to throughout the remainder of the monitoring period and/or the extension of the monitoring period. Still others will require the discontinuation of the monitoring arrangement with possible disciplinary or licensure consequences.

The appropriate response to an incident of non-compliance is unique to each case and involves many considerations, including:

- The nature and degree of severity of the particular incident of non-compliance involved
- The effect the incident of non-compliance had upon the monitored attorney's ability to discharge his or her duties to clients, the courts, and the profession
- The monitored attorney's compliance history to date
- The monitored attorney's response to the non-compliance – whether it was self-reported, acknowledged, or denied, and whether the monitored attorney has taken action to address the non-compliance either before or after being asked to

REMOVING MONITORS FROM PROGRAM

There may be circumstances where it is appropriate for an attorney monitor to be removed from performing that function with regard to a particular monitored attorney. Where appropriate, the Program Administrator of the Lawyers and Judges Assistance Program has the authority to remove an attorney monitor.

Examples of circumstances that could result in the removal of an attorney monitor include where:

- The attorney monitor's personal or professional interests conflict with his or her duties as a monitor
- The attorney monitor has knowledge of non-compliance by the monitored attorney and has failed to report such non-compliance to the monitoring authority.

CUSTOMARY CONDITIONS OF MONITORING

Where the monitored attorney has substance use issues, the monitoring contract would typically include the following requirements of the monitored attorney:

- Maintain abstinence from all alcohol and other mind altering drugs
- Actively participate in a stipulated recovery program (e.g. Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous) and/or treatment program (e.g. inpatient and/or outpatient treatment, aftercare groups) throughout the duration of the monitoring period
- Submit to random drug screens within a specified time period (usually within six hours of the call)
- Report any failure to maintain abstinence to the attorney monitor
- Maintain regular face-to-face contact with the attorney monitor, at the intervals prescribed in the monitoring contract
- Provide documentation of participation in the required recovery program (e.g. Alcoholics Anonymous) and any required treatment (e.g. outpatient treatment)
- Bear all costs associated with assessments, treatment, and drug screens.

SPECIAL SITUATIONS

Can a Recovery Monitoring Program be used with other impairments?

While the bulk of the monitoring contracts pertain to attorneys, law students, and judges whose impairment is chemical dependency, some clients with mental health issues as well as some who are dual diagnosis are participating in monitoring contracts. In some instances, persons are referred to other resources where a monitoring contract is not deemed appropriate.

Have Monitoring Contracts been used in matters other than discipline and admissions cases?

Some clients are self-reported or referred by persons and entities other than discipline or admission and participate as a result.

RESOURCES

For more information regarding the Michigan Lawyers and Judges Assistance Program contact Tish Vincent, at 517-346-6337.

**MICHIGAN LAWYERS AND JUDGES ASSISTANCE PROGRAM
NETWORK VOLUNTEER REGISTRATION FORM**

Network Recovery Panel Member: _____ Attorney Monitor
_____ Substance Use Disorders
_____ Mental Health Issues
_____ General Wellness
_____ Mentoring

(Please check your area(s) of experience or interest)

Why do you want to be a LJAP volunteer?

What makes you a good candidate to act as a LJAP volunteer?

How much time can you afford as a volunteer (measured in hours per month)?

CONTACT INFORMATION:

Last Name	First Name	Middle
-----------	------------	--------

Home Address

City	State	Zip
------	-------	-----

Business Address

City	State	Zip
------	-------	-----

Telephone: Home	Business
-----------------	----------

E-mail address	Cell Phone
----------------	------------

May we leave a message for you?

Home	_____Yes	_____No
Business	_____Yes	_____No
Cell	_____Yes	_____No

Preferred mailing address:

Home_____ Work_____ Either_____

Date of Birth:_____

Would you be willing to participate in a training to become a volunteer?

_____ Yes _____No

Once trained will you accept a monitoring role in our work with the Attorney
Grievance Commission?

Yes_____ No_____

FOR THOSE IN RECOVERY FROM SUBSTANCE USE DISORDERS:

Date continuous sobriety began_____

Do you attend AA/NA? Yes_____ No_____

Other Support groups/recovery activities (please list)

How many times per week:_____

Do you currently have a sponsor?

Yes_____ No_____

If no explain:_____

Did you enter recovery through:

_____Residential/Inpatient

_____Outpatient

_____Intensive Outpatient

_____AA/NA

_____Other (explain)_____

Briefly speak about your step work:_____

Chemicals used:

_____ Alcohol	
_____ Cocaine	Smoke_____Snort_____IV_____
_____ Methamphetamine	
_____ Heroin	Smoke_____Snort_____IV_____
_____ Marijuana	
_____ Narcotics	
_____ PCP	
_____ Tranquilizers	Types_____
_____ Barbiturates	Types_____
_____ Hallucinogens	Types_____
_____ Inhalants	Types_____
_____ Other	Types_____

I understand the above information will be held in confidence and used only by MLJAP Staff in assessing volunteer eligibility and matching volunteers with program participants. Should any information change I will immediately notify MLJAP Staff.

Signature

Date

Policies and Procedures for Training Peer Monitors

Michigan Policy

Provided 8/27/2015

Peer Monitor Training

The LJAP will collect volunteer request forms and will provide a formal Peer Monitor Training entitled “Understanding the Mechanics Of Monitoring,” to be presented by LJAP staff. This training will occur twice yearly, and will be held at the SBM during evening hours. In the event volunteers require monitor training in between scheduled training dates, case monitors may meet individually with volunteers to provide an informal training; but volunteers so trained are also expected to attend the next scheduled formal training.

Instructions for Organizing and Hosting Peer Monitor Training

Peer Monitor Training

Any electronic information about Peer Monitor Training is located in
Q > Network Members > Monitor Training

Scheduling the Training

At least once a year a peer monitor training is held for all those members of the volunteer network who have not had the training, those who wish for a refresher, and anyone interested in becoming a peer monitor. This can be done whenever deemed necessary and can also be done on a one by one basis by the clinician. ALL PEER MONITORS or VOLUNTEER RECOVERY SUPPORT PERSONS are REQUIRED to be trained.

Begin to set up the training by choosing a date; these trainings are typically done in the evenings at the State Bar Building from 5:30 to 7:30 pm. Reserve a room large enough to hold the number of participants attending (example rooms 1 & 2 for more than 20 people).

Send a training invitation letter to all existing network members and those who wish to become members. This should be done as soon as you choose a date; a reminder should also go out a month in advance. Ask for RSVPs to be in a week and a half before the training date.

A week before the In-Service ask the Program Administrator what they want included in the folder for the trainees. Make the number of necessary folders

as well as a few extra. The extras can be used for individual trainings throughout the year.

Have a nametag ready for each person that is coming. If you need more nametag cards or plastic sleeves, ask Doreen or Jalayne, they will unlock the cabinet and retrieve the needed materials. The sleeves and name cards are kept track of for State Bar purposes.

Make sure that when you book the room you put in a Help Desk Request for a projector and Loaner Laptop.

Dinner should be ordered no less than a week in advance, dessert and drinks should either be ordered with lunch or purchased separately. If purchased, the pop should be placed in the fridge the night before an in-service (you must label the pop "LJAP").

Print a sign in sheet to track who has come, this should be scanned in to the computer after the training.

Training completion certificates should be printed for each person who has indicated they are attending; these are given to them upon completion of the training.

If there are new network members attending and we do not have registration forms for them they should be filled out the day of the training.

If the program administrator asks for a survey hand them out at the end of the presentation.

After the Training

If the volunteer has not previously had the training make sure and change their status to YES in the excel database.

Add any new member information to the network member contact information sheets by location as well.

Peer Monitor Updates

Once a year a mailing/e-mail should go out to all the network members who do not have a monitree or have joined in the past 12 months to ask if they would like to remain on the list of volunteers. There should be a cover letter as well as the update information packet that is sent out. Update the list according to the responses.

**STATE BAR OF MICHIGAN - LAWYERS AND JUDGES ASSISTANCE
PROGRAM
306 TOWNSEND, LANSING, MI 48933
PEER/ATTORNEY MONITOR REPORT**

To:

From:

Re:

Date:

CC:

This report is furnished pursuant to the agreement between the above named attorney and Monitoring Authority. All information is provided based on the best knowledge and evaluation of the above named attorney monitor.

1. The attorney has remained abstinent since the last report.
Yes___ No___
Comments:

2. The attorney has attended the required number of 12-step meetings and such attendance has been verified on the 12-step meeting attendance record.
Yes___ No___
Comments:

3. Attorney has obtained and continues to utilize a 12-step sponsor.
Yes___ No___
Comments:

4. Attorney has _____ been requested to submit to a drug/alcohol screen.
Yes___ No___
Comments:

5. Attorney is in compliance with the terms of his/her Monitoring Agreement.
Yes___ No___
Comments:

Signature of Attorney Monitor:_____

**STATE BAR OF MICHIGAN - LAWYERS AND JUDGES ASSISTANCE
PROGRAM
306 TOWNSEND, LANSING, MI 48933
VOLUNTEER RECOVERY SUPPORT PERSON MONITOR REPORT**

To:

From:

Re:

Date:

CC:

This report is furnished pursuant to the agreement between the above named client and Monitoring Authority. All information is provided based on the best knowledge and evaluation of the above named volunteer recovery support person.

1. The client has remained abstinent since the last report.
Yes___ No___
Comments:

2. The client has attended the required number of 12-step meetings and such attendance has been verified on the 12-step meeting attendance record.
Yes___ No___
Comments:

3. Client has obtained and continues to utilize a 12-step sponsor.
Yes___ No___
Comments:

4. Client has _____ been requested to submit to a drug/alcohol screen.
Yes___ No___
Comments:

5. Client is in compliance with the terms of his/her Monitoring Agreement.
Yes___ No___
Comments:

Signature of Volunteer Recovery Support Person:_____

**STATE BAR OF MICHIGAN - LAWYERS AND JUDGES ASSISTANCE
PROGRAM**

**306 TOWNSEND, LANSING, MI 48933
STUDENT MONITORING REPORT**

To:

From:

Re:

Date:

CC:

This report is furnished pursuant to the agreement between the above named student and Monitoring Authority. All information is provided based on the best knowledge and evaluation of the above named student monitor.

1. The student has remained abstinent since the last report.
Yes___ No___
Comments:

2. The student has attended the required number of 12-step meetings and such attendance has been verified on the 12-step meeting attendance record.
Yes___ No___
Comments:

3. Student has obtained and continues to utilize a 12-step sponsor.
Yes___ No___
Comments:

4. Student has _____ been requested to submit to a drug/alcohol screen.
Yes___ No___ (If "yes" indicate the dates and times requested under the "Comments" section)
Comments:

5. Student is in compliance with the terms of his/her Monitoring Agreement.
Yes___ No___
Comments:

Signature of Monitor:_____

LAWYERS ASSISTANCE PROGRAM COMPARISONS

Lawyers Assistance Programs are of two distinct types. One type is based on the Lawyers Concerned for Lawyers Model. The other type is a Broad-brush Lawyers Assistance Program that offers service to those struggling with substance use disorders, as well as emotional, mental, and physical disabilities. The Broad-brush programs often offer monitoring agreements to law students, lawyers and judges. These programs report compliance or non-compliance by the legal professional with the monitoring agreement to a monitoring authority.

These two manifestations of Lawyers Assistance Programs operate with very different policies and procedures. They are staffed differently and view discipline differently. Comparing an LCL model LAP to a BB model LAP is not like comparing apples to oranges. It is like comparing apples to shrimp and grits.

