THREE FACES OF IMPAIRMENT:
THREE STORIES OF RECOVERY

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THE PRESENTERS

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I. INTRODUCTION

The legal community has known for some time that the rates of all forms of addiction, depression and suicide are higher among its population than the general population and other professions. However, a groundbreaking new study conducted by Hazelden/Betty Ford Foundation in conjunction with the American Bar Association’s Commission on Lawyer Assistance Programs (COLAP) (hereinafter “the Hazelden study”) identifies that the rates of addiction and depression within the legal community are much higher than previously thought.1 There is an urgent need for more information, education and treatment opportunities in order to educate and protect the Kentucky legal community.2

Through the Kentucky Lawyer Assistance Program (KYLAP), Kentucky’s law students, lawyers and judges are provided with opportunities to learn how to recognize addiction, depression and other mental health concerns, as well as how to confront them in ourselves and in others. These recent findings, however, reveal just how much work is yet to be done. More opportunities for screenings, peer assistance, monitoring, preventive education and counseling are all critical in reducing these statistics and improving each lawyer’s life.

It is KYLAP’s purpose and goal to assure that these opportunities and more are readily available. While the statistics are grim and the percentages shockingly high, the stories of recovery you will hear today affirm that there is always hope, there is always help, and that recovery is possible.

II. RESEARCH MECHANISMS AND STATISTICAL BASES

The Hazelden study is a result of a nationwide effort by Patrick Krill, JD, LLM, the Director of the Hazelden Legal Professionals’ Program, and several others who worked with the ABA Commission on Lawyer Assistance Programs through state lawyer assistance programs, bar associations and offices of discipline. A survey was mass-circulated amongst lawyers and judges with approximately 15,000 responses received. In an effort to focus the study only on licensed and employed attorneys, about 2,000 of the responses were discarded. As such, the results reflect the percentages and statistics of 12,825 of your professional contemporaries – lawyers who are employed and have their law licenses intact.


2 www.kybar.org.
A. Mechanisms

The Alcohol Use Disorders Identification Test (AUDIT-10) is a ten-question test developed by a World Health Organization-sponsored collaborative project to determine if a person may be at risk for alcohol abuse problems. In a systematic review of screening tools for alcohol problems, the AUDIT was found to be the "most effective in identifying subjects with at-risk, hazardous, or harmful drinking." The AUDIT-10 focuses on frequency, amount, and consequences of use.

The AUDIT Alcohol Consumption Test (AUDIT-C) is a three-question screening test for problem drinking which can be used more quickly than the AUDIT-10, and in a doctor's office. The focus on the abbreviated AUDIT-C is frequency and amount only, without addressing consequences of use. Copies of both the AUDIT-10 and AUDIT-C with grading scales are attached in the Appendix.

For mental health issues including stress, anxiety and depression, the authors used the Depression Anxiety Stress Scale-21-item version (DASS-21), which is also a self-report test consisting of three seven-item subscales which assess symptoms of depression, anxiety and stress. Ninety percent (90%) of the answering attorneys responded to all twenty-one questions on the DASS-21. The items are scored on a four-point scale (0-3). The test results will have ranges from 0-21 for each of the three subscales. A copy of the DASS-21 along with scoring criteria is attached in the Appendix.

The short-form Drug Abuse Screening Test-10 (DAST) is a ten-item, self-report questionnaire used to screen both quantity and use of drugs. As opposed to the 88 percent of lawyers who responded to the AUDIT-10 / AUDIT-C questions, only 27 percent responded to the DAST questions. The statistical results regarding drug use and/or addiction are lower than can be accepted as statistically sound. The authors of the study hypothesize that there remains a reluctance by attorneys to self-report,

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7 Krill, PR, et al, supra, 48.
even anonymously, any illicit drug use. As such, these statistics are not addressed herein.8

B. Alcohol Addiction

One of the more unfavorable lawyer stereotypes is that of the overworked alcoholic lawyer. This stereotype is (sadly) perhaps most memorably depicted in the movie The Verdict with Paul Newman as the boozing litigator trying a medical malpractice case – the case of his life – all while horribly impaired by alcohol addiction. While most lawyers don't operate in that fashion, there's some basis of truth in the stereotype. The fact is, lawyers have rates of addiction many times higher than the general population and also higher than other professions. This includes other notably "stressful" occupations, such as doctors. Often, though, many lawyers can continue to be high-functioning even in the throes of an impairment.

While it has been known for some time that the rates of addiction within the legal profession were higher than the general population, what wasn't known was just how high they were; until the release of the Hazelden study in February 2016. The purpose of this presentation is not to explain why lawyers suffer at such a higher rate, the purpose is to provide education about the problem, provide ways to identify addiction and addictive behavior, and how to find recovery solutions if you find yourself or someone you care about addicted.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 6.4 percent of Americans had an alcohol use disorder (AUD) in 2014.9 To be diagnosed with an AUD, individuals must meet certain criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).10

- The Eleven Symptoms of Alcohol Use Disorder
  1. Alcohol is often taken in larger amounts or over a longer period than was intended.
  2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
  3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.

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8 Id.
10 http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/alcohol-use-disorders. Under DSM-5 anyone meeting any two of the eleven criteria during the same twelve-month period receives a diagnosis of AUD. The severity of an AUD – mild, moderate, or severe – is based on the number of criteria met.
4. Craving, or a strong desire or urge to use alcohol.

5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.

6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.

7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.

8. Recurrent alcohol use in situations in which it is physically hazardous.

9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

10. Tolerance, as defined by either of the following: a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect; b) A markedly diminished effect with continued use of the same amount of alcohol.

11. Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for alcohol (refer to criteria A and B of the criteria set for alcohol withdrawal; b) Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

The presence of at least two of these symptoms indicates an alcohol use disorder (AUD). The severity of an AUD is graded mild, moderate, or severe:

- **Mild:** The presence of two to three symptoms.

