Substance Abuse Ethics: What All Attorneys Must Know

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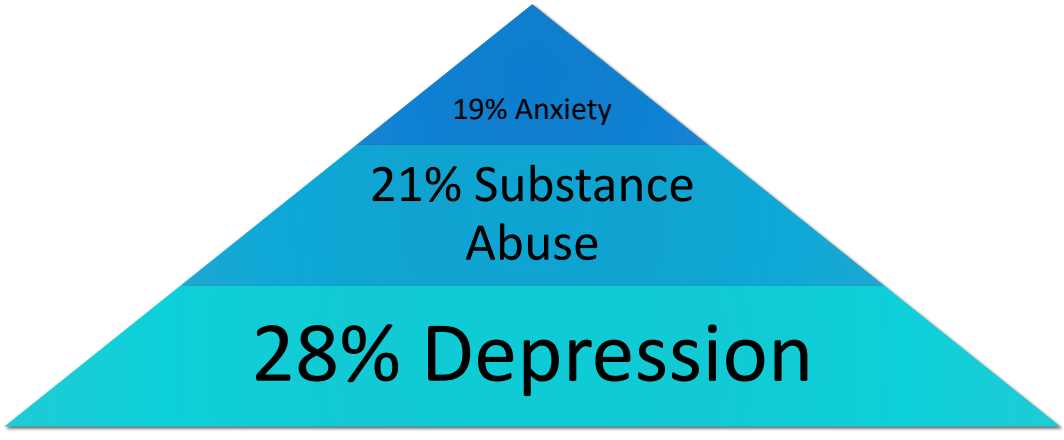
Attorneys disproportionately suffer from substance abuse disorders and mental health problems:



The Prevalence of Substance Use and Other Mental Health Concerns Among American Attorneys, Krill, Patrick R. JD, LLM; Johnson, Ryan MA; Albert, Linda MSSW.

Definitions of Relevant Terms:

This program relies on the definitions provided by the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–5)[1]:

- Alcohol Use Disorder ("AUD")
- Substance Use Disorder ("SUD")
- Gambling Addiction
- Food Addiction
- Depression
- Anxiety Disorders
- Obsessive-Compulsive Disorder
- Bipolar Disorder
- Suicidal Ideation

Common Addiction Disorders Facing Attorneys

Alcoholism

DSM-5 Criteria for Alcohol Use Disorder:

In the past year have you …

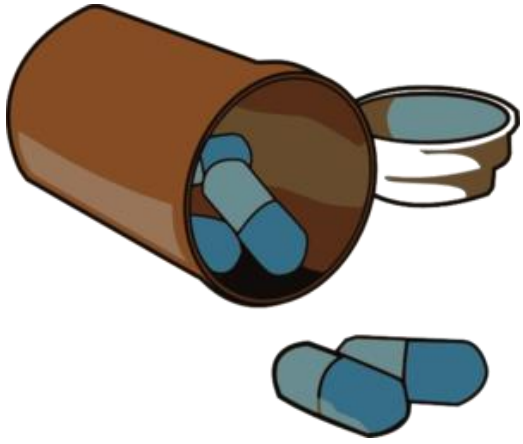
1. Had times when you ended up drinking more, or longer, than you intended?
2. More than once wanted to cut down or stop drinking, or tried to, but couldn't?
3. Spent a lot of time drinking? Or being sick or getting over the effects of drinking?
4. Wanted a drink so badly that you couldn't think of anything else?
5. Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?
6. Continued to drink even though it was causing trouble with your family or friends?
7. Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?

DSM-5 Criteria for Alcohol Use Disorder:

In the past year have you …

8. More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?
9. Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?
10. Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?
11. Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?

Substance Use Disorder



Substance Use Disorder:

The DSM-5 categorizes drug abuse and addiction under the new single category "Substance Use Disorder" ("SUD").

Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences.

It is considered a brain disease because drugs change the brain; they change its structure and how it works.

These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors.

