

AMERICAN BAR ASSOCIATION

**ADOPTED BY THE HOUSE OF DELEGATES
August 7-8, 2006**

RECOMMENDATION

RESOLVED, That the American Bar Association urges all federal, state, territorial and local legislative bodies and governmental agencies to adopt laws and policies that require health and disability insurers who provide coverage for the treatment of both abuse and dependence on drugs and alcohol to do so in a manner that is based on the most current scientific protocols and standards of care, so as significantly to enhance the likelihood of successful recovery for each patient.

REPORT

I. TREATMENT FOR SUBSTANCE USE CONDITIONS

Substance use and addiction are significant public health problems. Substance use, in itself, can be harmful, especially with intravenous routes of use. Although alcohol or other drug use is voluntary, research has demonstrated that chronic use causes biological, psychological and behavioral changes including demonstrable alteration of brain chemistry.¹ Today, there is greater recognition and acceptance than ever before of the fact that addiction is a treatable, chronic illness.² Nevertheless, current insurance laws and regulations covering both private and public (Medicaid and Medicare) insurers typically do not adequately require comprehensive substance abuse treatment.³

The long-term goal of all drug and alcohol addiction treatment is to enable the patient to achieve lasting abstinence.⁴ However, proximate treatment goals include reducing drug and alcohol abuse, improving the patient's ability to function, and minimizing the medical and social complications of drug and alcohol misuse.⁵

Treatment for drug and alcohol addiction includes both short- and long-term methods. Short-term treatment methods are of less than 6 months duration, and include residential therapy, medical therapy, and drug-free outpatient therapy.⁶ Longer term treatment may include, for example, methadone maintenance outpatient treatment for opiate addicts and residential therapeutic community treatment.⁷

¹ See, for example, Leshner, AI. "Addiction is a Brain Disease." *Issues in Science and Technology Online*, 17(3): Spring 2001.

² As early as 1972, the American Bar Association's House of Delegates approved the Uniform Alcoholism and Intoxication Treatment Act, which recognized that treatment, rather than criminal penalties, were the appropriate response to alcoholism.

³ Department of Health and Human Services, *Changing the Conversation: Panel Report, Public Hearings, and Participants*, (Rockville, Maryland: DHHS, 2000), page 19. The Substance Abuse and Mental Health Services Administration's ("SAMHSA") Center for Substance Abuse Treatment ("CSAT") began the National Treatment Plan Initiative ("NTP") in the fall of 1998 to provide an opportunity for the field to effect needed change. The first volume of the NTP ("Changing the Conversation: Panel Reports, Public Hearings, and Participants"), published in November 2000, recommends developing a standard insurance benefit for substance abuse treatment that provides for a full continuum of appropriate and continuing care to meet the needs of persons with substance abuse disorders.

⁴ National Institute on Drug Abuse ("NIDA") Info Facts: Drug Addiction Treatment Methods. The document is available at <http://www.drugabuse.gov/infofacts/treatmeth.html>.

⁵ Ibid

⁶ Ibid. Short-term residential programs, often referred to as chemical dependency units, involve a 3- to 6-week treatment phase followed by extended therapy or participation in 12-step self-help groups, such as Narcotics Anonymous or Cocaine Anonymous. Outpatient drug-free treatment does not include medications and involves myriad programs for patients who visit a clinic at regular intervals. The majority of the programs involve individual or group counseling. Patients entering these programs include those who are abusers of drugs other than opiates or are opiate abusers for whom maintenance therapy is not recommended, such as those who have stable lives and only brief histories of drug dependence.

⁷ Ibid. Therapeutic communities are highly structured programs in which patients stay at a residence, typically for 6 to 12 months. Patients in therapeutic communities include those with relatively long histories of drug dependence, involvement in serious criminal activities, and impaired social functioning.

Through appropriate treatment, patients can learn to control their condition and to live normal, productive lives.⁸ Many patients require services supplemental to addiction treatment, such as medical and mental health services and HIV prevention services.⁹ In general, the more treatment given, the better that the patient will successfully manage their addiction.¹⁰

II. STATEMENT OF THE PROBLEM

The National Survey on Drug Use and Health (“NSDUH”), an annual survey by the Substance Abuse and Mental Health Services Administration (“SAMHSA”) of the civilian, noninstitutionalized population of the United States aged 12 years or older, reports national estimates of rates of use, numbers of users, and other measures related to illicit drugs, alcohol, and tobacco.¹¹ The NSDUH also collects information regarding financing treatment and barriers to treatment.

