

Meeting Notice
Missouri State Board of Registration for the Healing Arts

Wednesday, July 27, 2016

Division of Professional Registration
3605 Missouri Blvd.
Jefferson City, MO 65109

The members of the Impaired Physician Liaison Committee will convene on Wednesday, July 27, 2016 at 1:00 p.m. The meeting will originate from the office of the Missouri State Board of Registration for the Healing Arts located at 3605 Missouri Boulevard in Jefferson City, Missouri.

Notification of special needs as addressed by the Americans with Disabilities Act should be forwarded to the Missouri State Board of Registration for the Healing Arts, 3605 Missouri Boulevard, Jefferson City, MO 65109, or by calling (573) 751-0098 to ensure available accommodations. The text telephone for the hearing impaired is (800) 735-2966.

Except to the extent disclosure is otherwise required by law, the Missouri State Board of Registration for the Healing Arts is authorized to close meetings, records, and votes, to the extent they relate to the following: Sections 610.021 (1), (3), (5), (7), (13), and (14) RSMo, and Sections 324.001.8 and 324.001.9 and 334.001 RSMo.

The Board may go into closed session at any time during the meeting. If the meeting is closed, the appropriate section will be announced to the public with the motion and vote recorded in open session minutes.

Please see attached tentative agenda for this meeting.

Posted: 7/20/2016

**Missouri State Board of Registration for the Healing Arts
Impaired Physicians Committee
July 27, 2016 – 1:00 p.m.**

**Division of Professional Registration
3605 Missouri Blvd.
Jefferson City, MO 65109
Tentative Agenda**

1:00 p.m.

- 1) Approval of Positive Sobriety on provider list
- 2) Annual review of Memorandum of Understanding (MOU)
- 3) ILOD start and end dates
- 4) Missed call in's
- 5) Vacation call in's
- 6) Dual call in for UA testing
- 7) Abstinence Agreement
- 8) Communication with PHP's regarding Hearing outcomes
- 9) DWI's

Closed Session Agenda

Closed Session in accordance with Section 610.021 Subsections (1), (5), (7), (14) and Chapters 324.001.8 and 324.001.9, RSMo; for the purpose of discussing investigative reports and complaints; information pertaining to licensees and applicants for licensure; privileged communication between this agency and its attorney; deliberation on discipline; discussing testing and examination materials; the medical, psychiatric, psychological, alcoholism or drug dependency diagnosis or treatment of specific Licensees; and for the purpose of reviewing and approving the closed session minutes of previous meetings

1. Approval of Positive Sobriety on providers list



POSITIVE SOBRIETY
INSTITUTE
CHICAGO, IL

June 16, 2016

680 N Lake Shore Drive, Suite 800
Chicago, Illinois 60611

RECEIVED
JUN 17 2016
BOARD OF
HEALING ARTS

Missouri Board of Registration for the Healing Arts
3605 Missouri Blvd.
P.O. Box 4
Jefferson City, MO 65102

Dear Missouri Board of Registration for the Healing Arts;

We are writing to request approval by The Missouri Board of Healing Arts for the treatment for Missouri physicians and other healthcare providers.

Positive Sobriety Institute (PSI) of RiverMend Health is a residential outpatient program for the treatment of substance use disorders and dual diagnoses. The founder and Medical Director is Daniel H. Angres MD, a national leader with almost four decades of experience treating healthcare and other professionals. He is the author of several textbooks on the subject, numerous scholarly and research journal articles and even a book of fiction. His treatment team, including Kathy Bettinardi-Angres APN-BC and Wally Cross RPH, have been with him for three decades, and also authored many articles in their areas of specialty, which include the treatment of nurses and pharmacists. *This program was conceptualized by Dr. Angres in the pursuit of excellence in the treatment of addictions; incorporating the best that addiction treatment can offer, coupled with the resources and expertise of a university medical center.*

PSI is located in the heart of Chicago on the lake, with easy access to Northwestern Medical Center, the Rehabilitation Center of Chicago, Prentiss Women's Hospital and two nationally recognized eating disorder programs (Insight and Ascend). These are additional resources that enhance the ability to treat numerous medical and psychiatric problems that co-exist with addiction in their clients. Contact with referral sources are very important, and a minimum of weekly updates are a part of the client's care to provide continuity of care when they return home and to the workplace.

The residences that house the clients are luxury, contemporary apartments across the street and supervised by a sober living manager living on the premises. They are equipped with state of the art gyms, swimming pools, and outdoor areas for relaxation.

The philosophy is an abstinence-based, 12 Step promoting, psychotherapeutic model that includes intensive daily small groups, individual psychotherapy, specialty groups that target process addictions and trauma, sober living with supervision, and the practice of non-chemical coping skills on a daily basis (i.e. exercise, DBT & CBT, yoga, meditation, mindfulness based stress reduction, art therapy, didactic groups, hemi-synch and an environment that is calm and supportive). Individuals may combine outside resources with their treatment, if necessary, such as boundary courses, EMDR therapy, or eating disorder treatment, in order to effectively and holistically improve the overall wellbeing of the client. Dialectical behavioral therapy is incorporated into small groups and also utilized as stand-alone groups

for ongoing support. There is a Board Certified Internist on staff fulltime for all clients at the program, along with a Board Certified Addiction Psychiatrist, Board Certified General Psychiatrist, Board Certified Psychiatric Nurse Practitioner and several Licensed Clinical Social Workers and Licensed Professional Counselors.

All clients are psychologically tested at intervals, too, to assist in their ability to know themselves better and observe improvement or areas that need continued improvement. Their progression is measured through the completion of their homework assignments, their growing leadership skills in their community, their participation in 12 Step groups and the constant observation of the client by the treatment team, which meet each weekday to discuss each client and their progress and needs.

The families and loved ones of the clients are strongly encouraged to participate in the treatment program, and offered family sessions and a three day Family Week. Access to the family therapist is available throughout the week for questions or concerns of loved ones.

Finally, the clients are encouraged to participate in a two year weekly aftercare program, with the option of urine drug screen monitoring. All physicians and other licensed healthcare providers are referred to their state physician health program for monitoring and follow-up care.

Resumes of the key clinicians are included with this information, along with a detailed account of the Multidisciplinary Comprehensive Assessment Program (M-CAP) at PSI, or Rivermend Health Chicago, which is as follows:

One Day Multidisciplinary Comprehensive Assessment Program (M-CAP) – This assessment includes multiple assessments by a psychiatric nurse practitioner/family therapist, addictions specialist, a general psychiatrist, an addiction psychiatrist and an internist (history and physical). There are labs and psychological testing, specifically urine and hair/nail toxicology for drug screens and (Millon) psychological testing interpreted by the psychiatrist. Collateral information from personal and professional sources are included, and the report is sent to the referral source within one to two weeks. The cost is \$2200.

Two Day M-CAP – Includes above, along with a half day with a psychologist that usually includes neurocognitive and additional psychological testing with a neuropsychologist. The lab work may be more extensive, and there may be additional assessments with a social worker and family therapist, which may include the significant other if they accompany the client to the M-CAP. The cost is \$4400.

Three Day M-CAP – Includes above, plus a full day of psychological testing and specialized assessments, such as boundary assessments, neurology, process addiction specialists, occupational assessment, medical specialists, additional testing, etc. The cost is \$6600.

What determines the length of the assessment is the amount of knowledge that is known about the client, and the request of the referral source. Additional information such as legal, medical, psychiatric and other pertinent documents are helpful and should be sent to PSI prior to the assessment. The fax number is 312-642-7055. The main number is 312-642-7230 for all

financial and logistical questions. The M-CAP Coordinator is Kathy Bettinardi-Angres APN, available at 708-822-2255.

The main M-CAP team members include:

Daniel H. Angres MD – Addiction Psychiatrist/ Northwestern University Faculty/PSI
Gaurava Agarwal MD – General Psychiatrist/Northwestern Memorial Inpatient Psychiatry/PSI
Frances Langdon MD – Internal Medicine/ PSI, Addiction Medicine
Tracy McKenzie MD – Internal Medicine
Joseph Siegler MD – Occupational Psychiatrist
Eugene Mele PsyD – Neuropsychologist
Michelle Holliday PhD - Psychologist
Kathy Bettinardi-Angres APN-BC, CADC – M-CAP Coordinator PSI/Psychiatric Nurse Practitioner
Daniel Kobosky LCSW, NCAC1 – Program Director PSI/ Licensed Clinical Social Worker/DBT

Sincerely;



Daniel H. Angres MD
Medical Director, Positive Sobriety Institute
680 N. Lake Shore Dr., Suite 800, Chicago Illinois, 60611

Chief Medical Officer, Addictions Services, RiverMend Health
Adjunct Associate Professor of Psychiatry
Northwestern Feinberg School of Medicine
Department of Psychiatry and Behavioral Medicine

Elevating the Standard of Care



POSITIVE SOBRIETY
INSTITUTE



Daniel Angres, MD
Medical Director
Positive Sobriety Institute

For many years, a very large population has been undertreated as they have been unable to recognize an addictive disorder in themselves—professionals such as doctors, nurses, pilots and judges. The Positive Sobriety Institute was created to fulfill this demand. We offer treatment for these individuals through expert-delivered addiction assessment, rehabilitation and recovery services. Treatment options include intensive partial and outpatient programs, independent living and mandatory after care.

We work very closely with referring entities and perform fitness for duty evaluations to determine appropriate course of action. We also have an aftercare program that follows individuals through recovery at home, supporting them, and providing the resources they need to maintain their sobriety. Our unique expertise in rehabilitating professionals enables us to get careers back on track and families back together.

A handwritten signature in black ink, appearing to read 'Daniel Angres MD', written in a cursive style.



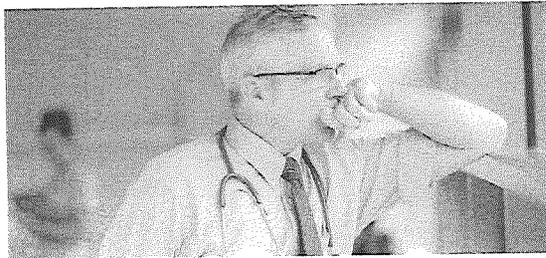
A RiverMend Health Treatment Program

The Multidisciplinary Comprehensive Assessment Program (M-CAP)



POSITIVE SOBRIETY
INSTITUTE
CHICAGO, IL

Expert Assessment for Professionals in Highly Accountable Roles.



Our program is designed to accommodate the individual needs of the client while addressing the concerns of the referring entity.

M-CAP is appropriate for healthcare providers, pilots, attorneys and business executives. Our program acts as an excellent diagnostic tool to ensure that an individual can practice with reasonable skill and safety.

Issues in the workplace prompting an assessment typically include:

- Substance abuse
- Sexual boundary issues
- Cognitive impairment
- Personality disorders
- Psychiatric issues
- Disruptive behavior
- Anger management

We emphasize compassionate advocacy based evaluation while determining issues like fitness for duty and need for treatment interventions.

Multidisciplinary Team

An expert team of board-certified physicians, psychologists and addiction medicine clinicians with decades of successful outcomes administers our Multidisciplinary Comprehensive Assessment over the course of one, two or three days based on the individual needs of the patient and the referring entity. A point person guides the process from start to finish, coordinating discussion among team members and assembling a detailed report that could be used in a deposition or court of law, if necessary.

Thorough Evaluation

A comprehensive assessment includes:

- Psychological, psychiatric and neuropsychological evaluations by a board certified addiction psychiatrist and board certified general psychiatrist
- Personality and neurocognitive testing by a

- board certified neuropsychologist
- Drug use, abuse, and dependence screening
- Toxicology that can include testing of urine, blood, hair, and nails
- Collateral information
- Specialty consultation when necessary, including lab work as determined by the staff and consultation with other board certified specialists at Northwestern Memorial Medical Center, located on the same campus
- Evaluation by a board certified psychiatric nurse practitioner, licensed clinical social worker, licensed professional addiction counselor and board certified internist
- Special assessments to include family, process addictions, eating disorder consultations, etc.
- Recommendations to referral sources on fitness for duty and return to work.
- M-CAP assessment is completed within two to three days.

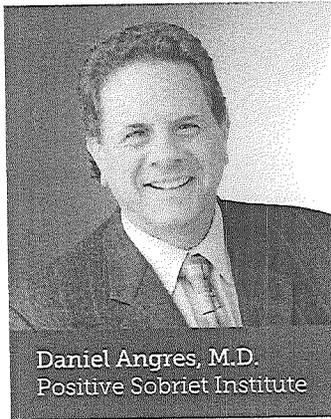


M-CAP Options

One-Day M-CAP – The one-day M-CAP assessment includes multiple assessments by a psychiatric nurse practitioner, family therapist, addiction specialist, general psychiatrist, addiction psychiatrist and an internist. Medical labs, including urine and hair/nail toxicology for drug screening, and psychological testing, including the Millon Clinical Multiaxial Inventory, are performed. Collateral information from personal and professional sources is included and the report is sent to the referral source within one to two weeks.

Two-Day M-CAP – The two-day M-CAP includes everything that the one-day M-CAP assessment includes as well as an additional half day of neurocognitive and psychological testing by a board-certified neuropsychologist. Lab work may be more extensive if indicated and additional assessments with a social worker and family therapist may be added. This additional assessment can include a significant other if present during the M-CAP assessment.

Three-Day M-CAP – In addition to all of the services provided in the two-day M-CAP, the three-day assessment includes a full day of psychological testing and specialized assessments. This may include boundary assessments, neurological testing, and additional addiction psychological evaluations.



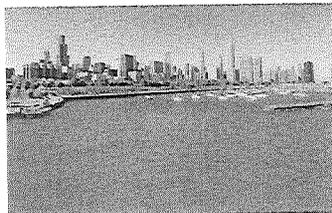
Daniel Angres, M.D.
Positive Sobriety Institute

Meet Our Medical Director

The Positive Sobriety Institute is led by Daniel Angres M.D., a national expert in psychiatry, addiction, and physicians' health programs who has successfully treated addicted professionals for over 30 years. He currently serves as the Medical Director of the Positive Sobriety Institute as well as Chief Medical Officer of RiverMend Health. He has lectured at major academic medical centers across the USA and his work has transformed addiction treatment methods and outcomes. Dr. Angres has been published in peer reviewed journals, referenced by other leaders, and has authored two ground-breaking books on the subject of chemical dependency, "Healing the Healer" and "Positive Sobriety." Dr. Angres has been active in teaching and research in Chicago and is an Adjunct Associate Professor of Psychiatry at Northwestern Feinberg School of Medicine's Department of Psychiatry and Behavioral Sciences.

Accessible from Anywhere in the U.S.

We are conveniently located near Lake Michigan in an upscale area of downtown Chicago, with nearly two dozen desirable hotels in close proximity. There are two international airports within 20 miles of the program, along with bus and train accessibility.



To learn more about the M-CAP or addiction treatment for professionals, contact (844) 285-2826.
All conversations are confidential.





(844) 285-2826
positivesobrietyinstitute.com

 A RiverMend Health Recovery Program



POSITIVE SOBRIETY
INSTITUTE
CHICAGO, IL

Positive Sobriety Institute
The Preferred Choice for Professionals

Recovery begins with a simple call (844) 285-2826

About Positive Sobriety Institute

Positive Sobriety Institute specializes in addiction assessment and rehabilitation for highly motivated individuals suffering from alcohol, drug and pain medication abuse and co-occurring disorders. Located in the heart of downtown Chicago on the calm waters of Lake Michigan, our program is uniquely designed to help working professionals — including executives, healthcare providers and attorneys who are struggling with addiction — rebuild their lives and return to their careers.

Aligned with a top academic medical center, we offer a complete continuum of care to assist professionals throughout every phase of the recovery process. Our multidisciplinary team of board certified physicians and licensed clinicians develop a personalized recovery plan for each patient based on their unique circumstances and regulatory or licensing requirements.

Our committed and compassionate team of practitioners will work closely with any referring entities to ensure that you receive complete support and are able to resume your career.

 A RiverMend Health Recovery Program



Specialized Treatment for Professionals

The effects of addiction can pose particularly negative consequences for healthcare and other professionals, especially those employed in safety-related industries. At Positive Sobriety Institute, we recognize that as a professional, coming to terms with your addiction and seeking help can be extremely difficult. We also know how empowering taking that first step can be. From the very first moment, we treat your right to anonymity as a top priority. Treatment between you and your medical team is always confidential. Our mission is to help you steer your life and career in the right direction, to equip you with the tools you need to avoid relapse.



Renowned Addiction Medicine Experts

Positive Sobriety Institute is the culmination of the vision of Daniel H. Angres, M.D., a nationally recognized addiction psychiatrist and author. Over the last 30 years, he has specialized in the evaluation and treatment of professionals suffering from addiction and dual disorders. He leads a team of psychiatrists, physicians, nurse practitioners, psychologists and other specialists who have contributed an astounding amount of research and thought leadership to the development of new addiction recovery approaches. Dr. Angres also serves as Chief Medical Officer of Addiction Services for RiverMend Health and is an Adjunct Associate Professor of Psychiatry at Northwestern Feinberg School of Medicine.



Easily Accessible From Anywhere in the U.S.

Positive Sobriety Institute is located on Lake Shore Drive in downtown Chicago along the southwestern shores of beautiful Lake Michigan. An urban oasis, our facility has sweeping views of the spectacular Chicago skyline providing the perfect environment to undergo treatment privately and confidentially.

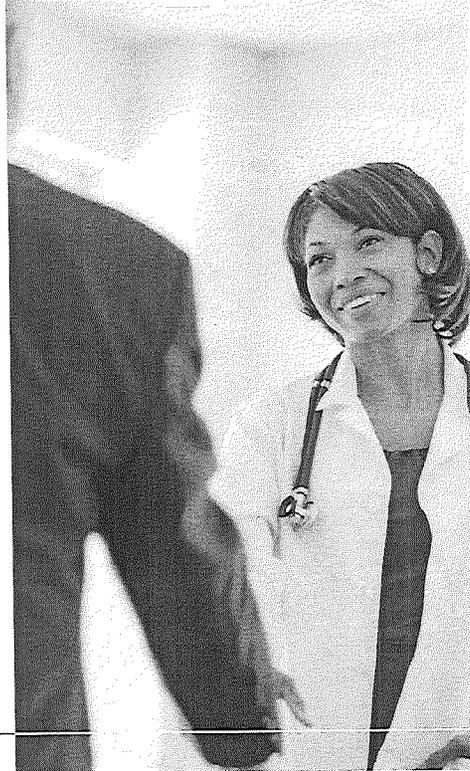
(844) 285-2826 | positivesobrietyinstitute.com

Our Clinical Team

At Positive Sobriety Institute, our goal is to restore your health from addictive behaviors. Our clients receive world-class treatment from a team of compassionate and empathetic practitioners who are experts in facilitating the rehabilitation process and are recognized leaders in the field of addiction medicine. Our evidence-based disease management model has been proven to deliver better patient outcomes and long-term recovery.

Our specialists work together to save lives, careers and set new standards in how addiction treatment is delivered and managed. Led by one of the industry's foremost experts, Dr. Daniel Angres, we continuously work to advance our understanding of the nature of this chronic illness and develop new ways to treat patients through ongoing research.

All of our practitioners are certified and licensed according to their scope of practice and are considered to be leading professionals in their respective fields. We are fully staffed 24 hours a day, seven days a week and offer outstanding clinician to patient ratios.



Daniel H. Angres, M.D.
Medical Director

For more than 30 years, Dr. Angres has been recognized as one of the nation's leading experts in psychiatry, addiction and treating healthcare professionals. He serves as the Medical Director of the Positive Sobriety Institute.



Daniel Allen Kobosky,
LCSW, NCAC1
Program Manager

Daniel is a Licensed Clinical Social Worker and Nationally Certified Addiction Counselor. He has more than 20 years experience providing individual and group counseling in communities.



Kathy Bettinardi Angres,
APN, MS, RN, CADC
Director of
Multidisciplinary
Comprehensive
Assessment Program

Kathy is a board-certified Nurse Practitioner, a licensed Advanced Practice Nurse, Certified Alcohol and Drug Counselor and a licensed Registered Professional Nurse.



Dominic Angres, LPC, CADC
Account Manager,
Admission Coordinator
& Sober Living Manager

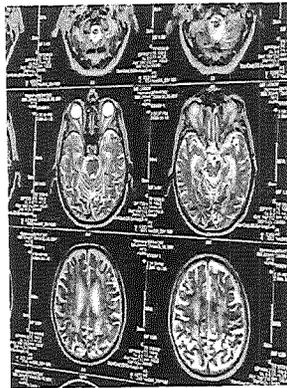
Dominic is the Account Manager, Admission Coordinator & Sober Living Manager at Positive Sobriety Institute. In this role, he serves as an advocate and ambassador to those seeking treatment and as the clinical liaison.

Our Approach

At Positive Sobriety Institute, we know from experience that addiction and recovery can be especially complex for physicians, nurses, pharmacists, lawyers, and other professionals. We treat all clients and their specific addictions, including any co-occurring mental health disorders, in a culturally-sensitive environment conducive to healing.

We view substance use disorders as a chronic brain disease and pay close attention to how it affects your brain's natural wiring and chemical balance. Our team of experts takes a neuroscience-driven approach when designing each patient's individualized treatment plan. Based on an initial comprehensive assessment that takes into account your medical condition, family history and work environment, we'll diagnose the root causes of your addiction and develop a recovery plan to help you improve your health and restore your career.

We provide an extensive range of treatment modalities such as detoxification, residential living, transitional living, outpatient programs and continuing care services for professional men and women. In addition to treating drug, alcohol and pain medication abuse, we also assess and accommodate other addictive conditions, including sex addiction, gambling, food addictions and co-occurring mental disorders.



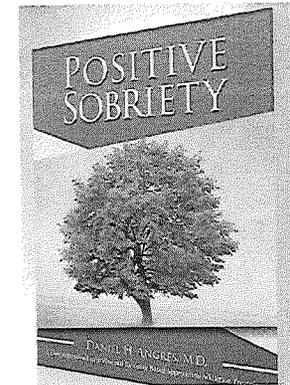
Neuroscience-Driven Treatment

Recent scientific research recognizes addiction as a chronic, but treatable brain disease. With proper care, long-term sobriety can be achieved. Our recovery programs focus on healing the brain through traditional and non-traditional approaches such as sound therapy, mirror imaging and psychodrama.



