LIGHT AND LIFE AT THE END OF THE TUNNEL

Recovering from Debilitating Mental Conditions or Addictions

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Your lawyer in practice spends a considerable part of his life in doing distasteful things for disagreeable people who must be satisfied against an impossible time limit in which there are hourly interruptions from other disagreeable people who want to derail the train; and for his blood, sweat, and tears, he receives in the end a few unkind words to the effect that it might have been done better, and a protest at the size of the fee.

-William L. Prossner

See http://fullmetalattorney.blogspot.com/2005/11/william-l-prossner-quote.html

<u>OUTLINE</u>

I. RESOURCES

- A. YOUR PHYSICIAN
- B. BAR PROGRAMS
  - 1. BarCares of North Carolina
  - 2. State Bar Lawyer Assistance Programs NCLAP
    - a. PALS
    - b. FRIENDS
- C. STATEWIDE MENTAL HEALTH GROUPS
- D. NATIONAL MENTAL HEALTH GROUPS

II. SYMPTOMS AND TREATMENT OF DEPRESSION AND BIPOLAR DISORDER

- A. Major Depression
  - 1. Symptoms
  - 2. Treatment
  - 3. Prognosis
  - 4. How to Deal with individuals Who Are Depressed

- B. Manic Depression or Bipolar Disorder
  - 1. Symptoms
  - 2. Treatment
  - 3. Prognosis
  - 4. How to Deal with Individuals Who Are Bipolar

- C. A “Test” for Depression

III. SUBSTANCE ABUSE

- A. An Anonymous Story
- B. A “Test” for Alcoholism

IV. STATISTICS

V. NORTH CAROLINA STATE BAR FORMAL ETHICS OPINION: RESPONDING TO OPPOSING COUNSEL’S MENTAL HEALTH PROBLEM

Introduction

In 2002 the Substance Abuse and Mental Health Services Administration estimated that 9.4 percent of Americans age 12 and over could generally be classified as substance abusers or substance dependent. According to reports by the American Bar Association, the corresponding estimate for lawyers is between 15 and 18 percent – nearly double the number of the general population.

Lawyers represent people and businesses who are in distress, under time pressures, and expect the impossible. We possess many secrets. We know things we cannot disclose about our clients, about ourselves, about other lawyers. We disclose other things in order to achieve the best result for our clients, even if the choices made on what to put forward do not reflect our own personal points of view. We make judgments about disclosure and non-disclosure every day because we are good secret keepers; and because we are zealous advocates.

Exercising that judgment and advising clients about what secrets to keep and what positions to put forward can be stressful. That stress is intensified when the outcome of our calculations can be the financial success or failure of a business or an individual or, in many cases, the client's liberty. We become excellent secret-keepers as an ethical imperative.

With secrecy as our guide, our ability and desire to communicate our own stories can be compromised from time to time, separating us from friends and family. Some of us find release in substances; some of us become depressed or overcome by panic and anxiety. Some of us "handle" it all quite well.

In his book, *A Lawyer's Guide to Healing*, Don Carroll, Director of the North Carolina Lawyer Assistance Program, asks the question whether the practice of law draws to it particular personality types that may be more prone to addiction. Carroll's answer is that it does. One profile which he describes is the person drawn to the legal profession because of a longing "to do justice" or "to change the world for the better." Not surprisingly, this desire to create an ideal world is ultimately frustrating as "the longed-for ideal is never achieved. . . the addictive romantic then refuses to live in the tension of the real human world and may find escape in chemical or other addictive behaviors." Another personality which Carroll targets is the person, perhaps less idealistically motivated, who simply has a need to control – to control others and to control all aspects of life. As with the romantic idealist, this person's mission is doomed to frustration and ultimately to failure because what we all discover, sooner or later, is that we cannot control others – clients, judges, adversaries – and cannot control the outcome of our trials or other legal pursuits even by doing our best work.

The purpose of this presentation is to remind you of the resources available for lawyers who may be struggling with balance. It is NOT just for those whose circumstances meet the definition of a person suffering from a mental illness or abusing substances, although information is provided regarding those matters. We begin with the resources available for lawyers. Many have been helped by the ability to share secrets with someone who is bound by ethical rules of confidentiality as well. If you, or someone

you know, could use the opportunity to share a few secrets in a safe environment, please call one of the organizations discussed below.

I. RESOURCES

A. YOUR PHYSICIAN

B. BAR PROGRAMS

Both the North Carolina Bar Association and the North Carolina State Bar offer programs intended to assist lawyers in crisis as a consequence of issues related to both substance abuse or mental disorders. Both programs have saved many lives and careers.

