South Carolina Local Government Attorneys' Institute

November 17, 2023

USC Alumni Center, Columbia

Desa Ballard

Mental Health/ Substance Abuse Presentation Materials

AMERICAN BAR ASSOCIATION
STANDING COMMITTEE ON ETHICS AND PROFESSIONAL RESPONSIBILITY

Formal Opinion 03-429 **June 11, 2003**

Obligations with Respect to Mentally Impaired Lawyer in the Firm

If a lawyer's mental impairment is known to partners in a law firm or a lawyer having direct supervisory authority over the impaired lawyer, steps must be taken that are designed to give reasonable assurance that such impairment will not result in breaches of the Model Rules. If the mental impairment of a lawyer has resulted in a violation of the Model Rules, an obligation may exist to report the violation to the appropriate professional authority. If the firm removes the impaired lawyer in a matter, it may have an obligation to discuss with the client the circumstances surrounding the change of responsibility. If the impaired lawyer resigns or is removed from the firm, the firm may have disclosure obligations to clients who are considering whether to continue to use the firm or shift their relationship to the departed lawyer, but must be careful to limit any statements made to ones for which there is a factual foundation. The obligation to report a violation of the Model Rules by an impaired lawyer is not eliminated by departure of the impaired lawyer.

This opinion addresses three sets of obligations arising under the Model Rules of Professional Conduct[1] with respect to mentally impaired lawyers.[2] First, it considers the obligations of partners in a law firm[3] or a lawyer super-

1. This opinion is based on the Model Rules of Professional Conduct as amended by the ABA House of Delegates in February 2002 and, to the extent indicated, the predecessor Model Code of Professional Responsibility of the American Bar Association. The laws, court rules, regulations, rules of professional responsibility, and opinions promulgated in the individual jurisdictions are controlling.

2. This opinion deals only with mental impairment, which may be either temporary or permanent. Physical impairments are beyond the scope of this opinion unless they also result in the impairment of mental facilities. In addition to Alzheimer's Disease and other mental conditions that are age-related and can affect anyone, mental impairment can result from alcoholism and substance abuse, which lawyers have been found to suffer from at a rate at least twice as high as the general population. George Edward Bailly, *Impairment, The Profession and Your Law Partner,* 11 No. 1 PROF. LAW. 2 (1999).

3. The term "partners in the firm" includes every partner of a legal partnership and every shareholder of a law firm organized as a professional corporation, not just members of the firm's executive or management committee. Rule 5.1 cmt. 1.

AMERICAN BAR ASSOCIATION STANDING COMMITTEE ON ETHICS AND PROFESSIONAL RESPONSIBILITY, 541 North Fairbanks Court, 14th Floor, Chicago, Illinois 60611-3314 Telephone (312)988-5300 CHAIR: Marvin L. Karp, Cleveland, OH ❑ Loretta C. Argrett, Washington, DC ❑ Michael E. Bragg, Bloomington, IL ❑ Thomas M. Fitzpatrick, Seattle, WA ❑ Daniel W. Hildebrand, Madison, WI ❑ Donald B. Hilliker, Chicago, IL ❑ Bruce Alan Mann, San Francisco, CA ❑ Charles McCallum, Grand Rapids, MI ❑ E. Fitzgerald Parnell, III, Charlotte, NC ❑ Hon. Henry Ranmsey, Jr., Berkeley, CA ❑ CENTER FOR PROFESSIONAL RESPONSIBILITY: George A. Kuhlman, Ethics Counsel; Eileen B. Libby, Associate Ethics Counsel

© 2003 by the American Bar Association. All rights reserved.

vising another lawyer to take steps designed to prevent lawyers in the firm who may be impaired from violating the Rules of Professional Conduct. Second, it addresses the duty of a lawyer who knows[4] that another lawyer in the same firm has, due to mental impairment, failed to represent a client in the manner required by the Model Rules to inform the appropriate professional authority or to communicate knowledge of such violation to clients or prospective clients of the impaired lawyer.[5] Third, it considers the obligations of lawyers in the firm when an impaired lawyer leaves the firm.[6]

Impaired lawyers have the same obligations under the Model Rules as other lawyers. Simply stated, mental impairment does not lessen a lawyer's obligation to provide clients with competent representation. Thus, for example, the lawyer who has failed to act with diligence and promptness in representing a client,[7] or has failed to communicate with the client in an appropriate manner,[8] has violated the Model Rules even if that failure is the result of mental impairment.[9] The matter of a lawyer's impairment is most directly addressed under the Model Rules of Professional Conduct under Rule 1.16,

---

4. "Knows" denotes actual knowledge, which may be inferred from the circumstances. Rule 1.0(f).

5. This opinion does not deal with the issues that could arise for the firm vis-a-vis its responsibilities to accommodate an impaired lawyer under the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101 *et seq.* (2003) (the "ADA"), or a state law equivalent, which protects disabled employees. Such statutes, although generally not applicable to equity partners in law firms, *see, e.g., Simpson v. Ernst & Young,* 100 F.3d 436, 443-44 (6th Cir. 1996)*, cert. denied,* 520 U.S. 1248 (1997) (partners not protected as employees under federal antidiscrimination laws)*,* may apply to non-equity partners, associates, in-house counsel, and of counsel. Thus, if a lawyer/employee is able to provide competent representation to a client if the firm provides the lawyer with a reasonable accommodation, the firm may have an obligation to maintain that lawyer's employment. For a discussion of an employer's obligations under the ADA, *see* Henry H. Perritt, Jr., *Employer Obligations*, *in* Americans with Disabilities Act Handbook § 4 (3rd ed. 1997). A number of documents discussing employers' obligations under the ADA are available on the Equal Employment Opportunity Commission website, http://www.eeoc.gov/publications.html.

6. This opinion does not deal with the potential fiduciary obligations or civil liability to clients of a firm with which the impaired lawyer is associated or with the issues that arise under a firm's partnership agreement if a lawyer is impaired. For a discussion of these issues, *see* Bailly, *supra*, note 2.