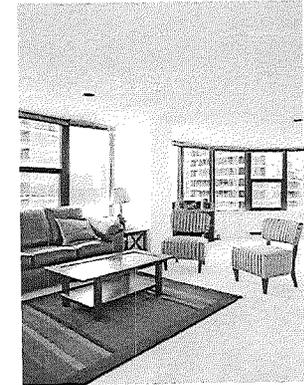
Leading Clinicians & Experts

At Positive Sobriety Institute, we employ many of the nation's leading board certified and licensed addiction recovery specialists. With expertise in addiction, neuroscience, psychology and alternative medicine, our clinicians deliver unparalleled, compassionate care that restores lives and careers.



Positive Sobriety

Our approach to addiction treatment is outlined in Dr. Angres' book, *Positive Sobriety*. This comprehensive manual serves as a curriculum guide for patients and highlights key aspects of our recovery model. Included in the book are worksheets similar to those utilized by our staff in the development of our clients' individualized treatment plans.



World Class Facilities

Positive Sobriety Institute provides a comfortable, private and healing environment to help you focus on recovery. For clients in our residential program, we offer modern space and amenities that are designed to give you the opportunity to integrate real life activities into your treatment experience.

Levels of Care

Detoxification

Positive Sobriety Institute works closely with inpatient detox programs in the Chicago area to provide services for severe cases of alcohol, drug, and pain medication abuse. Inpatient detox offers constant medical care and supervision provided by professional staff who can administer immediate treatment for serious complications.

Selected patients can be detoxed on an ambulatory basis. Our ambulatory detox program is a voluntary, outpatient model with many of the benefits of inpatient detoxification but in a less-restrictive environment. Individuals are under the care of an interdisciplinary medical team that includes physicians, registered nurses, nurse practitioners and addiction counselors.

Independent Living

Our Independent Living Program combines our Intensive Outpatient Program with residential occupancy in a therapeutic community. The goal of independent living is to prepare you for real-life situations that may trigger relapse. This program is available to individuals who are enrolled in our intensive outpatient or partial hospitalization program. Independent Living provides a safe, drug-free, structured and nurturing atmosphere for individuals in a clean, peaceful and active environment with ample opportunities for self-help, entertainment, study, reflection, exercise and teamwork.

Partial Hospitalization Program

Our Partial Hospitalization Program (PHP) provides a more intensive, structured treatment experience than a traditional outpatient setting. Our PHP delivers ancillary medical and psychiatric services for individuals leaving hospital or residential settings and who may still be at a high risk of relapsing. The goal of our PHP is to prepare you for transition to less intensive outpatient services and to provide relapse prevention skills for long-term sobriety. We provide multiple experiences through group, life skills training, addiction education and individual therapy.

Intensive Outpatient Program

We offer an Intensive Outpatient Program (IOP) for adults who are suffering from a substance use disorder and need more intensive therapy than weekly counseling, but not residential care. Our IOP allows you the opportunity to continue to work in the community and maintain family relationships at home while undergoing treatment. The goal is to promote lifestyle changes supportive of recovery.

Our staff recognizes that substance dependency is a family disease and dedicates time for family sessions. Your family members are an important part of our treatment approach. We invite patients, families and referring treatment team members to contribute to your recovery plan.

Programs & Services

	Detoxification	Partial Hospitalization (PHP)	Intensive Outpatient (IOP)	Continuous Care
Gender	Male/Female	Male/Female	Male/Female	Male/Female
Age	18 & Above	18 & Above	18 & Above	18 & Above
Schedule	Ambulatory & Full Time Residential	7 Days/Week Day & Evening Hours	Monday-Friday Day & Evening Hours	24 Hours/Day 7 Days/Week
Board Certified Medical Leadership	✓	✓	✓	✓
Psychiatric Evaluations & Psychological Testing	✓	✓	✓	✓
Alcohol & Drug Addiction Treatment	✓	✓	✓	✓
Pain Medication Abuse & Opioid Addiction Treatment	✓	✓	✓	✓
Healthcare & Other Professional Program	✓	✓	✓	✓
Individual & Family Therapy	✓	✓	✓	✓
Family Education	✓	✓	✓	✓
Relapse Prevention	✓	✓	✓	✓
Insurances Accepted	✓	✓	✓	✓
24 Hour Medical/Therapeutic Support	✓	✓		

Specialized Programs

Multidisciplinary Comprehensive Assessment Program

At Positive Sobriety Institute, we provide a compassionate, advocacy-based Multidisciplinary Comprehensive Assessment Program (M-CAP) that evaluates licensed professionals, executives and others to determine their fitness for duty. A thorough M-CAP evaluation is an in-depth series of screenings and assessments to gain the most detailed picture of your addiction. We provide individualized treatment recommendations based on the results of your evaluations. M-CAP is designed to accommodate your needs while addressing the concerns of your employer or referring entity.

Healthcare & Professionals Program

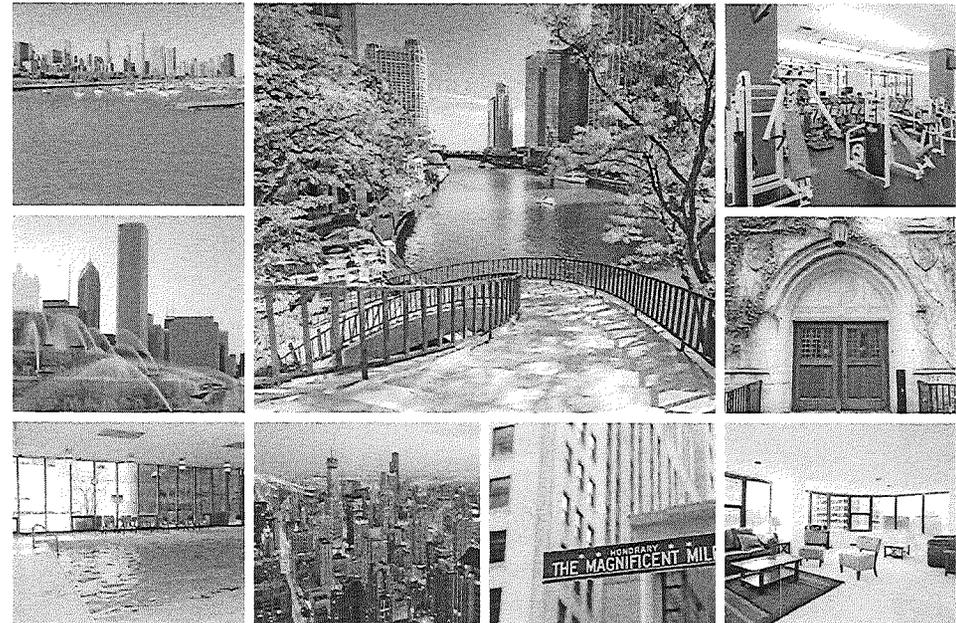
We understand how important your career is to you and how quickly you want to go back to doing what you love. If you need addiction treatment services, our Healthcare & Professionals Program will not only provide the necessary recovery plan but we will also develop a re-entry strategy to get you back to work. We'll determine any necessary restrictions or adjustments in your job and ensure that you can safely resume your duties when the time comes.

Continuing Aftercare

Our Continuing Aftercare program is a two-year commitment of scheduled check-ins, urine drug tests, continued counseling, support groups and sometimes transitional living that can help you maintain sobriety and prevent relapse. At Positive Sobriety Institute, our continuing aftercare provides a supportive environment allowing you to connect with recovering addicts, practice acquired skills for coping with stress and daily challenges, and offers invaluable guidance from a sponsor. For many of our healthcare professionals, we partner with the State's Professional Health Program to provide the required five year monitoring.

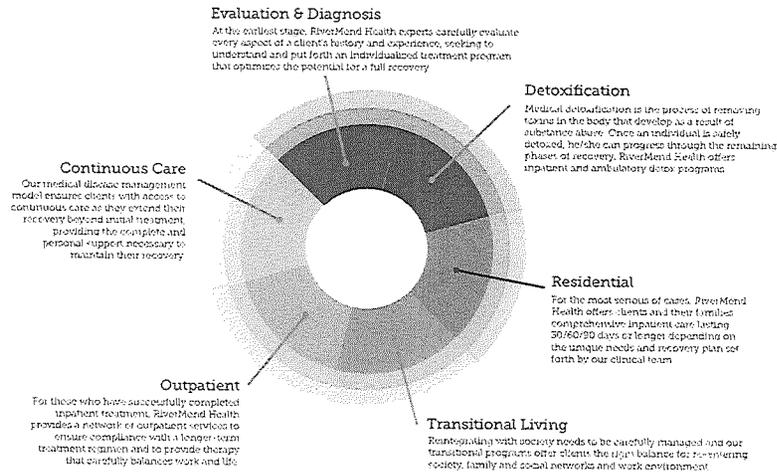
Dual Disorders Evaluation & Diagnosis

Individuals who suffer from a mental health disorder such as depression or severe anxiety and are addicted to drugs or alcohol are living with what is called a dual disorder. Demanding careers can often fuel levels of stress and anxiety. Professionals may lean on mood-altering drugs to soothe mental distress. Treating a dual disorder requires specialized, integrated care. At Positive Sobriety Institute, we understand that mental illness and addiction share many of the same symptoms. As such, we are committed to helping you maintain sobriety and long-term care for mental health issues.



A Comprehensive Continuum of Care

Positive Sobriety Institute is a member of the RiverMend Health portfolio of recovery programs, a nationwide network of scientifically driven, medically supervised treatment centers for every stage of addiction, eating disorders and obesity. Our recovery programs provide a comprehensive continuum of care and a smooth transition between each phase of treatment. Our clients receive optimal support as they reenter their family, home, and work lives and maintain their recovery on a long-term basis.



 A RiverMend Health Recovery Program

Introducing The RiverMend Health Portfolio of Recovery Programs

Founded on the belief that addiction, eating disorders and obesity are the nation's most pressing healthcare challenges, we bring together the world's preeminent experts, leading academic partnerships and a nationwide network of recovery programs to conduct evidence-based treatment, research and education.



(844) 285-2826 | positivesobrietyinstitute.com



Let's Begin Your Recovery Right Now.

Our recovery counselors are ready to help you. Get the professional expertise you deserve to get your life back on track.

Our Free Evaluation Includes:

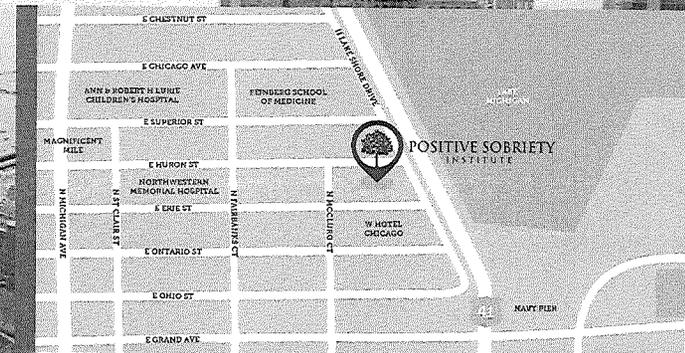
- ☒ A confidential, in-depth conversation with one of our recovery counselors.
- ☒ A review of your current condition and circumstances.
- ☒ A recommendation on the best course of treatment and on a recovery plan.
- ☒ An evaluation of your health coverage and the array of payment options available.

☒ A RiverMend Health Recovery Program

"With proper treatment, professionals can have a long and fruitful career that is no longer tainted by substance abuse."

Daniel H. Angres, M.D.
Medical Director
Positive Sobriety Institute

Call Now for Help **(844) 285-2826**
positivesobrietyinstitute.com



Curriculum Vitae

Personal Information:

Daniel H. Angres, M.D.

Chief Medical Officer, RiverMend Health Addiction Services
Medical Director – The Positive Sobriety Institute

Adjunct Associate Professor of Psychiatry, Department of Psychiatry
Northwestern University, Feinberg School of Medicine

Office Address Positive Sobriety Institute
680 N. Lake Shore Drive
Chicago, Illinois 60611

Home Address:

Undergraduate: Southern Illinois University - Carbondale, Illinois
(1 year at Madison, Wisconsin)
B.S. – Philosophy and Pre-Med
Honors: Philosophy

Medical: Autonomous University of Guadalajara, 1972-1976
January – June 1976: Exchange Student for: Pediatrics
Surgery, OB-GYN at Boston University and
Harvard Affiliated Hospitals

Rush University – 5th Pathway (Rush Medical College Affiliate,
July 1976 – July 1977) Rotating Internship – ECFMG #250-521-2

Licensure: Illinois #036-058641

Residencies:

R1 Psychiatry
Rush Presbyterian St. Luke's Medical Center, 1977 – 1978
R2/3 Neurology
University of Illinois and Northwestern University, 1978-1980

- R3/4 Psychiatry: Rush Presbyterian St. Luke's Medical Center, January 1980 – January 1981
- R4/5 Adjunct Attending and Fellowship in Geriatric Psychiatry, RPSLMC (JRB), January 1981 – May 1981. 16 months half-time rotation: Outpatient (12 months), Inpatient (4 months), Psychiatry RPSLMC (4 months), March 1988 – July 1989

Certifications:

1. Diplomat American Board of Psychiatry and Neurology, January 1991, Psychiatry, Certificate #33654, January 1991
Addiction Psychiatry, Certificate #489, October 1994
2. Certified in alcoholism and other drug dependencies through examination by the American Society of Addiction Medicine, (now American Board of Addiction Medicine or ABAM), Certificate #001893, 1986,
3. Certificate of Added Qualification in Addiction Psychiatry, Certificate #489, Certified by American Board of Psychiatry and Neurology, October 1994
Re-Certified June, 2004 and May 2014

Faculty Appointments:

January 1994 – present: Associate Professor, Psychiatry, Rush University, College of Medicine

July 2007-present: Visiting Associate Professor, University of Illinois, Department of Psychiatry

April 1, 2010- present: Adjunct Associate Professor, Psychiatry, Northwestern Feinberg School of Medicine

Hospital Appointments:

Date	Title	Hospital
April 2009 – 2014	Attending Physician	St. Joseph Hospital

Administrative Appointments:

Date	Title	Institution
2007-2014	Medical Director	Presence Behavioral Health, Addiction Services

Committee Service:

Date	Name of Committee/Hospital
1/1995- 3/2007	Chairman, Physician Health /Rush Medical Center
1/2010 – 7/2014	Chairman, Physician Health / St. Joseph Hospital

Awards/Honors/Distinctions:

Chief Resident: June 1980 – January 1981
Department of Psychiatry, RPSLMC

Founding Member, Physician Assistance Program of Illinois State Medical Society 1984-1994

Past-President, Illinois Society of Addiction Medicine, 2000-2002

Consultant to the U.S. office of National Drug Control Policy, Washington, D.C., 2001-2002

Lifetime Achievement Award, Illinois Society of Addiction Medicine, Sept. 2003

“Best Doctors in America”, Woodward/White, 1997-98, 2002-12

Top Doctors, Chicago Metropolitan Area”, Castle Connolly Guide 2001-2012

Professional Society Memberships:

- American Psychiatric Association
- Founding Member of American Academy in Alcoholism and Addictions – AAPAA
- ASAM – American Society of Addiction Medicine
- Chicago Medical Society
- Illinois State Medical Society
- American Medical Association
- Illinois Psychiatric Society
- Illinois Society of Addiction Medicine

Professional and Scientific Service:

Co-Chairman: Midwest Test Development Committee for American Society of Addiction Medicine (ASAM), 1988-1989

Chairman: ASAM Impaired Physician’s Committee, 1994-1996

Editorial Board of American Society of Addiction Medicine "Principles of Addiction Medicine", Second Edition 1996-1999

American Society of Addiction Medicine Delegate to Advisory Committee of Joint Commission on Accreditation of Hospitals, March 1999 to March 2000

Isaac Ray Board Member, Sept. 2003

Volunteer: DuPage Community Clinic, Wheaton, IL, 2001 to 2009

Illinois Professionals Health Program Advisory Board, 2003 to 2008.

Fellow, Chicago Institute of Medicine

Teaching

Provide clinical rotations – 1994 to present for:

- 2nd Year Rush Psychiatry Residents
- Rush Med-Psych Residents
- Rush Pain Fellows
- Addiction Fellows, University of Illinois

Scholarly Bibliography

Peer Reviewed Publications:

1. Angres, D.H., Benson, B., Cocainsim – A Workable Model for Recovery, *Psychiatric Medicine*, Vol. 3, No. 4, 1987
2. Angres, D.H., Busch, K., The Chemically Dependent Physician: Clinical and Legal Considerations. R.D. Miller (ed.), *Legal Implications of Hospital Policies and Practices*, New Directions for Mental Health Services no. 41. San Francisco: Jossey-Bass, Spring 1989
3. Mahoney, Neil D., Devine, James E., Angres, Daniel, Multidisciplinary Treatment of Benign Chronic Pain Syndrome in Substance Abusing Patients. *Current Review of Pain*, 1993, Current Science Inc., 3:321-331
4. Angres, D.H., McGovern, M.P., Leon, S. Treatment Matching and the Impaired Physician: Assessment of Substance Use, *Psychiatric and Behavioral Problems. Journal of Addictive Disease* 1997; 16(2) 99

5. Angres, D., Easton, M.S., Treatment Management for Acute and Continuing Care; Manual of Therapeutics for Addictions, Chapter on Treatment Modalities, Chapter 20, Addiction Psychiatry, Saunders, W.B., 1997
6. Angres, D.H., Larson, J., Pacione, A., Anderson, C., Costabilo, J., An Integrated Clinical Approach to Managed Care. *Psychiatric Annals*. 1998; 28(12)
7. McGovern, M.P., Angres, D.H., Leon, S., Differential Therapeutics and The Impaired Physician: Patient Treatment Matching by Specificity and Intensity. *Journal of Addictive Disease*, 1998 Vol. 17(2): 93-107
8. McGovern, M.P., Angres, D.H., Uziel-Miller, ND, Leon, S., Female Physicians and Substance Abuse: Comparisons with Male Physicians Presenting for Assessment. *Journal of Substance Abuse Treatment*, Vol. 15(2) 1998
9. Talbott, G.D., Gallegos, K.J., Angres, D.H., Impairment and Recovery in Physicians and Other Health Professionals, Alcohol and Drug Use in the Workplace, Principles of Addiction Medicine, Second Edition, 1998
10. Angres, Daniel H. "The State of Treatment Today." National Catholic Council on Alcoholism and Related Drug Problems, Inc. The Blue Book, Vol. XLIX, 1998, pp 7-17
11. McGovern, M.P., Angres, D.H., Leon, S., Characteristics of Physicians Presenting for Assessment at a Behavioral Health Center. *Journal of Addictive Diseases*, Vol. 19 (2) 2000. pp. 59-73
12. Angres, D.H., "Chemical Dependency in Anesthesiologists." American Society of Anesthesiologists. May 2001, pp 6-8
13. Angres, D.H., McGovern, M.P., Rawal, P., Shaw, M., "Psychiatric Comorbidity and Physicians with Substance Use Disorders: Clinical Characteristics, Treatment Experiences, and Post-Treatment Functioning. *Addictive Disorders and Their Treatment*, 2002, Vol. 1(3): 89-98
14. Angres, D.H., McGovern, M.P., Shaw, M., Rawal, P., Physicians with Substance Use Disorders: A Comparison between the 1980s and 1990s. *Journal of Addictive Diseases*, Vol. 22(3), 2003: 79-87
15. Shaw, M.F., McGovern, M.P., Angres, D.H., Rawal, P., Physicians and Nurses with Substance Use Disorders, (2004) *Journal of Advanced Nursing* 47(5), 561–571
16. Angres, D.H., Delisi S., Alam D., Williams, B. Physicians with a Dual Diagnosis:

A Programmatic Approach to Treatment. *Psychiatric Annals* 34:10,2004:776-780

17. **Angres, D.H.**, Bracha, A., "The Role of the TCI (Temperament and Character Inventory) in Individualized Treatment Planning in a Population of Addicted Professionals", *Journal of Addictive Diseases*, Volume 26, Supplement Number 1, 2007
18. Alam,D, **Angres, D.H.** "Advances in the Pharmacotherapy of Alcoholism" *International Drug Therapy Newsletter*, Volume 42, Number 3, 3/2007.
19. **Angres, D.H.**, Angres K., "The Disease of Addiction, Origins, Treatment, and Recovery" *Disease-A-Month*, Mosby Press, Volume 54, No. 10, October, 2008.
20. **Angres, D.H.**, Angres K., Cross, Wallace, "The Addicted Nurse" *Journal of Nursing Regulation* Volume 1, No.1, 2010
21. **Angres, D.H.** "The Temperament and Character Inventory in Addiction Treatment" *Focus: The Journal of Lifelong Learning in Psychiatry*, Spring 2010, Vol.VIII, No.2
22. **Angres, D.H.**, **Bologeorges, S.**, **Chou, J.** "A Two Year Longitudinal Outcome Study of Addicted Health Care Professionals: An Investigation of the Role of Personality Variables" *Substance Abuse: Research and Treatment* 2013:7 1-12.
23. Cross, W, Bologeorges, S., **Angres, D.H.**, "Issues and Data Associated with Addictive Disease in Pharmacists" *U.S. Pharmacist*, November 2013.

Papers and Poster Sessions

1. **Angres, D. H.**, Bologeorges, S. December 2011. Temperament and character adaptations to addictions treatment. Poster was presented at the 22nd Annual Meeting of the American Academy of Addiction Psychiatry, Scottsdale, AZ.
2. Cross, W., Bologeorges, S., **Angres, D. H.** December 2011. Issues and data associated with addictive disease in pharmacists. Poster was presented at the 22nd Annual Meeting of the American Academy of Addiction Psychiatry, Scottsdale, AZ.
3. Gupta, A., Bologeorges, S., Goulding E. **Angres D.H.**, "The Addicted Physician: Treatment Outcome and Risk Factors Correlating to Relapse" Paper Session at 44th Annual Medical Scientific Conference April 25-28, Chicago Il.
4. Bassett A., **Angres D.H.**, Bologeorges, S. "Assessing Motivations for Use in Addicted Professionals", Poster Session at 44th Annual Medical Scientific Conference April 25-28, Chicago Il.