- **Moderate:** The presence of four to five symptoms.

- **Severe:** The presence of six or more symptoms.\(^{11}\)

In contrast to the 6.4 percent rate of addiction in the general population, according to the Hazelden study between 21 percent and 36 percent of lawyers self-report problematic levels of drinking (the distinction between these two percentages is addressed below).\(^{12}\) In response to the same

\(^{11}\) *Id.*

\(^{12}\) *Id.*
three questions on the AUDIT-C which showed 36 percent of lawyers having alcohol use disorders, physicians self-reported at only a 15 percent level of problematic drinking. According to these new figures, then, attorneys have alcohol use disorders between 3.5 to five times greater than the general population; and twice as often as physicians when asked specifically about quantity and frequency of use.\textsuperscript{13} Prior numbers reflected that lawyers suffered alcohol use disorders at between two to 2.5 times that of the general population.

C. Statistics

1. **AUDIT-10.**

On the AUDIT-10, 20.6 percent of lawyers scored at a level consistent with problematic drinking or alcohol use disorder (AUD). Remember the AUDIT-10 measures levels of use (frequency and amount) plus problem behaviors or consequences. "Problematic drinking" is defined as hazardous drinking and possible dependence. More male lawyers (25.1 percent) than female lawyers (15.5 percent) self-reported problematic drinking and possible dependence. In comparison, only 11.8 percent of a "broad, highly educated workforce" screened positive for problematic drinking using the same measure.\textsuperscript{14}

2. **AUDIT-C.**

On the abbreviated AUDIT-C, 36.4 percent of lawyers scored at a level consistent with problematic drinking or alcohol use disorder. The AUDIT-C measures only frequency and amount (levels of use) but not problem behaviors or consequences. "A significantly higher proportion of women (39.5 percent) had AUDIT-C scores consistent with problematic use compared with men (33.7 percent)."\textsuperscript{15}

The contrast in the results between the AUDIT-10 (quantity and frequency plus consequences) versus the AUDIT-C (quantity and frequency only) could indicate a couple of things. First, it likely indicates that as lawyers, we're drinking far more than is safe for us, but that our self-perception of our problem is very low; and/or second, it indicates that we may not be suffering consequences at the same level as individuals in the general population. Both theories support what experts observe as a higher rate of denial by professionals versus that of (not only) the "low-bottom drunk,"

\textsuperscript{13} Krill, PR, \textit{et al}, supra.


\textsuperscript{15} Krill, PR, \textit{et al}, supra, 48.
but also of the general population. "Denial" is the tendency of alcoholics or addicts to either disavow or distort variables associated with their drinking or drug use in spite of evidence to the contrary. 16 "If a person doesn't recognize that his or her behavior is creating problems, then he or she wouldn't see the need to change or seek assistance," said Barbara McCrady, PhD, professor of psychology and clinical director of the Center for Alcohol Studies at Rutgers University in New Brunswick, NJ. "They are also likely to react negatively to people who believe they have a problem," says McCrady.

Consider the circumstance of the alcoholic who is a minimum-wage employee who is repeatedly late for her shift-work because of her drinking. That individual ultimately loses her job. In her case, alcohol is a factor and the consequences are evident pretty quickly – her position is one that may be filled by another worker fairly easily. It's harder to legitimately deny a problem with alcohol at this point, given the significant and immediate consequence. Compare that with the judge who is suiting up for court each day, meeting with litigants and preparing opinions and orders. Just like the shift worker, the judge may be perpetually late for court, unprepared at hearings, and late in issuing opinions and orders. In spite of this, he is still able to put on his black robe and maintain the impression that he is "fine" and that everything is okay. The judge's daily shortcomings – a direct result of excessive drinking – are not necessarily alerting anyone to his actual level of impairment. He is, himself, able to minimize the truth about his own alcohol abuse. This may go on for months or years.

The following definitions may be helpful in assessing one's own level of drinking and whether one's own perception of his or her alcohol use is consistent with national standards. The National Institute on Alcohol Abuse and Addiction (NIAAA) provides the following definitions:

a. A "drink" is defined as something containing fourteen grams or more of alcohol. Roughly, that's a 1.5 oz. shot of eighty-proof liquor; a twelve oz. beer; or a five oz. glass of wine. See Appendix for other standard measures.

b. "Heavy drinking" or "at risk drinking" for men is defined as having more than five drinks in a single day; or fourteen drinks or more per week (two drinks a day).

c. "Heavy drinking" or "at risk drinking" for women is defined as drinking four or more drinks per day; or eight drinks or more per week (just over one drink a day).

d. "Binge drinking" for men is defined as having more than five drinks on a single occasion; and for women it's defined as having more than four drinks on a single occasion.\(^{17}\) Drinking a bottle of wine (alone) is considered a "binge drinking episode" for either sex.

e. As defined by NIAAA, for women, "low-risk drinking" is no more than three drinks on any single day with no more than seven drinks per week. For men, it is defined as no more than four drinks on any single day and no more than fourteen drinks per week.\(^{18}\)

D. Work Environment Prevalence

The workplaces where lawyers have the highest rates of addiction are in private firms and in bar administration or lawyer assistance programs.\(^{19}\) Under both the AUDIT and AUDIT-C, there were higher rates (23 percent in private firms and 24 percent in bar administration or lawyer assistance programs) than any other workplaces.\(^{20}\) Judges scored the lowest rates of addiction, according to their responses, at 16 percent, which still ranked them two and a half times the addiction rate of the general population and also higher than physicians (again, 15 percent) using the same measure. Statistically, the in-between ranges are from 17.8 percent to 19.2 percent and comprise in-house or corporate counsel, sole practitioners, and government lawyers.\(^{21}\)

III. DEPRESSION AND OTHER MENTAL HEALTH ISSUES

Depressive disorders are among the most common mental health disorders in the United States. They are characterized by a sad, hopeless, empty, or irritable mood, and somatic and cognitive changes that significantly interfere with daily life. Major depressive disorder (MDD) is defined as having a depressed mood for most of the day and a marked loss of interest or pleasure, among other symptoms present nearly every day for at least a two-week period.\(^{22}\) Just like with substance use disorders, the rates of mental health disorders (including but not limited to depression, chronic stress and anxiety) are much higher within the legal profession, than the general population.