1. BarCares of North Carolina
http://www.ncbar.org Click on "About the NCBA" and follow the links to "BarCARES"
1-800-640-0735 is a direct contact to Human Resource Counsultants (HRC)

BarCARES is a confidential, short-term intervention program provided cost-free to members of local bar groups that have "opted in." The program is there to help attorneys (and their immediate family members) by providing confidential assistance and brief, solution-oriented counseling.

The BarCARES program provides up to three free visits each year, which may be used by the attorney or any immediate family member.

BarCARES, which stands for Confidential Attorney Resource and Enrichment Services, began as an idea of the NC Bar Association's Quality of Life Committee in the early 1990's following an NCBA-sponsored survey that showed many stress factors for attorneys (and their families).

Confidentiality. Only the attorney, his or her counselor and those the attorney chooses to tell will know if an attorney utilizes the BarCARES program. The counselors are licensed professionals, bound by the confidentiality requirements of their profession. Although the North Carolina Bar Association and local bar groups provide funding for the BarCARES program and monitor its overall operation, they have no access to the names or other identifying information of any program user.

BarCARES is designed to offer no-cost assistance in dealing with problems that might be causing distress and can be used to help with:

- Personal Issues: crisis intervention, depression/anxiety, substance abuse (drug or alcohol) and financial concerns
- Family Issues: marriage/relationships, children, adolescents, parenting, family conflict
- Work Issues: professional stressors, case-related stress and conflict resolution
- Student coaching on stress/time management, etc.

BarCARES of North Carolina, Inc. (a subsidiary of the NC Bar Association) and local bar groups contract with Human Resource Consultants (HRC) to administer the program and to identify and contract qualified provider groups for areas not serviced by HRC. To find out more about HRC, visit their Web site http://www.hrc-pa.com.

The foregoing information is drawn from the website of the North Carolina Bar Association (http://www.ncbar.org).

2. **State Bar Lawyer Assistance Programs – FRIENDS and PALS** http://www.ncbar.com **Click "Programs" and then click "Lawyer Assistance Programs" You will be directed to a separate website** http://www.NCLAP.org.

W. Donald (Don) Carroll Jr.
LAP Director
Western North Carolina District
907 Barra Row, Suite 205
Davidson, NC 28036
1-800-720-7257
1-704-892-5699
nclap@bellsouth.net

Towanda C. Garner
Piedmont LAP Coordinator
Piedmont North Carolina District
208 Fayetteville Street Mall
Raleigh, NC 27601
1-877-570-0991
1-919-828-4620 ext. 290
tgarner@ncbar.gov

Edmund (Ed) F. Ward III
LAP Asst. Director
Eastern North Carolina District
208 Fayetteville Street Mall
Raleigh, NC 27601
1-877-627-3743
1-919-828-6425
eward@ncbar.gov

The Lawyer Assistance Program (LAP) is a service of the North Carolina State Bar which provides **confidential** assistance to North Carolina lawyers to help them identify and address problems with alcoholism, other drug addictions and mental health disorders. The Lawyer Assistance Program supports two groups of volunteers that provide confidential assistance to impaired lawyers. The PALS program (Positive Action for Lawyers) provides assistance to lawyers suffering from alcoholism, substance abuse, or other chemical addictions. FRIENDS will assist lawyers who suffer from depression and other mental conditions that may impair their ability to practice law.
See 27 NCAC 1D, Section .0600.

a. PALS

The North Carolina State Bar formed the Positive Action for Lawyers Committee, or PALS Committee, in 1979 to implement a program of intervention for lawyers with chemical dependency problems affecting their professional conduct. The committee assists individual lawyers in need of guidance and support in dealing with a potentially fatal condition so that they may return to productive lives. To this end, the committee receives information concerning any lawyer who may have a substance abuse problem. Upon receipt of such information, the committee undertakes a discreet and confidential investigation followed by a careful evaluation of the facts. If the investigation reveals that the lawyer is impaired, the committee may intervene in an effort to get the lawyer the resources he or she needs to recover.

PALS offers assistance to any North Carolina lawyer who believes he or she may be suffering from chemical dependency. In addition, PALS assists the lawyer's partners and associates and provides referral information to the spouse and children of a

chemically dependent lawyer. Assistance to family members is often critical because alcoholism and chemical dependency are family problems. PALS helps family members find resources. A return to health for the impaired lawyer is greatly enhanced by a family that has recovered its own balance.

The information received by PALS is confidential. See 27 NCAC 1D, Rule .0603 and Rule 1.6 of the Revised Rules of Professional Conduct. If you call to seek help for yourself, your inquiry is confidential. If you call as the spouse, child, or friend of a lawyer you suspect may have an alcohol or drug problem, your communication is also treated as confidential. Moreover, PALS is entirely separate from the disciplinary department of the State Bar.

