Chronic Stress, Trauma, Mental Health and Addiction in the Legal Profession

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I. Introduction and Overview: Stress and the Legal Profession

What is STRESS? It's a series of physiological responses and adaptations to a real or imagined threat or demand. Stress occurs when the pressures experienced by the individual are perceived by them as exceeding their capacity to deal with them, in a situation where coping is perceived as important. It can be good or bad, healthy or unhealthy.

Eustress is beneficial to us. It charges us up and allows us to meet challenges head on and gives us the necessary energy to do so. Distress is the chronic feeling of being overwhelmed, oppressed and behind in tasks. There is a sense that life is controlling us and we see little hope for relief, all of which can have unhealthy results. Regardless of how beneficial our stress may be, our bodies react. Our heart beats faster, our pupils dilate, our digestive and immune systems shut down and the hormones adrenaline and cortisol are released. In the short term, this helps us, but over time, the chronic presence of these changes will hurt us with results like higher blood pressure, more frequent illnesses, and coping mechanisms that are reactions not solutions.

A. Sources of Stress for Lawyers

The legal profession presents many opportunities to take on someone else's problems, and it presents unique sources of stress. There are realities in the everyday practice of a lawyer, regardless of their area of practice and regardless of whether they litigate, are engaged in transactional work or perhaps even work in a non-traditional career.

1. Rules Based Morality. The way we help people; the way we make a difference for our clients, is to make their set of circumstances fit a set of rules. We apply the law to the facts. From that can come a tendency to see everything in terms of how we believe it should fit into the world as we see it. And we will use our finely tuned persuasive and argumentative skills to insist upon it.
2. Perfectionism. We are told from the beginning in law school that mistakes will cost us. From the humiliation of the Socratic method when we are not prepared (or even if we are) to cases where professional discipline occurs because of missing deadlines and important details, we learn that we must not fail. When we learn perfectionism it is not limited to our work life. Any possible failure becomes an opportunity for intense self scrutiny and every move we make can become defined by winning or losing.
3. Pessimism. We may be the only profession that succeeds because we can anticipate the worst that might happen. Yet, how else do we solve problems? The pessimist not only sees what can go wrong but is more likely to view bad things as permanent and unchangeable. Optimists see opportunity.
4. Vicarious Trauma. This may be our greatest risk. We are not the immediate first responders to the worst things that happen in our world, but we may spend more time with the details and people who experience the direct trauma than anyone else. Yet our need to be perfect (don't let them see you sweat) and pessimistic can make us even more vulnerable to the effects of this trauma. We don't show our weakness, we don't process and we hold it inside until we burnout. Yet studies have shown that simply talking about what one experienced, even and especially secondarily, can reduce the effects of the trauma.

B. How do you know that you are over-stressed?

1. Physical Signs

- Throbbing in Chest
- Indigestion
- Breathlessness
- Tiredness and Fatigue
- Aches and Pains
- Frequent Infections
- Headaches
- High blood pressure

2. Emotional Signs

- Mood Swings
- Lack of Enthusiasm
- Guilt
- Lack of Concentration
- Anxiety
- Lack of Confidence
- Loss of Self Esteem

3. Behavioral Signs

- Accident Proneness
- Increased smoking/drinking/drugging
- Appetite Changes
- Irritability
- Change in Sleeping Patterns
- Change in Working Patterns
- Chronic Lateness/Procrastination
- Poor Hygiene
- Clumsiness

C. Our Response to Stress

Many try to cope with stress by turning to tobacco, alcohol, caffeine, herbal remedies, legal or illegal drugs as well as diversions like gambling, internet shopping, games and porn or compulsive eating. These substances and processes may mask some of the symptoms of stress and provide temporary relief but they don't help in the development of effective stress-management techniques. They may harm your physical health, weakening resistance to stress even further and cause additional stressful complications in life.

II. Impact of Addiction and Dependency and the Practice of Law

A. Estimates of alcoholism and dependency among lawyers – Generally

1. A joint project of the ABA Commission on Lawyer Assistance Programs and the Hazelden Betty Ford Foundation looked at Substance use and mental health issues in attorneys. This is the first time that a study of this type has been conducted on a national basis. Among the findings: 20.6% of respondents met criteria for alcohol use disorder. Krill, Patrick, Johnson, Ryan, Albert, Linda, *The Prevalence Of Substance use and Other mental Health Concerns Among American Attorneys*, Journal of Addiction Medicine: January/February 2016

   Previously, the ABA estimated that 15 to 20 percent of U.S. lawyers suffer from alcoholism or chemical dependency. "Surveys reveal that as high as 18 percent of all lawyers—nearly one in five—will personally develop problems related to substance misuse. That figure does not include the number of partners, associates, family members, and colleagues who will be forced to deal with the effects of addiction as a result of an impaired attorney they know or work with." John W. Clark, Jr., *We're From the Bar and We're here to Help You*, G.P. Solo Magazine (A.B.A. Pub.; v.21, no. 7: October/November 2004).