7. Rule 1.3 states: "A lawyer shall act with reasonable diligence and promptness in representing a client."

8. Rule 1.4, which requires a lawyer to reasonably consult with the client and keep the client reasonably informed about the status of the matter, contains numerous obligations that the impaired lawyer may have difficulty satisfying.

9. Although mental impairment is most likely to cause Rules 1.1, 1.3, and 1.4 to be violated, it also may result in violations of other Model Rules. This opinion assumes that, but for his mental impairment, the lawyer would be able to comply with the requirements of all of the Model Rules.

which specifically prohibits a lawyer from undertaking or continuing to represent a client if the lawyer's mental impairment materially impairs the ability to represent the client.[10] Unfortunately, the lawyer who suffers from an impairment may be unaware of, or in denial of, the fact that the impairment has affected his ability to represent clients.[11] When the impaired lawyer is unable or unwilling to deal with the consequences of his impairment, the firm's partners and the impaired lawyer's supervisors have an obligation to take steps to assure the impaired lawyer's compliance with the Model Rules.

An impaired lawyer's mental condition may fluctuate over time. Certain dementias or psychoses may impair a lawyer's performance on "bad days," but not on "good days" during which the lawyer behaves normally. Substance abusers may be able to provide competent and diligent representation during sober or clean interludes, but may be unable to do so during short or extended periods in which the abuse recurs. If such episodes of impairment have an appreciable likelihood of recurring, lawyers who manage or supervise the impaired lawyer may have to conclude that the lawyer's ability to represent clients is materially impaired.

It also is important to understand that some disorders that may appear to be mental impairment (for example, Tourette's Syndrome), while causing overt conduct that appears highly erratic, may not interfere with competent, diligent legal representation such that they "materially impair" a lawyer's ability to represent his clients.

When considering what must be done when confronted with evidence of a lawyer's apparent mental disorder or substance abuse, it may be helpful for partners or supervising lawyers to consult with an experienced psychiatrist, psychologist, or other appropriately trained mental health professional.[12]

I. Obligations to Adopt Measures to Prevent Impaired Lawyers in the Firm from Violating the Model Rules

Although there is no explicit requirement under the Model Rules that a lawyer prevent another lawyer who is impaired from violating the Model Rules, Rule 5.1(a) requires that all partners in the firm and lawyers with comparable managerial authority in professional corporations, legal departments, and other organizations deemed to be a law firm[13] make "reasonable efforts" to establish internal policies and procedures[14] designed to provide "reasonable assurance" that all lawyers in the firm, not just lawyers known to be impaired, fulfill the requirements of the Model Rules. The measures required depend

10. Rule 1.16(a)(2).

11. Bailly, s*upra* note 2 at 12.

12. The extent to which information concerning the impaired lawyer may be communicated without his consent may be limited by the Americans with Disabilities Act, *supra* note 5.

13. Rule 1.0(c)

14. Rule 5.1, cmt. 2.

on the firm's size and structure and the nature of its practice.[15]

In addition to the requirement that the firm establish appropriate preventive policies and procedures, Rule 5.1(b) requires a lawyer having direct supervisory authority over another lawyer to make reasonable efforts to ensure that the supervised lawyer conforms to the Model Rules. When a supervising lawyer knows that a supervised lawyer is impaired, close scrutiny is warranted because of the risk that the impairment will result in violations.

The firm's paramount obligation is to take steps to protect the interests of its clients. The first step may be to confront the impaired lawyer with the facts of his impairment and insist upon steps to assure that clients are represented appropriately notwithstanding the lawyer's impairment. Other steps may include forcefully urging the impaired lawyer to accept assistance to prevent future violations or limiting the ability of the impaired lawyer to handle legal matters or deal with clients.[16]

Some impairments may be accommodated. A lawyer who, because of his mental impairment is unable to perform tasks under strict deadlines or other pressures, might be able to function in compliance with the Model Rules if he can work in an unpressured environment. In addition, the type of work involved, as opposed to the circumstances under which the work occurs, might need to be examined when considering the effect that an impairment might have on a lawyer's performance. For example, an impairment may make it impossible for a lawyer to handle a jury trial or hostile takeover competently, but not interfere at all with his performing legal research or drafting transaction documents. Depending on the nature, severity, and permanence (or likelihood of periodic recurrence) of the lawyer's impairment, management of the firm has an obligation to supervise the legal services performed by the lawyer and, in an appropriate case, prevent the lawyer from rendering legal services to clients of the firm.

If reasonable efforts have been made to institute procedures designed to assure compliance with the Model Rules, neither the partners in the firm nor the lawyer with direct supervisory authority are responsible for the impaired lawyer's violation of the rules unless they knew of the conduct at a time when its consequences could have been avoided or mitigated and failed to take reasonable remedial action.[17]

---

15. The black letter of Rule 5.1(a) does not identify what constitutes a reasonable effort or reasonable assurance, but some examples of appropriate measures appear in Comment [3] of the Rule.

16. Rule 1.16(a)(2).

17. Rule 5.1(c). Failure to intervene to prevent avoidable consequences of a violation also may violate Rule 8.4(a), which provides that it is professional misconduct for a lawyer to knowingly assist another to violate the Model Rules.

II. Obligations When an Impaired Lawyer in the Firm has Violated the Model Rules

The partners in the firm or supervising lawyer may have an obligation under Rule 8.3(a) to report violations of the ethics rules by an impaired lawyer to the appropriate professional authority.[18] Only violations of the Model Rules that raise a substantial question as to the violator's honesty, trustworthiness, or fitness as a lawyer must be reported.[19] If the mental condition that caused the violation has ended, no report is required. Thus, if partners in the firm and the supervising lawyer reasonably believe that the previously impaired lawyer has resolved a short-term psychiatric problem that made the lawyer unable to represent clients competently and diligently, there is nothing to report.[20] Similarly, if the firm is able to eliminate the risk of future violations of the duties of competence and diligence under the Model Rules through close supervision of the lawyer's work, it would not be required to report the impaired lawyer's violation.[21] If, on the other hand, a lawyer's mental impairment renders the lawyer unable to represent clients competently, diligently, and otherwise as required by the Model Rules and he nevertheless continues to practice, partners in the firm or the supervising lawyer must report that violation.