Call or email: Ed Ward (east), Don Carroll (west), Towanda Garner (piedmont) at the numbers or addresses above for PALS assistance.

b. FRIENDS

The FRIENDS program was initiated in 1999 by the North Carolina State Bar to provide assistance to lawyers suffering from depression and other mental conditions. (The name is intended to compliment the PALS program; it is not an acronym.) FRIENDS confidentially helps to evaluate mental or physical health problems and assists the impaired lawyer to find resources to address the problem. The program's goal is to provide such assistance before a lawyer's mental health disorder interferes with the lawyer's ability to represent clients.

FRIENDS offers assistance to any North Carolina lawyer who believes he or she may be suffering from depression or another mental condition. FRIENDS may also help family members find resources as a part of its assistance to a lawyer.

The information received by FRIENDS is confidential. See 27 NACA 1D, Rule .0652 and Rule 1.6 of the Revised Rules of Professional Conduct. If you call to seek help for yourself, your inquiry is confidential. If you call as the spouse, child, co-worker or friend of a lawyer you suspect has a mental health problem, your communication is also confidential. Moreover, FRIENDS is entirely separate from the disciplinary department of the State Bar.

Call or email: Ed Ward (east), Don Carroll (west), Towanda Garner (piedmont) at the numbers or addresses above for FRIENDS assistance.

The foregoing information is drawn from the website of **North Carolina State Bar (http://www.ncbar.com)**

C. STATEWIDE MENTAL HEALTH GROUPS

North Carolina Depressive and Manic Depressive Association
1046 Washington Street
Raleigh, NC 27605
919/821-4343

North Carolina Alliance for the Mentally Ill
4904 Waters Edge Drive
Raleigh, NC 27606
919/851-0063

Mental Health Association in North Carolina
3820 Bland Road
Raleigh, NC 27609
919/981-0740

North Carolina Psychiatric Association
4917 Waters Edge Drive
Raleigh, NC 27606
919/851-0067

North Carolina Psychological Association
1004 Dresser Court
Raleigh, NC 27609
919/872-1005

D. NATIONAL MENTAL HEALTH GROUPS

American Association of Pastoral Counselors
9504A Lee Highway
Fairfax, VA 22031-2303
703/385-6967

American Psychiatric Association
1400 K Street NW
Washington, DC 20005
202/682-6000

American Psychological Association
750 First Street, NE
Washington, DC 20002-4242
202/336-5500

Depression and Related Affective Disorders Association
John Hopkins Hospital
600 N. Wolfe Street, Meyer 3-181
Baltimore, MD 21287
410/955-4647

National Alliance for the Mentally Ill
200 North Glebe Road, Suite 1015
Arlington, VA 22203-3754
703/524-7600

National Depressive and Manic Depressive Association
730 N. Franklin, Suite 501
Chicago, IL 60610
312/642-0049

National Institute of Mental Health
5600 Fishers Lane, Room 10-85, Parldawa Bldg.
Rockville, MD 20857
800/421-4211

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
703/684-7722

II. SYMPTOMS AND TREATMENT OF DEPRESSION AND BIPOLAR DISORDER

A mental disorder is defined as a behavioral or psychological pattern that produces distress or impaired functioning (DSM-IV). The standard psychiatric nomenclature since 1994 has been the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition, commonly referred to as the DSM-IV.

As few mental disorders can be traced to a discreet cause, psychiatric diagnosis is descriptive; that is, diagnoses are made based on lists of observable symptoms. Mental disorders can be generally divided into the acute disorders and the personality disorders. Depression is an acute disorder.

A. Major Depression

1. *Symptoms*

A major depression is a sustained period (at least two weeks) during which an individual experiences a depressed mood or a loss of interest or pleasure in most or all activities. During this period the individual may also exhibit other symptoms of depression. Twice as many women as men suffer from major depression.

DSM-IV Diagnostic Criteria for a Major Depressive Episode

For a diagnosis of major depression, at least five of the following symptoms must have been present every day, or almost all day, over a two-week period. These symptoms will represent a change from previous functioning. A depressed mood, loss of interest or pleasure, or both will be among the symptoms.

- Depressed mood
- Disinterest or lack of enjoyment in usual activities
- Significant weight loss or weight gain when not dieting
- Insomnia or increased need for sleep (hypersomnia)

- Psychomotor agitation or psychomotor retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished concentration or ability to think clearly
- Recurrent thoughts of death, or suicidal thoughts, attempts, or plans

Associated Features of Major Depression

- Tearfulness
- Anxiety
- Irritability
- Brooding or obsessive rumination
- Excessive concern with physical health
- Phobia or panic attacks

2. *Treatment*

The treatment regime for major depression includes the following:

- psychotherapy, often in conjunction with medication;
- antidepressant medications;
- antianxiety medications if the depression is accompanied by anxiety;
- antipsychotic medications for brief periods of time for severe depression with psychotic features, for example, depression accompanied by delusions and hallucinations;
- hospitalization for severe cases; and
- electroconvulsive therapy (ECT or "shock therapy") for cases that have not responded to other treatments. (ECT has evolved to the point that it involves far less convulsing and clouded thinking than in the past. It is now more humane and widely used than most people think.)