The DSM-5 describes a problematic pattern of use of an intoxicating substance leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

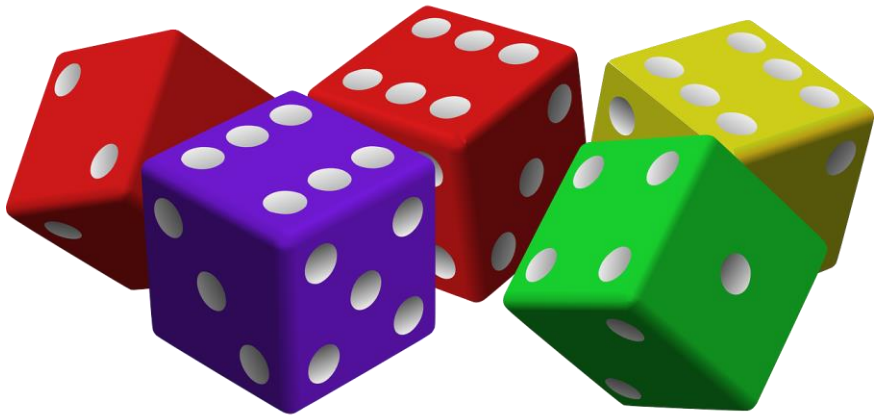
DSM-5 Criteria for Substance Use Disorder ("SUD"):

1. The substance is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful effort to cut down or control use of the substance.
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
4. Craving, or a strong desire or urge to use the substance.
5. Recurrent use of the substance resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.
7. Important social, occupational, or recreational activities are given up or reduced because of use of the substance.

DSM-5 Criteria for Substance Use Disorder ("SUD"):

8. Recurrent use of the substance in situations in which it is physically hazardous.
9. Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    - A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
    - A markedly diminished effect with continued use of the same amount of the substance.
11. Withdrawal, as manifested by either of the following:
    - The characteristic withdrawal syndrome for that substance (as specified in the DSM- 5 for each substance).
    - The substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Gambling Disorder



DSM-5 Diagnostic Criteria for Gambling Disorder:

Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12-month period:

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
2. Is restless or irritable when attempting to cut down or stop gambling.
3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble.

DSM-5 Diagnostic Criteria for Gambling Disorder:

5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).
6. After losing money gambling, often returns another day to get even ("chasing" one's losses).
7. Lies to conceal the extent of involvement with gambling.
8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
9. Relies on others to provide money to relieve desperate financial situations caused by gambling.

The gambling behavior is not better explained by a manic episode.

Feeding and Eating Disorders that Commonly Affect Lawyers:

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder

DSM-5 Criteria for Anorexia Nervosa

1. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
2. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

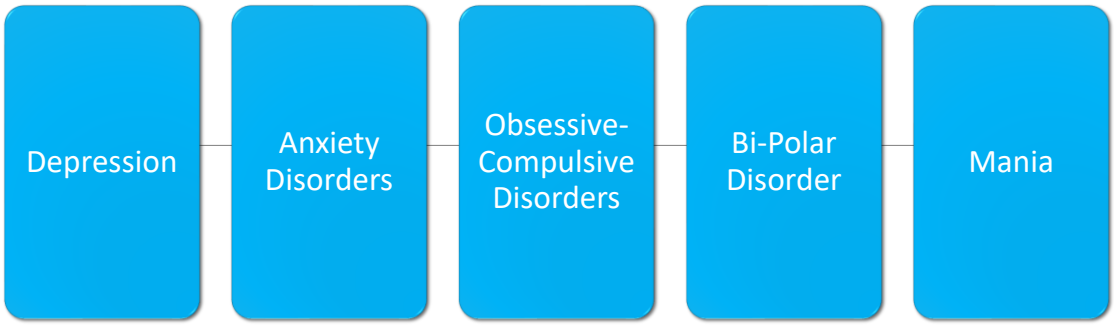
DSM-5 Criteria for Bulimia Nervosa

1. Recurrent episodes of binge eating:
   a. Eating, in a discrete period of time, an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
   b. A sense of lack of control over eating during the episode.
2. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
3. At least once a week for 3 months.
4. Self-evaluation is unduly influenced by body shape and weight.
5. The disturbance does not occur exclusively during episodes of anorexia nervosa.

