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ANNUAL REPORT: July 1, 2015 – June 30, 2016

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I. JLAP's MISSION STATEMENT

The Judges and Lawyers Assistance Program, Inc. (JLAP) is a 501(c)(3) non-profit corporation that serves the public, the Bar and the profession by assisting, on a confidential basis, judges, lawyers, law students, and bar applicants whose professional impairment may stem from substance use disorders or mental health issues. JLAP also provides assistance to family members of judges and lawyers.

JLAP is first and foremost an absolutely confidential method of providing life-saving help. By state statute and by Supreme Court Rule, any information received by the JLAP Director or LSBA Alcohol and Drug Abuse Committee member is absolutely privileged and confidential.

JLAP is meeting the challenge to provide increasingly comprehensive and effective mental health assistance to the Louisiana legal profession and its family members, and is now a fully-developed *professionals' program* that offers assistance with all types of mental health issues.

Our goals for upcoming 2016-2017 are to produce and provide educational programs that will effectively:

- 1) Reduce mental health stigmas and increase the profession's utilization of JLAP's confidential services;
- 2) Facilitate the profession's understanding of the importance of professional's programming clinical standards and protocols in both saving lives and protecting the public; and,
- 3) Promote the expansion of JLAP's confidential services to the Judiciary, and encourage judges experiencing difficulty to reach out discretely to JLAP when either they or a peer are in need of JLAP's assistance.

II. WATERSHED ACCOMPLISHMENTS January 2014 to June 2016

Louisiana's JLAP has completed a very challenging transformation process over the last three years so as to expand and improve its program and provide unprecedented top-tier services to the profession. Since January 2014, the following milestones have been achieved:

1. Increased Funding for JLAP

Beginning in 2011, Louisiana's JLAP program (then LAP) began seeking a significant increase in funding. Compared to fully-funded and leading programs in other states with similar numbers of bar members, our Louisiana program had fallen far behind.

The Louisiana State Bar Association (LSBA) came forward and made a commitment to financially support JLAP on a significant level and as necessary to support a top-quality full-service and fully-staffed clinical professionals' program that offers "Broad Brush" comprehensive mental health services to the Louisiana legal profession.

2. Restructuring of JLAP's Governance and Corporate Documents

In 2014, JLAP's governing documents were redesigned in order to facilitate the LSBA's involvement in the governance of JLAP at a level necessary to exercise its fiduciary duty in relation to the LSBA's increased funding of JLAP. The LSBA is the sole member of JLAP, Inc.

Much care was taken in the corporate restructuring to acknowledge and respect the unique operations of JLAP in terms of its processing of extremely confidential information that cannot be shared with or accessed by the LSBA, or any other outside entity. JLAP's internal clinical operations are managed independently from the LSBA. Client confidentiality is still fully protected internally at JLAP.

For more information on the current JLAP Board of Directors and JLAP Operations Committee please our website at www.louisianajlap.com.

3. Expansion of Professional Staff, Clinical Expertise, and Comprehensive Services

The LSBA's solid commitment to fully fund JLAP has facilitated JLAP's ability to greatly expand its professional clinical expertise and services.

When the original LAP, Inc. was formed in 1992, the program was focused on providing help to those experiencing issues with alcoholism and drug abuse, with programming expertise predominantly limited to that realm.

In fact, La. R.S. 37:221, referred only to assisting with alcohol and drug issues, and there was no mention of other mental health issues such as depression, anxiety, burnout and other mental health problems that lawyers and judges are now experiencing at high rates.

Mental health challenges in the legal profession have both grown and shifted over the last two decades. For example, depression is now more prevalent amongst lawyers than substance use disorders. As such, JLAP's professional clinical staff has been increased to facilitate the reliable and objective diagnosis and treatment of any category of mental health issue.

Underscoring the need for a full-service JLAP, in February of 2016 a new study was published entitled ***The Prevalence of Substance Use and Other Mental Health Concerns Among American Attorneys*** (Krill, Johnson, Albert; American Society of Addiction Medicine, Feb 2016). A copy is attached as **Exhibit A**.

The new study is the most reliable and comprehensive mental health study ever conducted within the legal profession. It provides a stark and very troubling view into the severity of mental health issues in our legal profession. The study contains valuable information and it is worth reading carefully, but the following provides a quick overview of its major findings:

Current Alcohol Use Issues:

20.6% Hazardous Drinking and Possible Alcohol Dependence Rate
36.4% Frequency and Quantity of Alcohol Use Consistent with Problematic Use Rate

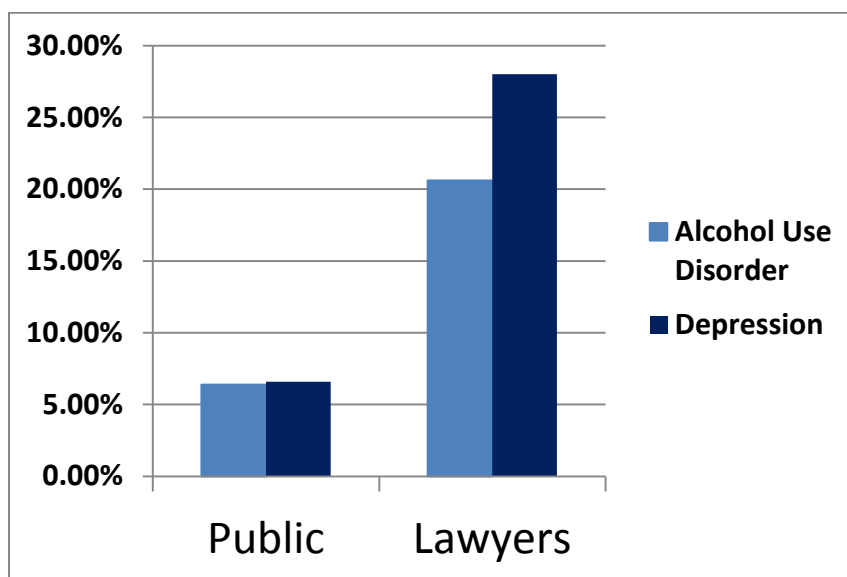
Current Mental Health Issues:

28% Depression Rate
23% Stress Rate
19% Anxiety Rate

Mental Health Issues Reported over the Span of One's Career:

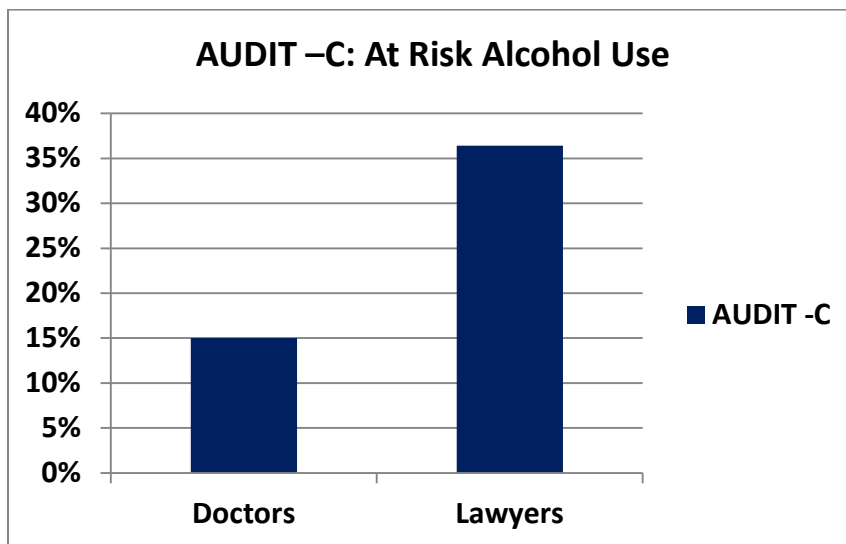
61.1% Anxiety Rate
45.7% Depression Rate
12.5% ADHD Rate
08.0% Panic Disorder Rate
02.4% Bipolar Disorder Rate

The following graphic demonstrates the true severity of Depression and Alcohol Use Disorder Rates in the legal profession compared to those suffered by the general public at only 6.6% and 6.4% respectively:



Moreover, as to problematic alcohol use as measured by the AUDIT-C in terms of how often legal professionals consume alcohol, how many alcoholic drinks they consume daily, and whether they ever consume six or more alcoholic drinks in one episode, the study identified that 36.4% of lawyers were positive for problematic alcohol use compared to only 15% within the physician population pursuant to recent 2012 study of doctors.

In simple terms, legal professionals are engaging in at-risk problematic alcohol use at over twice the rate of medical professionals.



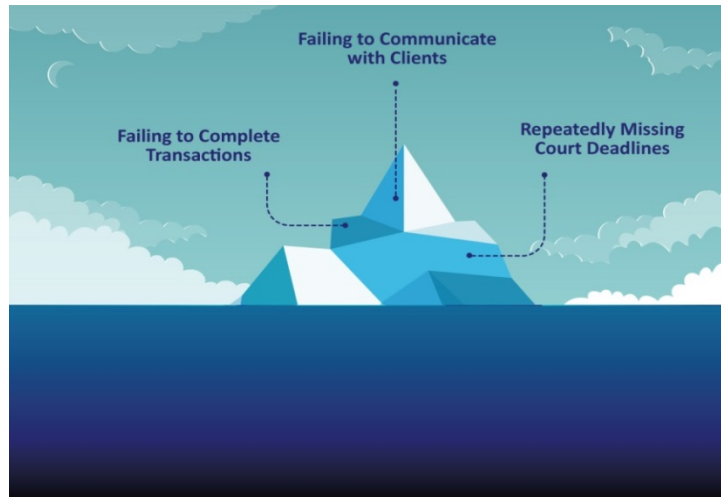
And while alcohol and drug-related impairment is still a very significant concern in the legal profession, it is clear that many other serious mental health issues are plaguing the members of our profession at comparatively high rates. JLAP is meeting the challenge and providing genuine “Broad Brush” comprehensive mental health services that address all of the issues.

4. JLAP’s Certified Clinical Interventions

JLAP has taken its substance use intervention expertise to a new level. JLAP’s Executive Director and Clinical Director are now both Certified Clinical Interventionists through the “Love First” training hosted by the Betty Ford Center in Palm Springs, California.

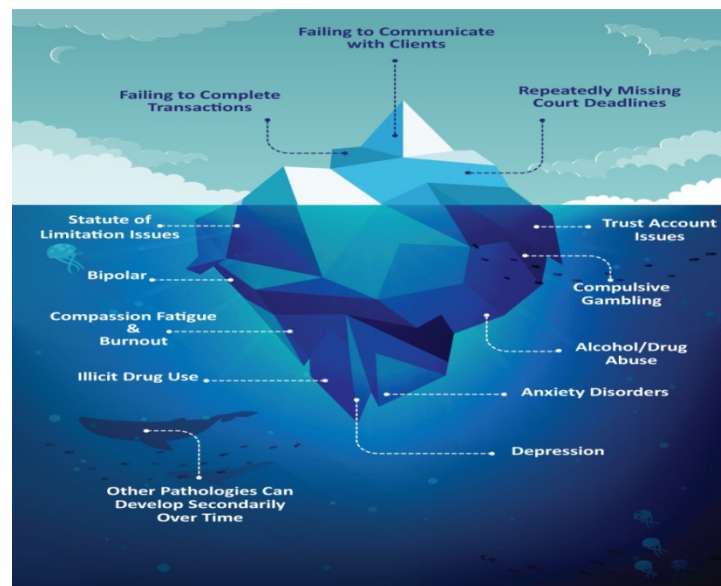
Through intervention it may be possible to get the person into recovery before irreversible harm is caused by the disease. Ongoing consequences such as DWI arrest or other substance-related charges, disciplinary complaints by clients harmed as a result of an impaired member of the profession, and other such issues can be avoided by getting the person help right now and without further delay.

Many times, in both mental health and substance use disorder cases, what the profession sees is merely the “tip of the iceberg” and the first signs of trouble are often witnessed as a reduction in the person’s diligence and competence.



JLAP's experience is that lawyers and judges are very high functioning. Even slight changes in performance can mark underlying problems that may be becoming severe. Lawyers and judges are adept at successfully hiding the true seriousness of their problems until something tragic happens and the problem can no longer be disguised.

There may be very serious mental health problems lurking under surface and the longer those problems go unaddressed the worse the mental health situation becomes and the greater chance for consequences to the person, the profession and the public.



In appropriate cases, JLAP will formally train an intervention team and conduct a professional intervention designed to successfully encourage an individual who is suffering to accept help and go to an effective and reliable JLAP-approved treatment facility that can reliably diagnose and treat the person. Such interventions often cost \$5,000 or more, but in suitable cases JLAP will provide this valuable service free of charge.