According to the 2004 NSDUH, the estimated number of persons aged 12 or older needing treatment for an alcohol or illicit drug use problem was 23.48 million (9.8 percent of the total population).¹² An estimated 2.33 million (1.0 percent of the total population and 9.9 percent of the people who need treatment) received treatment at a specialty facility.¹³ Thus, there were 21.25 million persons (8.8 percent of the total population) who needed treatment but did not receive treatment at a specialty addiction treatment facility in 2004.¹⁴

Based on 2003-2004 combined data, among persons who needed but did not receive illicit drug or alcohol use treatment, felt they needed treatment, and made an effort to receive treatment, the most often reported reasons for not receiving treatment were cost or insurance barriers (42.5 percent), not ready to stop using (25.3 percent), other access barriers (21.5 percent) and stigma (17.8 percent).¹⁵

Current insurance benefit packages, including private and public (Medicare and Medicaid) insurers, typically do not adequately cover substance abuse treatment.¹⁶ Many insurers do not cover specific services, limit the number of units of service with annual or lifetime caps, or provide coverage for no -- or only severely limited -- continuing care.¹⁷ In

⁸ Ibid

⁹ Ibid

¹⁰ Ibid

¹¹ Substance Abuse and Mental Health Services Administration, (2005). *Results from the 2004 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-28, DHHS Publication No. SMA 05-4062), Rockville, Maryland, page 7. The survey was formerly called the National Household Survey on Drug Abuse (“NHSDA”). The survey collects information on the sociodemographic characteristics of users, patterns of use, treatment, perceptions of risk and availability, criminal behavior, and mental health. Since 1999, the NSDUH/NHSDA has been designed to provide state-level estimates, based on about 67,500 respondents per year.

¹² Ibid, page 76.

¹³ Ibid. A specialty facility is defined by the NSDUH as a hospital (inpatient only), drug or alcohol rehabilitation facilities (inpatient or outpatient), or mental health centers. It excludes treatment at an emergency room, private doctor’s office, self-help groups, prison or jail, or hospital as an outpatient.

¹⁴ Ibid

¹⁵ Ibid, page 79.

¹⁶ Changing the Conversation: Panel Reports, Public Hearings, and Participants, page 19.

¹⁷ Ibid

addition, since alcohol and substance abuse and dependence are chronic, relapsing illnesses, an individual may exhaust their insurance coverage and be forced to rely on the use of public funds, such as Medicaid and State substance abuse treatment systems.¹⁸ These public resources were originally intended as a safety net and instead have become the primary insurance for many individuals in need of treatment.¹⁹ Government insurance packages (specifically Medicaid) generally do not provide comprehensive treatment.²⁰

Lacking a consensus among standards of care, reimbursement decisions among managed care or other third-party payers may be based on idiosyncratic clinical protocols, creating, in effect, their own standards for treatment.²¹ As a result, many individuals with an alcohol or other drug use disorder are placed in a treatment program based on availability and affordability, regardless of whether or not the treatment program is appropriate for the individual.²² Too often, patients do not receive care for co-occurring physical or mental problems.²³ People who are prescribed medication for addiction frequently receive doses that are too low to be effective, a problem seen in methadone maintenance therapy.²⁴ In addition, certain insurance companies require people to “fail” one level of care before authorizing a more intensive level of care.²⁵ Thus, limited and inconsistent coverage leads to inappropriate and insufficient care with negative consequences.²⁶ In addition to reimbursement for treatment services, both public and private insurance should provide reimbursement for screening and brief intervention. Primary health care settings provide the ideal opportunity to bring such substance abuse services directly to the patient. By the targeting and early identification in the continuum of care those whose substance use has not yet manifested in dependence and its consequences, patients with less severe drug and alcohol use are more likely to benefit from the effective intervention. Screening and brief intervention is a proven intervention for hazardous and harmful substance use, and is an important device to facilitate the entry of substance dependent persons into treatment. However, these services are not routinely provided by primary care practitioners, hospital emergency services, or hospital inpatient care services, despite considerable research evidence of effectiveness and substantial positive returns on investment. The lack of insurance reimbursement for these services is a major impediment to the expansion of this useful health care intervention.

Furthermore, treatment systems often do not provide services tailored for special population groups such as women, children and adolescents, the aging and disabled, ethnic groups and rural populations.²⁷ Historically, addiction programs have been directed at men; thus, there are a limited number of women- or juvenile-oriented programs.²⁸ Pregnant women and

¹⁸ Ibid and page 5.