If the matter in which the impaired lawyer violated his duty to act competently or with reasonable diligence and promptness still is pending, the firm may not simply remove the impaired lawyer and select a new lawyer to handle the matter. Under Rule 1.4(b), there may be a responsibility to discuss with the client the circumstances surrounding the change of responsibility. In

---

18. Rule 8.3(a) requires a lawyer who knows that another lawyer has committed a violation of the Model Rules that raises a substantial question as to that lawyer's fitness as a lawyer to inform the appropriate professional authority. Although a lawyer may satisfy her obligation under Rule 8.3 by disclosing the violation without identifying the impairment that caused the violation, in most cases, disclosure of the impairment will be appropriate. However, in doing so, the lawyer must be careful to avoid potential violations of the Americans With Disabilities Act.

19. Not every violation must be reported. Only those violations "that a self-regulatory profession must vigorously endeavor to prevent" must be reported, and judgment must be exercised in deciding whether prior violations fall into this category. Rule 8.3, cmt. 3.

20. N.Y.C. Opinion 1995-5 (April 5, 1995), *in* ABA/BNA Lawyers' Manual on Professional Conduct § 1001:6404 (ABA/BNA 1998).

21. If such supervision exceeds that which would be required in the case of a lawyer who is not impaired, it would not be proper for the firm to charge the client for the additional level of supervision. Although it is appropriate to charge a client for normal supervisory activities related to the quality of the client work product, fees for additional steps taken by the supervising lawyer because of the firm's fear that an impaired lawyer's work would not be competent would not be reasonable under Rule 1.5(a) unless the necessity for supervision and the fact that the client would be charged for it is communicated to, and agreed to by, the client. Rule 1.5(b).

discussions with the client, the lawyer must act with candor and avoid material omissions, but to the extent possible, should be conscious of the privacy rights of the impaired lawyer. Even if the matter in which the impaired lawyer violated the Model Rules no longer is pending, partners and lawyers in the firm with comparable managerial authority and lawyers with direct supervisory authority over the impaired lawyer may have obligations to mitigate any adverse consequences of the violation.[22]

III. Obligations When an Impaired Lawyer No Longer is in the Firm

The responsibility of the firm to the client does not end with the resignation from the firm, or the firm's termination of, the impaired lawyer. If the impaired lawyer resigns or is removed from the firm, clients of the firm may be faced with the decision whether to continue to use the firm or shift their relationship to the departed lawyer. Rule 1.4 requires the firm to advise existing clients of the facts surrounding the withdrawal to the extent disclosure is reasonably necessary for those clients to make an informed decision about the selection of counsel. In doing so, the firm must be careful to limit any statements made to ones for which there is a reasonable factual foundation.[23]

The firm has no obligation under the Model Rules to inform former clients who already have shifted their relationship to the departed lawyer that it believes the departed lawyer is impaired and consequently is unable to personally handle their matters competently.[24] However, the firm should avoid any communication with former clients who have transferred their representation to the departed lawyer that can be interpreted as an endorsement of the ability of the departed lawyer to handle the matter. For example, a joint letter from the firm and the departed lawyer regarding the transition could be seen as an implicit endorsement by the firm of the departed lawyer's competence.

In addition to considering what the firm may or must communicate to clients who are considering whether to take their representation to the departed lawyer, the firm must consider whether it has an obligation to report the

---

22. Rule 5.1(c)(2).

23. If such a communication also is designed to convince the client to remain with the firm rather than follow the impaired lawyer who continues to practice, it must be drafted in such a manner that it does not violate either the prohibition of false and misleading communications about the firm's services under Rule 7.1 or the prohibition of deceit or misrepresentation under Rule 8.4(c). In addition, the potential for claims of tortious interference with contractual relationships and unfair competition should be considered.

24. *See* Philadelphia Bar Ass'n Prof. Guidance Committee Op. 00-12, 2000 WL 33173008 (Dec. 2000).

25. The "appropriate professional authority" need not be the state disciplinary authority. If available in the jurisdiction, a peer review agency may be more appropriate under the circumstances. Rule 8.3, cmt. 3.

impaired lawyer's condition to the appropriate disciplinary authority.[25]

No obligation to report exists under Rule 8.3(a) if the impairment has not resulted in a violation of the Model Rules. Thus, if the firm reasonably believes that it has succeeded in preventing the lawyer's impairment from causing a violation of a duty to the client by supplying the necessary support and supervision,[26] there would be no duty to report under Rule 8.3(a).[27]

Subject to the prohibition against disclosure of information protected by Rule 1.6, however, partners in the firm may voluntarily report to the appropriate authority its concern that the withdrawing lawyer will not be able to function without the ongoing supervision and support the firm has been providing.[28]

26. An obligation exists under Rule 5.1 to take reasonable efforts to prevent violations of the Model Rules by the impaired lawyer if firm management or a direct supervisor of the impaired lawyer is aware of the risk of violation posed by the impairment.

27. As noted in Bailly, s*upra*, note 2 at 15: "It would be the ultimate irony if a partner were suspended for not reporting his impaired partner, while the impaired partner was able to use mitigating circumstances in any disciplinary hearing against him."