DSM-5 Criteria for Binge Eating Disorder:

1. Recurrent episodes of binge eating.
2. The binge-eating episodes are associated with three (or more) of the following:
   a. eating much more rapidly than normal.
   b. eating until feeling uncomfortably full.
   c. eating large amounts of food when not feeling physically hungry.
   d. eating alone because of feeling embarrassed by how much one is eating.
   e. feeling disgusted with oneself, depressed, or very guilty afterwards.
3. Marked distress regarding binge eating is present.
4. The binge eating occurs, on average, at least once a week for three months.
5. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior (for example, purging) and does not occur exclusively during the course Anorexia Nervosa, Bulimia Nervosa, or Avoidant/Restrictive Food Intake Disorder.

Common Mental Health Issues That Frequently Affect Attorneys



DSM-5 Criteria for Major Depressive Disorder:

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

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation)
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

DSM-5 Criteria for Major Depressive Disorder, cont.:

6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a mixed episode.

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

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

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

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

DSM-5 Criteria for Generalized Anxiety Disorder:

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms:
   1. Restlessness, feeling keyed up or on edge.
   2. Being easily fatigued.
   3. Difficulty concentrating or mind going blank.
   4. Irritability.
   5. Muscle tension.
   6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

DSM-5 Criteria for Generalized Anxiety Disorder, cont.:

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

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

F. The disturbance is not better explained by another medical disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

DSM-5 Definitions of Obsessions and Compulsions:

Obsessions:

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e. by performing a compulsion).

Compulsions:

1. Repetitive behavior (e.g. hand washing, ordering, checking) or mental acts (e.g. praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Examples of Obsessive-Compulsive Disorders:

- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania (Hair-Pulling Disorder)
- Excoriation (Skin-Picking) Disorder

➢ OCD can be caused by substance abuse or another medical condition.

Bipolar Disorder:

Bipolar I Disorder:

- Bipolar I Disorder involves one or more manic episodes or mixed (mania and depression) episodes and at least one major depressive episode. The episodes are not due to a medical condition or substance use.

Bipolar II Disorder:

- Bipolar II Disorder has one or more severe major depressive episodes with at least one hypomanic episode. There are no manic or mixed episodes. Hypomania is a lesser form of mania.

Mania:

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least one week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g. feels rested after only three hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli).
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g. engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

Mania, cont.:

C. The symptoms do not meet criteria for a Mixed Episode.

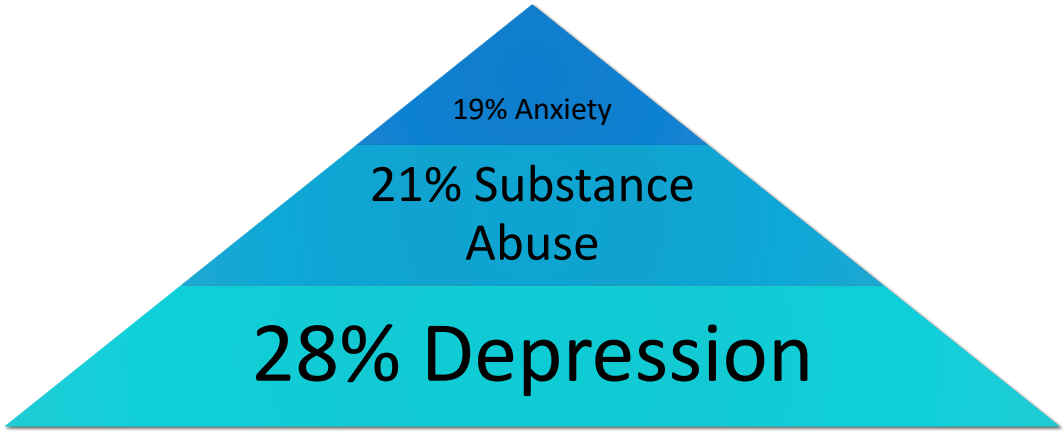
D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or other, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g. hyperthyroidism).

Why Lawyers?

Are lawyers more likely to be depressed or are depressed people more likely to become lawyers?