SUPPORT

The LCL model of a LAP is often staffed with an attorney as the program director. They may have a clinician on staff. They do have a network of volunteer recovering attorneys who serve as peer monitors to program participants. They may refer to clinicians in the state so that a legal professional can receive the counseling or other healthcare services needed. Their mission is to support the legal professional who is struggling with addiction or emotional illness in an effort to heal and be whole again.

This model does not provide monitoring agreements to students, attorneys, or judges who are in trouble with discipline or anticipate being in trouble with character and fitness. They are hesitant to testify in disciplinary or admissions hearings.

In some jurisdictions where the LAP is an LCL model monitoring is conducted by Discipline.

The LCL model is very dedicated to maintaining the privacy of their participants. They observe all federal and state requirements for confidentiality. Some jurisdictions have adopted MRPC 8.3 (c) which does not require disclosure of information otherwise protected by Rule 1.6 or information gained by a lawyer or judge while participating in a lawyers assistance program.¹

¹ *Model Rules of Professional Conduct – 2015 Edition*, ABA Publishing, 2015. Page 161.

SUPPORT & ACCOUNTABILITY

The Broad-brush model of a LAP is often staffed with a combination of attorneys and clinicians in the executive positions. These LAPs have a staff of clinician case monitors who perform case management services for the program participants. Program participants are offered monitoring agreements. The monitoring agreement is between the program participant and the LAP and it includes all the support and clinical services determined necessary based on input from a clinical evaluation. A clinical evaluation is completed by a clinician or team of clinicians vetted by the LAP. The written assessment is presented at a case conference of the LAP clinical staff and the case is staffed according to what will provide the best opportunity for healing.

When the program participant complies with the monitoring agreement a report is generated and provided to their monitoring authority. When the program participant does not comply with their monitoring agreement their monitoring authority is notified.

The BB LAPs that offer monitoring agreements and report to discipline require their program participants to sign specific releases of information allowing the LAP staff to communicate with all members of their monitoring team, the discipline office, any collateral contacts deemed necessary, and the lab that performs any screens. The process of signing specific releases is a reality in the delivery of mental health care and is covered by pertinent laws protecting the privacy and right to confidentiality of protected health information.

In jurisdictions with broad-brush programs the discipline system relies on the LAP to craft a proper monitoring agreement and hold the program participant accountable for complying with that agreement. In LCL jurisdictions it is presumed that the discipline system itself performs this function.

The BB LAPs must take measures to explain the nature of their relationship with discipline to the legal professional at the time of evaluation. They must also establish internal policies and procedures to be clear about their role as case managers.

IMPORTANT CONSIDERATIONS

When comparing one LAP to another one must first determine whether the LAP in question is an LCL model or a BB model. A LAP of one model must be compared to another LAP that operates on the same model. The Michigan

LAP (BB) cannot be compared to the Oregon LAP (LCL). Michigan can be compared to Florida. Oregon can be compared to Pennsylvania. In the body of complaints presented to the audit team the Louisiana JLAP (BB) was compared to Texas (LCL). The legal professional who compared the two is critical of the Louisiana LAP. This is an unfair comparison.

The Louisiana JLAP is a Broad-brush program with a monitoring component. The Louisiana JLAP monitors according to the LASC rules at the order of the Supreme Court. The Louisiana JLAP did not have the latitude to change the rules set by the Court to monitor this complainant according to the rules of a Lawyers Concerned for Lawyers LAP. It is unfortunate that applicants can compare two LAPs without the requisite knowledge of the differences.

It is noted that Louisiana has a rule for Conditional Admission and that the terms imposed on applicants are more exacting than other jurisdictions that have conditional monitoring. For a fair and true comparison decisions of the Louisiana JLAP would need to be compared to a LAP that is a Broad-brush program with monitoring in a jurisdiction that has conditional admission.

DR. JOHN THOMPSON INTERVIEW BY DR. MARTHA BROWN

Dr. Thompson practices general psychiatry. He has Forensic and Addiction Boards, meaning he is credentialed as having expertise in these areas. He was asked to consult with COBA on ADA issues with bar applicants. He does not know how the admissions committee picks cases to send to him for review. Considering the scrutiny by the DOJ of bar applicants with mental health issues he is concerned that the DOJ may decide to scrutinize the handling of Bar applicants with substance abuse diagnoses.

Dr. Thompson stated that he consulted with COBA and has done the work they asked of him. COBA did not express any desire for future regular meetings with him to discuss mental illness and how to handle cases. COBA explained that they did not think they could afford his fees after having him come to the first meeting.

Regarding the Louisiana JLAP Dr. Thompson stated that he agrees with 75-80% of what JLAP does. He would like to see development of a “stratification of treatment” model with consistent guidelines for clinical evaluation and case management. Clinical suspicions can be a strong source of information but they need to be supported by defensible clinical guidelines. He would like to see more consistency in JLAP recommendations.

Dr. Thompson recommended that JLAP expand the number of treatment centers it refers to. He mentioned that the Louisiana Physicians Health Program sends its clients to Emory in Atlanta as one trustworthy option.

SUMMARY

John W. Thompson, MD is Professor and Chair of the Department of Psychiatry and Behavioral Science at Tulane University Medical School. His commentary is self-explanatory.

JUDGE ZAINNEY INTERVIEW

Helen N. Henderson, Esq.-New Orleans Coordinator

She reported that in one case of a potential suicide, Judge Zainey worked on the case and she thought that it was Judge Zainey's intervention that saved the lawyer's life.

Hon. Jay C. Zainey-Director

He indicated that he works closely with Buddy Stockwell and does not hesitate to call him to not only discuss cases that have come to SOLACE, but also to refer cases to JLAP when appropriate.

He said that two years ago as a result of nine suicides of Louisiana attorneys, Mark Cunningham had promised to expand JLAP services to address this problem of lawyer depression.

Judge Zainey stated that he had referred 4-5 cases to JLAP over the past year and has received positive feedback from at least one attorney who was suicidal and went into treatment after being referred to JLAP.

The Judge said that he has made presentations with Buddy. In the past he had worked well with Bill Leary, and now works very well with Buddy Stockwell on common issues.

Judge Zainey has written a *BAR Journal* article describing his relationship with JLAP.

Judge Zainey ended the interview with the statement that he is a strong supporter of both Buddy and the LA JLAP. He stated that he thinks Buddy does have the lawyers' best interests at heart but that concern may not always be communicated clearly to them because of the strong message he delivers concerning the mandates that they are required to follow in order to satisfy the Court ordered monitoring contracts.

SUMMARY

The Hon. Jay C. Zainey is from the U.S. District Court, Eastern District of Louisiana, and is the Director of SOLACE. His commentary is self-explanatory

DR. BARRY LUBIN OF AFFINITY INTERVIEW BY TISH VINCENT, MSW, JD ON SEPTEMBER 2, 2015

Barry states that he has been working with Buddy Stockwell for 4 years. He did not work with Bill Leary, the previous director. Bill had a different screening system.

Affinity Labs provides services to the Florida, Tennessee, Mississippi, North Carolina, New Mexico and Arizona LAPs.

Barry said that he is impressed with the professionalism of the Louisiana LAP. He said that the clinical staff calls him with MRO (Medical Review Officer) questions regularly. They also turn to him with questions about medication issues with their program participants.

He stated, "Buddy runs a fine, honest, good program to protect the public."

I asked him about participants' complaints about not being informed about what benign substances may adulterate their screens. He said that routine information about substances that contain alcohol, such as hand sanitizers and mouthwash along with information about avoiding poppy seeds are a routine part of the information provided on Affinity's website. Any more specific information would be provided by the Louisiana LAP to their participants.

SUMMARY

Barry Lubin, MD is an MRO (Medical Review Officer) at Affinity Labs. As noted above he has extensive experience in this field. In addition to working with the 6 other State LAPs mentioned above, he also works with many Physician Health Programs. He is very familiar with the LA JLAP. In 2013, he accompanied the JLAP Executive and Clinical Directors on a 3 day trip to train peer monitors in Lafayette, Shreveport, and New Orleans.



July 26, 2015

To Whom It May Concern,

I am writing in regards to the importance of the Judges and Lawyers Assistance Program of the State of Louisiana. As an addictions professional for twenty-five years, author, columnist, nationally known speaker and trainer, I am well acquainted with addiction programs on a national level and their various levels of quality and competency. I can say without hesitation that the JLAP program of Louisiana has reached a pinnacle in our field and – possibly more than any other state program for lawyers and judges – demonstrates the highest quality of service. Their outcome numbers speak of their success, but do not tell the entire story. The depth of understanding of the disease of addiction as well as the clarity in thinking in terms of what is required for successful treatment and recovery culminates in an exemplary action-based program that works.

In a world where relapse rates for the general public reach 50 to 90 percent in the first year after treatment, it is with amazement that we study what Louisiana's JLAP program accomplishes to bring about incredibly low relapse rates over *five years post treatment*. They set an important example for programs across the country, and offer a blueprint for success that we desperately need.

The success of Louisiana's JLAP accomplishes three very important goals: 1) They protect the common good (clients) by serving the impaired attorney or judge and confirming that he or she will be in recovery before going back to practicing law; 2) They protect the reputation of the legal field by successfully helping so many lawyers and judges whose disease tears down the reputation of the field (thus the reputation of everyone within the profession); and 3) they save the lives of legal professionals who are also fathers, mothers, sisters, brothers, sons and daughters, well loved by those in their families as well as by those who they call colleagues.

Buddy Stockwell III understands the disease of addiction and how to recover from it like the back of his hand. He is a razor sharp thinker and a relentless fighter for the still suffering lawyer or judge. Nothing less will suffice, because we are battling a disease that does not allow its victims to reach out for help. Leah Rosa is a highly skilled and nuanced therapist who has the professional toughness to deal with a disease that fights against those who are trying to help. The level of professionalism, knowhow, and commitment of these two individuals cannot be overstated.

Please feel free to contact me at any time: 313-882-6921.

Sincerely yours,

Debra Erickson Jay



INTERVENTION



BOOKS & MEDIA



SUPPORT



TRAINING

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APPENDIX A

CV and Bio of Hon. Sarah L. Krauss (ret.)

Curriculum Vitae
Judge Sarah (Sallie) Krauss

Judge Sarah (Sallie) Krauss (now retired) is an Outreach Coordinator for the New York State Bar Association Lawyers Assistance Program and serves as a member of the Advisory Committee to the American Bar Association's Commission on Lawyer Assistance Programs (CoLAP) as well as co-chairing CoLAP's Judicial Assistance Initiative. Judge Krauss is the immediate past Co-Chair of the New York State Bar Association Judicial Wellness Committee.

Previously, Judge Krauss served as Chair of the CoLAP from 2011 to 2014 and also served as Chair of the Judicial Assistance Initiative (JAI) from 2008 to 2011. During her tenure as chair of JAI, The JAI published an ABA resource guide entitled "Judges Helping Judges; Resource and Education" in order to assist judges in finding help for themselves for issues amongst the judiciary which might hinder successful careers.

In the past, Judge Krauss had served as the Chair of the New York State Bar Association's Lawyer Assistance Committee from 2006-2010 and has served as chair of the Lawyers Helping Lawyers Committee for the Brooklyn Bar Association during two different periods in the last 15 years, and has been active as a lawyer/judge assistance volunteer and committee person in New York State since 1990.

Judge Krauss has presented education on the issues of impairments in the legal profession and in the judiciary and on the issues of wellness and stress for many bar associations and judges' groups in New York as well as in Arkansas, Arizona, California, New Jersey, South Dakota, Tennessee, Texas, Virginia, and Washington, D.C.