5. Angres D.H. "Physician Well-Being: Healing the Healer-Chapter 8", published in the proceedings of the AMA/CMS Physician Wellness Conference June 13-15 2013/14, Chicago, IL.

BOOKS:

Angres, D.H., Talbott, D., Angres, K., Healing the Healer, Treating the Chemically Dependent Physician. Connecticut: Psychosocial Press, 1998.

Angres, Daniel, Positive Sobriety, "Addiction Recovery as a Path to Well Being": Create Space, 2012

Gaurava Agarwal, M.D.

Home Address: [REDACTED]

Home Phone: [REDACTED]

Business Address: 446 E Ontario 7-247 Chicago, IL 60611

Business Phone: [REDACTED]

Email: [REDACTED]

Education

- 1999-2003 **Illinois Wesleyan University**, Bloomington, IL
-Magna Cum Laude, B.S. Biology, Minors Psychology and Chemistry
- 2003-2007 **Baylor College of Medicine**, Houston, TX
-Doctor of Medicine

Graduate Medical Education

- 2007-2011 **McGaw Medical Center of Northwestern University**, Chicago, IL
-Department of Psychiatry

Board Certification and Medical Licensure

- 2009 Licensed in State of Illinois
- 2009 Buprenorphine Certification
- 2011 American Board of Psychiatry and Neurology: Board certified 9/2011

Academic Appointments

- 2011- **Northwestern Feinberg School of Medicine**, Chicago, IL
-Assistant Professor Department of Psychiatry and Behavioral Sciences
-Assistant Professor Department of Medical Education
-Inpatient Unit Director
-Director of Undergraduate Medical Student Education, 8/2012-present
-Psychiatry Clerkship Director, 8/2012-present
-Associate Psychiatry Clerkship Director, 2011-2012

Hospital Appointments

- 2015- **Positive Sobriety Institute**, Chicago, IL.
-Staff Psychiatrist, Impaired Professionals Program
- 2009-2011 **Northshore University Health System**, Evanston, IL

Awards/ Honors

- 2014 George H. Joost Clinical Teacher of the Year Award, Feinberg School of Medicine
- 2013 Association for Academic Psychiatry Junior Faculty Development Award
-International organization promoting academic psychiatry and recognizing promising junior faculty leaders in academic psychiatry
- 2013 Harry Beaty Honors Day Speaker, Feinberg School of Medicine
-Selected faculty convocation speaker by graduating fourth year medical students
- 2013 Feinberg Academy of Medical Educators
-Selected Member to organization of outstanding teachers
- 2011 Medical Student Teaching Award, Feinberg School of Medicine, Department of Psychiatry and Behavioral Science, Chicago, IL
- 2011 Resident Service Award, Feinberg School of Medicine, Department of Psychiatry and Behavioral Science, Chicago, IL
- 2008 Medical Student Teaching Award, Feinberg School of Medicine, Department of Psychiatry and Behavioral Science, Chicago, IL
- 2007 Medical Student Teaching Award, Feinberg School of Medicine, Internal Medicine Department, Chicago, IL

Professional Society Memberships

- 2012-present Association of Directors of Medical Student Education in Psychiatry
-Special Interest Group Wellness Member, 2015-
- 2010-present Association for Academic Psychiatry
-AAP Awards Committee Member, 2013-present
-Medical Student Education Caucus Member, 2013-present
- 2010-2012 American Medical Association
- 2008-present American Psychiatric Association
-Fellow
- 2008-present Illinois Psychiatric Society
-IPS Councilor 2015-present
-IPS Nominating Committee 2016-present

Professional Activities

Institutional Service

- 2015-present Wellness Committee, Feinberg School of Medicine
-Academic Activities Subcommittee Chair
- 2014-present Wellness Initiative for Student Health (WISH), Feinberg School of Medicine
-Faculty Advisor for Medical Student Interest Group
- 2014-present Northwestern Memorial Hospital Practitioner Health Committee
- 2014-present Clinical Competency Committee, Department of Psychiatry
- 2012-present Education Committee, Northwestern Memorial Hospital
- 2011-present Inpatient Psychiatry Committee, Northwestern Memorial Hospital
- 2011-present Clerkship Directors Committee, Feinberg School of Medicine
- 2011-present Resident Recruitment and Selection Committee
- 2011-present Professional Behavior and Moral Reasoning Curriculum Renewal Committee, Feinberg School of Medicine
-Personal Awareness and Self-Care Subcommittee Chair
- 2010-2011 McGaw Residents and Fellows Forum, Chicago, IL
-Co-President
-Graduate Medical Education Committee representative for 1,200 member group of fellows and residents
-Conducted Neuropathology Fellowship Program Internal Review
- 2010-2011 Graduate Medical Education Committee, Northwestern Memorial Hospital, McGaw Medical Center
- 2010- 2011 Chief Resident Committee, Northwestern Memorial Hospital
- 2008-present Residency Training Committee, Department of Psychiatry, Northwestern Memorial Hospital
- 2008-2009 Rapid Stabilization and Inpatient Psychopharmacology Guidelines Task Force, Northwestern Memorial Hospital Psychiatry Department
- 2005-2007 Couch Psychiatry Student Interest Group, Baylor College of Medicine
-President

Teaching

Curriculum Development and Courses Coordinated

- 2015- I-human Stimulated Case, Co-author
- 2015- Instructor, "Psychopharmacology of Bipolar Disorder," PGY-1 Department of Psychiatry and Behavioral Sciences.
- 2013- Course Director and Creator, "Personal Transition to the Profession-1 and 2," Feinberg School of Medicine
- Design, coordinate, and direct monthly program for 320 M1 and M2 students, 40 small group faculty members, and eight college mentors about the core competency of personal awareness and self-care
- 2013- Co-Leader Health and Society for Psychiatry. "How society makes and breaks disease: The role of stigma in the delivery of psychiatric care," Feinberg School of Medicine
- 2012-2013 Co-Course Creator and Director, "Personal Awareness and Self-Care," Feinberg School of Medicine
- 2013 Instructor and Co-Course Director, "Critical Thinking and Psychotherapeutics," PGY-4 residents, Northwestern Department of Psychiatry and Behavioral Sciences
- 2012 Instructor and Co-Course Director, "Advanced Psychopharmacology," PGY-4 residents, Northwestern Department of Psychiatry and Behavioral Sciences
- 2011 Instructor, "Psychiatry for the Neurologist" for all residents in Northwestern Department of Neurology
- 2011 Instructor and Co-Course Director, "Psychopharmacology for the Psychologist," Psychology Doctoral Candidates, Northwestern Department of Psychiatry and Behavioral Sciences
- 2009 Co-Creator of "Stone Inpatient Junior Attending," Northwestern Memorial Hospital

Individual Lectures

"Personal Finance and Wellness in Medicine"
-Capstone Project M4, 5/2015, 2016

"Wanting and Accepting Critical Feedback: Identifying Common Psychological Barriers in High Achievers"
-Instructor M1 students, 10/2013, 11/2013, 11/2014

Clinical Interviewing

-Instructor for Genetics Master's student

Psychiatric Interview

-Instructor Physician's Assistant Program, Feinberg School of Medicine,
Annual Lecture starting 2013

Psychiatric Interviewing Course

-Instructor M3 students, weekly 8/2012-2014

Preceptor Group for Psychiatric Oral Presentations

-Instructor M3 students, weekly 7/2011-2012, Intermittent in 2013-2014

"Wellness in the M3 year"

-Presenter M3 orientation, 6/2012, 6/2013, 4/2014, 3/2015

"Temperament and Character Inventory"

-Presenter M2 students, 3/2012

"Evaluating Capacity"

-Instructor PGY-1 class, 2/2012

"Professional Transitions: Senior Resident to Junior Faculty"

-Instructor PGY-4 class, 9/2011, 9/2012, 9/2013, 9/2014

Patient Physician and Society M3/M4

-Small Group Leader, monthly 2011-2013, Feinberg School of Medicine

"Ethics and Psychiatry"

-Instructor M3 Students, 6/5/2011, 8/2011, Monthly 8/2012-present

"Depression and Medical Student Suicide"

-Small group leader M2 class 4/2011, 4/2012, 4/2013

"Patient Perspectives in Psychiatry"

-Instructor M1 students, Feinberg School of Medicine, 2010-2011

"Suicide Risk Analysis and Interview Techniques"

-Instructor M3 students monthly 11/2009-8/2012

"Mental Status Exam"

-Instructor M2 students, 4/2010, 4/2011, 4/2012, 4/2013

Review Responsibilities

2015-present Ad hoc Reviewer, Journal of Schizophrenia Research

2014-present Ad Hoc Reviewer, Clinical Schizophrenia and Related Psychoses

2011-2012 Ad Hoc Reviewer, Residents' Journal American Journal of Psychiatry
2010-present Ad Hoc Reviewer, Academic Psychiatry

Grant Awards/Research Projects

Title: Long acting Aripiprazole in schizophrenia and bipolar disorder: ARRIVE and ATLAS
Source: Otsuka
Role: Co-investigator

Title: Bipolar Depression and Melatonin
Source: Takeda
Role: Co-investigator

Title: Treatment-resistant schizophrenia and high dose lurasidone
Source: Sunovion
Role: Co-investigator

Title: Glyx cognitive enhancement in healthy controls and schizophrenia
Source: Naurex
Role: Co-investigator

Invited Lectures and Presentations

Lectures

- 6/2016 Lewis, C., Malloy, E., Agarwal, G., Stuber, M. "Burned Out on Physician Burnout? A Holistic Look at Prevention." Plenary, Association of Directors of Medical Student Education in Psychiatry Annual Meeting, Excelsior Springs, MO.
- 2014 "From Burnout and Impairment to Resilience and Engagement in Physicians." Year in Internal Medicine Conference, Northwestern Memorial Hospital
- 2014 "Burnout and Resilience in Psychiatrists," Case Western University MetroHealth Medical Center, Grand Rounds, Cleveland, OH.
- 2009 "Patient No-Shows: Who is most likely to no-show, what can be done, and the effect on residency education." Co-Presenter, Northwestern Department of Psychiatry and Behavioral Sciences, Grand Rounds, Chicago, IL

Posters

- 5/2016 Mosquero, M., Victorson, D., Ring, M., Agarwal, G. "Development and Psychometric Properties of a New Measure of Medical Student Stress: the Medical Student Stress Scale 10 (MSSS-10)." International Congress on Integrative Medicine and Health, Las Vegas, Nevada.
- 2015 Agarwal, G. "Personal Transition to the Profession (PTTP): A novel longitudinal wellness curriculum." Association of Directors of Medical Student Education in Psychiatry Annual Meeting, Stowe, VT.
- 2015 Agarwal, G., Brisson, G., Sanguino, S. Hauser, J. "Personal Transition to the Profession (PTTP): A four year longitudinal intraprofessional development and wellness medical student curriculum." CGEA/CGSA/COSR Joint Meeting, Columbus, OH.
- 2010 Agarwal, G. and Anzia, J. "Psychiatry resident engagement and why it matters: Preliminary Data." Association for Academic Psychiatry Annual Meeting, Pasadena, California, 9/2010.
- 2009 Reichlin, A. and Agarwal, G. "Myspace, Facebook, Twitter: The Prevalence and Pitfalls in Psychiatric Practice. What do our residents need to know?" Association for Academic Psychiatry Annual Meeting, Washington D.C., 9/2009.

Workshops

- 6/2016 Malloy, E., Agarwal, G. Fox, G., Stagno, S., Stuber, M. "Wellness: Walking the Walk." Association of Directors of Medical Student Education in Psychiatry Annual Meeting, Excelsior Springs, MO.
- 6/2016 Marcangelo, M., Agarwal, G., Schilling, D. "Evaluation of Third Year Medical Students: Which tools, how many, and what matters?" Association of Directors of Medical Student Education in Psychiatry Annual Meeting, Excelsior Springs, MO.
- 2016 Agarwal, G., Anzia, J., Franklin, J., You, W., Gollan, J. "Wellness in the M2 Year: Preparing for Step 1 and the Transition to Clerkships through Cognitive Reframing Skills." Feinberg School of Medicine, Chicago, IL.
- 2015 Agarwal, G., Anzia, J. "Wellness: Recognizing the Resident (or Chief Resident) in Distress." McGaw/FAME Chief Resident Retreat, McGaw Medical Center, Chicago, IL.
- 2015 Agarwal, G., Gathright, M., Guise, B., Thrush, C. "Mastering the \$30,000 Meeting: Using Parallel Thinking Methods to Improve Morale and Outcomes." Association for Academic Psychiatry Annual Meeting, San Antonio, TX.

- 2015 Mosquera,M., Victorson,D., Ring, M., Agarwal,G. “The Medical Student Stress Scale: Development of a New Measure of Medical Student Stress Using Modern Measurement Theory Applications.” International Conference to Promote Resilience, Empathy and Well-Being in the Health Professions, Washington, DC.
- 2012 Caplan, J. Anzia, J, Agarwal, G.,Lalone,K.. “Professional Transitions.” Association for Academic Psychiatry Annual Meeting, Nashville, TN
- 2011 Agarwal, G. Doyle, M. Anzia, J. “Actions Speak Louder than Words: Teaching Professionalism through Behavioral Simulations.” Association for Academic Psychiatry Annual Meeting, Scottsdale, Arizona
- 2010 Benjamin, Sheldon, Anzia, J, Boland,R, Agarwal,G., et al. “Web 2.0 and Psychiatry: Professional and Ethical Issues for Trainees.”American Association of Directors of Psychiatric Residency Training, Annual Meeting, Orlando, Fl

Publications

Original Investigations

1. Agarwal, G. “Psychiatrists use of Social Networking and Patient-Psychiatrist Interactions.” The American Journal of Psychiatry Residents’ Journal, 2011 January; 6 (1):13.
2. Kastenholz, K. Agarwal, G. "A qualitative analysis of medical students' reflection on attending an Alcoholics Anonymous Meeting: Insights for future addiction curricula." Academic Psychiatry, June 25, 2015, 1-7. DOI: 10.1007/s40596-015-0380-3
3. Agarwal, G., Lake, MB. “Personal Transition to the Profession: A Novel Longitudinal Professional Development and Wellness Medical Student Curriculum.” Academic Psychiatry, 2016: 40(1), 105-108. DOI: 10.1007/s40596-015-0463-1
4. Agarwal,G., Karpouzian,T. “An Exploratory Analysis of Work Engagement, Satisfaction, and Depression in Psychiatry Residents.” Academic Psychiatry, 2016: 40(1), 85-88. DOI: 10.1007/s40596-015-0459-x

Reviews and Case Reports

1. Martin, S., Agarwal, G. “Subcutaneous Fat Necrosis as the presenting feature of a pancreatic carcinoma: The challenge of differentiating endocrine and acinar pancreatic neoplasms.” Pancreas, 2009 Mar; 38(2):219-22.
2. Rodriguez-Cabezas, L. Kong, B., Agarwal, G. “Priapism associated with iloperidone: A case report.” General Hospital Psychiatry, 2014. DOI:10.1016/j.genhosppsy.2014.03.011.

3. Backes, K., Christian, T. Agarwal, G. "Turner Mosaicism and Schizoaffective Disorder: The First Reported Case." *Clinical schizophrenia and Related Psychoses*, Manuscript in press, 2014. DOI: [10.3371/CSRP.KBTC.061314](https://doi.org/10.3371/CSRP.KBTC.061314)
4. Agarwal, G., Pirigy, M. Meltzer, H. "Schizophrenia and Suicide: Treatment Optimization." *Current Treatment Options in Psychiatry*. June 2014, Volume 1, Issue 2, pp 149-162
5. Davis L, Agarwal G. Successful Treatment of Delusional Disorder, Persecutory Type with Lurasidone: A Case Report. *Journal of Schizophrenia Research*. 2015;2(2): 1014.
6. Curtis,A., Agarwal,G., Attarian,H. "Treatment of subjective total insomnia after suicide attempt with olanzapine and electroconvulsive therapy: A multidimensional approach to treatment of comorbid sleep and psychiatric disorders." *Journal of Clinical Psychopharmacology*. Manuscript in press.

Book Chapters

1. Cronenwett, W., Agarwal, G., Csernansky, J. "Basic Science Underlying Schizophrenia." *Clinical Manual for Treatment of Schizophrenia*. AAPI, 2012.

Frances Jane Langdon, MD

Summary of Clinical Experience:

- Director of Complex Medical Care, RML Specialty Hospital, Chicago Campus --- 2012 to present
- Private practice, Internal Medicine, Chicago --- 2007 to present
- Group private practice, Internal Medicine, Senior Partner, Chicago Lakeshore Medical Associates --- 1987-2007
- Senior Partner, Peri-Operative Management Team, Chicago Institute of Neurosurgery and Neuro Research, 1987-2007 [Supported twenty-five neurosurgeons at busy academic medical facility]
- Medical Director, Northwestern University Eating Disorder Program --- 1987-2003
- Medical Director, Inpatient Anorexia and Bulimia Unit (35-bed) --- 1987-2001
- Director, Outpatient Medical Services, *PAR (People At Risk)* Program (for morbidly obese), Northwestern University --- 1987-2003
- Occupational Physician, *IBM Corporation*, Medical Department --- 1989-1995
- Occupational Physician, *Santa Fe Railway, Chicago Tribune, US Occupational Health*

Academic Appointments:

- Clinical Instructor, Internal Medicine, Northwestern Memorial Hospital, Northwestern University School of Medicine [yearly management of complete hospital floor team] --- 1987 to 2014
- Instructor, Physical Diagnosis, Northwestern University School of Medicine (first and second year medical students) --- 1989 to 2014

Education:

- MD – Loyola University Stritch School of Medicine, 1984
- Residency – Internal Medicine, University of Illinois – Mercy Hospital, 1984-1987
- BS – Biology, Loyola University of Chicago, 1979

Certification (State Licensure – Illinois):

- Board Certified, 1996-2011: *American Board of Internal Medicine* – recertification examination scheduled for October 2014

Publication:

- *Journal of Chicago Neuroscience*: “Peri-Operative Assessment of the Neurosurgical Patient,” Lead article, September 1998

CURRICULUM VITAE

Teresa S. McKenzie, M.D.



DATE OF BIRTH:



Oak Park, Illinois

SPOUSE:

Jeffrey Alan Leef
Associate Professor of Radiology
University of Chicago

UNDERGRADUATE
EDUCATION:

Triton College, River Grove, Illinois
AS in Nuclear Medicine 1975-1979

Roosevelt University, Chicago, Illinois
Biochemistry 1979-1980

University of Illinois, Chicago
BS in Biology 1980-1982

MEDICAL
EDUCATION:

Chicago Medical School, M.D.
North Chicago, Illinois 1982-1986

POSTGRADUATE
TRAINING:

Loyola University Medical Center
Internship and Residency 1986-1989
Internal Medicine

Loyola University Medical Center
General Internal Medicine Fellowship 1989-1990

ACADEMIC
POSITIONS:

Assistant Professor of Medicine
Loyola University Medical Center 1990-2000

HOSPITAL
APPOINTMENTS:

Attending Physician
Loyola University Medical Center 1990-2000

Attending Physician
Rush Oak Park Hospital 2/04-present

	<p>Attending Physician Gottlieb Memorial Hospital 1/07- 4/2014</p>
PROFESSIONAL PRACTICE:	<p>Teresa McKenzie, M.D. LLC Owner-private practice 3/04-present</p>
CONSULTATIVE WORK: Abuse	<p>Rush Behavioral Health/Resurrection Behavioral Health Consulting Physician for Intensive Outpatient Substance Program, 2004-2009</p> <p>Rush Behavioral Health, then Resurrection Behavioral Health, now called Presence Health Medical Consultant for Professionals undergoing Multidisciplinary Assessment Program 2004-2015</p> <p>Local #4 SEIU Healthcare Medical Consultant – Insurance claim review 8/09-12/2012</p>
AWARDS AND HONORS:	<p>‘Top 500 Doctors in Chicago Area’, listed in Chicago magazine, January, 1997</p> <p><u>The Best Doctors in America</u>, Fourth listing, March, 1999, Woodward/White, Inc.</p> <p><u>The National Registry of Who’s Who</u>, Accepted December, 1999</p>
ACADEMIC MEMBERSHIPS:	<p>Member of the American College of Physicians 1986-present</p> <p>Fellow American College of Physicians 2013-present</p> <p>Member of Society of General Internal Medicine 1989</p>
PROFESSIONAL CERTIFICATION BOARDS:	<p>American Registry of Radiologic Technologists Certification Exam 1979</p> <p>Diplomate of the National Board of Medical Examiners 1987</p> <p>Diplomate of the American Board of Internal Medicine 1989</p>

PROFESSIONAL
LICENSURE:

Illinois 036-076673

ACADEMIC AND
HOSPITAL
SERVICE:

Resident/Medical Student Teaching Rounds
Loyola University 1989-1994

Instructor of Medical Interviewing and
Physical Diagnosis, Loyola University 1990-1991

Student Health Services 1989-1990

Marketing Committee Oakbrook Terrace Satellite
Loyola University, 1990-1991

Committee for CME in Satellite Clinics Loyola University
1995

Clinical Instructor of Loyola Univ. Medical Students in
Student Anchor Program 1997-2000

Rush Health Associates Credentialing
Committee 11/04 -5/08

Clinical Instructor of Rush Medical College
Generalist Curriculum Preceptorship Program
8/05 – present

Clinical Instructor for Rush University Medical Center
Nurse Practitioner Preceptor Program
1/011 - 2014

COMMUNITY
SERVICE:

Fenwick High School – sports physicals for
Female athletes 2006-present

River Forest Girl's Majors softball team - Sponsor in 2007,
2008, and 2009

St. Luke Parish Dinner Dance and Auction
Ad Committee 2005

St. Luke Parish Dinner Dance
Auction Committee 2003

St. Luke School Board Election Committee 2002

Forest Park Annual Community Health Fair
1991-1999, 2001

Well Women Over Forty Seminar
Speaker, Jan. 1994 and Oct. 1994

PREVIOUS WORK
EXPERIENCE:

Nuclear Medicine Technologist
Alexian Brothers Medical Center 1978

Nuclear Medicine Technologist
Michael Reese Hospital and Medical Center 1979-1982

PERSONAL
ENDEAVORS:

Temporary retirement/family time
May 2000-September 2003

Windows 98/Triton College
Fall semester 2000

ACLS (Re)Certification
Rush Pres. St. Luke Medical Center
Dec. 2000

ACLS (Re)Certification
Elmhurst Hospital
May 2004

CME Category 1; 50 hours/year
Boston University School of Medicine-Journal Watch
1998-present

Joseph E. Siegler, MD

Spheres® Leadership Coaching

www.SpheresCoaching.com

Email 

Employment:

- | | |
|--------------|--|
| 1998-Present | <p>President and Founder</p> <p>Spheres® Leadership Coaching (Full Life®, LLC)
Chicago, Illinois
<i>Head, leadership coaching and consulting</i> providing services for raising performance in individuals, teams, and senior leaders.</p> <p>Dr. Siegler is a board-certified physician and psychiatrist, a well-known Wiley author and an inspirational keynote speaker. He has coached many successful business leaders, physicians, and teams.</p> |
| 1999-2001 | <p>Executive Director of Behavioral Managed Care</p> <p>UIC Behavioral Healthcare
Chicago, Illinois
<i>Head, university-based managed care operations.</i></p> <p>He was operational and clinical head of Behavioral Health for 140,000 lives. For 2 years facilitated the Resident Faculty Retreat. He has also served as Assistant Professor of Clinical Psychiatry in the Department of Psychiatry at the University of Illinois. He teaches a course on "Health Care Business" for residents.</p> |
| 1991-98 | <p>Chairman, Behavioral Health (Mental Health and Addictions)</p> <p>Humana
Chicago, Illinois
<i>Clinical and operational head of a department with a \$12 million budget and approx. 500,000 lives.</i></p> <p>Managed a staff of >200 persons at 12 centers, a network of 1000 providers, had 25 direct reports, and a management team of 15 managers. Bank One found Humana Behavioral Health to be the most effective behavioral health system in Chicago.</p> |

Joseph E. Siegler, MD

- | | |
|---------|--|
| 1990-91 | Medical Director,
Integra, National Employee Assistance Program
Radnor, PA
Operational head of clinical services in outpatient centers
and managed medical and clinical interface with large
corporate clients. |
| 1979-80 | Clinical Researcher/Administrator, Baylor College of
Medicine, Department of Community Medicine, Houston, TX |

Postgraduate Training and Fellowship Appointments:

- | | |
|---------|--|
| 1988-90 | Robert Wood Johnson Foundation Clinical Scholar,
University of Pennsylvania, Philadelphia |
| 1988-90 | Senior Fellow, Leonard Davis Institute of Health
Economics, The Wharton School, University of
Pennsylvania, Philadelphia |
| 1987-88 | Chief Resident, New York University-Bellevue,
New York, NY |
| 1984-87 | Resident in Psychiatry, New York University-Bellevue, New
York, NY |

Faculty Appointments:

- | | |
|---------|--|
| 1992-07 | Assistant Professor of Clinical Psychiatry, Department of
Psychiatry, University of Illinois College of Medicine |
| 1991-96 | Clinical Assistant Professor, Department of Psychiatry,
University of Pennsylvania School of Medicine |
| 1988-91 | Assistant Instructor, Department of Psychiatry,
University of Pennsylvania School of Medicine
Clinical Instructor, Department of Psychiatry,
New York University-Bellevue, New York, NY |
| 1987-88 | |

Hospital and Administrative Appointments:

- | | |
|------|--|
| 1986 | Candidate Selection Committee, New York University
Psychiatry Residency Program |
|------|--|

Joseph E. Siegler, MD

Specialty Certification:

1990	Board Certified, American Board of Psychiatry
1985	Diplomate, National Board of Medical Examiners
Licensure:	Illinois

Education:

1980 – 84	M.D., George Washington University Medical School, Washington, DC
1975 – 79	B.A. Health Care and Society, Honors Individualized Major, University of Pennsylvania, Philadelphia, PA

Further Educational Training:

1994	Northwestern University, Executive Management Course, Kellogg School, Evanston, Illinois
1993	PIM I Course. Management Skills for Physician Managers. The American College of Physician Executive, 1993
1992	Psychopharmacology Update, Harvard Medical School, Boston, Massachusetts
1992	Financial Management Seminar, The American College of Physician Executives, Palm Springs, California

Organizational Clients:

1995 - Present	Betty Ford; Medical District of Illinois; Chicago Public Schools; East Bank Club; Chicago Department of Law; Northwest Indiana Health Alliance; Texas A&M College of Architecture; Mental Health and Mental Retardation Authority of Harris (Houston, TX) County; Health Plan of New York; Cheetah Gym; Women's Expo Evanston Illinois; Association for Worksite Health Promotion; Behavioral Healthcare Tomorrow Conference; Institute for Behavioral Healthcare; Association for Ambulatory Behavioral Health; Group Health Association; Northwest Indiana Healthcare Summit; Association for Worksite Health Promotion; Horizons Social Services
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Key Conferences Attended:

Joseph E. Siegler, MD

1997-2016	American Psychiatric Association annual meetings
2015	Federation of Physician Health Programs Annual Meeting. Fort Worth.
2013	AMA/BMA/CMA International Conference in Montreal.
1996	Institute for Behavioral Healthcare - Establishing Value and Values for Behavioral Healthcare at the Millennium, San Francisco, CA
1996	Institute for Behavioral Healthcare - The Behavioral Healthcare Quality and Accountability Summit, Oak Brook, Illinois
1996	The American College of Psychiatrists 1996 Annual Meeting. - Thriving in an Evolving Health Care System, Tucson, Arizona
1995	Disease Management in Behavioral Healthcare: The First National Forum on Patient-Centered Systems to Manage Behavioral Healthcare Outcomes, Phoenix, Arizona
1993	GHAA Annual Behavioral Health Conference, Lake Tahoe, Nevada
1992	GHAA Annual Behavioral Health Conference, Phoenix, Arizona
1991	Academy of Occupational Psychiatry, Phoenix, Arizona

Abstracts:

Steinman WC, Nichols CW, Siegler JE. Institution of a new screening program: a successful model. RWJ Foundation Clinical Scholars Program, National Meeting Program, 1978.

Siegler, JE; Axelband, MA (1993). Maximizing System Improvements-Physicians Must Assume Leadership In Managed Health Care. Robert Wood Johnson Clinical Scholars Program: Annual Meeting Program Fort Lauderdale, Florida.

Book:

Siegler, JE July 2009. Fire Your Therapist. John Wiley and Sons. 259 pages. Self-Improvement/Non-Fiction.

Joseph E. Siegler, MD

Professional Publication:

Siegler, JE (May/June, 2016) Raising Physician Performance With Coaching. American College of Healthcare Executives, Healthcare Executive Magazine.

Siegler, JE (February 24, 2014) Future Leaders in Peak Performance: A new hybrid of competency, authenticity and inclusiveness. American College of Healthcare Executives, Physician Executives Forum Newsletter.

Siegler, JE (July/August 1995) Leadership for Change in Behavioral Healthcare. Behavioral Health Tomorrow, pp. 78-80.

Siegler, JE; Axelband, MA;- Isikoff, J, (July 1993) Psychiatry Taking A Leadership Role in Managed Health Care. Psychiatric Times p 32;Vol. X, No. 7.

Siegler, JE; Axelband, MA, Krupa, L, Isikoff, J (1993). Alternative To Hospitalization Developed For Psychiatric Patients. Innovations '93 -pp. 334-337, published by the American College of Physician Executives.

Siegler, JE; Isikoff, J (August-September, 1993). The Stress of Being a Man. HealthGram pp. 4-6.

Editors, Reviews, Chapters, Letters to the Editor:

Siegler JE (1 989, June* 1). Let's Not Chain Women to a Pedestal Again (Letter to the Editor). New York Times, p. A22.

Siegler JE, (1989, January 4). Enough Stigma (Letter to the Editor). New York Times, p. A20. (In response to William Styron).

Steinman WC, Licht E, Siegler JE, Nichols CW. Screening for Glaucoma by General Medicine Residents. Arch Int Med 1982; 142:785-6.

Steinman WC, Siegler JE, Nichols CW. The Use of a Technician to Teach Resident Physicians a Clinical Skill. J Med Ed 1979; 54:960.

Awards, Honors, and Memberships in Honorary Societies:

1987-2016	American Psychiatric Association
1993	<i>The American College of Physician Executives National Awards Program - "Recognition of Innovation in Improving Health Care Quality and Cost Management" for Humana Partial Hospital Program.</i>
1991	Academy of Occupational Psychiatry
1988-91	Psychiatric Physicians of Pennsylvania
1988-91	Philadelphia Psychiatric Society

Joseph E. Siegler, MD

1987

Awarded the **Laughlin Fellowship** of the American College of Psychiatrists awarded to fifteen residents nationwide making a significant contribution to the field of psychiatry

Joseph E. Siegler, MD

Other Professional Activities:

1994	Reviewer, The American Journal of Medicine
1992	Reviewer, Journal of Hospital and Community Psychiatry
1989-90	Director of the Public Affairs Committee of the Philadelphia Branch of the American Psychiatric Assoc.
1986-87	Editor of psychiatric texts, Macmillan Publishing Company, New York, NY

Keynotes and Media Talks: (keynotes & television presentations are bolded)

2014	American Hospital Association , keynote to the Diversity Board during the ACHE meetings in Chicago, March 24, 2014 Peak Leadership and Diversity/Equity
2011	Advocate Illinois Masonic Medical Center Keynote , Chicago, June 2011 The Aging Physician: Facing Real Challenges while Maintaining Peak Performance
2011	Evolve Workshop , Panel Discussion, Chicago, April 2011 Topic: Business Owners Discovering What's Next
2010	Advocate Illinois Masonic Medical Center Keynote , Chicago, October 2010 A Practical Formula for Physician Wellness, Balance, and Resilience.
2010	ABC Television Appearance , Chicago, January 2010 Topic: Avoid winter gloom: "Pull" Summer Into Winter
2009	WGN Television Appearance , Chicago, September 2009 What we can learn from Celebrity Meltdowns.
2009	ABC Television Appearance , Chicago, April 2009 Living Fearlessly in the Face of Financial Worries
2009	WYSL1040.com , radio show Health Talk, June 17, 2009 Topic: How to create and live a healthy life via podcast.
2009	WGN Television Appearance , Chicago, July 2009, Topic: Relationship Advice
2009	Gulf Cost Issues Radio Interview, Biloxi, July, 2009 Topic: Recession

Joseph E. Siegler, MD

- 2009 WKRQ-FM Interview, Cincinnati, July, 2009
Topic: Love Coach
- 2009 WKRQ-FM Interview, Western Kentucky University, July 2009
Topic: Aging Issues
- 2009 Pro Sports Wives Radio Interview, Chicago, August 2009
Topic: Spousal Job Loss
- 2009 WJFK-FM Interview, Chicago, August 2009
Topic: Love and Relationship Issues
- 2009 Bill and Joel Morning Show, Northeast Georgia, August 2009
Topic: Spousal Job Loss
- 2009 Down to Business with Andy Johnson, Jacksonville, August 2009
Topic: Spousal Job Loss
- 2009 Richmond Times Dispatch, Richmond, August 2009
Topic: Spousal Job Loss
- 2009 Manic Mommies Skype Interview, Boston, August 2009
Topic: Spousal Job Loss
- 2009 Family Circle Interview
Topic: Family Financial Problems, August 2009
- 2009 Blog Talk Radio & Wikipedia
Topic: Education and a Break from Traditional modes of Psychiatry
- 2009 The Chris Voss Show, Chicago, September 2009
Topic: Successful Entrepreneurs
- 2009 **ABC Television Appearance**, Chicago, September 2009
Topic: Household Executives
- 2008 **WGN Television Appearance**, Chicago, December 2008,
Topic: Dealing with Family over the Holiday Season
- WCPT 820-AM George Watts' Seeds for Success Weekly Program**, Chicago, 2008 through 2009.
- 2008-2009 Shared expertise on how to achieve enhanced career performance, satisfaction and greater contentment in all aspects of life; the importance of diversity in organizations; and definitions of success.
- 2008 **American College of Physician Executives (ACPE) Keynote**, Arizona 2008
Achieve High Energy Outcomes and Avoid Burnout in Your Life
- 2007 **Provena Health Keynote**, Geneva Illinois 2007
Achieving Peak Performance and Keeping Stress in Check

Joseph E. Siegler, MD

- 2007 Advocate Health Care Workshop, Chicago 2007
Topic: Dealing with Difficult Patients
- 2007 **Advocate Healthcare. Keynote and Workshop**, Chicago 2007
Avoid Burnout and Increase Productivity
- 2006 University of Chicago, Chicago Alumni Association 2006
Topic: Don't Settle! Design a Career You Love
- 2005 **WGN Television Appearance**, Chicago, November 2005
Topic: Dealing with your Dysfunctional Family at the Holidays
- 2004 Women's Expo, Evanston, Illinois 2004
Topic: Rules for Dating
- 2003 Catalyst Ranch, Chicago 2003
Topic: Rules for Dating
- 2003 **WGN Television Appearance**, Chicago, December 2003
Topic: Avoiding Family Conflict
- 2003 **WGN Television Appearance**, Chicago, September 2003
Topic: Finding Meaning in Your Life as You Remember 9-11
- 2003 **NBC Television Appearance**, Chicago, November 2003
Topic: Dr. Joe's Rules for Dating: Sex, Love & Everything in Between
- 2001 Cheetah Gym Wellness Alliance, Chicago 2001
Topic: Dealing with Anxiety after 9/11
- 2000 University of Illinois at Chicago, Facilitated Year 2000 Annual Resident-Faculty Retreat
Topic: Improving Communication and Organizational Functioning
- 2000 Cheetah Gym Wellness Alliance, Chicago 2000
Topic: Male Body Image
- 2000 Cheetah Gym Wellness Alliance, Chicago 2000
Topic: Female Body Image
- 2000 Horizons Social Services, Chicago 2000
Topic: Avoiding Staff Burnout and Improving Organizational Productivity
- 1998 Northwest Indiana Health Alliance, Merrillville, Indiana 1998
Topic: Anxiety, Depression, and the Impact These Conditions have on the Workplace
- 1997 Behavioral Healthcare Summit, Chicago 1997
Topic: The Primary Care Physician as Customer: Developing Services to Manage Demand in a Limited Resource Environment

Joseph E. Siegler, MD

- 1997 Behavioral Healthcare Tomorrow Conference Washington, DC. 1997
Facilitator in Dinner Discussion Groups: HMO Mental Health Program Directors
- 1997 Humana's Ninth Annual Conference on Worksite Wellness, Chicago 1997
Topic: Depression at the Workplace: Reducing Costs with Values-Based Management and Provision of Coordinated Care
- 1996 Northwest Indiana Health Alliance, Merrillville, Indiana 1996
Topic: Leadership for Change in Behavioral Health
- 1996 Association for Ambulatory Behavioral Health, Minneapolis 1996
Topic: Values-Based Management
- 1996 MHMRA of Harris County, Houston 1996
Topic: Change in Behavioral HealthCare: Linking Innovation with Cost Control
- 1996 Association for Worksite Health Promotion, Wellness Seminar, Chicago 1996
Topic: Win-Win Relationships Between HMOs and EAPs
- 1995 Institute for Behavioral HealthCare - Behavioral Health Tomorrow Conference, Dallas 1995
Topic: Leadership for Change in Behavioral Healthcare as a Foundation for Ambulatory Service Delivery
- 1995 Radio Show WGCI, Chicago January 1995
Dr. Sema Ralston's Program - "Be Healthy"
Topic: When Someone You Know is Mentally Ill
- 1994 Institute for Behavioral HealthCare - Behavioral Health Tomorrow Conference, Washington, DC 1994
Topic: How to Structure Access, Benefits, and Operations to Achieve Quality and Customer Satisfaction in HMO Behavioral Health Programs
- 1994 Group Health Association of America's (GHAA) Behavioral Health Conference, Miami Beach, Florida 1994
Topic: Multi-disciplinary Treatment Teams
- 1994 Radio Show WGCI, Chicago December 1994
Dr. Sema Ralston's Program - "Be Healthy"
Topic: Holiday Depression

Joseph E. Siegler, MD

1993

HIP Plan Keynote, New York City 1993

Topic: Reorganization of a Department of Behavioral Health:
Clinicians Must Assume Leadership in Managed Care

Print Publications:

- 2010 Self Magazine, Should you give your therapist the slip? By Marisa Cohen, May 1, 2010, Dr. Siegler gives advice on how to break up with your therapist in a healthy efficient way. www.cheekychicago.com, "Fire Your Therapist"...No Really
- 2009 Fire Your Therapist by Jessica Zweig, May 13, 2009
Topic: Therapy vs. Coaching
- 2009 Today's Chicago Woman Expert Q&A, February 2009 Dr. Siegler addresses reader's questions regarding Valentine's Day stresses because of weight gain during the winter months.
- 2009 AM-New York, Coping with Post-Layoff Emotions by Lucy Blatter, August 9, 2009, Dr. Siegler gives his take on how to emotionally deal with being laid off.
- 2007 Chicago Sun Times, Secret Society by Maureen Jenkins, February 23, 2007. Dr. Siegler weighs in on the influential book The Secret and the benefits it offers.
- 2007 Crain's Chicago Business, May 28, 2007, Dr. Siegler discusses his views on "cloaked discrimination" and the importance of equality in our society, specifically in the corporate world.
- 2007 Time Out Chicago, by Liz Plosser, September 28, 2007, Make a commitment: How to get the job done. Dr. Siegler creates a career quiz to help encourage healthy decision-making regarding employment.
- 2006 Chicago Reader, Chicago Antisocial, by Liz Armstrong, February 2, 2006, Dr. Siegler discusses "repackaging your anxiety" and "wanting more out of life".
- 2006 Chicago Sun-Times, Realistic Resolve, by Tammy Chase and Maureen Jenkins, January 2, 2006, Dr. Siegler suggests first discovering your own inner "driver," or what core values steer your life. He also discusses altruism, higher power and how to be your best self.
- 2005 Chicago Sun-Times, Redefining Single, by Maureen Jenkins, December 4, 2005. Dr. Siegler says "Never before have women had all these choices. With more women feeling free to shape their own realities – choosing to stay unmarried, entering long-term relationships, deciding not to have kids "

Joseph E. Siegler, MD

- 2005 Chicago Sun-Times, Realistic Resolve, by Tammy Chase and Maureen Jenkins, Wednesday with Mommy: How women are taking themselves out of the workforce.
- 2005 Crain's Chicago Business, Op Ed Opinion: Life Coaching is Therapy Renamed, June 20, 2005, Dr. Siegler states "coaching brings a new redefining stage to the field of therapy".
- 2003 Angies List, Debra Hale-Shelton. Cover article on Full Life Coaching Centers
- 2002 Chicago Sun-Times, Coach Wants Field to be More Visible
Article about the opening of Full Life Coaching Centers

Kathy Bettinardi-Angres

APN-BC, MS, RN, CADC



Positive Sobriety Institute (PSI)

680 N. Lake Shore Drive

Suite 800

Chicago, Illinois 60611



Experience

Positive Sobriety Institute (part of RiverMend Health), Chicago, Illinois

- Psychiatric Mental Health Nurse Practitioner – Responsibilities include Multidisciplinary Assessments for Healthcare Professionals (Physicians, Nurses, Dentists, etc.) and Fitness for Duty Assessments
2014 –Present

Director of Family Services at Positive Sobriety Institute – Responsibilities include communication, education and family therapy of patients at PSI
2014 -Present

Presence Behavioral Health Program for Professionals (formerly Rush Behavioral Health), Chicago, Illinois

- Psychiatric Mental Health Nurse Practitioner – Responsibilities include Multidisciplinary Assessments for Healthcare Professionals (Physicians, Nurses, Dentists, etc.) and Fitness for Duty Assessments
2012 -2014
- Director of Family Services – Responsibilities include communication, education and assessment of family members of professionals treated at Presence Behavioral Health Program for Professionals
1997 - 2014

Rush University, Chicago, Illinois

2009 - Present

- Adjunct Faculty for Department of Nursing – Lecturing and mentoring nursing students



Education

- * Rush University, Chicago, Illinois 2004
Psychiatric Mental Health Nurse Practitioner
- * Rush University, Chicago, Illinois 1987
Masters in Psychiatric Nursing
- * Loyola University of Chicago, Chicago, Illinois 1978
Bachelor of Science in Nursing

Certifications

- CADC (Certified Alcohol and Drug Counselor) Certification #17394
- ANCC (American Nurses Credentialing Center)
Accreditation Board for Specialty Nursing Certification #2005003007
- APN-BC – Licensed Advanced Practice Nurse Certified Nurse Practitioner
License # 209.005790/ 041.184232
- RN – Registered Professional Nurse License #041.184232

Publications:

- 1990 – “The effect of physician impairment on the family” by Karl V. Gallegos MD, Kathy Bettinardi-Angres MS, RN & Douglas Talbott MD (*Maryland Medical Journal* November 1990)
- 1999 – *Healing The Healer* by Daniel H. Angres MD, Douglas Talbott MD & Kathy Bettinardi-Angres MS, RN
- 2010 – “Nurses with chemical dependency: successful treatment and reentry” by Daniel H. Angres MD, Kathy Bettinardi-Angres APN, & Wally Cross RPh, MHS (*Journal of Nursing Regulation* April 2010)
- 2010 – “Understanding the disease of addiction” by Kathy Bettinardi-Angres APN & Daniel H. Angres MD (*Journal of Nursing Regulation* July 2010)
- 2011 – “Addressing chemically dependent colleagues” by Kathy Bettinardi-Angres APN & Stephanie Bologeorges MPH (*Journal of Nursing Regulation* July 2011)
- 2012 – “Non-medical use of prescription drugs: implications for NP’s” by Kathy Bettinardi-Angres APN, Ethan Bickelhaupt MD & Stephanie Bologeorges MPH (*The Nurse Practitioner Journal* July 2012)
- 2012 – “Substance use disorders and accessing alternative-to-discipline programs” by Kathy Bettinardi-Angres APN, Janet Pickett RN, & Dianne Patrick MS, RN (*Journal of Nursing Regulation* July 2012)

Daniel A. Kobosky LCSW, NCAC1

Self-motivated individual possessing strong clinical and organizational skills with experience in program development, substance abuse and mental health counseling. Demonstrated strengths in:

- Motivational Interviewing techniques
- Program Development and Staff Training
- Co-Occurring disorders
- Dialectical Behavioral Therapy

PROFESSIONAL EXPERIENCE

- 10/14- Present **The Positive Sobriety Institute**, Executive Director Chicago, IL
- DBT individual and group facilitator primarily focusing on patients with AXIS II disorders in treatment.
 - Management and supervision for all clinical and office
 - Fiscal oversight and development for the program
 - Program Development
- 10/13- 10/14 **Presence Health**, *Counselor* Chicago, IL
- Individual and group counselor for the Professionals program of impaired physicians, nurses and professional level staff in safety sensitive positions.
 - Provided clinical concurrent reviews with insurance companies, licensure boards, Physicians Health Assistance Programs and Employee Assistance Programs.
 - Facilitator for the evening aftercare program for individuals in the 2 year monitoring program.
- 11/09-10/13 **Group Health**, *Master Level Therapist/ Lead Therapist* Bellevue, WA
- Individual therapist for outpatient facility providing individual therapy, evaluations, group facilitation, and dialectical therapy group facilitator and individual therapist for co-occurring disorders.
 - As lead therapist – program development focused on integration of behavioral health with primary care, rapid improvement processes of agency practices with leadership team. Chart reviews for compliance standards; weekly management rounding's to orientate multiple clinics with LEAN processes, HEDIS measurements and meeting clinic scope of service goals.
- 8/08- 10/09 **Fairfax Hospital**, *Clinical Therapist* Kirkland, WA
- Responsible for facilitating inpatient groups and individual therapy on the co-occurring unit.
 - Facilitator for family sessions and family education groups.
 - Completion of psycho social and chemical dependency assessments.
- 2/08 – 8/08 **Building Changes**, *Technical Advisor* Seattle, WA
- Responsible for training services providers and community organizations around providing services to homeless and ex-offender populations
 - Focus on agency operating issues, service planning, integration mixed populations and development of effective strategies to successfully house and increase self-sufficiency of homeless, dual diagnosed individuals.
- 1/07- 10/07 **Rush University Medical Center**, Contracted *Counselor* Chicago, IL
- Individual and group counselor for the Professionals program of impaired physicians, nurses and professional level staff in safety sensitive positions.
 - Provided clinical concurrent reviews with insurance companies, licensure boards, Physicians Health Assistance Programs and Employee Assistance Programs.
 - Facilitator for the evening aftercare program for individuals in the 2 year monitoring program.

