RESPONSE TO COMMENT ON PETITION TO AMEND RULES 2-13.1 AND 3-11 OF THE RULES REGULATING ADMISSIONS TO THE BAR

The Board of Bar Examiners received one comment in response to its Petition to amend Rules 2-13.1 and 3-11 of the Rules Regulating Admissions to the Bar (the “Comment”). The Comment took no issue with the proposed amendment to Rule 2-13.1 and proposed additional revisions to Rule 3-11.

I. INTRODUCTION

There are important points on which the Comment and the board agree. Both agree that the language in Rule 3-11(j) and (k) is outdated and should be revised. Both agree that applicants should seek treatment for substance use and mental health issues when they need it. Both agree that applicants who are effectively treating their substance use and mental health issues should be commended. Both agree that the board should not recommend the denial of a license without finding disqualifying conduct.

The board’s disagreement with the Comment involves two general areas. First, relying on misconceptions about the board’s investigative and decision-
making process that the board has clarified on the bar application and elsewhere, the Comment mischaracterizes the board’s approach to matters involving substance use or mental disorders. The board welcomes the opportunity to clarify those matters again in this response.

Second, the board disagrees with the Comment’s proposal to limit the investigative scope of Rule 3-11(j) and (k) to only “conduct indicating” a substance use or mental disorder. The Comment’s proposed revision fails to consider that applicants with uncontrolled substance use or severe mental disorders\(^1\) present significant risks to the public and the judicial system, even if they have not had criminal convictions or other disqualifying conduct before applying to the Bar. Those risks warrant an inquiry before applicants are recommended for licensure.

A Florida law license is a general license. Licensed attorneys can open their own law practices. They can represent members of the public and handle client funds in any matter without supervision. Those important responsibilities require a serious and complete inquiry into whether all applicants meet the essential eligibility requirements for practicing law. Verifying that applicants have their substance use disorders and severe mental disorders treated and under control helps protect the public and fosters public confidence in the profession. Unlike the

\(^1\) This response uses the term “severe mental disorders” to refer to schizophrenia, psychotic disorders, bipolar disorders, and major depressive disorder. Those are the only severe mental disorders that the Florida Bar Application asks applicants to disclose. See infra at 3-5.
Comment’s proposal, the board’s recommended revisions allow the board to perform those beneficial and focused investigative tasks in every case involving a substance use disorder or a severe mental disorder.

II. THE BOARD CONDUCTS A LIMITED AND FOCUSED INVESTIGATION OF SUBSTANCE USE DISORDERS AND MENTAL DISORDERS.

Contrary to the Comment’s claim, the board does not “investigate any and every piece of evidence that may indicate that an applicant has or had any one of the over 300 mental disorders listed in the DSM-5.” Comment at 13. The board investigates recent and specific substance use and severe mental disorders that may impair an applicant’s ability to meet the essential eligibility requirements for practicing law. See Fla. Bar Admiss. R. 3-10.1 (listing requirements).

Importantly, nothing in the Petition seeks to change how the board operates in practice. The board does not intend to change the questions on the Bar application or any other aspect of its investigation or decision-making on cases involving substance use or mental disorders. The purpose is to align the rule with the board’s current approach to investigating those disorders and the current medical terminology relating to those disorders. See Petition at 10.

A. The Florida Bar Application Asks Limited and Focused Questions About Substance Use Disorders and Mental Disorders

On the Florida Bar Application, the board asks about substance use disorders, schizophrenia and other psychotic disorders, bipolar disorders, and major
depressive disorder. The board does not, and will not, investigate any other disorder unless the applicant cites it to explain potentially disqualifying conduct. This focused approach balances the need to protect the public with applicants’ privacy interests.

In 2018, the board revised the Florida Bar Application, its presentation to first-year students at every Florida law school, and the Frequently Asked Questions page of its website to clarify what applicants did and did not have to disclose. The board made those revisions to dispel the same misconception that the Comment expresses: that the board seeks to investigate anything and everything about an applicant’s mental health. It was not true then and it is not true now.

Item 25 of the Florida Bar Application asks: “Within the past 5 years, have you been treated for, or experienced a recurrence of, schizophrenia or any other psychotic disorder, a bipolar disorder, or major depressive disorder, that has impaired or could impair your ability to practice law?” See Ex. 1. Item 26 asks: “Within the past 5 years, have you been treated for, or had a recurrence of, a substance-related disorder that has impaired or could impair your ability to practice law?” Id.

Items 25 and 26 are limited in time to the past five years and to disorders that have impaired or could impair the ability to practice law. Item 25 is further limited only to certain severe mental health disorders.
To reinforce that the Florida Bar Application calls for disclosure of only a limited set of disorders, the board’s first-year presentation includes a slide listing common disorders that applicants do not need to disclose. See Ex. 2. The board’s Frequently Asked Questions ("FAQ") webpage likewise advises applicants:

The Florida Bar Application asks applicants to disclose only certain thought disorders (Schizophrenia and other psychotic disorders) and mood disorders (Bipolar disorder and Major Depressive Disorder) that could impair an applicant’s ability to practice law. **You do not need to disclose any other mental health conditions or treatment, including any counseling for stress or anxiety.**

Ex. 3 (emphasis added). The Florida Bar Application, first-year presentation, and FAQ page also encourage applicants to seek treatment when they need it and assure them that effective treatment from a licensed professional enhances their ability to meet the requirements for practicing law. See Ex. 1-3.

The questions on the Florida Bar Application are hardly outliers. Other professional applications in Florida ask similar or broader questions. For example, Florida’s judicial application asks applicants to disclose whether they currently have any “mental impairment” that limits their “ability or fitness to properly exercise” duties as a member of the judiciary. Ex. 4, JNC Nomination Application at 8, [https://bit.ly/2Rom4FR](https://bit.ly/2Rom4FR) (Question 65). It also asks applicants whether in the last 10 years they have experienced periods of hyperactivity, frequent mood swings, or impaired judgment. Id. at 8-9 (Questions 64, 70).
In addition, applicants for a medical license must disclose any “diagnosed mental disorder that has impaired [the applicant’s] ability to practice medicine within the last five years,” not just the specific severe mental disorders in Item 25 of the bar application. Ex. 5, Florida Board of Medicine Application for Medical License, https://bit.ly/3mnyaNo (Question 9(C); Question 9(F) parallels Florida Bar Application Item 26 with respect to substance-related disorders).

Items 25 and 26 are also permissible under the ADA. In Hobbs v. Florida Board of Bar Examiners (“Hobbs”), the plaintiff challenged Items 25 and 26 as violating the ADA. The district court determined that the questions were proper. See Ex. 6, Hobbs Summary Judgment Tr. at 41, Case No. 4:17-cv-422 (N.D. Fla. Feb. 22, 2019) (“[B]ottom line, it’s okay for the Florida Board of Bar Examiners to inquire about substance use issues. The new Questions 25 and 26 are consistent with that analysis of what’s proper.”). The Hobbs ruling on Items 25 and 26 is in line with other district courts that have upheld bar application questions about substance use disorders and mental disorders, which had similar scope or were broader than Florida’s. See ACLU of Ind. v. Individual Members of the Ind. State Bd. of Law Exam’rs, 2011 WL 4387470 *8 (S.D. Ind. Sep. 20, 2011) (“Indiana”) (rejecting ADA challenge to question: “Have you ever been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder); O’Brien v. Va. Bd. of Bar Exam’rs, 1998 WL 391019 *3 (E.D.
B. The Board’s Investigation of Substance Use Disorders and Mental Disorders Focuses on Whether the Disorder May Impair the Applicant’s Ability to Practice Law

The Comment relies on another misconception about the board’s process to claim that the proposed revisions to Rule 3-11 are overbroad. According to the Comment, the application questions are “very different” from the investigation, which disregards the “nexus between mental illness or substance abuse and otherwise disqualifying conduct.” Petition at 10. This assertion is incorrect.

If an applicant answers “yes” to Items 25 or 26 on the Florida Bar Application, the applicant must identify any treatment providers within the scope of the question. The board then contacts the treatment providers for more information. See Ex. 7 (standard form sent to treatment providers). The board informs the provider about the essential eligibility requirements, asks whether the applicant’s
condition impairs or could impair the applicant’s ability to practice law, and seeks
the provider’s opinion about the applicant’s treatment progress and whether further
treatment or monitoring is necessary for the applicant to practice law.\textsuperscript{2} \textit{Id.}

The response from the treatment provider is relevant for two reasons. First,
treatment providers are a source of information about the severity of the disorder
and whether and how the disorder has impaired or could impair the applicant’s
ability to practice law. The diagnostic criteria for alcohol and drug use disorders
necessarily involve some form of significant impairment. \textit{See} Ex. 8 (DSM-5
excerpts discussing diagnostic criteria for substance use disorders relating to
alcohol, cocaine and amphetamines, cannabis and opioids). Similarly, applicants
can be diagnosed with psychotic disorders, bipolar disorders, and major depressive
disorder only if there is significant impairment. \textit{See} Ex. 9 (DSM-5 excerpts
discussing diagnostic criteria for schizophrenia, bipolar disorders, and major
depressive disorder). In some cases, that evidence of impairment may raise an issue
as to the applicant’s ability to meet the essential eligibility requirements for
practicing law. In others, the evidence of impairment may have no connection to
practicing law and further inquiry is unnecessary.

\textsuperscript{2} In cases involving hospitalization relating to the specific disorders
identified on the Florida Bar Application, including instances of involuntary
hospitalization under the Baker Act, the board requests hospital records as well.
Second, treatment providers can, and do, opine on the success of the treatment regimen, including the applicant’s compliance with the provider’s recommendations and the applicant’s insight about knowing when to seek treatment in the future. This information is relevant on the issue of whether the applicant can be trusted to manage a recurrence of the disorder without harming the public. Treatment providers also can, and do, opine on whether conditions, such as compliance with a Florida Lawyers Assistance contract for a defined period of time, are necessary to ensure that the applicant will be able to meet the essential eligibility requirements. See Ex. 7 (sample letter to provider asking: “In light of the Essential Eligibility Requirements, is further treatment, monitoring, or supervision necessary for the applicant to practice law?”).

Substance use disorders are known to recur, even after a period of recovery. See, e.g., Fla. Bar v. Bloom, 972 So. 2d 172, 177 (Fla. 2007) (“Although Bloom completed rehabilitation programs and broke free of the immediate grip of the addiction several times, his recovery was always short-lived.”); Fla. Bar ex rel. McGraw, 903 So. 2d 905, 911 (Fla. 2005) (discussing disciplined lawyer’s “serious problems with refraining from drugs and alcohol” even after participating in recovery programs). The same is true for the severe mental disorders identified on the Florida Bar Application, even after long periods between episodes. See Indiana, 2011 WL 4387470 at *8 (citing Texas, 1994 WL 923404 at *3). Verifying
with a treatment provider that an applicant adequately has addressed or is addressing a disorder is a straightforward way to protect the public with little or no burden on the applicant.