Judge Krauss was elected to the New York City Civil Court in 1994 and again in 2004, served in the Brooklyn Civil and Criminal Courts from 1995 to 2004 and served as an Acting Supreme Court Justice in both the Supreme Court and the Family Court in Brooklyn, New York, from 2005 to her retirement in 2012.

APPENDIX B

CV and Bio of Tish Vincent, MSW, JD

TISH VINCENT

Tish Vincent joined the staff of the State Bar of Michigan as the Program Administrator for the Lawyers & Judges Assistance Program in April, 2012 bringing twenty six years of experience as a mental health professional and five years of experience as an attorney. She began her career in mental health offering outreach to therapists struggling with their own eating disorders. After earning her Masters in Social Work she worked at Community Mental Health, Saint Lawrence Health System Psychiatry and Addiction Units, Psychological Health Systems Behavioral Medicine MCO, conducted trainings for the State of Michigan Department of Human Services, and maintained a private practice. She has developed expertise working with professionals who are struggling with addiction and mental health challenges. Ms. Vincent chose law as her second career and practiced Health Law and Alternative Dispute Resolution in the mid-Michigan area. She is an ICLE contributor, a provider for the Health Professionals Recovery Program, and an immediate past board member of the mid-Michigan Chapter of the Women Lawyers Association of Michigan. She has a Bachelor of Arts in Psychology from Aquinas College in Grand Rapids and a Masters of Social Work and a Juris Doctor from Michigan State University.

TISH VINCENT

Personal Contact Information

Work Address:

State Bar of Michigan
306 Townsend
Lansing, MI 48933
Work Phone: (517)-346-6337
Work Email: tvincent@mail.michbar.org

Home Address:

825 Pebblebrook Lane
East Lansing, MI 48823
Personal Phone: (517)-614-5082
Personal Email: TVinc1988@gmail.com

Birthdate: December 4, 1950

Citizenship: USA

Academic Background

- Michigan State University College of Law
 - 2006
 - Juris Doctor
 - Health Law and Alternative Dispute Resolution Concentrations
- Michigan State University School of Social Work
 - 1992
 - Masters in Social Work
 - Clinical concentration
- Aquinas College
 - 1972
 - Bachelor of Arts
 - Majors in Psychology and German

Professional Licenses and Certifications

- Member of the State Bar of Michigan
- State of Michigan Licensed Masters Social Worker (LMSW)
- State of Michigan Certified Advanced Alcohol and Drug Counselor (CAADC)
- Credentialed to practice independently by Academy of Certified Social Workers (ACSW)

Professional Positions

- Program Administrator of State Bar of Michigan Lawyers and Judges Assistance Program
 - April 2, 2012 to present
- Law Office of Tish Vincent
 - December 1, 2007 to April 2, 2012
- Legal Intern to Macomb County Prosecutor
 - October 1, 2005 to June 1, 2006
- Legal Intern to Director of Dispute Resolution Association of Michigan
 - August 1, 2005 to December 1, 2005
- Tish Vincent, MSW, Private Practice of Clinical Social Work
 - July 1, 1992 to present
- Staff Therapist at Psychological Health Systems, a Behavioral Medicine Managed Care Company
 - February 1, 1996 to March 1, 1998
- Staff Therapist at Saint Lawrence Health Systems, Addictions Unit
 - December 1, 1993 to March 1, 1996
- Staff Therapist at Saint Lawrence Health Systems, Adult Psychiatry Unit
 - September 1, 1991 to December 1, 1993
- Staff Therapist at Ingham County Community Mental Health, Child and Adolescent Unit
 - September 1, 1990 to September 1, 1991

Professional Association Memberships

- American Bar Association
 - Health Law Section
 - Alternative Dispute Resolution Section
 - Professional Responsibility Section
 - Family Law Section
- American Health Lawyers Association
 - Behavioral Health Task Force Member
- National Association of Social Workers
- Women Lawyers Association of Michigan
 - Immediate Past Vice-President of Mid-Michigan Region

Related Experience

- ABA CoLAP Student Assistance Committee Member, 2013 to present
- ABA CoLAP Judicial Wellness Committee Member, 2015
- SBM Staff Liaison to Lawyers and Judges Assistance Committee, 2012 to 2015
- SBM Staff Liaison to Building a 21st Century Practice Task Force, 2015
- Member of MBC, focusing on improving public speaking skills. 2008 - 2011
- Journal of Medicine and Law at MSU Law, 2004 to 2006
- Founder and President of OWLS (Older Wiser Law Students) at MSU Law, student organization for nontraditional law students, 2004
- Co-founder and Vice-President of the Society for Mental Health Law at MSU Law, 2005

Academic Teaching Experience

State Bar of Michigan

Judges

- Judicial Roundtables
 - Judge Donald Allen and I have facilitated Judicial Roundtables for Michigan's judges in January, April, May and August of 2015. This service has been provided to our District Judges and our Circuit Judges.
- Judicial Wellness
 - Judge Donald Allen and I have presented on Judicial Wellness to our Michigan Probate Judges Association, Michigan District Judges Association, and Michigan Judges Association.

Lawyers

- Dealing With Difficult Personalities
- Stress Management for Attorneys
- Civility in the Practice of Law
- Transitioning Toward Working Less

Students

- Mental Health, Substance Abuse, and Wellness to Professional Responsibility Classes
 - University of Detroit Mercy Law School
 - Michigan State University College of Law
 - Wayne State University College of Law
 - Western Michigan University Thomas M. Cooley College of Law

Discipline

- LJAP: Accountability and Support. *Presentation to the Attorney Grievance Commission and the Attorney Discipline Board*. Detroit, MI. September 12, 2012.
- Contractual Probation: How to Utilize Motivational Fulcrum of Impending Discipline in Treatment of Substance Use Disordered Legal Professionals. *Presentation to the Commission Members of the Attorney Grievance Commission*. Detroit, MI. July, 2013.
- Lawyers & Judges Assistance Program: A Brief Overview of Contractual Probation in Discipline Cases. *Presentation to Panel Members of the Attorney Discipline Board*. State Bar of Michigan Annual Meeting. Grand Rapids, MI. September, 2014.
- Compliance with LJAP Monitoring, What Does That Mean? *Presentation to members of Character and Fitness Committee*. SBM Building, Lansing, MI. March 2013 and March 2015.

Institute for Continuing Legal Education (ICLE)

- Mental Health Parity Addiction Equity Act: Impact & Implementation. *Presentation at ICLE Health Law Institute*, March 11, 2011.

Association of Social Work Boards credentialed provider of Continuing Education Units for Michigan State University College of Social Work

- What Should I Do? Ethical Dilemmas in Social Work Practice. *Presentation at MSU College of Social Work Great Lakes Summer Institute*. Traverse City, MI. July, 2009
 - MSU College of Social Work, Okemos, MI., February, 2010
 - Benzie, Manistee County Community Mental Health, September, 2010.
 - Ingham, Eaton, Clinton Community Mental Health Center for Excellence, Lansing, MI. March, 2013.
- Where Do I Start? Diagnosis & Treatment of Co-Occurring Disorders. *Presentation at MSU College of Social Work Great Lakes Summer Institute*. Traverse City, MI. July, 2009
 - MSU College of Social Work, Okemos, MI, February, 2010.
 - MSU College of Social Work, Great Lakes Summer Institute, July, 2010.
 - State Bar of Michigan Lawyers and Judges Assistance Program Provider In-Service, February, 2012.
 - State Bar of Michigan Lawyers and Judges Assistance Program Provider In-Service, October, 2013.
- LENSES That Bring Eating Disorder Treatment Into Focus. *Presentation at MSU College of Social Work*, East Lansing, MI. April, 2009
 - MSU College of Social Work Great Lakes Summer Institute, Traverse City, MI., July 2010.

State of Michigan Departmental Trainings for Family Independence Agency

- 1999 to 2003
- Assessment, Diagnosis and Referral to Appropriate Level of Care of Substance Abusers
- Screening for Chemical and Process Addictions for FIA Workers
- Assessment, Diagnosis and Referral to Appropriate Level of Care for Individuals With Co-Occurring Disorders

Academic Honors

- MSU College of Law Jurisprudence Award in Health Law, 2005
- *Phi Alpha Honor Society for Social Work*, 1992
- *Aquinas College Award for Superior Academic Achievement*, 1972

Publications

Articles

Vincent, T. (2015). First Do No Harm. *Michigan Bar Journal*, June 2015.

Vincent, T. (2014). Hero or Foe?, *Michigan Bar Journal*, November, 2014.

Vincent, T. (2014). Grace Under Pressure, *Michigan Bar Journal*, October, 2014.

Vincent, T. (2014). Protecting the Public, *Michigan Bar Journal*, September, 2014.

Vincent, T. (2014). Lawyers and Post-Traumatic Stress Disorder, *Michigan Bar Journal*, June, 2014.

Vincent, T. (2014). Seasonal Affective Disorder, *Michigan Bar Journal*, May, 2014.

Vincent, T. (2014). Assuming Another's Responsibility, *Michigan Bar Journal*, March, 2014.

Vincent, T. (2014). Misery or Happiness, Which Will You Choose? *Michigan Bar Journal*, January, 2014.

Vincent, T. (2013). Information Management, *Michigan Bar Journal*, December, 2013.

Vincent, T. (2013). Gearing Down Gracefully, *Michigan Bar Journal*, September, 2013.

Vincent, T. (2013). Suicide Prevention: Raising Awareness, Generating Hope. *Michigan Bar Journal*, July, 2013.

Vincent, T. (2013). Sleep: The Gentle Tyrant, *Michigan Bar Journal*, May, 2013.

Vincent, T. (2013). Wellness Checklist. *Michigan Bar Journal*, February, 2013.

Vincent, T. (2013) Creativity and Intrinsic Motivation, *Michigan Bar Journal*, January, 2013.

Vincent, T. (2012). Change is Possible, *Michigan Bar Journal*, December, 2012.

Vincent, T. (2012). Am I Teachable? *Michigan Bar Journal*, October, 2012.

Vincent, T. (2012). Conflict Resolution Revisited, *Michigan Bar Journal*, September, 2012.

Vincent, T. (2012), Stress Management: Healthy vs. Unhealthy, *Michigan Bar Journal*, July, 2012.

Vincent, T. (2012). Attorney Optimism, *Michigan Bar Journal*, June, 2012.

Jaffee, D., Dubin, L., Timmer, A., Vincent, T. Commission on Lawyer Assistance Programs Panel on Best Practices Engaging Law Schools, *American University Journal of Gender, Social Policy & the Law*. Vol. 21, Iss.3 (2013).

APPENDIX C

CV and Bio of Martha E. Brown, MD

Martha E. Brown, MD

Dr. Brown was trained as a psychiatrist and additionally completed a 2 year fellowship in substance abuse at the Medical University of South Carolina. She has been involved in working with professionals with substance abuse, psychiatric, and behavioral disorders for over 30 years. She developed the Louisiana State Physicians Health Program and then served as the State Medical Director for the program from 1994-2000, before resigning to move to Florida. While serving as the Louisiana State Medical Director, she also consulted and worked with the Louisiana programs for lawyers and nurses. She is currently the Associate Medical Director of the Professionals Resource Network and is an Associate Professor of Psychiatry at the University Florida College of Medicine, having joined the University of Florida in October 2010. She is in the UF Division of Addiction Medicine where she has continued the work she has done in substance abuse and forensics for the last 25 years. She is actively involved in medical education and serves as the UF Psychiatry Clerkship Director. Additionally, she is the UF Course Director for the CME course on Distressed Physicians and Professionals, as well as Prescribing Controlled Substances. She continues to serve as a consultant and/or treating physician for the NFL, Major League Baseball, Florida Department of Health, IPN (Intervention Project for Nurses), and various other organizations. She has published, as well as trained and consulted extensively on Disruptive Behavior, Fitness For Duty issues, drug testing, MRO services, EAPs, and impairment issues in the workplace, particularly concerning professionals.