Antidepressant medications do not take effect immediately and are generally prescribed for six months or longer. Unfortunately some people will stop taking medication if it does not have an immediate effect or if they start to feel better. Effective treatment depends on continuing to take medication under a doctor's care. Costs and the absence of distribution programs are also problematic.

3. *Prognosis*

Major Depression may be chronic. There is no known cure. However modern treatment methods have made it possible to reduce its symptoms for most, who suffer from this disorder. As the disorder is episodic, people with this disorder can often lead normal lives in between depressive episodes.

4. *How to Deal with individuals Who Are Depressed*

Depressed individuals often have trouble initiating or following through on constructive action. They feel as though everything is a monumental effort requiring

more energy than they have. Constructive suggestions are met with “Yes, but....” Furthermore, they do not value their lives and futures enough to care about the outcome.

What can be done?

Suggest Treatment. Depression is now very treatable. The most effective treatment is generally a combination of medication and psychotherapy. Modern antidepressants (e.g. Prozac, Zoloft, Paxil, etc.) are safe and effective.

Wait for Normal Mood. Both major depression and bipolar disorder are characterized by periods of depressed or manic mood alternating with period of normal mood.

Enlist the Help of Family and Friends. A family member or friend may be able to ensure compliance when the depressed person could not do so on his own.

Beware of Suicide. Up to 15% of people with severe major depression and 10-15% of those with bipolar disorder commit suicide. Bankruptcy may contribute to their despair. In emergency situations refer the individual to a mental health professional or suicide help line. The National Hopeline Network number is 1-800-SUICIDE (784-2433). The crisis hotline for Covenant House is 1-800-999-9999.

B. Manic Depression or Bipolar Disorder

1. *Symptoms*

Individuals with bipolar disorders suffer one or more manic episodes, usually accompanied by one or more major depressive episodes. With manic-depressive illness, mood swings are sometimes separated by periods of normal mood. Equally prevalent in men and women, bipolar disorder affects an estimated 0.4% to 1.2% of the adult population.

DSM-IV Diagnostic Criteria and Associated Features for a Depressive Episode

Refer to the diagnostic criteria and associated features for major depression.

DSM-IV Diagnostic Criteria for a Manic Episode

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood lasting for at least one week has occurred.

- During a period of mood disturbance, at least three of the following symptoms have persisted and have been present to a significant degree:

  - grandiosity, inflated self-esteem;
  - decreased need for sleep;
  - increased talkativeness;
  - flight of ideas or racing thoughts;

- distractibility, i.e., attention is too easily drawn to unimportant or irrelevant external stimuli;
- increase in goal-oriented activity (either socially, at work, at school, or sexually), or psychomotor agitation; or
- excessive involvement in pleasurable activities, with a lack of concern for the high potential for painful consequences, such as buying sprees, foolish business ventures, reckless driving, or casual sex.
- Mood disturbance is severe enough to cause marked impairment in occupational or social functioning or to necessitate hospitalization to prevent harm to others.

Associated Features of a Manic Episode

- Inability to recognize presence of an illness; resistance to treatment
- Rapid shift to depression or anger
- Hallucinations or delusions
- Euphoric, elevated, expansive, or irritable mood

2. *Treatment*

The treatment regime for bipolar disorders includes the following:

- Psychotherapy is often used in conjunction with medication.
- Lithium is the standard drug treatment for acute manic episodes.
- Depakote (valproic acid) is also frequently used.
- Antidepressant medications are sometimes prescribed for bipolar disorders, but the patient must be carefully observed for the emergence of manic symptoms.
- Antipsychotic, and sometimes antianxiety, medications are occasionally used at the initiation of treatment to control agitation.
- Hospitalization may be necessary during acute phases of the illness.
- ECT is sometimes effective when other treatments have failed.

3. *Prognosis*

The prognosis for people with Bipolar Disorder is worse than for people with Major Depression. About a third have chronic symptoms and social decline. Only about 15% are totally well (i.e. without relapse or partial impairment.) Mood stabilizers (Lithium, Depakote) are sometimes successful in eliminating or modifying manic episodes. When this is possible, people are not as likely to swing into a deep depression after mania subsides. However, treatment compliance is a significant problem as people who are manic frequently do not choose to medicate away such an exhilarating state, nor are they likely to be realistic in seeing their behavior as abnormal. Furthermore, antidepressants must be used with caution as they can precipitate manic episodes.