\(^{18}\) Id.

\(^{19}\) Krill, PR et al, supra, at 49.

\(^{20}\) Id. at Table 3, 49.

\(^{21}\) Id.

According to SAMHSA, 6.6 percent of adult Americans experienced a major depressive episode (MDE). Lawyers’ higher stress levels (which scientists are now identifying as one of the roots of higher rates of depression and substance abuse) may have their genesis in the adversarial nature of the practice of law. There are very few professions whose core of work is completely adversarial.

The 2016 Hazelden study reveals that the percentages of lawyers with mental health concerns are even higher than previously thought. The statistical information previously relied upon was a 1990 Johns Hopkins University study which identified lawyers as having depression at a rate 3.6 times higher than non-lawyers, who shared the same socio-demographic traits. The Hazelden study quantifies lawyers as actually suffering from depression at a rate of 28 percent, or almost 4.5 times that of the general population. Approximately 61 percent of the study acknowledged concerns with high levels of anxiety during the course of their career; and 46 percent – almost half – reported having experienced depression during the course of their career. Finally, and perhaps most chilling is the fact that almost 12 percent admitted suicidal thoughts at some point over the course of their career.

One still-reliable finding of the 1990 Johns Hopkins study is that in all graduate-school programs in all professional fields, the optimists outperformed the pessimists – except in one profession. The only exception was among law students, where pessimists outperformed optimists. This is logical when you consider that pessimism is an asset for attorneys. Pessimism creates skepticism about what our clients, our witnesses, opposing counsel, and judges tell us, as well as assisting us in effectively questioning interpretations of the law. Pessimism inspires lawyers to anticipate the worst, and thus prepare for it. Benjamin Disraeli, former Prime Minister of the United Kingdom said that “I am prepared for the worst, but hope for the best.” He probably learned this while training as a solicitor (he ultimately abandoned the law). But pessimism is bad for your health: it leads to stress and disillusionment, which makes us vulnerable to depression.

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25 Id.


27 Krill, PR, et al, supra, 50.


In addition to the character traits and other stressors which may decrease the good mental health of lawyers (perfectionism, pessimism, financial insecurity, etc.), Britain's Medical Research Council established a clear link between longer work hours and depression. In the study, the white collar workers who put in eleven hour workdays had a two and a half times higher likelihood of developing a major depressive episode (MDE) than the employees who worked only seven to eight hour days. There was a link between long work days even after the researchers took things into account such as level of support in the workplace, job strain, alcohol use, smoking and chronic physical disease. The study indicated that the overworked junior and mid-level employees appear to be more prone to depression than the people at higher levels, which supports the Hazelden study's findings that junior associates and entry-level attorneys have the highest rates of depression (employees under thirty showed depression rates of 32 percent). The takeaway is that regardless of age, and ignoring every other contributing factor (i.e., increased rates of addiction, poor health habits and increased rates of depression), many lawyers are still two and a half times more likely to develop depression than those who work less than eleven hours a day as a result of the long hours.

While age is the primary predictor of risk for mental health issues in the Hazelden study, sex is also a factor. Historically, men have had higher rates of depression and women have higher rates of anxiety. The Hazelden study corroborates these statistics among lawyers. Regarding anxiety, more than twice as many women are diagnosed with generalized anxiety disorder than men, which usually occurs along with other mental health conditions, substance abuse problems and mood disorders. It also commonly co-occurs with major depression. The Hazelden study also validates that non-problematic drinkers on the AUDIT had lower levels of depression, anxiety and stress than those who drank more, as measured by the DASS-21.

- Co-Occurring Disorders

Mental health issues such as depression or anxiety and substance abuse conditions often co-occur. In other words, individuals with substance use conditions often have a mental health condition at the same time, and vice versa. This is known as a co-occurring disorder, a dual disorder or a dual diagnosis. It is well-established that co-occurring disorders are more

31 Id.
32 Id.
33 Krill, PR, et al, supra, Table 3, 49.
34 Krill, PR, et al, supra, 50.
35 Id.
likely to remit when they are addressed concurrently.\textsuperscript{36} Without integrated treatment, one or both disorders may not be addressed properly.\textsuperscript{37} Alcohol dependence appears to prolong the course of depression and increases the risk of suicidal symptoms and behaviors. Patients with depression and alcohol use disorders are at increased risk of relapse to heavy drinking.\textsuperscript{38} Individuals with alcohol dependence are up to ninety times more likely to be at risk for suicide than the non-psychiatrily-ill population.\textsuperscript{39}

The more you drink, the more likely you are to suffer from anxiety and depression. It is estimated that more than one third of people diagnosed with mental disorders abuses or is dependent on psychoactive substances, especially alcohol; among alcohol-dependent patients 37 percent suffer from other mental disorders.\textsuperscript{40} Alcohol dependence is also associated with increased risk of mood disorders – more than three times higher, depression – almost four times higher, bipolar disorder – more than six times higher, anxiety disorders in general – more than twice, generalized anxiety disorder – more than four times higher, panic disorders – almost double, posttraumatic stress disorder – more than twice.\textsuperscript{41} People who drink more than six drinks per week were more likely to have symptoms of depression and anxiety than those drinking less, regardless of age, while for women in their 20s and 40s, the lowest rates of symptoms were in those who did not drink any alcohol at all.\textsuperscript{42}

\textbf{IV. DEMOGRAPHIC FACTORS FOR ALL DISORDERS}

Contrary to the results of the 1990 Johns Hopkins study, the Hazelden results indicate that the age group with the highest rate of both addiction and mental health issues are younger lawyers. The highest percentage of lawyers with alcohol use disorders as well as depression is the under thirty crowd.\textsuperscript{43} In fact,


\textsuperscript{37} www.samhsa.gov/co-occurring.