Attorneys disproportionately suffer from substance abuse disorders and mental health problems:



The Prevalence of Substance Use and Other Mental Health Concerns Among American Attorneys, Krill, Patrick R. JD, LLM; Johnson, Ryan MA; Albert, Linda MSSW.

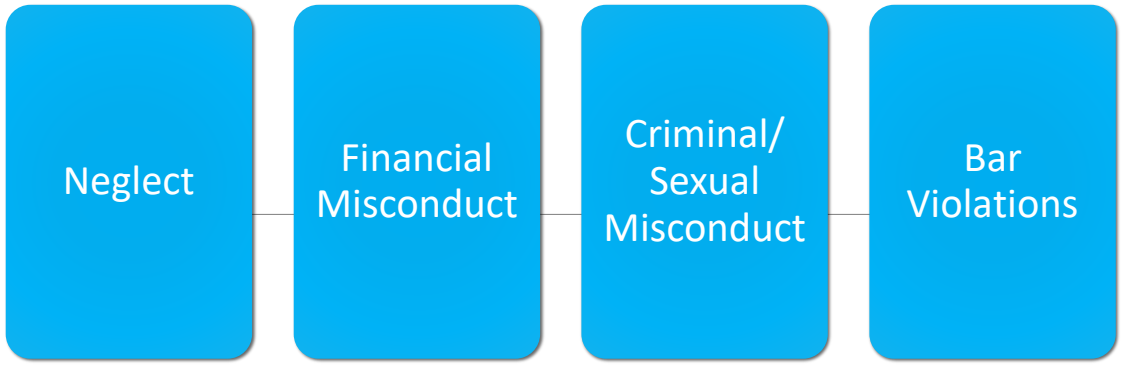
Some Possible Causes:

- Adversarial Nature of Practice
- Perfectionism
- Pessimism
- Long Hours
- Difficult Clients, Adversaries, Judges
- Deadlines
- Serious Nature of Work
- For Younger Attorneys, a Lack of Control Over Case Load and Tasks
- Culture of Drinking – With Firm, Clients, Prospective Clients
- Isolation as a Solo Practitioner

Young Lawyers Are At Particular Risk:

The Krill Study found that, contrary to previous studies, attorneys in the first 10 years of their practice are now suffering from 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. Correspondingly, junior associates have the highest rates of problematic use, and the rates decrease as seniority increases.

Common Misconduct Resulting From Impairment



Neglect:

- Incompetent effort
- Failure to respond to client inquiries
- Failure to appear
- Failure to prosecute case
- Miss statute of limitations
- Providing false information to client
- Poor office/file management

Rule 1.1, Competence[1]:

(a) A lawyer should provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.

(b) A lawyer shall not handle a legal matter that the lawyer knows or should know that the lawyer is not competent to handle, without associating with a lawyer who is competent to handle it.

(c) A lawyer shall not intentionally:

(1) fail to seek the objectives of the client through reasonably available means permitted by law and these Rules; or

(2) prejudice or damage the client during the course of the representation except as permitted or required by these Rules.

[1] New York Rules of Professional Conduct.

Rule 1.3, Diligence:

(a) A lawyer shall act with reasonable diligence and promptness in representing a client.

(b) A lawyer shall not neglect a legal matter entrusted to the lawyer.

(c) A lawyer shall not intentionally fail to carry out a contract of employment entered into with a client for professional services, but the lawyer may withdraw as permitted under these Rules.

Rule 1.4, Communications:

(a) A lawyer shall:

(1) promptly inform the client of:

(i) any decision or circumstance with respect to which the client's informed consent, as defined in Rule 1.0(j), is required by these Rules;

(ii) any information required by court rule or other law to be communicated to a client; and

(iii) material developments in the matter including settlement or plea offers.

(2) reasonably consult with the client about the means by which the client's objectives are to be accomplished;

(3) keep the client reasonably informed about the status of the matter;

(4) promptly comply with a client's reasonable requests for information; and

(5) consult with the client about any relevant limitation on the lawyer's conduct when the lawyer knows that the client expects assistance not permitted by these Rules or other law.