5. Structured Family Recovery

In addition to offering top-quality clinical services to members of the bar who need assessment, treatment, and recovery support, JLAP's Clinical Director is now certified in, and facilitates the use of, Structured Family Recovery (SFR).

SFR is a product offered by the *Love First* organization and the mission is to try and transfer some of the success of professionals' programming for lawyers, doctors and nurses to the greater public as well and greatly reduce the "revolving-door" of continued relapses that members of the general public endure. In SFR, the family participates in conference calls with a professional counselor trained in SFR so as to work through the family's own issues that have developed while interacting with the family member suffering from alcohol or addiction issues.

By participating in SFR, the family is better able to maintain healthy boundaries and effectively support the person's recovery without returning to prior, ineffective family behaviors that can include enabling, judging, and blaming. JLAP has seen SFR make astonishingly positive differences in some of its cases.

6. LAP to JLAP and Expansion of Services (Amendment of La. R.S. 37:221); and, New JLAP Diversion Option for Judges in Rule XXIII

A) Judges Assistance Committee and Expansion of JLAP's Services

In 2015-16, the "Judges Assistance Committee" continued to make headway led by the Committee Chairman, the Honorable Benjamin Jones (Ret.), 4th Judicial District Court in Monroe, La.

The continued mission was to formalize confidential assistance and monitoring as may be necessary for members of the judiciary. All options were considered and, after careful deliberation and based upon the successful programs of other states, it was determined that our existing Lawyers Assistance Program (LAP) should formally and specifically offer assistance to the judiciary and become the Judges and Lawyer Assistance Program (JLAP).

Thus, the name of LAP needed to be formally amended to JLAP within its governing documents and also within the state statute granting confidentiality and immunity.

In addition, as to JLAP's services to both lawyers and judges, the increased scope of JLAP's services needed to be acknowledged in the statutory language so as to recognize that JLAP's mental health services are now comprehensive and no longer limited to just issues of alcohol and drug abuse.

The amendment of La. R.S. 37:221 was approved and supported by the Louisiana Supreme Court and the Louisiana State Bar Association and marked the culmination of efforts by the

Judges Assistance Committee to provide JLAP's reliable, confidential mental health and substance-abuse services to the judiciary.

Per the Louisiana Legislature's news bulletin:

JUNE 5, 2015

La. R.S. 37:221 has been amended as follows, effective August 1, 2015:

ACT 59 (HB 197) 2015 Regular Session Shadoin

Prior law provided for the Lawyer's Assistance Program to encourage the successful treatment of alcoholism and drug addiction among the judiciary, members of the La. State Bar Association, law students, and prospective law students. New law changes the name of the Lawyer's Assistance Program, Inc., to the Judges and Lawyers Assistance Program, Inc. and expands the directive of the program to include counseling and intervention services for judges, lawyers, law students, and other members of the legal profession who may suffer from mental health issues. Existing law provides that any information, report, or record that the Committee on Alcohol and Drug Abuse of the La State Bar Association, Lawyer's Assistance Program, Inc., or any member, or employee, or agent of either generates or gathers is confidential and privileged, and that no member of the Committee on Alcohol and Drug Abuse, or agent, or employee of Lawyer's Assistance Program, Inc., may disclose that information, report or record without written approval of the subject judge, lawyer, law student, or prospective lawyer. Existing law provides immunity from liability for any licensed lawyer, and his supporting staff, resulting from any act made in good faith while engaged in efforts to assist judges, lawyers, law students, or prospective lawyers in connection with substance abuse counseling or intervention pursuant to the programs of the La. State Bar Association. New law extends the application of these privileges and immunities to the Judges and Lawyers Assistance Program, Inc. to also include mental health issues.

House Bill 197 was sponsored by long-time JLAP volunteer and past JLAP Board Member Rob Shadoin, a Louisiana State Representative in District 12 from Ruston, La. By unanimous vote, the above referenced ACT 59 (HB 107) was passed by the Louisiana Legislature and La. R.S. 37:221 was formally amended and signed into law by Governor Jindal.

Appearances were made at the State Capitol in support of House Bill 107 by Mark Surprenant, President of JLAP, House Representative Rob Shadoin, Honorable Benjamin Jones 4th JDC, Buddy Stockwell Executive Director of JLAP, and Mark Cunningham, LSBA President.



(L-R) Mark Surprenant, Rob Shadoin, Hon. Benjamin Jones, 4th JDC (Retired), Buddy Stockwell, and Mark Cunningham. Appearance at 2015 Legislative Session in support of the amendment of La. R.S. 37:221.

B) New JLAP Diversion Rule XXIII for Judges

It was also the finding of the Judges Assistance Committee that it is important to provide the Judiciary Commission with JLAP's services regarding JLAP-approved facilitation of evaluation, assessment and treatment, and formal JLAP monitoring and compliance in judicial disciplinary matters wherein the alleged misconduct emanated in whole or part from a mental health, or alcohol or drug issue.

With JLAP's services, it may be possible for a judge to mitigate his or her professional consequences by demonstrating that they are fit to practice and their impairment has been removed via successful and reliable participation in JLAP.

As such, in July of 2016, the Louisiana Supreme Court amended its Rule XXIII to provide Section 3(f) that now specifies the availability of a diversionary track for judges specifically to JLAP:

Rule XXIII 3(f) During any stage of a proceeding before the Commission, either before or after the filing of a notice of hearing as provided for in Section 4 of this rule, the Commission may, in its discretion, consider referring the matter to the Judges and Lawyers Assistance Program.

If the Commission is in favor of such a referral, the Commission shall notify the judge in writing of the opportunity for diversion. If the judge agrees to the diversion, the form of diversion will be worked out among the Judges and Lawyers Assistance Program, Counsel to the Commission (Special Counsel and/or Commission Counsel), and the judge. The judge will be required to sign a written contract outlining the nature and extent of diversion. In the event of an unsuccessful diversion, the matter will be referred back to the Commission for

further action. If in the course of fulfilling a diversionary contract, violations of the ethical rules contained in the Code of Judicial Conduct or Article V, § 25(C) of the Constitution are discovered, the Commission shall be notified, the contract may be nullified, and if so, the matter will be referred back to the Commission. A diversion contract may be reinstated or new terms added for good cause shown and with the consent of the judge.

With the above Supreme Court Rule now in place, Louisiana has formally endorsed JLAP as a full-service and comprehensive program that delivers its complete services to law students, lawyers, and now formally to judges as well.

7. New JLAP Website Provides Comprehensive Mental Health Information and Support

In concert with JLAP's efforts to expand its mission and provide top-quality services to the profession, JLAP's Staff undertook efforts that spanned almost two years of work (when it could be accomplished in addition to JLAP's fulltime day-to-day workload) to produce an extremely detailed website that provides information and valuable mental health resources to all classes of legal professionals and their family members.

The website also includes "Self-Tests" and other materials that allow persons to visit JLAP online and in complete privacy investigate on their own whether or not their symptoms, or the behavior of a peer or loved one, may be indicative of a mental health issue that needs professional attention.

The JLAP website is located at www.louisianajlap.com and JLAP encourages all members of the bar to visit the site and familiarize themselves with the services JLAP provides.

8. LSBA Summer School 2016

A) Mark Surprenant Received the 2016 LSBA President's Award

Per the *Louisiana Bar Journal*:

"Mark C. Surprenant, a partner in the New Orleans office of Adams and Reese, L.L.P., was recognized for his efforts in the implementation of the Access to Justice Intern Program and the Reentry Program and as chair of the Judges and Lawyers Assistance Program, Inc. Currently the chair of JLAP, Surprenant also is a member of the Louisiana Access to Justice Commission. Since the beginning of his legal career, he has been dedicated to community service. In 1988, he created HUGS, his law firm's corporate philanthropy program. In 2000, he established CA&RE, his firm's official pro bono program. He also is the co-founder of SOLACE, Inc. (Support of Lawyers-Legal Personnel — All Concern Encouraged)."



Mark Surprenant (L) receives the LSBA 2016 President's Award from Mark Cunningham, LSBA President 2015-2016

And while we at JLAP owe a tremendous debt of gratitude to all of the hard-working volunteers who serve on JLAP's Board of Directors and Operations Committee, we are all extremely proud of Mark and his excellent leadership as the President of JLAP's Board of Directors. Mark has dedicated countless hours to the mission of JLAP and his unflagging efforts have played a vital role in JLAP's evolution into a fully-funded top-tier program.

B) JLAP Exhibit at 2016 LSBA Summer School

JLAP's Exhibit at the 2016 LSBA Summer School was very well received. Summer School attendees had an opportunity to meet JLAP's Clinical Staff in person and learn more about JLAP and the services it provides.



(L-R) JLAP Clinical Director Leah Rosa; JLAP Clinical Case Manager Jennifer Gros; and JLAP Clinical Case Manager Jessica Duplantis at the new JLAP Exhibit at the 2016 LSBA Summer School in Sandestin, Florida

In addition to handling the LSBA Summer School JLAP Exhibit, JLAP's Clinical Staff offered wellness services and provided meditation classes early each morning. Lawyers and judges learned more about the benefits of meditation and participated in a meditation exercises. Throughout the week, participants reported that they genuinely enjoyed and appreciated the meditation workshops.

More and more, JLAP will be providing information, education, and services that promote wellness, balance and mental health for the entire profession, with the goal of helping people better manage the stress and pressure that is attendant to the practice of law. By so doing, it can help all of us be happier lawyers and judges and reduce our risks for developing issues with depression or substances in the first place.

9. JLAP Presentations Approved for CLE Credit

One of JLAP's main challenges is to gain audiences with members of the bar and judiciary so as to provide educational presentations that will facilitate JLAP's efforts to: reduce stigmas associated with mental health issues; highlight JLAP's independence and strict confidentiality as a matter of law; and promote early intervention through JLAP.

JLAP has developed many new CLE presentations in the last three years. JLAP also provides custom presentations to suit any particular need. In addition to presentations to law schools, LSBA CLEs and LSBA Ethics Schools, JLAP has made many presentations to law firms, local Bar Associations, Inns of Court, District Courts, Federal Courts, Family Law Sections, Estate Planning Sections, Public Defenders, Administrative Law Judges, and national audiences at ABA functions and other associations in the legal profession.

A sampling of JLAP formal PowerPoint presentations are as follows:

- Treatment of Substance Use Disorders versus Mental Health Disorders**
- ABA Model Rule 8.3 and Reporting Impairment-related Conduct**
- Professional Intervention in Substance Use Disorder Cases**
- Bridging the GAP JLAP CLE for Newly Admitted Lawyers**
- Happy Lawyering**
- The Prevalence of Mental health Disorders in the Legal Profession**
- Compassion Fatigue and Solutions**
- Judicial Compassion Fatigue**
- QPR Suicide Prevention**
- Depression in the Legal Profession**
- The Purpose of JLAP Monitoring**
- What is Your JLAP IQ?**
- Perfectionism and Anxiety**

JLAP welcomes the opportunity to provide presentations to any and all segments of the legal profession. JLAP never charges a fee for its presentations and will provide its programs anywhere (with its reasonable travel expenses reimbursed).

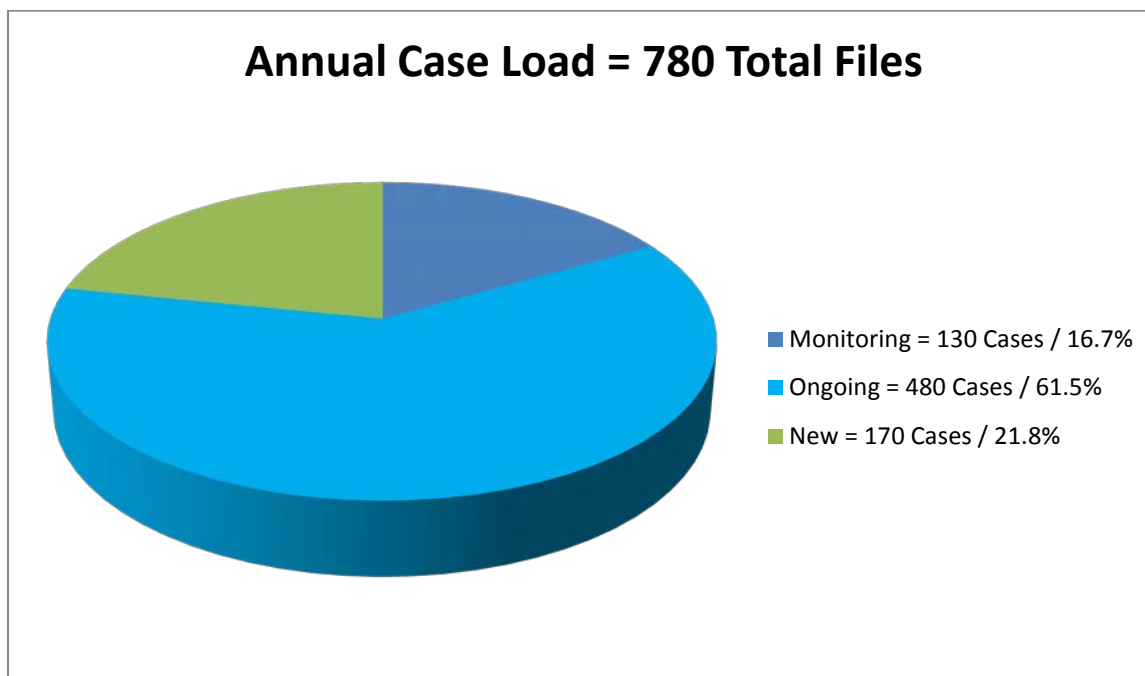
III. JLAP OPERATIONS STATISTICS 2015-2016

In the fiscal year 2015-2016 JLAP initiated new methods for collecting performance data, all as was developed in concert with JLAP's Performance Audit.