4. *How to Deal with Individuals Who Are Bipolar*

The following are suggestions for dealing with someone who is in a manic phase:

Wait for Normal Mood. When in a normal mood state (i.e. neither manic nor depressed), a person with Bipolar Disorder can be reasonable and realistic about his/her illness.

Suggest Treatment. Bipolar Disorder can sometimes be very effectively controlled with a combination of medication, psychotherapy and family support and education.

Be Skeptical. The manic individual is energetic, confident and often convincing. However, (s) he is also unrealistic and grandiose. Consequently, what (s) he says (s) he is going to do is a poor predictor of what (s) he is going to do. Observed patterns of past behavior are better predictors.

Enlist the Help of Family Members. Although the manic person may sound convincing, his/her family members will have observed patterns of unrealistic plans, reckless spending, or lack of follow-through and can give a more realistic picture of what can be expected of this individual.

Limit Talking. The manic individual can be extremely talkative and tangential. It is sometimes necessary to keep him/her focused on answering only what was asked.

Control Angry Outbursts. The manic individual can become belligerent, especially when a manic episode is ending.

C. TAKE THE TEST

If you or someone you care about answers yes to five or more of these questions (including questions #1 or #2)...and if the symptoms described have been present nearly every day for 2 weeks or more, you should consider speaking to a health care professional about different treatment options for depression.

Answer these questions	Yes	No
Do you or they feel a deep sense of depression, sadness, or hopelessness most of the day?		
Have you or they experienced diminished interest in most or all activities?		
Have you or they experienced significant appetite or weight change when not dieting?		
Have you or they experienced a significant change in sleeping patterns?		
Do you or they feel unusually restless...or unusually sluggish?		
Do you or they feel unduly fatigued?		
Do you or they experience persistent feelings of hopelessness or inappropriate feelings of guilt?		
Have you or they experienced a diminished ability to think or concentrate?		
Do you or they have recurrent thoughts of death or suicide?		

Other explanations for these symptoms may need to be considered. Adapted from

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition. Washington, DC. American Psychiatric Association: 1994

III. SUBSTANCE ABUSE

A. An Anonymous Story. My normal day at the office ended with my dismay and disappointment at how little I had accomplished, coupled with my fear that tomorrow might be worse. So I mustered my "will power" whenever I got home, and I resolved that if I could just relax and get a good night's sleep, I could attack that work the next day and clear it up. I preferred drinking at home where I could be left alone-reading my newspaper and magazines and watching TV and where, when the alcohol took effect, I could revel in my grandiose schemes to make the world a better place. This is how I avoided my fear and anxiety -- my fear of making mistakes, and my anxiety that unsolvable problems lurked at every turn ahead. Others prefer bars and drinking buddies, because those places and people help keep the alcoholic's thoughts diverted from the reality of their feelings of fear and anxiety about the real world.

Like other alcoholics, once I had the first drink I wanted another, and then another. What I sought was enough alcohol to get me to sleep. My living "Hell" was being in bed at night with the lights out, alone with my feelings, and being unable to get to sleep. I would do anything to avoid that, which usually meant staying up until about 2:00 a.m. when my exhaustion and high coincided.

. . . .

Looking back, I realize [my] hangovers provided me with two rewards. First, it provided me the punishment I felt I deserved for my lack of productivity and my excessive drinking the night before. Secondly, it gave me something to do -- deal with the chaos of the hangover. Alcoholics thrive on chaos because it gives us something on the surface to address rather than the ache underneath. But the problem of the practicing alcoholic is that we learn this only in recovery, never when we are living it.

. . . .

The afternoon was a whirlwind of activity. I was busy "putting out fires;" meeting trial deadlines that had been put off forever because I was afraid of making mistakes; dodging clients who came to the office checking on their work; lying to the clients who had legitimate complaints that I had ignored their work; giving secretaries messages for other clients I was afraid to call; calling other attorneys to manufacture reasons to continue court cases by consent; worrying that I was not providing my share of the firm's income and hoping this omission might go unnoticed; and creating a catastrophic atmosphere in the office where everyone was working faster and harder than they would they day before, getting out the work I had been ignoring. In short, my life was "motivation by crises."

The really hard part came at 5:00 p.m., when I was in the office by myself. I couldn't bear being alone because I might actually have to face my inner fear and anxiety. I would leave to coach or get to a civic meeting where I wouldn't have that problem of "feeling." We alcoholics try to stay too busy to feel. When we can't run from our feelings, we drug them.

At night came another honest resolve to do better the next day after a night of relaxing and a good night's sleep induced by alcohol. I did this over 3,000 times in my career. And believe it or not it never really dawned on me I was doing wrong, and that alcohol was my problem.