Currently, in the majority of cases where an applicant answers affirmatively to Item 25 or 26, the investigation into the disorder does not go beyond contacting treatment providers and the board can recommend admission without conditions once the applicant passes the Florida Bar Examination. The minority of cases that require hearings, other investigation, or offers of admission with conditions involve potentially disqualifying conduct, information from treatment providers that raises legitimate questions about the applicant’s ability to meet the essential eligibility requirements, or both. In some cases, treatment providers recommend conditions for the applicant’s admission for a defined time period, which the board may adopt.

When the investigation is complete, the board makes a recommendation on admission to the Court. The board can recommend admitting the applicant with or without conditions, withholding admission until the applicant complies with conditions, or denying the applicant. Fla. Bar Admiss. R. 3-22.5, 3-23.6. As discussed below, the legal standards for making admission recommendations are different from the standards for what the board can investigate. See infra at 13-15.

The board does not recommend a denial or withhold unless there is disqualifying conduct or a failure to prove rehabilitation from a prior denial based
on disqualifying conduct. The Court’s bar admission decisions bear out this fact, as all of them discuss the applicant’s disqualifying conduct or efforts to establish rehabilitation from disqualifying conduct. See Comment at 8 (noting the absence of Court decisions addressing whether an applicant can be denied solely for having a substance use disorder or a mental disorder). If the board were regularly recommending denials or withholds in cases without disqualifying conduct, one would think that the Court would have decided such a case on appeal. It has not.

Most recent recommendations for admission with conditions involve potentially disqualifying conduct that is related to a substance use or severe mental disorder. Information about treatment is relevant to whether conditions are necessary for the applicant’s admission. The Court can confirm these facts because the board files a Report and Recommendation in every case stating its individualized assessment of the applicant, which includes a discussion of conduct and progress in treatment. The Report and Recommendation is filed on a confidential docket to protect the applicant’s privacy. See generally Fla. Bar Admiss. R. 1-61 (requiring confidentiality).

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Admission with conditions, except after a formal hearing, is recommended only with the applicant’s consent. An offer to recommend admission with conditions can occur before or after an investigative hearing, or after a formal hearing. An applicant who disagrees with the recommended conditions after a formal hearing can seek the Court’s review under Rule 3-40.
The Comment asserts that the board’s current guidelines on the length of a conditional period for admission somehow show that the board does not consider conduct in cases involving substance use or severe mental disorders. See Comment at 11-12 (quoting guidelines). The guidelines themselves refute the assertion. The guidelines state that when considering the time period for the conditions, “the board must consider the factors in Rule 3-12” in addition to other factors that may apply in cases involving substance use or mental disorders. Id. (emphasis added). Rule 3-12 directs the board to consider factors “in assigning weight and significance to prior conduct.” Its subsections use the word “conduct” seven times. Fla. Bar Admiss. R. 3-12(a)-(f), (h). Far from showing “disregard” of conduct, see Comment at 10, the guidelines affirm the board’s conduct-focused approach when making recommendations.

C. The Board’s Investigative Process Is Consistent with the ADA

The Comment argues that the ADA precludes the board from investigating substance use disorders or severe mental disorders without first finding disqualifying conduct. Comment at 2 (arguing that board’s proposed revision does “not conform the rule to the requirements of the Americans with Disabilities Act”); id. at 5-8. No court has adopted the Comment’s reading of the ADA.

There is no dispute that the ADA prohibits a public licensing authority from denying a professional license solely because an applicant has an alcohol use
disorder or a mental disorder. But substance use disorders and severe mental health disorders are matters that may be investigated:

That an applicant has bipolar disorder or any of a variety of other mental health conditions does not, without more, preclude his admission to the Florida Bar, but neither does such a mental health condition insulate the applicant from a full inquiry into his background and fitness to practice law … And this inquiry could properly include both mental health issues and other apparently unrelated indicia of fitness, such as any history of financial irresponsibility or unprofessional conduct.


The same principle applies for alcohol use disorders: an applicant cannot be denied admission solely because of an alcohol use disorder, but the ADA allows an investigation of the disorder. See Ex. 10, Hobbs Order on Summary Judgment (N.D. Fla. Feb. 25, 2019) (“Extensive alcohol use and even alcoholism, without more, do not preclude a person from practicing law. But they are matters the Board may investigate.”). The ADA also allows the board to recommend conditions on admission when necessary to mitigate risk to the public. See Ex. 6, Hobbs Summary Judgment Tr. at 40 (“If necessary, the Board can insist on conditions to Bar admission to make sure that any substance use disorder is under control.”).

Substance use disorders involving illegal drug use necessarily involve potentially disqualifying conduct because mere use and possession of the substance is against the law. See Fla. Bar Admiss. R. 3-10.1(c)(5) (essential for applicants to demonstrate that they have the ability to “avoid acts that are illegal”).
The board’s process follows the basic principles stated in *Stoddard* and *Hobbs*. The board investigates substance use disorders and certain severe mental disorders to conduct an individualized assessment about the applicant’s ability to meet the essential requirements for practicing law. When the investigation is complete, the board does not recommend denial solely on the basis of a disorder. The board’s investigation and decision-making follow the ADA, which allows the board to protect against the risk presented by attorneys with certain uncontrolled disorders. *See Indiana*, 2011 WL 4387470 at *7 ("[C]lients entrust their attorneys with their money, their property, their familial status, and, often, their freedom. Obviously, an attorney in the throes of a debilitating bout of mental illness could wreak havoc on his clients’ lives."); Ex. 6, *Hobbs* Summary Judgment Tr. at 39-40 ("The Board is certainly entitled to investigate possible substance abuse issues and to insist that any substance abuse disorder is sufficiently under control prior to admission to the Bar.").

**III. THE COURT SHOULD ADOPT THE BOARD’S PROPOSED REVISIONS.**

A. **The Board’s Proposed Revisions**

The board proposed revising Rule 3-11(j) and (k) as follows:

**3-11 Disqualifying Conduct.** A record manifesting a lack of honesty, trustworthiness, diligence, or reliability of an applicant or registrant may constitute a basis for denial of admission. The revelation or discovery of any of the following
may be cause for further inquiry before the board recommends whether the applicant or registrant possesses the character and fitness to practice law:

[…]

(j) evidence of mental or emotional instability a mental disorder that may impair the ability to practice law;

(k) evidence of drug or alcohol dependency a substance use disorder that may impair the ability to practice law;

The board has two reasons for the proposed revisions. First, the revisions remove the medically obsolete phrases “mental or emotional instability” and “drug or alcohol dependency” from the rule. Petition at 7-8. The Comment agrees that those phrases should be updated. Comment at 3-4.

Second, the revisions add the phrase “that may impair the practice of law” to Rules 3-11(j) and (k). The Comment ignores this change when it contends that the “proposed changes only update medical terminology.” Comment at 2. The board proposed adding that language to reinforce that the board’s investigative focus is on conduct that may relate to the eligibility requirements for practicing law. Petition at 10 (noting that there are “dozens of disorders in the DSM-5 that the board generally does not investigate, and would investigative only if the applicant claimed that the disorder was a factor in illegal behavior or some other disqualifying conduct”). The
Comment’s argument that the board intends to use the Petition to start investigating disorders that it does not currently investigate is groundless. Comment at 13.

B. The Comment’s Proposed Revisions

The Comment agrees that Rule 3-11 should be revised. The only dispute is whether to include the words “conduct indicating” before the language that the board proposed in subsections (j) and (k):

(j) evidence of mental or emotional instability conduct indicating a mental disorder that may impair the ability to practice law;

(k) evidence of drug or alcohol dependency conduct indicating a substance use disorder that may impair the ability to practice law;

Comment at 16 (emphasis added to Comment’s proposed new language).

The Comment contends that the words “conduct indicating” must be included because otherwise, Rule 3-11(j) and (k) would be overbroad. Comment at 13. Under the Comment’s proposed approach, the board would not be able to ask an applicant about a substance use disorder or a severe mental disorder unless the board first found potentially disqualifying conduct. The Comment is unclear on whether its proposal would require the applicant to raise the disorder before the board could inquire about it, or whether the board could ask an applicant about having a disorder based on conduct, such as whether a DUI conviction is “conduct indicating” a possible alcohol use disorder.
C. The Board’s Proposed Revisions Better Protect the Public

Rule 3-11 establishes two principles: (1) the “record … [that] may constitute a basis for denial of admission” and (2) what the board may investigate in assessing “whether the applicant or registrant possesses the character and fitness to practice law.” The board’s proposed amendments to Rule 3-11 do not address what is disqualifying for admission. Rather, they address what the board can investigate.

Because the proposed rule change is about what the board can investigate, its proposed language strikes a better balance between protecting the public and applicant privacy. An untreated and uncontrolled substance use or severe mental disorder presents significant risks to the public and the judicial system. See, e.g., Fla. Bar ex rel. McGraw, 903 So. 2d 905, 911 (Fla. 2005) (“Serious impairment—perhaps resulting in serious harm to a client—can occur in a single episode … Impaired attorneys are a serious problem that this Court takes very seriously.”); Ex. 6, Hobbs Summary Judgment Tr. at 39 (“[U]ncontrolled substance abuse ordinarily renders one unfit to practice law. That’s so as a matter of common sense … If an attorney does go off the rails, it risks substantial harm to the clients, to the judicial system, and frankly to the profession.”); Indiana, 2011 WL 4387470 at *7.

The Comment’s proposal, which aims to preclude the board from asking at least some applicants about their substance use and severe mental disorders, unfairly asks the public to bear that risk. Rule 3-11 should allow the board to
continue its focused practice of verifying that all applicants with substance use disorders or severe mental disorders are properly treated and can meet the essential eligibility requirements for practicing law.

As it stands today, for a majority of applicants who answer affirmatively to Items 25 or 26, treatment providers report that the applicants are effectively treating their conditions. The public benefits from those applicants obtaining effective treatment. The public also benefits from the board identifying the minority of applicants who need further inquiry, additional treatment, or conditions on admission before they can be recommended to hold a general law license.