1. JLAP Case Load for the Year

For fiscal year July 1, 2015, through June 30, 2016, JLAP serviced 780 formal files.

Of the 780 files, 130 were formal recovery monitoring files, 170 were other, brand new files, and 480 other files were either ongoing from a file opened the prior year(s) or re-opened from an inactive file from the past due to a former client experiencing new mental health challenges and reaching out again to JLAP.



Unlike legal matters, there are never any closed files at JLAP. Mental health issues are not subject to prescription or peremption. At any time, as long as the person who JLAP assisted is still alive, their old file can become active again. In some cases a file becomes active again years or even decades after it was placed into inactive status. The person encounters some new mental health complication that causes them to circle back to JLAP for its help once again.

2. Relapse Statistics

Of 130 total participants under monitoring, eight (8) participants relapsed while under contract in FY 2015-2016. A ratio of 8 out of 130 demonstrates a 6% Relapse Rate for the FY 2015-2016 and thus rendered a **94% relapse-free success rate under JLAP monitoring.**

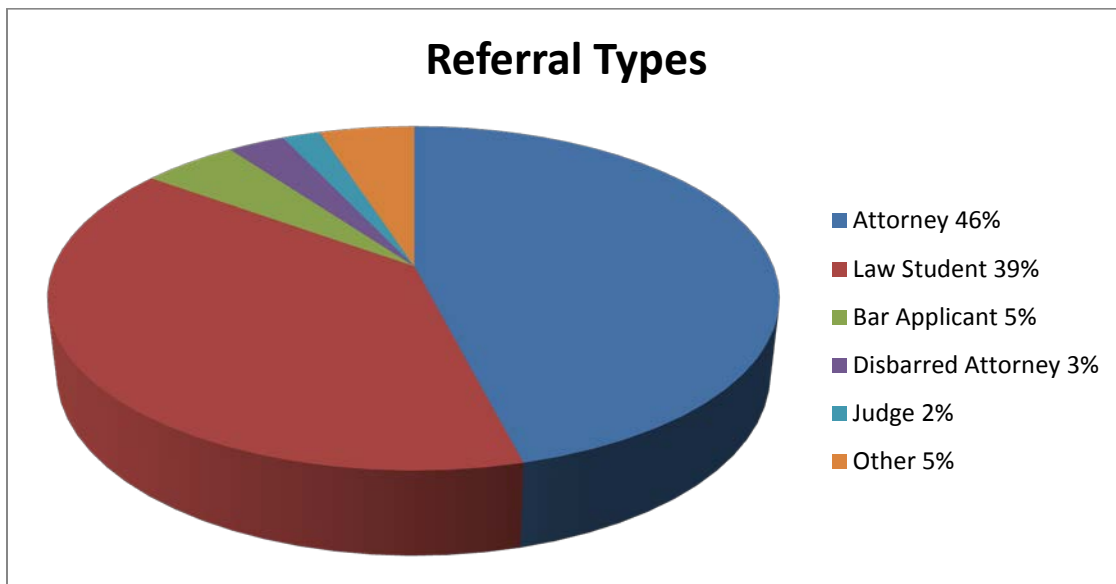
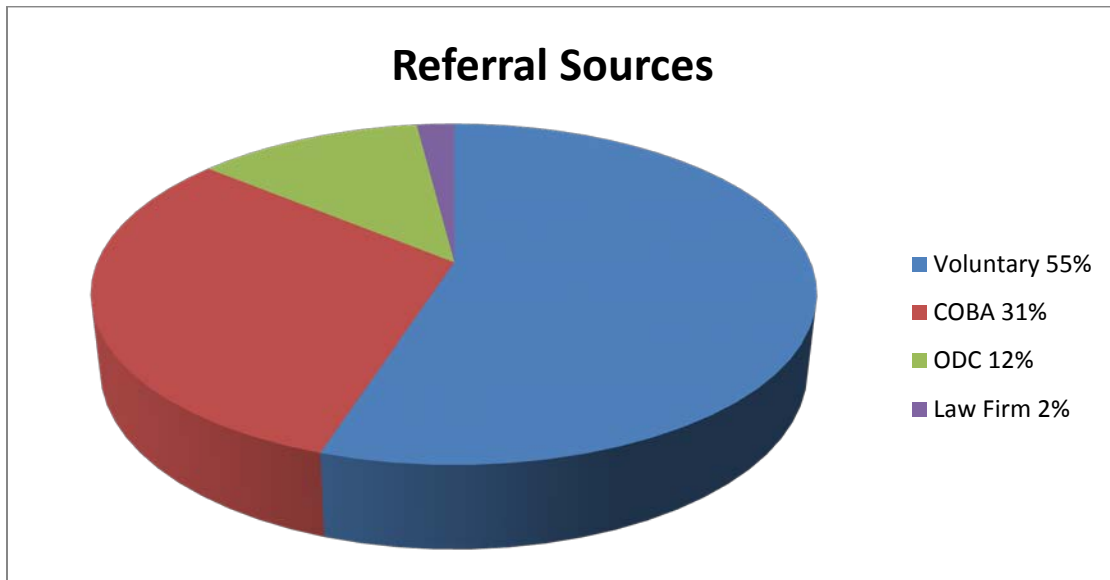
As to final outcomes for those who relapsed, five (5) went to updated JLAP-approved post-relapse assessments, they all completed the assessment, successfully completed the treatment recommendations via JLAP-approved and facilitated clinical efforts, and are now successfully participating in monitoring with new, reliable monitoring contracts in place.

Thus, the true failure rate in the monitoring population is reflected by the three (3) persons who relapsed and declined to address the issue and declined further JLAP participation. As such, when gauged within a total population of 130 monitoring participants, the failure rate for the year was only 2.3%. As such, **97.7% of JLAP monitoring participants successfully remained in JLAP and reliably addressed their mental health issues. It is paramount to keep in mind that everyone is always welcome back into JLAP. All that is required is cooperation and compliance with JLAP's standards.**

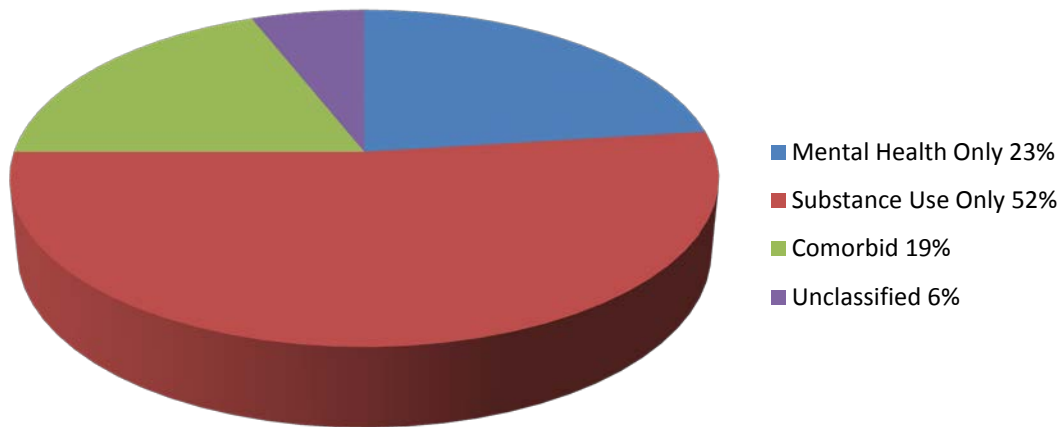
It is also of moment to note that there was no report of any client harm or harm to the public in the relapse cases wherein the person immediately cooperated with JLAP's clinical recommendations to address the relapse. It is additionally noteworthy that under JLAP monitoring, the relapses were quickly detected due to JLAP's effective drug and alcohol screening protocol. Thus, both the health interests of the participant and the public's need for protection were served.

3. Referral Sources

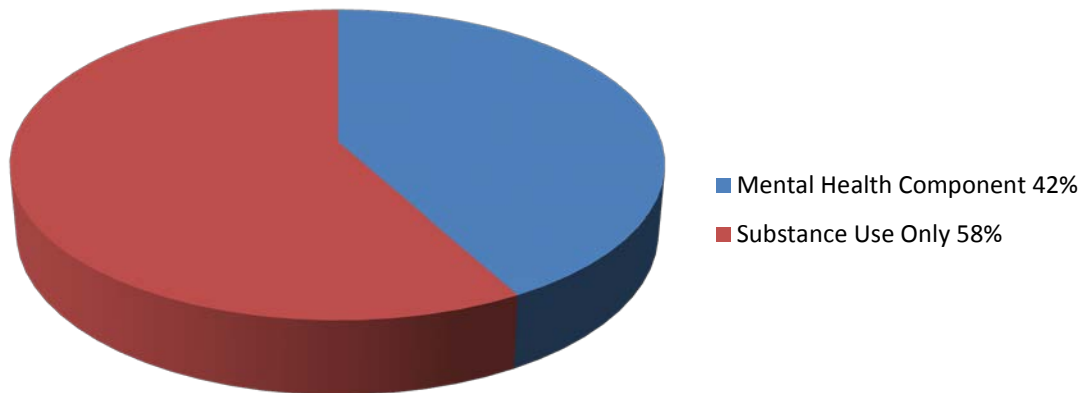
The below charts represent the referral sources and type for all of JLAP's newly opened files in the FY 2015-2016.



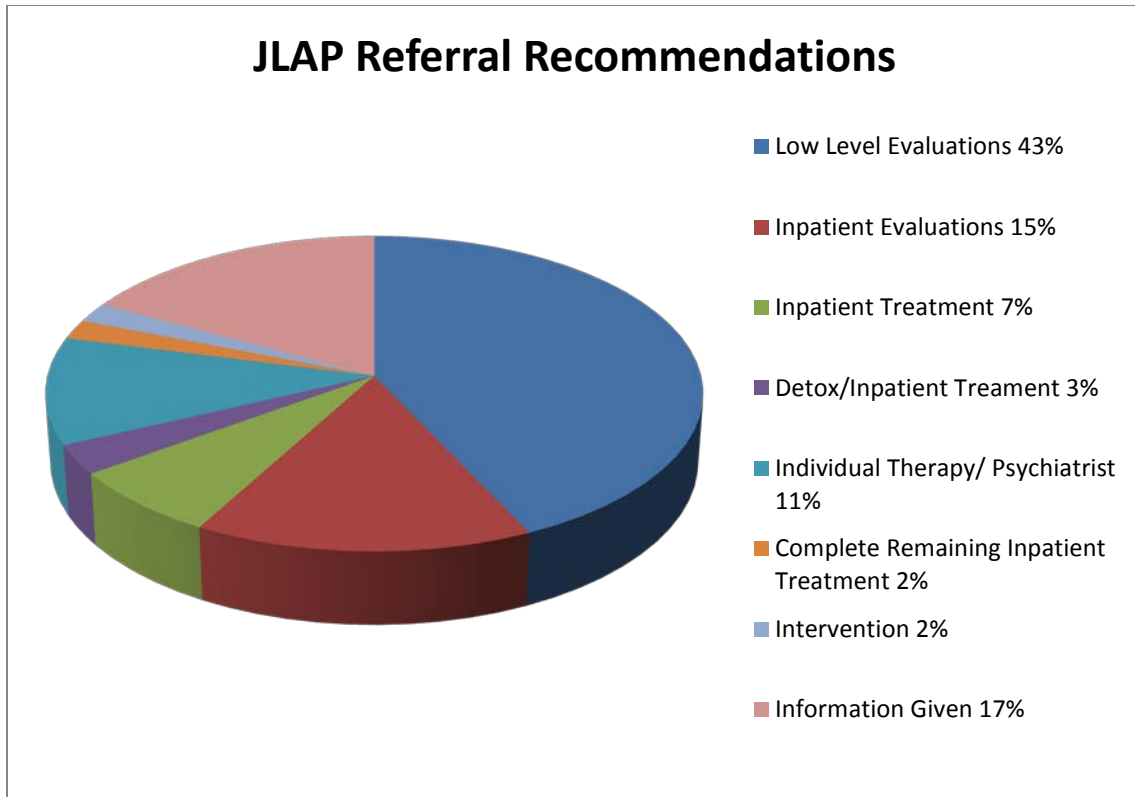
Mental Health and SUD Referrals



Mental Health vs SUD



It is noteworthy that forty-two (42%) percent of new cases had at least one mental health component outside of substance use disorders.