(b) A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.

Financial Misconduct:

- Conversion of client funds
- Comingling client funds
- Failure to promptly refund fees
- Over-billing/bill padding
- Deliberate destruction of financial records
- Failure to get contingency fee in writing

Rule 1.5: Fees

Rule 1.5 states, in relevant part:

(a) A lawyer shall not make an agreement for, charge, or collect an excessive or illegal fee or expense. A fee is excessive when, after a review of the facts, a reasonable lawyer would be left with a definite and firm conviction that the fee is excessive….

(b) A lawyer shall communicate to a client the scope of the representation and the basis or rate of the fee and expenses for which the client will be responsible. This information shall be communicated to the client before or within a reasonable time after commencement of the representation and shall be in writing where required by statute or court rule….

Rule 1.15: Preserving the Identity of Funds and Property of Others; Fiduciary Responsibility; Commingling and Misappropriation of Client Funds or Property; Maintenance of Bank Accounts; Record Keeping Examination of Records

(a) *Prohibition Against Commingling and Misappropriation of Client Funds or Property.*

A lawyer in possession of any funds or other property belonging to another person, where such possession is incident to his or her practice of law, is a fiduciary, and must not misappropriate such funds or property or commingle such funds or property with his or her own.

* * * *

(i) *Availability of Bookkeeping Records: Records Subject to Production in Disciplinary Investigations and Proceedings.*

The financial records required by this Rule shall be located, or made available, at the principal New York State office of the lawyers subject hereto, and any such records shall be produced in response to a notice or subpoena duces tecum issued in connection with a complaint before or any investigation by the appropriate grievance or departmental disciplinary committee, or shall be produced at the direction of the appropriate Appellate Division before any person designated by it. All books and records produced pursuant to this Rule shall be kept confidential, except for the purpose of the particular proceeding, and their contents shall not be disclosed by anyone in violation of the attorney-client privilege.

* * * *

(j) *Disciplinary Action.*

A lawyer who does not maintain and keep the accounts and records as specified and required by this Rule, or who does not produce any such records pursuant to this Rule, shall be deemed in violation of these Rules and shall be subject to disciplinary proceedings.

Criminal and Sexual Misconduct:

- Drunk Driving
- Possession/Sale of Narcotics
- Assault
- Domestic violence
- Vehicular homicide
- Forged drug prescription
- Sexual Assault
- Harassment
- Stalking/Cyber-stalking
- Perjury

Rule 8.3: Reporting Professional Misconduct

(a) A lawyer who knows that another lawyer has committed a violation of the Rules of Professional Conduct that raises a substantial question as to that lawyer's honesty, trustworthiness or fitness as a lawyer shall report such knowledge to a tribunal or other authority empowered to investigate or act upon such violation.

(b) A lawyer who possesses knowledge or evidence concerning another lawyer or a judge shall not fail to respond to a lawful demand for information from a tribunal or other authority empowered to investigate or act upon such conduct.

(c) This Rule does not require disclosure of:

(1) information otherwise protected by Rule 1.6; or

(2) information gained by a lawyer or judge while participating in a bona fide lawyer assistance program.

Rule 8.4, Misconduct, in relevant part:

A lawyer or law firm shall not:

(a) violate or attempt to violate the Rules of Professional Conduct, knowingly assist or induce another to do so, or do so through the acts of another;

(b) engage in illegal conduct that adversely reflects on the lawyer's honesty, trustworthiness or fitness as a lawyer;

(c) engage in conduct involving dishonesty, fraud, deceit or misrepresentation;

(d) engage in conduct that is prejudicial to the administration of justice;

* * * *

(h) engage in any other conduct that adversely reflects on the lawyer's fitness as a lawyer.