The Comment’s main reason for including “conduct indicating” at the beginning of subsections (j) and (k) appears to be a concern that the board would have unfettered discretion to investigate any disorder. Comment at 12-14. This concern is unfounded not only based on the board’s public statements about how it conducts its investigation, but also because the board has proposed language that limits subsection (j) and (k) to disorders “that may impair the ability to practice law.” See Petition at 7-8. The purpose of this language is to reinforce to applicants that the board is not interested in investigating all mental disorders and everything about them. Id. at 10. The board’s proposal does not “simply update outdated medical terminology” as the Comment contends. Comment at 12.
For similar reasons, the Comment’s assertion that the board or its proposed rule change would “prevent otherwise qualified persons from becoming lawyers simply because they have or had a disability” is baseless. Id. at 14. As discussed above, Florida Bar applicants are not denied “simply because they have or had a disability.” The proposed rule change would do nothing of the sort.

IV. CONCLUSION

The board hopes that the explanation of its investigative process in this response helps to dispel some of the myths about the board that are expressed in the Comment. Applicants should not allow misinformation to discourage them from seeking needed treatment.

For the reasons stated in the Petition and in this Response, the board respectfully requests that the Court adopt its proposed revisions to Rules 2-13.1 and 3-11 of the Rules of the Supreme Court Relating to Admissions to the Bar.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that a true and correct copy of the foregoing Response has been
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CERTIFICATE OF TYPE SIZE AND STYLE

I certify that the type used in this petition is 14-point Times New Roman.

/s/ James T. Almon
James T. Almon
IN THE SUPREME COURT OF FLORIDA

FLORIDA BOARD OF BAR EXAMINERS
RE AMENDMENTS TO RULES 2-13.1 AND 3-11 OF THE RULES OF THE SUPREME COURT RELATING TO ADMISSIONS TO THE BAR

Case No. SC20-850

EXHIBIT 1
Florida Board of Bar Examiners  
SECTIONS A & B  
(to be completed by all applicants)

The Bar Application is continuing in nature. You must give correctly and fully the information requested in each item or in subsequent requests for information up until the date of the submission to the Oath of Attorney in Florida. During completion of this application, click the "instructions" link beside each item heading for additional information about completing that item. If there is inadequate space following any item, include your responses on an addendum, numbering each response according to the Item number, and attach it to the back of this application. Reference the addendum under the item in the application with which the addendum is associated. Do not insert addenda between the pages of the application.

1. Current Name, Contact Information and Driver License

Filing Status

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a. Enter your full name with no initials
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   First Name:
   Middle Name:
   Last Name:
   Suffix:

b. Enter your name as you wish it to appear on your Certificate of Admission
   First Name:
   Middle Name:
   Last Name:
   Suffix:

c. Current Mailing Address
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   Line 2:
   City:
   State:
   Zip:
   Country:

d. Daytime telephone number
   Daytime telephone number:
   ext.:

e. Driver License
   State:
Professional Licenses - Violation of Examination Rules

Type of Examination: 
Date of Examination: 
Name of entity administering examination: 
Number & Street: 
City: 
State: 
Zip: 
Country: 
Nature of Accusation: 
Detailed Explanation: 
Disposition: 

25. Substance Use and Mental Health

The Board of Bar Examiners, as part of its responsibility to protect the public, must assess whether an applicant manifests any mental health or substance use issue that impaired or could impair the applicant's ability to meet the essential eligibility requirements for the practice of law.

The Board supports applicants seeking mental health or substance use treatment, and views effective treatment by a licensed professional as enhancing the applicant's ability to meet the essential eligibility requirements to practice law.

Seeking counseling to assist with stress or anxiety will not adversely affect the outcome of a Florida Bar Application. The Board does not request that applicants disclose such counseling.

Within the past 5 years, have you been treated for, or experienced a recurrence of, schizophrenia or any other psychotic disorder, a bipolar disorder, or major depressive disorder, that has impaired or could impair your ability to practice law?

If your answer to Item 25. is "yes," please; (i) identify each condition for which you received treatment or had a recurrence; (ii) state the beginning and end dates of any treatment (or state "present" if no end date); (iii) state the name and address of each professional who treated you; and (iv) identify any medication that was prescribed for you during treatment. Please direct each treating professional to provide any information or records that the Board may request regarding treatment, which includes, without limitation, hospitalization.

Substance Use and Mental Health

Mental Condition: 
Dates: 
Name of Treatment Professional: 
Number & Street: 
City: 
State: 
Zip: 
Country: 
Medication:
26. Substance Use and Mental Health – Continued

The Board of Bar Examiners, as part of its responsibility to protect the public, must assess whether an applicant manifests any mental health or substance use issue that impaired or could impair the applicant’s ability to meet the essential eligibility requirements for the practice of law.

The Board supports applicants seeking mental health or substance use treatment, and views effective treatment by a licensed professional as enhancing the applicant’s ability to meet the essential eligibility requirements to practice law.

Seeking counseling to assist with stress or anxiety will not adversely affect the outcome of a Florida Bar Application. The Board does not request that applicants disclose such counseling.

Within the past 5 years, have you been treated for, or had a recurrence of, a substance-related disorder that has impaired or could impair your ability to practice law? For Item 26., the term “substance-related” includes, without limitation, alcohol, marijuana, cocaine, and misuse of prescription drugs.

If your answer to Item 26. is “yes,” please: (i) identify each substance involved in your treatment or recurrence; (ii) identify any substance use disorder diagnosis; (iii) state the beginning and end dates of any treatment (or state “present” if no end date); (iv) state the name and address of each professional who treated you; (v) if applicable, state your sobriety date; and (vi) if applicable, describe your participation in any recovery program and your current support system.

### Substance Use and Mental Health – Continued

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#### Treatment Professional

- **Name of treatment professional:**
- **Number & Street:**
- **City:**
- **State:**
- **Zip:**
- **Country:**

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27a. Involvement in an Organization Advocating Overthrow by Unlawful Means

Have you ever organized or helped to organize or been a member of any organization or group of persons that, during the period of your membership or association, you knew was advocating or teaching that the government of the United States or any state or any political subdivision thereof should be overthrown or overturned by force, violence, or any unlawful means? If yes, state the facts below.

### Involvement in an Organization Advocating Overthrow by Unlawful Means

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IN THE SUPREME COURT OF FLORIDA

FLORIDA BOARD OF BAR EXAMINERS
RE AMENDMENTS TO RULES 2-13.1 AND 3-11 OF THE RULES OF THE SUPREME COURT RELATING TO ADMISSIONS TO THE BAR

Case No. SC20-850

EXHIBIT 2
Florida Bar Admissions Process

Florida Board of Bar Examiners

August 2020
UNTREATED SUBSTANCE USE DISORDERS
AND
UNTREATED SEVERE MENTAL HEALTH DISORDERS

WHAT DO I HAVE TO REPORT?

- What to disclose:
  - Substance Use Disorders
    - Dependency and Abuse
  - Severe Thought Disorders
    - Schizophrenia
    - Psychotic Disorder
  - Severe Mood Disorders
    - Bipolar Disorder
    - Major Depressive Mood Disorder
  - (that impair ability to practice law and occurred within the past 5 years)

- What NOT to disclose (WILL NOT BE INVESTIGATED):
  - Adjustment disorders
  - Attention Deficit Disorder
  - General Anxiety and General Depression
  - Grief or marital counseling
  - Stress management or counseling
UNTREATED SUBSTANCE USE DISORDERS AND UNTREATED SEVERE MENTAL HEALTH DISORDERS

- Treatment for stress and anxiety **IS:**
  - Encouraged by the Florida Board of Bar Examiners

- Treatment for substance use and mental health **IS:**
  - Encouraged by the Florida Board of Bar Examiners

- Treatment for substance use or mental health **IS NOT:**
  - Cause For Delay in Bar Admission Process
  - Disqualifying

- Florida Lawyers Assistance offers confidential services for:
  - Substance Abuse and Mental Health Support
  - Stress and Anxiety Support
  - Health and Wellness Counseling

(800) 282-8981
www.fla-lap.org
IN THE SUPREME COURT OF FLORIDA

FLORIDA BOARD OF BAR EXAMINERS
RE AMENDMENTS TO RULES 2-13.1 AND 3-11 OF THE RULES OF THE SUPREME COURT RELATING TO ADMISSIONS TO THE BAR

Case No. SC20-850

EXHIBIT 3
What does the Florida Bar Application ask about an applicant’s mental health?

Item 25 on the Florida Bar Application asks applicants to disclose any treatment for, or recurrence of, certain thought disorders (Schizophrenia and other psychotic disorders) and mood disorders (Bipolar Disorder and Major Depressive Disorder) that could impair an applicant’s ability to practice law. When applying, you should read Item 25 carefully. If you are unsure of how to answer it, consider consulting with your mental health provider.

The Board supports applicants seeking mental health treatment, and views effective treatment from a licensed professional as enhancing the applicant’s ability to meet the essential eligibility requirements to practice law.

I sought counseling for stress or anxiety while I was in law school or as a practicing lawyer in another state. Do I need to report my treatment for stress or anxiety on my Florida Bar Application?

No. The Florida Bar Application asks applicants to disclose only certain thought disorders (Schizophrenia and other psychotic disorders) and mood disorders (Bipolar Disorder and Major Depressive Disorder) that could impair an applicant’s ability to practice law. You do not need to disclose any other mental health conditions or treatment, including any counseling for stress or anxiety.

The Board supports applicants seeking mental health treatment, and views effective treatment as enhancing the applicant’s ability to meet the essential eligibility requirements to practice law.

Will my mental health information be kept confidential?

Yes. Like all matters before the board, any information about an applicant’s mental health is confidential.

What does the Florida Bar Application ask about substance use?

Item 26 on the Florida Bar Application asks you to disclose any treatment for, or recurrence of, a substance-related disorder that could impair your ability to practice law. “Substance-related” includes, without limitation, alcohol, marijuana, cocaine, and misuse of prescription drugs.
IN THE SUPREME COURT OF FLORIDA

FLORIDA BOARD OF BAR EXAMINERS
RE AMENDMENTS TO RULES 2-13.1 AND 3-11 OF THE RULES OF THE SUPREME COURT RELATING TO ADMISSIONS TO THE BAR

Case No. SC20-850

EXHIBIT 4
APPLICATION FOR NOMINATION TO THE _______________ COURT

Instructions: Respond fully to the questions asked below. Please make all efforts to include your full answer to each question in this document. You may attach additional pages, as necessary, however it is discouraged. In addition to the application, you must provide a recent color photograph to help identify yourself.