- 9/06-1/07 **City of Chicago, Social Worker III** Chicago, IL
- In home support services and resource referrals for women with at Risk Pregnancies
 - Pre and Post-Partum Depression Screening
- 11/97-8/06 **Heartland Alliance, Clinical Administrator** Chicago, IL
- Supervision and professional training of all residential staff on Ex-Offender issues, Motivational Interviewing Techniques and Harm Reduction Care Models to enable clients to maintain housing and services.
 - Designed and developed the only HIV+ specific residential recovery program in Chicago.
 - Responsible for the supervision of eight clinical staff and master level student interns in diagnosis, treatment planning and therapeutic interventions.
 - Extensive experience with statistical reporting to the Chicago Department of Public Health, the AIDS Foundation and HOPWA
- 5/96-11/97 **Lawrence Hall Youth Services, Psychotherapist** Chicago, IL
- Individual and group counseling for wards of the state suffering from physical/sexual abuse.
 - Responsible for quarterly reporting to DCFS and court permanency placement hearings.

CLINICAL TRAINING

- 9/95-5/96 **Hines VA Hospital, Internship** Maywood, IL
- Provided individual psychotherapy to inpatient psychiatric population.
 - Grief and Loss group facilitator for individuals with physical disabilities
- 9/94-5/95 **Howard Brown Health Center, Internship** Chicago, IL
- Case manager for HIV+ individuals needing referrals for mental health and physical health care.
 - Individual therapist and group facilitator for family support groups.
- 7/88-8/94 **PATH, Volunteer** Bloomington, IL
- Crisis intervention hotline volunteer. Assisted in support and training new volunteers in risk assessment, emergency crisis intervention and community referrals.
- 2013 **Behavioral Tech LLC / University of Washington**
- Behavioral Tech, LLC, founded by Dr. Marsha Linehan, trains mental health care providers and treatment teams who work with complex and severely disordered populations to practice mindfulness techniques, conduct a behavioral chain analysis, improve interpersonal effectiveness, understand emotion regulation and increase distress tolerance to replace negative behaviors such as self-harm and substance abuse in tandem to increasing in coping skills.

MICHELLE Y. HOLLIDAY, PH.D.



EDUCATION & TRAINING

Illinois State Psychologist Licensure, 2006
Postdoctoral Fellowship
University of Illinois in Chicago, 1999 - NIDA Youth Violence & Drug Prevention
Postdoctoral Fellowship
University of Illinois in Chicago, 1996 - NIMH Youth Mental Health Research
Ph.D. University of Maryland in College Park, 1995 - Clinical/Community Psychology
APA-Accredited Internship in Clinical Psychology, 1992 - UMDNJ Hospital
NIMH Psychogeriatric Predoctoral Fellowship, 1989 - Johns Hopkins University Hospital
B.A. Northwestern University in Evanston, IL, Psychology

CLINICIAN

- 2014 – Present POSITIVE SOBRIETY INSTITUTE MULTIDISCIPLINARY-COMPREHENSIVE ASSESSMENT PROGRAM (M-CAP) - CHICAGO, ILLINOIS
- *conduct comprehensive psychological evaluations to determine fitness for duty of impaired professionals with substance, alcohol, process use disorders, personality disorders, cognitive impairment, and workplace boundary behavioral complaints
 - *administer, score, interpret a comprehensive psychological test battery, including neuropsychological screening, personality, cognitive, substance abuse, mood disorders, and sexual addiction assessments
 - *collaborate with M-CAP team members to develop a comprehensive advocacy-based, recovery plan designed to restore and optimize professional efficacy
- 2008 – 2014 RESURRECTION HEALTH MULTIDISCIPLINARY ASSESSMENT PROGRAM (MAP)
OAK PARK / DOWNERS GROVE / CHICAGO, ILLINOIS
- *conducted psychological assessment of impaired physicians/professionals
 - *collaborated with MAP team members to achieve a holistic assessment
 - *contributed to diagnostic clarity of comprehensive evaluation report
- 2007 – 2008 RESURRECTION HEALTH IMPAIRED PHYSICIANS PROGRAM
CHICAGO, ILLINOIS
- *provided aftercare individual therapy to impaired physicians/professionals
 - *interpreted psychological test results, provided feedback & delivered milieu therapy
 - *conducted treatment efficacy data analysis, designed survey, managed data set
-

CLINICIAN

2008 – Present SAINT JOSEPH HOSPITAL–CHICAGO INSTITUTE OF ADVANCED BARIATRICS
(CIAB) CLINICAL PSYCHOLOGIST-CHICAGO, ILLINOIS

- *conduct psychological assessments of bariatric surgery candidates
- *collaborate with surgeon, psychiatrist, PCP, nurse, and dietician
- *provide CBT evidence-based, individual psychotherapy to establish healthy dietary patterns & catalyze lifestyle behavior modifications

2008 – Present PRIVATE PRACTICE – CHICAGO & OAK PARK, ILLINOIS

- *impaired professionals - foster sustained sobriety and abstinence through adaptation of relapse prevention skills, craving resistance strategies, entrenched involvement in 12 Step recovery support groups.
- *bariatric surgery candidates – conduct pre-operative assessments & provide stability-optimizing, cognitive-behavioral, medical & psychosocial-embeddedness strategies for healthy weight management peri-op
- *pregnant/postpartum mood dysfunction – assess, treat, manage the spectrum of hormonal, biochemical, neurochemical mood states
- *adult individual therapy – cultivate cognitive, interpersonal, and psychospiritual skills; develop adaptive thought management, character growth, & conflict resolution skills

2003 – 2009 EDGEWATER SYSTEMS FOR BALANCED LIVING - GARY, INDIANA

- *conducted child welfare parenting ability assessments
- *administered court/school-mandated, culturally-relevant, psychological and psychoeducational test evaluations to children, adolescents, & adults that address intellectual, academic, adaptive, personality, & emotional functioning
- *conducted neuropsychological screenings and cognitive functioning evals for adults to address Medicaid & Social Security eligibility

2001 – 2006 FILLMORE COMMUNITY SERVICES - OAK PARK & BERWYN, ILLINOIS

- *conducted psychological testing to neuropsychologically screen and assess cognitive, academic, adaptive, & personality functioning for children, adolescents, & adults
 - *provided child, adolescent, family, & adult psychodynamic/family systems therapy
 - *delivered brief cognitive-behavioral therapy to youth & adolescents to manage ADHD & co-morbid disorders
-

RESEARCHER

NIDA YOUTH VIOLENCE, DRUG, & SEX PREVENTION POSTDOCTORAL RESEARCH

1999 - 2002 UNIVERSITY OF ILLINOIS, HEALTH RESEARCH & POLICY CENTERS

Prevention Research – Researcher

- *provided theoretical and conceptual direction for longitudinal analysis
- *collaboratively wrote manuscripts for peer-reviewed journals
- *as principal investigator, initiated & developed NIH grant proposal
- *disseminated research outcomes via conference presentations

NIMH YOUTH MENTAL HEALTH POSTDOCTORAL RESEARCH

1997 - 1998 URBAN CHILDREN'S MENTAL HEALTH PREVENTION RESEARCH
TRAINING PROGRAM POSTDOCTORAL FELLOWSHIP
UNIVERSITY OF ILLINOIS AT CHICAGO, DEPARTMENT OF PSYCHOLOGY

Basic Research – Program Coordinator

- *collaboratively designed measurement instruments, research survey, and interview protocols
- *established research partnerships with and functioned as research liaison to public and parochial schools
- *co-conducted youth focus groups
- *supervised graduate student research assistants
- *trained & supervised undergraduate research assistants

NIMH YOUTH MENTAL HEALTH POSTDOCTORAL RESEARCH

1996 - 1997 Cognitive Ability Test Research – Principal Investigator
*conducted a replication study investigating cultural knowledge & SAT test performance at a predominantly AngloEuropean American urban university

COGNITIVE ABILITY TEST RESEARCH

1996 HOWARD UNIVERSITY, DEPARTMENT OF PSYCHOLOGY
CO-INVESTIGATORS JULES P. HARRELL, PH.D. & A. WADE BOYKIN, PH.D.

Cognitive Ability Test Research – Principal Investigator

- *designed & implemented a replication study investigating the relationships among cultural knowledge, racial climate, & SAT test performance variables for African American undergraduate students at an historically Black university
-

SELECTED PROFESSIONAL PAPERS

Flay, B.R., Graumlich, Segawa, E., Burns, J., Holliday, M.Y., Campbell, R. T., S. Amuwo, S., Bell, C., Cooksey, J., Cowell, J., Dancy, B., Jagers, R., Levy, S., Paikoff, R., Pamwani, I., Weissberg, R. (2004). The Aban Aya Youth Project: Effects of a comprehensive prevention program to reduce violence, substance use, & sexual behavior among inner-city African American youth. Archives of Pediatrics and Adolescent Medicine, 158, 377-384.

Holliday, M.Y. (2002, August). Does Exposure to White Americans Moderate the Mediated Effect of Cultural Knowledge on SAT Performance Among African American College Students? Paper presented at the 110th Annual Convention of the American Psychological Convention, Chicago, IL.

Holliday, M.Y. (2001, January). A Contextually Mediated Model of SAT Performance Among African American Students at a Predominantly AngloEuropean American College. Paper presented at the annual meeting of Arizona State University's Conference on the Relevance of Assessment & Culture in Evaluation. Tempe, AZ.

Holliday, M.Y., Shao, L., Flay, B.R., Campbell, R.D., Segawa, E., Burns, J., Zou, I. (2000, September). Intersect of the Aban Aya Preventive Intervention & Cultural Socialization for African American Male Adolescent Substance Use. Poster presented at the Third International Addictions Conference. Hyannis, Cape Cod, MA.

Holliday, M.Y. (2000, August). Race, Culture, and Allegedly Standardized Cognitive Ability Tests. Symposium paper presented at the 108th Annual Convention of the American Psychological Convention. Washington, D.C.

AWARDS

- 2001 Penn State Methodology Center Scholarship for Summer Institute on Longitudinal Methods with Mplus
- 1999 - 2002 National Institutes of Drug Abuse (NIDA) Research Associate
- 1996 - 1999 National Institutes of Mental Health (NIMH) Postdoctoral Fellowship in Urban Children's Mental Health Prevention Research Training Program
-

REFERENCES AVAILABLE UPON REQUEST

CURRICULUM VITAE

Professional Experience

- 2001-Present** Medical Staff Member: St. James Hospital, Olympia Fields - Chicago Heights, IL
Practice includes neuropsychological evaluation of geriatric and adult patients.
- 1997-Present** Neuropsychologist: Resurrection Behavioral Health, Chicago, IL (formerly RUSH Behavioral Health)
Responsibilities include neuropsychological evaluations of physicians for fitness for duty determinations.
- 1996-Present** Adjunct Professor: Roosevelt University, Chicago, IL
Responsibilities include teaching graduate and undergraduate courses in neuropsychology, psychotherapy, forensic psychology and general psychology.
- 1995-2005** Medical Staff Member: Lutheran General Hospital, Park Ridge, IL
Privileges included neuropsychological and psychological evaluations of geriatrics, adolescents, substance abuse and traumatically brain injured population. Individual and group psychotherapy with geriatrics, adults, adolescents substance abuse, and traumatically brain injured population.
- 2001-04** Consulting Psychologist: St. James Center for Psychological Wellness, Matteson, IL
Responsibilities included neuropsychological and psychological evaluations of geriatrics, adults, adolescents and children. Individual therapy and crisis intervention. Forensic and inpatient psychiatric consultation.
- 1997-2000** Staff Psychologist: Adult Division, Forensic, Clinical Services, Circuit of Cook County, Chicago, IL
Responsibilities included forensic evaluations to determine fitness to stand trial, sanity and comprehension of Miranda warnings, Neuropsychological evaluations, and child custody evaluations.
- 1995-1999** Consulting Psychologist: Georgemiller, Whyte and Associates, Park Ridge, IL
Responsibilities included neuropsychological and psychological evaluations of geriatrics, adults, adolescents and children. Individual and family therapy. Forensic consultation and mental health utilization review.
- 1997** Presiding Neuropsychologist: Premiere Brain Injury Rehabilitation Center of Downers Grove, Park Ridge, IL
Responsibilities included neuropsychological evaluations and psychotherapy with traumatically brain injured geriatrics, adults and adolescents. Consultant and advisor to clinical staff.
- 1995-1997** Staff Neuropsychologist: Meadowbrook of Chicago, Brain Injury Rehabilitation Center, Park Ridge, IL
Responsibilities included neuropsychological evaluations, individual and group psychotherapy with traumatically brain injured geriatrics, adults and adolescents. Consultant and advisor to clinical staff.
- 1994-5**
1992-3 Staff Psychologist: Comprehensive Psychological Services, Mesa, AZ
Responsibilities included counseling adults, adolescents, children, couples and families; psychological and neuropsychological evaluations.
- 1990-92** Intern: Chicago Counseling and Psychotherapy Research Center, Chicago, IL
Responsibilities included individual psychotherapy, play therapy, crisis intervention, psychological and neuropsychological evaluations. Facility was a continuation of the original C.C.P.R. Center founded by Carl Rogers Ph.D., at U. of Chicago, in 1945.
- 1990-92** Intern: Dreikurs Psychological Services Center, Chicago, IL
Responsibilities included psychological evaluations, counseling adults, adolescents and children.
- 1990-91** Intern: Chicago Osteopathic Hospital, Inpatient Addiction Treatment Unit, Chicago, IL
Responsibilities included psychological and neuropsychological evaluation of inpatient population, individual and group psychotherapy.

Education

- Licensed Clinical Psychologist, Arizona, 1993**
Licensed Clinical Psychologist, Illinois 1995
Psy.D. Doctor of Clinical Psychology, Adler School of Professional Psychology, Chicago 1993
M.A. Master of Counseling Psychology, Adler School of Professional Psychology, Chicago 1991
B.A. Bachelor of Arts, DePaul University, Chicago 1988

Gene Mele, Psy.D.



Addendum to Curriculum Vitae

Professional Experience

- 2016 St. Anthony Hospital Physical Rehabilitation RIC Unit, Michigan City, Indiana: Member Medical Staff
- 2015 Positive Sobriety Institute , Chicago, IL: Neuropsychological Evaluations
- 2015 Licensed Clinical Psychologist-Indiana



POSITIVE SOBRIETY
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Daniel Angres MD, the founder and director of PSI, has been a leader in the field of addiction treatment for healthcare professionals for over three decades. He has published and presented research and findings of his successful work to esteemed universities around the country, and continue to lead in the area of research and treatment in this specialized area.

In October 2014, Dr. Angres and a group of handpicked experienced clinical staff left Presence Behavioral Health and started Positive Sobriety Institute (PSI) on the campus of Northwestern University's medical center. PSI is affiliated with the departments of psychiatry, psychology and soon, internal medicine, to continue the work in this field in an academic setting. Philosophically, the program remains committed to the wellbeing and sobriety of individuals with substance use disorders and dual diagnoses, and adheres to the abstinent, 12 Step-based approach with long-term aftercare in a Caduceus group and a PHP. However, there are a few improvements.

PSI is located on a huge medical campus with access to Northwestern Memorial Hospital, The Rehab Institute of Chicago, Prentice Women's Hospital and a number of exceptional medical professionals. The sober living for the patients is literally across the street from the program, and the area is additionally rich with public transportation, 12 Step meetings, exercise facilities, and restaurants within walking distance from the program. It is also a very safe neighborhood in Chicago, and considered one of the most desirable.

PSI is part of RiverMend Health, a group of treatment facilities dedicated to exceptional treatment of addiction and eating disorders, and collaborates with other leaders in addiction medicine such as Mark Gold MD and Paul Earley MD to improve treatment and outcome. This is a true collaboration of the best minds in the field working together to help those individuals suffering with addictions. For example, Dr. Earley, with the input of Dr. Angres, has written a comprehensive, evolutionary workbook for all the RiverMend patients that will guide their treatment in a more concerted and effective way. This workbook is being implemented in the very near future.



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The staff at PSI, under the leadership of Dr. Angres, is exceptional and experienced. Kathy Bettinardi-Angres is a Psychiatric Nurse Practitioner and the Coordinator of the Comprehensive Assessment Program (CAP) for professionals, and the Director of Family Services. Her experience spans three decades, too, and she founded the only family week program in treatment in the state of Illinois. The CAP's are exceptional because of her vast experience and access to consultants with specific expertise in many areas, such as process addictions, disruptive and impairment other than substance use disorders, and medical conditions outside the realm of addictions. Daniel Kobosky is the Program Manager and is certified by Marsha Linehan in Dialectical Behavioral Therapy (DBT), which is incorporated into the program for all patients. Interestingly, Dr. Linehan's inspiration for DBT began in Chicago. The other staff are all Master or Doctorate level practitioners with years of experience and the respect of alumni and peers in the field. PSI is committed to excellence and dedicated to improve treatment and outcome for recovery of addictions.

The Positive Sobriety Institute

The Positive Sobriety Institute is an abstinence based, individualized, comprehensive addictions program located in metro Chicago on Lake Michigan. It utilizes a physician lead multidisciplinary team to facilitate insight into the disease of addiction and a number of evidence based therapies to provide all that may be necessary to maintain abstinence and recovery from the disease of addiction. This includes providing a therapeutic community with 12-step immersion, intensive group and individual therapy, didactic and experiential sessions as well as mindfulness training and appropriate pharmacologic approaches. Patients with co-morbid issue issues that can include psychiatric problems or chronic pain are also included in our patient populations. Although addicted professionals are the target population, those non-professionals that are deemed appropriate to the milieu are also involved in the programs. Addicted professionals are expected to participate in their respective state Professional Health Programs after treatment.

Levels of Care:

Treatment has different levels of intensity and recommendations are based on a variety of factors; i.e. legal issues, financial constraints, type of professional, number of previous treatments, etc.

The following summarizes the typical abstinence based program structure:

Partial Hospital Programs (PHP)

- Averages five and 1/2 days a week, eight hours/day for four to six weeks, often longer for licensed professionals**
- Small group therapy plus didactic and experiential groups**
- Family week involvement**
- 12-step involvement**

-Two years of weekly professionally facilitated monitoring groups and random toxicologies for all local patients.

Independent (supervised) living programs can accompany PHP. This is common for professionals and allows for more structure, intensity and an opportunity for exposure to a therapeutic community as compared with more standard PHP's.

We also provide a multidisciplinary comprehensive assessment program (CAP) that can run anywhere from ½ day to three days based on individual needs.

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A Two Year Longitudinal Outcome Study of Addicted Health Care Professionals: An Investigation of the Role of Personality Variables

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Abstract: The co-morbidity of personality disorders (PDs) and other dysregulatory personality patterns with addiction have been well-established, although few studies have examined this interplay on long-term sobriety outcome. In addition, health care professionals suffering from addiction have both a significant public health impact and a unique set of treatment and recovery challenges. The aim of this study was to investigate if personality variables differentiated sobriety outcome in this population over a two year interval. A clinical sample of health care professionals participated in a substance abuse hospital treatment program individually tailored with respect to personality. Participants took the Temperament and Character Inventory and the Millon Clinical Multiaxial Inventory at intake, and were tracked two years post-discharge to determine sobriety status. Univariate analyses showed antisocial personality, female gender, and alcohol dependence were independent predictors of relapse, however a significant relationship between personality and substance use did not exist in multivariate analysis when controlling for demographic variables. The lack of multivariate relationships demonstrates the heterogeneity in self-report measures of personality, which suggests the interplay of personality and addiction is complex and individualized.