The above chart represents JLAP's clinical referrals and responses for new cases in the FY 2015-2016.

When a person seeks JLAP's help or is referred to JLAP, the first step is to determine the appropriate level of evaluation or assessment that is needed to objectively and reliably rule out or diagnose mental health and/or substance use issues. JLAP's professional Clinical Staff determines the clinically-indicated level of JLAP-facilitated evaluations or assessments, all within the clinical standards applicable to licensed professionals.

A) Low-Level Evaluations

The majority of JLAP's participants begin with a low level evaluation. There were a total of 73 participants (43%) that were initially referred for low level evaluations. Fifty four of them (74%) received definitive results that required no further evaluation with outcome recommendations as follows:

- No recommendations – (65%)
- No show for evaluation – (16%)
- Intensive Outpatient Program – (6%)
- Monitoring – (7%)
- Individual Therapy - (4%)
- Scheduled - (2%)

B) Low -Level Evaluations converted to Inpatient Evaluations

There were a total of 73 participants referred for low level evaluations. Nineteen of them (26%) received a referral for an additional inpatient evaluation as a result of the initial low level evaluation with outcome recommendations as follows:

- No show for inpatient evaluation - (32%)
- IOP - (16%)
- Referred for inpatient treatment - (37%)
- No recommendations - (5%)
- Currently scheduled to attend the inpatient evaluation - (10%)

C) Inpatient Evaluations

Twenty-Six of the participants (15%) were referred straight from JLAP to an inpatient multi-disciplinary assessment without completing a low level evaluation, with outcomes as follows:

- Participated in the inpatient evaluation - (62%)
- Did not participate - (38%)

Of the participants that attended the inpatient assessment, ten (10) were referred to and completed treatment, five (5) have not yet completed the recommended treatment as of the writing of this report, and one (1) outcome is unknown.

D) Conversion Rates

The internal status of cases at JLAP can and do change sometimes depending on what circumstances and events are concurrently developing externally and independently from JLAP participation.

For example, a voluntary participant may reach out confidentially to JLAP and be receiving JLAP's support in total privacy and doing well in addressing their mental health issues through JLAP. But at some certain moment, and wholly unrelated to confidential JLAP participation, some third party may place demands upon the JLAP participant.

Outside pressure can come to bear due to a client filing a complaint with the Office of the Disciplinary Counsel, or some other third party such as an employer may discover a problem that emanated from the prior impairment of the person and that pre-dated the person's involvement in assessment, treatment, and recovery in JLAP.

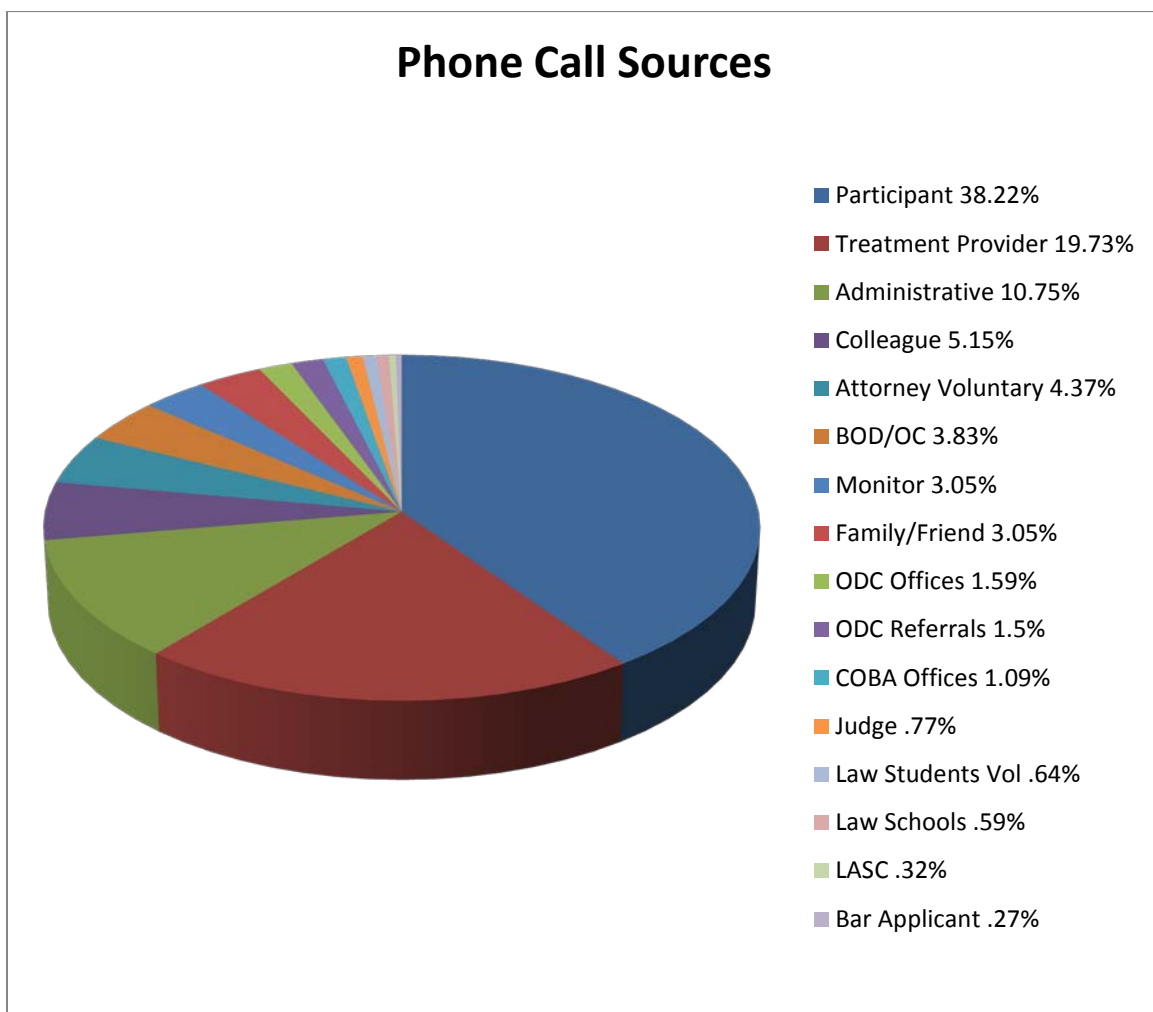
At that point, the JLAP participant, **and only the participant**, decides if it is in his or her best interest to waive confidentiality so that JLAP can report that they sought JLAP-approved assistance and are JLAP-compliant. JLAP compliance is not a defense to unethical conduct, but it can serve in some cases as a mitigating factor in disciplinary consequences.

There were conversions in JLAP case classification in 2015-2016 as follows:

Voluntary to ODC:	9
Voluntary to COBA:	2
COBA to ODC:	6
Voluntary to Law Firm	1
Voluntary to COBA to ODC	1

E) Communications Traffic via Telephone

In the FY 2015-2016 JLAP totaled 2,195 phone calls.



IV. JLAP OPERATIONS AND CLINICAL INFORMATION UPDATES

1. JLAP's Expansion into Full Mental Health Services

It has been a primary goal of JLAP in the last five (5) years to grow as a full-service program and provide professional clinical support for all categories of mental health issues, not just the specialized areas of substance use disorders. Of course, this expansion required hiring professional Clinical Staff qualified to diagnose and provide stabilization and effective case management in the full spectrum of mental health.

As demonstrated by JLAP's statistics, *supra*, many of the cases it handled in FY 2015-2016 (42%) have at least *some* component of a mental health issue other than substance use disorders. Almost one-fourth of its cases (23%) involved diagnoses such as depression or anxiety and without involving any substance use disorders. As such, JLAP has successfully begun promoting and delivering effective mental health services to the profession.

JLAP has also provided specific mental health products to various categories of legal professionals as follows:

A) Law Students

a. Uncommon Counsel Presentation

To all Louisiana law schools that are receptive, JLAP sponsors the cost of hosting Dave Nee Foundation "Uncommon Counsel" presentations yearly. These presentations are conducted by Dr. Kate Bender and provide students with information that equips them to spot suicidal behavior in fellow students and how to reach out if they fear a peer is in distress. Louisiana has suffered the tragedies of law student suicide within some of its law schools and JLAP's hosting of the Uncommon Counsel Program is an effective tool in taking concrete steps toward averting such tragedies in the future.

b. JLAP Office Hours at Law Schools

JLAP now offers "Office Hours" at law schools wherein law students have onsite, direct access to a JLAP Clinical Professional in person, on their campus.

Students can either make an appointment or drop by impromptu and confidentially discuss mental health issues they or a peer are experiencing. JLAP provides these services at no cost whatsoever to the students. The response has been very good and students are taking advantage of JLAP's support.

In the future, JLAP hopes to be allowed to make presentations to law school faculty on how to spot symptomology of mental health issues in the student body and how to reach out confidentially to JLAP and facilitate the student receiving confidential help.

B) Lawyers and Judges

JLAP has expanded its CLE presentations to provide education on mental health topics such as depression, anxiety and perfectionism, compassion fatigue, and treating those types of mental issues.

Also, JLAP has developed a protocol for assisting those who contact JLAP confidentially about a mental health issue. JLAP has amassed an in-house library of top quality professionals'-level books that address predominant mental health issues lawyers and judges face (depression, anxiety, and burnout).

When someone reaches out for help, in addition to the initial clinical consultation to assess the situation, JLAP sends an applicable book along with a personalized letter of support. Also, JLAP schedules follow-up emails and phone calls, and a JLAP clinical staff member circles back to help facilitate effective clinical management/resolution of the issue(s).

JLAP's core mission in mental health cases is the same as in substance use disorder cases to the extent that it is JLAP's role to help stabilize the person and encourage the person to participate in a JLAP-facilitated and approved evaluation or assessment with a JLAP-approved mental health care provider to obtain an objective and reliable diagnosis. Once that is accomplished, appropriate JLAP-approved treatment or therapy can be defined and facilitated.

After the person is stable and in recovery, JLAP provides mental health recovery monitoring and supports the person in the same fashion that JLAP does in substance use disorder cases, thus greatly improving the odds that the person will remain successful in managing ongoing mental health issues.

C) Wellness and Mindfulness

In the realm of general mental health, JLAP is dedicated to delivering new clinical products to the entire profession, not just those who may have developed a diagnosable problem. Quality of life as a legal professional requires developing healthy boundaries and applying practices that will improve life balance and wellness.

For many lawyers and judges, anxiety is a constant companion as they are driven by fierce competitiveness and perfectionism. Depending on the individual, anxiety levels may rise dramatically during law school and then continue into the practice of law.

JLAP is now offering Meditation and Mindfulness CLE's and workshops to teach the practice of meditation to participants. To ensure mental health, however, our brains need sufficient downtime wherein we actually think of *nothing*. This is an extremely challenging concept for lawyers who live in a fast-paced world of intense analytical reasoning and thinking. Nonetheless, some lawyers are successfully learning how to meditate and they are experiencing its benefits.

On JLAP's website there are several links to valuable resources about anxiety and how to manage it. The mission is to always be proactive and encourage attorneys to take care of their personal mental health before pathologies have any chance to fully develop.

2. ASAM and FSPHP Guidelines for JLAP's Standards in Substance Use Disorder Cases

When it comes to addressing concerns regarding substance use-related issues in particular, JLAP's role as a "professionals' program" is to facilitate objective and reliable evaluation, assessment, and treatment at clinical levels that are necessary to treat the licensed professional and also protect the public. This requires higher levels of assessment and specialized treatment that exceeds what is customary for the general public, because recovery and fitness to practice, and not relapse, must be the expected outcome.