Full Name: _______________________________ Social Security No.: __________________
Florida Bar No.: ___________ Date Admitted to Practice in Florida: _______________
Cell Phone No.: ___________________ E-Mail: ___________________________________

1. Please state your current employer and title, including any professional position and any public or judicial office you hold, your business address and telephone number.

2. Please state your current residential address, including city, county, and zip code. Indicate how long you have resided at this location and how long you have lived in Florida. Additionally, please provide a telephone number where you can be reached (preferably a cell phone number).

3. State your birthdate and place of birth.

4. Are you a registered voter in Florida (Y/N)?

5. Please list all courts (including state bar admissions) and administrative bodies having special admissions requirements to which you have ever been admitted to practice, giving the dates of admission, and if applicable, state whether you have ever been suspended or resigned. Please explain the reason for any lapse in membership.

6. Have you ever been known by any aliases? If so, please indicate and when you were known by such alias.

EDUCATION:

7. List in reverse chronological order each secondary school, college, university, law school or any other institution of higher education attended and indicate for each the dates of attendance, whether a degree was received, the date the degree was received, class standing, and graduating GPA (if your class standing or graduating GPA is unknown, please request the same from such school).

8. List and describe any organizations, clubs, fraternities or sororities, and extracurricular activities you engaged in during your higher education. For each, list any positions or titles you held and the dates of participation.
state the date of complaint or accusation, specifics surrounding the complaint or accusation, and the resolution or disposition.

58. Are you currently the subject of an investigation which could result in civil, administrative, or criminal action against you? If yes, please state the nature of the investigation, the agency conducting the investigation, and the expected completion date of the investigation.

59. Have you ever filed a personal petition in bankruptcy or has a petition in bankruptcy been filed against you, this includes any corporation or business entity that you were involved with? If so, please provide the case style, case number, approximate date of disposition, and any relevant details surrounding the bankruptcy.

60. In the past ten years, have you been subject to or threatened with eviction proceedings? If yes, please explain.

61. Please explain whether you have complied with all legally required tax return filings. To the extent you have ever had to pay a tax penalty or a tax lien was filed against you, please explain giving the date, the amounts, disposition, and current status.

HEALTH

62. Are you currently addicted to or dependent upon the use of narcotics, drugs, or alcohol?

63. During the last ten years have you been hospitalized or have you consulted a professional or have you received treatment or a diagnosis from a professional for any of the following: Kleptomania, Pathological or Compulsive Gambling, Pedophilia, Exhibitionism or Voyeurism? If your answer is yes, please direct each such professional, hospital and other facility to furnish the Chairperson of the Commission any information the Commission may request with respect to any such hospitalization, consultation, treatment or diagnosis. ["Professional" includes a Physician, Psychiatrist, Psychologist, Psychotherapist or Mental Health Counselor.] Please describe such treatment or diagnosis.

64. In the past ten years have any of the following occurred to you which would interfere with your ability to work in a competent and professional manner: experiencing periods of no sleep for two or three nights, experiencing periods of hyperactivity, spending money profusely with extremely poor judgment, suffering from extreme loss of appetite, issuing checks without sufficient funds, defaulting on a loan, experiencing frequent mood swings, uncontrollable tiredness, falling asleep without warning in the middle of an activity. If yes, please explain.

65. Do you currently have a physical or mental impairment which in any way limits your ability or fitness to properly exercise your duties as a member of the Judiciary in a competent and professional manner? If yes please explain the limitation or impairment and any treatment, program or counseling sought or prescribed.
66. During the last ten years, have you ever been declared legally incompetent or have you or your property been placed under any guardianship, conservatorship or committee? If yes, provide full details as to court, date, and circumstances.

67. During the last ten years, have you unlawfully used controlled substances, narcotic drugs, or dangerous drugs as defined by Federal or State laws? If your answer is "Yes," explain in detail. (Unlawful use includes the use of one or more drugs and/or the unlawful possession or distribution of drugs. It does not include the use of drugs taken under supervision of a licensed health care professional or other uses authorized by Federal or State law provisions.)

68. In the past ten years, have you ever been reprimanded, demoted, disciplined, placed on probation, suspended, cautioned, or terminated by an employer as result of your alleged consumption of alcohol, prescription drugs, or illegal drugs? If so, please state the circumstances under which such action was taken, the name(s) of any persons who took such action, and the background and resolution of such action.

69. Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of alcohol or drugs? If so, please state the date you were requested to submit to such a test, the type of test required, the name of the entity requesting that you submit to the test, the outcome of your refusal, and the reason why you refused to submit to such a test.

70. In the past ten years, have you suffered memory loss or impaired judgment for any reason? If so, please explain in full.

SUPPLEMENTAL INFORMATION

71. Describe any additional education or experiences you have which could assist you in holding judicial office.

72. Explain the particular contribution you believe your selection would bring to this position and provide any additional information you feel would be helpful to the Commission and Governor in evaluating your application.

REFERENCES

73. List the names, addresses, e-mail addresses and telephone numbers of ten persons who are in a position to comment on your qualifications for a judicial position and of whom inquiry may be made by the Commission and the Governor.
IN THE SUPREME COURT OF FLORIDA

FLORIDA BOARD OF BAR EXAMINERS)
RE AMENDMENTS TO RULES 2-13.1 AND 3-11 OF THE RULES OF THE SUPREME COURT RELATING TO ADMISSIONS TO THE BAR

Case No. SC20-850

EXHIBIT 5
FLORIDA BOARD OF MEDICINE
MEDICAL DOCTOR LICENSURE APPLICATION
Apply for your license online at www.flboardofmedicine.gov

GENERAL INFORMATION
For a detailed list of licensure requirements, please visit www.flboardofmedicine.gov

Mailing Information:
Submit your application, fees, and any supplemental documentation you are sending with your application to the following address:

Department of Health
P.O. Box 6330
Tallahassee, Florida 32314-6330

Mail additional documentation, not included with your application, to the following address:

Florida Board of Medicine
4052 Bald Cypress Way, BIN #CO3
Tallahassee, Florida 32399-3253

All documents must have your name as listed on your application to ensure materials reach your application in a timely manner.

Fees:
Make one cashier’s check or money order for the total amount payable to the Department of Health-Board of Medicine.

An applicant, who is denied licensure, or withdraws the application prior to licensure, is entitled to a refund of the initial licensure fee and NICA fee. A request to withdraw and receive a refund must be made in writing.

Fees for an applicant, not in a residency or fellowship:

- Application fee: $350.00 (non-refundable)
- Initial license fee: $350.00
- Unlicensed Activity fee: $5.00
- NICA fee: $250.00 or $5,000.00 (please read information at www.nica.com)
- Dispensing Practitioner fee: $100.00 (if selling pharmaceuticals in your office)
- Military Veteran Fee Waiver: Application fee and initial fee waived if qualified.

Fees for an applicant in a residency or fellowship at the time of licensure:

- Application fee: $350.00 (non-refundable)
- Initial license fee: $200.00
- Unlicensed Activity fee: $5.00
- NICA fee: Exempt (please read information at www.nica.com)
- Dispensing Practitioner fee: $100.00 (if selling pharmaceuticals in your office)
- Military Veteran Fee Waiver: Application fee and initial fee waived if qualified.

To receive the fee reduction your training director must send a letter addressed to the Florida Board of Medicine verifying dates of your training. NOTE: “in-training” status will not limit your practice to training; license issued will be an unrestricted medical license.
9. HEALTH HISTORY

If you answer “Yes” to any of the questions in this section, you are required to send the following items:

- A self-explanation providing accurate details that include name of all physicians, therapists, counselors, hospitals, institutions, and/or clinics where you received treatment and dates of treatment.
- A report directed to the Florida Board of Medicine from each treatment provider about your treatment, medications, and dates of treatment. If applicable, include all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).

A. ☐ Yes ☐ No In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?

B. ☐ Yes ☐ No In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

C. ☐ Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?

D. ☐ Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?

E. ☐ Yes ☐ No In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

F. ☐ Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice medicine within the past five years?

Name: __________________________________________

Last First Middle

Social Security Number: ________________________________

Social Security Information - * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Section 456.013(1), 409.2577 and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub.L. Section 317) Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.
IN THE SUPREME COURT OF FLORIDA

FLORIDA BOARD OF BAR EXAMINERS
RE AMENDMENTS TO RULES 2-13.1 AND 3-11 OF THE RULES OF THE SUPREME COURT RELATING TO ADMISSIONS TO THE BAR

Case No. SC20-850

EXHIBIT 6
UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF FLORIDA  
TALLAHASSEE, FLORIDA

JULIUS HOBBS, )            
               ) Case No: 4:17-cv-422 
Plaintiff, ) Tallahassee, Florida 
               ) February 22, 2019 
vs. ) 1 P.M. 
FLORIDA BOARD OF BAR EXAMINERS, and MICHELLE GAVAGNI, )  
Defendants. )

TRANSCRIPT OF MOTION FOR SUMMARY JUDGMENT  
BEFORE THE HONORABLE ROBERT L. HINKLE,  
UNITED STATES DISTRICT JUDGE

APPEARANCES VIA TELEPHONE:

For the Plaintiff, Julius Hobbs: Law Offices of Matthew W. Dietz, PL  
By: MATTHEW W. DIETZ  
    Attorney at Law  
    mdietz@justdigit.org  
    2990 Southwest 35th Avenue  
    Miami, Florida 33133

Syracuse University  
College of Law  
By: PETER D. BLANCK  
    Attorney at Law  
    pblanck@syr.edu  
    Dineen Hall  
    Syracuse, New York 13244

DISABILITY INDEPENDENCE GROUP, INC.  
By: LISA C. GOODMAN  
    Attorney at Law  
    lgoodman@justdigit.org  
    2990 Southwest 35th Avenue  
    Miami, Florida 33133
judgment of the evaluators? Yes. Is it reasonable for the Board to defer to the financial relationship as long as it is reasonable there? Yes.

If somebody charged an exorbitant fee, that would be a different issue, but that's not this case. The only evidence is it's below market.

We would maintain that all of the above, everything that I just went through, is necessary for the Board's process of determining the essential eligibility requirements, and that's the Board's specialty. That's the Board's specialty, not substance use disorder evaluations. That's the evaluator's specialty. Is it reasonable for the Board to rely on that? Absolutely.

So, Your Honor, we would ask that the court grant the Board's motion for summary judgment.

THE COURT: All right. Thank you. Give me just a second.

(Pause.)