¹⁹ Ibid, page 19.

²⁰ Ibid

²¹ Ibid, page 24.

²² Join Together. Ending Discrimination Against People with Alcohol and Drug Problems: Recommendations from a National Policy Panel. Boston, Massachusetts: Join Together, Boston University School of Public Health. April 2004. page 7.

²³ Ibid

²⁴ Ibid

²⁵ Ibid

²⁶ Ibid

²⁷ Changing the Conversation: Panel Report, Public Hearings, and Participants, page 9.

²⁸ Ibid

addicted women with young children needing child care services face special barriers to participating in residential or outpatient addiction care.²⁹ In addition, ethnic and racial differences frequently impede individuals from accessing treatment due to language or other cultural barriers.³⁰

III. RECOMMENDATIONS

Effective and appropriate care can facilitate remission of alcohol or substance abuse and dependence, similar to the successful treatment of other chronic illnesses such as diabetes, hypertension and asthma.³¹ Similar to coverage of other chronic disease states, by providing coverage for a full continuum of care,³² standard insurance benefits will allow individuals with alcohol or drug problems to gain access to the appropriate level of initial care and continuing care as they progress through treatment.³³ In order to be effective, the standard benefit should be designed such that there is no conflict between the clinically appropriate strategy and the allowances of the insurance plan.³⁴

In addition to attending to the clinical health care of an individual in recovery, ancillary services, such as child care and transportation, must be addressed. Ancillary services should be considered as integral to ensuring a successful recovery. Ancillary services should be identified and included in treatment plans.³⁵

Several organizations have recognized the consequences of a highly managed and constrained health care delivery system, with little or no regard to individualized care, on appropriate addiction treatment services. Recently, the Institute of Medicine (“IOM”) published a report which calls for action from clinicians, health care organizations, purchasers, health plans, quality oversight organizations, researchers, public policy makers, and others to ensure that individuals with mental and substance-use health conditions receive the care that they need to recover.³⁶ The IOM report recommends capitalizing on two critical developments occurring in health care delivery: (1) the increasing attention to improving the quality of health care that takes into consideration the preferences and values of the patient, in addition to scientific

²⁹ Ibid

³⁰ Ibid

³¹ see, for example, McLellan AT, Lewis D, O’Brien CP, Kleber H. “Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance and Outcomes Evaluation.” *Journal of the American Medical Association*. 2000; 284: 1689-1695.

³² Changing the Conversation: Panel Reports, Public Hearings, and Participants, page 23. A continuum of care includes education, prevention, screening and assessment, brief intervention and treatment determined by the client, as well as the severity of the addiction and co-occurring health problems, and maintenance care.

³³ Ibid, page 20.

³⁴ Ibid

³⁵ Ending Discrimination Against People with Alcohol and Drug Problems, page 8.

³⁶ *Improving the Quality of Health Care for Mental and Substance-Use Conditions*. Washington, D. C.: Institute of Medicine of the National Academies, 2006. The Institute of Medicine was established in 1970 by the National Academy of Sciences to secure the services of eminent members of appropriate professions in the examination of policy matters pertaining to the health of the public. The Institute acts under the responsibility given to the National Academy of Sciences by its congressional charter to be an adviser to the federal government and, upon its own initiative, to identify issues of medical care, research, and education. Dr. Harvey V. Fineberg is president of the Institute of Medicine.

findings about effective care; and, (2) scientific research that enhances the understanding and treatment of mental and substance-use conditions.³⁷ The report concludes that improving the nation's health and health care delivery system relies upon attending to the quality problems in health care for mental and substance-use conditions.³⁸ These quality problems prominently include the insufficiency of treatment based on the best scientific protocols and standards of care.

The American Society of Addiction Medicine (“ASAM”) has adopted a policy statement on insurance benefits for primary care and specialty treatment of substance use disorders, which has eleven principles.³⁹ Excerpts from that policy appear below.