2. "[M]ore than 20 percent of the male Washington lawyers are scoring above the cutoff for probable alcohol related problems for the current year…. This percentage is over twice the approximately 9% alcohol abuse and/or dependency prevalence rates estimated for adults in the United States." "Approximately 70% of the lawyers in the sample are likely to develop alcohol problems in their lifetime." Connie J.A. Beck, et al., *Lawyer Distress: Alcohol-Related Problems and Other Psychological Concerns Among a Sample of Practicing Lawyers*, 10 Jour. of Law & Health 1, 50-51 (1995-96).

3. A study in Arizona revealed that 26% of the practicing attorneys were concerned about their alcohol use. G. Andrew H. Benjamin, et al.; *The Prevalence of Depression, Alcohol Abuse, and Cocaine Abuse Among United States Lawyers*; 13 Intern'l. Jour. of Law and Psychiatry 233, 240 (1990).

4. Gender Differences – Women are less likely to have substance use problems in general and as attorneys. Most often, women don't seek help until the disease is more advanced than for men, partly because of stigma attached to public intoxication for women.

B. Impact of alcoholism on discipline and malpractice claims

1. Alcohol misuse has been estimated to be a factor in at least 27 percent of the attorney discipline cases in the United States. G. Andrew, H. Benjamin, et al.; *supra* at 243.

2. "A study conducted in 1986, by the Oregon State Bar Professional Liability Fund (OSBPLF) showed the relationship of alcohol and drug problems with malpractice claims. OSBPLF reviewed the records of 100 consecutive lawyers who entered its lawyer's assistance program. Sixty percent of the lawyers had malpractice suits filed against them while suffering from substance abuse." G. Andrew H. Benjamin, et al.; *supra* at 244.

3. Minnesota's experience

   a. The number of probationary cases where chemical dependency was a component of the agreement was10.8% as of December 31, 2013. *Annual Report of the Lawyers Professional Responsibility Board and the Office of Lawyers Professional Responsibility*

(July 2012). In recent years the numbers have varied between 16.4% (2007), 8.4% (2008) and 11% (2010).

b. The actual impact of chemical misuse is much higher. Mike Hoover, former Director of the Office of Lawyers Professional Responsibility (OLPR), stated that his staff expected to find chemical dependency in at least half the discipline cases they investigated. Amy Lindgren, *Counting the Costs: Substance Abuse in the Legal Profession*, Bench and Bar of Minnesota, Vo. 47, no 3, p. 22 (March 1990). Anecdotally, OLPR staff estimates the present rate at about one-third.

c. The difference between these figures is partly caused by attorneys denying how their chemical use affects their practice. Many misconduct allegations involve behaviors closely related to the symptoms of chemical misuse and dependency. Marcia E. Femrite, "Addicted Attorneys in Disciplinary Proceedings", *Michigan Bar Journal*, February 1991, p. 152. For example, over half of all OLPR open probationary files involved competence, diligence or non-communication. *Annual Report*, supra at 10.

III. Understanding Substance Misuse

A. Addiction

1. Why do people take drugs?
2. What it is.
3. How it develops.
4. Risk factors. These include genetics, age at first use, chronic stress, physical or mental health, culture, history of abuse and unresolved emotions.

B. Definitions:

The disease of addiction

1. The American Medical Association (AMA) defines "alcoholism" as a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Robert M. Morse and Daniel K. Flavin, "The Definition of Alcoholism." *Journal of the American Medical Association*, August 26, 1992, Vol. 268, No. 8, pp. 1012 – 1014.

   a. Primary
   b. Genetic
   c. Psychosocial
   d. Environmental
   e. Often Progressive and Fatal

f. Impaired Control

g. Preoccupation

h. Denial

2. The American Society of Addiction Medicine (ASAM) defines "addiction" as a disease process characterized by the continued use of a specific psychoactive substance despite physical, psychological or social harm. *Principles of Addiction Medicine*, 2d ed., 1968.

3. The American Psychiatric Association's Diagnostic and Statistical Manual (DSM V) 2013, has combined the prior categories of "substance dependence" and "substance abuse" into the category of "Substance Use Disorder. Substance use disorders are patterns of symptoms resulting from use of a substance which the individual continues to take, despite experiencing problems as a result.