Keywords: addiction, tailored treatment, personality disorders, health professionals, MCMI, TCI

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Addiction and Personality Disorder Co-Morbidity

The prevalence of substance abuse disorders in the United States is a significant public health problem. The lifetime prevalence of drug use disorders has been reported to be 10.3%, with a higher odds ratio for men than women.¹ Estimates for lifetime alcohol dependence are also disparate by gender with the rate for men being approximately 17% and that for women being 8%.² Results from the National Epidemiologic Survey on Alcohol and Related Conditions also found a 5.6 odds ratio for comorbid alcohol and drug use disorders when adjusted for both demographic variables and other psychiatric conditions.¹ Interestingly, this same epidemiologic study found individuals with any drug use disorder were 2.2 times more likely to have a comorbid personality disorder (PD) when adjusted for demographic variables and other psychiatric conditions.¹ Prior research has also found PDs are more than twice as prevalent among individuals with alcohol use disorders than in the general population.³ Further, the rates of specific comorbid PDs with addiction has also been varied, although multiple studies have identified the Cluster B PDs, specifically Antisocial and Borderline Personality Disorders, as most prevalent across various types of substance abusers.⁴⁻⁶ As such, treatment for such individuals is not without considerable difficulty; the presence of a comorbid PD has been associated with failure to complete treatment as well as poorer treatment outcomes and a higher propensity for relapse.⁶⁻⁹ The study of PDs and other dysregulatory personality patterns with addiction has thus become the subject of recent research interest and the high prevalence rates suggest an increased need for understanding possible predictors of substance abuse as well as researched treatment outcomes that include longevity specific to the treatment population. Characteristics unique to PDs highlight the need to guide and tailor addictions treatment in order to best meet individual needs.

Common personality profiles in addictions

The Temperament and Character Inventory (TCI),¹⁰ has been used to describe typologies in terms of both biologically driven aspects of personality (Temperament) as well as behavioral and experience-driven components (Character). The developer of the TCI, Robert Cloninger, posits that biologically

influenced temperament traits have a central role in addictions, which is consistent with the disease model of addiction.¹¹ His tridimensional theory of alcohol abuse postulates alcohol abuse is related to high novelty seeking (NS), low harm avoidance (HA), and low reward dependence (RD), which has received support in the literature.^{12,13} NS is described as a tendency to seek out new and exciting experiences, which has been linked to the construct of sensation-seeking.¹⁴ Such a temperament has been linked as a factor that both increases risk for substance abuse and other risk-taking behaviors, and such sensation seeking has been consistently associated with substance abuse in a number of populations.¹⁵ The literature also supports NS most consistently as a predictor of alcohol misuse across both setting and population.¹⁶⁻¹⁹ HA is a construct associated with anxiety, with low levels being indicative of fearlessness and higher levels being indicative of anxiety and distress.¹¹ RD reflects the degree to which an individual is dependent on others (high RD), or can function autonomously (low RD). Cloninger further asserts that individuals with the high NS, low HA, and low RD typology consume alcohol for the enjoyment of disinhibition, which additionally increases the likelihood of engaging in antisocial behaviors.²⁰

Applications of Cloninger's theory have more recently been extended to drugs other than alcohol. In a nonclinical sample of university students, alcohol and drug users scored significantly higher on NS relative to non-substance users.²¹ Additionally, this study used TCI scores to generate a measure of antisocial personality using high NS, low HA, and low RD, and found antisocial personality to be positively related to the social deviance (legal vs. illegal status) of substances used as well as the quantity consumed.²¹ Similar to these findings that NS increases with the degree of social deviance of the substance, research using a community sample found NS to be higher among heroin users than alcohol users.²² While there have been disparate findings regarding personality typologies of substance abusers, there is converging evidence to support that high NS is related to substance abuse regardless of drug of choice.

One possible confounding variable identified for differences in TCI personality profiles is education level. In a more recent investigation,²³ a stratified random sample of 917 adults was obtained to ascertain



normative data on the temperament and character scales by demographic strata, one of which being education level. The levels of education in this study were broken down as follows: no high school diploma, high school diploma only, some post-high school education but no degree obtained, college degree, and graduate degree or higher. Given the availability of these norms, a further examination of the interplay between personality and addiction can be conducted comparing a clinical sample of individuals with the non-addicted community sample holding education level constant. By holding education level constant in such a comparison, the potential unique contribution of addiction on personality can be better identified, and treatment recommendations can be appropriately tailored to the population.

Addiction and the health care professional

One well-identified population of individuals with a relatively homogenous high education level is that of health care professionals. Further, while the population of addicted health care professionals has received attention in the clinical literature,²⁴ there is a paucity of empirical research that examines the interplay of personality variables with the clinical treatment for addiction in this population and the subsequent impact on post-discharge outcome. With the role of health care professionals in maintaining public health, it is critically important to understand potential underlying factors of addiction, such as personality, that may predict both substance abuse and treatment outcome.

It is estimated that at some point during their career, 10%–15% of all health care professionals will misuse drugs or alcohol.²⁵ This estimate implicates a serious public health impact due to the responsibility of health care professionals to care for the health and well-being of the general population. Research has also indicated the rate of addiction for physicians is near to or higher than the rate of addiction in the general population.²⁶ In order to estimate the prevalence of substance abuse among physicians, 5,426 randomly selected physicians were surveyed from the American Medical Association. Nearly 8% of physicians who participated in the study reported substance abuse or dependence at some point in their lives, and the majority also reported receiving treatment.²⁷ In another survey study, dentists, physicians and the general population were compared for prevalence

data and substance abuse rates.²⁸ Lifetime use of drugs reported by dentists and physicians exceeded the general population for people aged 50–54 years.²⁸ Given the prevalence of addiction in this population and its importance to maintaining public health and safety, attention to treatment and outcome is critical.

As such, health care professionals with addiction face unique challenges in treatment. Treating health care professionals with substance abuse disorders is not only challenging, but requires a multidisciplinary team with experience working with addiction in this population, as the degree of resistance to treatment may be great. Further, the intellect and education level inherent to this population has been associated with exceptional rationalization and denial, which can further perpetuate treatment difficulties.^{25,26} Many may also face losing a medical license, and thus admission to treatment may not be completely voluntary. A five year review of medical records in the United States was conducted to evaluate the overall effectiveness of physician's health programs in treating physicians with substance abuse disorders.²⁹ Of the 515 physicians who completed their contracted period of health programs, there were 159 documented incidents of substance abuse, 10 of which were while actively practicing medicine. A five year follow-up concluded that 95% of physicians who completed their respective program and 82% of whom had extended contracts in the program still had their licenses, whereas only 21% of physicians who did not complete the program retained their licenses.²⁹ Other studies have also suggested health care professionals may have better abstinence outcomes than the general addicted population if properly treated and monitored.²⁴ In a longitudinal, 7-year investigation of 278 professionals who completed an addiction program with particular attention on challenges inherent to their profession, only 15% relapsed; of 101 physicians, 17.8% relapsed.²⁴ These findings point to the capability of returning addicted medical professionals to work, yet also highlight the need for actively addressing unique challenges inherent to their field. It is therefore necessary to gain an understanding of treatment modalities for addicted health care professionals in order to maintain both their well-being and that of the general population.

In addition to understanding the unique considerations inherent to treatment of the health care professional, investigating risk factors in relation to relapse



rates is essential. Unfortunately, research in this area is lacking. In one study, Domino and colleagues³⁰ investigated opioid use versus alcohol and non-opioids as a risk factor for relapse in health care professionals. Of the 292 participants, one fourth of the total sample relapsed at least once, and 58% of relapses happened within the first two years of monitoring. Family history of substance abuse and dual diagnosis also nearly doubled the risk of relapse. Specific Axis I and Axis II diagnoses were not listed for dual diagnoses in this study, although it was noted that 93% of dual diagnoses were on Axis I.³⁰ This study further illuminates the need for treatment outcome and longevity research for health care professionals, particularly in regards to specific dual diagnoses of personality dysregulation on Axis II.

Aims of the present study

Although there is a substantial amount of research on addiction with both personality patterns and disorders as well as among the population of health care professionals, there is a paucity of research that examines the interplay of personality and addiction in this population. The present study aims to narrow the deficit in the extant literature by integrating personality and addiction factors with two-year treatment outcomes for health care professionals, for which longitudinal data is lacking. Personality variables that may be predictors of sobriety outcome at the two-year follow-up interval will also be examined for prevalence and also to investigate potential differences in treatment needs from that of the general population.

Methods

Institutional Review Board approval of this study # 2010–11 was obtained from St. Joseph Hospital prior to its initiation. All investigators completed human subjects training through the National Institutes of Health and certificates were on file.

Participants

A clinical sample of participants (N = 116) were patients at an intensive substance abuse hospital day-treatment program with associated supervised independent living. All participants were health care professionals referred to treatment by their respective Professional Board of Regulation, wherein successful completion and adherence to treatment program

recommendations was a requirement to keep their professional license. 68.1% of participants were male (n = 79) and 31.9% were female (n = 37). Inclusion criteria for admission required medical stabilization, an active diagnosis as alcohol or other substance dependent, and occupation as a health care professional. The breakdown of profession in the sample is as follows: doctors (n = 56), nurses (n = 28), pharmacists (n = 21), dentists (n = 8), medical student (n = 1), optometrist (n = 1), and physician's assistant (n = 1). The mean age of the sample was 43.5 years, SD = 9.42, and had a range from 22–77. There was no significant difference in age across gender (males (M = 45.1), female (M = 40.1), $P > 0.05$).

Procedure

To be included in the study, program patients had to meet DSM-IV criteria for a clinical diagnosis of chemical dependency as well as provide informed consent to review de-identified clinical charts and testing materials. All 116 participants who were eligible for inclusion completed the professionals' treatment program. The program is an abstinence-based, 12-step oriented boarded partial setting with a therapeutic community comprised of licensed healthcare professionals. The program ranged from 6–8 weeks in duration, which was largely determined based on recommendations made by the patient's individual Professional Board of Regulation for the maintenance of their health care licensure. These recommendations were supplemented by those of the clinical treatment team with regard to patient personality and individual need. The program structure complements the therapeutic community living environment, with a community check-in each morning followed by guided meditation and a three-hour group therapy session with a licensed addictions treatment clinician. Afternoons consist of psycho-education on topics related to chemical dependency, recovery, 12-step programs, the neurobiology of addiction, coping skills, emotion regulation strategies, the disease concept of addiction, and the impact of personality variables with respect to ongoing maintenance of sobriety and recovery. A board certified physician in addiction psychiatry provided ongoing medical management of all patients.

Within one week of admission, participants completed both the TCI-R and the MCMI-III self-report instruments, which are both components in routine



clinical assessment and treatment at the program. Upon completion of both testing instruments, each patient received a 60 minute individual feedback session to go over their testing results and to identify personality patterns that may contribute to chemical dependency. Patients then met individually on a weekly basis thereafter to discuss the impact of their individual personality profile on components of their addiction (eg, craving and motivations for use) and recovery strategies. Assessment findings were presented to the rest of the clinical team so as to inform treatment needs and duration. In cases wherein criteria for a PD were met, the clinical team recommended an extended stay, averaging two additional weeks. In conjunction with personality assessment, patients participated in a 90-minute weekly group workshop facilitated by the program medical director. The aims of the workshop were to openly discuss the patients' influence of personality on their addiction so as to gain feedback and insight from the therapeutic community as well as to allow insight of individual personality variables to emphasize or de-emphasize aspects of the program, thereby tailoring the program with respect to personality. All program components were equivalent in intensity and frequency for all patients, the only difference being the tailoring of individual sessions with respect to patients' personality.

Upon primary treatment completion, all patients were required to attend a weekly After-Care program for a period of two years. The After-Care program consists of a 90 minute, professionally facilitated weekly post-discharge and Caduceus group for health professionals to monitor ongoing progress and provide a forum to discuss professional issues related to addictions. The program also mandates adjunctive random urine monitoring through an automated system that requires patients to check in daily. Two-year sobriety status was obtained through self-disclosure at After-Care program follow-up, as well as through reports by post-discharge treatment coordinators. Status was biologically confirmed through urine monitoring. Participants were then classified as either relapsed or sober at the end of the two year interval. All data was kept strictly confidential and de-identified by respective clinicians before being transferred to the researcher for data entry. A unique participant identification number was assigned to each participant

for matching individual self-report measures and follow-up variables for analyses.

Measures

Millon Clinical Multiaxial Inventory (MCMI)³¹

The Millon Clinical Multiaxial Inventory-III (MCMI-III) is a 175 item self-report questionnaire comprised of true-false items designed to measure personality traits. It is widely used in the assessment of chemical dependency, is easy to administer, and can be completed relatively quickly (less than 30 minutes). The measure yields fourteen PD scales (Axis II), ten Axis I clinical syndrome scales (including drug and alcohol dependence), as well as Disclosure, Desirability and Debasement correction scales. Raw scores are adjusted to base rate scores for analyses. A base rate score of 85 or higher is indicated in the manual as conservatively indicative of a clinical PD and is the base rate score used to detect PDs in this study. The reliability of the MCMI-III has been found acceptable in substance abusers.³² Reliability and validity studies indicate it is a well-constructed psychometric instrument. Measures of internal consistency are strong, with alpha coefficients exceeding 0.80 for 20 of the 26 scales, and ranging from 0.66 to 0.90. The MCMI-III manual reports that over a 5- to 14-day interval, test-retest reliability has a median of 0.91, ranging from 0.82 to 0.96. More than 20 factor-analytic studies have been performed on the measure, which have supported the keying of its items and organization of scales. Correlations with other clinical measures have all yielded findings in expected directions and are reported in detail in the MCMI-III manual.³¹

Temperament and Character Inventory-Revised (TCI-R)¹⁰

The Temperament and Character Inventory-Revised (TCI-R) is a 240 item self-report questionnaire consisting of 5-point Likert scale items. The measure yields four temperament dimensions, postulated to be indicative of relatively fixed emotional drives which guide one's automatic responses to experiences. The four dimensions include: Novelty Seeking (NS), Harm Avoidance (HA), Reward Dependence (RD) and Persistence (P). Three dimensions of character are also obtained, which may change over time in response to one's actions and collective experiences. These dimensions include: Self-Directedness (SD),



Cooperativeness (CO) and Self-Transcendence (ST). Reliability for the TCI-R is generally high. Chronbach alphas for the temperament scales of NS, HA, RD and P are 0.78, 0.87, 0.76, and 0.65 respectively. Chronbach alphas for the character scales of SD, CO and ST are 0.86, 0.89, and 0.84 respectively.¹⁰ Convergent validity between the TCI-R and the MCMI has been established, wherein the seven dimensions of the TCI accounted for most of the variance in MCMI measures of both Axis I and Axis II disorders.³³

Post-treatment sobriety outcome

Post-treatment sobriety outcome was measured by tracking the relapse behavior of participants through the two year period following discharge. Participants were followed with random urine-monitoring at an average of twice a month during this interval, and also participated in a weekly After-Care group to discuss their sobriety status. Classification was made into one of two groups: (1) remained sober or completely abstinent with no positive urine toxicologies; or (2) relapsed to substance use based on positive urine toxicologies and corroborating follow-up reports by post-discharge treatment coordinators.

Results

All data entry and statistical analyses were computed using the Statistical Package for the Social Sciences (SPSS) version 18.0 for Windows.

The overall two-year sobriety outcome was determined categorically as either relapsed or sober at the end of the follow-up interval through weekly check-ins with after care coordinators and confirmed through random urine monitoring. At the end of the two-year interval, 85 of the 116 health care professionals (73.3%) had maintained complete abstinence from all addictive substances.

The prevalence of PDs in the sample was calculated using the MCMI-III base rate scale ≥ 85 for each of the PD scales. Of the total sample, 35.3% (41) of participants scored in the clinical range. Of those participants with a detectable PD on the MCMI-III, 24.4% (10 of the 41) met criteria for more than one PD. To determine if the presence of any PD differentially affected sobriety outcome status at the end of the two-year follow-up interval, a 2×2 Pearson's Chi Square analysis was conducted using the presence of

any PD on one dimension (no vs. yes) and outcome status (sober vs. relapsed) on the other. No significant association was found between having any PD and outcome status; $\chi^2 (1) = 0.210, P = 0.666$. The analysis was repeated to determine if meeting criteria for more than one PD differentially affected outcome sobriety status, and again no significant association was found; $\chi^2 (1) = 0.600, P = 0.726$.

Sample means of each of the MCMI-III and the TCI-R scales were calculated and are presented in Tables 1 and 2 with respect to two-year sobriety outcome group. Significant differences between outcome groups are noted at the $P < 0.05$ level. To determine if personality variables were predictive of longitudinal sobriety, the data were analyzed in two steps. First, univariate comparisons were made between sobriety outcome groups and categorical demographic variables using Pearson's Chi Square tests, and between sobriety outcome groups and personality variables using independent sample *t*-tests. Gender was significantly associated with outcome. Of the 79 males, 16 relapsed, whereas of the 37 females, 15 had relapsed. The Pearson Chi Square analysis thus showed that women were more likely than men to have relapsed at the end of a two-year follow-up interval; $\chi^2 (1) = 5.296, P < 0.05$. Alcohol dependence as assessed by the MCMI-III was significantly associated with outcome. The Levene's test for equality of variance first showed that equal variances were not assumed; $F (114) = 5.447, P = 0.021$. The independent sample *t*-test revealed a significant mean difference between groups of 10.84, where the mean for the sober group was 58.29, $SD = 29.80$, and

Table 1. TCI-R scale means for sober and relapsed outcome groups within the sample.

TCI-R scales	Sober (N = 85)		Relapsed (N = 31)	
	M	SD	M	SD
Novelty seeking	102.39	16.05	102.90	10.63
Harm avoidance	99.25	17.47	101.52	19.87
Reward dependence	102.88	16.05	104.90	12.64
Persistence	122.00	20.11	123.26	16.60
Self directedness	146.18	20.30	145.06	17.91
Cooperativeness	146.74	18.14	145.87	12.73
Self-transcendence	75.23	16.51	74.97	16.43

Notes: Table 1 depicts the sample means for each of the TCI-R scales separated by sobriety outcome status (sober vs. relapsed) at the end of a two-year follow-up interval. No between group differences were found with regard to TCI-R scales and personality.

**Table 2.** MCMI-III scale means for sober and relapsed outcome groups within the sample.

MCMI-III scales	Sober (N = 84)		Relapsed (N = 31)	
	M	SD	M	SD
Paranoid	28.24	25.83	23.61	25.23
Schizoid	52.82	27.32	51.29	28.74
Schizotypal	27.12	27.23	25.48	25.67
Antisocial**	48.61	25.56	58.48	20.38
Borderline	35.10	25.82	36.84	21.63
Histrionic	46.86	22.26	46.90	21.91
Narcissistic	54.69	16.29	52.94	18.33
Avoidant	44.65	30.70	45.55	29.98
Dependent	48.61	27.80	49.52	29.70
Compulsive	55.57	16.62	55.52	14.86
Depressive	50.57	31.37	50.55	31.92
Negativistic	31.02	24.62	28.61	23.05
Aggressive	41.12	21.61	43.39	18.76
Masochistic	44.54	31.76	48.19	32.94
Anxiety disorder	49.82	32.91	44.58	35.33
Somatoform disorder	37.62	30.70	38.65	28.00
Bipolar mania	27.29	23.15	28.97	23.16
Dysthymic	49.02	32.23	46.32	32.22
Alcohol dependence**	58.29	29.80	69.13	24.24
Drug dependence	57.43	22.85	61.68	25.02
Post traumatic stress disorder	33.96	27.74	33.94	28.31
Thought disorder	36.45	27.31	25.90	25.76
Major depressive disorder	38.93	32.37	38.83	29.77
Delusional disorder	14.53	20.29	10.07	17.35

Notes: Table 2 depicts the sample means and standard deviations for each of the MCMI-III clinical syndrome scales separated into two-year follow-up outcome status group: Sober = 84, Relapsed = 31. **Scales with significant between group differences are flagged as being significant at the $P < 0.05$ level.

the mean for the relapsed group was 69.13, $SD = 24.24$; $t(65.44) = -1.996$, $P = 0.050$. Thus, greater scores on the MCMI-III scale for alcohol dependence were negatively associated with having maintained sobriety at follow-up and were independently predictive of relapse group membership. Antisocial PD assessed on the MCMI-III was also significantly associated with outcome group membership. As with Alcohol dependence, equal variances were not assumed with the Levene's test; $F(114) = 7.089$, $P = 0.009$. The independent sample t -test revealed a significant mean differences of 9.88, where the mean for the relapsed group was 58.48, $SD = 20.38$, which was higher than the mean for the sober group ($M = 48.61$, $SD = 25.56$); $t(66.80) = -2.146$, $P = 0.035$. Thus, greater antisocial scores on the MCMI-III were associated with

relapse group membership at follow-up. No significance differences between groups was found for any of the other MCMI-III scales, nor for any of the TCI-R dimensions.

Second, binary logistic regression was used to identify the multivariate contribution of all explanatory variables that were significant in the univariate analyses, and sought to determine the contribution of each of the independent predictors of sobriety outcome while holding the effects of other predictors constant. The dependent variable in the regression model was the two-year sobriety outcome status (sober = 0, relapsed = 1). As independent variables, all the variables that were significant in the univariate analyses were included in the model. The following covariates were included in the model: gender (male = 0, female = 1), alcohol dependence score, and antisocial personality score. A test of the full model versus a model with the intercept only was significant: $\chi^2(3) = 9.042$, $P = 0.029$. The percent classification rate for the model was 73.9%, which was better than that predicted by the intercept alone. The Cox & Snell R square was 0.076, indicating the model accounted for about 8% of the total variance in longitudinal sobriety outcome. The Homer and Lemeshow Chi Square test was not significant, revealing that the data fit the model well; $\chi^2(8) = 9.603$, $P = 0.294$. Table 3 presents the variables in the binary logistic regression equation, their coefficients, standard error terms, the Wald Chi Square statistic, significance values, and the predicted odds of relapse. Although the full model is significant, the only individual predictor that was

Table 3. Binary logistic regression predicting sobriety outcome from gender, antisocial, and alcohol dependence.

Predictor	B	Standard error	Wald χ^2	P	Exp(B)
Gender	-0.969	0.464	4.365	0.037	0.380
Antisocial	0.006	0.012	0.223	0.637	1.006
Alcohol dependence	0.013	0.011	1.523	0.217	1.014
Constant	-1.545	0.729	4.494	0.034	0.213

Notes: Table 3 presents the regression coefficients, standard error terms, the Wald chi square tests of the unique contribution of each predictor holding the effects of the other predictors constant, the significance value, and the model predicted odds of relapse for the overall binary logistic regression model predicting sobriety outcome. Gender was coded in binary, with male as the reference code. The overall regression equation is thus: $\ln(\text{Odds}) = -1.545 + 0.013 \text{ Alcohol Dependence} + 0.006 \text{ Antisocial} - 0.969 \text{ Gender}$.



significant was gender. The Exp (B) for gender was 0.380, 95% CI [0.153, 0.942] using male gender as the reference term. Inverting this statistic for interpretation, the odds ratio for women to relapse is 2.63 times that for men. For antisocial and alcohol dependence scores, the odds of relapse did not increase significantly for every one point increase on the MCMI-III scale. Overall, the multivariate model is significant and predicts relapse better than an intercept only model. Gender is, however, the only significant predictor in the model when holding the effects of all other variables constant, and thus suggests heterogeneity among the factors that may influence relapse.

