

1 **IN THE SUPREME COURT OF THE STATE OF NEVADA**

2 In the matter of Amendments to SCR
3 210 regarding minimum continuing
4 legal education requirements and
5 making mandatory continuing legal
6 education in substance abuse, addictive
7 disorders and/or mental health issues

ADKT NO.: 0478

FILED

JUN 21 2016

TRACIE K. LINDEMAN
CLERK OF SUPREME COURT
BY *[Signature]*
CHIEF DEPUTY CLERK

8 **PETITION**

9 On February 2, 2016, the State Bar of Nevada Board of Governors ("State
10 Bar") filed with this Court an amendment which would make one hour of
11 continuing legal education (CLE) in the area of substance abuse, addictive
12 disorders and/or mental health required on an annual basis. A public hearing on
13 the proposed amendment was held on June 6, 2016, at which time the Court
14 suggested the State Bar consider suggestions to eliminate carry forward credits
15 and the crediting excess hours to an attorney's annual ethics and professional
16 conduct requirements. Additionally, the Court requested the State Bar propose an
17 effective date for when the requirement would take effect.

18 The State Bar considered the suggestions received at the public comment
19 hearing and submits to the Court an amendment to ADKT 0478 which would:

- 20 - Increase the total number of CLE hours required annually from twelve (12)
21 to thirteen (13), to include ten hours general education, two hours ethics,
22 and one hour in the area of abuse, addictive disorders and/or mental health;
23 - Require any CLE obtained in the area of abuse, addictive disorders and/or
24 mental health to be earned annually, with no carry forward provision; and

25 **RECEIVED**

JUN 15 2016

TRACIE K. LINDEMAN
CLERK OF SUPREME COURT
DEPUTY CLERK

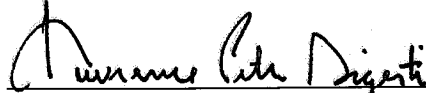
- 1 - Eliminate the current provision to apply excess abuse, addictive disorders
2 and/or mental health credits to an attorney's annual ethics and professional
3 conduct requirement.

4 The State Bar proposes the amendments become effective as of January 1,
5 2017. This would give those attorneys who earned the abuse, addictive disorder
6 and/or mental health credit in 2014 the full benefit of the three year requirement
7 implemented in that year.

8 The amendments to SCR 210 are submitted in their entirety as Exhibit A.

9
10 Respectfully submitted this 13th day of June 2016.

11 STATE BAR OF NEVADA
12 BOARD OF GOVERNORS

13 

14 LAURENCE P. DIGESTI, President

15 Nevada Bar No. 88

16 State Bar of Nevada

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21
22
23
24
25

Exhibit A

Rule 210. Minimum continuing legal education requirements.

To meet the annual minimum continuing legal education requirements imposed by these rules, each attorney subject to these rules must timely: submit an annual fee, complete the requisite number of credit hours, and submit an annual compliance report.

1. **Annual Fee.** The amount of the annual fee is \$40, made payable to the Nevada Board of Continuing Legal Education, and must be postmarked on or before March 1 of the year for which the fee is required to be paid.

2. **Credit hours.**

(a) Subject to the carry forward provisions of subparagraph (c), a minimum of ~~[twelve (12)]~~ thirteen (13) hours of accredited educational activity, as defined by the regulations adopted by the board, must be completed by December 31 of each year. Of the ~~[twelve (12)]~~ thirteen (13), at least two (2) shall be exclusively in the area of ethics and professional conduct~~[-At least]~~ and one (1) ~~[hour every three (3) years]~~ shall be exclusively in the area of substance abuse, addictive disorders and/or mental health issues that impair professional competence. ~~[In a year in which the attorney is subject to the requirement in the area of substance abuse, addictive disorders and/or mental health issues that impair professional competence, the attorney shall complete at least nine (9) hours of general continuing legal education, at least two (2) hours exclusively in the area of ethics and professional conduct, and at least one (1) hour exclusively in the area of substance abuse, addictive disorders and/or mental health issues that impair professional competence; in the remaining two years of the three-year cycle, the attorney shall complete at least ten (10) hours of general continuing legal education and at least two (2) hours exclusively in the area of ethics and professional conduct. Credit hours in the area of ethics and professional conduct, and credit hours in the area of substance abuse, addictive disorders and/or mental health issues that impair professional competence, shall be tracked separately from general educational credit hours.]~~

—(b) The three-year cycle for completion of the requirement regarding substance abuse, addictive disorders and/or mental health issues that impair professional competence shall be determined as follows:

—(1) Attorneys subject to these rules must complete the requirement within the same calendar year that this amendment becomes effective; except that attorneys who completed the requirement in the calendar year preceding this amendment shall receive credit as though they completed it within the same calendar year that this amendment becomes effective.]

