

ALRP MCLE

APRIL 5, 2017

YOU PASSED THE BAR,
REALLY? OR YOU LIVE THERE?
(1.0 SUBSTANCE HOURS)

PANELISTS:

KENNETH D. MARTINSON, ESQ

FERNANDO HIDALGO, ESQ

Stress, Depression, And Substance Abuse In The Legal Profession

By Richard Carlton, MPH

The Lawyer Assistance Program

Here is a scenario frequently presented to those of us who work in the field of lawyer assistance:

A colleague or attorney friend is having major problems with his or her practice. You suspect or know that these problems result from substance abuse, depression, other psychological problems, or a combination of these conditions. You know that the road this person is on is downhill all the way, but you feel powerless. You're concerned about your friend's welfare, but you don't want to do anything that will get your attorney-friend in more trouble. Where can you call for free, strictly confidential, knowledgeable advice and assistance with such a situation?

The answer is the Lawyer Assistance Program (LAP). Established by the California Legislature (Business & Professions Code §§6140.9, 6230-6238), the Lawyer Assistance Program is a confidential service of the State Bar of California. Staffed by professionals with many years of experience assisting the legal community with personal issues, the LAP provides assistance to attorneys whose personal or professional life is being detrimentally impacted by substance abuse, other compulsive behaviors, and/or mental health concerns such as depression and anxiety.

The statute that created the program (SB 479, Burton) states that it is the "intent of the legislature that the State Bar of California seek ways and means to identify and rehabilitate attorneys with impairment due to abuse of drugs or alcohol, or due to mental illness, affecting competency so that attorneys so afflicted may be treated and returned to the practice of law in a manner that will not endanger the public health and safety."

The LAP is a comprehensive program offering support and structure from the beginning stage of recovery through continuing care. It includes:

- individual counseling;
- expert assessment and consultation;

- assistance with arrangements for intensive treatment;
- monitored continuing care;
- random lab testing;
- professionally facilitated support groups; and
- peer support groups.

The program also works with family members, friends, colleagues, judges and other court staff who wish to obtain help for an impaired attorney. Financial assistance is available so that no one is prevented from participating in the program due to financial limitations.

Attorneys may self-refer into this program or may be referred as the result of an investigation or disciplinary proceeding (B&P Code § 6232). In some cases, monitored participation may result in a lower level of disciplinary action. When requested by an attorney who is facing disciplinary charges and whose practice has been impaired by personal problems, the LAP can monitor the attorney's continuing recovery for the State Bar Court's alternative discipline program and for the probation unit.

One of the unique characteristics of this program is that the confidential nature of participation in the program is mandated in the statute that created the program. The fact that an attorney is participating in the LAP is confidential (B&P Code § 6234). No information concerning participation in the program will be released without the attorney's prior written consent.

The creation of attorney-only assistance programs is an outgrowth of years of experience in addressing substance-related disorders and mental health issues in professional populations and the unique challenges associated with such efforts. Most licensed professionals in California have some type of assistance resource available through their regulatory agency or otherwise.

The Brain Diseases: Substance Use Disorders And Mood Disorders

Substance abuse is often referred to as a "brain disease." Although the disease has a profound impact on many of the major organ systems in the body, it is altered brain chemistry that creates the craving for mood-altering substances and explains the loss of control that occurs. The differences in brain chemistry that lead to substance abuse occur in the core of the brain where the autonomic nervous system is regulated — not in the frontal lobe area where conscious, rational decision-making takes place. This altered

brain chemistry produces an obsessive, compulsive and irrational need to drink or use drugs despite adverse consequences to the user's own life and health.¹

With addiction, the compulsion to consume coming from the core of the brain literally overrides the awareness and thought process occurring on the outside of the brain. As the disease progresses, the afflicted individual becomes increasingly unable to accurately perceive what is happening. Perception becomes distorted. The individual denies symptoms of abuse and continues to use. Denial is often mistaken for deceit or dishonesty instead of the distorted perception that it represents.

Substance-related disorders appear to be a more common problem in the legal profession than in most other occupations. While household studies indicate that roughly 10 percent of the adult population experiences a problem at some point in life as a result of the abuse of alcohol or drugs, some studies suggest that the incidence of this abuse among legal professionals may be as much as 50 percent higher than the general adult population. Depression may be even more overrepresented in the legal professional than substance abuse problems. A study of 12,000 adults by a team of researchers from Johns Hopkins University discovered that among all the occupational groups represented in that large sample, attorneys had the highest prevalence of signs and symptoms of clinical depression. The rate of depression among the attorneys studied was 3.6 times the norm for all occupations.²

It is now understood that differences in brain chemistry also account for depression and bipolar conditions. In the case of depression, certain neurotransmitters are present in the core of the brain in insufficient quantities.³ These neurotransmitters are necessary for the experience of normal mood states and positive feelings. Effective antidepressant medications cause the brain to absorb these necessary chemicals more slowly and thereby minimize fluctuations in mood state.