28. Pennsylvania Bar Ass'n Committee on Legal Eth. Op. 98-124, 1998 WL 988111 (Dec. 7, 1988).

AMERICAN BAR ASSOCIATION
STANDING COMMITTEE ON ETHICS AND PROFESSIONAL RESPONSIBILITY

Formal Opinion 03-431 **August 8, 2003**

Lawyer's Duty to Report Rule Violations by Another Lawyer Who May Suffer from Disability or Impairment

*A lawyer who believes that another lawyer's known violations of disciplinary rules raise substantial questions about her fitness to practice must report those violations to the appropriate professional authority. A lawyer who believes that another lawyer's mental condition materially impairs her ability to represent clients, and who knows that that lawyer continues to do so, must report that lawyer's consequent violation of Rule 1.16(a)(2), which requires that she withdraw from the representation of clients***.**

In this opinion, we examine the obligation of a lawyer who acquires knowledge that another lawyer, not in his firm, suffers from a mental condition that materially impairs the subject lawyer's ability to represent a client.[1] Under Rule 1.16(a)(2) of the Model Rules of Professional Conduct,[2] a lawyer must not undertake or continue representation of a client when that lawyer suffers from a mental condition that "materially impairs the lawyer's ability to represent the client."[3] That requirement reflects the conclusion that allowing persons who do

---

1. In ABA Standing Committee on Professional Responsibility Formal Opinion 03-429 (Obligations With Respect to Mentally Impaired Lawyer in the Firm) (June 11, 2003), we addressed the obligations of lawyers within a firm when another lawyer within that firm violates the Model Rules of Professional Conduct due to mental impairment. Like that opinion, this opinion deals only with mental impairment, which may be either temporary or permanent. Physical impairments are beyond the scope of this opinion unless they also result in the impairment of mental faculties. In addition to Alzheimer's disease and other mental conditions that are age-related and affect the entire population, lawyers have been found to suffer from alcoholism and substance abuse at a rate at least twice as high as the general population. *See* George Edward Bailly, *Impairment, The Profession and Your Law Partner,* 11 No. 1 PROF. LAW. 2 (1999).

2. This opinion is based on the Model Rules of Professional Conduct as amended by the ABA House of Delegates in February 2002 and, to the extent indicated, the predecessor Model Code of Professional Responsibility of the American Bar Association. The laws, court rules, regulations, rules of professional responsibility, and opinions promulgated in the individual jurisdictions are controlling.

3. Rule 1.16(a)(2) states that a lawyer shall not represent a client or, where representation has commenced, shall withdraw from the representation of a client if "the

---

AMERICAN BAR ASSOCIATION STANDING COMMITTEE ON ETHICS AND PROFESSIONAL RESPONSIBILITY, 541 North Fairbanks Court, 14th Floor, Chicago, Illinois 60611-3314 Telephone (312)988-5300 CHAIR: Marvin L. Karp, Cleveland, OH o Loretta C. Argrett, Washington, DC o Michael E. Bragg, Bloomington, IL o Thomas M. Fitzpatrick, Seattle, WA o Daniel W. Hildebrand, Madison, WI o Donald B. Hilliker, Chicago, IL o Bruce Alan Mann, San Francisco, CA o Charles McCallum, Grand Rapids, MI o E. Fitzgerald Parnell, III, Charlotte, NC o Hon. Henry Ramsey, Jr., Berkeley, CA o CENTER FOR PROFESSIONAL RESPONSIBILITY: George A. Kuhlman, Ethics Counsel; Eileen B. Libby, Associate Ethics Counsel

© 2003 by the American Bar Association. All rights reserved.

not possess the capacity to make the professional judgments and perform the services expected of a lawyer is not only harmful to the interests of clients, but also undermines the integrity of the legal system and the profession.

Under Rule 8.3(a), a lawyer with knowledge[4] that another lawyer's conduct has violated the Model Rules in a way that "raises a substantial question as to that lawyer's honesty, trustworthiness or fitness as a lawyer in other respects" must inform the appropriate professional authority.[5] Although not all violations of the Model Rules are reportable events under Rule 8.3, as they may not raise a substantial question about a lawyer's fitness to practice law, a lawyer's failure to withdraw from representation while suffering from a condition materially impairing her ability to practice, as required by Rule 1.16(a)(2), ordinarily would raise a substantial question requiring reporting under Rule 8.3[6].

When considering his obligation under Rule 8.3(a), a lawyer should recognize that, in most cases, lack of fitness will evidence itself through a pattern of conduct that makes clear that the lawyer is not meeting her obligations under the Model Rules, for example, Rule 1.1 (Competence) or Rule 1.3 (Diligence). A lawyer suffering from an impairment may, among other things, repeatedly miss court deadlines, fail to make filings required to complete a transaction, fail to perform tasks agreed to be performed, or fail to raise issues that competent counsel would be expected to raise. On occasion, however, a single act by a lawyer may evidence her lack of fitness.[7]

---

lawyer's physical or mental condition materially impairs the lawyer's ability to represent the client." *See*, *e.g.*, In re Morris, 541 S.E.2d 844 (S.C. 2001) (lawyer failed to notify clients that he would be unavailable while being treated at in-patient drug and alcohol rehabilitation program); State ex rel. Oklahoma Bar Ass'n v. Southern, 15 P.3d 1 (Okla. 2000) (lawyer had been suffering severe, untreated vitamin B-12 illness that essentially destroyed his short-term memory and exacerbated his depression; lawyer neglected five clients and their cases); In re Francis, 4 P.3d 579 (Kan. 2000) (lawyer's depression resulted in misconduct, including failure to comply with discovery requests, to prosecute civil suit, to return telephone calls, and to withdraw from representing client); People v. Heilbrunn, 814 P.2d 819 (Colo. 1991) (lawyer who neglected, deceived, and abandoned clients due to drugs, alcohol, and depression failed to withdraw); State v. Ledvina, 237 N.W.2d 683 (Wis. 1976) (lawyer with compulsive personality disorder with paranoid trends engaged in hostile and aggressive conduct).

4. "Knows" denotes actual knowledge, which may be inferred from the circumstances. Rule 1.0(f). Thus, the duty to report the violation caused by the mental impairment of another lawyer will likely arise only in very limited situations.

5. Note that the disclosure obligation does not apply to information protected by Rule 1.6 or acquired by the lawyer from his participation in an approved lawyers assistance program. Rule 8.3(c).

6. As noted in Comment [3] to Rule 8.3, the rule "limits the reporting obligation to those offenses that a self-regulating profession must vigorously endeavor to prevent. A measure of judgment is, therefore, required in complying with the provisions of this Rule."