I am not going to resolve the entire case by summary judgment. I am going to substantially narrow the issues. So, essentially, I'm going to grant summary judgment in part. Here's my analysis at this point:

The Board, of course, may require information that may bear on fitness to practice law. The Board may require information that may be useful in evaluating fitness to
practice law. How likely it needs to be that the information bears on fitness is something I need not address at this point. It need not be certain. On the other hand, a remote possibility is not enough. And I can apply the general principle here without trying to set out any more specific formulation about how close the connection has to be between requested information and fitness to practice law.

Next, uncontrolled substance abuse ordinarily renders one unfit to practice law. That's so as a matter of common sense. Practicing law is, in many settings at least, a high stress undertaking. It is not okay for an attorney to go off the rails. If an attorney does go off the rails, it risks substantial harm to the clients, to the judicial system, and frankly to the profession.

Now, there are lots of alcoholics and even some current substance abusers who perform very well; and being an alcoholic is not, without more, a basis to exclude somebody from the Bar. But the Bar is certainly entitled to investigate, and the Board -- sometimes I will refer to the Bar, and I do recognize that there is a difference between the Board of Bar Examiners and the Florida Bar. These principles really apply to both: the Board at the stage of admitting somebody to the Bar, and then the Bar dealing with someone who is practicing, already admitted.

The Board is certainly entitled to investigate
possible substance abuse issues and to insist that any
substance abuse disorder is sufficiently under control prior
to admission to the Bar. If necessary, the Board can insist
on conditions to Bar admission to make sure that any substance
use disorder is under control.

As I say, the record supports those conclusions.
They are true just as a matter of common sense and basic
understanding of the Americans with Disabilities Act. I give
you an example which illustrates, I think, how this ought to
work. Certainly different from what Mr. Hobbs asked for, and
probably not quite the same as what the Board asked for.

I mentioned in the argument, I had a case where a
lawyer showed up drunk. And, frankly, it was after a high
stress jury trial. And the jury went out, and while the jury
was out, a lawyer who had an alcohol problem, history of
alcohol problems, had a drink and then another, and the next
thing you know he was badly impaired, and it affected things
briefly. It was the end of the day when I found out about it,
and so instead of letting the jury keep deliberating, I sent
them home. They came back the next day. We finished up the
trial without a problem. The lawyer had performed pretty well
in the trial, got a pretty good result. It was one of several
lawyers on that side of the case.

So the matter got referred to the Bar. I don't know
the details from there on, other than I know that the Bar
insisted on treatment and monitoring and so forth. Happily, the lawyer got it back under control. The lawyer is back practicing law, handling cases. Did a good job before and is doing a good job again. So that's how that ought to work.

If somebody has a disability, including a substance use disorder, it needs to be controlled and accommodated and worked out so that the trial doesn't have to be cancelled and done over, and a client doesn't get represented poorly, and the person gets back on track and things work out.

In any event, bottom line, it's okay for the Florida Board of Bar Examiners to inquire about substance use issues. The new Questions 25 and 26 are consistent with that analysis of what's proper. The old Questions 25 and 26 no longer make any difference. We would be at the same place now that we are regardless of whether those questions had ever been asked.

Applying some of this to Mr. Hobbs, he is properly subject to follow-up inquiries. I think to some extent the argument is, and I think Mr. Dietz made this explicit during the argument here, the argument is, well, the Bar looked into this, that's all they need to do, they found out everything they need to find out, and Mr. Hobbs is fine, and there shouldn't be any more inquiry.

This record does not support that conclusion.

Mr. Hobbs had two DUI arrests. He had very high blood
IN THE SUPREME COURT OF FLORIDA

FLORIDA BOARD OF BAR EXAMINERS
RE AMENDMENTS TO RULES 2-13.1 AND
3-11 OF THE RULES OF THE SUPREME
COURT RELATING TO ADMISSIONS
TO THE BAR

Case No. SC20-850

EXHIBIT 7
Re: Ms. Portal Tester Applicant
File No: B64945
D.O.B: 10/13/1994
SSN: XXX-XX-xxxx

Dear Sir or Madam:

The Florida Board of Bar Examiners investigates the character and fitness of all applicants for admission to The Florida Bar. The Board is responsible for making recommendations to the Supreme Court of Florida regarding an applicant’s admission to the Bar.

The applicant listed above reports that you provided treatment for a mental condition that requires further inquiry before the Board can make its recommendation about the applicant’s admission to the Bar. The applicant has also executed the enclosed Authorization and Release to authorize you to provide information to the Board about the treatment.

The Board’s recommendation depends on whether an applicant satisfies the Essential Eligibility Requirements for practicing law in Florida. The Supreme Court has provided the Essential Eligibility Requirements, which are:

- Knowledge of the fundamental principles of law and their application
- Ability to reason logically and accurately analyze legal problems; and
- Ability to and the likelihood that, in the practice of law, the applicant will:
  - Comply with deadlines;
  - Communicate candidly and civilly with clients, attorneys, courts, and others;
  - Conduct financial dealings in a responsible, honest, and trustworthy manner;
  - Avoid acts that exhibit disregard for the rights, safety, or welfare of others;
  - Avoid acts that are illegal, dishonest, fraudulent, or deceitful; and,
  - Comply with the requirements of applicable state, local, and federal laws, rules, and regulations; any applicable order of a court or tribunal; and the Bar’s Rules of Professional Conduct.

The Board considers the Essential Eligibility Requirements to include the ability to be truthful even if doing so may be embarrassing, financially detrimental, or otherwise disadvantageous to the applicant. They also include the ability to diligently represent clients and handle money for others.

- To assist the Board in making its recommendation for this applicant, please respond to the items below at your earliest convenience.
- Describe the treatment that you provided to the applicant, including the reasons for starting treatment, the goals of treatment, and the applicant’s progress in achieving goals.
• Identify any diagnosis or diagnoses, and state whether the DSM-IV OR DSM 5 was the basis for the diagnosis.

• To the extent that you conducted any psychological testing, what tests did you conduct and do the results have any bearing on whether the applicant can meet the Essential Eligibility Requirements?

• Is there evidence that the applicant has, or has had, a condition that has impaired or could impair the applicant's ability to meet one or more of the Essential Eligibility Requirements? If yes, please explain, including:
  
  o Is the condition ongoing and does it currently impair the applicant’s ability to meet one or more of the Essential Eligibility Requirements?

  o Do you believe that the applicant can meet the Essential Eligibility Requirements if the applicant receives regular treatment while practicing law?

  o In light of the Essential Eligibility Requirements, is further treatment, monitoring, or supervision necessary for the applicant to practice law?

If you have any questions or need additional information to respond to this request, please call at (850) 681-5707 or (850) 488-0637. Your cooperation is greatly appreciated.

Sincerely yours,

Enclosure: Authorization and Release

Return envelope
IN THE SUPREME COURT OF FLORIDA

FLORIDA BOARD OF BAR EXAMINERS
RE AMENDMENTS TO RULES 2-13.1 AND 3-11 OF THE RULES OF THE SUPREME COURT RELATING TO ADMISSIONS TO THE BAR

----------------------------------

Case No. SC20-850

EXHIBIT 8
Substance-Related Disorders

Substance Use Disorders

Features

The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. As seen in Table 1, the diagnosis of a substance use disorder can be applied to all 10 classes included in this chapter except caffeine. For certain classes some symptoms are less salient, and in a few instances not all symptoms apply (e.g., withdrawal symptoms are not specified for phencyclidine use disorder, other hallucinogen use disorder, or inhalant use disorder).

An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders. The behavioral effects of these brain changes may be exhibited in the repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli. These persistent drug effects may benefit from long-term approaches to treatment.

Overall, the diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance. To assist with organization, Criterion A criteria can be considered to fit within overall groupings of impaired control, social impairment, risky use, and pharmacological criteria. Impaired control over substance use is the first criteria grouping (Criteria 1–4). The individual may take the substance in larger amounts or for a longer period than was originally intended (Criterion 1). The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use (Criterion 2). The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects (Criterion 3). In some instances of more severe substance use disorders, virtually all of the individual’s daily activities revolve around the substance. Craving (Criterion 4) is manifested by an intense desire or urge for the drug that may occur at any time but is more likely when in an environment where the drug previously was obtained or used. Craving has also been shown to involve classical conditioning and is associated with activation of specific reward structures in the brain. Craving is queried by asking if there has ever been a time when they had such strong urges to take the drug that they could not think of anything else. Current craving is often used as a treatment outcome measure because it may be a signal of impending relapse.

Social impairment is the second grouping of criteria (Criteria 5–7). Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home (Criterion 5). The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (Criterion 6). Important social, occupational, or recreational activities may be given up or reduced because of substance use (Criterion 7). The individual may withdraw from family activities and hobbies in order to use the substance.

Risky use of the substance is the third grouping of criteria (Criteria 8–9). This may take the form of recurrent substance use in situations in which it is physically hazardous (Criterion 8). The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (Criterion 9). The key issue in evaluating this criterion is not the existence of the problem, but rather the individual’s failure to abstain from using the substance despite the difficulty it is causing.
Functional Consequences of Substance/Medication-Induced Mental Disorders

The same consequences related to the relevant independent mental disorder (e.g., suicide attempts) are likely to apply to the substance/medication-induced mental disorders, but these are likely to disappear within 1 month after abstinence. Similarly, the same functional consequences associated with the relevant substance use disorder are likely to be seen for the substance-induced mental disorders.

Recording Procedures for Substance/Medication-Induced Mental Disorders

Coding notes and separate recording procedures for ICD-9-CM and ICD-10-CM codes for other specific substance/medication-induced mental disorders are provided in other chapters of the manual with disorders with which they share phenomenology (see the substance/medication-induced mental disorders in these chapters: “Schizophrenia Spectrum and Other Psychotic Disorders,” “Bipolar and Related Disorders,” “Depressive Disorders,” “Anxiety Disorders,” “Obsessive-Compulsive and Related Disorders,” “Sleep-Wake Disorders,” “Sexual Dysfunctions,” and “Neurocognitive Disorders”). Generally, for ICD-9-CM, if a mental disorder is induced by a substance use disorder, a separate diagnostic code is given for the specific substance use disorder, in addition to the code for the substance/medication-induced mental disorder. For ICD-10-CM, a single code combines the substance-induced mental disorder with the substance use disorder. A separate diagnosis of the comorbid substance use disorder is not given, although the name and severity of the specific substance use disorder (when present) are used when recording the substance/medication-induced mental disorder. ICD-10-CM codes are also provided for situations in which the substance/medication-induced mental disorder is not induced by a substance use disorder (e.g., when a disorder is induced by one-time use of a substance or medication). Additional information needed to record the diagnostic name of the substance/medication-induced mental disorder is provided in the section “Recording Procedures” for each substance/medication-induced mental disorder in its respective chapter.