Bar Violations:

- Failure to pay dues
- Failure to: respond to Grievance Committee, cooperate with the Grievance Committee, be truthful in response to Grievance Committee
- Failure to meet CLE requirements
- False statements to bar disciplinary authorities
- Failure to cooperate with the bar
- False statements on reinstatement questionnaire

Additional Relevant Rules of Professional Conduct:

Client-Lawyer Relationship

Rule 1.1: Competence

Rule 1.3: Diligence

Rule 1.4: Communications

Rule 1.6: Confidentiality of Information

Advocate

Rule 3.1: Meritorious Claims and Contentions

Rule 3.2: Expediting Litigation

Rule 3.3: Candor toward the Tribunal

Rule 3.4: Fairness to Opposing Party and Counsel

Additional Relevant Rules of Professional Conduct, cont.:

Transactions with Persons Other Than Clients

Rule 4.1: Truthfulness in Statements to Others

Law Firms and Associations

Rule 5.1: Responsibilities of a Partner or Supervisory Lawyer

Rule 5.2: Responsibilities of a Subordinate Lawyer

Maintaining the Integrity of the Profession

Rule 8.1: Bar Admission and Disciplinary Matters

Some Examples of Impaired Attorneys:

In re Disability of Caramagno, 47914 (NEV. 9-22-2006)

- A Las Vegas lawyer who arrived in court "90 minutes late in the company of a young woman wearing a black halter top and tight pants."
- The Court orders that he take a breathalyzer and his BAC level is .075.
- Google "drunk lawyer" and the YouTube video of Mr. Caramagno's appearance on behalf of client facing life imprisonment is the first item.

Discipline: Went on disability status and has since ceased practicing law.

Board of Professional Responsibility, Wyoming State Bar v. Anderson, 261 P.3d 695 (2011)

Initial proceeding in 2006 due to a report that Respondent had appeared in court under the influence of alcohol. Respondent acknowledged that he had an alcohol problem and entered into a diversion contract. In event of breach, the Respondent agreed to an immediate six-month suspension.

During 2010, Respondent was twice convicted of driving under the influence of alcohol. Also during 2010, court staff reported that Respondent was not adequately representing his clients in court proceedings. Similar concerns were received by Bar Counsel from clients of Respondent.

Discipline: Respondent retired from the practice of law, and did not contest the formal charge. Respondent agreed to a one-year license suspension.

Some other examples of impaired attorneys:

- A DWI lawyer in New Mexico who stumbled into the wrong courtroom: Alcohol level .11.
- An Indiana attorney accused of inappropriately touching a court employee three different times: Alcohol level .154.
- Drunken judge proclaims 'I f---ing kill people' before he punches out Legal Aid lawyer and leaves him on sidewalk.

Hypothetical #1

Lucy Litigator has been battling with a particularly contentious adversary for several months. The trial date has finally arrived. After arriving in the courthouse parking lot, Lucy sees her adversary, Dick Coker, pull into the lot. They have had a hostile relationship throughout the preliminaries so Lucy ducks behind some cars, hoping that Dick won't see her and will go into the courthouse first.

Instead, Dick remains in his car and Lucy sees him appear to snort cocaine off a handheld mirror. Lucy is so shocked, she is not sure if she actually saw what she thinks she saw. Dick proceeds to get out of his car and enter the courthouse. Lucy follows a few minutes after him.

What is Lucy's duty? Would it make a difference if she saw the same thing in a restaurant parking lot the night before the trial?

Hypothetical #2:

David Drinker has built a successful personal injury firm from the ground up, Drinker & Associates, PC. He has had several of the largest jury verdicts ever in his state and he served as lead attorney in one of the nation's most prominent trials. Because David is bringing in tremendous business and press attention, the other members of the firm do not want to address his drinking or his erratic behavior. David is also the sole signatory on the firm's escrow account, but he is often absent from the office so his paralegal has started to sign checks in his name.

Members of the firm begin to panic when they start to receive complaints from clients who have not received their settlement checks. Finally, at that point, one of the senior attorneys, Nota Enabler, tries to get David to seek treatment. She also calls the state's Lawyers Assistance Program to report David's drinking and potential misconduct.

What Obligations Do Other Members of Drinker & Associates Have?