7. A single act of aberrant behavior may be part of a pattern of conduct affecting the lawyer while under the influence of drugs or alcohol or while displaying the symp-

A lawyer may be impaired by senility or dementia due to age or illness or because of alcoholism, drug addiction,[8] substance abuse, chemical dependency, or mental illness.[9] Because lawyers are not health care professionals, they cannot be expected to discern when another lawyer suffers from mental impairment with the precision of, for example, a psychiatrist, clinical psychologist, or therapist.[10] Nonetheless, a lawyer may not shut his eyes to conduct reflecting generally recognized symptoms of impairment (*e.g.*, patterns of memory lapse or inexplicable behavior not typical of the subject lawyer, such as repeated missed deadlines).

Each situation, therefore, must be addressed based on the particular facts presented. A lawyer need not act on rumors or conflicting reports about a lawyer. Moreover, knowing that another lawyer is drinking heavily or is evidencing impairment in social settings is not itself enough to trigger a duty to report under Rule 8.3. A lawyer must know that the condition is materially impairing the affected lawyer's representation of clients[11].

In deciding whether an apparently impaired lawyer's conduct raises a substantial question of her fitness to practice, a lawyer might consider consulting with a psychiatrist, clinical psychologist, or other mental health care professional about the significance of the conduct observed or of information the lawyer has learned from third parties.[12] He might consider contacting an

---

toms of a mental illness that manifest themselves only on occasion. As noted in Comment [1] to Rule 8.3, "[a]n apparently isolated violation may indicate a pattern of misconduct that only a disciplinary investigation can uncover."

8. In certain cases, the conduct of the lawyer may involve violation of applicable criminal law. In such cases, Rule 8.4(b) is implicated. That rule provides that it is professional misconduct for a lawyer to "commit a criminal act that reflects adversely on the lawyer's honesty, trustworthiness or fitness as a lawyer in other respects."

9. *See* ABA Formal Opinion 03-429 for discussion of mental impairments that affect a lawyer only on occasion.

10. There is a wealth of information about impairments available for the general reader. For an initial overview, *see* such sources as David R. Goldmann, AMERICAN COLLEGE OF PHYSICIANS COMPLETE HOME MEDICAL GUIDE WITH INTERACTIVE HUMAN ANATOMY CD-ROM (DK Publishing 1999); Charles R. Clayman, THE AMERICAN MEDICAL ASSOCIATION FAMILY MEDICAL GUIDE (3rd ed. Random House 1994); and Anthony L. Komaroff, THE HARVARD MEDICAL SCHOOL FAMILY HEALTH GUIDE (Simon & Schuster 1999). Websites for various organizations also can be a good starting point for information. The American Medical Association's website at http://www.ama-assn.org has links to various sites, as does the website of the National Institutes of Health, http://www.nih.gov. For Alzheimer's disease and related conditions, *see* the websites of the Alzheimer's Disease Education and Referral Center, http://www.alzheimers.org, and the American Association of Geriatric Psychiatry, http://www.aagpgpa.org.

11. *See* Rule 1.16(a)(2).

12. The reporting lawyer may become aware of the impaired lawyer's conduct either from personal observation or from a third party, such as a client of the lawyer who complains of the impaired lawyer's conduct.

established lawyer assistance program.[13] In addition, the lawyer also might consider speaking to the affected lawyer herself about his concerns. In some circumstances, that may help a lawyer understand the conduct and why it occurred, either confirming or alleviating his concerns. In such a situation, however, the affected lawyer may deny that any problem exists or maintain that although it did exist, it no longer does. This places the lawyer in the position of assessing the affected lawyer's response, rather than the affected lawyer's conduct itself. Care must be taken when acting on the affected lawyer's denials or assertions that the problem has been resolved. It is the knowledge of the impaired conduct that provides the basis for the lawyer's obligations under Rule 8.3; the affected lawyer's denials alone do not make the lawyer's knowledge non-reportable under Rule 8.3.

If the affected lawyer is practicing within a firm, the lawyer should consider speaking with the firm's partners or supervising lawyers.[14] If the affected lawyer's partners or supervising lawyers take steps to assure that the affected lawyer is not representing clients while materially impaired, there is no obligation to report the affected lawyer's past failure to withdraw from representing clients. If, on the other hand, the affected lawyer's firm is not responsive to the concerns brought to their attention, the lawyer must make a report under Rule 8.3. We note that there is no affirmative obligation to speak with either the affected lawyer or her firm about her conduct or condition before reporting to the appropriate authority.

If a lawyer concludes there is material impairment that raises a substantial question about another lawyer's fitness to practice, his obligation ordinarily is to report to the appropriate professional authority.[15] As we said in ABA Formal Opinion 03-429, however, if information relating to the representation of one's own client would be disclosed in the course of making the report to the appropriate authority, that client's informed consent to the disclosure is required. In the usual case, information gained by a lawyer about another lawyer is unlikely to be information protected by Rule 1.6, for example, observation of or information about the affected lawyer's conduct in litigation or in the completion of transactions. Given the breadth of information protected by Rule 1.6,[16] however, the reporting lawyer should obtain the client's

---

13. In most states, lawyer assistance programs are operated through the state or major metropolitan bar associations. Information about these systems is available from the staff of the ABA Commission on Lawyer Assistance Programs. *See* http://www.abanet.org/legalservices/colap/home.html.

14. Such contact is solely discretionary. Although partners and supervising lawyers have a responsibility to ensure that lawyers in their own firms comply with the rules of professional conduct, *see* ABA Formal Opinion 03-429, no lawyer is obligated under the Model Rules to take any action to ensure compliance with the rules by lawyers in other firms.

15. Rule 8.3 cmt. 3. There is no duty to report information learned from participation in an approved lawyers assistance program.

16. Rule 1.6 cmts. 3 and 4.

informed consent to the disclosure in cases involving information learned in the course of representation through interaction with the affected lawyer.