Finally, in an effort to better understand the interplay between addiction and personality, we compared the raw TCI-R mean scores of our sample of health care professionals with the TCI-R community sample mean scores, stratified by education level. As health care professionals represent a highly educated subset of the population, having normative data from a non-addiction sample of comparable education level enabled these comparisons. One sample *t*-tests were used to compare the addicted health care professional sample means with the community sample using the means for graduate degree level of education as the test values. Table 4 shows the raw score means for the present sample compared with the community sample of comparable education level. The sample of addicted health care professionals scored significantly higher on novelty seeking than the community sample ($t(115) = 4.034, P < 0.001$), on harm avoidance ($t(115) = 8.251, P < 0.001$), and on cooperativeness ($t(115) = 2.247, P = 0.027$). The addicted health care

professionals scored significantly lower on persistence than the community sample ($t(115) = -2.625, P = 0.010$), on self-directedness ($t(115) = -3.910, P < 0.001$), and on self-transcendence ($t(115) = -2.511, P = 0.013$). There was no difference between the two graduate sample educated groups on reward dependence ($P > 0.05$).

Discussion

This is the first study to date to integrate a range of health care professionals and multiple drugs of choice. This study provides 2-year longitudinal outcome data for health care professionals outside of a formal employer sponsored monitoring program and includes the heterogeneity of addiction in this population.

Univariate factors predictive of relapse in this sample were female gender, alcohol as drug of choice, and higher scores on personality inventories consistent with antisocial personality. These factors were more commonly found among those in the relapsed outcome group than the sober outcome group. These indicators, in conjunction with previous research, can be utilized to identify tools by which treatment providers can use to achieve best practice.

Gender

Finding gender as a predictor of relapse is an extension of prior findings among previous research. The current findings demonstrate a need to understand gender-related socialization roles that may interfere with relapse prevention. In general, research has indicated that women form identity through attachment

Table 4. Comparison of raw TCI-R sample means with community sample means of comparable education level.

	Health care professional sample mean	Community sample (graduate degree) mean	<i>t</i>	<i>P</i>	Mean difference	95% CI (mean difference)	
						Lower	Upper
TCI-R subscale							
Novelty seeking	102.53	97	4.03	<0.001	5.53	2.81	8.24
Harm avoidance	99.85	86	8.25	<0.001	13.85	10.53	17.18
Reward dependence	103.42	105	-1.12	0.266	-1.58	-4.37	1.22
Persistence	122.33	127	-2.63	0.010	-4.67	-8.20	-1.15
Self-directedness	145.88	153	-3.91	<0.001	-7.12	-10.73	-3.51
Cooperativeness	146.51	143	2.25	0.027	3.51	0.42	6.6
Self-transcendence	75.17	79	-2.51	0.013	-3.83	-6.85	-0.81

Notes: Table 4 shows the comparison of the present sample mean ($N = 116$) with Cloninger's community sample stratified by education level using one-sample *t*-tests. The education stratum selected for comparison was graduate degree or higher ($N = 131$).



and thus social support and networks are pertinent to satisfactory functioning.³⁴ Because of the emphasis on social networks for women, it is important to consider the difficulty of removing a network that is promoting substance use. Additionally, society offers a double standard that shames females' use of alcohol and drugs more than that of males.³⁴ The interplay of these variables may provide insight into the relapse rates for women in the current study.

Female physicians are a unique population that have reportedly less spousal and workplace support and higher utilization of psychotherapeutic support than their non-physician counterparts.^{35,36} Consequently female physicians have also been found more likely to be dependent upon alcohol and to use alcohol exclusively, which links the independent predictors of gender and drug of choice in the present findings.³⁶ Previous research suggests that women, compared to their male counterparts, are less likely to enter treatment for substance abuse.³⁷ This further supports the notion of the integral part of various systems that may impact the support for gaining treatment.

Gender appears to influence the treatment process, retention, completion, and outcome of substance abuse recovery programs.³⁸ More specifically, the rate of relapse has been varied between men and women substance users. It has been found that women's relapse is associated with psychosocial factors including stress from marriage, being apart from children, being depressed, and substance use within the context of romantic relationships.³⁸ Exposure to trauma, victimization, diagnoses of depression and anxiety, as well as intimate partner violence (IPV), have been linked to risk factors for substance use in women.^{39,40} Baseline characteristics differ between gender in that women's baseline variables have been linked to poorer relapse prevention, compared to male counterpart.⁴¹ Many of the abovementioned triggers to relapse are a result of gender-related norms,³⁴ which suggests a need for treatment tailored to provide a frame of reference for clinicians. This is especially pertinent as research has demonstrated that most treatment modalities for substance use have been standardized for male populations.³⁹

Substance use

Alcohol was the most prominent substance in relapse, although not significant in multivariate findings. As such, the workplace was generally spared the issue

of diversion of controlled substances, although job impairment remains a significant problem. Opiate dependence was not a factor associated with higher risk of relapse as previously indicated.³⁰ These divergent findings may be related to re-entry assessments and aids for opioid dependent health care professionals, including opiate antagonist medications and the transparency and careful monitoring in the workplace setting of those who diverted narcotics as part of their addiction presentation. Alcohol as the drug of choice most used in relapse also correlates with clinical observation that this is the substance most readily available and where home and/or social pressures for alcohol consumption are high. This would especially be a factor in a highly controlled workplace environment. The interpretation that alcohol is a predictive factor for relapse is not supported by this study's findings, merely a descriptive factor worth noting for relapse prevention efforts in community based settings.

Personality

Univariate analyses indicated a relationship between personality and alcohol use but this was not evident in multivariate analyses when controlling for other variables. This may be an indication that, when taken as a whole, other variables may be more prominent in predicting relapse. Thus, focusing on previous studies' implications of the relationship between personality and substance use can provide insight into the current results and suggestions for future research. In a previously published comparison of physicians between the 1980s and 1990s, it was noted that increases in psychiatric co-morbidity, including antisocial PDs, contributed to relapse.⁴² Impulsivity has consistently been found to be related to substance use and treatment failure, and is a main characteristic of antisocial PD (ASPD).⁶ Thus, individuals with ASPD that are functioning in a controlled work environment (such as health care) may seek substances for instant gratification that cannot otherwise be found. Further tailored treatment can promote variables that have been found to generate successful treatment in co-occurring diagnoses of substance abuse and antisocial PD. These include anticipating, being deliberate, and planned harm or manipulation.⁶ More research on the relationship between ASPD and addiction recovery is needed to examine associated factors that may be required for relapse prevention in this population.



In examining the TCI-R personality profiles of the sample with a comparable community sample controlling for education, some significant differences were found. Increased scores on novelty seeking and harm avoidance as well as decreased scores on persistence maybe explained by the underpinnings of addiction or addiction-prone individuals, which have been previously described. Higher scores on harm avoidance also reflect a more cautious dimension, given the professional group that could help with outcome and increase the likelihood of better treatment outcomes. That the sample population was comprised of health care professionals offers an explanation for the higher cooperativeness scores relative to the community sample, as membership to this professional group requires a certain degree of helpfulness, empathy, and compassion for others. Additionally, the lower relative scores on self-directedness and self-transcendence can be expected for those initiating addictions treatment and can be interpreted as a consequence of the addiction.

Giving patients access to their TCI-R results and professional guidance for understanding them allows for the robust participation of improving their temperament and character scores and making adaptations to facilitate the recovery process. Because patients have unique personality configurations and motives for use, using the TCI-R creates an opportunity to delve into the unique adaptive personality style of the individual, which is essential to the understanding of what drives the addiction and what encourages recovery.⁴³ This study's favorable longitudinal outcome provides preliminary support for the effectiveness of individualizing treatment recommendations and planning with respect to personality variables. Furthermore, doing so in collaboration with the patient allows for their greater control and personalization of the recovery process.

Clinical implications and future research

Interestingly, results investigating the interplay of gender, alcohol use, and personality types did not find significant multivariate differences across outcome groups, thus revealing the heterogeneity of personality among addicts and alcoholics, particularly those of such a high functioning population. It is essential to examine character and temperament traits that may exist predominately in the healthcare population in

order to tailor treatment to individuals within this population.

Brown and colleagues found that matching age, gender, substance abuse profile, and psychological status to aftercare treatment had significant impact on relapse and recovery rate.⁴⁴ Specifically, females with multi substance abuse profile who were matched with 12-step facilitation had better alcohol outcomes than counterparts in a structured relapse prevention program. This highlights the need to take into account specific client characteristics that may impact treatment for substance users. The current findings also suggest a need to tailor treatment to individual needs based on gender, substance abuse profile, and personality types within a healthcare population. It may require substance abuse recovery programs to tailor interventions to be more gender sensitive as well as to take into account the impact of Axis II diagnosis, specifically successful communication with antisocial personality disordered individuals.

Research has indicated that gender differences exist in initiation and maintenance of substance use.³⁸ As previously stated, research has shown that women relapse due to depression, marriage stressors, and being apart from children.³⁸ This suggests a need to tailor treatment and address various motivations behind substance use and maintenance. Examining the impact of treatment from a systemic perspective may be essential in relapse prevention for women. Recovery programs that do not involve relational work and support may be positioning clients for relapse. Addressing the difficulty of separation from one's child while at a recovery program and exploring relationship discord may help reduce the rate of relapse for women. One hypothesis for the current study finding that females had a higher rate of relapse may coincide with previous research in that female health professionals may spend more time away from their children and partners for work commitments.

Further research should address the efficacy of individualized treatment planning on long-term sobriety and quality of life. Additionally, further research on healthcare populations may be necessary in order to examine characteristics exclusive to the population that may increase risk for substance abuse relapse.



Limitations

The limitations in this study provide opportunities for improvement in subsequent research. It is possible that the relationship between personality and outcome could be moderated either by specific drug of choice, motivations for use, or specific Axis I or Axis II diagnoses or their co-morbidities. A much larger sample size would be needed to examine this possibility, particularly as the small percentage of patients who relapsed presents a challenge in having adequate statistical power to be confident of findings. Given the limiting nature of a small sample size, it is difficult to interpret the logistic regression results with enhanced confidence. If it is possible to obtain detailed information on the temporal nature of when relapses take place, future research endeavors should attempt to use survival curves to strengthen analytic capabilities. Finally, it could be useful to re-administer the TCI-R upon program completion to determine if addiction treatment received produces meaningful changes in the mutable character dimensions of personality that may better predict abstinence and sobriety outcome long-term.

It is critical that more outcome studies be conducted so as to better understand the risks for relapse, and to inform and improve treatment and continuing care strategies. Relapse indicators in particular can be useful clinical tools by which treatment providers of the addicted professional can characterize potential risks for relapse in this population. Doing so could also better identify patients that may need more specialized treatment planning.

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Author Contributions

Conceived and designed the experiments: DA. Analyzed the data: SB. Wrote the first draft of the manuscript: SB. Contributed to the writing of the manuscript:

DA, SB, JC. Agree with manuscript results and conclusions: DA, SB, JC. Jointly developed the structure and arguments for the paper: DA, SB, JC. Made critical revisions and approved final version: SB. All authors reviewed and approved of the final manuscript.

Competing Interests

Author(s) disclose no potential conflicts of interest.

Disclosures and Ethics

As a requirement of publication author(s) have provided to the publisher signed confirmation of compliance with legal and ethical obligations including but not limited to the following: authorship and contributorship, conflicts of interest, privacy and confidentiality and (where applicable) protection of human and animal research subjects. The authors have read and confirmed their agreement with the ICMJE authorship and conflict of interest criteria. The authors have also confirmed that this article is unique and not under consideration or published in any other publication, and that they have permission from rights holders to reproduce any copyrighted material. Any disclosures are made in this section. The external blind peer reviewers report no conflicts of interest.

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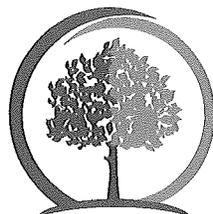
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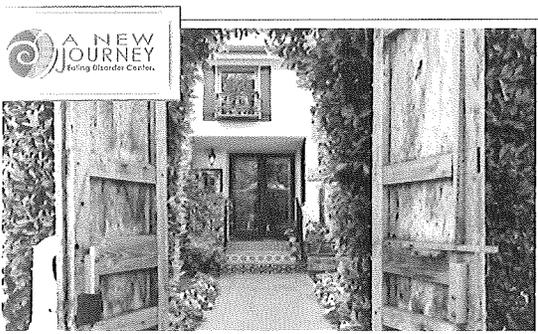
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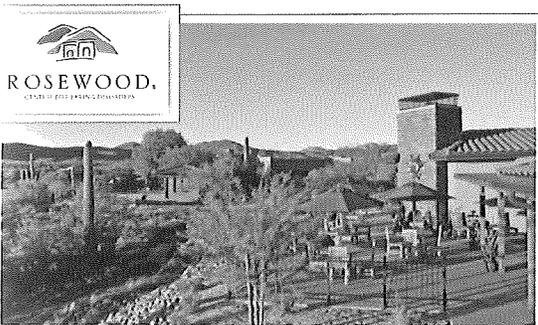


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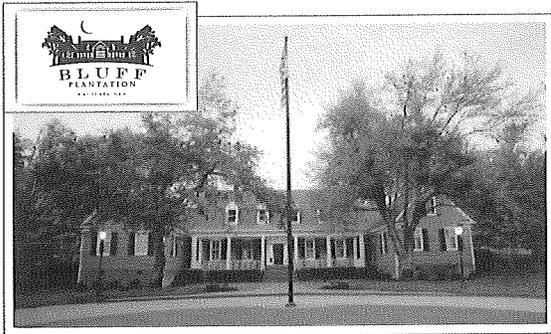


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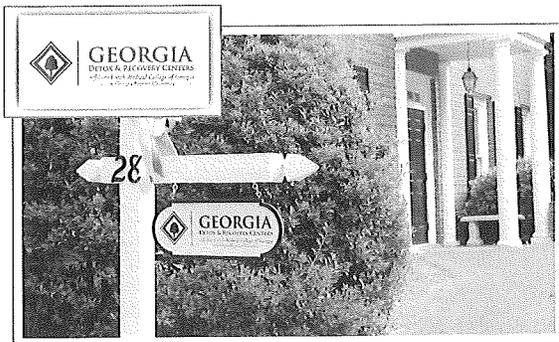


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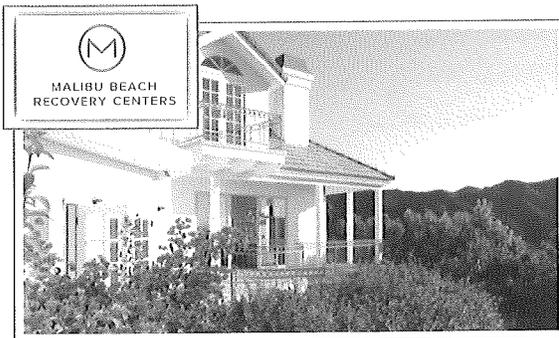


Georgia Detox & Recovery Centers

Locations: Atlanta, Athens, Augusta, Macon & Savannah, Georgia
Specializing In: Alcohol Use Disorders & Addiction, Drug Use Disorders & Addiction, Pain Medication Abuse & Addiction, Impaired Professionals

Georgia Detox and Recovery Centers specializes in treating drug and alcohol addiction, dual disorders and pain medication abuse through a state-wide network of detoxification, intensive outpatient programs (IOPs) and partial hospitalization programs (PHPs).

(844) 691-7855 www.georgiadetoxandrecoverycenters.com

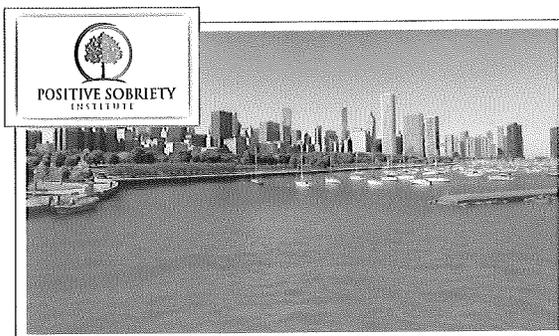


Malibu Beach Recovery Centers

Locations: Malibu, Brentwood & Pacific Palisades, California
Specializing In: Alcohol Use Disorders & Addiction, Drug Use Disorders & Addiction and Pain Medication Abuse & Addiction.

Situated in the mountains high above Malibu and overlooking the Pacific Ocean, Malibu Beach Recovery Centers is renowned for its innovative neuroscience-driven residential and outpatient addiction treatment blending the science and art of addiction recovery.

(800) 366-8101 www.malibubeachrecoverycenter.com



Positive Sobriety Institute

Location: Chicago, Illinois
Specializing In: Alcohol Use Disorders & Addiction, Drug Use Disorders & Addiction, Pain Medication Abuse & Addiction and Impaired Professionals

Located on Lake Michigan in downtown Chicago, Illinois, Positive Sobriety Institute specializes in expert-delivered addiction assessment, rehabilitation and recovery services to healthcare and other professionals.

(844) 286-2826 www.positivesobrietyinstitute.com

Multi-Disciplinary Evaluation and Assessment Providers

Drug, Alcohol and Mental Health

Comprehensive Multidisciplinary Assessment of Licensed Professionals

Acumen Assessments LLC.

730 New Hampshire Suite 222

Lawrence, KS 66044

Phone: 785-856-8218

Fax: 785-841-8781

Website: <http://www.acumenassessments.com>

Center for Personalized Education for Physicians (CPEP)

CPEP

7351 Lowry Blvd. Suite 100

Denver, CO 80230

Phone: 303-577-3232

Fax: 303-577-3241

Website: <http://www.cpepdoc.org>

Physician Assessment and Clinical Education (PACE) Program

University of California, San Diego School of Medicine

1899 McKee St. Suite 126

San Diego, CA 92110

Phone: 619-543-6770

Fax: 619-543-2353

Web Site: <http://www.paceprogram.ucsd.edu>

Multidisciplinary Assessment & Evaluation of Professionals

Professional Renewal Center– Lawrence KS

1421 Research Park Drive, #3B

Lawrence, KS 66049

Phone 877-978-4772 or 785-842-9772

Fax: 785-842-5321

Website: <http://www.prckansas.org>

Five-Day Evaluation for Impaired Professionals

Rogers Memorial Hospital-Herrington Recovery Center

34700 Valley Drive

Oconomowoc, WI 53066

Phone: 800-767-4411 or 262-646-4411

Fax: 262-646-3158

Website: <http://www.rogershospital.org>

Professional Assessment Program
Santé Center for Healing
914 Country Club Road
PO Box 448
Argyle, TX 76226

Phone: 800-258-4250 Ext. 271 or 940-464-7222
Fax: 940-464-7220
Website: <http://www.santecenter.com>

Multidisciplinary Assessment Program
Presence Health
2001 Butterfield Road, Suite 320
Downers Grove, IL 60515

Phone: 847-493-3600
Fax: 847-493-3627
Website: <http://www.reshealth.org>

Residential Evaluation Program
Hazelden
PO Box 11
15251 Pleasant Valley Rd.
Center City, MN 55012-0011

Phone: 800-257-7810 or 651-213-4200
Fax: 651-213-4793
Website: <http://www.hazelden.org>

Talbott Recovery Campus
5448 Yorktowne Drive
Atlanta, GA 30349

Phone: 800-445-4232 or 770-994-0185
Fax: 770-997-8480
Website: <http://www.talbottcampus.com>

Cedar Bridge
3230 S. Wisconsin Ave, Suite E
Joplin, MO 64804

Phone: 417-347-7001
Fax: 417-347-7079
Website: <http://www.cedarbridge.org>

Clayton Behavioral
9890 Clayton Road, Suite 100
Saint Louis, MO 63124

Phone: 314-222-5830
Fax: 314-222-5831
Website: <http://claytonbehavioral.com>

The Menninger Clinic
12301 Main Street
Houston, TX 77035

Phone: 800-351-9058 or 713-275-5000
Fax: 713-275-5107
Website: <http://www.menningerclinic.com>

Pine Grove Behavioral Health and Addiction Services
2255 Broadway Drive
Hattiesburg, MS 39402

Phone: 888-574-4673
Fax: 601-288-4773
Website: <http://www.pinegrovetreatment.com>

Promises

2073 Rockcroft Drive
Malibu, CA 90265

Phone: 877-959-6078
Fax: 310-317-9287
Website: <http://promises.com>

Competency Assessment and Evaluation Providers

CPEP

7351 Lowry Blvd. Suite 100
Denver, CO 80230

Phone: 303-577-3232
Fax: 303-577-3241
Website: <http://www.cpepdoc.org>

Physician Assessment and Clinical Education (PACE) Program
University of California, San Diego School of Medicine
1899 McKee St. Suite 126
San Diego, CA 92110

Phone: 619-543-6770
Fax: 619-543-2353
Website: <http://www.paceprogram.ucsd.edu>

Drexel Medicine Physician Refresher/Re-Entry Course
Drexel University College of Medicine
1427 Vine St. Room 405
Philadelphia, PA 19102

Phone: 215-762-2580
Fax: 215-762-2589
Website: <http://webcampus.drexelmed.edu>

KSTAR

**Texas A&M Health Science Center Rural & Community Health Institute
Health Professions Education Building
8447 State Highway 47
Bryan, Texas 77807**

Phone: 817-702-3593
Fax: 817-702-1691
Website: <http://www.rchitexas.org>

Treatment Providers for Disruptive Behavior (Distressed Physicians)

Understanding Disruption in Distressed Physicians & Medical Organizations

**Acumen Institute LLC.
730 New Hampshire, Suite 222
Lawrence, KS 66044**

Phone: 785-856-0473
Fax: 785-841-8781
Website: <http://www.acumeninstitute.org>

**Pine Grove Behavioral Health and Addiction Services
2255 Broadway Drive
Hattiesburg, MS 39402**

Phone: 888-574-4673
Fax: 601-288-4773
Website: <http://www.pinegrovetreatment.com>