Depression associated with a significant personal loss or bereavement is normal, and not considered a clinical condition unless it lasts for a period of months. Of greater concern is the presence of the above symptoms in the absence of any obvious event or trigger, or symptoms that don't go away. Common forms of depression include a Major Depressive Episode, characterized by some or all of the above symptoms lasting two weeks or longer; and Dysthymia, characterized by less severe, but chronic symptoms lasting two years or longer. Dysthymia can be insidious. Many people cope with

depressive symptoms for years before recognizing or acknowledging that they have a condition that isn't going to abate without help.

Depression sufferers undergoing treatment typically experience a marked decline in the severity of symptoms. Treatment usually consists of psychotherapy, medication, or a combination of the two. Often, people with depression will begin to see positive results within a month of beginning treatment.

What accounts for higher levels of substance abuse and depression in the legal profession? Certainly the practice of law is a challenging experience for many legal professionals and lawyers are thought to contend with levels of stress that are higher than most other occupations. But stress alone does not account for the higher incidence of substance abuse and depression in the legal profession. While many attorneys experience high levels of stress at times during their careers, only a minority experience substance use and mood disorder problems. As discussed, differences in brain chemistry—not stress alone—distinguish those who suffer from substance use disorders and mood disorders from those who do not.

There may be a natural self-selection process at work in the legal profession. For reasons that we don't yet fully understand, some individuals who are susceptible to experiencing substance use and mood problems appear to be drawn to the practice of law. The same personality traits that are over-represented in the populations of adults recovering from substance-related disorders and mood disorders—high achievement orientation, perfectionism, obsessive-compulsive—are also common in the legal community.⁴ Law School Professor and Psychologist Susan Daicoff explains that the law school experience further exacerbates these tendencies, often producing increased aggression under stress, a preference for competition versus cooperation, and a failure to rely on natural sources of social support from one's peers.⁵ These tendencies, combined with the law school experience, produce individuals with a disproportionate preference for "thinking" versus "feeling" and a pessimistic outlook on life. Lawyers are taught to anticipate and prepare for a whole range of problems that non-lawyers are generally blind to—even far-fetched outcomes need to be considered; this trait that helps lawyers be good at their profession may make many miserable when applied to one's personal life.⁶

How Can Attorneys Cope?

Absence of control over the outcome of one's efforts, inadequate time to complete work satisfactorily, constant pressures to produce faster, the adversarial nature of most legal work, the dire consequences of an error in judgment or oversight—all are common sources of considerable stress in legal practice. In a recent sample of North Carolina lawyers, 31 percent of the respondents strongly agreed or agreed with the statement “I often feel worried or anxious.”⁷ Still, the majority of attorneys learn to cope successfully with these challenges.

There are differences in how people experience challenges. Stress is a physical reaction—it is our body's way of rising to the occasion and responding to any demand.⁸ This response (commonly referred to as “fight or flight”) is a good thing, because it allows the body to be optimally prepared for any situation. It is precisely how we interpret or perceive any challenge—the degree to which we feel “threatened” by that challenge—that determines the level of stress we experience. Temperamentally, some people are drawn to and invigorated by challenges, while others fear challenges and become overwhelmed. The extent to which we are naturally optimistic or pessimistic plays a role here as well. While some see a catastrophe around every corner, others are more naturally optimistic.

Because so much of an attorney's work requires anticipating and preparing for outcomes, coping with the stress of legal practice requires a certain amount of mental discipline. Learning to *prepare for, but not obsessing, about* potential negative consequences will significantly reduce stress. Keeping such situations in perspective will help as well. Since doing your job dictates that you may not flee from most challenges, it helps to occasionally ask yourself whether or not a particular matter really justifies your current stressful reaction to it — or, whether it will appear to be so consequential a month later. This approach, practiced regularly, may help to ensure that the stress experienced is appropriate relative to the importance of the situation.

Getting Help

Attorneys may be less likely to take care of themselves than medical doctors and other professionals. Psychologists have observed that attorneys, who are trained to be impersonal and objective, often apply the same approach to their personal problems and are reluctant to focus on their inner emotional lives. Some attorneys believe they should be able to handle their personal problems just as effectively as they handle their clients' problems.

Emotional distress, if not managed or treated, can lead to adverse impacts on an attorney's professional practice, clients, colleagues and personal life. Concerned colleagues and friends, therefore, should encourage a depressed or substance abusing attorney to seek professional help from available resources such as the LAP.