CURRICULUM VITAE

Martha E. Brown, MD

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LICENSURE:

National Board Medical Examiners, (#246321), July 1982
State Board of Medical Examiners of SC, (#10961), July 1982
Flex (#550805903), February 1988
Louisiana State Board of Medical Examiners, (#07593R), February 1988
State of Florida Department of Health (ME-0076978), October 1998

EDUCATIONAL BACKGROUND

7/1985-6/1987	Fellow in Alcohol and Drug Abuse Medical University of South Carolina, Charleston, SC
7/1984-6/1985	Clinical Chief Resident, Psychiatric Inpatient Division Medical University of South Carolina, Charleston, SC
7/1982-6/1985	Resident in Psychiatry, Department of Psychiatry Medical University of South Carolina, Charleston, SC
7/1981-6/1982	Categorical Internship Medical University of South Carolina, Charleston, SC
1977-5/1981	M.D., 1981, Medical University of South Carolina, Charleston, SC
1976 -1977	Postgraduate Research in Ecology, Clemson University, Clemson, SC
1974-1976	B.S. in Zoology, Clemson University, Clemson, SC
1973-1974	University of South Carolina, Columbia, SC

POSITIONS HELD

4/2013- Present	Associate Medical Director, Professionals Resource Network (PRN)
4/2014-Present	Psychiatry Clerkship Director, UF College of Medicine, Gainesville, FL
10/2010 -4/2013	Assistant Medical Director, Professionals Resource Network (PRN)
10/2010 -Present	Associate Professor of Psychiatry, UF College of Medicine, Gainesville, FL
1/2011-4/2014 FL	Associate Director (ABAM) Fellowship, UF College of Medicine, Gainesville, FL
1/2011- 6/2011 Gainesville, FL	Addiction Psychiatry Associate Clerkship Director, UF College of Medicine, Gainesville, FL
1/2011-Present	Program Director, Dual Disorder Inpatient Addiction Psychiatry, UF College of Medicine, Gainesville, FL
9/2006-10/2010	Associate Dean for Faculty Development, USF College of Medicine, Tampa, FL
5/2004-10/2010	Director, Division of Addiction Medicine and Professional Health Services, USF College of Medicine, Tampa, FL
2/2003-10/2010	Associate Professor of Psychiatry, USF College of Medicine, Tampa, FL
12/2002-7/2009	Medical Director, Drug Abuse Comprehensive Coordinating Office, Tampa, FL
4/2000 -2/2003	Courtesy Associate Professor of Psychiatry, USF College of Medicine, Tampa, FL
2/2000-12/2002	Staff Psychiatrist and Chief (2000-2001), Women's Mental Health, Tampa VA, Tampa, FL
1998-2000	Associate Medical Director for Mental Health Services, Medical Center of Louisiana at New Orleans, New Orleans, LA
1/1995-2/2000	Associate Professor of Clinical Psychiatry, LSU Medical Center, New Orleans, LA
1994-2000	State Medical Director, Physician Health Program, LA State Medical Society, Baton Rouge, LA
1994-2000	Adjunct Assistant Professor, Department of Pharmacology, LSU Medical Center, New Orleans, LA
1994-2000	Medical Director and Administrator, MCLNO Assistance Program and Drug Testing Program, New Orleans, LA
1993-2000	Medical Director, E905 Dual Diagnosis Unit, Medical Center of Louisiana at New Orleans, New Orleans, LA
1990-2000	Medical Director and Administrator, LSUMC Campus Assistance Program, New Orleans, LA

1995-1998	Clinical Program Director for the Dually Diagnosed, Mental Health Services for the Medical Center of Louisiana at New Orleans, New Orleans, LA (Position abolished)
1992-1995	Associate Medical Director for Substance Abuse and Mental Health Services for the Medical Center of Louisiana at New Orleans, New Orleans, LA (Position abolished)
1989-2000	Chief, Division of Addictive Disorders, LSU Medical Center, New Orleans, LA
1/1989-1994	Assistant Professor of Psychiatry, LSU Medical Center, New Orleans, LA
5/1988-12/88	Private Practice, E.T. Frank, M.D. and Associates, New Orleans, LA
7/1987-4/1988	Medical Director of the Adolescent Recovery Program, Jo Ellen Smith Psychiatric Hospital, New Orleans, LA

CONSULTANT/EXPERT WITNESS EXPERIENCE

1990-Present drug	Qualified as expert witness in civil court. Cases have included substance abuse, testing, disruptive behavior, dual diagnosis, and impairment in professionals.
1996-Present	Treating Clinician, NFL Program for Substances of Abuse
2009-Present	Clinician, Major League Baseball
2000-Present	Consultant to Florida Department of Health (DOH), Professional Resource Network (PRN), Intervention Project for Nurses (IPN), and Florida Lawyer's Assistance Program (FLA)
2000-2010	Consultant Examiner for Florida Board of Bar Examiners
2003-Present	Consultant to FAA, Major League Baseball
1990-2002	Consultant to the Louisiana State Board of Medicine
2000-2002	Consultant to the LA State Physicians Health Program
2000-2001	Consultant to Drug Testing and EAP Services, LSUMC
1997-2000	Consultant to the Louisiana State Board of Nursing
1997	Advisor and consultant to the LA Governor's Task Force on Drug Testing
1982-1985	Psychiatric Consultant, South Carolina Probate Court

TEACHING EXPERIENCE

2010-Present	Lecturer and supervision/teaching medical students, residents, and fellows, UF College of Medicine
2003-2010	Involved in the following lectures at the University of South Florida College of Medicine:

First year medical student Introduction to Behavioral Medicine Course and Profession of Medicine Seminar, Psychiatry Third Year Medical Student Clerkship Psychotherapy lecture and Colloquium, Substance Abuse lectures for Psychiatry residents, and invited lecturer to USF Anesthesia Pain Program Lecture Series.

2000-2010	Lecturer and supervision/teaching of medical students and residents, USF College of Medicine
1989-2000 Series,	Lecturer in Psychiatry Third-year Clerkship, Psychiatry Psychopath Lecture
to	Medical Ethics, Psychiatry and Medicine, Medical Pharmacology, Introduction
	Clinical Medicine (ICM), Department of Medicine Core Lecture Series, Senior Special Topics, LSU
1989 - 2000	Supervision and teaching of medical students and psychiatric residents, LSU
1982-1987	Supervision and teaching of medical students and psychiatric residents, Medical University of South Carolina

CLINICAL/PSYCHOTHERAPY EXPERIENCE

2000-2002	Staff Psychiatrist, Tampa VA Hospital, Tampa, FL
1988	Private Practice, E.T. Frank, M.D. and Associates, New Orleans, LA
1987-1988	Private Practice, Westbank Center for Psychotherapy, New Orleans, LA
1985-1987	Alcohol and Drug Consultant for Psychiatric Residents and the Consultation-Liaison Service, Medical University of South Carolina
1985 Charleston, SC	Attending on the VA Alcohol and Drug Treatment Unit, VA Hospital,

RESEARCH EXPERIENCE

Current Research Interests

Disruptive behavior in professionals

Misprescribing of controlled substances

Treatment models for impaired professionals and evaluation of national assistance programs for professionals

Impact of assistance programs and drug testing programs on health and wellness including EtG

Early intervention with CPE courses on misprescribing and disruptive behaviors

Past Research Projects

Investigator in the NIDA/Department of Veterans Affairs Study #1018, A Multi-center Safety Trial of Buprenorphine/Naloxone, 2000-2002, Tampa VA Hospital

Alcohol Withdrawal Seizures - Clinical Variables and Alcohol Use History, MUSC

VA Cooperative Study #228 - Lithium Treatment in Alcohol Dependency, Charleston VA Hospital

Open Lithium Follow-Up Study for Alcohol Dependence, Charleston VA Hospital

Evaluation of Carbamazepine in the Treatment of Alcohol Withdrawal Syndrome and Alcoholic Rehabilitation, Charleston VA Hospital

RESEARCH REVIEW COMMITTEES

Reviewer for Rural, Remote and Culturally Distinct Populations, Center for Substance Abuse Treatment, 1993.

CME PROJECTS

Course Director of the UF CME course *Prescribing Controlled Drugs: Critical Issues and Common Pitfalls of Misprescribing* (in collaboration with William Swiggart, M.S. and Vanderbilt Medical Center) given approximately 5 times a year

Course Director of the UF CME course *Program for Distressed Physicians* (in collaboration with William Swiggart, M.S. and Vanderbilt Medical Center) given approximately 5 times a year

Course Director of the UF and FMA course *Common Sense Pain Management*, June 29-July 1, 2012

Course Director of the UF and FMA course on pain management currently in development for early 2016

OTHER ADMINISTRATIVE EXPERIENCE

Administrative rotation (1987) in the Office of the Administrator with Dr. Ian MacDonald, Alcohol, Drug Abuse, and Mental Health Administration, Rockville, MD

Part-time administrative work (1986 - 1987) at the S.C. Commission on Alcohol and Drug Abuse, Columbia, SC

BOOK CHAPTERS

Brown, M.E., Trinkoff, A.M., Christen, A.G., and Dole, E.J. Chapter 8: Impairment Issues for Professionals: Review and Recommendations. In Haack, M.R. and Adger, H., Eds. *Strategic Plan for Interdisciplinary Faculty Development: Arming the Nation's Health Professional Workforce for a New Approach to Substance Use Disorders*. Providence, Rhode Island: AMERSA, pages 155-165, 2002.

Contributing author to several book chapters being prepared in: *The Professional Health and Wellness of Physicians and their Professionalism Lapses in Behavioral and Social Science in Medicine*. Muldoon, M., Satterfield, J., Novack, D., Cole, S., eds, in final preparation.

Professionalism: A Physician Development Program© consisting of 5 individual modules and one assessment module. Contributing author to the module on Physician Misprescribing and Consequences for "The Proper Prescribing of Controlled Prescription Drugs." In final preparation for publication through Vanderbilt Medical Center.

PAPERS

Dewey, C.M., Swiggart, W., Brown, M.E., Baron, M., and Ghulyan, M. "Proper Prescribing of Opioids: Twelve Tips for Teaching Future Prescribers" to be considered for the "*From Education to Implementation: Addressing the Opioid Misuse Epidemic*" special issue.

Dewey, C.M., Swiggart, W., Brown, M.E., Baron, M., and Ghulyan, M. "Proper Prescribing of Controlled Prescription Drugs for the Primary Care Provider." Submitted for review.

Dewey, C.M., Swiggart, W., Brown, M.E., Baron, M., and Ghulyan, M. Twelve Tips for Teaching Proper Prescribing of Controlled Prescription Drugs. Submitted for review.

Brown, M.E. and Rivenbark, J. The Mission of PRN. Miami Medicine, Dade County Medical Association, 8-9, January 2013.

Brown, M.E., Swiggart, W., and Dewey, C.M. Searching For Answers: Proper Prescribing of Controlled Prescription Drugs. *Journal of Psychoactive Drugs* 44(1):79-85, 2012.

Brown, M.E. and Rivenbark, J. Professionals Resource Network. *House Calls*, Alachua County Medical Society, 10-12, Summer 2012.

Brown, M.E. Dealing with Disruption. *Florida Medical Magazine*, Professionals Resources Network insert, 36-39, Spring, 2011.