\textsuperscript{38} Gianoli, MO, \textit{et al}, supra.


\textsuperscript{41} Id.

\textsuperscript{42} Id.

\textsuperscript{43} Krill, PR, \textit{et al}, supra.
age was the greatest predictor of risk for addiction and other mental health disorders. We see the same pattern with law students, who also have higher levels of distress symptoms than the general population (and even other professional school programs) but with limited help-seeking behaviors.44

This new research also established that the majority of individuals with problem drinking reported developing those problems during their first fifteen years out of law school (typically from ages twenty-five to forty). Ages thirty and under reported a 32 percent rate of problem drinking, and the thirty-one to forty year olds reported a 25 percent rate of problem drinking. Starting at age fifty-one the percentages fell below 20 percent. Older research showed just the opposite – that the rates of addiction rose as lawyers progressed in their careers. That data suggested that the longer somebody stayed in the profession, the more likely they were to become a problematic drinker. "That aligned with a perception that the legal culture sort of promotes drinking and it's a stressful profession, so the more exposure a person has in terms of years, the more likely a problem would develop. We found that that's not true at all. It's the reverse now."45

The overall statistics related to age and alcohol from the Hazelden study are as follows:

- 22.6 percent of attorneys felt their use of alcohol/substances was a problem sometime during their lives;
- 27.6 percent of attorneys reported problematic use prior to law school;
- 14.2 percent of attorneys reported problematic use started during law school;
- 43.7 percent of attorneys reported problematic use started within the first fifteen years after law school; and
- 14.5 percent of attorneys reported problematic use started more than fifteen years after law school.46

V. BARRIERS TO TREATMENT

The Hazelden study reveals that only 6.8 percent of attorneys have sought help for alcohol or drug use. Compare this with the general population whose percentage of seeking help is 19.8 percent.47 Of those 6.8 percent of lawyers, 21


45 Forward, Joe, supra, quoting Patrick Krill.

46 Krill, PR, et al, supra.

percent of attorneys sought treatment programs specifically tailored to legal professionals. The AUDIT scores of those attorneys who had specialized treatment were significantly lower than participants who attended more generic treatment programs. Many treatment facilities are moving towards specialized programs. A typical "professionals program" may include pilots, physicians, nurses, lawyers and judges; while some facilities offer programs exclusively for legal professionals. There are also many types of treatment, facilities and programs of recovery including twelve-step recovery; faith-based recovery; and SMART recovery, among others. One size does not fit all when it comes to recovery solutions.

As mentioned earlier, denial is one of the very first barriers to treatment. As lawyers, periodic instances of heavy or binge drinking is not all that unusual. Professional events are often dotted with cocktail parties, and happy hour is practically a rite of passage in many law firms and other employment settings. As such, we have a barrier to overcoming denial. When the problem drinker's behavior is similar to his or her peers – it's hard for them to accept or understand that anything is wrong. "Also feeding denial is the stigma and shame associated with alcoholism. Unfortunately, much of society still perceives alcoholism as a moral failure."

All of the individuals involved in the Hazelden study who reported a previous treatment for substance use were asked about barriers to treatment and how this impacted their ability to obtain treatment services. Individuals who had not had any treatment were asked about hypothetical barriers to treatment in the event they needed help in the future. It's likely no surprise that the two most common barriers to treatment were the same for both groups: not wanting others to know that they needed help (50 percent for those who have had treatment, and 25.7 percent for those who have not); and concerns regarding privacy or confidentiality (44 percent for the treatment group and 23 percent for the non-treatment group).

Fifty percent (or less) of the lawyers responding said that they would not seek treatment because of shame or confidentiality reasons. This percentage doesn't make sense mathematically, though. The legal population suffers from addiction in the range of 20 percent to 36 percent, and only 7 percent have sought treatment. The probability, then, is that there are much higher barriers to treatment than the 50 percent response. It also evidences that too many lawyers are suffering in silence – many out of the fear of being "found out." Given the rate of suicide among lawyers reported by the Centers for Disease Control (sixty-six lawyer suicides per 100,000 deaths versus eleven general population

48 Krill, PR, et al, supra, 50.

49 www.hazeldenbettyford.org.

50 Id.

51 Krill, PR, et al, supra, at 50.
suicides per 100,000 deaths), suffering in silence can be deadly. In a similar study conducted in 2015 among law students, the barriers to treatment were nearly identical, although at a much higher rate based upon students' fears of impacting or preventing their initial bar licensure.

The Kentucky Bar Association’s arm of discipline, the Office of Bar Counsel, recognizes and understands that impairment issues are often at the root of disciplinary complaints. Recognition and treatment of the impairment is the very best course of resolution for practicing attorneys and their clients. Seeking treatment will not negatively impact the individual attorney’s disciplinary process. According to Tommy Glover, Chief Bar Counsel,

The Office of Bar Counsel investigates complaints of violation of the Rules of Professional Conduct by members of the bar. Some of those violations are directly related to substance abuse. Often the substance abuse leads to the violation. Attorneys should not fear losing their license to practice by seeking treatment with KYLAP. Both KYLAP and the OBC operate under strict rules of confidentiality. Shared communication may only occur when the attorney being investigated consents. In those cases, the OBC and KYLAP may work together to get the attorney the treatment they need so they can avoid the mistakes which interfered with their ability to practice. It’s often the failure to ask for assistance which gets lawyers in ethical trouble.

The Kentucky Lawyer Assistance Program is a completely confidential program for all law students, lawyers and judges. Pursuant to SCR 3.990, all contact with KYLAP is confidential. Neither bar counsel nor the bar association are notified if a call is received for help. No information may be disclosed unless the attorney who is seeking help signs a waiver allowing the disclosure. (SCR 3.990(1)(a)). In Kentucky, it is safe to seek help.