Legal professionals need an assistance program specifically geared to the unique pressures of legal practice and to the unique recovery support needs of attorneys. The Lawyer Assistance Program is that resource for all legal professionals licensed by the State Bar. Call toll-free 877-LAP 4 HELP (877-527-4435) for confidential assistance for yourself, a friend, colleague or a family member.

• *Richard Carlton is the Acting Director of the Lawyer Assistance Program at the State Bar of California.*

¹ National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services, *Drugs, Brains, and Behavior: The Science of Addiction* (2007).

² Eaton, Anthony, Mandel & Garrison, "Occupations and the Prevalence of Major Depressive Disorder," *Journal of Occupational Medicine*, 32 (11), 1079-1086 (1990).

³ K. Nathan, D. Musselman, A. Schatzberg & C. Nemeroff, *Biology of Mood Disorders, Textbook of Psychopharmacology* (edited by A. Schatzberg and C. Nemeroff), APA Press (1995).

⁴ S. Daicoff, *Lawyer Know Thyself: A Psychological Analysis of Personality Strengths and Weaknesses*, Law and Public Policy: Psychology and the Social Sciences (2004).

⁵ Daicoff, note 4.

⁶ M. Seligman, *Authentic Happiness*, Free Press (2002).

⁷ National Institute to Enhance Leadership and Law Practice (Buies Creek, North Carolina), *North Carolina Chief Justice's Commission on Professionalism, State of the Profession and Quality of Life Survey* (2002-2003).

⁸ H. Selye, *Stress without Distress*, Philadelphia: J.P. Lippincott Co. (1974).

Substance Abuse: Alcohol, Specifically

Lawyers Assistance Program (LAP)

Stephen O. Dell, M.D.

MES Solutions

Saturday, May 3, 2014

Dr. Stephen Dell, May 3, 2014

WHO'S THE AUDIENCE?

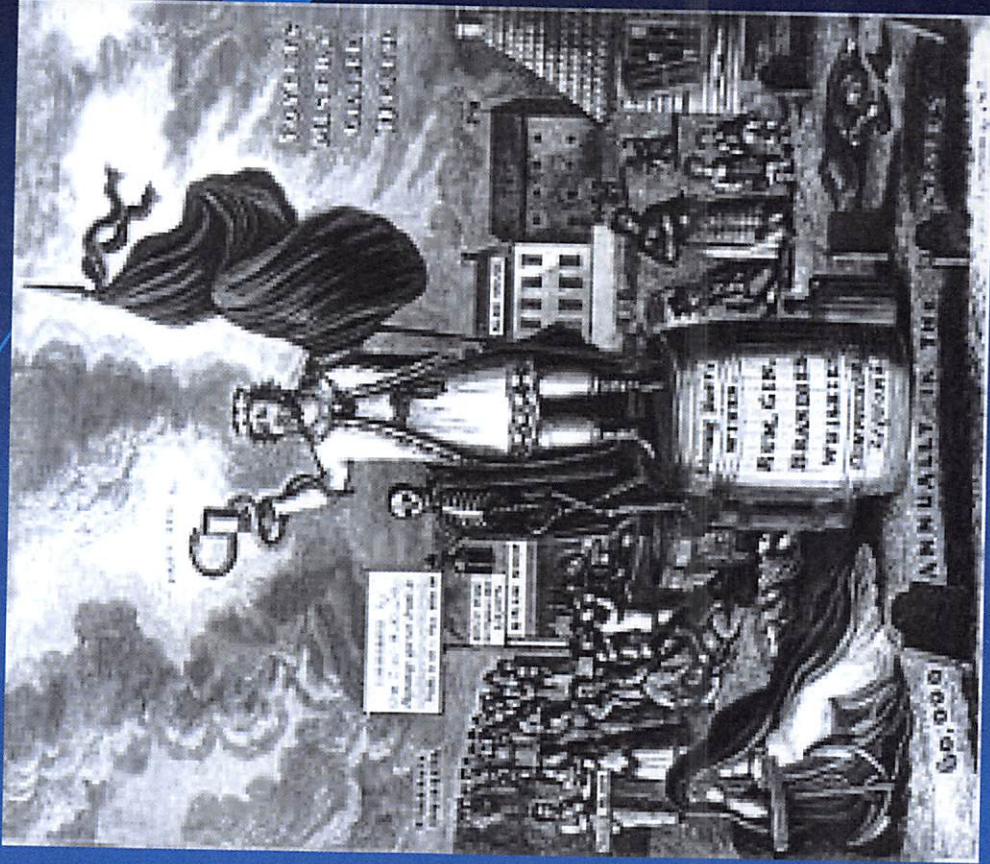
- Nurses (and doctors):
 - Diagnosis (Dx)
 - Prognosis (Px)
 - Treatment (Rx)
- Patients:
 - Alternatives
 - Risks
 - Benefits
- ATTORNEYS
 - Protocols / Regulations
 - Reasonableness
 - RED FLAGS for inappropriate diagnosis / treatment