1. Primary care and specialty treatment for substance use disorder should be specifically included in any basic health benefit, rather than be subsumed under some other category, such as mental health.⁴⁰
2. Coverage should include a continuum of primary care and specialty services that provide effective treatment for substance use disorders.⁴¹
3. Provision should be made for simultaneous treatment of substance use disorders and their physical and psychiatric comorbidity, wherever indicated.⁴²
4. Ongoing treatment evaluation, case management, cost benefit and outcome studies should be an integral part of the ongoing evaluation of all substance use disorder services.⁴³
5. Eligibility criteria should be based on competent diagnosis of substance use disorders by use of objective criteria such as the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (“DSM-IV”) or International Classification of Diseases, Tenth Revision (“ICD-10”), and on medical necessity.⁴⁴
6. Patient placement should be based on objective criteria with quality of care assured by appropriate review.⁴⁵
7. Where specialized substance use disorder services are provided, these services must be linked to the rest of the health care system.⁴⁶

³⁷ Ibid

³⁸ Ibid

³⁹ The entire ASAM Public Policy Statement entitled, “Public Policy Statement on Core Benefit for Primary Care and Specialty Treatment and Prevention of Alcohol, Nicotine and Other Drug Abuse and Dependence,” is available at <http://asam.org/ppol>. The Public Policy Statement was adopted by the ASAM Board of Directors, April 1993.

⁴⁰ Ibid

⁴¹ Ibid

⁴² Ibid

⁴³ Ibid

⁴⁴ Ibid

⁴⁵ Ibid

8. Medicine must work closely with other professional providers and self-help groups, and all must avail themselves of the broad network of community services to address the long-term vocational, education, and other needs of people with substance use disorders.⁴⁷

9. Linkage between medical institutions and nonmedical rehabilitative services should be assured by requiring such institutions to be licensed and accredited (for example, state licensing boards, the Joint Commission on the Accreditation of Healthcare Organizations (“JCAHO”), and the Commission on Accreditation of Rehabilitation Facilities (“CARF”).⁴⁸

10. Coverage for alcohol, nicotine and other drug dependencies should be non-discriminatory on the same basis as any other medical care.⁴⁹

11. Caps or limits on numbers of treatment visits, days or payments should be applied in the same manner as with any chronic disease.⁵⁰

The ASAM also adopted a public policy position that address various issues related to managed care and addiction medicine.⁵¹ Excerpts from that policy appear below.

1. Treatment costs should be carefully monitored by providers, third-party payers, and managed care agencies, but the paramount consideration in evaluating the need for any addiction treatment service should be the therapeutic value of the service at a given time for a given patient.⁵²

2. Addiction medicine services should be provided in the most economical manner possible, consistent with the welfare and well-being of the patient and with effective treatment of his or her disease state.⁵³ This means treatment should be individualized to match patients to the most effective treatment plans, and patients should have timely access to levels and modalities of treatment appropriate to their condition.⁵⁴ The confidentiality of patient records should be safeguarded in all cases.⁵⁵

3. The long-term benefits of individualized, comprehensive treatment should be taken into account by managed care agencies, and be carefully compared to any short-term savings and long-term costs that might result from care of substandard quality.⁵⁶

⁴⁶ Ibid

⁴⁷ Ibid

⁴⁸ Ibid

⁴⁹ Ibid

⁵⁰ Ibid

⁵¹ The entire ASAM Public Policy Statement entitled, “Public Policy Statement on Managed Care and Addiction Medicine,” is available at <http://asam.org/ppol>. The Public Policy Statement was adopted by the ASAM Board of Directors, November 1990.

⁵² Ibid

⁵³ Ibid

⁵⁴ Ibid

⁵⁵ Ibid

⁵⁶ Ibid

4. Peer review should be precisely performed only by persons who are experienced in, and knowledgeable about, addiction medicine.⁵⁷ Written standards that are uniform to all managed care operations in the addictions field should be developed to delineate review procedures and qualifications of personnel.⁵⁸ Direct concurrent review discussion should be reserved only for those cases where an individual is atypical, or when some extenuating circumstances must be considered.⁵⁹

5. National accreditation standards should be developed for organizations and their personnel involved in managed care and review of addiction treatment services.⁶⁰

IV. RELATED ABA POLICY POSITIONS

The American Bar Association has several policies that address long-term solutions to alcohol or other drug abuse.

At the 1972 Midyear Meeting, the House of Delegates approved the Uniform Alcoholism and Intoxication Treatment Act, which provides for treatment of alcoholics and intoxicated persons instead of subjecting such persons to criminal penalties, establishes facilities and machinery for treatment of such persons, and provides for voluntary commitment to a treatment facility or involuntary commitment by court order.