Brown, M.E., Moering, R., Brown, L., and McKown, K. Ethyl Glucuronide Levels in Urine: Initial Data for the Identification of Intentional Use of Alcohol. 2009. Unpublished.

Denton, S. and Brown, M.E. Forming Effective Alliances with IPPs. *Journal of Employee Assistance*, 3rd Quarter: 21-23, 2005.

Goforth, H.W., Lupash, D.P., Brown, M.E., Tan, J., and Fernandez, F. Role of Alcohol and Substances of Abuse in the Immunomodulation of Human Immunodeficiency Virus Disease: A Review. *Addictive Disorders & Their Treatment* 3(4):174-182, 2004.

Brown, M.E., Denton, S., and Vargas, I. A Needs Assessment of Health and Wellness Services for Medical Students, Residents and Faculty. *Substance Abuse* 15(1):29-32, 1994.

Hoffman, E. and Brown, M.E. (Editors). *The Physicians' Health Program Reference Manual*. New Orleans: Louisiana State Medical Society. Fifth Edition: July 1994.

Brown, M.E., Denton, S., and Vargas, I. Attitudinal Challenges in a Medical Center Employees Assistance Program. *Substance Abuse* 14(1):45-52, 1993.

Hoffman, E., Brown, M.E., and Helwick, S.A. The Effect of Underlying Philosophy Upon Utilization of a Program for Impaired Medical Students. *Journal of the Louisiana State Medical Society* 143:39-44, 1991.

Brown, M.E., Anton, R.F., Malcolm, R., and Ballenger, J.C. Alcohol Detoxification and Withdrawal Seizures: Clinical Support for a Kindling Hypothesis. *Biological Psychiatry* 23:507-514, 1988.

Cleveland, C.C. and Brown, M.E. Spirit Distilled and Culturally Instilled. *Bulletin of the American Protestant Hospital Association*, 1986.

ABSTRACTS (peer reviewed)

Ziegler, P., Brown, M., Merlo, L. "Psychiatric and Other Conditions Affecting Disruptive Behavior." Presented at the 2015 Federation of Physician Health Programs, Fort Worth, Texas, April 25, 2015.

Ziegler, P., Brown, M., Johnson, J. "Challenging Toxicology Cases In Monitoring Healthcare Professionals." Presented at the 2015 Federation of Physician Health Programs, Fort Worth, Texas, April 25, 2015.

Brown, M., Troupe, D., Ziegler, P., Gold, M. "Disruptive Behavior in the Workplace: Dealing With the Distressed and Disruptive Physician." Presented at the American Psychiatric Association National Conference, New York, New York, May 5, 2014.

Brown, M. and Ziegler, P. "Ensuring Compliance: Exploring Best Practices in Drug Testing of Healthcare Professionals." Presented at the 2014 Federation of Physician Health Programs, Denver, Colorado, April 23, 2014.

Ziegler, P. and Brown, M. "The Impact of DSM 5 on Physician Health Programs." Presented at the 2014 Federation of Physician Health Programs, Denver, Colorado, April 24, 2014.

Brown, M. and Ziegler, P. "Disruptive Behavior: Challenges PHPs Face in Monitoring." Poster presentation at the 2014 Federation of Physician Health Programs, Denver, Colorado, April 24, 2014.

Brown, M. and Swiggart, W. Disruptive Behavior in the Workplace: Dealing With the Distressed and Disruptive Physician. Presented at the American Psychiatric Association National Conference, San Francisco, CA, May 18, 2013.

Brown, M., Rivenbark, J., Troupe, D, D'Aprix, J. Exploring the Reliability, Frequency and Methods of Drug Testing: What is Enough to Ensure Compliance? Presented at the National Federation of Physician Health Program, Boston, MA, April 20, 2013.

Swiggart, W., Dewey, C., Brown, M.E. Proper Prescribing and Substance Abuse Identification: A Continuing Medical Education Intervention. Presented at the National Federation of Physician Health Programs, Ft. Worth, Texas, April 24, 2012.

Merlo, L., Rivenbark, J., Brown, M., Merlo, L. Mandatory Naltrexone Treatment as Component of the Monitoring Contract for Opiate Dependent Anesthesiologists and Pharmacists. Presented at the National Federation of Physician Health Programs, Ft. Worth, Texas, April 25, 2012.

Rivenbark, J., Brown, M., Merlo, L. Policies and Research on Identifying, Assessing, and Monitoring PHP Participants. Presented at the National Federation of Physician Health Programs, Ft. Worth, Texas, April 25, 2012.

Swiggart, W., Finlayson, R., Williams, B., Brown, M.E., Gundersen, D. Physician Behavior, Patients and PHPs. Presented at the National Federation of Physician Health Programs, Chicago, Illinois, April 22, 2010.

Brown, M.E., Pomm, R., Skipper, G., McCall, S. Toxicology Update. Presented at the national Federation of Physician Health Programs, San Antonio, Texas, April 29, 2008.

Brown, M.E. Caring For Our Own: How to Help Our Impaired Colleagues. Presented at the 25th Annual AMERSA National Conference, Old Towne, Alexandria, VA, November 8-10, 2001.

Brown, M.E., Denton, S.L., Wetsman, H. Legalities and Ethics of Treating Professionals with Substance Abuse Problems: What Can I Really Do? Presented at the 23rd Annual AMERSA National Conference, Old Towne, Alexandria, VA, November 4-6, 1999.

Brown, M.E., Denton, S.L. Developing Assistance Programs For Physicians and Healthcare Professionals. Accepted for AAAP 9th Annual Meeting and Symposium, December 3-6, 1998 (not presented secondary to not being able to attend).

Brown, M.E. Prevention to Intervention: Assistance for Physicians and Healthcare Professionals (Workshop). 1998 International Conference on Physician Health, Victoria, British Columbia, Canada, May 2, 1998.

Brown, M.E., Johnson, N.P., Mallin, R., Otto, D., Tumblin, M. Developing Intervention Techniques and Assistance Programs For Impaired Professionals (Workshop). AMERSA National Conference, Alexandria, VA, November 15, 1997.

Johnson, N.P., Brown, M.E., Mallin, R., Tompkins, D. Providing Institutional Assistance to Impaired Residents, Students, and Faculty (Workshop). AMERSA National Conference, Reston, VA, November 7 and 8, 1996.

Brown, M.E. Guidelines for School, Hospital, and State Assistance Programs: Experiences in Louisiana, 1996 International Conference on Physician Health, Chandler, AZ, February 9, 1996.

Johnson, N.P., Brown, M.E., Mallin, R. Institutional Assistance for Impaired Residents, Students, and Faculty (Workshop). AMERSA National Conference, Washington, D.C., November 9, 1995.

Holleran, S.A., Brown, M.E., Denton, S.L., Vargas I.C. Medical Center Employee Assistance Programs. AMERSA National Conference, Washington, D.C., November 8, 1995.

Brown, M.E., Denton, S., Percy, P., Boshell, J. A Model for Developing a Campus Assistance Program. AMERSA National Conference, Bethesda, MD, November 20, 1994.

Johnson, N.P., and Brown, M.E. Dealing with Impaired Faculty and Students (Workshop). AMERSA National Conference, Bethesda, MD, November 18, 1994.

Brown, M.E., Denton, S., Vargas, I., Percy, P., Hoffman, E. Alcohol and Drug Programs at Medical Schools/Centers in the U.S. 1994 International Conference on Physician Health, Ontario, Canada, September 17, 1994.

Hoffman, E. and Brown, M.E. The Influence of Professional Similarity in Physicians' Health Programs: Potential Advantages and Disadvantages. 1994 International Conference on Physician Health, Ontario, Canada, September 18, 1994.

Brown, M.E., Denton, S., Percy, P.M., Vargas, I.C. Alcohol and Drug Programs at Medical Schools/Centers in the U.S. AMERSA National Conference, Bethesda, MD, November 20, 1993.

Brown, M.E., Denton, S., Vargas, I. Addressing the Problems of Substance Abuse in an Academic Environment Utilizing an Employee Assistance Program. 1993 International Conference on Physician Health, Scottsdale, AZ, January, 1993.

Brown, M.E., Denton, S., Vargas, I. A Needs Assessment on Health and Wellness Services for Medical Students, Residents, and Faculty. AMERSA National Conference, Bethesda, MD, November 13, 1992.

Brown, M.E., Denton, S., Vargas, I. The Problems of Substance Abuse in an Academic Environment: A Model Program Utilizing an Employee Assistance Program. AMERSA National Conference, Bethesda, MD, November 13, 1992.

Brown, M.E., Denton, S., Vargas, I., McCleary, R., Becnel, J. Attitudinal Challenges in a Medical Center EAP. AMERSA National Conference, Bethesda, MD, November 16, 1991.

Becnel, J., Brown, M.E., Denton, S. Substance Abuse and Trauma: Training in Rehabilitation Medicine. AMERSA National Conference, Bethesda, MD, November 16, 1991.

Anton, R.F., Brown, M.E., Malcolm, R., and Ballenger, J.C. Alcohol Detoxification and Withdrawal Seizures: Clinical Support for a Kindling Hypothesis. International Symposium on Alcohol and Seizures, Washington, DC, September 29-30, 1988.

Brown, M.E., Anton, R.F., Malcolm, R., and Roitich, J.C. Alcohol Withdrawal Seizures - Clinical Variables and Alcohol Use History, joint meeting of AMSAODD-RSA. San Francisco, April 19, 1986. Alcohol Clinical and Experimental Research, 1:93, 1986, Abstract #8C.

INVITED PRESENTATIONS

“Improving Communication In The Operating Room.” Presented for UF Health HR Department and Departments of Surgery and Anesthesiology, Gainesville, Florida, January 30, 2015.

“Challenging Toxicology Cases In Monitoring Healthcare Professionals.” Presented at the 2015 Federation of Physician Health Programs, Fort Worth, Texas, April 25, 2015.

“Psychiatric and Other Conditions Affecting Disruptive Behavior.” Presented at the 2015 Federation of Physician Health Programs, Fort Worth, Texas, April 25, 2015.

“Evaluator Training.” Presented at the annual PRN meeting, Amelia Island, FL, September 13, 2014.

“Disruptive Behavior in the Workplace: Dealing With the Distressed and Disruptive Physician.” Symposium presented at the American Psychiatric Association National Conference, New York, New York, May 5, 2014.

“Ensuring Compliance: Exploring Best Practices in Drug Testing of Healthcare Professionals.” Presented at the 2014 Federation of Physician Health Programs, Denver, Colorado, April 23, 2014.

“The Impact of DSM 5 on Physician Health Programs.” Presented at the 2014 Federation of Physician Health Programs, Denver, Colorado, April 24, 2014.

“Disruptive Behavior: Challenges PHPs Face in Monitoring.” Poster presentation presented at the 2014 Federation of Physician Health Programs, Denver, Colorado, April 24, 2014.

“The impaired Physician.” Presented at the UF Pediatric Grand Rounds, Gainesville, FL, May 8, 2014.

“Dealing With Difficult Colleagues.” Presented at the Women and Science Meeting, UF College of Medicine, Gainesville, FL, February 25, 2014.

“2013 Policies and How To Do An Evaluation.” Presented at the annual PRN meeting, Amelia Island, FL, September 14, 2013.

“The Impaired Physician.” Presented at the UF Addiction Medicine Grand Rounds, Gainesville, FL, July 31, 2013.

“Disruptive Behavior in the Workplace: Dealing With the Distressed and Disruptive Physician.” Workshop presented with William Swiggart at the American Psychiatric Association National Conference, San Francisco, CA, May 18, 2013.