Program for Distressed Physicians

**Professional Renewal Center – Lawrence KS
1421 Research Park Dr. #3B
Lawrence, KS 66049**

Phone: 877-978-4772 or 785-842-9772
Fax: 785-842-5231
Website: <http://www.prckansas.org>

Professionals Program

**Elmhurst Memorial Healthcare
360 West Butterfield Road, Suite 340
Elmhurst, IL 60126**

Phone: 630-758-58110
Fax: 630-758-5039
Website: <http://www.professionalsprogram.org>

The Menninger Clinic
12301 Main Street
Houston, TX 77035

Phone: 800-351-9058 or 713-275-5000
Fax: 713-275-5107
Website: <http://www.menningerclinic.com>

Assessment and Treatment for Sexual Misconduct

Behavioral Medicine Institute (BMI)
1401 Peachtree Street, NE, Suite 140
Atlanta, GA 30309

Phone: 404-872-7929
Fax: 404-872-2588
Website: <http://www.bmiatlanta.com>

Pine Grove Behavioral Health and Addiction Services
2255 Broadway Drive
Hattiesburg, MS 39402

Phone: 888-574-4673
Fax: 601-288-4773
Website: <http://www.pinegrovetreatment.com>

Promises
3743 S. Barrington Ave
Los Angeles, CA 90066

Phone: 877-959-6078
Fax: 310-391-6434
Website: <http://www.promises.com>

The Ranch
PO Box 38
6107 Pinewood Road
Nunnally, TN 37137

Phone: 931-729-9631
Fax: 931-729-9632
Website: <http://www.recoveryranch.com>

Treatment Providers for Chemical Dependency

Hazelden

**PO Box 11
15251 Pleasant Valley Rd.
Center City, MN 55012-0011**

**Phone: 800-257-7810 or 651-213-4200
Fax: 651-213-4793
Website: <http://www.hazelden.org>**

Presence Health

**2001 Butterfield Road, Suite 320
Downers Grove, IL 60515**

**Phone: 847-493-3600
Fax: 847-493-3627
Website: <http://www.reshealth.org>**

Santé Center for Healing

**914 Country Club Road
PO Box 448
Argyle, TX 76226**

**Phone: 800-258-4250 Ext. 271 or 940-464-7222
Fax: 940-464-7220
Website: <http://www.santecenter.com>**

Talbott Recovery Campus

**5448 Yorktowne Drive
Atlanta, GA 30349**

**Phone: 800-445-4232 or 770-994-0185
Fax: 770-997-8480
Website: <http://www.talbottcampus.com>**

Betty Ford Clinic

**39000 Bob Hope Drive
Rancho Mirage, CA 92270**

**Phone: 888-577-2303
Fax: 760-674-3342
Website: <http://bettyfordcenter.org>**

Bradford Healthcare Professional Program

**1600 Browns Ferry Road
Madison, AL 35758**

Phone: 800-879-7272 or 256-461-7272

Fax: 256-542-5728

Website: <http://www.bradfordhealth.com/healthcare-professional-program/>

Caron Foundation

**PO Box 150
243 North Galen Hall Road
Wernersville, PA 19565**

Phone: 800-854-6023

Fax: 610-743-6469

Website: <http://www.caron.org>

Cedar Bridge

**3230 S. Wisconsin Ave, Suite E
Joplin, MO 64804**

Phone: 417-347-7001

Fax: 417-347-7079

Website: <http://www.cedarbridge.org>

Cumberland Heights

**8283 River Road
Nashville, TN 37209**

Phone: 800-646-9998 or 615-352-1757

Fax: 615-432-3021 or 615-432-3333

Website: <http://www.cumberlandheights.org>

Elmhurst Memorial Healthcare

**360 West Butterfield Road, Suite 340
Elmhurst, IL 60126**

Phone: 630-758-58110

Fax: 630-758-5039

Website: <http://www.professionalsprogram.org>

Promises

**3743 S. Barrington Ave
Los Angeles, CA 90066**

Phone: 877-959-6078

Fax: 310-391-6434

Website: <http://www.promises.com>

University of Florida-Shands Recovery Center

**4001 S.W. 13th Street
Gainesville, FL 32608**

Phone: 352-465-4372

Fax: 352-265-5504

Website: <http://www.floridarecoverycenter.ufhealth.org>

2. Annual review of Memorandum of Understanding (MOU)

MEMORANDUM OF UNDERSTANDING
BETWEEN
THE BOARD OF REGISTRATION FOR THE HEALING ARTS
AND THE
MISSOURI PHYSICIANS HEALTH PROGRAM

Both the Board of Registration for the Healing Arts (“Board”) and the Missouri Physicians Health Program (MPHP) have a recognized responsibility to protect the health and welfare of the public by insuring that quality medicine is being practiced in the state of Missouri.

The Board’s mission is to protect the citizens of the state through the licensing of physicians and other health designated professionals, assessing their competence to practice and their moral character. It is also the board’s duty to investigate all complaints against its licensees in a fair and equitable manner.

MPHP’s mission is to facilitate a physician’s return to a healthy personal and professional life through early intervention, treatment referral, monitoring, and advocacy of substance abuse and mental health problems. The program’s long-term goal is to provide the impaired physician with essential tools with which to work toward a strong personal and professional recovery.

Therefore, the Board and MPHP recognize that their missions, while different, are complementary.

The following definitions, conditions and reporting requirements establish the parameters that will govern the relationship between the two organizations in this important activity.

I. DEFINITIONS

For the purpose of this Memorandum of Understanding (“MOU”) the following terms are defined:

Client – a participant in the Program. A person becomes a client by signing an impairment agreement with the Program.

Mandatory Client – any individual who either enters an impairment program: (1) as a requirement of his/her formal disciplinary agreement or order with the Board of Registration for the Healing Arts or (2) in lieu of possible formal disciplinary action by the Board.

Multi-disciplinary Evaluation – An evaluation which includes, but is not necessarily limited to, evaluation of a person’s physical, mental, neuropsychological status and substance abuse history.

Noncompliance – any breach of any provision of the contract between the MPHP and the client.

The Program – the Missouri Physicians Health Program.

Progress Report – A quarterly memorandum that provides a statement of compliance. Updated information on results of drug screenings, aftercare performance, monitoring meetings, AA/NA meetings and record of attendance, therapy, recommended revisions, any legal action or other relevant information will be provided in this report. The Report may contain other information particular to the client.

Relapse – any use of alcohol or controlled substance after the date of sobriety.

Voluntary Client – Any individual who decides to participate in the program either on his own or through referral and who is currently not under a disciplinary order or in lieu of discipline agreement with the Board.

II. GUIDELINES

1. The Program and the Board agree that most mandatory clients should undergo a multi-disciplinary evaluation. Unless otherwise specified in an agreement or order from the Board, it is within the Program's discretion whether an individual mandatory client undergoes a multi-disciplinary evaluation. However, if an evaluation is required by the Board in an order or settlement agreement, the Program agrees to facilitate the evaluation and to incorporate the recommendations of the evaluation into their treatment plan.
2. The Program agrees to utilize comprehensive drug screenings when initially testing all mandatory clients and to continue the comprehensive drug screenings if the results of the initial test are positive. If the results of the initial test are negative, it is agreed the Program may utilize simpler testing. It is also agreed that if a client has a positive urine drug screen it will be followed initially by a comprehensive drug screen. If the screen is negative, the client may then be subject to a simpler test.
3. The Program recognizes that it is within the Board's discretion to determine, after a hearing or through a formal settlement, if a positive test, self-report, or breach of any term of the impairment agreement is a violation of the Board's order, the Board's agreement with the client or a violation of §334.100.2(25), RSMo.
4. The Board agrees to permit the Director of the Program or his designee to accompany any client at the client's request to a Board meeting or any meeting with a Board designee, including a probation supervisor.
5. The Program further agrees that all mandatory clients with a history of substance abuse or substance dependence should be randomly tested via blood, breath, urine, or hair testing or via another scientifically accepted method. The frequency of such testing should be related to the status of the client, including the length of sustained recovery, and is in the discretion of the Program. However, the Board or its designee may request a test at any time, which the Program agrees to

- facilitate. Testing shall include, but not be limited to, the mandatory client's drug of choice.
6. The Program agrees to provide to the Board a directory of all hospitals, clinics, facilities and other providers utilized by the Program and to notify the Board when a hospital, clinic, facility or other provider is added or deleted. When the hospitals, clinics, facilities or other provider is deleted the Program agrees to notify the Board in writing why the relationship was terminated.
 7. The Program agrees the Board reserves the right to evaluate the Program.
 8. The Program shall provide to the Board by January 15 each year, annual statistical data for the previous calendar year. This data should include the number of clients in the program, the number of those clients that are mandated clients, the number of clients that experienced a relapse, the number of clients that left the Program because their contracts expired and the number of clients that left the Program despite still being under the term of their contract.
 9. If an issue arises concerning the relationship between the Board and the programs, or one of their employees, the issue shall be submitted to the Liaison Subcommittee of the Board. The Liaison Subcommittee and the program representative(s) shall make a reasonable effort to agree to a solution to the issue. If the Liaison Subcommittee cannot agree to a solution, the issue shall be presented to the entire Board and MSMA for review and input. The Liaison Subcommittee shall be a standing subcommittee as this agreement is enforceable.

III. REPORTING REQUIREMENTS

10. The Board agrees to provide the Program a copy of the signed order or agreement for all mandated clients within 14 days of the date signed.
11. The Program agrees to provide to the Board a copy of the signed impairment agreement within 14 days of the date signed. Part of this agreement shall include a release which allows the Program and the Board to freely exchange information.
12. The Program agrees to provide to the Board quarterly progress reports as specified in the definition.
13. The Program agrees to notify the Board the next working day by telephone and to follow-up in writing no later than 14 days of any positive test of a mandated client's blood, breath, urine, or hair or a self-report by a mandated client of consumption of alcohol or a controlled substance that was not prescribed by a physician with a valid physician-patient relationship.
14. The Program agrees to notify the Board the next working day by telephone and to follow-up in writing no later than 14 days of any breach of any term of the impairment agreement by a mandated client.
15. The Board agrees to notify the Program by phone the next business day and follow-up in writing no later than 14 days of any use of alcohol or controlled substances or any breach of a term of the impairment agreement by a mandated client.

3. ILOD start and end dates

DRAFT ILOD Process

1. Board determines that there is cause to discipline, but that they wish to defer discipline if the licensee agrees to be in a treatment program.
2. Prior to extending an offer for ILOD, the Board may request that a licensee undergo a multi-disciplinary evaluation, provide a copy of a prior evaluation, or provide medical records.
3. The Board extends this offer to the licensee via a letter which states in essence:

During its most recent meeting the Missouri State Board of Registration for the Healing Arts reviewed your application for licensure as a [PHYSICIAN, PHYSICAL THERAPIST, ETC]. It was the Board's decision to [grant your license if you agree to an "in lieu of discipline" (ILOD) status OR request that you enter "in lieu of discipline" status]. This status requires you to sign a contract with the Missouri Physicians Health Program (MPHP) or the Missouri Association of Osteopathic Physicians and Surgeons Physician Health Program (MAOPS PHP) within 21 days from the date of this letter and to comply with all terms of that contract. This status is authorized by Section 334.043, RSMo (2011).

"In lieu of discipline" status is not considered a disciplinary action and therefore is not reportable to the National Practitioner Data Bank. However, a licensee who agrees to become an "in lieu of discipline" client with a PHP and then fails to comply with the PHP, is subject to disciplinary action pursuant to Section 334.100.2(25), RSMo in addition to any other causes for discipline that may exist. In addition to complying with all requirements of his/her agreement with MPHP or MAOPS, ILOD status requires a licensee to meet periodically with a Board representative. Additionally, the Board can review any new information that becomes available during the ILOD period and take further appropriate action, which could include discipline.

If you agree to become an "in lieu of discipline" client with MPHP or MAOPS PHP, please sign and return the attached form, provide us with a copy of the PHP contract, and complete and return the attached form authorizing the exchange of information between the PHP and the Board. If you do not want to accept the ILOD status, then the Board will reconsider your application at the next meeting.

4. The attached form will say the following:

I, _____, agree to the following terms and conditions:

A. I understand that the Board of Healing Arts (“Board”) believes that cause exists to discipline my [PHYSICIAN AND SURGEON’S, PHYSICAL THERAPY, ETC.] license.

B. The Board is agreeing to defer prosecution of those charges, if I agree that the statute of limitations will toll for the time period of this agreement pursuant to section 324.043, RSMo. I understand that means if I violate this agreement the Board may prosecute for the current violation of section 334.100 in addition to any violations that may occur in the future.

C. In order to effectuate the above paragraph, the Board must follow the normal procedures listed in Chapter 334.

D. I also understand that this agreement requires that I join the Missouri Physician’s Health Program (MPHP), the Missouri Osteopathic Physician’s Health Program (MAOPS) or any other professional health program approved by this Board.

E. I understand that the violation of my contract with any of the above physician’s health programs may be cause to discipline my license pursuant to section 334.100.2(25).

F. The term of this agreement is [FIVE, TWO, ETC.] years from the date it is received by the Board.

G. I agree to sign any release required to effectuate the Board’s monitoring of this agreement, including but not limited to, release for the physician’s health program and any other treatment providers. (A release is included with this form.)

H. I agree to cooperate with the Board and/or a representative of the Board with regards to correspondence, meetings, inquiries of progress, etc.

I. I understand that I have the right to consult an attorney before signing this agreement.

Licensee

5. Upon receipt of the above, the Board will consider the Licensee to be in ILOD status. The program shall consider the person to be an ILOD client as soon as they are informed, in writing, by the Board that the person has accepted ILOD status.

6. Board Probation Supervisors shall visit ILOD clients on a yearly basis and as needed.

4. Missed call in's

5. Vacation call in's

6. Dual call in for UA testing

7. Abstinence Agreement



680 Craig Road, Ste. 308
St. Louis, MO 63141
Tel: 800-958-7124
Fax: 314-569-9444
Hotline: 800-274-0933
www.themphp.org
info@themphp.org

Charles H. Sincox, M.D.
Medical Director
csincox@themphp.org

Robert Bondurant, RN, LCSW
Executive Director * mobile 314 954-5858
rbondurant@themphp.org

Mary Fahey, LCSW
Clinical Coordinator *mobile 314 578-9574
mfahey@themphp.org

Missouri Physicians Health Program(MPHP) has instituted a new agreement called an "abstinence agreement". This agreement will be used with physicians who are not willing to participate in an evaluation or treatment process. It requires that the physician maintain abstinence for one year. We will randomly drug test throughout the year to verify this. In the event that we get a positive toxicology screen or any pattern of non-compliance, the participant will be required to complete a multidisciplinary assessment to determine need for treatment. In addition, they will sign a new agreement for participation with the MPHP.



Missouri State Medical Association
Physicians Health Program
ABSTINENCE AGREEMENT

(Please Print Clearly)

Name: _____ MD/DO/MED/RES Date: _____

Home Address: _____

Work Address: _____

Work Phone: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Specialty: _____

1. I agree to abstain from the use of medications, alcohol and any other mood-altering substances including over-the-counter medications unless ordered by my primary physician and when appropriate in consultation with the Clinical Coordinator of the Missouri Physicians Health Program (MPHP). If my physician prescribes **any scheduled medication** (Class II through V,) including **Ambien and Tramadol**, I agree to bring this to the attention of the MPHP staff before using such medication unless there had been a true emergency necessitating its immediate use. **I will provide all documentation (copy of prescriptions including refills, letters from physician(s), etc...) that confirms proper dispensing of the medication within 24 hours.**

Initials: _____

2. I agree not to self-medicate, including over-the-counter medications that may contain potentially addictive ingredients, such medications would include **cough medicine**. Typical over-the-counter medications that would be acceptable without prior approval are ASA, acetaminophen, antacids and ibuprofen.

Initials: _____

3. **In the event of a positive toxicology screen or any pattern of noncompliance, I understand I will be required to participate in a Multi-Disciplinary Assessment to determine need for treatment and will sign a new MPHP agreement.** I understand that should the MPHP staff become concerned about my participation in my recovery, I may be required to meet with the MPHP staff to review my requirements.

Initials: _____

4. I understand that my MPHP case manager is _____.

Initials: _____

5. I agree to participate in observed urine, nail, hair, blood, breathalyzer, saliva or any MPHP testing mechanism initiated during my agreement with MPHP. I understand that a standard frequency phase will be established but additional testing may be requested at any time during my agreement timeframe. These tests are used to screen for use of alcohol and/or drugs and will be performed by a MPHP designated provider. The MPHP and/or its designated monitors may request such testing. Results of this testing will be sent directly to the Clinical Coordinator. Such results will be used to monitor and assess my progress in recovery. Any requests for second opinions from outside service providers must be coordinated with MPHP.

Initials: _____

6. I understand that I am financially responsible for drug screens and any other professional services rendered on my behalf.

Initials: _____

7. I acknowledge that if at any time, whether I am mandated participant or not, if the MPHP staff has evidence or reasonable concern that I may be impaired in my practice, have relapsed, or if I am noncompliant with this agreement, and fail to comply with therapeutic recommendations from the MPHP staff, I authorize the Clinical Coordinator of the MPHP to staff my case confidentially (using my code number) with a subcommittee of the Missouri Physicians Health Program Committee. I understand that the final recommendation of this staffing may be referral to one or more outside authorities* (see definition at end of agreement).

Initials: _____

8. I agree to cease the practice of medicine as requested by MPHP pending the completion of a Fitness for Duty evaluation if problems develop that potentially interfere with my professional practice.

Initials: _____

9. If I have been mandated** to the MPHP, quarterly reports will be provided to the appropriate outside authorities* (see definition at end of agreement). I agree to inform MPHP of all verbal and written communications coming from regulatory agencies and will provide MPHP copies of all written documentation corresponding with these outside authorities.

Initials: _____

10. I understand if I appear before my state licensing board, the length of my MPHP agreement may change to coincide with the licensing board mandated outcome.

Initials: _____

11. When required, I agree to provide appropriate release forms for any drug screen results, treatment center records, service provider reports and other written & verbal information requested for use by the MPHP.

Initials: _____

Initials: _____

12. As part of my agreement for participation I am required to have a primary care physician.

I select Dr. _____ as my primary physician, located at:

Address: _____

Contact Phone Number(s): _____

I have informed this professional about my participation in the MPHP. Should I be prescribed any mood-altering medications including **any scheduled medication** (Class II through Class IV) including ambien and tramadol, I understand that my primary physician **must** provide documentation to the MPHP staff verifying diagnosis, indications, prescription dose, refills and duration. Should drug screen analysis prove positive for medication and my primary care physician has provided no documentation, I will be considered to be noncompliant with this agreement until such documentation is received. Typical medications not requiring documentation could include ASA, acetaminophen, antacids and ibuprofen.

Initials: _____

13. If I am required to have a pain management plan, I will authorize the professional to provide communication and documentation to and from MPHP.

Initials: _____

14. Other requirements:

I agree to submit a biographical statement, **if requested**, by MPHP, in ten (10) days of signing an agreement with the MPHP. I understand the MPHP will give me details on the specifics of the content that is to be included in the biographical statement. In addition, I will provide MPHP a current copy of my Curriculum Vitae.

Initials: _____

15. I understand that I will be billed \$ _____ per month administrative fee for the MPHP. An invoice will be sent the first day of the month following the signing of the agreement and each month hereafter or within 30 days of my first contact, whichever comes first. I understand that I am responsible for the fees and will pay it on a monthly basis. Failure to meet my financial obligations could result in MPHP status reports being delayed or compromised.

Initials: _____

16. Should I relocate to another state, I authorize the MPHP to disclose information regarding my affiliation with the MPHP to the applicable physician health program in the state to which I am relocating so that there may be continuous monitoring and documentation of my recovery.

Initials: _____

17. I understand that the MPHP agrees to assume an advocacy role with the Board of Healing Arts, Bureau of Narcotics and Dangerous Drugs and any other outside referring authority* for me provided that I agree to and meet all conditions of all of the above terms. The duration of this agreement will be for 1 year(s) with renewal subject to review by the Missouri Physicians Health Programs at anytime during this agreement.

Initials: _____

18. In consideration of my being allowed to participate in the Physicians Health Program, I expressly acknowledge that neither Missouri State Medical Association nor the Missouri Physicians Health Program nor any of their employees, board members, agents or independent contractors will be responsible for or provide any professional services to me, and I expressly release Missouri State Medical Association, the Missouri Physicians Health Program, and all of their employees, board members, agents, and independent contractors from any and all claims, whether now existing or hereafter arising, related to or arising from my participation in the Missouri Physicians Health Program or any services provided to me thereunder, including but not limited to any claims that I might hereafter assert that Missouri State Medical Association, the Missouri Physicians Health Program, any of their agents or independent contractors, board members or employees were negligent or that any of said persons or entities committed any acts of omission or commission that I claim are or were negligent or that I claim are or were acts of professional malpractice, it being the intent hereof that I shall be forever barred from asserting any such claims hereafter.

In the event I hereafter assert any such claim, I agree that such assertion shall disqualify me from further participation in the Missouri Physicians Health Program and that the



Missouri Physicians Health Program shall be absolutely entitled to discharge me from said program.

Initials: _____

Participant Signature: _____

Date: _____

Witness: Name: _____

Title: _____

Date: _____

*Outside authorities may include but not be limited to Missouri Board of Healing Arts, Bureau of Narcotics and Dangerous Drugs or any other outside agency, authority, institution or individual who may be able to limit the continued pursuit by the program participant of medical practice, education or related activities and who may require documentation of recovery as a condition for allowing the program participant to pursue such activity.

**A mandated participant refers to any individual directed to the Missouri Physicians Health Program by outside authorities who require evidence of documented recovery (e.g. quarterly reports) as a condition of continued pursuit by the participant of medical practice, employment, education or related activities. Such reports will be provided under contractual agreement (s) between participant and the outside referring authorities.

19. I have read the above definitions regarding what constitutes outside authorities and a mandated participant.

Initials: _____

**8. Communication
with PHP's
regarding Hearing
outcomes**

9. DWI's