   Substance use disorders span a wide variety of problems arising from substance use, and cover 11 different criteria. Assessors will base severity on the number of criteria found to exist within a 12 month period. 2–3 criteria indicate a mild disorder, 4–5 criteria indicate a moderate disorder and 6 or more indicate a severe disorder

   1. The substance is taken in larger amounts or for longer than intended.
   2. A desire or unsuccessful efforts to cut down, control or stop using the substance.
   3. Spending significant time acquiring, using, or recovering from use of the substance.
   4. Cravings or a strong desire to use the substance.
   5. Failure to fulfill major obligations at work, home or school, because of recurrent substance use.
   6. Continuing to use, despite the occurrence of persistent or recurrent problems in social or interpersonal relationships.
   7. Reducing involvement in or giving up important social, occupational or recreational activities because of substance use.
   8. Recurrent use even when it is physically hazardous.
   9. Continued use despite knowing of a persistent or recurring physical or psychological problem that may have been caused or exacerbated by the substance.
   10. Requiring more of the substance to achieve intoxication or the desired effect or s diminished effect with the same amount of use (tolerance).
   11. Development of withdrawal symptoms that are characteristic of the substance or use of the substance to avoid withdrawal symptoms.

   The DSM-V also lists substance-induced disorders which include intoxication, withdrawal, substance induced mental disorders, including substance induced psychosis, substance induced bipolar and related disorders, substance induced depressive disorders, substance induced anxiety disorders, substance induced obsessive-compulsive and related disorders, substance induced sleep disorders, substance induced sexual dysfunctions, substance induced delirium and substance induced neurocognitive disorders.

C. Stages of Dependency

1. Early Stage: includes relief use, loss of control over use, increasing frequency of use and amount, and blackouts or memory loss.

2. Middle Stage: includes employment, school or family problems; personality changes; behaviors not consistent with the person's value system; and work and financial difficulties.

3. Late Stage: includes increased tolerance of the substance, physical deterioration, free-floating fears and anxiety, institutionalization because of a decline in mental health, and death.

D. How Chemicals Affect the Brain

- Necessary neurotransmitters are blocked or released in abnormal ways
- The brain tries to return to normal but what if chemical use is perceived as normal?
- Then chemicals become <u>necessary</u> to return to normal and addiction has set in.
- <u>Any</u> mood-altering drug will now have this effect.

E. A basic checklist for signs of impairment in a legal professional.

Personal behavior

- Gradual deterioration of personal appearance [hygiene/health].
- Loses control at social gatherings, even where professional decorum is expected.
- Distorts the truth; is dishonest.
- Manages finances poorly; fails to make tax filings and payments on a timely basis.

Attendance

- Routinely arrives late and/or leaves early.
- Regularly returns late or fails to return from lunch.
- Fails to keep scheduled appointments.
- Has frequent sick days or unexplained absences.

Job performance

- Procrastinates; has a pattern of missed deadlines.
- Neglects prompt processing of mail or timely return of calls.
- Shows decline in productivity/number of hours worked each month.
- Overreacts to criticism; shifts blame to others.
- Is unable to get along with or withdraws from fellow lawyers and other staff.
- Performance declines throughout the day.
- Clients complain about performance/communication.
- Co-mingles or borrows clients' trust funds.
- Appears under the influence and/or smells of alcohol in the office or during court appearances. Waldhauser, Carol; "Identifying Addictions"; G.P. Solo Magazine (A.B.A. Pub.; v.18, no. 5: July/Aug 2001).

BUT, the lawyer must continue to work to support the addiction so she or he may function very well in a work setting. By the time work performance begins to suffer, significant destruction may have occurred in other aspects of his or her life.

The employer can do a number of things to encourage those who may be more quickly aware of problems to bring them to the attention of management, another employee or to call LCL for help:

- Educate support staff
- Provide non-threatening reporting options
- Give family members a contact
- Distribute LCL or other information with benefits materials

F. Reaching Out to Others. There are various places where a concerned person can reach out.

- Expression of concern from one lawyer to another
  - Drop off a brochure, e-mail or call LCL
  - LCL will provide coaching
- Visits and calls by LCL volunteers
- Intervention
- Crisis Response (immediate assistance needed)

G. Recovery

1. Types and Settings of Treatment
   a. Types
      i. Social and Behavioral
      - Cognitive – Behavioral
      - 12 Step Model (Minnesota Model)
      - Contingency Management
      - Motivational Interviewing

      ii. Pharmacological
   b. Settings
      i. Inpatient (detox/stabilization, short term C.D. units)
      ii. Residential (Therapeutic Communities)
      iii. Outpatient
      iv. Treatment via medication

2. Does treatment work?

   Generally, statistics reflect that substance use treatment is at least as successful as treatment for other chronic diseases.
   Studies of outcomes for selected chronic diseases have shown:

   - 40% to 60% of clients from treatment programs are continuously abstinent and an additional 15% to 30% have cut down on their use.

   Of the other chronic diseases, the proportion of patients fully adhering to their medication schedule is:

   - Type 2 diabetes (adults) – less than 60%
   - Hypertension – Less than 40%
   - Asthma – less than 40%

In addition to treatment adherence, relapse rates are very similar among all four of these chronic disorders:

- Chemical dependency relapse: 40% to 60%.

Of the other chronic diseases, the proportion of adult patients who require medical care to reestablish symptom remission in one year:

- Type 2 diabetes – 30% to 50%.
- Hypertension – 50% to 70%.
- Asthma – 50% to 70%.