At the 1975 Midyear Meeting, the American Bar Association reaffirmed its support for the Uniform Alcoholism and Intoxication Treatment Act drafted by the National Conference of Commissioners on Uniform State Laws and urged states that have not already done so to utilize the newly available federal funding (P. L. No. 93-282) to implement its provisions. The American Bar Association also generally reaffirmed its support for the principle of decriminalization of alcoholism.

At the 1994 Midyear Meeting, the House of Delegates approved a policy supporting development of a comprehensive, systemic approach to addressing the needs of defendants with drug and alcohol problems through multidisciplinary strategies that include coordination among the criminal justice, health, social service and education systems, and the community. The policy urges the courts to adopt certain treatment-oriented, diversionary drug court programs as one component of a comprehensive approach. The policy also urges bar associations to facilitate the development of such programs that result in dismissal of drug-related charges upon the completion of drug rehabilitation.

At the 1995 Annual Meeting, the House of Delegates endorsed the U. S. Sentencing Commission's proposal to amend federal sentencing guidelines to eliminate differences in sentences based on drug quantity for offenses involving crack versus powder cocaine, and assign greater weight in drug offense sentencing to other factors that may be involved in the offense, such as weapons used, violence, or injury to another person.

⁵⁷ Ibid

⁵⁸ Ibid

⁵⁹ Ibid

⁶⁰ Ibid

At the 1995 Annual Meeting, the House of Delegates approved a policy urging bar associations to join the American Bar Association in developing and encouraging initiatives aimed at preventing inhalant abuse.

At the 1997 Annual Meeting, the House of Delegates approved a policy supporting the removal of legal barriers to the establishment and operation of approved needle exchange programs that include drug counseling and drug treatment referrals in order to further scientifically-based public health objectives to reduce HIV infection and other blood-borne diseases and in support of the American Bar Association's long-standing opposition to substance abuse.

At the 2004 Annual Meeting, the House of Delegates approved a policy urging federal, state, territorial and local governments to eliminate policies that sanction discrimination against people seeking treatment or recovery from alcohol or other disease, including specific recommendations in the area of public benefits.

At the 2005 Annual Meeting, the House of Delegates approved a policy urging all state, territorial and local legislative bodies and governmental officials to repeal laws and discontinue practices that permit insurers to deny coverage for alcohol or drug related injuries or losses covered by accident and sickness insurance policies that provide hospital, medical and surgical expense coverage; the policy also supports the 2001 Amendment by the National Association of Insurance Commissioners to its model law, the Uniform Accident and Sickness Policy Provision law, for injuries involving alcohol or drugs, permitting coverage in accident and sickness insurance policies that provide hospital, medical and surgical expense coverage.

V. CONCLUSION

Similar to other treatable chronic diseases, treatment for substance use, based on current scientific research, scientific protocols and standards of care, offers individuals in recovery the greatest opportunity to successfully address their addiction. Adoption of the proposed policy recommendation will enhance the American Bar Association's ability to encourage a review of and change in federal, state, territorial and local insurance laws and policies to ensure appropriate and sufficient care for chemical dependency.

The recommendation is consistent with several of the American Bar Association's missions and goals, including Goal I (To promote improvements in the American System of Justice) and Goal III (To provide ongoing leadership in improving the law to serve the changing needs of society).

Respectfully submitted,

Barbara J. Howard
Chair
Standing Committee on Substance Abuse

August 2006

GENERAL INFORMATION FORM

To Be Appended to Reports with Recommendations
(Please refer to instructions for completing this form.)

Submitting Entity: Standing Committee on Substance Abuse

Submitted By: Barbara J. Howard, Esq., Chair, Standing Committee on Substance Abuse

1. Summary of Recommendation(s).

This recommendation urges all federal, state, territorial and local legislative bodies and governmental officials to adopt laws that require insurers to provide coverage for the treatment of alcohol or drug abuse and dependence based on the best scientific protocols and standards of care, so as significantly to enhance the likelihood of successful recovery for each patient.

2. Approval by Submitting Entity.

Approved by the Standing Committee on Substance Abuse on May 2, 2006.

3. Has this or a similar recommendation been submitted to the House or Board previously?

No.

4. What existing Association policies are relevant to this recommendation and how would they be affected by its adoption?

The proposed recommendation will supplement the following American Bar Association policies:

At the 1972 Midyear Meeting, the House of Delegates approved the Uniform Alcoholism and Intoxication Treatment Act, which provides for treatment of alcoholics and intoxicated persons instead of subjecting such persons to criminal penalties, establishes facilities and machinery for treatment of such persons, and provides for voluntary commitment to a treatment facility or involuntary commitment by court order.