The guidelines and criteria that support JLAP's professionals' programming standards for substance use disorders emanate from immutable authorities such as: a) The American Society of Addiction Medicine (ASAM); and, b) the Federation of Physicians' Health Programs (FSPHP).

A) ASAM Criteria for Safety Sensitive Workers

ASAM was founded in 1954 and, for over six decades, ASAM has led the way in providing treatment criteria for addressing substance use disorders. Its membership includes over 3,600 physicians, clinicians and associated professionals practicing medicine within the specialized field of addiction.

It also publishes *The ASAM Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (American Society of Addiction Medicine, Third Edition, 2013)*. The ASAM Criteria is the most widely used and comprehensive set of guidelines for placement, continued stay and discharge of patients with substance use disorders.

ASAM and many professionals' programs including JLAP recognize that certain occupations require specialized guidelines for treatment so as to minimize the risk of substance-use related impairment amongst its members. A higher level of clinical response is necessary because of the severity of potential risk to the public when someone in such a profession practices while impaired.

These special types of professions are deemed by ASAM Criteria to be Safety Sensitive Occupations within which Safety Sensitive Workers (SSW) are licensed and employed. At the core of the ASAM SSW criteria, there are two very important stakeholders: 1) the professional who may have developed a substance use disorder and is facing a health issue and needs to be objectively diagnosed and effectively treated at a reliable level to regain mental health; and 2) the public, potentially placed at risk of significant harm that can be done by an impaired professional due to the very nature of the work at issue.

The ASAM Criteria recognizes that SSWs require specialized treatment so as to greatly reduce the statistical odds of relapse. According to ASAM:

*“With Safety Sensitive Workers, there is not the luxury for the treating clinician to stand back and sagely watch while a series of lapses and relapses helps the patient internalize full acceptance of his or her addiction. **For many Safety Sensitive Workers there can be little or no tolerance for relapse.** This intolerance comes from two places: a) the potential for real public harm; and b) the reprisal from licensing agencies, legal action, professional organizations, or command structures” (Emphasis Supplied).*

Additionally, ASAM Criteria outlines the following concerns:

- SSWs with untreated, or insufficiently treated, substance use disorders place the public at undue risk and therefore the SSWs should not practice until safely in remission pursuant to guidelines for professionals’ programming;
- Assessment, treatment, and recovery efforts must meet ASAM SSW and professionals’ program guidelines in order to produce outcomes with very reliable recovery rates so as to protect the public and provide confidence that the person’s disease is in long-term remission and is now fit to practice;
- The ASAM SSW criteria seek to greatly reduce the risk of relapse within SSW professionals so as to protect the person, the profession, and the public.

Assisting ASAM SSW’s with substance use issues begins with a high-quality JLAP-approved evaluation or assessment to reliably determine the presence and extent of a substance use disorder. It is also important to establish executive functioning and the potential for the presence of other mental health issues as well. Also, the assessment usually includes a “Safety to Practice” expert clinical opinion.

Appropriate SSW-level treatment routinely requires the use of treatment facilities that have specialized experience in treating SSWs. It has been established that “professionals’ track” treatment programs yield a much higher rate of long-term and relapse-free recovery. When both the treatment staff and the patient understand and meet the specialized needs of SSWs, the odds of relapse after treatment are substantially reduced.

B) FSPHP Clinical Guidelines for Professionals' Programs

The Federation of State Physicians Health Programs (FSPHP) is the national organization of professionals' programs for physicians. Its roots can be traced back to 1958 when the Federation of State Medical Boards (FSMB) was already realizing that disciplinary complaints against doctors are often rooted in their own personal alcohol and drug problems.

Two missions presented: 1) saving the lives of addicted physicians and helping them overcome alcoholism and addiction to regain their fitness to practice; and, 2) protecting the public from impaired physicians by requiring highly-effective treatment and recovery monitoring thereafter.

In 1975 the American Medical Association (AMA) officially acknowledged the problem of physician impairment and by the late 1970s there was an increase in education and awareness about physician addiction. By 1980 all but three of the 54 U.S. medical societies of all states and jurisdictions had authorized or implemented impaired physician programs. As such the medical profession led the way in designing specific, professionals' programming.

Other categories of "Safety Sensitive" professions soon followed suit. In the 1980s, Lawyers Assistance Programs (LAPs) and Judges and Lawyers Assistance Programs (JLAPs) began to spring up in various states. Here in Louisiana, the LSBA's Impaired Professionals Committee was formed in 1985. Soon thereafter, in 1992 and under the auspices of the LSBA and its newly-formed Committee on Alcohol and Drug Abuse, the Lawyers Assistance Program, Inc. (LAP) was formed.

Today's JLAP is operating as a genuine professionals' program and in the context of the protocols and parameters suggested by the ASAM SSW Criteria and the FSPHP's Clinical Guidelines for professionals programming.

3. JLAP Speaking Engagements and CLE Presentations 2015-2016

More often than not, a person confidentially reaching out to JLAP has decided to do so after hearing a live presentation by a JLAP professional. Sometimes the call does not come immediately and the person may wait months or even years to call, but often the conversation begins with "I heard a presentation and I think I might need some assistance from JLAP."

As such, one of the most effective and proven tools in building trust in the profession and encouraging its members to reach out to JLAP is through public speaking engagements. In the year 2015-2016 the JLAP Director conducted the following Public Speaking Presentations:

10/8/15	LSU Law 45 th Annual Estate Planning Seminar
10/20/15	LSBA Bridging the GAP CLE (by Don Massey)
11/13/15	Department of Administrative Law CLE
12/15/15	LSBA Quality of Life Seminar
12/18/15	Baton Rouge Bar Association CLE by the Hour

01/17/16	LSBA Disabilities CLE
01/29/16	Annual Community Law Association Seminar
01/29/16	LSBA Ethics School
02/23/16	Tulane Law Character and Fitness Panel
03/09/16	LSU Law Character and Fitness Panel
03/15/16	Tulane Law Uncommon Counsel Presentation
03/19/16	ABA Labor and Employment Law Section CLE
03/23/16	LSU Law 2L Professionalism Class
03/30/16	Southern Law Mental Health Day
04/01/16	JLAP Annual CLE
04/08/16	Southern Law Character and Fitness Panel
04/12/16	Tulane Law Character and Fitness
04/21/16	LSBA Loyola Law Bar Admissions Program
04/22/16	22 nd J.D.C. Family Law Section CLE
06/09/16	LSBA Summer School
06/16/16	LSU Law 2L Professionalism Class
06/22/16	LSBA Ethics School

4. JLAP Annual CLE in Baton Rouge

The Annual JLAP Wellness CLE was held in Baton Rouge, Louisiana, on April 1, 2016.

Presentations included:

ASAM Standards for Safety Sensitive Workers

Dr. Greg Skipper, Promises Treatment Center, Santa Monica, California

Assisting Judges with Mental Health Issues

Hon. Sarah “Sallie” Krauss, Brooklyn, New York; past Chair of ABA CoLAP

Mindfulness and Mental Health

Dr. Geralyn Datz, Southern Behavioral Health

The Benefit of JLAP Compliance in Disciplinary Cases (Ethics)

Damon Manning, Esq., Schiff, Scheckman and White, L.L.C.

Treatment Approaches for Mental Illness and Substance Use Disorders (Prof.)

Buddy Stockwell, Executive Director JLAP

In addition, JLAP hosted an appreciation dinner for JLAP Volunteer Monitors and their guests.

5. JLAP Volunteer Monitor Training

JLAP's volunteer monitors around the state serve as a local resource to provide support to JLAP participants throughout the monitoring process. They meet in-person monthly with their assigned participant(s) and file reports with JLAP. All JLAP monitors are members of the LSBA's Committee on Alcohol and Drug Abuse and are bound by confidentiality.

The monitors provide vital peer support and personal interaction with the participant that helps to increase the program's reliability while also increasing support to the participant. JLAP is extremely grateful for the volunteers who provided this support.

In 2015-2016, JLAP's Clinical Staff provided statewide in-depth JLAP Monitor Training Seminars to educate and update monitors regarding recent changes at JLAP. The training seminars were conducted in Shreveport, Lafayette, and New Orleans. Training was provided on the following topics: 1) requirements for participants entering JLAP monitoring; 2) referral sources of participants being monitored; 3) self-help, ODC and COBA referral processes; 3) understanding substance use disorder diagnoses under the new DSM 5; 4) determining and reporting non-compliance; 5) recent developments in law and jurisprudence; and 6) drug screening policies, protocols and challenges.

JLAP's clinical staff intends to continue to provide these training seminars annually to support the volunteer monitors and discuss any questions or issues that arise when monitoring a JLAP participant.

6. ABA Commission on Lawyer Assistance Programs (CoLAP)

The JLAP Director and JLAP Clinical Director attended the 2015 ABA National Conference of Lawyers Assistance Programs Annual Seminar in Albuquerque, New Mexico, October 20-22, 2015.

Presentations during the CoLAP Seminar included:

The Current Rates of Substance Use, Depression and Anxiety within the Legal Profession: A Review of the Results of the ABA/Hazelden-Betty Ford Foundation Collaborative Research Project

Linda Albert, LCSW, CSAC, Manager, Wisconsin Lawyers Assistance Program
Patrick R. Krill, J.D., LL.M, M.A., L.A.D.C., Director, Hazelden Betty Ford Foundation, Legal Professionals Program

Neuropsychological Assessment of the Senior Attorney: Conceptual and Clinical Aspects

Daniel Marson, JD, PhD, University of Alabama at Birmingham

Marijuana: From Medicinal to Recreational: What Has Happened Along the Way?

Doris C. Gundersen, MD, Medical Director, Colorado Physicians Health Program James C. Coyle, Attorney Regulation Counsel, Colorado Supreme Court

Bringing It Together to Help the Distressed Attorney: Discipline, Clinical and Practice Management

Barbara Bowe, LICSW, Massachusetts Lawyers Concerned for Lawyers Rodney Dowell, Esq., Executive Director, Massachusetts Lawyers Concerned for Lawyers Lisa Villarreal-Rios, JD, LMSW, LCDC-I, Office of the Chief Disciplinary Counsel, State Bar of Texas

How LAP Volunteers Can Save the World

Stuart Teicher, Esq., Teicher Professional Growth, LLC

Positive Psychology for Lawyers – An Effective Intervention for Superior Professionalism and Substance Abuse and Relapse Prevention

Hallie N. Love, Esq.

Co-Occurring Disorders

Gregory K. Gable, Psy.D Executive Director, Professionals Programs, Caron Treatment Centers Joseph Garbely, D.O. Medical Director, Addiction Psychiatrist, Caron Treatment Centers C. Stuart Mauney, Esq., Gallivan, White & Boyd, P.A.

Past Your “Best By” Date? Helping Lawyers Face Up To Their Mortality

William D. Slease, Chief Disciplinary Counsel, New Mexico Supreme Court Disciplinary Board

Myths and Misconceptions about Alcoholics Anonymous

Michele Grinberg, J.D., Board Member, General Service Board of Alcoholics Anonymous

Reinstatement – Rising to the Challenge

Peter J. DeTroy, Esq., Norman Hanson & DeTroy Aria Eee, Esq., Deputy Bar Counsel, Maine Board of Overseers of the Bar William Nugent, Esq., Director, Maine Assistance Program for Lawyers & Judges

Addiction Recognition, Understanding and Intervention Connecting the Continuum: Prevention, Early Intervention and Recovery

Michael E. Larson, Esq., Director, Montana Lawyer Assistance Program Maryann Rosenthal, Ph.D., Executive Director, Recovery Ways

From "At-Risk" to "Intervened" Upon: Effective Ways to Help Identify and Educate At-Risk Law Students

David Jaffe, Co-chair, ABA Commission on Lawyer Assistance Programs, Law School Assistance Committee and Associate Dean for Student Affairs, American University Washington College of Law

Suicide Prevention Now

Henry (Chip) Glaze, Director, Lawyers & Judges Assistance Program, The Mississippi Bar
Shari R. Gregory, LCSW, JD, Assistant Director and Attorney Counselor, Oregon Attorney Assistance Program
Yvette Hourigan, Director, Kentucky Lawyer Assistance Program

Conditional Admission: Past, Present and Future

Tracy L. Kepler, Office of the Solicitor, USPTO

It's a Brain Disease ... and It Matters!

Navjyot Singh Bedi, MD, Medical Director, Talbott Recovery
Anne McDonald, Esq., Executive Director, Kansas Lawyers Assistance Program

Louisiana's JLAP organized the 2015 CoLAP Director's Day in Albuquerque, NM, preceding the conference on October 21, 2015, providing Directors from across the nation with the opportunity to network and enjoy time together. Activities included: tour of the Indian Pueblo Cultural Center; Luncheon with Native American Dance Presentation; and outdoor teambuilding exercises with the Routes Bicycle Tours of Albuquerque.