“Exploring the Reliability, Frequency, and Methods of Drugs Testing: What is Enough To Ensure Compliance?” Presented at the 2013 National Federation of Physician Health Programs, Boston, MA, April 19, 2013.

“Recognizing Disruptive Behavior in the Workplace.” Presented at the FMA Board of Governors and the PRN Board Meeting, Gainesville, Florida, February 8, 2013.

“Recognizing Disruptive Behavior in the Workplace.” Presented at the UF Addiction Medicine Grand Rounds, Gainesville, Florida, November 14, 2012.

“Evaluator Training.” PRN Annual Meeting, Amelia Island, Florida, September 15, 2012.

“Managing the Disruptive or Impaired Physician.” Symposium presented with Frank Kelly, MD, Gerald Hickson, MD, Will Latham, and Ed Craig, MD at the American Academy of Orthopedic Surgeons, Philadelphia, PA, October 19, 2012.

“Managing Distressed Behaviors.” Presented at the 2012 Florida Board of Governor’s Meeting, Boca Raton, Florida, July 27, 2012.

“History And Physicals, Office Visit Procedures, Progress Notes, And Using The Prescription Drug Monitoring Database.” Presented with Marguerite Poreda, MD at the UF and FMA Common Sense Pain Management Conference, Gainesville, Florida, June 29-July 1, 2012.

“Why Do We Misprescribe? Recognizing Risky Prescribing Practices and Identifying Potential Drug Seeking Patients.” Presented the UF and FMA Common Sense Pain Management Conference, Gainesville, Florida, June 29-July 1, 2012.

“Overview of Substance Abuse and Dependency.” Presented the UF and FMA Common Sense Pain Management Conference, Gainesville, Florida, June 29-July 1, 2012.

“Toxicology Update.” Presented at the 2012 FSAM-FMPG Convention, Orlando, Florida, June 14, 2012.

“Proper Prescribing and Substance Abuse Identification: A Continuing Medical Education Intervention.” Presented with Bill Swiggart and Charlene Dewey at the 2012 National Federation of Physician Health Programs, Ft. Worth, Texas, April 24, 2012.

“Mandatory Naltrexone Treatment as Component of the Monitoring Contract for Opiate Dependent Anesthesiologists and Pharmacists.” Presented with Judy Rivenbark, MD and Lisa Merlo, PhD at the 2012 National Federation of Physician Health Programs, Ft. Worth, Texas, April 25, 2012.

“Policies and Research on Identifying, Assessing, and Monitoring PHP Participants. Presented with Judy Rivenbark, MD and Lisa Merlo, PhD at the 2012 National Federation of Physician Health Programs, Ft. Worth, Texas, April 25, 2012.

“Distressed Professionals.” Presented to the Medical Staff, Fort Walton Beach Hospital, Fort Walton Beach, Florida, March 13, 2012.

“How To Do An Evaluation.” Presented at the annual PRN meeting, Amelia Island, Florida, November 12, 2011.

“Distressed Professionals.” Presented at UF Neurosurgery Grand Rounds, Gainesville, Florida, November 7, 2011.

“Psychiatry or Psychology: What Is The Right Path For You?” Presented at the UF Psychology Club, Gainesville, Florida, November 2, 2011.

“Intervention: Who, When, Where, How.” Presented at the Florida Pharmacy Association's MidYear Clinical and Nuclear Conference, Orlando, Florida, October 16, 2011.

“Toxicology Update and Latest EtG Ruling.” Presented at the annual FSAM FMPG Conference, Orlando, Florida, June 16, 2011.

“Work Smart and Live Well-Balancing Practice with Life.” Presented to the UF Professional Student Organization, Gainesville, Florida, March 17, 2011.

“Toxicology Update and Latest EtG Ruling.” Presented at the annual FSAM Conference, Orlando, Florida, March 5, 2011.

“Dealing With Disruptive Professionals.” Presented with Dr. Michael Herkov at the UF Psychiatry Grand Rounds, January 14, 2011.

“Misprescribing Controlled Drugs.” Presented at USF Psychiatry Grand Rounds, September 2, 2010, Tampa, FL.

“Physician Behavior, Patients and PHPs.” Presented at the national Federation of Physician Health Programs, Chicago, Illinois, April 22, 2010. (Panel with Swiggart, W., Finlayson, R., Williams, B., Brown, M.E., Gundersen, D.)

“Lawyer or Psychiatrist? Handling Disruptive or Impaired Physician Cases.” Panel presentation for the ABA in Chicago, Illinois, June 2010.

“The Disruptive Physician.” Presented at the Resident Orientation, Tampa, Florida, June 29, 2009.

“Toxicology Update.” Moderator at the FSPHP Annual Conference, New Orleans, LA, April 2009.

“Toxicology Update.” Presented at the Florida Society of Addiction Medicine, Tampa, Florida, March 7, 2009.

“Distressed Physicians.” Presented at the USF Ortho Grand Rounds, Tampa, Florida, February 6, 2009.

“Addictions.” Presented at the Family Medicine Grand Rounds, Tampa, Florida, February 5, 2009.

“Disruptive Behavior: The Mental Health and Legal Perspective.” Presented at the USF OB/GYN Grand Rounds, at Tampa General Hospital, Tampa, Florida, November 19, 2008.

“Proper Prescribing Practices for Controlled Substances and Pitfalls for Physicians.” Presented at the USF Department of Neurology at Tampa General Hospital, Tampa, Florida, October 31, 2008.

“Disruptive Behavior: The Mental Health and Legal Perspective.” Presented at the USF Cardiology Grand Rounds at Tampa General Hospital, Tampa, Florida, October 29, 2008.

“Disruptive Behavior: The Mental Health and Legal Perspective.” Presented at the USF Neurosurgery Grand Rounds, at Tampa General Hospital, Tampa, Florida, October 17, 2008.

“Review of Addictions in Patients.” Presented at the USF Pediatrics Grand Rounds, Tampa, Florida, October 9, 2008.

“PRN and Resident Assistance.” Presented at the USF Department of Otolaryngology, Tampa, Florida, October 8, 2008.

“Disruptive Behavior: The Mental Health and Legal Perspective.” Presented at the USF Department of Surgery Grand Rounds, Tampa, Florida, September 15, 2008.

Work Smart and Live Well: Balancing Practice With Life Pediatrics of Tomorrow Conference, St. Petersburg, Florida, September 9, 2008.

“The Disruptive Physician.” Presented at the USF Resident Orientation, Tampa, Florida, July 1, 2008.

“Review of Addictions.” Presented at Bayfront Medical Center, St. Petersburg, Florida, June 26, 2008.

Toxicology Update. Moderator/Presented at the national Federation of Physician Health Programs, San Antonio, Texas, April 29, 2008.

“Review of Addictions in Professionals and Patients.” Presented at the USF Department of Internal Medicine Grand Rounds, February 28, 2008.

“Disruptive Physicians.” Presented at the USF Department of Cardiology Grand Rounds at Tampa General Hospital, Tampa, Florida, January 16, 2008.

“Disruptive Behavior: The Mental Health and Legal Perspective.” Presented at the USF Pediatrics Grand Rounds, Tampa, Florida, November 29, 2007.

“Players in the Panopticon: Treatment as a Mandate.” Presented at the national conference of the NFL Program for Substances of Abuse, Phoenix, Arizona, November 5, 2007.

“Intervening and Monitoring Impaired Professionals.” Presented at the Louisiana State Board of Medical Examiners, New Orleans, LA, September 17, 2007.

“Impairment in Professionals.” Presented at the Hillsborough County Bar Association meeting on Mental Health Issues and the Law, Tampa, Florida, September 7, 2007.

“The Use of EtG in Monitoring,” Presented at the FMPG 2007 meeting, Orlando, Florida, August 18, 2007.

“Disruptive Behavior: Dealing with the Problem, Legal Implications and Future Directions.” Presented at the USF Department of Surgery Grand Rounds, Tampa, Florida, July 30, 2006.

“Substance Abuse and Psychiatric Disorders in Athletes.” Presented at the USF Athletic Training Program, Tampa, Florida, June 18, 2007.

“Prescribing Controlled Drugs: Critical Issues and Common Pitfalls of Misprescribing.” Presented at USF Cardiology Grand Rounds, Tampa, Florida, May 30, 2007.

“Impairment Issues: Am I My Brother’s Keeper?” Presented at the 35th Annual Physician Assistant Conference, Philadelphia, Pennsylvania, May 27, 2007.

“The Use of EtG in Monitoring.” Presented at the Oklahoma Pharmacist Association meeting, Oklahoma City, Oklahoma, April 16, 2007.

“Impairment in Healthcare Professionals.” Presented at the Oklahoma Pharmacist Association meeting, Oklahoma City, Oklahoma, April 16, 2007.

“Review of Addiction.” Presented at the Oklahoma Pharmacist Association meeting, Oklahoma City, Oklahoma, April 15, 2007.

“Impairment in Healthcare Professionals.” Presented at the USF Department of Pediatrics Grand Rounds, Tampa, Florida, March 15, 2007.

“The Use of EtG in Monitoring.” Presented at the Florida Society of Addiction Medicine, University of Florida, Gainesville, Florida, March 3, 2007.

“Impairment in Healthcare Professionals.” Presented at the USF Department of Internal Medicine Grand Rounds, Tampa, Florida, February 22, 2007.

“Impairment in Healthcare Professionals.” Presented at the Haley VA Hospital, Tampa, Florida, January 31, 2007.

“Disruptive Behavior: Dealing with the Problem, Legal Implications and Future Directions.” Presented at the USF Department of Psychiatry and Behavioral Medicine Grand Rounds, Tampa, Florida, December 7, 2006.

“Psychotherapeutic Medications and Suicidal Behavior.” Presented at the 2006 Florida Suicide Prevention Symposium, Clearwater, Florida, December 5, 2006.

“The Disruptive Physician: Dealing With the Problem, Legal Implications, and Future Directions.” Presented at The AMA Section on Medical Schools with R. B. Friedlander, Chicago, Illinois, June 10, 2006.

“Impairment Issues: Am I My Brother’s Keeper?” Presented at the 34th Annual Physician Assistant Conference, San Francisco, California, May 28, 2006.

“The Disruptive Physician.” Presented at The 2005 AAMC Annual Meeting: GRA Plenary Session II, Washington, DC, November 8, 2005.

“Controversies in Treating Insomnia-The Case for Psychopharmacology.” Martha E. Brown, M.D. vs. Francisco Fernandez, M.D. Presented at The 3rd Annual Keys to Neuropsychiatric Care, Key West, Florida, December 11, 2005.

“Risk Factors for Substance Abuse Among Health Care Professionals.” Presented at The 3rd Annual Keys to Neuropsychiatric Care, Key West, Florida, December 10, 2005.

“Addictive Behaviors Associated with Brain Impairments.” Presented at The 3rd Annual Keys to Neuropsychiatric Care, Key West, Florida, December 9, 2005.

“Effective Drug Abuse Screening in the Neuropsychiatric Patient.” Presented at The 3rd Annual Keys to Neuropsychiatric Care, Key West, Florida, December 10, 2005.

“Sleep and its Disorders.” Presented at Florida Psychiatric Society, 2005 Fall Meeting with Selim Benbadis, M.D., and Francisco Fernandez, M.D. at Disney’s Contemporary Resort, Orlando, Florida, October 8, 2005

“Impairment Issues for Healthcare Professionals.” Presented at the American Academy of Physician Assistants 33rd Annual Physician Assistant Conference, Orlando, Florida, May 30, 2005.