Alcohol-Related Disorders

Alcohol Use Disorder
Alcohol Intoxication
Alcohol Withdrawal
Other Alcohol-Induced Disorders
Unspecified Alcohol-Related Disorder

Alcohol Use Disorder

Diagnostic Criteria

A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
Alcohol Use Disorder

3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.

4. Craving, or a strong desire or urge to use alcohol.

5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.

6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.

7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.

8. Recurrent alcohol use in situations in which it is physically hazardous.

9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

10. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
   b. A markedly diminished effect with continued use of the same amount of alcohol.

11. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for alcohol withdrawal, pp. 499–500).
   b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Specify if:

In early remission: After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, "Craving, or a strong desire or urge to use alcohol," may be met).

In sustained remission: After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, "Craving, or a strong desire or urge to use alcohol," may be met).

Specify if:

In a controlled environment: This additional specifier is used if the individual is in an environment where access to alcohol is restricted.

Code based on current severity: Note for ICD-10-CM codes: If an alcohol intoxication, alcohol withdrawal, or another alcohol-induced mental disorder is also present, do not use the codes below for alcohol use disorder. Instead, the comorbid alcohol use disorder is indicated in the 4th character of the alcohol-induced disorder code (see the coding note for alcohol intoxication, alcohol withdrawal, or a specific alcohol-induced mental disorder). For example, if there is comorbid alcohol intoxication and alcohol use disorder, only the alcohol intoxication code is given, with the 4th character indicating whether the comorbid alcohol use disorder is mild, moderate, or severe: F10.129 for mild alcohol use disorder with alcohol intoxication or F10.229 for a moderate or severe alcohol use disorder with alcohol intoxication.

Specify current severity:

305.00 (F10.10) Mild: Presence of 2–3 symptoms.
303.90 (F10.20) Moderate: Presence of 4–5 symptoms.
303.90 (F10.20) Severe: Presence of 6 or more symptoms.
Unspecified Caffeine-Related Disorder

292.9 (F15.99)

This category applies to presentations in which symptoms characteristic of a caffeine-related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any specific caffeine-related disorder or any of the disorders in the substance-related and addictive disorders diagnostic class.

Cannabis-Related Disorders

Cannabis Use Disorder
Cannabis Intoxication
Cannabis Withdrawal
Other Cannabis-Induced Disorders
Unspecified Cannabis-Related Disorder

Cannabis Use Disorder

Diagnostic Criteria

A. A problematic pattern of cannabis use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Cannabis is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control cannabis use.
3. A great deal of time is spent in activities necessary to obtain cannabis, use cannabis, or recover from its effects.
4. Craving, or a strong desire or urge to use cannabis.
5. Recurrent cannabis use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued cannabis use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of cannabis.
7. Important social, occupational, or recreational activities are given up or reduced because of cannabis use.
8. Recurrent cannabis use in situations in which it is physically hazardous.
9. Cannabis use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by cannabis.
10. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of cannabis to achieve intoxication or desired effect.
   b. Markedly diminished effect with continued use of the same amount of cannabis.
11. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for cannabis (refer to Criteria A and B of the criteria set for cannabis withdrawal, pp. 517–518).
b. Cannabis (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Specify if:

In early remission: After full criteria for cannabis use disorder were previously met, none of the criteria for cannabis use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, “Craving, or a strong desire or urge to use cannabis,” may be met).

In sustained remission: After full criteria for cannabis use disorder were previously met, none of the criteria for cannabis use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, “Craving, or a strong desire or urge to use cannabis,” may be present).

Specify if:

In a controlled environment: This additional specifier is used if the individual is in an environment where access to cannabis is restricted.

Code based on current severity: Note for ICD-10-CM codes: If a cannabis intoxication, cannabis withdrawal, or another cannabis-induced mental disorder is also present, do not use the codes below for cannabis use disorder. Instead, the comorbid cannabis use disorder is indicated in the 4th character of the cannabis-induced disorder code (see the coding note for cannabis intoxication, cannabis withdrawal, or a specific cannabis-induced mental disorder). For example, if there is comorbid cannabis-induced anxiety disorder and cannabis use disorder, only the cannabis-induced anxiety disorder code is given, with the 4th character indicating whether the comorbid cannabis use disorder is mild, moderate, or severe: F12.180 for mild cannabis use disorder with cannabis-induced anxiety disorder or F12.280 for a moderate or severe cannabis use disorder with cannabis-induced anxiety disorder.

Specify current severity:

305.20 (F12.10) Mild: Presence of 2–3 symptoms.
304.30 (F12.20) Moderate: Presence of 4–5 symptoms.
304.30 (F12.20) Severe: Presence of 6 or more symptoms.

Specifiers

“In a controlled environment” applies as a further specifier of remission if the individual is both in remission and in a controlled environment (i.e., in early remission in a controlled environment or in sustained remission in a controlled environment). Examples of these environments are closely supervised and substance-free jails, therapeutic communities, and locked hospital units.

Changing severity across time in an individual may also be reflected by changes in the frequency (e.g., days of use per month or times used per day) and/or dose (e.g., amount used per episode) of cannabis, as assessed by individual self-report, report of knowledgeable others, clinician’s observations, and biological testing.

Diagnostic Features

Cannabis use disorder and the other cannabis-related disorders include problems that are associated with substances derived from the cannabis plant and chemically similar synthetic compounds. Over time, this plant material has accumulated many names (e.g., weed, pot, herb, grass, reefer, mary jane, dagga, dope, bhang, skunk, boom, gangster, kne, and ganja). A concentrated extraction of the cannabis plant that is also commonly used is hashish. Cannabis is the generic and perhaps the most appropriate scientific term for the psychoactive substance(s) derived from the plant, and as such it is used in this manual to refer to all forms of cannabis-like substances, including synthetic cannabinoid compounds.
Opioid Use Disorder

Diagnostic Criteria

A. A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
   b. A markedly diminished effect with continued use of the same amount of an opioid.
   Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.
11. Withdrawal, as manifested by either of the following:
   a. The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal, pp. 547–548).
   b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.
   Note: This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Specify if:

In early remission: After full criteria for opioid use disorder were previously met, none of the criteria for opioid use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, "Craving, or a strong desire or urge to use opioids," may be met).

In sustained remission: After full criteria for opioid use disorder were previously met, none of the criteria for opioid use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, "Craving, or a strong desire or urge to use opioids," may be met).

Specify if:

On maintenance therapy: This additional specifier is used if the individual is taking a prescribed agonist medication such as methadone or buprenorphine and none of the criteria for opioid use disorder have been met for that class of medication (except tolerance to, or withdrawal from, the agonist). This category also applies to those individu-
uals being maintained on a partial agonist, an agonist/antagonist, or a full antagonist such as oral naltrexone or depot naltrexone.

In a controlled environment: This additional specifier is used if the individual is in an environment where access to opioids is restricted.

Coding based on current severity: Note for ICD-10-CM codes: If an opioid intoxication, opioid withdrawal, or another opioid-induced mental disorder is also present, do not use the codes below for opioid use disorder. Instead, the comorbid opioid use disorder is indicated in the 4th character of the opioid-induced disorder code (see the coding note for opioid intoxication, opioid withdrawal, or a specific opioid-induced mental disorder). For example, if there is comorbid opioid-induced depressive disorder and opioid use disorder, only the opioid-induced depressive disorder code is given, with the 4th character indicating whether the comorbid opioid use disorder is mild, moderate, or severe: F11.14 for mild opioid use disorder with opioid-induced depressive disorder or F11.24 for a moderate or severe opioid use disorder with opioid-induced depressive disorder.

Specify current severity:

- 305.50 (F11.10) Mild: Presence of 2–3 symptoms.
- 304.00 (F11.20) Moderate: Presence of 4–5 symptoms.
- 304.00 (F11.20) Severe: Presence of 6 or more symptoms.

Specifiers

The “on maintenance therapy” specifier applies as a further specifier of remission if the individual is both in remission and receiving maintenance therapy. “In a controlled environment” applies as a further specifier of remission if the individual is both in remission and in a controlled environment (i.e., in early remission in a controlled environment or in sustained remission in a controlled environment). Examples of these environments are closely supervised and substance-free jails, therapeutic communities, and locked hospital units.

Changing severity across time in an individual is also reflected by reductions in the frequency (e.g., days of use per month) and/or dose (e.g., injections or number of pills) of an opioid, as assessed by the individual’s self-report, report of knowledgeable others, clinician’s observations, and biological testing.

Diagnostic Features

Opioid use disorder includes signs and symptoms that reflect compulsive, prolonged self-administration of opioid substances that are used for no legitimate medical purpose or, if another medical condition is present that requires opioid treatment, that are used in doses greatly in excess of the amount needed for that medical condition. (For example, an individual prescribed analgesic opioids for pain relief at adequate dosing will use significantly more than prescribed and not only because of persistent pain.) Individuals with opioid use disorder tend to develop such regular patterns of compulsive drug use that daily activities are planned around obtaining and administering opioids. Opioids are usually purchased on the illegal market but may also be obtained from physicians by falsifying or exaggerating general medical problems or by receiving simultaneous prescriptions from several physicians. Health care professionals with opioid use disorder will often obtain opioids by writing prescriptions for themselves or by diverting opioids that have been prescribed for patients or from pharmacy supplies. Most individuals with opioid use disorder have significant levels of tolerance and will experience withdrawal on abrupt discontinuation of opioid substances. Individuals with opioid use disorder often develop conditioned responses to drug-related stimuli (e.g., craving on seeing any heroin powder–like substance)—a phenomenon that occurs with most drugs that cause intense psychological changes. These responses probably contribute to relapse, are difficult to extinguish, and typically persist long after detoxification is completed.
Stimulant-Related Disorders

Stimulant Use Disorder
Stimulant Intoxication
Stimulant Withdrawal
Other Stimulant-Induced Disorders
Unspecified Stimulant-Related Disorder

Stimulant Use Disorder

Diagnostic Criteria

A. A pattern of amphetamine-type substance, cocaine, or other stimulant use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. The stimulant is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control stimulant use.
3. A great deal of time is spent in activities necessary to obtain the stimulant, use the stimulant, or recover from its effects.
4. Craving, or a strong desire or urge to use the stimulant.
5. Recurrent stimulant use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued stimulant use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the stimulant.
7. Important social, occupational, or recreational activities are given up or reduced because of stimulant use.
8. Recurrent stimulant use in situations in which it is physically hazardous.
9. Stimulant use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the stimulant.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of the stimulant to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of the stimulant.