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MOTIVATION: LAWYERS AND ALCOHOL

- ABA: 15-20% Attorney alcohol / Substance abuse
- Almost twice that of other professions
- True? If so: Why?
- Not to be answered today or here

“King Alcohol and his Prime Minister” c. 1820



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ALCOHOLISM

- 1. Compulsive and uncontrolled consumption
- 2. Medically considered an addictive illness
- 3. Psychiatry:
 - a. “Alcohol abuse”
 - b. “Alcohol dependence”
 - c. “Alcohol use disorder”
- 4. WHO (1979) “alcohol dependence syndrome”
- 5. “Dipsomania”

HISTORY

- 1. Volsted Act (1920)
- 2. “Alcoholism” (Magnus Huss [1849])
- 3. “Dipsomania” (C. W. Hufeland [1819])
- 4. “Habitual drunkenness” (18th Century)
- 5. Chronic alcohol misuse (Agapios [1647])
- 6. Ancient history of worship and condemnation

ALCOHOLISM EPIDEMIOLOGY

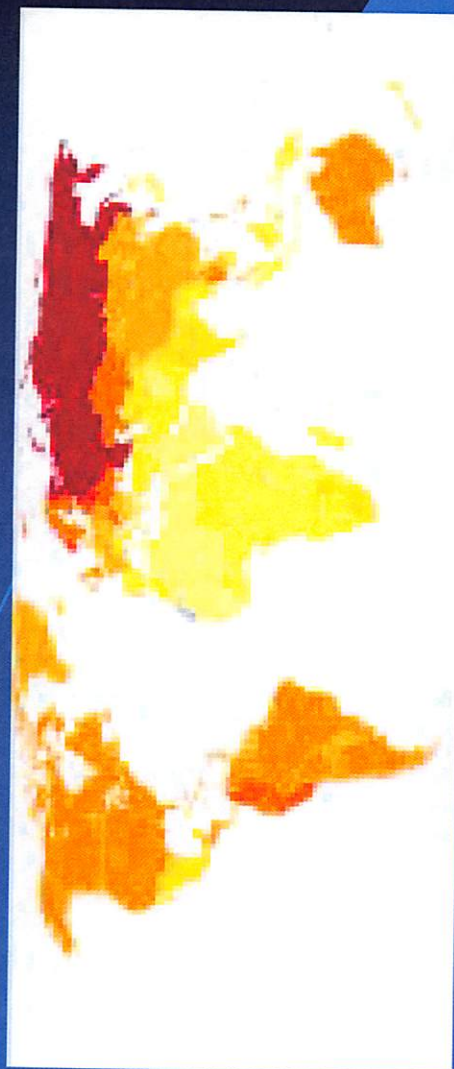
1. US life time occurrence: 12%
 - a. 10-20% males
 - b. 5-10% females
2. Prevalence: 140M world wide
3. Determinants: equivocal assessment
 - a. 50-60% genetic
 - b. 40-50% environmental
4. Usually commenced in youth

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ALCOHOLISM: USE

1. Most available / abused substance
2. Beer: most widely consumed
 - a. Third after water and tea
 - b. Probably oldest fermented beverage
3. SAMHSA 2004-2005 (persons over 12): %
 - a. Alcohol dependence in past year, by past month
 - b. 44.7 heavy; 18.5 binge; 3.8 non-binge; 1.3 non
 - c. M/F past month: 10.5/3.3 (heavy); 30.8/15.1 (binge); 57.5/45.0 (any)
 - d. M/F past year dependence/abuse: 10.5/5.1
4. HSPH (college students):
 - a. 31% abuse, 6% dependence
 - b. 37% satisfy DSM-IV alcoholic criteria