McLellan, A.T.; Lewis D.C.; O'Brien, C.P. and Kieber, H.D. Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation, Journal of the American Medical Association, v.284, No. 13, p. 1689 (2000).

IV. Other Addictions and Compulsive Behaviors

Gambling

A. Definition: Problem gambling is gambling behavior which causes disruptions in any major area of life: psychological, physical, social or vocational. The term "Problem Gambling" includes, but is not limited to, the condition known as "Pathological", or "Compulsive" Gambling, a progressive addiction characterized by increasing preoccupation with gambling, a need to bet more money more frequently, restlessness or irritability when attempting to stop, "chasing" losses, and loss of control manifested by continuation of the gambling behavior in spite of mounting, serious, negative consequences. (National Council on Problem Gambling, www.ncpgambling.org)

B. Scope

Nationwide, over 75% of adults have gambled at least once in the past year. 2 million (1%) of U.S. adults are estimated to meet criteria for pathological gambling in a given year. Another 4-8 million (2-3%) would be considered problem gamblers; that is, they do not meet the full diagnostic criteria for pathological gambling, but meet one of more of the criteria and are experiencing problems due to their gambling behavior. The estimated social cost of problem gambling from bankruptcy, divorce, job loss & criminal justice costs was $6.7 billion last year. Research also indicates that most adults who choose to gamble are able to do responsibly. (National Council on Problem Gambling, www.ncpgambling.org)

C. Diagnostic Criteria

In the DSM-V, pathological gambling has been moved from "Impulse Control Disorder Not Elsewhere Classified," to now be defined as a gambling disorder (and the only disorder) within the category of "Substance-Related and Addictive Disorders." Of the 10 criteria listed, 4-5 indicate mild severity, 6-7 moderate severity and 8-9, severe. The criteria are:

1. Preoccupation with gambling
2. Need to gamble with increasing amounts of money
3. Repeated unsuccessful efforts to control, cut back, or stop
4. Restless or irritable when attempting to cut down or stop
5. Gambling used as a way of escaping problems or distressed mood

6. "Chasing" losses
7. Lying to conceal the extent of involvement with gambling
8. Committed illegal acts to finance gambling
9. Jeopardized or lost a relationship or job
10. Relies on others to provide money to relieve a desperate financial situation (bail out). [i]

D. Stages

a. In the *winning* stage, the gambler still has money and feels in control. Gambling enhances self-esteem and ego, and winning seems exciting and social. The gambler may shower family and friends with gifts or take expensive vacations.

b. Eventually, the winning stage turns into the *losing* stage. As losses pile up, the gambler becomes preoccupied with gambling and makes larger and more frequent bets, "chasing" losses in the hopes of breaking even. At this point, the gambler will "max out" credit cards, cash in insurance policies, pawn or sell personal property, and dip into retirement or investment accounts. Lawyers with access to client funds frequently are tempted to shift these funds "temporarily," a decision that ends up costing them their license to practice law. Lies, loan fraud, absenteeism, family disputes, and job changes are frequent danger signs.

c. Gambling counselors note that compulsive gamblers frequently lose all having real value. It becomes like play money. One counselor reports, "They'll talk about bets, and simply say, 'I was down 500,' but have to be forced to say the word, 'dollars.' They don't view it as money anymore." Compulsive gamblers may approach family or friends to ask for money, but loans or gifts do not solve the problem. They only provide the gambling addict with fuel for another gambling episode.

d. Some problem gamblers will seek professional help at this stage, but many proceed to the next stage before getting help. At the *desperation* stage, the gamblers experience health problems such as panic or insomnia as debts pile up and relationships deteriorate. Having exhausted their financial resources, some gamblers turn to crime, and action gamblers begin gambling like escape gamblers to avoid their misery and feelings of hopelessness. Others simply run away from their family and debts, or attempt suicide. Melody Crawford Chadwick, "Bumps in the Road: Gambling." G.P. Solo Magazine (A.B.A. Pub.; v.21, no. 7: October/November 2004).

E. Signs and Symptoms - 10 Questions to Ask About Gambling Behavior

1. You have often gambled longer than you had planned.
2. You have often gambled until your last dollar was gone.
3. Thoughts of gambling have caused you to lose sleep.
4. You have used your income or savings to gamble while letting bills go unpaid.
5. You have made repeated, unsuccessful attempts to stop gambling.
6. You have broken the law or considered breaking the law to finance your gambling.
7. You have borrowed money to finance your gambling.
8. You have felt depressed or suicidal because of your gambling losses.
9. You have been remorseful after gambling.
10. You have gambled to get money to meet your financial obligations.