7. Treatment Center Relations and Inspections

JLAP maintains inspections of facilities and personally visits treatment facilities to verify current suitability for referrals. JLAP does not publish a list of treatment centers or providers because the industry is dynamic and treatment that was great last year, month, or week may have experienced a problem or change that now renders it unsuitable for JLAP-approval.

Moreover, depending on the person's individual symptomology and circumstances, there may be certain facilities that are better suited to provide treatment. Also, it is JLAP's duty to ensure that any JLAP-approved effort is reliable, genuine and based on complete disclosure of clinically-relevant information and history.

As such, persons seeking JLAP's help should always contact JLAP's clinical staff and discuss their assessment and treatment needs prior to selecting a treatment facility. It can be very frustrating to complete a non-approved treatment program and then find out after the fact that JLAP cannot endorse those efforts.

During FY 2015-2016 JLAP's Staff personally inspected five (5) inpatient facilities with professionals' track treatment programs and with expertise in diagnosing and treating ASAM Safety Sensitive Workers. At present, JLAP has eight (8) different facilities available.

JLAP's clinical professionals stand ready to, on a case-by-case basis and based upon each person's specific issues, facilitate inpatient assessment or treatment that is tailored to the individual and best meet their clinical needs.

8. Louisiana Supreme Court's Committee On Bar Admissions ("COBA")

JLAP continues to facilitate independent evaluations and recovery monitoring for the Louisiana Supreme Court's COBA. By facilitating JLAP-approved independent evaluations, JLAP assists COBA in its efforts to determine whether or not a student with past alcohol/drug issues is currently fit to practice law.

Depending on the diagnosis, and after the completion of any necessary clinical intervention or treatment, COBA may require successful monitoring prior to recommending conditional admission and during conditional admission thereafter.

Pursuant to Supreme Court Rule XVII, JLAP is the Monitoring Authority for conditionally admitted lawyers in cases involving "substance abuse, physical, mental, or emotional disability or instability."

As such, JLAP's role in the conditional admission process is comprehensive, and JLAP renders services to COBA in all applicable mental health and substance related monitoring cases.

9. Louisiana State Bar Association ("LSBA")

In 2015-16, the *Louisiana Bar Journal* published a JLAP column in each issue. Articles included topics such as what JLAP is and what it does, the diseases of alcoholism, addiction, depression, and mental illnesses that impair lawyers and judges. Moreover, articles discussed how to attenuate stigmas surrounding alcoholism, addiction and depression so as to encourage members of the legal profession to reach out early to JLAP for confidential help. A complete library of JLAP's articles can be found at the "Resources" link on JLAP's website at www.louisianajlap.com.

The Bar Journal also produced high quality advertisements to raise awareness about depression and JLAP's available services.

The LSBA also continues to produce a Bar Admissions Education Program in all the law schools. The JLAP Director participates to help inform law students about the challenges they face in the legal profession, not only as to being admitted but also maintaining good mental health under the pressures of practicing law.

Each year the JLAP Director and Clinical Staff participate personally in various LSBA produced CLE programs across the state and JLAP strives to provide high-quality presentations that help contribute to the LSBA's ongoing success in providing excellent legal education services to the Louisiana legal profession.

JLAP is extremely grateful for the LSBA Board of Governors' ongoing, zealous support of JLAP. The financial and marketing support provided by the LSBA is critical to JLAP's operation and effectiveness.

10. The Office of the Disciplinary Counsel (“ODC”)

Referrals from the ODC cover a wide range of issues. No longer limited to substance use disorder-related problems, JLAP fields all mental health referrals coming to bear in disciplinary investigation matters including, but not limited to, depression, anxiety, burnout, anger management, and any other mental health issue that may have been a contributing factor or cause in fact of alleged unethical conduct being investigated.

JLAP also provides full services to ODC investigation referrals including JLAP-approved screening and evaluations, formal monitoring agreements, random drug screening, and quarterly compliance reports to ODC as required by the ODC.

During formal disciplinary proceedings, parties may depend heavily on JLAP’s expertise in obtaining independent and reliable diagnoses, facilitating high-quality treatment or therapy as indicated, and documenting long-term success (or failure) in recovery, all to support the individual’s recovery and concurrently help protect the public from the damage that impaired lawyers can cause.

JLAP continues to provide expert testimony in Louisiana Disciplinary Board (“LADB”) Hearings for the Supreme Court’s consideration in disciplinary matters and as to respondents’ compliance or non-compliance in JLAP. Whether subpoenaed by the ODC or the Respondent, JLAP provides testimony and evidence regarding the quality of participants’ efforts at JLAP.

It is paramount to keep JLAP’s mandate of confidentiality under La. R.S. 37:221 at the forefront when discussing JLAP’s involvement in disciplinary matters. JLAP is not an arm of discipline and serves no prosecutorial or punitive function whatsoever. JLAP never refers participants to Discipline. Even when the ODC refers a person to JLAP, all contact with JLAP remains strictly confidential and voluntary unless the person executes a release. Only the attorney in trouble can waive confidentiality and allow JLAP to communicate with the ODC and testify at LADB hearings.

11. SOLACE Program

Each year JLAP receives direct referrals from the “SOLACE” program which the Louisiana State Bar Association/Louisiana Bar Foundation’s Community Action Committee reaches out in meaningful and compassionate ways to judges, lawyers, court personnel, paralegals, legal secretaries and their families who experience deaths or other catastrophic illnesses, sickness or injury.

SOLACE’s volunteer support can range from simply sending the family a card signed by local and state leaders to providing the family with meals, needed support, assistance with grocery shopping or child care, or other similar services.

Fourteen volunteer SOLACE coordinators are serving around the state to rally local support for those in need of help from their community. The SOLACE Program was founded by JLAP's President, Mark Surprenant, and also the Honorable, Jay C. Zainey, U.S District Court, Eastern District of Louisiana. Judge Zainey serves as the main contact for SOLACE and he maintains a listserv to broadcast calls for help to the whole group. JLAP is included on the listserv.

In the course of fielding calls for community support, SOLACE occasionally receives a call involving a person in crisis with drugs, alcohol, depression or even demonstrating suicidal ideations. SOLACE confidentially refers these cases to JLAP. JLAP then confidentially assists the person appearing to be in need of mental health care, clinical intervention, and JLAP support.

12. SUMMARY

2015-2016 and the preceding two years mark a period of very challenging tasks for JLAP in its transition into a full-service professionals' program with appropriate clinical staff and clinical standards necessary to reliably serve licensed professionals.

JLAP's campaign of upgrades and improvements has required unprecedented effort, not only by JLAP's staff but by all of the members of JLAP's Board of Directors and Operations Committee who have dedicated a truly unbelievable amount of their volunteer time toward creating and supporting Louisiana's new JLAP as a top-tier program.

Moreover, JLAP owes a tremendous debt of gratitude to the Louisiana Supreme Court; the LSBA Leadership; the Office of the Disciplinary Counsel; the Louisiana Supreme Court's Committee on Bar Admissions; and the Judiciary Commission for uniform and strong support of our Louisiana JLAP. By all entities working together, JLAP is now able to save more lives than ever before.

The Judges and Lawyers Assistance Program will not rest. Its unflagging commitment to excellence remains resolute and it looks forward to effectively supporting the mental health of our noble profession while also helping to protect the public that it serves.

Respectfully Submitted,



Buddy Stockwell, Executive Director



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LSBA Board of Governors
(The report is also available to the public online at: www.louisianajlap.com)

EXHIBIT A

2016 STUDY:

*The Prevalence of Substance Use and Other Mental
Health Concerns Among American Attorneys*

By

Patrick Krill, JD, LLM, Ryan Johnson, MA, and Linda Albert, MSSW

OPEN

The Prevalence of Substance Use and Other Mental Health Concerns Among American Attorneys

Patrick R. Krill, JD, LLM, Ryan Johnson, MA, and Linda Albert, MSSW

Objectives: Rates of substance use and other mental health concerns among attorneys are relatively unknown, despite the potential for harm that attorney impairment poses to the struggling individuals themselves, and to our communities, government, economy, and society. This study measured the prevalence of these concerns among licensed attorneys, their utilization of treatment services, and what barriers existed between them and the services they may need.

Methods: A sample of 12,825 licensed, employed attorneys completed surveys, assessing alcohol use, drug use, and symptoms of depression, anxiety, and stress.

Results: Substantial rates of behavioral health problems were found, with 20.6% screening positive for hazardous, harmful, and potentially alcohol-dependent drinking. Men had a higher proportion of positive screens, and also younger participants and those working in the field for a shorter duration ($P < 0.001$). Age group predicted Alcohol Use Disorders Identification Test scores; respondents 30 years of age or younger were more likely to have a higher score than their older peers ($P < 0.001$). Levels of depression, anxiety, and stress among attorneys were significant, with 28%, 19%, and 23% experiencing symptoms of depression, anxiety, and stress, respectively.

Conclusions: Attorneys experience problematic drinking that is hazardous, harmful, or otherwise consistent with alcohol use disorders at a higher rate than other professional populations. Mental health distress is also significant. These data underscore the need for greater resources for lawyer assistance programs, and also the expansion of available attorney-specific prevention and treatment interventions.

Key Words: attorneys, mental health, prevalence, substance use

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Little is known about the current behavioral health climate in the legal profession. Despite a widespread belief that attorneys experience substance use disorders and other mental health concerns at a high rate, few studies have been undertaken to validate these beliefs empirically or statistically. Although previous research had indicated that those in the legal profession struggle with problematic alcohol use, depression, and anxiety more so than the general population, the issues have largely gone unexamined for decades (Benjamin et al., 1990; Eaton et al., 1990; Beck et al., 1995). The most recent and also the most widely cited research on these issues comes from a 1990 study involving approximately 1200 attorneys in Washington State (Benjamin et al., 1990). Researchers found 18% of attorneys were problem drinkers, which they stated was almost twice the 10% estimated prevalence of alcohol abuse and dependence among American adults at that time. They further found that 19% of the Washington lawyers suffered from statistically significant elevated levels of depression, which they contrasted with the then-current depression estimates of 3% to 9% of individuals in Western industrialized countries.

While the authors of the 1990 study called for additional research about the prevalence of alcoholism and depression among practicing US attorneys, a quarter century has passed with no such data emerging. In contrast, behavioral health issues have been regularly studied among physicians, providing a firmer understanding of the needs of that population (Oreskovich et al., 2012). Although physicians experience substance use disorders at a rate similar to the general population, the public health and safety issues associated with physician impairment have led to intense public and professional interest in the matter (DuPont et al., 2009).

Although the consequences of attorney impairment may seem less direct or urgent than the threat posed by impaired physicians, they are nonetheless profound and far-reaching. As a licensed profession that influences all aspects of society, economy, and government, levels of impairment among attorneys are of great importance and should therefore be closely evaluated (Rothstein, 2008). A scarcity of data on the current rates of substance use and mental health concerns among lawyers, therefore, has substantial implications and must be addressed. Although many in the profession have long understood the need for greater resources and support for attorneys struggling with addiction or other mental health concerns, the formulation of cohesive and informed strategies for addressing those issues has been handicapped by the

outdated and poorly defined scope of the problem (Association of American Law Schools, 1994).

Recognizing this need, we set out to measure the prevalence of substance use and mental health concerns among licensed attorneys, their awareness and utilization of treatment services, and what, if any, barriers exist between them and the services they may need. We report those findings here.

METHODS

Procedures

Before recruiting participants to the study, approval was granted by an institutional review board. To obtain a representative sample of attorneys within the United States, recruitment was coordinated through 19 states. Among them, 15 state bar associations and the 2 largest counties of 1 additional state e-mailed the survey to their members. Those bar associations were instructed to send 3 recruitment e-mails over a 1-month period to all members who were currently licensed attorneys. Three additional states posted the recruitment announcement to their bar association web sites. The recruitment announcements provided a brief synopsis of the study and past research in this area, described the goals of the study, and provided a URL directing people to the consent form and electronic survey. Participants completed measures assessing alcohol use, drug use, and mental health symptoms. Participants were not asked for identifying information, thus allowing them to complete the survey anonymously. Because of concerns regarding potential identification of individual bar members, IP addresses and geo-location data were not tracked.