VI. ETHICAL CONSIDERATIONS

A. Manifestation of Impairment

The areas in which bar associations see the highest level of complaints are not coincidentally the three areas in which the impaired attorney will have the greatest struggle. Refer to the identifying traits, supra. Specifically: communication, competency and diligence.

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52 This statistic has previously (repeatedly) been reported by the Centers for Disease Control, although the source of the statistical data has not been identifiable by researchers in any of the studies referenced in this article.

53 Bender, KM, et al, supra.
B. Pursuant to Supreme Court Rule 3.130(1.4) Communication

(a) A lawyer should keep a client reasonably informed about the status of a matter and promptly comply with reasonable request for information.

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

C. Pursuant to Supreme Court Rule 3.130(1.1) Competence

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

Comments: Thoroughness and Preparation

[5] Competent handling of a particular matter includes inquiry into and analysis of the factual and legal elements of the problem, and use of methods and procedures meeting the standards of competent practitioners. It also includes adequate preparation. The required attention and preparation are determined in part by what is at stake; major litigation and complex transactions ordinarily require more elaborate treatment than matters of lesser consequence.

Maintaining Competence

[6] To maintain the requisite knowledge and skill, a lawyer should engage in continuing study and education. If a system of peer review has been established, the lawyer should consider making use of it in appropriate circumstances.

D. Supreme Court Rule 3.130 (1.3) Diligence

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

How can you tell when you or another attorney is on the verge of or may have already crossed ethical lines and possibly opened up themselves or your firm to a disciplinary action or legal malpractice claim? A wonderful resource and starting point is to take the "Ethics At-Risk II Quiz for Lawyers," prepared by Gregory Brock, Ph.D., in the Appendix. Take this self-test, and see what your risk factors are.
E. Your Duty to Report

The duty to report unethical behavior, as set forth in Supreme Court Rule 3.130(8.3), requires a lawyer "who knows that another lawyer has committed a violation of the Rules of Professional Conduct that raises a substantial question as to the lawyer's honesty, trustworthiness or fitness as a lawyer in other respects, shall inform the Association's Bar Counsel." The same rule requires attorneys to report judges to the Judicial Conduct Commission for misconduct. However, before you report an attorney for unethical conduct, it is prudent to first call your local Ethics Hotline attorney, and run the scenario, in hypothetical format, through the Ethics Hotline. Each Supreme Court District has at least two representatives. The current representatives may be found on the Kentucky Bar Association website under Ethics Hotline Committee Members. The information discussed with the Ethics Hotline is not subject to disclosure nor does it fall under the reporting requirement. That is, the Ethics Hotline attorney is excluded from the reporting requirement, just as KYLAP is excluded from a reporting requirement when unethical or illegal conduct is reported to us or our volunteers while seeking or obtaining assistance from KYLAP. In addition, reporting an individual to KYLAP to obtain help for that individual does not satisfy the requirement of SCR 3.130(8.3) of reporting unethical conduct to the KBA's Office of Bar Counsel. These are two distinct entities and the reporting obligation is on the practicing attorney.

VII. SOLUTIONS, RECOVERY, AND RESTORATION

The foundation of recovery begins when the impaired lawyer seeks help. There are even times when the help comes to the attorney, by way of the intervention. Whenever and however the help is sought or offered, it is the acceptance of that help which opens up the door to a new life for the impaired attorney. In active addiction one is surrendered to the substance (the term "addiction" is from the Latin, "to adore," "to surrender oneself"). Recovery begins when the individual is able to surrender themselves to the fact that they have lost their power to choose whether or not to use the substance. Early intervention and treatment for the affected attorney often leads to sustained recovery and often helps to prevent bar complaints or sanctions against one's law license. Chemical dependency and depression are treatable illnesses. They are neither moral defects nor a result of lack of willpower.

VIII. KENTUCKY LAWYER ASSISTANCE PROGRAM

If you think you need help, call the Kentucky Lawyer Assistance Program (KYLAP). KYLAP is a program of the Kentucky Supreme Court funded by Kentucky Bar Association lawyer dues that offers confidential help to members of the Kentucky legal community (law students, lawyers and judges) who are

54 Supreme Court Rule 3.130(8.3)(c) A lawyer is not required to report information that is protected by Rule 1.6 or by other law. Further, a lawyer or a judge does not have a duty to report or disclose information that is received in the course of participating in the Kentucky Lawyer Assistance Program or Ethics Hotline.
struggling with mental health issues, such as depression, alcohol and drug abuse, stress, compulsive gambling or any other condition that may adversely impact the individual's personal or professional life.

A. All Contact with KYLAP Is Confidential

Pursuant to the Kentucky Lawyer Assistance Program (Supreme Court Rule 3.990), all contact with KYLAP is confidential. The Rule is as follows:

SCR 3.990 Confidentiality

(1) All communications to KYLAP and all information gathered, records maintained and actions taken by KYLAP shall be confidential, shall be kept in strict confidence by KYLAP’s staff and volunteers, shall not be disclosed by KYLAP to any person or entity, including any agency of the Court and any department of the Association, and shall be excluded as evidence in any proceeding before the Board of Governors or the Office of Bar Admissions, except that:

(a) if the person who is the subject of KYLAP's assistance has provided a written release authorizing disclosure of communications to KYLAP or information gathered, records maintained or actions taken by KYLAP, KYLAP may disclose such information in strict accordance with the terms and conditions of that written release;

(b) if the matter was assigned to KYLAP by the Court pursuant to paragraph SCR 3.980, KYLAP may issue reports, disclose information and provide testimony as set forth in paragraph (3) of that Rule, and this Rule 3.990 shall not be construed as a basis for excluding otherwise admissible evidence from any admission, disciplinary, restoration or reinstatement proceeding; and

(c) if KYLAP provided assistance pursuant to an agency referral under SCR 3.970, KYLAP may issue reports, disclose information and provide testimony as set forth in paragraph (5) of that Rule, and this Rule 3.990 shall not be construed as a basis for excluding otherwise admissible evidence from any admission, disciplinary, restoration or reinstatement proceeding.