At the 1975 Midyear Meeting, the American Bar Association reaffirmed its support for the Uniform Alcoholism and Intoxication Treatment Act drafted by the National Conference of Commissioners on Uniform State Laws and urged states that have not already done so to utilize the newly available federal funding (P. L. No. 93-282) to implement its provisions. The American Bar Association also generally reaffirmed its support for the principle of decriminalization of alcoholism.

At the 1994 Midyear Meeting, the House of Delegates approved a policy supporting development of a comprehensive, systemic approach to addressing the needs of defendants with drug and alcohol problems through multidisciplinary strategies that include coordination among the criminal justice, health, social service and education systems, and the community. The policy urges the courts to adopt certain treatment-oriented, diversionary drug court programs as one component of a comprehensive approach. The policy also urges bar associations to facilitate the development of such programs that result in dismissal of drug-related charges upon the completion of drug rehabilitation.

At the 1995 Annual Meeting, the House of Delegates endorsed the U. S. Sentencing Commission's proposal to amend federal sentencing guidelines to eliminate differences in sentences based on drug quantity for offenses involving crack versus powder cocaine, and assign greater weight in drug offense sentencing to other factors that may be involved in the offense, such as weapons used, violence, or injury to another person.

At the 1995 Annual Meeting, the House of Delegates approved a policy urging bar associations to join the American Bar Association in developing and encouraging initiatives aimed at preventing inhalant abuse.

At the 1997 Annual Meeting, the House of Delegates approved a policy supporting the removal of legal barriers to the establishment and operation of approved needle exchange programs that include drug counseling and drug treatment referrals in order to further scientifically-based public health objectives to reduce HIV infection and other blood-borne diseases and in support of the American Bar Association's long-standing opposition to substance abuse.

At the 2004 Annual Meeting, the House of Delegates approved a policy urging federal, state, territorial and local governments to eliminate policies that sanction discrimination against people seeking treatment or recovery from alcohol or other disease, including specific recommendations in the area of public benefits.

At the 2005 Annual Meeting, the House of Delegates approved a policy urging all state, territorial and local legislative bodies and governmental officials to repeal laws and discontinue practices that permit insurers to deny coverage for alcohol or drug related injuries or losses covered by accident and sickness insurance policies that provide hospital, medical and surgical expense coverage; the policy also supports the 2001 Amendment by the National Association of Insurance Commissioners to its model law, the Uniform Accident and Sickness Policy Provision law, for injuries involving alcohol or drugs, permitting coverage in accident and sickness insurance policies that provide hospital, medical and surgical expense coverage.

5. What urgency exists which requires action at this meeting of the House?

Action at this meeting of the House of Delegates will allow the American Bar Association, in coordination with state, territorial and local bar associations, to advise legislative bodies and governmental officials regarding amendments to insurance laws.

6. Status of Legislation. (If applicable.)

Not applicable.

7. Cost to the Association. (Both direct and indirect costs.)

Not applicable.

8. Disclosure of Interest. (If applicable.)

Not applicable.

9. Referrals.

In May 2006, the recommendation was referred to the following entities for review and support:

Special Committees and Commissions

Commission on Domestic Violence

Commission on Homelessness and Poverty

Commission on Lawyer Assistance Programs

Commission on Mental and Physical Disability Law

Council on Racial and Ethnic Justice

Steering Committee on the Unmet Legal Needs of Children

Commission on Women in the Profession

Sections, Divisions and Forums

Criminal Justice Section

Family Law Section

General Practice, Solo and Small Firm Section

Health Law Section

Individual Rights and Responsibilities Section

Labor and Employment Law Section

Litigation Section

Tort Trial and Insurance Practice Section

Law Student Division

Senior Lawyers Division

Young Lawyers Division

Standing Committees

Standing Committee on Legal Aid and Indigent Defendants

Standing Committee on Pro Bono and Public Service

10. Contact Person. (Prior to the meeting.)

Barbara J. Howard, Esq.
Howard & Co., L.P.A.
960 Mercantile Center
120 East Fourth Street
Cincinnati, Ohio 45202-4096
513/421-7300 office
513/702-1955 cell

11. Contact Person. (Who will present the report to the House.)

Barbara J. Howard, Esq.
Howard & Co., L.P.A.
960 Mercantile Center
120 East Fourth Street
Cincinnati, Ohio 45202-4096
513/421-7300 office
513/702-1955 cell