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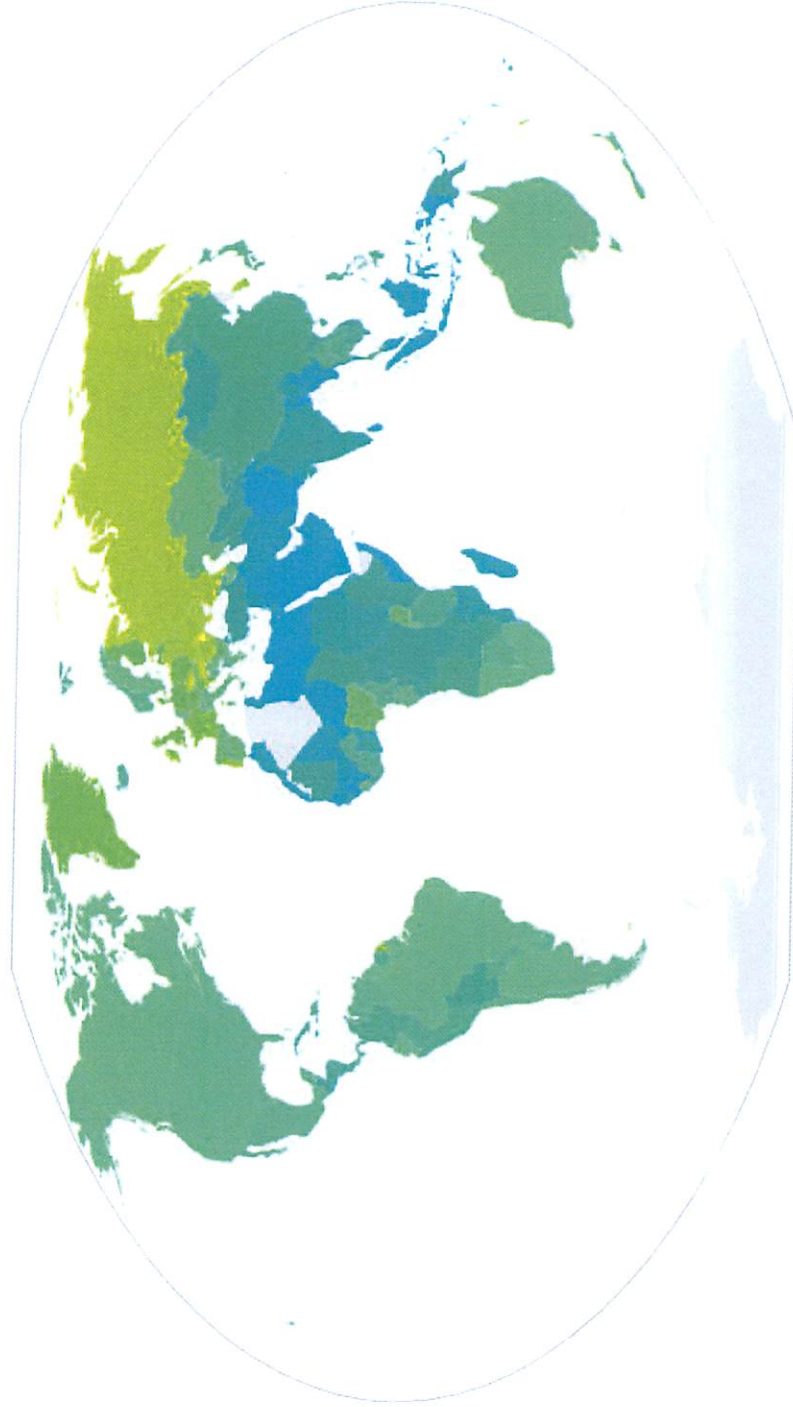


no data
<50
50-170
170-290
290-410
410-530
530-650

650-770
770-890
890-1010
1010-1130
1130-1250
>1250

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Annual alcohol per capita consumption (Litres EtOH)