Note: This criterion is not considered to be met for those taking stimulant medications solely under appropriate medical supervision, such as medications for attention-deficit/hyperactivity disorder or narcolepsy.

11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for the stimulant (refer to Criteria A and B of the criteria set for stimulant withdrawal, p. 569).
    b. The stimulant (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.
Note: This criterion is not considered to be met for those taking stimulant medications solely under appropriate medical supervision, such as medications for attention-deficit/hyperactivity disorder or narcolepsy.

Specify if:

In early remission: After full criteria for stimulant use disorder were previously met, none of the criteria for stimulant use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, “Craving, or a strong desire or urge to use the stimulant,” may be met).

In sustained remission: After full criteria for stimulant use disorder were previously met, none of the criteria for stimulant use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, “Craving, or a strong desire or urge to use the stimulant,” may be met).

Specify if:

In a controlled environment: This additional specifier is used if the individual is in an environment where access to stimulants is restricted.

Coding based on current severity: Note for ICD-10-CM codes: If an amphetamine intoxication, amphetamine withdrawal, or another amphetamine-induced mental disorder is also present, do not use the codes below for amphetamine use disorder. Instead, the comorbid amphetamine use disorder is indicated in the 4th character of the amphetamine-induced disorder code (see the coding note for amphetamine intoxication, amphetamine withdrawal, or a specific amphetamine-induced mental disorder). For example, if there is comorbid amphetamine-type or other stimulant-induced depressive disorder and amphetamine-type or other stimulant use disorder, only the amphetamine-type or other stimulant-induced depressive disorder code is given, with the 4th character indicating whether the comorbid amphetamine-type or other stimulant use disorder is mild, moderate, or severe: F15.14 for mild amphetamine-type or other stimulant use disorder with amphetamine-type or other stimulant-induced depressive disorder or F15.24 for a moderate or severe amphetamine-type or other stimulant use disorder with amphetamine-type or other stimulant-induced depressive disorder. Similarly, if there is comorbid cocaine-induced depressive disorder and cocaine use disorder, only the cocaine-induced depressive disorder code is given, with the 4th character indicating whether the comorbid cocaine use disorder is mild, moderate, or severe: F14.14 for mild cocaine use disorder with cocaine-induced depressive disorder or F14.24 for a moderate or severe cocaine use disorder with cocaine-induced depressive disorder.

Specify current severity:

Mild: Presence of 2–3 symptoms.

305.70 (F15.10) Amphetamine-type substance
305.60 (F14.10) Cocaine
305.70 (F15.10) Other or unspecified stimulant

Moderate: Presence of 4–5 symptoms.

304.40 (F15.20) Amphetamine-type substance
304.20 (F14.20) Cocaine
304.40 (F15.20) Other or unspecified stimulant

Severe: Presence of 6 or more symptoms.

304.40 (F15.20) Amphetamine-type substance
304.20 (F14.20) Cocaine
304.40 (F15.20) Other or unspecified stimulant
IN THE SUPREME COURT OF FLORIDA

FLORIDA BOARD OF BAR EXAMINERS )
RE AMENDMENTS TO RULES 2-13.1 AND )
3-11 OF THE RULES OF THE SUPREME )
COURT RELATING TO ADMISSIONS )
TO THE BAR )

------------------------------------------ )

Case No. SC20-850

EXHIBIT 9
Schizophrenia: brief psychotic disorder; delusional disorder; other specified or unspecified schizophrenia spectrum and other psychotic disorder; schizotypal, schizoid, or paranoid personality disorders; autism spectrum disorder; disorders presenting in childhood with disorganized speech; attention-deficit/hyperactivity disorder; obsessive-compulsive disorder; posttraumatic stress disorder; and traumatic brain injury.

Since the diagnostic criteria for schizoaffective disorder and schizophrenia differ primarily in duration of illness, the discussion of the differential diagnosis of schizophrenia also applies to schizoaffective disorder.

Brief psychotic disorder. Schizoaffective disorder differs in duration from brief psychotic disorder, which has a duration of less than 1 month.

Schizophrenia

Diagnostic Criteria

295.90 (F20.9)

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. Delusions.
2. Hallucinations.
3. Disorganized speech (e.g., frequent derailment or incoherence).
4. Grossly disorganized or catatonic behavior.
5. Negative symptoms (i.e., diminished emotional expression or avolition).

B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).

C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

Specify if:
The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.

First episode, currently in acute episode: First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An acute episode is a time period in which the symptom criteria are fulfilled.
**Schizophrenia Spectrum and Other Psychotic Disorders**

**First episode, currently in partial remission:** Partial remission is a period of time during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.

**First episode, currently in full remission:** Full remission is a period of time after a previous episode during which no disorder-specific symptoms are present.

**Multiple episodes, currently in acute episode:** Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission, and a minimum of one relapse).

**Multiple episodes, currently in partial remission**

**Multiple episodes, currently in full remission**

**Continuous:** Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course.

**Unspecified**

Specify if:

**With catatonia** (refer to the criteria for catatonia associated with another mental disorder, pp. 119–120, for definition).

**Coding note:** Use additional code 293.89 (F06.1) catatonia associated with schizophrenia to indicate the presence of the comorbid catatonia.

**Specify current severity:**

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter “Assessment Measures.”)

**Note:** Diagnosis of schizophrenia can be made without using this severity specifier.

**Diagnostic Features**

The characteristic symptoms of schizophrenia involve a range of cognitive, behavioral, and emotional dysfunctions, but no single symptom is pathognomonic of the disorder. The diagnosis involves the recognition of a constellation of signs and symptoms associated with impaired occupational or social functioning. Individuals with the disorder will vary substantially on most features, as schizophrenia is a heterogeneous clinical syndrome.

At least two Criterion A symptoms must be present for a significant portion of time during a 1-month period or longer. At least one of these symptoms must be the clear presence of delusions (Criterion A1), hallucinations (Criterion A2), or disorganized speech (Criterion A3). Grossly disorganized or catatonic behavior (Criterion A4) and negative symptoms (Criterion A5) may also be present. In those situations in which the active-phase symptoms remit within a month in response to treatment, Criterion A is still met if the clinician estimates that they would have persisted in the absence of treatment.

Schizophrenia involves impairment in one or more major areas of functioning (Criterion B). If the disturbance begins in childhood or adolescence, the expected level of function is not attained. Comparing the individual with unaffected siblings may be helpful. The dysfunction persists for a substantial period during the course of the disorder and does not appear to be a direct result of any single feature. Avolition (i.e., reduced drive to pursue goal-directed behavior; Criterion A5) is linked to the social dysfunction described under Criterion B. There is also strong evidence for a relationship between cognitive impairment (see the section “Associated Features Supporting Diagnosis” for this disorder) and functional impairment in individuals with schizophrenia.
Bipolar and related disorders are separated from the depressive disorders in DSM-5 and placed between the chapters on schizophrenia spectrum and other psychotic disorders and depressive disorders in recognition of their place as a bridge between the two diagnostic classes in terms of symptomatology, family history, and genetics. The diagnoses included in this chapter are bipolar I disorder, bipolar II disorder, cyclothymic disorder, substance/medication-induced bipolar and related disorder, bipolar and related disorder due to another medical condition, other specified bipolar and related disorder, and unspecified bipolar and related disorder.

The bipolar I disorder criteria represent the modern understanding of the classic manic-depressive disorder or affective psychosis described in the nineteenth century, differing from that classic description only to the extent that neither psychosis nor the lifetime experience of a major depressive episode is a requirement. However, the vast majority of individuals whose symptoms meet the criteria for a fully syndromal manic episode also experience major depressive episodes during the course of their lives.

Bipolar II disorder, requiring the lifetime experience of at least one episode of major depression and at least one hypomanic episode, is no longer thought to be a "milder" condition than bipolar I disorder, largely because of the amount of time individuals with this condition spend in depression and because the instability of mood experienced by individuals with bipolar II disorder is typically accompanied by serious impairment in work and social functioning.

The diagnosis of cyclothymic disorder is given to adults who experience at least 2 years (for children, a full year) of both hypomanic and depressive periods without ever fulfilling the criteria for an episode of mania, hypomania, or major depression.

A large number of substances of abuse, some prescribed medications, and several medical conditions can be associated with manic-like phenomena. This fact is recognized in the diagnoses of substance/medication-induced bipolar and related disorder and bipolar and related disorder due to another medical condition.

The recognition that many individuals, particularly children and, to a lesser extent, adolescents, experience bipolar-like phenomena that do not meet the criteria for bipolar I, bipolar II, or cyclothymic disorder is reflected in the availability of the other specified bipolar and related disorder category. Indeed, specific criteria for a disorder involving short-duration hypomania are provided in Section III in the hope of encouraging further study of this disorder.

### Bipolar I Disorder

#### Diagnostic Criteria

For a diagnosis of bipolar I disorder, it is necessary to meet the following criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes.
Manic Episode
A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
   1. Inflated self-esteem or grandiosity.
   2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
   3. More talkative than usual or pressure to keep talking.
   4. Flight of ideas or subjective experience that thoughts are racing.
   5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
   6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
   7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.
Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.
Note: Criteria A–D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

Hypomanic Episode
A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.
B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:
   1. Inflated self-esteem or grandiosity.
   2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
   3. More talkative than usual or pressure to keep talking.
   4. Flight of ideas or subjective experience that thoughts are racing.
   5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
   6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
   7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
Bipolar I Disorder

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).

Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

Note: Criteria A–F constitute a hypomanic episode. Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Criteria A–C constitute a major depressive episode. Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense
toms of mania, such as rapid speech, racing thoughts, distractibility, and less need for sleep. The “double counting” of symptoms toward both ADHD and bipolar disorder can be avoided if the clinician clarifies whether the symptom(s) represents a distinct episode.

PERSONALITY DISORDERS. Personality disorders such as borderline personality disorder may have substantial symptomatic overlap with bipolar disorders, since mood lability and impulsivity are common in both conditions. Symptoms must represent a distinct episode, and the noticeable increase over baseline required for the diagnosis of bipolar disorder must be present. A diagnosis of a personality disorder should not be made during an untreated mood episode.

DISORDERS WITH PROMINENT IRRITABILITY. In individuals with severe irritability, particularly children and adolescents, care must be taken to apply the diagnosis of bipolar disorder only to those who have had a clear episode of mania or hypomania—that is, a distinct time period, of the required duration, during which the irritability was clearly different from the individual’s baseline and was accompanied by the onset of Criterion B symptoms. When a child’s irritability is persistent and particularly severe, the diagnosis of disruptive mood dysregulation disorder would be more appropriate. Indeed, when any child is being assessed for mania, it is essential that the symptoms represent a clear change from the child’s typical behavior.