F. Help for Problem Gamblers
   a. Northstar Problem Gambling Alliance – 1-800-333-hope, www.northstarproblemgambling.org
   b. www.miph.org/gambling
   c. Gamblers Anonymous – www.gamblersanonymous.org
   d. Debtors Anonymous – www.debtorsanonymous.org

Sexual Compulsivity

A. One definition: Recurrent and intense normophilic sexually arousing fantasies, sexual urges, or behaviors which cause clinically significant subjective distress in social, occupational, or other important areas of functioning. (Coleman, et al 2000)
B. There is disagreement regarding whether compulsive sexual behavior is a psychosexual disorder, an addiction, a mood disorder, an impulse control disorder or an obsessive compulsive disorder.
C. Assessment Questions include:

   1. Do you, or others who know you, find that you are overly preoccupied or obsessed with sexual activity?
   2. Do you find yourself compelled to engage in sexual activity in response to stress, anxiety, or depression?
   3. Have serious problems developed as a result of your sexual behavior (e.g., loss of a job or relationship, sexually transmitted diseases, injuries or illnesses, or sexual offenses)?

D. Resources:
   A. U of M Center for Sexual Health, 612-625-1500, www.phs.umn.edu
   B. Sex Addicts Anonymous www.sexaa.org
   C. COSA www.cosa-recovery.org
   D. Society for the Advancement of Sexual Health www.sash.net

Eating Disorders

A. Eating disorders are serious health conditions that can be both physically and emotionally destructive. Professional help is always recommended. If not identified or treated in their early stages, eating disorders can become chronic, debilitating, and even life-threatening.
B. Resources:
   a. www.nationaleatingdisorders.org
   b. www.eatingdisordersanonymous.org

V. Discipline & Malpractice: Impact of Chemical Dependency on Lawyers

Specifically, treatment has been shown to have a tremendous impact on attorneys' malpractice liability and discipline. A recent study in Oregon analyzed a group of 55 recovering lawyers.

PERIOD	DISCIPLINARY COMPLAINTS	MALPRACTICE COMPLAINTS
five years before beginning sobriety	76	83
five years after beginning sobriety	20	21

GROUP	DISCIPLINARY RATE	MALPRACTICE RATE
five years after beginning sobriety	7%	8%
all lawyers in the state	9%	13.5%

Zarov, Ira and Fishleder, Barbara S.; New Study Shows Recovery Saves Dollars, Highlights of the A.B.A. Commission on Lawyer Assistance Programs (v5, #2: Spring 2002)

VI. Mental Health Issues and the Practice of Law

Psychological Distress and Law School. "Although not present prior to law school, a variety of forms of psychological distress become evident at clinically significant levels within the first few months of law school attendance. These symptoms increased as the law students progressed through the three years of the program and did not significantly decrease during the first two years of practice." Connie J.A. Beck, et al., *Lawyer Distress: Alcohol-Related Problems and Other Psychological Concerns Among a Sample of Practicing Lawyers*, 10 Jour. of Law & Health 1, 44 (1995-96) citing G.A.H. Benjamin, et al, *The role of legal education in producing psychological distress among law students and lawyers,* American Bar Foundation Research Journal 225-252, (1986).

A. Surveys of mental health issues among lawyers.

1. The ABA/ Hazelden study found the following:

Men reported higher rates of depression and women reported higher rates of anxiety and stress.

- Overall, the rate of depression was 28% and anxiety was 19%.
- Men reported higher rates of depression and women reported higher rates of anxiety and stress.
- 11.5% reported suicidal thoughts at some time during their careers.

2. "This sample of lawyers gives substantial indication of a profession operating at extremely high levels of psychological distress." The study asked attorneys to self report on psychological distress symptoms. The results, with comparisons from other studies of the general population, were:

	Generalized Anxiety Disorder	Obsessive-Compulsiveness	Depression
Gen'l Pop. – Male	4%	2.1%	8.5%
Gen'l Pop – Female	4%	1.4%	14.1%
Male Lawyers	30%	20%	Almost 21%
Female Lawyers	Nearly 20%	15%	16%

Connie J.A. Beck, et al., *Lawyer Distress: Alcohol-Related Problems and Other Psychological Concerns Among a Sample of Practicing Lawyers*, 10 Jour. of Law & Health 1, 49-50 (1995-96).

3. "Compared with the 3 to 9 percent of individuals in Western industrialized countries who suffer from depression, 19% of the Washington [state] lawyers suffered from statistically significant elevated levels of depression. Of these individuals, most were experiencing suicidal ideation. In addition, they typically isolated themselves, which greatly exacerbates

their risk of their acting upon suicidal ideations." G. Andrew H. Benjamin, et al.; *The Prevalence of Depression, Alcohol Abuse, and Cocaine Abuse Among United States Lawyers*; 13 Intern'l. Jour. of Law and Psychiatry 233, 240 – 41 (1990).

4. A 1990 study by Johns Hopkins University found that of 28 professions, attorneys are the most likely to suffer from depression, at a rate 3.6 times the average for the adult population. W.W. Eaton, et al., *Occupations and the Prevalence of Major Depressive Disorder*, 32 Jour. of Occupational Medicine 1079 (1990).