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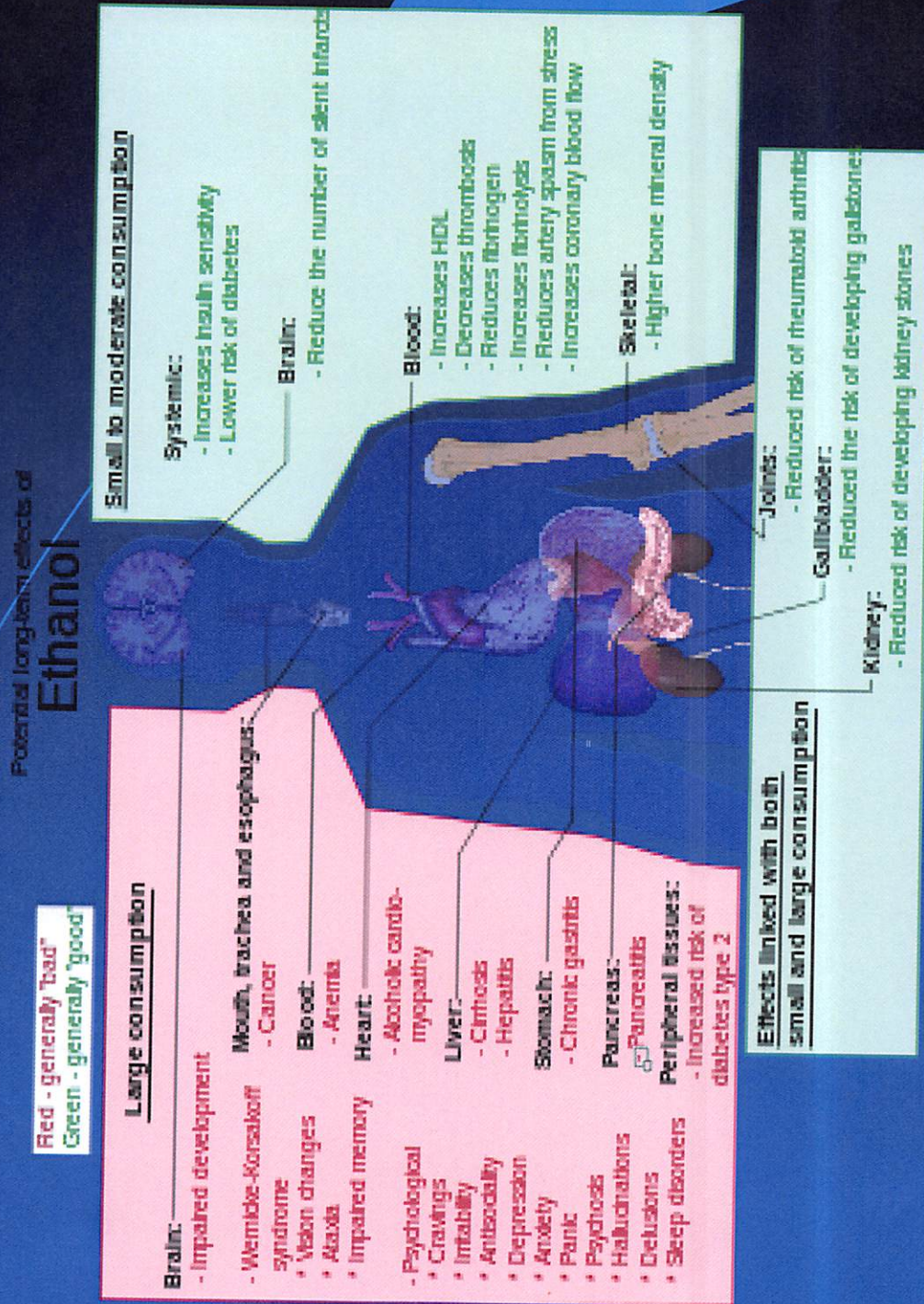
ALCOHOL AND SOCIETY

- 1. Ancillary costs:
 - a. Lost labor, ...
 - b. Treatment costs (MVA, TBI, Fetal EtOH)
- 2. WHO: 1-6% GDP lost
- 3. Drug abuse costs: 24-41% EtOH
- 4. US TOTAL costs ~ \$223.5B (2006): > cancer
- 5. ~ Proportional to GDP
- 6. Caucasians vs. Chinese
 - a. Much lower abstinence (11.8% vs 33.4%)
 - b. Much higher tolerance-to-symptoms (3.4 vs. 2.2 drinks)

LONG TERM MISUSE

1. Mental changes: depression, suicidality
2. Binge drinking: to BAC = 0.08 (NIAAA)
 - a. Males: 5 standard drinks (SD) / 2 hours
 - b. Females: 4 SD / 2 hours
3. Chronic EtOH:
 - a. Males: > 14 SD / week or 4 / day
 - b. Females: > 7 SD / week or 3 / day
4. SD: 12 oz. beer, 5 oz. wine, 1.5 oz spirits

Long-term alcohol effects excluding pregnancy



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LONG TERM ALCOHOL EFFECTS

- 1. Liver
- 2. Pancreas
- 3. GI tract
- 4. Nutritional deficiencies
- 5. Hormonal abnormalities
- 6. Sexual and reproductive function
- 7. Cardiovascular disease
- 8. CNS and PNS disease
- 9. Musculoskeletal fragility (accidents)
- 10. Immune deficiencies
- 11. Cancer (especially breast)

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ALCOHOL: PSYCHE EFFECTS

- 1. Cognition: 10 % dementia cases (2nd)
- 2. Social skills: prefrontal cortex, emotion and prosody perception, humor impaired
- 3. Psychiatric Dx (25%): depression, anxiety, psychosis, OBS, panic attacks
- 4. Major depressive disorder: “substance-induced” vs. “independent”
- 5. Typology:
 - a. Males: antisocial, bipolar, schizophrenia, impulse, ADHD
 - b. Females: depression, anxiety, panic, bulimia, PTSD