Whether the lawyer is obligated under Model Rule 8.3 to make a report or not, he may report the conduct in question to an approved lawyers assistance program, which may be able to provide the impaired lawyer with confidential education, referrals, and other assistance. Indeed, that may well be in the best interests of the affected lawyer, her family, her clients. and the profession. Nevertheless, such a report is not a substitute for reporting to a disciplinary authority with responsibility for assessing the fitness of lawyers licensed to practice in the jurisdiction.

In conclusion, a lawyer should review the situation and determine his responsibilities under Rule 8.3 when he has information that another lawyer has failed to meet her obligation to withdraw from the representation of client when suffering from a mental condition materially impairing her ability to represent her clients.

OPEN

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

Downloaded from http://journals.lww.com/journaladdictionmedicine by BhDMf5ePHKav1zEoum1tQfN4a+kJLhEZgbsIHo4XMi0hCywCX1AWnYQp/IlQrHD3i3D0OdRyi7TvSFl4Cf3VC1y0abggQZXdgGj2MwlZLeI= on 10/30/2023

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

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

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

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

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

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

(*J Addict Med* 2016;10: 46–52)

From the Hazelden Betty Ford Foundation (PRK, RJ); Wisconsin Lawyers Assistance Program (LA).

Received for publication June 26, 2015; accepted October 25, 2015.

Funding: The study was funded by the Hazelden Betty Ford Foundation and the American Bar Association Commission on Lawyer Assistance Programs.

Conflicts of interest: Linda Albert is an employee of the State Bar of Wisconsin. Remaining authors are employees of the Hazelden Betty Ford Foundation. No conflicts of interest are identified.

Send correspondence and reprint requests to Patrick R. Krill, JD, LLM, Hazelden Betty Ford Foundation, PO Box 11 (RE 11), Center City, MN 55012-0011. E-mail: pkrill@hazeldenbettyford.org.

Copyright © 2016 American Society of Addiction Medicine. This is an open-access article distributed under the terms of the Creative Commons Attribution-Non Commercial-No Derivatives License 4.0, where it is permissible to download and share the work provided it is properly cited. The work cannot be changed in any way or used commercially.

ISSN: 1932-0620/15/0901-0031

DOI: 10.1097/ADM.0000000000000182

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

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

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

Copyright © 2016 American Society of Addiction Medicine. Unauthorized reproduction of this article is prohibited.

Downloaded from http://journals.lww.com/journaladdictionmedicine by BhDMf5ePHKav1zEoum1tQfN4a+kJLhEZgbsIHo4XMi0hCywCX1AWnYQp/IlQrHD3i3D0OdRyi7TvSFl4Cf3VC1y0abggQZXdgGj2MwlZLeI= on 10/30/2023

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

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

METHODS

Procedures

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

Participants

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

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

TABLE 1. Participant Characteristics

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

*Substance use includes both illicit and prescribed usage.

Materials

Alcohol Use Disorders Identification Test

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

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

Copyright © 2016 American Society of Addiction Medicine. Unauthorized reproduction of this article is prohibited.

Downloaded from http://journals.lww.com/journaladdictionmedicine by BhDMf5ePHKav1zEoum1tQfN4a+kJLhEZgbsIHo4XMi0hCywCX1AWnYQp/IlQrHD3i3D0OdRyi7TvSFl4Cf3VC1y0abggQZXdgGj2MwlZLeI= on 10/30/2023

TABLE 2. Professional Characteristics

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

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

Depression Anxiety Stress Scales-21 item version

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

Drug Abuse Screening Test-10 item version

The short-form Drug Abuse Screening Test-10 (DAST) is a 10-item, self-report instrument designed to screen and quantify consequences of drug use in both a clinical and research setting. The DAST scores range from 0 to 10 and are categorized into low, intermediate, substantial, and severe-concern categories. The DAST-10 correlates highly with both 20-item and full 28-item versions, and has demonstrated reliability and validity (Yudko et al., 2007).

RESULTS

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

Alcohol Use

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

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

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

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

© 2016 American Society of Addiction Medicine

Copyright © 2016 American Society of Addiction Medicine. Unauthorized reproduction of this article is prohibited.

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

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

*The AUDIT cut-off for hazardous, harmful, or potential alcohol dependence was set at a score of 8.
**Comparisons were analyzed using Mann-Whitney *U* tests and Kruskal-Wallis tests.

Downloaded from http://journals.lww.com/journaladdictionmedicine by BhDMf5ePHKav1zEoum1tQfN4a+kJLhEZgbsIHo4XMi0hCywCX1AWnYQp/IlQrHD3i3D0OdRyi7TvSFl4Cf3VC1y0abggQZXdgGj2MwlZLeI= on 10/30/2023

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

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

Drug Use

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

Mental Health

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

Copyright © 2016 American Society of Addiction Medicine. Unauthorized reproduction of this article is prohibited.

Downloaded from http://journals.lww.com/journaladdictionmedicine by BhDMf5ePHKav1zEoum1tQfN4a+kJLhEZgbsIHo4XMi0hCywCX1AWnYQp/IlQrHD3i3D0OdRyi7TvSFl4Cf3VC1y0abggQZXdgGj2MwlZLeI= on 10/30/2023

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

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

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

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

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

Treatment Utilization and Barriers to Treatment

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

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

© 2016 American Society of Addiction Medicine

Copyright © 2016 American Society of Addiction Medicine. Unauthorized reproduction of this article is prohibited.

Downloaded from http://journals.lww.com/journaladdictionmedicine by BhDMf5ePHKav1zEoum1tQfN4a+kJLhEZgbsIHo4XMi0hCywCX1AWnYQp/IlQrHD3i3D0OdRyi7TvSFl4Cf3VC1y0abggQZXdgGj2MwlZLeI= on 10/30/2023

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

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

AUDIT, Alcohol Use Disorders Identification Test; DASS-21, Depression Anxiety Stress Scales-21.
*The AUDIT cut-off for hazardous, harmful, or potential alcohol dependence was set at a score of 8.
**Means were analyzed using Mann-Whitney *U* tests.