COMORBIDITY

Co-occurring mental disorders are common, with the most frequent disorders being any anxiety disorder (e.g., panic attacks, social anxiety disorder [social phobia], specific phobia), occurring in approximately three-fourths of individuals; ADHD, any disruptive, impulse-control, or conduct disorder (e.g., intermittent explosive disorder, oppositional defiant disorder, conduct disorder), and any substance use disorder (e.g., alcohol use disorder) occur in over half of individuals with bipolar I disorder. Adults with bipolar I disorder have high rates of serious and/or untreated co-occurring medical conditions. Metabolic syndrome and migraine are more common among individuals with bipolar disorder than in the general population. More than half of individuals whose symptoms meet criteria for bipolar disorder have an alcohol use disorder, and those with both disorders are at greater risk for suicide attempt.

**Bipolar II Disorder**

**Diagnostic Criteria**

296.89 (F31.81)

For a diagnosis of bipolar II disorder, it is necessary to meet the following criteria for a current or past hypomanic episode and the following criteria for a current or past major depressive episode:

**Hypomanic Episode**

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree:

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
Bipolar II Disorder

4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
D. The disturbance in mood and the change in functioning are observable by others.
E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment).

Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to a medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, a suicide attempt, or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The episode is not attributable to the physiological effects of a substance or another medical condition.
Note: Criteria A–C above constitute a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual’s history and the cultural norms for the expression of distress in the context of loss.

Bipolar II Disorder

A. Criteria have been met for at least one hypomanic episode (Criteria A–F under “Hypomanic Episode” above) and at least one major depressive episode (Criteria A–C under “Major Depressive Episode” above).

B. There has never been a manic episode.

C. The occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

D. The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Coding and Recording Procedures

Bipolar II disorder has one diagnostic code: 296.89 [F31.81]. Its status with respect to current severity, presence of psychotic features, course, and other specifiers cannot be coded but should be indicated in writing (e.g., 296.89 [F31.81] bipolar II disorder, current episode depressed, moderate severity, with mixed features; 296.89 [F31.81] bipolar II disorder, most recent episode depressed, in partial remission).

Specify current or most recent episode:

Hypomanic
Depressed

Specify if:

With anxious distress (p. 149)
With mixed features (pp. 149–150)

1In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in a MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of a MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of a MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in a MDE. In grief, self-esteem is generally preserved, whereas in a MDE feelings of worthlessness and self-loathing are common. If self-deprecatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about “joining” the deceased, whereas in a MDE such thoughts are focused on ending one’s own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

Diagnosis Fe

Bipolar II disorder is consisting of one or more Episode") and at least aode”). The major dep

With rapid cycling
With mood-congruent
With mood-incongruent
With catatonia (p.
With peripartum
With seasonal pattern
episodes.

Specify course if full or:
In partial remission
In full remission ()

Specify severity if full or:
Mild (p. 154)
Moderate (p. 154)
Severe (p. 154)

Clinical information ful in establishing th
should receive one of those diagnoses rather than disruptive mood dysregulation disorder. Children with disruptive mood dysregulation disorder may have symptoms that also meet criteria for an anxiety disorder and can receive both diagnoses, but children whose irritability is manifest only in the context of exacerbation of an anxiety disorder should receive the relevant anxiety disorder diagnosis rather than disruptive mood dysregulation disorder. In addition, children with autism spectrum disorders frequently present with temper outbursts when, for example, their routines are disturbed. In that instance, the temper outbursts would be considered secondary to the autism spectrum disorder, and the child should not receive the diagnosis of disruptive mood dysregulation disorder.

**Intermittent explosive disorder.** Children with symptoms suggestive of intermittent explosive disorder present with instances of severe temper outbursts, much like children with disruptive mood dysregulation disorder. However, unlike disruptive mood dysregulation disorder, intermittent explosive disorder does not require persistent disruption in mood between outbursts. In addition, intermittent explosive disorder requires only 3 months of active symptoms, in contrast to the 12-month requirement for disruptive mood dysregulation disorder. Thus, these two diagnoses should not be made in the same child. For children with outbursts and intercurrent, persistent irritability, only the diagnosis of disruptive mood dysregulation disorder should be made.

**Comorbidity**

Rates of comorbidity in disruptive mood dysregulation disorder are extremely high. It is rare to find individuals whose symptoms meet criteria for disruptive mood dysregulation disorder alone. Comorbidity between disruptive mood dysregulation disorder and other DSM-defined syndromes appears higher than for many other pediatric mental illnesses; the strongest overlap is with oppositional defiant disorder. Not only is the overall rate of comorbidity high in disruptive mood dysregulation disorder, but also the range of comorbid illnesses appears particularly diverse. These children typically present to the clinic with a wide range of disruptive behavior, mood, anxiety, and even autism spectrum symptoms and diagnoses. However, children with disruptive mood dysregulation disorder should not have symptoms that meet criteria for bipolar disorder, as in that context, only the bipolar disorder diagnosis should be made. If children have symptoms that meet criteria for oppositional defiant disorder or intermittent explosive disorder and disruptive mood dysregulation disorder, only the diagnosis of disruptive mood dysregulation disorder should be assigned. Also, as noted earlier, the diagnosis of disruptive mood dysregulation disorder should not be assigned if the symptoms occur only in an anxiety-provoking context, when the routines of a child with autism spectrum disorder or obsessive-compulsive disorder are disturbed, or in the context of a major depressive episode.

**Major Depressive Disorder**

**Diagnostic Criteria**

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

**Note:** Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). **(Note: In children and adolescents, can be irritable mood.)**

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A–C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in MDE. In grief, self-esteem is generally preserved, whereas in MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in MDE such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.
IN THE SUPREME COURT OF FLORIDA

FLORIDA BOARD OF BAR EXAMINERS
RE AMENDMENTS TO RULES 2-13.1 AND 3-11 OF THE RULES OF THE SUPREME COURT RELATING TO ADMISSIONS TO THE BAR

Case No. SC20-850

EXHIBIT 10
ORDER ON SUMMARY JUDGMENT

The plaintiff Julius Hobbs asserts claims under the Americans with Disabilities Act against the Florida Board of Bar Examiners and its executive director in her official capacity. This order confirms and briefly summarizes the ruling announced on the record of a hearing on February 22, 2019. Trial of the remaining claims is imminent. A plenary order will be entered after the trial. A more detailed order at this time would serve no purpose.

Mr. Hobbs served in combat before returning to the United States and entering law school. While a first-year student, he submitted to the Florida Board of Bar Examiners a “Florida Registrant Bar Application.” The Board allows and
indeed encourages first-year students to do this if they intend to apply for membership in the Florida Bar upon graduation.

Mr. Hobbs had been diagnosed with adjustment disorder and alcohol use disorder. The Board undertook an investigation and eventually insisted that Mr. Hobbs submit to an extensive evaluation by one of eleven doctors specified by the Board. The Board said Mr. Hobbs would be required to pay for the evaluation. The Board said Mr. Hobbs could contest the requirement at a hearing but would have to pay both a hearing fee and for the cost of a transcript. Deeming these requirements unlawful, Mr. Hobbs withdrew his application and filed this lawsuit. He intends to apply for admission to the Bar upon graduation from law school later this year.

The case was narrowed by earlier rulings. Still pending as of February 22 were cross-motions for summary judgment and a motion to dismiss on jurisdictional grounds. The ruling announced on the record narrowed the issues but did not resolve the entire case.

As it turns out, the Board’s contested actions relate only to Mr. Hobbs’s alcohol use and related diagnosis, not to any adjustment disorder. Mr. Hobbs has twice been arrested, though not convicted, for driving under the influence of alcohol. Two treating professionals diagnosed him with mild alcohol use disorder.

The defendants are correct that Mr. Hobbs can challenge in this action only practices that are likely to affect him when he again applies for membership in the
Florida Bar. It is certain, or nearly so, that he will apply. He has standing to challenge practices that will again affect him. His challenge to those practices is not moot.

The ADA applies to a person who has a physical or mental impairment that substantially limits a major life activity. 42 U.S.C. § 12102(1)(A). Mr. Hobbs denies that he has such an impairment. But the ADA also protects a person who has “a record of such an impairment,” id. § 12102(1)(B), or who is “regarded as” having such an impairment, id. § 12102(1)(C). A person is “regarded as” having an impairment if the person is subjected to a prohibited action “because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.” 42 U.S.C. § 12102(3)(A). The record would support a finding that Mr. Hobbs has a record of a covered impairment or that the Board regard him as having such an impairment.

The Board reasonably concluded that Mr. Hobbs’s history of DUI arrests, together with the other information available to the Board, warranted further investigation. And this remains true. Mr. Hobbs has a regular practice of drinking substantial amounts of beer—more than his last treating professional recommended. To be sure, since his last DUI arrest, he has performed well in school, and there is no evidence that he has suffered adverse effects of alcohol use. Extensive alcohol use and even alcoholism, without more, do not preclude a person
from practicing law. But they are matters the Board may investigate. The ADA does not prohibit the Board from continuing its investigation or from requiring Mr. Hobbs to submit to a professional evaluation of appropriate scope.

A compelled evaluation may address only matters bearing on fitness to practice law. This may include alcohol use or abuse and related mental health. An evaluation may include those parts of a physical examination that relate to these subjects. The evaluation may include psychological testing only to the extent the testing is likely to produce information that bears on the relationship between any alcohol use or abuse and fitness to practice law. That a consultant recommends a procedure does not insulate the procedure from review under the ADA. Nor is it necessarily dispositive that a professional treating a willing patient routinely collects information or conducts tests of the same kind. Patients often willingly disclose information to treating professionals that the patients do not wish to disclose to the government—and that the patients cannot be compelled to disclose to the government without a reason.

This record does not resolve without genuine dispute the question whether the ADA prohibits parts of the evaluation the Board demanded before Mr. Hobbs withdrew his application and is likely to demand again. Nor does the record resolve without genuine dispute the question whether Mr. Hobbs can be required to pay for the evaluation.
For these reasons,

IT IS ORDERED:

1. The plaintiff’s summary-judgment motion, ECF No. 75, is denied.

2. The defendants’ motion to dismiss, ECF No. 78, and summary-judgment motion, ECF No. 81, are granted in part and denied in part.

3. The issues are narrowed as set out in this order and on the record of the February 22 hearing.

4. I do not direct the entry of judgment under Federal Rule of Civil Procedure 54(b).

SO ORDERED on February 25, 2019.

s/Robert L. Hinkle
United States District Judge