ALCOHOL: SOCIAL EFFECTS

- 1. Crime: domestic violence, child abuse, rape, burglary, assault
- 2. Loss of employment
- 3. DUI, public disorder, etc.
- 4. Social isolation
- 5. Child neglect: emotional problems in next generation

ALCOHOL PATHOPHYSIOLOGY

- 1. Increases GABA-A receptor *AND* endorphin release
- 2. Promotes CNS excitation *AND* depression therefore
- 3. Chronic use:
 - a. Receptors desensitized and fewer
 - b. Result: tolerance and physical dependence
- 4. *Kindling*: increased GABA-A, NMDA, AMPA receptor activity
- 5. Women: [EtOH] greater per dose
 - a. Hormonal effects
 - b. Reduced body water effects

ALCOHOL GENETICS

1. African, East Asian, Indo-European metabolism differences
- 2. ADH1 B*3 allele accelerates EtOH metabolism
- 3. Found in African, Native American populations only
- 4. Reduced alcoholism risk for (+)
- 5. BUT: Just one factor among many

ALCOHOL: CAUSES

- 1. Genetic + Environmental
- 2. Metabolism
- 3. Family History
- 4. Age at onset (40% by late adolescence)
- 5. Childhood trauma, poor supports
- 6. Neurotoxicity (cortical degeneration)

“The Drunkard’s Progress” (1846)



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ALCOHOL TERMINOLOGY

- 1. Misuse, problem use, abuse, heavy use” alcohol dependence, ...
- 2. “Moderate” (definition): $M/F \leq 2/1$ EtOH beverages/day
- 3. “Alcoholism” both abuse and dependence
- 4. APA (DSM-IV): alcohol “abuse” vs “dependence”
- 5. WHO ICD-10: alcohol “harmful use” vs “dependence syndrome”
- 6. Also NCADD, ASAM, MeSH, ...
- 7. Imprecise

ALCOHOLISM: STAGING

- 1. Johnson (1980):
 - a. 'Learning the mood swing'
 - b. 'Seeking the mood swing'
 - c. 'Physical and social consequences
 - d. 'Drink to feel normal'
- 2. Milam and Ketcham (1983) [physical deterioration]:
 - a. 'Adaptive stage'
 - b. 'Dependent stage'
 - c. 'Deterioration stage'

ALCOHOLISM: SCREENING

- 1. Social barriers, attitudes, stereotypes: affect men more than women
- 2. CAGE questionnaire:
 - a. Felt need to Cut down?
 - b. Annoyed by others criticizing your drinking?
 - c. Felt Guilty about drinking?
 - d. AM Eye-opener to steady nerves or relieve hangover?
- 2. Many others exist:
 - a. ADDQ (Alcohol Dependence Data Questionnaire)
 - b. MAST (MI Alcohol Screening Test)
 - c. AUDIT (Alcohol Use Disorders ID Test)
 - d. PAT (Paddington Alcohol Test) [ERs]

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ALCOHOLISM: TREATMENTS

- 1. Prevention:
 - a. Restricting mass media
 - b. Early intervention
- 2. Management:
 - a. Detoxification / Support / Self-help
 - b. Abstinence vs. harm-reduction approaches
- 3. Detoxification:
 - a. Not a treatment
 - b. Inpatient care for severe withdrawal
 - c. Avoid benzodiazepines
 - d. Depression/anxiety may take weeks/months
 - e. Cognitive recovery ~ 12 months

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ALCOHOLISM: TREATMENTS

- 4. Psychological
 - a. Group Therapy: AA, LifeRing Secular Recovery, SMART, Women for Sobriety, Secular Organizations for Sobriety, The Other Bar, ...
 - b. Moderation management, Drink Wise: less effective²
 - c. 2002 NIAAA study: 17.7% alcohol-dependent > one year, returned to low-risk drinking with diminished dependency
 - d. 2004-2005 study: abstinence most effective
 - e. 60-year study: controlled drinking relapsed or became abstinent after ~ 10 years