B. Impact of mental health issues on discipline and malpractice claims.

1. "[N]eglect cases tend to arise among lawyers who are procrastinating because they are clinically depressed. Finally, lawyers who go untreated tend to become defendants in malpractice claims." Benjamin, supra at 244.

2. Minnesota's experience

a. The number of disability related probationary cases due to mental health issues has been increasing substantially.

	12/31/99	12/31/08	12/31/13
Proportion of Probation Cases With Mental Health Disorder as a Factor To all Disciplinary Probation Cases	9/9%	23.3%	10.3%

Annual Report of the Lawyers Professional Responsibility Board and the Office of Lawyers Professional Responsibility, (June 2000, June 2009, July 2014)

b. During the MSBA Depression Task Force discussion in 1999, OLPR Director Ed Cleary reported that the rate at which mental health is being reported as a factor in disciplinary cases is increasing, while the rate at which alcohol and drugs are being reported as a factor is decreasing.

c. Many misconduct allegations involve behaviors closely related to the symptoms of mental health issues, primarily depression. For example, 50% of all OLPR open probationary files involved charges of neglect and non-communication; 23% involved non-cooperation with OLPR; and 36% involved conduct prejudicial to the administration of justice (primarily missed court appearances). *Annual Report*, (June 2002).

A significant number of attorney discipline cases involve impaired attorneys. Since the Supreme Court addressed the impact of alcoholism on discipline in *In re Johnson* in 1982, more than 100 suspension or disbarment cases have involved alcoholism or alcohol dependency. Since *In re Weyhrich*, when the court applied the mitigation test to mental illness, more than 50 public discipline decisions have included the requirement that the attorney prove psychological fitness before being reinstated to practice.

The very best way to prevent discipline of yourself or your colleagues is to get the attorney the help he or she needs by contacting LCL.

VII. Mood Disorders

A. Common types of depression

1. Major depression – manifested by a combination of symptoms (see below) that interferes with the ability to work, study, sleep, eat, and enjoy once pleasurable activities. An episode may occur only once, but more commonly returns several times in a lifetime.

2. Dysthymia – involves long-term, chronic symptoms that do not disable, but keep one from functioning well or feeling good. An individual with dysthymia may also experience major depressive episodes.

3. Bipolar disorder – also called manic depression. Not nearly as frequent, is characterized by cycling mood changes from extreme elation (mania) to depression. Most often the mood change is gradual. Depressive condition is similar to major depression. A manic period is characterized by being over-talkative and overactive, and having excess energy. It affects thinking, judgment, and social behavior and may lead to grand romantic or business schemes that create serious problems and embarrassment. Untreated mania can lead to a psychotic state.

B. Characteristics of depression

1. It is defined as a mood disorder that also affects our body and thoughts.

2. Symptoms of major depression include:
   a. Persistent sad, anxious or "empty" (absence of feelings) mood.
   b. Feelings of hopelessness and pessimism.
   c. Loss of interest or pleasure in activities we once enjoyed, e.g. sex.
   d. Feelings of guilt, worthlessness, helplessness.
   e. Decreased energy, fatigue, being "slowed down."
   f. Difficulty concentrating, remembering, making decisions.
   g. Insomnia, early-morning awakening, or oversleeping.
   h. Appetite and/or weight loss or overeating and weight gain.
   i. Thoughts of death or suicide, suicide attempts.
   j. Restlessness, irritability.
   k. Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain.

3. These symptoms must persist over a period of time. Depression is not a blue mood that passes after a few hours or days.

4. Often, the symptoms occur in stages. For instance, feelings of sadness will precede the empty feeling which reflects an absence of feelings. This is followed by a feeling of helplessness or hopelessness, which is <u>often</u> followed by thoughts of death or suicide.

5. Depression from the Outside
   Gloomy · Tearful · Pessimistic · Negative · Moody · Irritable · Complaining
   Brooding · Anxious · Critical

6. Gender Differences
   a. Women report depression twice as frequently as men and may be misdiagnosed.

b. Men are less likely to admit depression and doctors are less likely to suspect it. Men tend to cover up symptoms with alcohol, drugs, and work. Depression in men is more likely to show up as anger and irritability, rather than hope/helplessness.