Participants

A total of 14,895 individuals completed the survey. Participants were included in the analyses if they were currently employed, and employed in the legal profession, resulting in a final sample of 12,825. Due to the nature of recruitment (eg, e-mail blasts, web postings), and that recruitment mailing lists were controlled by the participating bar associations, it is not possible to calculate a participation rate among the entire population. Demographic characteristics are presented in Table 1. Fairly equal numbers of men (53.4%) and women (46.5%) participated in the study. Age was measured in 6 categories from 30 years or younger, and increasing in 10-year increments to 71 years or older; the most commonly reported age group was 31 to 40 years old. The majority of the participants were identified as Caucasian/White (91.3%).

As shown in Table 2, the most commonly reported legal professional career length was 10 years or less (34.8%), followed by 11 to 20 years (22.7%) and 21 to 30 years (20.5%). The most common work environment reported was in private firms (40.9%), among whom the most common positions were Senior Partner (25.0%), Junior Associate (20.5%), and Senior Associate (20.3%). Over two-thirds (67.2%) of the sample reported working 41 hours or more per week.

TABLE 1. Participant Characteristics

	n (%)
Total sample	12825 (100)
Sex	
Men	6824 (53.4)
Women	5941 (46.5)
Age category	
30 or younger	1513 (11.9)
31–40	3205 (25.2)
41–50	2674 (21.0)
51–60	2953 (23.2)
61–70	2050 (16.1)
71 or older	348 (2.7)
Race/ethnicity	
Caucasian/White	11653 (91.3)
Latino/Hispanic	330 (2.6)
Black/African American (non-Hispanic)	317 (2.5)
Multiracial	189 (1.5)
Asian or Pacific Islander	150 (1.2)
Other	84 (0.7)
Native American	35 (0.3)
Marital status	
Married	8985 (70.2)
Single, never married	1790 (14.0)
Divorced	1107 (8.7)
Cohabiting	462 (3.6)
Life partner	184 (1.4)
Widowed	144 (1.1)
Separated	123 (1.0)
Have children	
Yes	8420 (65.8)
No	4384 (34.2)
Substance use in the past 12 mos*	
Alcohol	10874 (84.1)
Tobacco	2163 (16.9)
Sedatives	2015 (15.7)
Marijuana	1307 (10.2)
Opioids	722 (5.6)
Stimulants	612 (4.8)
Cocaine	107 (0.8)

*Substance use includes both illicit and prescribed usage.

Materials

Alcohol Use Disorders Identification Test

The Alcohol Use Disorders Identification Test (AUDIT) (Babor et al., 2001) is a 10-item self-report instrument developed by the World Health Organization (WHO) to screen for hazardous use, harmful use, and the potential for alcohol dependence. The AUDIT generates scores ranging from 0 to 40. Scores of 8 or higher indicate hazardous or harmful alcohol intake, and also possible dependence (Babor et al., 2001). Scores are categorized into zones to reflect increasing severity with zone II reflective of hazardous use, zone III indicative of harmful use, and zone IV warranting full diagnostic evaluation for alcohol use disorder. For the purposes of this study, we use the phrase “problematic use” to capture all 3 of the zones related to a positive AUDIT screen.

The AUDIT is a widely used instrument, with well established validity and reliability across a multitude of populations (Meneses-Gaya et al., 2009). To compare current rates of problem drinking with those found in other populations, AUDIT-C scores were also calculated. The AUDIT-C is a subscale comprised of the first 3 questions of the AUDIT

TABLE 2. Professional Characteristics

	n (%)
Total sample	12825 (100)
Years in field (yrs)	
0–10	4455 (34.8)
11–20	2905 (22.7)
21–30	2623 (20.5)
31–40	2204 (17.2)
41 or more	607 (4.7)
Work environment	
Private firm	5226 (40.9)
Sole practitioner, private practice	2678 (21.0)
In-house government, public, or nonprofit	2500 (19.6)
In-house: corporation or for-profit institution	937 (7.3)
Judicial chambers	750 (7.3)
Other law practice setting	289 (2.3)
College or law school	191 (1.5)
Other setting (not law practice)	144 (1.1)
Bar Administration or Lawyers Assistance Program	55 (0.4)
Firm position	
Clerk or paralegal	128 (2.5)
Junior associate	1063 (20.5)
Senior associate	1052 (20.3)
Junior partner	608 (11.7)
Managing partner	738 (14.2)
Senior partner	1294 (25.0)
Hours per wk	
Under 10 h	238 (1.9)
11–20 h	401 (3.2)
21–30 h	595 (4.7)
31–40 h	2946 (23.2)
41–50 h	5624 (44.2)
51–60 h	2310 (18.2)
61–70 h	474 (3.7)
71 h or more	136 (1.1)
Any litigation	
Yes	9611 (75.0)
No	3197 (25.0)

focused on the quantity and frequency of use, yielding a range of scores from 0 to 12. The results were analyzed using a cut-off score of 5 for men and 4 for women, which have been interpreted as a positive screen for alcohol abuse or possible alcohol dependence (Bradley et al., 1998; Bush et al., 1998). Two other subscales focus on dependence symptoms (eg, impaired control, morning drinking) and harmful use (eg, blackouts, alcohol-related injuries).

Depression Anxiety Stress Scales-21 item version

The Depression Anxiety Stress Scales-21 (DASS-21) is a self-report instrument consisting of three 7-item subscales assessing symptoms of depression, anxiety, and stress. Individual items are scored on a 4-point scale (0–3), allowing for subscale scores ranging from 0 to 21 (Lovibond and Lovibond, 1995). Past studies have shown adequate construct validity and high internal consistency reliability (Antony et al., 1998; Clara et al., 2001; Crawford and Henry, 2003; Henry and Crawford, 2005).

Drug Abuse Screening Test-10 item version

The short-form Drug Abuse Screening Test-10 (DAST) is a 10-item, self-report instrument designed to screen and quantify consequences of drug use in both a clinical and

research setting. The DAST scores range from 0 to 10 and are categorized into low, intermediate, substantial, and severe-concern categories. The DAST-10 correlates highly with both 20-item and full 28-item versions, and has demonstrated reliability and validity (Yudko et al., 2007).

RESULTS

Descriptive statistics were used to outline personal and professional characteristics of the sample. Relationships between variables were measured through χ^2 tests for independence, and comparisons between groups were tested using Mann-Whitney *U* tests and Kruskal-Wallis tests.

Alcohol Use

Of the 12,825 participants included in the analysis, 11,278 completed all 10 questions on the AUDIT, with 20.6% of those participants scoring at a level consistent with problematic drinking. The relationships between demographic and professional characteristics and problematic drinking are summarized in Table 3. Men had a significantly higher proportion of positive screens for problematic use compared with women (χ^2 [1, *N* = 11,229] = 154.57, *P* < 0.001); younger participants had a significantly higher proportion compared with the older age groups (χ^2 [6, *N* = 11,213] = 232.15, *P* < 0.001); and those working in the field for a shorter duration had a significantly higher proportion compared with those who had worked in the field for longer (χ^2 [4, *N* = 11,252] = 230.01, *P* < 0.001). Relative to work environment and position, attorneys working in private firms or for the bar association had higher proportions than those in other environments (χ^2 [8, *N* = 11,244] = 43.75, *P* < 0.001), and higher proportions were also found for those at the junior or senior associate level compared with other positions (χ^2 [6, *N* = 4671] = 61.70, *P* < 0.001).

Of the 12,825 participants, 11,489 completed the first 3 AUDIT questions, allowing an AUDIT-C score to be calculated. Among these participants, 36.4% had an AUDIT-C score consistent with hazardous drinking or possible alcohol abuse or dependence. A significantly higher proportion of women (39.5%) had AUDIT-C scores consistent with problematic use compared with men (33.7%) (χ^2 [1, *N* = 11,440] = 41.93, *P* < 0.001).

A total of 2901 participants (22.6%) reported that they have felt their use of alcohol or other substances was problematic at some point in their lives; of those that felt their use has been a problem, 27.6% reported problematic use manifested before law school, 14.2% during law school, 43.7% within 15 years of completing law school, and 14.6% more than 15 years after completing law school.

An ordinal regression was used to determine the predictive validity of age, position, and number of years in the legal field on problematic drinking behaviors, as measured by the AUDIT. Initial analyses included all 3 factors in a model to predict whether or not respondents would have a clinically significant total AUDIT score of 8 or higher. Age group predicted clinically significant AUDIT scores; respondents 30 years of age or younger were significantly more likely to have a higher score than their older peers (β = 0.52, Wald [*df* = 1] = 4.12, *P* < 0.001). Number of years in the field

TABLE 3. Summary Statistics for Alcohol Use Disorders Identification Test (AUDIT)

	AUDIT Statistics			Problematic %*	P**
	n	M	SD		
Total sample	11,278	5.18	4.53	20.6%	
Sex					
Men	6012	5.75	4.88	25.1%	<0.001
Women	5217	4.52	4.00	15.5%	
Age category (yrs)					
30 or younger	1393	6.43	4.56	31.9%	<0.001
31–40	2877	5.84	4.86	25.1%	
41–50	2345	4.99	4.65	19.1%	
51–60	2548	4.63	4.38	16.2%	
61–70	1753	4.33	3.80	14.4%	
71 or older	297	4.22	3.28	12.1%	
Years in field (yrs)					
0–10	3995	6.08	4.78	28.1%	<0.001
11–20	2523	5.02	4.66	19.2%	
21–30	2272	4.65	4.43	15.6%	
31–40	1938	4.39	3.87	15.0%	
41 or more	524	4.18	3.29	13.2%	
Work environment					
Private firm	4712	5.57	4.59	23.4%	<0.001
Sole practitioner, private practice	2262	4.94	4.72	19.0%	
In-house: government, public, or nonprofit	2198	4.94	4.45	19.2%	
In-house: corporation or for-profit institution	828	4.91	4.15	17.8%	
Judicial chambers	653	4.46	3.83	16.1%	
College or law school	163	4.90	4.66	17.2%	
Bar Administration or Lawyers Assistance Program	50	5.32	4.62	24.0%	
Firm position					
Clerk or paralegal	115	5.05	4.13	16.5%	<0.001
Junior associate	964	6.42	4.57	31.1%	
Senior associate	938	5.89	5.05	26.1%	
Junior partner	552	5.76	4.85	23.6%	
Managing partner	671	5.22	4.53	21.0%	
Senior partner	1159	4.99	4.26	18.5%	

*The AUDIT cut-off for hazardous, harmful, or potential alcohol dependence was set at a score of 8.

**Comparisons were analyzed using Mann-Whitney *U* tests and Kruskal-Wallis tests.

approached significance, with higher AUDIT scores predicted for those just starting out in the legal profession (0–10 yrs of experience) ($\beta = 0.46$, Wald [$df = 1$] = 3.808, $P = 0.051$). Model-based calculated probabilities for respondents aged 30 or younger indicated that they had a mean probability of 0.35 (standard deviation [SD] = 0.01), or a 35% chance for scoring an 8 or higher on the AUDIT; in comparison, those respondents who were 61 or older had a mean probability of 0.17 (SD = 0.01), or a 17% chance of scoring an 8 or higher.

Each of the 3 subscales of the AUDIT was also investigated. For the AUDIT-C, which measures frequency and quantity of alcohol consumed, age was a strong predictor of subscore, with younger respondents demonstrating significantly higher AUDIT-C scores. Respondents who were 30 years old or younger, 31 to 40 years old, and 41 to 50 years old all had significantly higher AUDIT-C scores than their older peers, respectively ($\beta = 1.16$, Wald [$df = 1$] = 24.56, $P < 0.001$; $\beta = 0.86$, Wald [$df = 1$] = 16.08, $P < 0.001$; and $\beta = 0.48$, Wald [$df = 1$] = 6.237, $P = 0.013$), indicating that younger age predicted higher frequencies of drinking and quantity of alcohol consumed. No other factors were significant predictors of AUDIT-C scores. Neither the predictive model for the dependence subscale nor the harmful use subscale indicated significant predictive ability for the 3 included factors.

Drug Use

Participants were questioned regarding their use of various classes of both licit and illicit substances to provide a basis for further study. Participant use of substances is displayed in Table 1. Of participants who endorsed use of a specific substance class in the past 12 months, those using stimulants had the highest rate of weekly usage (74.1%), followed by sedatives (51.3%), tobacco (46.8%), marijuana (31.0%), and opioids (21.6%). Among the entire sample, 26.7% ($n = 3419$) completed the DAST, with a mean score of 1.97 (SD = 1.36). Rates of low, intermediate, substantial, and severe concern were 76.0%, 20.9%, 3.0%, and 0.1%, respectively. Data collected from the DAST were found to not meet the assumptions for more advanced statistical procedures. As a result, no inferences about these data could be made.