1 (2) Attorneys entitled to an exemption pursuant to Rule 214(1)(a) must
2 complete the requirement within the same calendar year in which they are first
3 subject to continuing legal education requirements.

4 (3) Attorneys who, for reasons other than an exemption pursuant to Rule
5 214(1)(a), become subject to these rules subsequent to or in the same calendar year
6 that this amendment becomes effective, must complete the requirement within the
7 same calendar year in which they become subject to these rules.

8 (c) Any attorney subject to these rules who completes more than ~~[twelve (12)]~~
9 thirteen (13) hours of accredited educational activity in any calendar year may
10 carry forward up to twenty (20) hours of excess credit and apply the same to the
11 attorney's general educational requirement for the next two (2) calendar years.
12 Likewise, any attorney subject to these rules who completes more than two (2)
13 hours of ethics and professional conduct credit in any calendar year may carry
14 forward up to four (4) hours of excess credit and apply the same to the attorney's
15 ethics and professional conduct educational requirement for the next two (2)
16 calendar years.

17 (d) Any attorney subject to these rules who completes more than one (1) hour
18 in the area of substance abuse, addictive disorders and/or mental health issues that
19 impair professional competence ~~[in a three-year cycle]~~ may not carry forward the
20 excess credit hours to the next ~~[three-year cycle]~~ calendar year. ~~[, but may have the~~
21 ~~excess hour(s) credited toward the attorney's ethics and professional conduct~~
22 ~~requirement, subject to the carry forward provisions set forth in subparagraph (c)~~
23 ~~above. Excess hour(s) in the area of ethics and professional conduct may be~~
24 ~~credited toward the attorney's general educational requirement, subject to the carry~~
25 ~~forward provisions set forth in subparagraph (c) above.]~~

3. **Annual compliance report.** A properly completed and verified written
compliance report must be submitted to the board, and must be postmarked on or
before March 1 each year. The report must be submitted on a form to be provided
by the board. The board shall, no later than six (6) weeks prior to the due date,
send a compliance report form to each attorney subject to these rules. The report
shall include the attorney's mailing address and shall state the attorney's
compliance with the credit hour requirements during the preceding calendar year.
It shall not be a defense to noncompliance that the attorney did not receive the
compliance report form.



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

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

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

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

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

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

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

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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.

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

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

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

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

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

METHODS

Procedures

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

Participants

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

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

TABLE 1. Participant Characteristics

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

*Substance use includes both illicit and prescribed usage.

Materials

Alcohol Use Disorders Identification Test

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

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

TABLE 2. Professional Characteristics

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

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

Depression Anxiety Stress Scales-21 item version

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

Drug Abuse Screening Test-10 item version

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

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

RESULTS

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

Alcohol Use

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

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

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

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

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

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

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

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

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

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

Drug Use

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

Mental Health

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

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

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

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

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

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

Treatment Utilization and Barriers to Treatment

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

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

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

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

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

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

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

DISCUSSION

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

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

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

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

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

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

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

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

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

CONCLUSIONS

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

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STATE BAR OF NEVADA



June 13, 2016

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RE: ADKT 0478 and Amendments to SCR 210

Dear Chief Justice Parraguirre:

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Thank you for the opportunity to provide comment to the Court at the public hearing on June 6, 2016 and for the Court's valuable feedback. Following the public hearing, the State Bar of Nevada's Board of Governors convened to discuss the Court's comments and hereby submit additional amendments to SCR 210 which would:

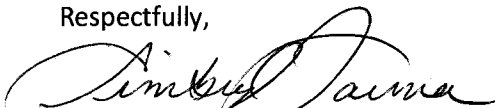
- Increase the total number of CLE credits required annually from 12 to 13, with one hour required in the area of abuse, addictive disorders and/or mental health;
- Require any CLE earned in this subject to be earned annually, with no carry forward provision; and
- Eliminate the current provision to apply excess credits in this area to an attorney's annual ethics and professional conduct requirement.

The State Bar proposes that the requested amendments become effective January 1, 2017.

Also enclosed is a copy of the study cited during the public hearing, *The Prevalence of Substance Use and Other Mental Health Concerns Among American Attorneys*. This study was released following the State Bar's submission of ADKT 0478 to the Court and provides the most current and definitive study regarding addiction in the profession.

On behalf of the Board of Governors, I thank the Court for its time and consideration. I am available to provide further information as requested.

Respectfully,


Kimberly K. Farmer
Executive Director

cc: Laurence P. Digesti, President
Tracie Lindeman

Enclosures