(NIH Pub No. 00-3561, 2000; avail. At www.nimh.nih.gov/publicat/depression.cfm)

C. Anxiety

1. Generalized Anxiety Disorder (GAD), is an anxiety disorder characterized by chronic anxiety, exaggerated worry and tension, even when there is little or nothing to provoke it. (**www.nimh.nih.gov/healthinformation/gadmenu.cfm**)

2. Obsessive Compulsive Disorder – people with OCD have persistent, upsetting thoughts (obsessions) and use rituals (compulsions) to control the anxiety these thoughts produce. Most of the time, the rituals end up controlling them. (www.nimh.nih.gov/publicat/anxiety.cfm#anx3)

3. Post-traumatic stress disorder (PTSD) develops after a terrifying ordeal that involved physical harm or the threat of physical harm. The person who develops PTSD may have been the one who was harmed, the harm may have happened to a loved one, or the person may have witnessed a harmful event that happened to loved ones or strangers. (www.nimh.nih.gov/publicat/anxiety.cfm#anx4)

D. ADHD

1. ADHD is a neurobiological condition that affects individuals across the lifespan.
2. Signs and symptoms include
    a. Distractibility
    b. Disorganization
    c. Low self esteem
    d. Fidgeting
    e. Incomplete projects
    f. Emergencies
    g. Procrastination
    h. Chronic lateness
    i. Boredom
    j. Interrupting others
    k. Losing things
    l. Perfectionism
    m. Hyperfocus
    n. Impulsivity

3. One of the biggest challenges is a shame based distortion that everyone else has it all together.
4. Resources:
    a. www.ldaminnesota.org – click on Attention Deficit Support Services
    b. www.add.org
    c. www.help4adhd.org/
    d. www.chadd.org/

E. Unresolved Grief

1. Grief characterized by the extended duration of the symptoms, by interference of the grief symptoms with the normal functioning of the mourner, and/or by the intensity of the symptoms (for example, intense suicidal thoughts or acts)
2. Resources include hospital based and community survivor support as well as web links

F. Age Related Dementia (Alzheimer's Disease)

1. Alzheimer's Disease is the most common form of dementia. It destroys brain cells and causes problems with memory, thinking and behavior severe enough to affect work, lifelong hobbies or social life. It is progressive and fatal
2. There are ten warning signs (www.alz.org)
    a. Memory loss
    b. Difficulty performing familiar tasks
    c. Problems with language
    d. Disorientation to time and place
    e. Poor or decreased judgment
    f. Problems with abstract thinking
    g. Misplacing things
    h. Changes in mood or behavior
    i. Changes in personality
    j. Loss of initiative

3. Comparisons between Alzheimer's Disease and normal age related changes

Someone with Alzheimer's disease symptoms	**Someone with normal age-related memory changes**
Forgets entire experiences	Forgets part of an experience
Rarely remembers later	Often remembers later
Is gradually unable to follow written/spoken directions	Is usually able to follow written/spoken directions
Is gradually unable to use notes as reminders	Is usually able to use notes as reminders
Is gradually unable to care for self	Is usually able to care for self

4. Lawyers experiencing sings of dementia may deny the problem and yet can make mistakes or neglect matter resulting in harm to clients. Sensitive and respectful intervention is needed to help the lawyer retire with dignity. LCL can be a resource.

VIII. Suicide

Depression, untreated, is the #1 cause of suicide. Lawyers die by suicide at a higher rate than the general population. You may even know of some lawyers who have taken their own lives.

By offering help you can often (not always) prevent a suicide

Warning Signs of Suicide:

- Talking about ending one's life
- Statements about hopelessness, helplessness or worthlessness
- Preoccupation with death
- Suddenly happier, calmer
- Visiting or calling people one cares about, especially those one hasn't contacted recently
- Making arrangements, setting one's affairs in order
- Giving things away
- Significant symptoms of depression

QPR (Question Persuade Refer) is an approach to preventing suicide that has been proven to work. Over 250,000 people have been trained in QPR and suicide rates in setting where these people work have declined significantly. QPR teaches you how to ask someone if they are thinking about killing themselves, how to determine the seriousness of their situation, how to persuade them to accept help and how to connect them with appropriate resources. To become a QPR gatekeeper takes 2 hours or less. MN LCL offers this training free of charge. Your bar association or other legal group can schedule a training session for up to 25 people by calling LCL.

If you have not had the training, you can still make a difference by doing the following:

- Be aware of the signs of depression and the warning signs of suicide
- Be willing to get involved
- Ask the person you are concerned about if they are considering harming themselves
- Tell them you care about them and can assist them in getting help
- Help them access help by calling LCL, by going to a mental health clinic, by going to a hospital, etc.
- Do talk with their family or others if they are reluctant to accept help
- If the person is clearly planning on taking their life and refuses any offers of assistance, call local law enforcement. They are authorized to place the person on a 72-hour hold and take them to a hospital or other treatment facility. The person may be angry with you, but better mad than dead.

IX. The Interrelationship between Addiction and Mental Health.

A. Frequency of occurrence (using depression as an example).

Addiction and dependency disorders (both alcohol and other substances) frequently coexist with depression. Substance use disorders are present in 32 percent of individuals with depression disorders. They co-occur in 27 percent of those with major depression and 56 percent of those with bipolar disorder. National Institute of Mental Health, Fact Sheet, "Co-Occurrence of Depression with Medical, Psychiatric, and Substance Abuse Disorders." http://www.nimh.nih.gov/publicat/abuse.cfm

B. Diagnosis issues

Substance use must be discontinued in order to clarify the diagnoses and maximize the effectiveness of psychiatric interventions. Treatment for depression as a separate condition is necessary if the depression remains after the substance use problem is ended. Id.