(2) The foregoing requirement of confidentiality shall apply to all members of the KYLAP Commission, all KYLAP staff members and volunteers, all employees of the Association, all volunteer counselors, all persons who provide information or other assistance to KYLAP in connection with any referral or assignment, and all other
persons who participate in the performance or delivery of KYLAP’s services.

Referrals to KYLAP may be made by the individual in need or by anyone concerned about an impaired attorney or judge. It is a safe place to turn for confidential assistance.

KYLAP is entirely separate from the Office of Bar Counsel of the Kentucky Bar Association. Information received by KYLAP concerning any lawyer seeking help or to whom assistance is offered is confidential. The confidentiality provided is that of the attorney-client privilege. If you call as the spouse, child, or friend of the law student, lawyer or judge whom you suspect may have a chemical dependency and/or mental health problem, your communication is also treated as confidential, and the individual you are referring does not know who referred them.

In order to assure this highest degree of trust and confidence, the Kentucky Lawyer Assistance Program is, by rule of the Kentucky Bar Association, which has been approved by order of the Kentucky Supreme Court, entirely separate from any ethics, disciplinary counsel or character and fitness committee of the KBA or the Office of Bar Admissions.

B. How Can KYLAP Help?

Among the services which KYLAP can offer the individual in need or their support people are:

1. Immediate and continuing assistance to members of the legal profession who suffer from the effects of chemical dependency or mental conditions that result from disease, disorder, trauma or other infirmity and that affects their ability to practice;

2. Planning and presentation of educational programs to increase the awareness and understanding of members of the legal profession to recognize problems in themselves and in their colleagues; to identify the problems correctly; to reduce stigma; and to convey an understanding of appropriate ways of interacting with affected individuals;

3. Investigation, planning, and participation in interventions, assessments and/or evaluations with members of the legal profession in need of assistance;

4. Sponsoring and/or maintaining substance abuse and/or mental health support meetings for members of the legal profession around the state;

5. Aftercare services upon request, by order, or under contract that may include but are not limited to, the following: assistance in structuring aftercare and discharge planning; assistance for entry into appropriate aftercare and professional peer support meetings;
and assistance in obtaining a primary care physician or local peer counselor; and;

6. Monitoring services that may include, but are not limited to, the following: alcohol and/or drug screening programs; tracking aftercare, peer support and twelve-step meeting or other abstinence-based program attendance; providing documentation of compliance; and providing such reports concerning compliance by those participating in a monitoring program as may be required by the terms of that program.

IX. CONCLUSION

More than ever, we know that the increased threat of life-ending addictions and other mental health issues are real and they’re increasingly prevalent among lawyers. Don’t be afraid to get confidential help. Your license is not jeopardized by your seeking treatment. If you call KYLAP or reach out to one of our volunteers, the Office of Bar Counsel is not notified. Your KBA membership is neither at risk nor is it threatened. Supreme Court Rule 3.990 protects you. As lawyers, and as the profession most likely to change public policies, it is our opportunity and our responsibility to help remove the stigma of addiction and other mental illnesses. Your friends, co-workers and colleagues are far more educated on addiction, depression and other mental health maladies than you likely know. Every family is touched by something – whether it’s addiction, depression, suicide or another mental health issue.

When you are standing in that forest of sorrow, you cannot imagine that you could ever find your way to a better place. But if someone can assure you that they themselves have stood in that same place, and now have moved on, sometimes this will bring hope.

— Elizabeth Gilbert, Eat, Pray, Love

We are not alone. Many, many law students, lawyers and judges have experienced these and other mental health issues. They have not only moved on to the place where their own mental health has been improved, but as a result of their own difficulties, they will make themselves available to help another lawyer who finds herself in similar circumstances. There is no shame in seeking help in order to regain good mental health. Not only might your job depend on it, but your life might, too.
I'll never forget the first time I tried cocaine.

It was a Saturday afternoon in early fall during my third year of law school at the University of Kentucky, sufficiently early in the semester such that the pressure of final exams was not yet on the horizon and those of us so inclined could feel free to "let loose." A classmate was having a pre-game party before a big UK football game and it was one of those picturesque autumn days in Lexington where the temperature was just right, the colors of the season simply magnificent. Despite the day's beauty, I have a distinct memory of feeling sad. There was a heaviness about my heart – the sort of weight recognized only in hindsight as the kind attributable to a deeply-aggrieved soul. I can't remember how exactly I found my way into that clandestine back room – the one where I found a handful of party-goers hunched over a shiny mirror covered in a snow-like substance that I immediately recognized to be cocaine. In hindsight, I can understand that I was looking for that room. Although I had never before used a "hard" drug, I had seen enough to know that such recreational drugs were always just around the corner from every booze-fueled party. And on that particular Saturday, the booze just wasn't getting the job done. With the benefit of fifteen years of hindsight, I can look back now and recognize that it was an inner anguish – a deep, spiritual malady, incomprehensible at the time – that guided me to where I then stood. And it was that same spiritual malady that motivated me to put a straw to my nose and do my first "line."

Such was my introduction to cocaine. It was an introduction that would rock my world. I was hooked the moment the substance entered my body, and over the course of the next year or so my relationship with the drug would come to take over my life. Slowly but surely, my uncontrollable desire for that ever-diminishing period of synthetic numbness led me to push everything good in my life farther and farther away. Friends, family, hopes, dreams – one by one, these things slipped away. Over time, my existence was reduced to a chemical romance that would end, as it always does for alcoholics and addicts, only when I "hit bottom" amid consequences so impactful that the agony of my addictive existence could no longer be denied.