See:

- Rule 5.1: Responsibilities of Law Firms, Partners, Managers and Supervisory Lawyers
- Rule 5.2: Responsibilities of a Subordinate Lawyer
- Rule 8.3: Reporting Professional Misconduct
- ABA Formal Opinion 03-429 (June 11, 2003) – Obligations with Respect to Mentally Impaired Lawyer in the Firm
- *Matter of Dean*, 541 N.Y.S.2d 555 (2d Dept. 1989)

Hypothetical #3:

Debbie Downer has been a solo practitioner ever since she graduated from law school, five years ago. She can barely make ends meet and is now months behind on her office rent. She is afraid to go to the office because she doesn't want to see her mail. She has stopped answering emails and her voicemail box has been full for weeks. The last time she was at the office, two months ago, she received a check for a small settlement. She deposited the funds into her escrow account but has procrastinated notifying the client. She doesn't think the client really cares about the case because they were indifferent regarding settlement amount.

The settlement check would cover her outstanding rent and some food. Debbie is expecting a tax refund in the next couple weeks which would cover any amount she took out of escrow.

Hypothetical #4:

Debbie has also failed to keep her other clients informed about the status of their cases. She is afraid to contact one of her clients on an immigration matter because she missed a deadline, causing that client's visa application to be denied.

She has also missed two court appearances on a third case. The first time she failed to appear, she called the court claiming that her father had died. She did not consider that statement false because her father had died – seven years ago. She didn't even bother to notify the court the second time.

Finally, she is certain that there are several letters from the Grievance Committee at her office. Two weeks ago, the Committee personally served her at her home with three disciplinary complaints – including one *sua sponte* complaint due to her failure to respond to the Committee's requests.

Debbie has spent much of the past two months sleeping. When she is awake, she is constantly tempted to jump out of her high-rise apartment window.

Discipline:

Private discipline can range from a letter of caution to a private censure.

Public discipline can range from a brief suspension to disbarment.

Many states now have diversion programs for impaired attorneys. Diversion usually consists of the respondent attorney agreeing to a set of requirements, such as drug treatment, mental health treatment, law practice management education, monitoring – for substance abuse, mental health, practice management.

Diversion often requires that the respondent attorney make an application for diversion. The attorney must also demonstrate some causal connection between the mental health or substance abuse issue and the misconduct.

Law Students

How To Get Help

Lawyers Assistance Programs:

Lawyer assistance programs (LAPs) are here to support lawyers, judges, students and other legal professionals who suffer from alcohol dependence and abuse. They are in every state.

The ABA Commission on Lawyer Assistance Programs ("CoLAP") has the mandate to educate the legal profession concerning alcoholism, chemical dependencies, stress, depression and other emotional health issues, and assist and support all bar associations and lawyer assistance programs in developing and maintaining methods of providing effective solutions for recovery.

CoLAP: http://www.americanbar.org/groups/lawyer_assistance.html

List of LAPs by State:
http://www.americanbar.org/groups/lawyer_assistance/resources/lap_programs_by_state.html

Rule 8.3 and LAPs:

Rule 8.3 Reporting Professional Misconduct

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

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

(c) This Rule does not require disclosure of information otherwise protected by Rule 1.6 or information gained by a lawyer or judge while participating in an approved lawyers assistance program.

Depression and suicide resources:

- US Suicide Hotline: 1-800-784-2433
- National Suicide Prevention Lifeline: 1-800-273-8255
- David Nee Foundation: www.daveneefoundation.org
- Depression and Bipolar Support Alliance: www.dbsalliance.org
- Substance Abuse and Mental Health Services Administration: www.samhsa.gov

Addiction Recovery Resources:

- Alcoholics Anonymous (AA): www.aa-intergroup.org
- National Eating Disorders Association: www.nationaleatingdisorders.org
- National Center for Problem Gambling: www.ncpgambling.org
- International Lawyers in A.A.: www.ilaa.org
- Substance Abuse and Mental Health Services Administration: www.samhsa.gov

Americans with Disabilities Act ("ADA"):

The ADA protects "qualified individuals with disabilities," which means anyone with a physical or mental impairment that substantially limits one or more major life activities, or who has a record of such an impairment, or is generally regarded as having such an impairment. 42 U.S.C. § 12102(1). The ADA covers people suffering from both mental illness and substance abuse.