X. Lawyers Concerned for Lawyers (LCL): Minnesota's Lawyers Assistance Program (LAP)

A. History of LCL: LCL was founded nearly 40 years ago by lawyers to provide confidential assistance to other lawyers with alcohol problems. Services are now available to lawyers, judges, law students and immediate family members for a wide variety of problems. Primary importance is placed on two (2) factors.

1. Lawyers, judges and law students providing voluntary assistance to peers.
2. Absolute confidentiality.

a.) For the attorney being helped
   i.) The stigma of being chemically dependent, mentally ill, or otherwise needing help from others.
   ii.) The fear of problems with the Office of Lawyers Professional Responsibility.

b.) For the concerned person (coworker, colleague, family members, friend): fear that the attorney needing help will retaliate.

c.) For an attorney providing help: duty to report misconduct under Rule 8.3, Minn. Rules of Professional Conduct.

i.) **"Rule 8.3 Reporting Professional Misconduct** provides, inter alia:

(a) A lawyer who knows that another lawyer has committed a violation of the Rules of Professional Conduct that raises a substantial question as to that lawyer's honesty, trustworthiness or fitness as a lawyer in other respects, shall inform the appropriate authority.

(b) A lawyer who knows that a judge has committed a violation of the applicable Code of Judicial Conduct that raises a substantial question as to the judge's fitness for office shall inform the appropriate authority.

(c) This rule does not require disclosure of information that Rule 1.6 requires or allows a lawyer to keep confidential <u>or</u> information gained by a <u>lawyer or judge while participating in a lawyer's assistance program or other program providing assistance, support, or counseling to lawyers who are chemically dependent or have mental disorders</u>."

Addition to the comment for this rule.

"Information about a lawyer's or judge's misconduct or fitness may be received by a lawyer in the course of that lawyer's participation in a bona fide lawyers assistance program or other program that provides assistance, support, or counseling to lawyers, including lawyers and judges who may be impaired due to chemical abuse or dependency, behavioral addictions, depression, or other mental disorders. In that circumstance, providing for the confidentiality of information obtained by a lawyer-participant encourages lawyers and judges to participate and seek treatment through such programs. Conversely, without such confidentiality, lawyers and judges may hesitate to seek assistance, which may then result in additional harm to themselves, their clients, and the public. The rule, therefore, exempts lawyers participating in such programs from the reporting obligations of paragraphs (a) and (b) with respect to information they acquire while participating. A lawyer exempted from mandatory reporting

under part (c) of the rule may nevertheless report misconduct in the lawyer's discretion, particularly if the impaired lawyer or judge indicates an intent to engage in future illegal activity, for example, the conversion of client funds. See Rule 1.6."

B. Services include:

1. Information, assessment and referral for substance misuse (drugs and alcohol) problems; compulsive behavior related to issues such as gambling, sex, and food; mental health issues such as depression, bipolar, anxiety disorder, PTSD, and obsessive compulsive disorder and stress, financial, career, relationship and other issues.
2. Intervention - formal and informal
3. Support
   a. Individual – peer support
   b. Group – AA meetings, support groups, job groups, membership meetings
4. Education and Outreach
   a. CLE programs on a variety of addiction, mental health and wellness topics
   b. Law school presentations
   c. Public service announcements to remind lawyers, judges and law students of LCL services CLE programs on a variety of addiction, mental health and wellness topics
5. Confidential 24-hour crisis line at 651-430-3383.
6. Up to 4 free counseling sessions throughout Minnesota

C. In 2015-16 LCL helped over 400 lawyers, judges, law students or their family members. Approximately 40% of those presented with a mental health problem. Over 200 referrals were made for professional assistance.

About 40% sought help for addiction and dependency - primarily alcohol, but also involving other legal and illegal drugs, gambling, and other compulsive behaviors. A significant percentage of those seen for addiction are diagnosed with co-occurring mental health disorders. Some depression cases involve suicidal ideation.

Lawyers, judges, law students and their family members also sought help for general stress as well as career, financial, family and legal problems.

XI. CONCLUSION

There is hope and there is help for impaired lawyers, judges, and law students, and it may start with you. Chemical dependency and many mental health disorders share a common symptom – the impaired person will begin to isolate him/herself from colleagues, friends, and family. The intervention process can be as simple as not mirroring that behavior. When you see a colleague begin to withdraw, reach out and try to keep communication lines open: talk about LCL's services and attorney support groups. Remember that you, too, may call LCL if you'd like help and support in your efforts. We're here as a confidential and free resource for both the impaired person and the concerned person who wants to help.