Looking back, it is easy to see that cocaine was hardly the cause of my fall. It merely accelerated my journey down a path that I had been on for some time. Already an alcohol-abuser (my first drink was at the ripe age of 14), I had for years relied on alcohol to soothe a troubled soul and "cure" what ailed me. What ailed me – I would come to recognize only later, in sobriety – was a deeply-rooted selfishness, insecurity, and dislike-of-self. I simply did not like the person I had somehow become. Worse still, I didn't know how to change. Alcohol became my crutch and mask – a tool to drown out the things that haunted and something to hide me from me. I had been drinking heavily even prior to law school, but its pressure-packed atmosphere and competitive undercurrent seemed to take the need to escape, and hence to drink, to a whole new level. I started drinking alone.
Like many alcoholics and addicts, however, my fragile state and substance abuse was hidden by my outward "success." To the untrained eye, I was the consummate achiever. In the top 10 percent of my class and editor-in-chief of the law review, my drinking (and later, my drugging) did not bring academic consequences. I was popular enough. I had a girlfriend. I was on my way to professional success, a federal clerkship position waiting for me upon graduation. Problems? How could I have problems when I was so clearly a "success"?

So long as I enjoyed such outward "success," it was easy to look past the increasingly-more-serious consequences of my substance abuse. (The DUI in my 2L year was explained away as "bad luck." When my closest law school friends suddenly wanted nothing to do with me, they were to blame.) But such "success" served only to perpetuate the lie. While slowly dying inside, I didn't dare get honest. The thought of living without booze or cocaine was at that point downright scary. (As I would later say to the doctor to whom my parents dragged me after becoming concerned: "You don't understand. The alcohol isn't a problem. It's my solution." It would be many years before I would appreciate the fantastic irony of this "denial.")

Mercifully, in the end my "bottom" did come. But it hardly seemed "merciful" at the time.

For me, "bottom" came in the form of my bar exam results. I failed. Not only that, I failed in humiliating fashion. I was the first editor-in-chief in the history of the University of Kentucky College of Law to fail the bar exam. (To my knowledge, I still hold this "distinction.") The correspondence informing me of my failure arrived on letterhead bearing the name of my father, who happened to be at the time a member of the Board of Bar Examiners. I was working for a federal judge.

The veneer of "success" suddenly stripped away, I was confronted for the first time with the harsh reality: I had a problem. I had spent the summer drinking and drugging (and not studying), and for the first time there was a serious, tangible consequence. Yes, I had a drinking and drugging problem, and I could deny it no more.

With that simple act of surrender, my road to recovery was begun. In my case (as with many others), recovery was not an event. It was, rather, a process. That process was at first marked by fits and starts, half-measures and hedging. After months of outpatient treatment, sustained sobriety still eluded my grasp. I would get a couple months, only to relapse. Though I had taken step one – admitting I had a problem – I was still having trouble buying into the solution. I still couldn't get it.

Enter Kentucky Lawyer Assistance Program (KYLAP). At the time operating as "Lawyers Helping Lawyers," the organization and I had an involuntary introduction when I reapplied for the bar. Having been honest in my re-application about my drinking and drugging issues, my application predictably was pulled from the pile. The Character and Fitness Committee gave me a "choice": agree to a two-year term of supervision by KYLAP (assuming I passed the bar exam) or be deemed unfit. Not much of a choice.

If only I knew then how lucky I was. Blessed rather, as anyone in recovery would be sure to correct me. Under the watchful eye of a score of Kentucky lawyers who had once "been where I'd been" – and under the particularly watchful eyes of my designated KYLAP monitor – I was forcibly immersed in recovery. Four AA meetings a week, a check-in call with my monitor, a monthly face-to-face – these requirements attached me
to recovery long enough for me to come to understand the miracle and gift that it is. As it was, I came to this understanding rather quickly. It was no time at all before I came to realize that I wanted with all my heart what those folks "in the rooms" had – and I wanted it damn bad. Serenity, peace, happiness. The very things that had eluded me for so long, and ironically the very things that I had destructively and artificially sought in the form of drink and drug.

It wasn't easy. I had to do things (the 12 steps) – take "suggestions," as the old-timers would call them – that weren't always easy to do. Like "making amends," believing in a God of my understanding (a "higher power"), taking a daily "inventory" of my actions, promptly admitting when I was wrong, and – above all – being rigorously honest. I had to get a "sponsor" and take direction. I had to, quite simply, change everything. (Only in time would I come to understand that that was precisely the point.)

It wasn't long before I started seeing changes in me – changes I could be proud of. I started to like myself, and be myself. Not drinking wasn't the half of it, I came to learn. Sobriety was a way of life. It was a way of living – a creed. I started too to see changes in my life. I had friends again. People seemed to enjoy being around me more. I enjoyed being around me more. I found my footing in the profession. I found myself contributing. In short, I found myself … happy.

And so it should come as no surprise that I barely noticed when my two-year term of supervision expired. By that point, I was all in. Recovery had long since become not something I needed but something I wanted. It had become my most prized possession. The thought of going back to the way it had been only served to propel me forward. I felt as though I had won some lottery and the Big Man Upstairs had seen fit to reach down and give me – undeserving, hapless me – the "secret to life." There was simply no going back – thank the Lord.

As it is, I have not gone back. Not for 12 years, 9 months, and 30 days. I have the grace of God, KYLAP, and the fellowship of Alcoholics Anonymous to thank for that string of continuous sobriety. That, my friends, is a miracle. And my existence during this time has been no less miraculous. To say that I have been blessed simply does not do it justice. The truth is, my life today is silly, stupid awesome. Recovery has given me the love of my life and three precious children. Recovery has given me the opportunity to do what I love to do – be a lawyer – and make a living doing it. Recovery has given me the privilege of representing the United States of America (as a federal prosecutor for five years), the experience of being a partner at a large national law firm, and now the thrill of starting and managing my own firm. Most of all, though, recovery has given me the joy of giving – the truest form of happiness, as I have come to find out.