ALCOHOLISM: TREATMENTS

- 5. Medications:
 - a. Acamprosate (Campral): glutamate antagonist; reduces NMDA; reduces relapses (2010)
 - b. Benzodiazepines: for acute withdrawal; high relapse rate
 - c. Calcium carbimide (Temposil): ~ Disulfiram, without drowsiness and hepatotoxicity
 - d. Disulfiram (Antabuse): inhibits EtOH - acetaldehyde elimination; produces severe discomfort (~ hangover)
 - e. Naltrexone (opioid receptor competitive antagonist): blocks EtOH-induced endorphin release (which activate dopaminergic pathways) reward
- 6. Dual addictions:
 - a. Most common benzodiazepine dependence (10-20%)
 - b. Increase cravings for and volume of EtOH consumed
 - c. Sedative-hypnotics (zolpidem, zopiclone) and/or opiates common
 - d. EtOH itself a cross-tolerant sedative hypnotic
 - e. Withdrawal can be severe: psychosis / seizures / C-V collapse

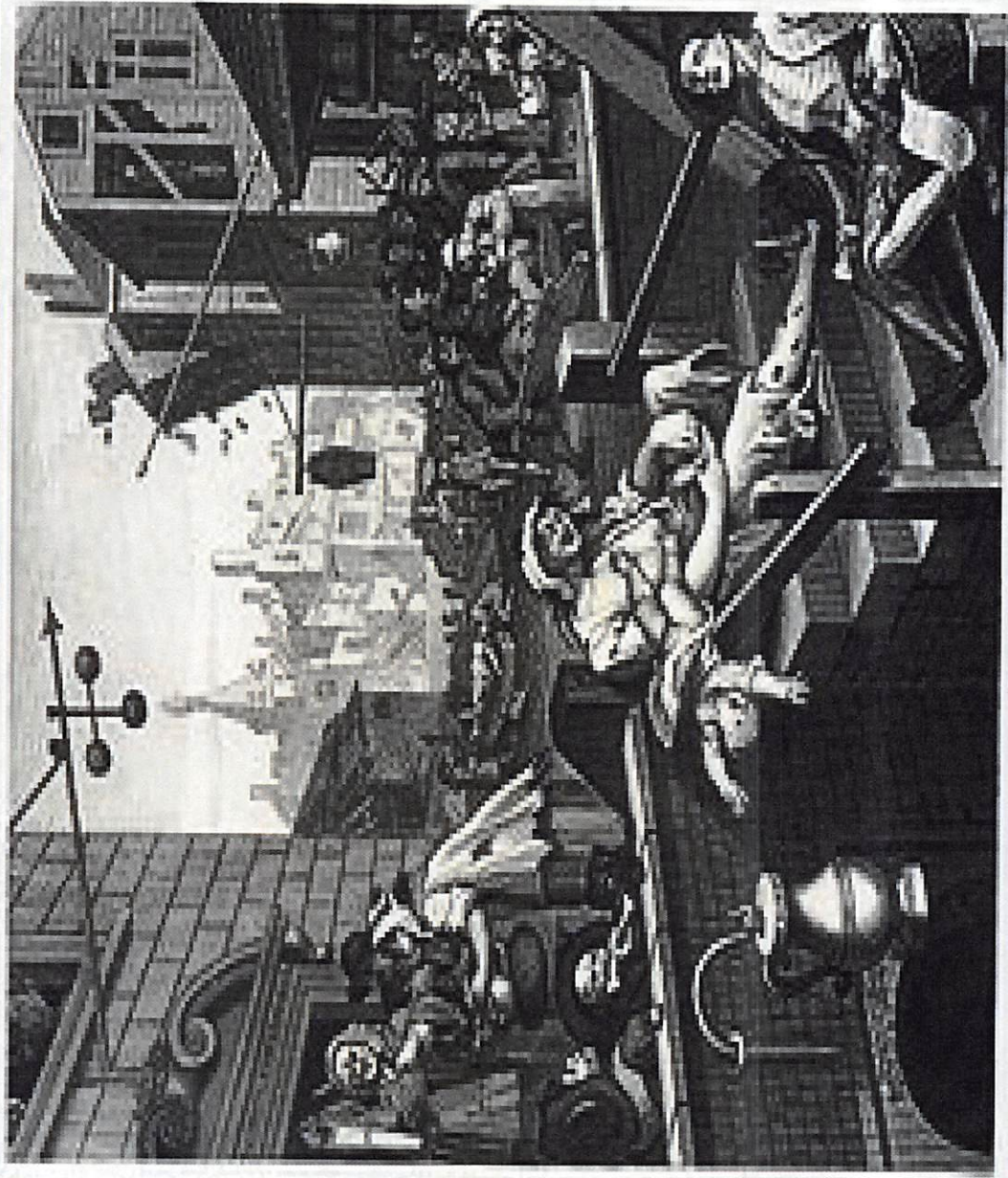
Inn with Drunken Peasants (Adriaen Brouwer [1620s])



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Gin Lane (William Hogarth [1751])



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Thank you for your attention. Any Questions?

To schedule an appointment with Dr. Dell or
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