“Domestic Violence: The Role of the Psychiatrist.” Presented at the Florida Psychiatric Society Annual Meeting, Clearwater, Florida, April 16, 2005.

“Warning Signs of Drug Abuse in Patients.” Presented at the USF Department of Anesthesiology, Tampa, Florida, March 14, 2005.

“Fitness For Duty – The Psychiatric Evaluation.” Presented at the USF Department of Psychiatry and Behavioral Medicine Grand Rounds, Tampa, Florida, January 20, 2005.

“Legislative Changes Allowing Office-based Opioid Dependence Treatment.” Presented at the course entitled Buprenorphine and Office-Based Treatment of Opioid Dependence sponsored by the American Society of Addiction Medicine, Tampa, Florida, December 11, 2004.

“Patient Assessment and Selection For Office Based Care.” Presented at the course entitled Buprenorphine and Office-Based Treatment of Opioid Dependence sponsored by the American Society of Addiction Medicine, Tampa, Florida, December 11, 2004.

“Problems of Addiction.” Presented to the Academy of Sr. Professionals at Eckerd College, St. Petersburg, Florida, November 10, 2004.

“Different Aspects of ADHD.” Presented at the USF educational program, Adult ADHD and Prescribing Issues, University of South Florida, Tampa, Florida, November 3, 2004.

“Managing Mood Disorders I and II.” Presented at the Clinical, Legal and Ethical Issues in Prescribing Abusable Drugs – A Physician’s Education Program sponsored by University of South Florida, Tampa, Florida, November 3, 2004.

“Professional Health and Substance Abuse.” Presented at the Keys to Neuropsychiatric Care Conference, University of South Florida, Tampa, Florida, September 18, 2004.

“Talking About Alcohol: The Good, The Bad and The Ugly.” Presented at The Carter-Jenkins Center, Tampa, Florida, September 9, 2004.

“Creating a Co-occurring Clinic.” Presented at the Florida Alcohol and Drug Abuse Association 2004 Conference, Orlando, Florida, August 26, 2004.

“Fitness for Duty: Psychiatric Evaluation.” Presented at the Michigan Health Professionals Recovery Program, Detroit, Michigan, August 10, 2004.

“Pharmacology Primer: Everything You Need To Know About Chemical Abuse.” Presented at the National Organization of Bar Counsel Conference, Atlanta, Georgia, August 5, 2004.

“Fitness For Duty: Psychiatric Evaluation.” Presented at the LSU Health Sciences Center’s Best Practices Conference on “Intervention & Treatment of Impaired Employees & Professionals,” New Orleans, Louisiana, June 11, 2004.

“Substance Abuse and Psychiatric Disorders.” Presented at the USF Department of Physical Education, June 4, 2004.

“Use of Opioids (Narcotics) to treat RSD/CRPS in Adults and Children.” A live internet symposium presented by International Research Foundation for RSD/CRPS at the University of South Florida, Tampa, Florida, August 6, 2003.

“Impairment Issues For Healthcare Professionals.” Presented at the University of South Florida Department of Psychiatry and Behavioral Medicine Grand Rounds, Tampa, Florida, May 16, 2003.

“Effective Treatment For Patients With Co-occurring Disorders.” Presented at the Florida Alcohol and Drug Abuse Association 2003 Multicultural Symposium Program, Tampa, Florida, March 28, 2003.

“Bringing Communities Together Through Cultural Awareness.” Presented at the Florida Alcohol and Drug Abuse Association, Tampa, Florida, March 26-28, 2003.

“Recent Advancement in Understanding the Neurobiology of Addiction.” Presented at the PALS 23rd Annual Meeting & Workshop, Wrightsville Beach, North Carolina, November 9, 2002.

“Second Stage Recovery: Things Are Getting Better and I’m Feeling Worse.” Presented at the PALS 23rd Annual Meeting & Workshop, Wrightsville Beach, North Carolina, November 9, 2002.

“Effective Intervention Techniques.” Presented at the PALS 23rd Annual Meeting & Workshop, Wrightsville Beach, North Carolina, November 9, 2002.

“Character Pathology and Addiction.” Presented at the Florida Medical Professionals Group “Humor in Recovery Addiction Medicine Update,” Orlando, Florida, November 2, 2002.

“Professional Impairment: Problems, Solutions, and Legalities.” Presented at the University of South Florida Department of Psychiatry and Behavioral Medicine Grand Rounds, Tampa, Florida, May 26, 2000.

“Binge Drinking.” Presented at the Louisiana State Medical School Department of Psychiatry Grand Rounds, New Orleans, November 18, 1999.

“Binge Drinking.” Presented at The University of Texas-Houston Health Science Center conference on Alcohol, Nicotine and Other Drugs: Expanding Concepts, Houston, TX, September 16, 1999.

“Adolescent Alcohol Use.” Presented at the Louisiana Sports Medicine Society 1998 Winter Symposium and Business Meeting, New Orleans, LA, December 12, 1998.

“Impairment in the Healthcare Professional.” Presented at the AMERSA National Conference, Washington, DC, November 6, 1998.

“Alcoholism: Treating A Family Disease.” Presented at the Family Practice Update in New Orleans, New Orleans, LA, March 31, 1998.

“Clinical Manifestations of Drugs of Abuse.” Presented at An Update on the Dynamics of Addiction, Nicholls State University, Department of Nursing and Alcohol & Drug Abuse Council for South Louisiana, Thibodaux, LA, October 30, 1997.

“Substance Abuse.” Presented at Yale-Ochsner Fifth Annual Comprehensive Review of Psychiatry and Neurology, New Orleans, LA September 18, 1997.

“Fitness For Duty.” Presented at the Violence in the Workplace Workshop, sponsored by the Governor’s Task Force on Workplace Violence, Baton Rouge, LA, March 6, 1997.

“What’s Our Prognosis, Doc?” Presented at the Lawyers Assistance Program 5th Annual Workshop, St. Francisville, LA, March 15, 1997.

“Physician Impairment: Problems, Consequences, and Solutions.” Presented at Ochsner Psychiatry Grand Rounds, New Orleans, January 14, 1997.

“Physician Impairment: Problems, Consequences, and Solutions.” Presented at the National Association Medical Staff Services 1996 20th Annual Conference, New Orleans, LA, October 17, 1996.

“Alcohol and Drug Abuse.” Presented at the Fourth Annual Yale/Ochsner Comprehensive Review of Psychiatry and Neurology, New Orleans, LA, October 3, 1996.

“Drug Abuse in the 90's. The Latest from your Street Corner.” Presented at the Family Practice Update, New Orleans, LA, April 18, 1996.

“Alcohol and Drug Abuse.” Presented at the Third Annual Yale/Ochsner Comprehensive Review of Psychiatry and Neurology, New Orleans, LA, September 7, 1995.

"Medication Prescription Practices." Presented at the New Orleans Employee Assistance Program Association, New Orleans, LA, October 27, 1995.

"Alcohol Use, Abuse, and Dependency." Presented at the Second Annual Yale/Ochsner Comprehensive Review of Psychiatry and Neurology, New Orleans, LA, January 20, 1994.

"Drug Abuse." Presented at the Second Annual Ochsner/Yale Comprehensive Review of Psychiatry and Neurology, New Orleans, LA, January 20, 1994.

"Alcohol Use, Abuse, and Dependency." Presented at Grand Rounds for Department of Medicine, LSUMC, New Orleans, LA, August 19, 1993.

"Prescription Drug Use, Abuse, and Dependency." Presented at the Family Practice Update, New Orleans, LA, April 14, 1994.

"The Mentally Ill Substance Abuser." One day workshop presented with Stan Denton, BCSW for State Mental Health Office of Louisiana, Mandeville, LA, March 25, 1993.

"Alcohol Abuse and Dependency." Presented at the Family Practice Update, New Orleans, LA, March 2, 1993.

"Clinical Aspects of Opiate Addiction." Presented at the Greater New Orleans Society for Neuroscience symposium entitled Opiates: From Biochemistry to Behavior, New Orleans, LA, February 27, 1993.

"Who Heals the Healer? Professional Assistance for Faculty, Staff, and Students in Clinical Institutions." Presented at the AMERSA national Conference, Bethesda, MD, November 15, 1992.

"Dual Diagnosis and HIV/AIDS." Presented for the HIV/AIDS Substance Abuser: One Person, One Population Workshop sponsored by the NO/AIDS Task Force, Committee on Alcoholism and Drug Abuse, New Orleans Substance Abuse Clinic and Louisiana State University Medical Center, New Orleans, LA, November 6, 1992.

"Sex, Drugs, and Rock & Roll." Presented at LSUMC in Shreveport, Shreveport, LA, August 13, 1992.

"Causes of Drug Use and Abuse Genetic, Physiological and Other Micro Theories." Presented at the Louisiana State Medical Society's Annual Impaired Physicians Program, Pennington Center, Baton Rouge, LA, June 6, 1992.

"Psychiatric Perspective of FAS/FAE." Presented at the Fetal Alcohol Syndrome seminar sponsored by the Louisiana Division of Alcohol and Drug Abuse, April 29, 1992.

"Women, Drinking & Drugs." Presented at the Fetal Alcohol Syndrome seminar sponsored by the Louisiana Division of Alcohol and Drug Abuse, Nichols State University, April 21, 1992.

"Substance Abuse in 1992." Presented at the Family Practice Update, New Orleans, LA, March 18, 1992.

"The Mentally Ill/Substance Abusing Client." Workshop presented with Stan Denton, BCSW at the 1991 Annual Meeting of the National Council of Community Mental Health Centers, New Orleans, LA, May 30, 1991.

"Advances in Prenatal Cocaine Abuse." Presented at the annual meeting of the American Psychiatric Association, New Orleans, LA, May 16, 1991.

"Dysfunctional Families." Presented at the Family Practice Update, New Orleans, LA, April 11, 1991.

"Substance Abuse - New Threats." Presented at the Family Practice Update, New Orleans, LA, May 11, 1990.

"Crispy Critters or Coping With Stress and Burnout." Presented at the Association of Medical Assistants, New Orleans, LA, June 21, 1988.

"Adolescent Substance Abuse Treatment." Presented at the New Orleans Adolescent Hospital, New Orleans, LA January 7, 1988.

"Adolescent Substance Abuse." Presented as part of a community education seminar at Jo Ellen Smith psychiatric Hospital, New Orleans, LA, November 10, 1987.

"Signs and Symptoms of Adolescent Substance Abuse." A workshop presented at Jo Ellen Smith Psychiatric Hospital, New Orleans, LA, September 15, 1987.

GRANT SUPPORT

Past

Expansion grant for "Tigers Under the Rainbow." Funded by Baptist Community Ministries Board of Trustees and Management, Martha E. Brown, MD, Investigator, January 1, 1997 through December 31, 1997, \$71,500.

"Tigers Under the Rainbow" - CANDO, a prevention program for children ages 5-10 living in a housing project. Funded by HANO, Martha E. Brown, MD, Co-Principal Investigator, April 1, 1996 through December 31, 1997, \$199,336.

"Tigers Under the Rainbow" - CANDO, a prevention program for children ages 5-10 living in a housing project. Funded by HUD, Martha E. Brown, M.D., Co-Principal Investigator, March 1, 1995 through March 31, 1996, \$44,000.

The Fund for the Improvement of Postsecondary Education (FIPSE), Department of Education - Martha E. Brown, M.D., Principal Investigator, September 1993 - June 1996, \$125,885.

"Tigers Under The Rainbow" - CANDO, a prevention program for children ages 5-10 living in a housing project. Funded by HUD and the New Orleans Business Council, Martha E. Brown, M.D., Co-Principal Investigator, September 1993 - September 1994, \$120,000.