As my story unfolded, I unconsciously created crises to avoid my problems. There were lies to get court continuances, feigned illnesses to avoid trial, three nervous breakdowns and trips to mental institutions, and outpatient visits to psychologists where I told them what I wanted them to know. Finally, when I could take no more fear and anxiety, I attempted suicide, escaping death by only a miracle. And now thanks to my recovery program covering the last 15 years, I practice law as I intended to from the beginning.

If you had observed me closely 15 plus years ago, maybe my suicide attempt could have been avoided. And now maybe you can help someone else avoid believing suicide is the only option.

The North Carolina State Bar Journal, Vol. 4, No. 1, Spring 1999

B. TAKE THE TEST

The following test is reprinted from a page on the NCLAP website: http://www.nclap.org.

Ask yourself the following questions and answer them as *honestly* as you can.

Answer these questions	Yes	No
Do you lose time from work due to drinking?		
Is drinking making your home life unhappy?		
Do you drink because you are shy with other people?		
Is drinking affecting your reputation?		
Do you feel remorse after drinking?		
Have you gotten into financial difficulties as a result of drinking?		
Do you turn to lower companions and an inferior		

environment when drinking?		
Does your drinking make you careless of your family's welfare?		
Has your ambition decreased since drinking?		
Do you crave a drink at a definite time daily?		
Do you want a drink the next morning?		
Does drinking regularly cause you to have difficulty sleeping?		
Has your efficiency decreased since drinking?		
Is drinking jeopardizing your job or business?		
Do you drink to escape from worries or trouble?		
Do you routinely drink alone?		
Have you ever had a loss of memory (blackout) as a result of drinking?		
Has your physician ever treated you for drinking?		
Do you drink to build up your self-confidence?		
Have you ever been to a hospital or institution on account of drinking?		

If you have answered YES to one or more of the questions, this is a warning that you may be an alcoholic.
If you have answered YES to two or more of the questions, there is a very good chance are that you are an alcoholic.
If you have answered YES to three or more of the questions, it is highly likely that you are an alcoholic.

IV Statistics.

"Alcoholism, drug addiction, and mental health problems are afflictions that affect a great number of professionals including lawyers and judges. Reports now estimate that while ten percent of the general population has problems with alcohol abuse, anywhere from fifteen to eighteen percent of the lawyer population battles the same problem. Because many lawyers and judges are overachievers who carry an enormous workload, the tendency to "escape" from daily problems through the use of drugs and alcohol is prevalent in the legal community. Also, the daily pressures placed on these men and women can lead to inordinate amounts of stress and mental illness. Recent reports have

also shown that a majority of disciplinary problems involve chemical dependency or emotional stress."[1]
"Alcoholics, roughly 10% of the population, consume 50% of the beer, wine, and distilled spirits sold in this county. The other 90% of the population that use alcohol consume the other half. From the active alcoholic's perspective, the problem is not drinking but not being able to drink."[2]

"'Are lawyers really that much more likely to become alcoholics or drug addicts?' Or, said another way, are lawyers more apt than others to contract addictive disease? The statistics for the general population reflect that approximately 10% of the population is or will be afflicted with alcoholism or other chemical dependency disease. Statistical evidence among the legal profession indicates that as many as 18-20% of us will suffer from some type of chemical dependency addictive disease during our years of practice."[3]

"There is also the complicating tendency of two co-occurring disorders – addiction and depression – to create a greater barrier to a person's perception of a problem. A recent study finds that 61% of persons with both a serious mental illness and a substance use disorder who had not received treatment for either illness, perceived no unmet need for treatment."[4]

"In a study of 5000 people over age 65 those who had frequent depressive symptoms were 40% more likely to develop coronary artery disease, and 60% more likely to die than those who do not have depressive symptoms."[5]

"A longitudinal study by John Hopkins Medical School tracked individuals every five years for forty years. Those who had suffered clinical depression - even a depressive episode more than ten years earlier - were at twice the risk of developing coronary disease.

"In another study, men in their 50's with high levels of depression and anxiety were over three times more likely than average to have a fatal stroke during the next fourteen years.

"Even among people who are not clinically depressed, these studies confirm what the Big Book [of Alcoholics' Anonymous] says that resentment is a killer. People with normal blood pressure, who scored high on a rating scale for anger, were nearly three times more likely to have a heart attack or require by-pass surgery within the next three years.