DISCUSSION

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

We also found interesting differences among attorneys at different stages of their careers. Previous research had demonstrated a positive association between the increased prevalence of problematic drinking and an increased amount of years spent in the profession (Benjamin et al., 1990). Our findings represent a direct reversal of that association, with attorneys in the first 10 years of their practice now experiencing the highest rates of problematic use (28.9%), followed by attorneys practicing for 11 to 20 years (20.6%), and continuing to decrease slightly from 21 years or more. These percentages correspond with our findings regarding position within a law firm, with junior associates having the highest rates of problematic use, followed by senior associates, junior partners, and senior partners. This trend is further reinforced by the fact that of the respondents who stated that they believe their alcohol use has been a problem (23%), the majority (44%) indicated that the problem began within the first 15 years of practice, as opposed to those who indicated the problem started before law school (26.7%) or after more than 15 years in the profession (14.5%). Taken together, it is reasonable to surmise from these findings that being in the early stages of one's legal career is strongly correlated with a high risk of developing an alcohol use disorder. Working from the assumption that a majority of new attorneys will be under the age of 40, that conclusion is further supported by the fact that the highest rates of problematic drinking were present among attorneys under the age of 30 (32.3%), followed by attorneys aged 31 to 40 (26.1%), with declining rates reported thereafter.

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

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

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

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

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

Copyright © 2016 American Society of Addiction Medicine. Unauthorized reproduction of this article is prohibited.

Downloaded from http://journals.lww.com/journaladdictionmedicine by BhDMf5ePHKav1zEoum1tQfN4a+kJLhEZgbsIHo4XMi0hCywCX1AWnYQp/IlQrHD3i3D0OdRyi7TvSFl4Cf3VC1y0abggQZXdgGj2MwlZLeI= on 10/30/2023

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

CONCLUSIONS

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

ACKNOWLEDGMENTS

The authors thank Bethany Ranes, PhD, and Valerie Slaymaker, PhD, of the Hazelden Betty Ford Foundation for their contributions to the analyses (BR) and overall manuscript (VS).

The authors also thank the Hazelden Betty Ford Foundation and The American Bar Association for their support of this project.

REFERENCES

Antony M, Bieling P, Cox B, Enns M, Swinson R. Psychometric properties of the 42-item and 21-item versions of the depression anxiety stress scales in clinical groups and a community sample. *Psychol Assess* 1998;2:176–181.

Association of American Law Schools. Report of the AALS special committee on problems of substance abuse in the law schools. *J Legal Educ* 1994;44:35–80.

Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. The alcohol use disorders identification test: guidelines for use in primary care [WHO web site]. 2001. Available at: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf. Accessed August 5, 2014.

Beck C, Sales B, Benjamin, GA. Lawyer distress: alcohol-related problems and other psychological concerns among a sample of practicing lawyers. J.L. Health 1995–1996; 10(1):1–60.

Benjamin GA, Darling E, Sales B. The prevalence of depression, alcohol abuse, and cocaine abuse among United States lawyers. *Int J Law Psychiatry* 1990;13:233–246. ISSN 0160-2527.

Bradley K, Bush K, McDonell M, Malone T, Fihn S. Screening for problem drinking comparison of CAGE and AUDIT. *J Gen Intern Med* 1998;13(6):379–989. 0884-8734.

Bush K, Kivlahan D, McDonell M, Fihn S, Bradley K. The AUDIT Alcohol Consumption Questions (AUDIT-C): an effective brief screening test for problem drinking. *Arch Intern Med* 1998;158:1789–1795. 0003-9829.

Clara I, Cox B, Enns M. Confirmatory factor analysis of the depression-anxiety-stress scales in depressed and anxious patients. *J Psychopathol Behav Assess* 2001;23:61–67.

Crawford J, Henry J. The Depression Anxiety Stress Scale (DASS): normative data and latent structure in a large non-clinical sample. *Br J Clin Psychol* 2003;42:111–131 (0144-6657).

DuPont R, McLellan AT, White W, Merlo L, Gold M. Setting the standard for recovery: Physicians' Health Programs. *J Subst Abuse Treat* 2009;36: 1597–2171 (0740-5472).

Eaton W, Anthony J, Mandel W, Garrison R. Occupations and the prevalence of major depressive disorder. *J Occup Med* 1990;32(11):1079–1087 (0096-1736).

Gianoli MO, Petrakis I. Pharmacotherapy for and alcohol comorbid depression dependence: Evidence is mixed for antidepressants, alcohol dependence medications, or a combination. January 2013. Available at: http://www.currentpsychiatry.com/fileadmin/cp_archive/pdf/1201/1201CP_Petrakis.pdf. Accessed June 1, 2015.

Henry J, Crawford J. The short-form version of the Depression Anxiety Stress Scales (DASS-21): construct validity and normative data in a large non-clinical sample. *Br J Clin Psychol* 2005;44:227–239 (0144-6657).

Lovibond, SH, Lovibond, PF. Manual for the Depression Anxiety Stress Scales. 2nd ed. Sydney: Psychology Foundation; 1995.

Matano RA, Koopman C, Wanat SF, Whhitsell SD, Borggrefe A, Westrup D. Assessment of binge drinking of alcohol in highly educated employees. *Addict Behav* 2003;28:1299–1310.

Meneses-Gaya C, Zuardi AW, Loureiro SR, Crippa A. Alcohol Use Disorders Identification Test (AUDIT): an updated systematic review of psychometric properties. *Psychol Neurosci* 2009;2:83–97.

Oreskovich MR, Kaups KL, Balch CM, et al. Prevalence of alcohol use disorders among American surgeons. *Arch Surg* 2012;147(2):168–174.

Rothstein L. Law students and lawyers with mental health and substance abuse problems: protecting the public and the individual. *Univ Pittsburgh Law Rev* 2008;69:531–566.

Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the drug abuse screening test. *J Subst Abuse Treat* 2007;32:189–198.

© 2016 American Society of Addiction Medicine

Copyright © 2016 American Society of Addiction Medicine. Unauthorized reproduction of this article is prohibited.