Submitted (but not funded)

Consultant to Principle Investigator Darcy Sibert on "Alcohol Misuse and Consequences in Helping Professionals" submitted to NIAAA, October 2004. The focus is alcohol misuse and consequences among physicians, nurses, dentists, pharmacists, social workers and lawyers.

CONTRACT SUPPORT

Present

Professional Resource Network, Inc. Contract to be Assistant Medical Director at .4 FTE. November 1, 2011 - October 31, 2013.

Consultant and MRO Services for professional programs, 1998 - Present. Current services are provided consulting work with Compass Vision in Oregon. Consultant work for Fortes Lab and Compass Vision ranges from <\$5,000 to \$100,000 per year depending on services.

Past

Start up funds from the USF Office of Research for substance abuse research in the Division of Professional Health Services, 2004, \$50,000.

DACCO Contract for Medical Director, Methadone Services, and Substance Abuse Treatment Services. Martha E. Brown, M.D., Medical Director, December 11, 2002-July 15, 2009, \$160,000 per year.

Charity Employee Assistance Program and Drug Testing Program. Martha E. Brown, M.D., Co-Principal Investigator and Project Director, July 1, 1995 - June 30, 1999, \$246,870 per year.

Campus Assistance Program. Martha E. Brown, M.D., Co-Principal Investigator and Medical Director, originating in 1990, approximately \$120,000 per year.

Medical Center of Louisiana contract support for Associate Medical Director and other staff.

SPECIALTY BOARD CERTIFICATION

Certified with Added Qualifications in Addiction Psychiatry by the American Board of Psychiatry and Neurology, March 2003. Currently in the process of Maintenance of Certification.

Certified with Added Qualifications in Addiction Psychiatry by the American Board of Psychiatry and Neurology, June 1993.

Certified by the American Association of Medical Review Officers as a Medical Review Officer, November 1992.

Re-certified by the American Association of Medical Review Officers, December 1997.

Re-certified by the American Association of Medical Review Officers, October 2004.

Re-certified by the American Association of Medical Review Officers, October 2009.

Certification Examination of the American Medical Society on Alcoholism and Other Drug Dependencies, Certified in October 1986.

Certified in Psychiatry by the American Board of Psychiatry and Neurology, October 1988.

PROFESSIONAL COMMITTEES

2015-present	Tri-chair of the National Program Committee, Federation of Physician Health Programs
2015-present	Member National Program Committee, International Conference on Physician Health
2013	Delegate to FMA, Alachua Medical Society
2012-present	Member Santa Fe Athletic Association Substance Abuse Committee
2012-present	Elected representative, UF Faculty Senate
2012	Member and Chair of FMA Reference Committee
2012	Delegate to FMA, Alachua Medical Society
2011	Delegate to FMA, Alachua Medical Society
2011	Member FMA Reference Committee
2011-present	Member UF Athletic Association Substance Abuse Committee
2009-2010	President, USF Women Status Committee

2009-2010	Professional Student Affairs Committee, USF COM
2008-2010	Elected representative, USF Physicians Group
2008-2010	USF Women Status Committee
2009-2009	President-elect, USF Women Status Committee
2007-present	National Program Committee, Federation of Physician Health Programs
2010-present	Co-Chair, Medical Student Committee, Federation of Physician Health Programs
2007-present	Medical Student Committee, Federation of Physician Health Programs
2007-2008	USF Health Leadership Development Council
2007-2008	USF Health Leadership Mentor
2007-2010	Invited FSPHP Committee Member, Federation of State Physician Health Programs
2007-2010	Women In Academic Medicine, USF College of Medicine
2007-2009	Executive Committee Member, Mental Health America of Greater Tampa Bay
2006-2009	Continuing Professional Education Advisory Committee, USF College of Medicine
2006-2008	Professional Student Affairs Committee, USF COM
2006-2007	College of Medicine Strategic Advisory Cabinet
2006-2007	LCME Faculty Issues Committee, USF College of Medicine
2004-2006	Elected Faculty Council Member, College of Medicine Faculty Council, University of South Florida, College of Medicine
2004-2010	Service Chief's Committee, Department of Psychiatry and Behavioral Medicine, University of South Florida, College of Medicine
2004-2010	Outpatient Clinic Committee, Department of Psychiatry and Behavioral Medicine, University of South Florida, College of Medicine
2004	Convener, Project to Advance Clinical Education, University of South Florida, College of Medicine
2003-2009	Learning Group co-leader for USF medical students, USF College of Medicine
1999-2001	Executive Committee, AMERSA
1999-2000	Medical Faculty Assembly representative, LSUMC
1998-1999	Medical Faculty Assembly alternate representative, LSUMC
1994-2000	Medical Director, Louisiana State Medical Society Physician Health Program
1994	Chairman, LCME Accreditation Institutional Self-Study Committee on Medical Students, LSUMC
1994-2004	Co-Chair, Assistance for Healthcare Professionals Task Force, AMERSA
1993-1995	Medical Faculty Assembly representative and their representative to Administrative Council, LSUMC
1996-2000	Chair, Evaluation Committee, AMERSA National Meeting
1993-2002	Program Committee, AMERSA National Meeting
1993-1994	Director, Committee on Alcoholism and Drug Abuse for Greater New Orleans
1993	Graduate Medical Education Committee, Long- Range Plans for LSUMC
1992-1994	Chairman, Louisiana State Medical Society Physicians Health Committee
1992-1995	Delegate to the LSU Medical Faculty Assembly
1992-2000	Chairman, Committee on Education, Prevention, and Treatment Research, LSUMC Alcohol and Drug Abuse Center
1991-1994	Co-chairman, Impairment in Students, Residents, Faculty Small Group, AMERSA
1991-1992	State Council to Prevent Chemically Exposed Infants
1991-1993	Study Committee on Problems Based Learning, LSUMC
1991	Chair, Orleans Parish Medical Society Physicians Health Committee
1990-2000	Louisiana State Medical Society Physicians Health Committee
1990-2000	Orleans Parish Medical Society Physicians Health Committee
1990-2000	LSU Medical School Admissions Committee
1989-1993	Membership Committee, AMERSA
1989-1992	Phoenix Society Advisor, LSUMC
1989-2000	Graduate Education Committee, Department of Psychiatry, LSUMC

1989-1991	Credentials Committee, DePaul Psychiatric Hospital
1988	Executive Committee, JESPH
1986-1987	Medical Student Impaired Physicians Committee, MUSC
1986-1987	Curriculum Committee for the South Carolina School of Alcohol and Drug Studies
1983-1987	Residency Recruitment and Selection Committee, MUSC

MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS

American Psychiatric Association
 Florida Psychiatric Association
 American Society of Addiction Medicine
 Federation of State Physician Health Programs
 Florida Medical Association
 Association of Directors of Medical Student Education in Psychiatry

ADDITIONAL AWARDS AND HONORS

Elected Fellow in American Psychiatric Association
 Exemplary Teacher 2011, UF College of Medicine
 ELAM Learning Community Partner 2006-2007
 ELAM (Executive Leadership in Academic Medicine) Fellow 2005-2006
 Listed in 2007 Best Tampa Bay Area Doctors
 Listed in 2004 Best Tampa Bay Area Doctors
 Listed in 2002-2003 Guide to America's Top Psychiatrists
 Listed in 2002 Best Tampa Bay Area Doctors
 Editor, AMERSA E-Letter, 2000 - 2001
 Special Recognition Award, Orleans Parish Medical Society, February 2000
 Listed in The Best Doctors in America Southeast Region 1996 - 1997 for Addiction Psychiatry
 Phi Kappa Phi
 Recipient of a J.M. Foundation Scholarship to the Summer School of Alcohol Studies, The Center of Alcohol Studies, Rutgers, 1985

APPENDIX D

CV and Bio of Lynn Hankes, MD, FASAM

Lynn Hanks, MD, FASAM

Doctor Lynn Hanks is a graduate of the University of Notre Dame and Georgetown University School of Medicine. Over 30 years ago, he was among the 100 pioneer physicians in the entire country who passed the first certification exam in Addiction Medicine, and he is also an honored Fellow of the American Society of Addiction Medicine. Dr. Hanks is a Clinical Professor Emeritus at the University of Washington School of Medicine in the Department of Psychiatry and Behavioral Sciences. He served 13 years as the full-time Director of the Washington Physicians Health Program, and he is also a Past President of the Federation of State Physician Health Programs. Dr. Hanks is on the Advisory Boards of the Air Line Pilots Association and the Jupiter (FL) Medical Center Detox Unit. He is currently a member of the Board of Directors of the Florida Professionals Resource Network, a program that facilitates the rehabilitation of health professionals with substance use and mental disorders.

*1151 Bimini Lane
Riviera Beach, FL 33404
206-399-7245*

LYNN HANKES, MD, FASAM

CURRICULUM VITA

EDUCATION

1954-58 University of Notre Dame, A.B., *cum laude*
1958-59 University of Notre Dame, B.S., *cum laude*
1959-60 Loyola University Graduate School
1960-64 Georgetown University School of Medicine

INTERNSHIP

1964-65 Jersey City Medical Center, Straight Medicine

MILITARY

1965-66 Naval Aerospace Medical Institute, Pensacola
 Designated Naval Flight Surgeon
1966-68 Senior Medical Officer, Chu Lai Air Base, Vietnam
 Awarded Navy Commendation Medal

RESIDENCY

1968-72 New Jersey College of Medicine, Urologic Surgery

PRACTICE

1972-82 Private Practice of Urology, Aurora, IL
1982-84 Medical Director, Alcoholism and Drug Dependency
 Unit, Lakeland Regional Medical Center, Lakeland, FL
1984-93 Director, Addiction Treatment Program, South Miami
 Hospital, Miami, FL
1993-2006 Director, Washington Physicians Health Program
 Seattle, WA

ORGANIZATIONS

Federation of State Physician Health Programs
Florida Medical Association
American Medical Association
American Society of Addiction Medicine

CERTIFICATION

Diplomate, National Board of Medical Examiners, 1965
Diplomate, American Board of Urology, 1977
Certified Addiction Professional, Certification Board of
Addiction Professionals of Florida, 1985
Certified in Alcoholism and Other Drug Dependencies through examination
by the American Society of Addiction Medicine, Certificate # 424, 1986

ADDICTION MEDICINE

Former Member, Illinois State Medical Society, Panel for Impaired Physicians
Former Chairman and Gubernatorial Appointee, State of Florida, Department
of Professional Regulation Impaired Practitioners Committee
Past Secretary, Board of Directors, American Society of Addiction Medicine
Past Director, ASAM's Annual Ruth Fox Course for Physicians
Fellow, American Society of Addiction Medicine
Past President, Federation of State Physician Health Programs
Past Director, Washington Physicians Health Program
Member, Board of Directors, Florida Physicians Resource Network
Member, Advisory Board, Air Line Pilots Association
Member, Advisory Board, Jupiter (FL) Medical Center Detox Unit

ACADEMIC

Former Clinical Assistant Professor, Department of Medicine,
University of Miami School of Medicine
Clinical Professor Emeritus, Department of Psychiatry and Behavioral Sciences,
University of Washington School of Medicine

PUBLICATIONS

Co-Author, Chapter on Health Professionals. In: Lowinson, Ruiz, Millman, eds.
Substance Abuse, A Comprehensive Textbook. Baltimore, MD: Williams and
Wilkins, 1992: 897-908.
Co-Author, Domino, Hornbein, et al. Risk Factors For Relapse in Health Care
Professionals With Substance Use Disorders. *JAMA*, 2005; 293:1453-1460.

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