"And here is a zinger! In another three-year study, hostility, measured by a personality test, predicted heart attack and heart disease better than other factors such as high cholesterol, smoking, or being overweight."[6]

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[1] http://www.abanet.org/legalservices/colap/home.html
[2] Carroll, W. Donald, "Old Ideas and Stories," http://www.nclap.org/Default.aspx?Page=OldIdeasAndStories
[3] Carroll, W. Donald, "The Addictive Personality and the Legal Profession," *The North Carolina State Bar Quarterly, Vol. 43, No. 2, Spring 1996;* http://www.nclap.org/Default.aspx?Page=AddictivePersonality
[4] Carroll, W. Donald, "Addicted to Depression," http://www.nclap.org/Default.aspx?Page=AddictedtoDepression
[5] Carroll, W. Donald, "Depression and the Heart," http://www.nclap.org/Default.aspx?Page=DepressionAndTheHeart

[6] Carroll, W. Donald, "Depression and the Heart," http://www.nclap.org/Default.aspx?Page=DepressionAndTheHeart

"Of course, this is not just a problem of the legal profession, but statistical data suggests that lawyers are more at risk for suicide than any other profession or vocation. In recent years, one North Carolina district bar experienced eight suicides in nine years. As a profession, we must take suicide as seriously as our profession takes homicide…. Suicide is a phenomena that tends to perpetuate itself in families. Once a family member commits suicide there is a much greater risk that other family members will follow. The highest rates of suicide are for single or widowed men over 55."[7]

V. NC STATE BAR FORMAL ETHICS OPINION: RESPONDING TO OPPOSING COUNSEL'S MENTAL HEALTH PROBLEM

2003 Formal Ethics Opinion 2
October 24, 2003

Responding to Opposing Counsel's Mental Health Problem

Opinion rules that a lawyer must report a violation of the Rules of Professional Conduct as required by Rule 8.3(a) even if the lawyer's unethical conduct stems from **Mental** impairment (including substance abuse).

Inquiry #1:

Attorney A and Attorney B represent opposing parties in a legal matter. Attorney A's behavior has led Attorney B to suspect that Attorney A has a serious Mental Health problem (or possible substance abuse problem) that may be interfering with the representation of Attorney A's client. May Attorney B report her concerns directly to Attorney A's client?

Opinion #1:

No, Rule 4.2(a) prohibits communications about the representation with a person a lawyer knows is represented by another lawyer unless the other lawyer consents. There is no exception in the rule for reporting concerns about a lawyer's Mental competency to the opposing party.

Inquiry #2:

May Attorney B take advantage of Attorney A's erratic behavior for the benefit of her client? What if her client instructs her to do this?

Opinion #2:

[7] Carroll, W. Donald and Ward, Edmund F., "Lawyer Suicide," http://www.nclap.org/Default.aspx?Page=LawyerSuicide2

Although a lawyer must competently and diligently represent her clients, she does not have a duty to press every advantage for a client particularly when such conduct is inconsiderate or repugnant. The client establishes the legal objectives of the representation, but the lawyer is primarily responsible for choosing the means by which those objectives are obtained. As noted in Rule 1.2(a)(2), a lawyer does not violate the duty to abide by the client's decisions relative to the objectives of the representation, "...by avoiding offensive tactics, or treating with courtesy and consideration all persons involved in the legal process."
A lawyer may resolve the conflict between the duty of competent representation and the desire not to take advantage of the impaired lawyer by making a confidential report to the Lawyer Assistance Program (LAP) of the State Bar and/or seeking the court's oversight when appropriate. If the client is insistent and the client-lawyer relationship is no longer functional because of the disagreement about tactics, the lawyer may withdraw from the representation pursuant to Rule 1.16(b)(4).

Inquiry #3:

Is Attorney B required to report her observations about Attorney A's Mental Health to the State Bar or other authority?

Opinion #3:

No, reporting to the State Bar is not required unless a lawyer has knowledge of an actual violation of the Rules of Professional Conduct by the other lawyer. Specifically, Rule 8.3(a) requires a lawyer "who knows that another lawyer has committed a violation of the Rules of Professional Conduct that raises a substantial question as to that lawyer's honesty, trustworthiness, or fitness as a lawyer in other respects [to] inform the North Carolina State Bar or the court having jurisdiction over the matter." The Preamble to the Rules of Professional Conduct, Rule 0.1, cmt. [6], on the other hand, underscores a lawyer's obligations to the legal system and would encourage the lawyer to communicate the situation of a distressed lawyer to LAP.

Inquiry #4:

If Attorney B does not have knowledge that Attorney A has violated the Rules of Professional Conduct, may she report her observations about Attorney A's Mental Health to LAP or other lawyer assistance program approved by the State Bar?

Opinion #4:

Yes, Attorney B may report, and professionalism would encourage her to communicate her observations about Attorney A's Mental Health to an approved lawyer assistance program without regard to whether she had knowledge of a violation of the Rules of Professional Conduct by Attorney A. See , e.g., Rule 1.6(b); see also , 27 N.C.A.C. 1D, Rule .0613 of the Rules Governing the Lawyer Assistance Program.