APPENDIX 7 - WHOQOL-100 IMPORTANCE QUESTIONS

The following questions ask about **how important** various aspects of your life are to you. We ask that you think about how much these affect your quality of life. For example one question asks about how important sleep is to you. If sleep is not important to you, circle the number next to "not important". If sleep is "very important" to you, but not "extremely important", you should circle the number next to "Very important". Unlike earlier questions, these questions do not refer only to the last two weeks.

Thank you for your help.

ImpG.1 How important to you is your overall quality of life?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

ImpG.2 How important to you is your health?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp1.1 How important to you is it to be free of any pain?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp2.1 How important to you is having energy?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp3.1 How important to you is restful sleep?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp4.1 How important to you is it to feel happiness and enjoyment of life?

		Moderately		

Not important	A little important	important	Very important	Extremely important
1	2	3	4	5

Imp4.2 How important to you is it to feel content?

Not important	A little important	Moderately important	Very important	Extremely important
1	2	3	4	5

Imp4.3 How important to you is it to feel hopeful?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp5.1 How important to you is being able to learn and remember important information?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp5.2 How important to you is being able to think through everyday problems and make decisions?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp5.3 How important to you being able to concentrate?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp6.1 How important to you is feeling positive about yourself?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp7.1 How important to you is your body image and appearance?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp8.1 How important to you is it to be free of negative feelings (sadness, depression, anxiety, worry...)?

Not important	A little important	Moderately important	Very important	Extremely

1	2	3	4	important 5

Imp9.1 How important to you is it to be able to move around?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp10.1 How important to you is being able to take care of your daily living activities (e.g. washing, dressing, eating)?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp11.1 How important to you is it to be free of dependence on medicines or treatments?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp12.1 How important to you is being able to work?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp13.1 How important to you are relationships with other people?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp14.1 How important to you is support from others?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp15.1 How important to you is your sexual life?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp16.1 How important to you is feeling physically safe and secure?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp17.1 How important to you is your home environment?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp18.1 How important to you are your financial resources?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp19.1 How important to you is being able to get adequate health care?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp19.2 How important to you is being able to get adequate social help?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp20.1 How important to you are chances for getting new information or knowledge?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp20.2 How important to you are chances to learn new skills?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp21.1 How important to you is relaxation / leisure?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp22.1 How important to you is your environment (e.g. pollution, climate, noise, attractiveness)?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp23.1 How important to you is adequate transport in your everyday life?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

Imp24.1 How important to you are your personal beliefs?

Not important 1	A little important 2	Moderately important 3	Very important 4	Extremely important 5

APPENDIX 8- THE WHOQOL-BREF

ABOUT YOU I.D. number ☐☐☐☐

Before you begin we would like to ask you to answer a few general questions about yourself: by circling the correct answer or by filling in the space provided.

What is your **gender**? Male Female

What is your **date of birth**? ________ / ________ / ________
Day / Month / Year

What is the highest **education** you received?
None at all
Primary school
Secondary school
Tertiary

What is your **marital status**?
Single
Married
Living as married
Separated
Divorced
Widowed

Are you currently **ill**? Yes No

If something is wrong with your health what do you think it is?___________________________

Instructions

This assessment asks how you feel about your quality of life, health, or other areas of your life. **Please answer all the questions.** If you are unsure about which response to give to a question, **please choose the one** that appears most appropriate. This can often be your first response.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life **in the last two weeks.** For example, thinking about the last two weeks, a question might ask:

		Not at all	Not much	Moderately	A great deal	Completely
	Do you get the kind of support from others that you need?	1	2	3	4	5

You should circle the number that best fits how much support you got from others over the last two weeks. So you would circle the number 4 if you got a great deal of support from others as follows.

		Not at all	Not much	Moderately	A great deal	Completely
	Do you get the kind of support from others that you need?	1	2	3	4	5

You would circle number 1 if you did not get any of the support that you needed from others in the last two weeks. Please read each question, assess your feelings, and circle the number on the scale for each question that gives the best answer for you.

THE WHOQOL-BREF

		Very poor	Poor	Neither poor nor good	Good	Very good
1 (G1)	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2 (G4)	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the last two weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3 (F1.4)	To what extent do you feel that (physical) pain prevents you from doing what you need to do?	1	2	3	4	5
4 (F11.3)	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5 (F4.1)	How much do you enjoy life?	1	2	3	4	5
6 (F24.2)	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7 (F5.3)	How well are you able to concentrate?	1	2	3	4	5
8 (F16.1)	How safe do you feel in your daily life?	1	2	3	4	5
9 (F22.1)	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about **how completely** you experience or were able to do certain things in the last two weeks.

		Not at all	A little	Moderately	Mostly	Completely
10 (F2.1)	Do you have enough energy for everyday life?	1	2	3	4	5
11 (F7.1)	Are you able to accept your bodily appearance?	1	2	3	4	5
12	Have you enough money to meet your	1	2	3	4	5

(F18.1)	needs?					
13 (F20.1)	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14 (F21.1)	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15 (F9.1)	How well are you able to get around?	1	2	3	4	5

The following questions ask you to say how **good or satisfied** you have felt about various aspects of your life over the last two weeks.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16 (F3.3)	How satisfied are you with your sleep?	1	2	3	4	5
17 (F10.3)	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18 (F12.4)	How satisfied are you with your capacity for work?	1	2	3	4	5
19 (F6.3)	How satisfied are you with yourself?	1	2	3	4	5
20 (F13.3)	How satisfied are you with your personal relationships?	1	2	3	4	5
21 (F15.3)	How satisfied are you with your sex life?	1	2	3	4	5
22 (F14.4)	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23 (F17.3)	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24 (F19.3)	How satisfied are you with your access to health services?	1	2	3	4	5
25 (F23.3)	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to **how often** you have felt or experienced certain things in the last two weeks.

		Never	Seldom	Quite often	Very often	Always
26 (F8.1)	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

Did someone help you to fill out this form?..

How long did it take to fill this form out?..

Do you have any comments about the assessment?

....
...

....
...

THANK YOU FOR YOUR HELP