Mental Health

Among the sample, 11,516 participants (89.8%) completed all questions on the DASS-21. Relationships between demographic and professional characteristics and depression, anxiety, and stress subscale scores are summarized in Table 4. While men had significantly higher levels of depression ($P < 0.05$) on the DASS-21, women had higher levels of anxiety ($P < 0.001$) and stress ($P < 0.001$). DASS-21 anxiety,

TABLE 4. Summary Statistics for Depression Anxiety Stress Scale (DASS-21)

	DASS Depression				DASS Anxiety				DASS Stress			
	n	M	SD	P*	n	M	SD	P*	n	M	SD	P*
Total sample	12300	3.51	4.29		12277	1.96	2.82		12271	4.97	4.07	
Sex												
Men	6518	3.67	4.46	<0.05	6515	1.84	2.79	<0.001	6514	4.75	4.08	<0.001
Women	5726	3.34	4.08		5705	2.10	2.86		5705	5.22	4.03	
Age category (yrs)												
30 or younger	1476	3.71	4.15	<0.001	1472	2.62	3.18	<0.001	1472	5.54	4.61	<0.001
31–40	3112	3.96	4.50		3113	2.43	3.15		3107	5.99	4.31	
41–50	2572	3.83	4.54		2565	2.03	2.92		2559	5.36	4.12	
51–60	2808	3.41	4.27		2801	1.64	2.50		2802	4.47	3.78	
61–70	1927	2.63	3.65		1933	1.20	2.06		1929	3.46	3.27	
71 or older	326	2.03	3.16		316	0.95	1.73		325	2.72	3.21	
Years in field												
0–10 yrs	4330	3.93	4.45	<0.001	4314	2.51	3.13	<0.001	4322	5.82	4.24	<0.001
11–20 yrs	2800	3.81	4.48		2800	2.09	3.01		2777	5.45	4.20	
21–30 yrs	2499	3.37	4.21		2509	1.67	2.59		2498	4.46	3.79	
31–40 yrs	2069	2.81	3.84		2063	1.22	1.98		2084	3.74	3.43	
41 or more yrs	575	1.95	3.02		564	1.01	1.94		562	2.81	3.01	
Work environment												
Private firm	5028	3.47	4.17	<0.001	5029	2.01	2.85	<0.001	5027	5.11	4.06	<0.001
Sole practitioner, private practice	2568	4.27	4.84		2563	2.18	3.08		2567	5.22	4.34	
In-house: government, public, or nonprofit	2391	3.45	4.26		2378	1.91	2.69		2382	4.91	3.97	
In-house: corporation or for-profit institution	900	2.96	3.66		901	1.84	2.80		898	4.74	3.97	
Judicial chambers	717	2.39	3.50		710	1.31	2.19		712	3.80	3.44	
College or law school	182	2.90	3.72		188	1.43	2.09		183	4.48	3.61	
Bar Administration or Lawyers Assistance Program	55	2.96	3.65		52	1.40	1.94		53	4.74	3.55	
Firm position												
Clerk or paralegal	120	3.98	4.97	<0.001	121	2.10	2.88	<0.001	121	4.68	3.81	<0.001
Junior associate	1034	3.93	4.25		1031	2.73	3.31		1033	5.78	4.16	
Senior associate	1021	4.20	4.60		1020	2.37	2.95		1020	5.91	4.33	
Junior partner	590	3.88	4.22		592	2.16	2.78		586	5.68	4.15	
Managing partner	713	2.77	3.58		706	1.62	2.50		709	4.73	3.84	
Senior partner	1219	2.70	3.61		1230	1.37	2.43		1228	4.08	3.57	
DASS-21 category frequencies	n	%			n	%			n	%		
Normal	8816	71.7			9908	80.7			9485	77.3		
Mild	1172	9.5			1059	8.6			1081	8.8		
Moderate	1278	10.4			615	5.0			1001	8.2		
Severe	496	4.0			310	2.5			546	4.4		
Extremely severe	538	4.4			385	3.1			158	1.3		

*Comparisons were analyzed using Mann-Whitney *U* tests and Kruskal-Wallis tests.

depression, and stress scores decreased as participants' age or years worked in the field increased ($P < 0.001$). When comparing positions within private firms, more senior positions were generally associated with lower DASS-21 subscale scores ($P < 0.001$). Participants classified as nonproblematic drinkers on the AUDIT had lower levels of depression, anxiety, and stress ($P < 0.001$), as measured by the DASS-21. Comparisons of DASS-21 scores by AUDIT drinking classification are outlined in Table 5.

Participants were questioned regarding any past mental health concerns over the course of their legal career, and provided self-report endorsement of any specific mental health concerns they had experienced. The most common mental health conditions reported were anxiety (61.1%), followed by depression (45.7%), social anxiety (16.1%), attention deficit hyperactivity disorder (12.5%), panic disorder (8.0%), and bipolar disorder (2.4%). In addition, 11.5% of the participants reported suicidal thoughts at some point during their career, 2.9% reported self-injurious behaviors, and 0.7% reported at least 1 prior suicide attempt.

Treatment Utilization and Barriers to Treatment

Of the 6.8% of the participants who reported past treatment for alcohol or drug use ($n = 807$), 21.8% ($n = 174$) reported utilizing treatment programs specifically tailored to legal professionals. Participants who had reported prior treatment tailored to legal professionals had significantly lower mean AUDIT scores ($M = 5.84$, $SD = 6.39$) than participants who attended a treatment program not tailored to legal professionals ($M = 7.80$, $SD = 7.09$, $P < 0.001$).

Participants who reported prior treatment for substance use were questioned regarding barriers that impacted their ability to obtain treatment services. Those reporting no prior treatment were questioned regarding hypothetical barriers in the event they were to need future treatment or services. The 2 most common barriers were the same for both groups: not wanting others to find out they needed help (50.6% and 25.7% for the treatment and nontreatment groups, respectively), and concerns regarding privacy or confidentiality (44.2% and 23.4% for the groups, respectively).

TABLE 5. Relationship AUDIT Drinking Classification and DASS-21 Mean Scores

		Nonproblematic	Problematic*	P**
		M (SD)	M (SD)	
DASS-21 total score		9.36 (8.98)	14.77 (11.06)	<0.001
DASS-21 subscale scores	Depression	3.08 (3.93)	5.22 (4.97)	<0.001
	Anxiety	1.71 (2.59)	2.98 (3.41)	<0.001
	Stress	4.59 (3.87)	6.57 (4.38)	<0.001

AUDIT, Alcohol Use Disorders Identification Test; DASS-21, Depression Anxiety Stress Scales-21.

*The AUDIT cut-off for hazardous, harmful, or potential alcohol dependence was set at a score of 8.

**Means were analyzed using Mann-Whitney *U* tests.

DISCUSSION

Our research reveals a concerning amount of behavioral health problems among attorneys in the United States. Our most significant findings are the rates of hazardous, harmful, and potentially alcohol dependent drinking and high rates of depression and anxiety symptoms. We found positive AUDIT screens for 20.6% of our sample; in comparison, 11.8% of a broad, highly educated workforce screened positive on the same measure (Matano et al., 2003). Among physicians and surgeons, Oreskovich et al. (2012) found that 15% screened positive on the AUDIT-C subscale focused on the quantity and frequency of use, whereas 36.4% of our sample screened positive on the same subscale. While rates of problematic drinking in our sample are generally consistent with those reported by Benjamin et al. (1990) in their study of attorneys (18%), we found considerably higher rates of mental health distress.

We also found interesting differences among attorneys at different stages of their careers. Previous research had demonstrated a positive association between the increased prevalence of problematic drinking and an increased amount of years spent in the profession (Benjamin et al., 1990). Our findings represent a direct reversal of that association, with attorneys in the first 10 years of their practice now experiencing the highest rates of problematic use (28.9%), followed by attorneys practicing for 11 to 20 years (20.6%), and continuing to decrease slightly from 21 years or more. These percentages correspond with our findings regarding position within a law firm, with junior associates having the highest rates of problematic use, followed by senior associates, junior partners, and senior partners. This trend is further reinforced by the fact that of the respondents who stated that they believe their alcohol use has been a problem (23%), the majority (44%) indicated that the problem began within the first 15 years of practice, as opposed to those who indicated the problem started before law school (26.7%) or after more than 15 years in the profession (14.5%). Taken together, it is reasonable to surmise from these findings that being in the early stages of one's legal career is strongly correlated with a high risk of developing an alcohol use disorder. Working from the assumption that a majority of new attorneys will be under the age of 40, that conclusion is further supported by the fact that the highest rates of problematic drinking were present among attorneys under the age of 30 (32.3%), followed by

attorneys aged 31 to 40 (26.1%), with declining rates reported thereafter.

Levels of depression, anxiety, and stress among attorneys reported here are significant, with 28%, 19%, and 23% experiencing mild or higher levels of depression, anxiety, and stress, respectively. In terms of career prevalence, 61% reported concerns with anxiety at some point in their career and 46% reported concerns with depression. Mental health concerns often co-occur with alcohol use disorders (Gianoli and Petrakis, 2013), and our study reveals significantly higher levels of depression, anxiety, and stress among those screening positive for problematic alcohol use. Furthermore, these mental health concerns manifested on a similar trajectory to alcohol use disorders, in that they generally decreased as both age and years in the field increased. At the same time, those with depression, anxiety, and stress scores within the normal range endorsed significantly fewer behaviors associated with problematic alcohol use.

While some individuals may drink to cope with their psychological or emotional problems, others may experience those same problems as a result of their drinking. It is not clear which scenario is more prevalent or likely in this population, though the ubiquity of alcohol in the legal professional culture certainly demonstrates both its ready availability and social acceptability, should one choose to cope with their mental health problems in that manner. Attorneys working in private firms experience some of the highest levels of problematic alcohol use compared with other work environments, which may underscore a relationship between professional culture and drinking. Irrespective of causation, we know that co-occurring disorders are more likely to remit when addressed concurrently (Gianoli and Petrakis, 2013). Targeted interventions and strategies to simultaneously address both the alcohol use and mental health of newer attorneys warrant serious consideration and development if we hope to increase overall well being, longevity, and career satisfaction.

Encouragingly, many of the same attorneys who seem to be at risk for alcohol use disorders are also those who should theoretically have the greatest access to, and resources for, therapy, treatment, and other support. Whether through employer-provided health plans or increased personal financial means, attorneys in private firms could have more options for care at their disposal. However, in light of the pervasive fears surrounding their reputation that many identify as a barrier to treatment, it is not at all clear that these individuals would avail themselves of the resources at their disposal while working in the competitive, high-stakes environment found in many private firms.

Compared with other populations, we find the significantly higher prevalence of problematic alcohol use among attorneys to be compelling and suggestive of the need for tailored, profession-informed services. Specialized treatment services and profession-specific guidelines for recovery management have demonstrated efficacy in the physician population, amounting to a level of care that is quantitatively and qualitatively different and more effective than that available to the general public (DuPont et al., 2009).

Our study is subject to limitations. The participants represent a convenience sample recruited through e-mails and

news postings to state bar mailing lists and web sites. Because the participants were not randomly selected, there may be a voluntary response bias, over-representing individuals that have a strong opinion on the issue. Additionally, some of those that may be currently struggling with mental health or substance use issues may have not noticed or declined the invitation to participate. Because the questions in the survey asked about intimate issues, including issues that could jeopardize participants' legal careers if asked in other contexts (eg, illicit drug use), the participants may have withheld information or responded in a way that made them seem more favorable. Participating bar associations voiced a concern over individual members being identified based on responses to questions; therefore no IP addresses or geo-location data were gathered. However, this also raises the possibility that a participant took the survey more than once, although there was no evidence in the data of duplicate responses. Finally, and most importantly, it must be emphasized that estimations of problematic use are not meant to imply that all participants in this study deemed to demonstrate symptoms of alcohol use or other mental health disorders would individually meet diagnostic criteria for such disorders in the context of a structured clinical assessment.

CONCLUSIONS

Attorneys experience problematic drinking that is hazardous, harmful, or otherwise generally consistent with alcohol use disorders at a rate much higher than other populations. These levels of problematic drinking have a strong association with both personal and professional characteristics, most notably sex, age, years in practice, position within firm, and work environment. Depression, anxiety, and stress are also significant problems for this population and most notably associated with the same personal and professional characteristics. The data reported here contribute to the fund of knowledge related to behavioral health concerns among practicing attorneys and serve to inform investments in lawyer assistance programs and an increase in the availability of attorney-specific treatment. Greater education aimed at prevention is also indicated, along with public awareness campaigns within the profession designed to overcome the pervasive stigma surrounding substance use disorders and mental health concerns. The confidential nature of lawyer-assistance programs should be more widely publicized in an effort to overcome the privacy concerns that may create barriers between struggling attorneys and the help they need.

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