Inquiry #5:

Attorney A's representation of his client is clearly incompetent in violation of Rule 1.1 of the Rules of Professional Conduct. Is Attorney B required to report this conduct to the State Bar? Will a report to LAP satisfy the reporting requirement?

Opinion #5:

Attorney B must report to the State Bar, or a court having jurisdiction, any violation of the Rules that raises a substantial question about another lawyer's fitness to practice law. A lawyer's violation of the duty of competent representation, set forth in Rule 1.1, may raise a substantial question about a lawyer's fitness to practice law and, therefore, be sufficient to trigger the reporting requirement under Rule 8.3(a).

If a disclosure of client confidential information is necessary to make the report, the client's consent must be obtained. Rule 8.3(c). Whether the opposing counsel's conduct alone constitutes confidential client information is debatable. See Rule 1.6(a). The clear incompetence of opposing legal counsel may afford an apparent advantage to Attorney B's client in the matter at hand, and reporting (and thereby possibly terminating) such incompetent representation arguably would be contrary to the client's interests. However, the termination of a somewhat conjectural individual advantage gained through the obvious incompetence of opposing counsel is not the kind of detriment to the client that would normally preclude reporting particularly when the failure to report may produce disproportionate future harm to current and future clients of Attorney A.

The report of misconduct should be made to the Grievance Committee of the State Bar if a lawyer's impairment results in a violation of the Rules that is sufficient to trigger the reporting requirement. The lawyer must be held professionally accountable. See, e.g., Rule .0130(e) of the Rules on Discipline and Disability of Attorneys, 27 N.C.A.C. 1B, Section .0100 (information regarding a member's alleged drug use will be referred to LAP; information regarding the member's alleged additional misconduct will be reported to the chair of the Grievance Committee).

Making a report to the State Bar, as required under Rule 8.3(a), does not diminish the appropriateness of also making a confidential report to LAP. The bar's disciplinary program and LAP often deal with the same lawyer and are not mutually exclusive. The discipline program addresses conduct; LAP addresses the underlying illness that may have caused the conduct. Both programs, in the long run, protect the public interest.

Inquiry #6:

Another lawyer in Attorney B's law firm is demonstrating Mental Health Problems that may be affecting the representation of his clients. What duty does Attorney B have to notify the lawyer's clients? What duty does Attorney B have to report this conduct to LAP or the State Bar?

Opinion #6:

Attorney B should intervene to assist the lawyer and to avoid harmful consequences to

the lawyer's clients. See, e.g ., Rule 5.1(a). Such intervention may include, if necessary, notifying the clients and switching their representation to another lawyer in the firm. Rule 4.2 does not prohibit direct communications with the clients of other lawyers in a firm.

For a discussion of reporting another lawyer's Mental Health problem to LAP or the State Bar, see opinions #3, #4, and #5 above.

Inquiry #7:

Attorney X attends a LAP support group meeting that Attorney A is attending. During the meeting, Attorney A discloses conduct that is otherwise reportable to the State Bar pursuant to Rule 8.3(a). Is Attorney X required to report this conduct to the State Bar?

Opinion #7:

No. 2001 Formal Ethics Opinion 5 holds that disclosures made by a lawyer during a LAP support group meeting are confidential and not reportable to the State Bar under Rule 8.3.

(Emphasis added)

Conclusion

The antidote for the lawyer's addictive personality is as easy to state as it is difficult to live. As hard as it is to do for many lawyers, the solution lies in accepting that there is much we cannot control. Many recovery programs have adopted what has come to be known as the serenity prayer: "Grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference."

In Carroll's book he describes this as exchanging willfulness for willingness. Instead of being determined to impose our will over all things, we must be willing to be open to change and, again, borrowing a phrase from many recovery programs, to live life on life's terms. This does not require any lessening of our zealous advocacy or, for that matter, that we work less hard or be less intentional in carrying out our responsibilities as attorneys. It does require understanding that we cannot control, and are not responsible for, the outcome of every situation in which we find ourselves. It also involves creating good habits for dealing with our stress to take the place of the bad habits into which we have retreated.

None of these good habits are secrets. They include physical exercise, social support, some form of spirituality which accepts that we are not ourselves the source of power or the arbiter of the outcomes in other people's lives, and a sense of humor. The exercises in which one can engage in recovery are as simple as thinking positively instead of negatively, listing the things for which one is grateful, being honest with others and with yourself about yourself, not trying to control what you have no control over, and learning to live in the moment, neither forever regretting the past nor living only for the future.

There are many excellent programs available to our lawyers and their families suffering from mental illness or substance abuse problems. Descriptions of diseases or answers to questions on tests are not intended and cannot be a substitute for professional assistance with very real medical problems. If you, or someone you know, has symptoms, please seek or encourage them to seek assistance just as you would in the case of a physical illness.