My story, like all of those in recovery, has no ending. It continues to be written. By design, we take it "one day at a time."

But this story must have an ending, and it is only fitting – given the audience – that it read like this: KYLAP and AA saved my life. I am but an ordinary miracle whose journey from despair to hope was infinitely assisted by this small but growing band of Kentucky lawyers who have dedicated themselves so selflessly to the mission of recovery and who every day give of themselves quietly and nobly in support of the greater good. It is without question my greatest professional honor to be associated with them. I will be forever indebted to KYLAP for introducing me to recovery's greatest gift: hope.
Appendix
AUDIT-C Questionnaire

Patient Name ___________________________ Date of Visit ____________

1. How often do you have a drink containing alcohol?
   □ a. Never
   □ b. Monthly or less
   □ c. 2-4 times a month
   □ d. 2-3 times a week
   □ e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
   □ a. 1 or 2
   □ b. 3 or 4
   □ c. 5 or 6
   □ d. 7 to 9
   □ e. 10 or more

3. How often do you have six or more drinks on one occasion?
   □ a. Never
   □ b. Less than monthly
   □ c. Monthly
   □ d. Weekly
   □ e. Daily or almost daily

AUDIT-C is available for use in the public domain.
AUDIT-C - Overview

The AUDIT-C is a 3-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10 question AUDIT instrument.

Clinical Utility

The AUDIT-C is a brief alcohol screen that reliably identifies patients who are hazardous drinkers or have active alcohol use disorders.

Scoring

The AUDIT-C is scored on a scale of 0-12.

- Each AUDIT-C question has 5 answer choices. Points allotted are: a = 0 points, b = 1 point, c = 2 points, d = 3 points, e = 4 points
- **In men**, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.
- **In women**, a score of 3 or more is considered positive (same as above).
- However, when the points are all from Question #1 alone (#2 & #3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient’s alcohol intake over the past few months to confirm accuracy.³
- Generally, the higher the score, the more likely it is that the patient’s drinking is affecting his or her safety.

Psychometric Properties

For identifying patients with heavy/hazardous drinking and/or Active-DSM alcohol abuse or dependence

<table>
<thead>
<tr>
<th></th>
<th>Men¹</th>
<th>Women²</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥3</td>
<td>Sens: 0.95 / Spec. 0.60</td>
<td>Sens: 0.66 / Spec. 0.94</td>
</tr>
<tr>
<td>≥4</td>
<td>Sens: 0.86 / Spec. 0.72</td>
<td>Sens: 0.48 / Spec. 0.99</td>
</tr>
</tbody>
</table>

For identifying patients with active alcohol abuse or dependence

<table>
<thead>
<tr>
<th></th>
<th>Men¹</th>
<th>Women²</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 3</td>
<td>Sens: 0.90 / Spec. 0.45</td>
<td>Sens: 0.80 / Spec. 0.87</td>
</tr>
<tr>
<td>≥ 4</td>
<td>Sens: 0.79 / Spec. 0.56</td>
<td>Sens: 0.67 / Spec. 0.94</td>
</tr>
</tbody>
</table>

3. Frequently Asked Questions guide to using the AUDIT-C can be found via the website: www.ogp.med.va.gov/general/uploads/FAQ%20AUDIT-C
AUDIT questionnaire: screen for alcohol misuse

Please circle the answer that is correct for you

1. How often do you have a drink containing alcohol?
   - Never
   - Monthly or less
   - 2–4 times a month
   - 2–3 times a week
   - 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day when drinking?
   - 1 or 2
   - 3 or 4
   - 5 or 6
   - 7 to 9
   - 10 or more

3. How often do you have six or more drinks on one occasion?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily

4. During the past year, how often have you found that you were not able to stop drinking once you had started?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily

5. During the past year, how often have you failed to do what was normally expected of you because of drinking?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily

6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?
7. During the past year, how often have you had a feeling of guilt or remorse after drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

8. During the past year, have you been unable to remember what happened the night before because you had been drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- No
- Yes, but not in the past year
- Yes, during the past year

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

- No
- Yes, but not in the past year
- Yes, during the past year

Scoring the audit

Scores for each question range from 0 to 4, with the first response for each question (eg never) scoring 0, the second (eg less than monthly) scoring 1, the third (eg monthly) scoring 2, the fourth (eg weekly) scoring 3, and the last response (eg, daily or almost daily) scoring 4. For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4 (from left to right).

A score of 8 or more is associated with harmful or hazardous drinking, a score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

<table>
<thead>
<tr>
<th>STANDARD DRINK EQUIVALENTS</th>
<th>APPROXIMATE NUMBER OF STANDARD DRINKS IN:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BEER or COOLER</strong></td>
<td></td>
</tr>
<tr>
<td>12 oz.</td>
<td>12 oz. = 1</td>
</tr>
<tr>
<td></td>
<td>16 oz. = 1.3</td>
</tr>
<tr>
<td></td>
<td>22 oz. = 2</td>
</tr>
<tr>
<td></td>
<td>40 oz. = 3.3</td>
</tr>
<tr>
<td>~5% alcohol</td>
<td></td>
</tr>
<tr>
<td><strong>MALT LIQUOR</strong></td>
<td></td>
</tr>
<tr>
<td>8-9 oz.</td>
<td>12 oz. = 1.5</td>
</tr>
<tr>
<td></td>
<td>16 oz. = 2</td>
</tr>
<tr>
<td></td>
<td>22 oz. = 2.5</td>
</tr>
<tr>
<td></td>
<td>40 oz. = 4.5</td>
</tr>
<tr>
<td>~7% alcohol</td>
<td></td>
</tr>
<tr>
<td><strong>TABLE WINE</strong></td>
<td></td>
</tr>
<tr>
<td>5 oz.</td>
<td>a 750 mL (25 oz.) bottle = 5</td>
</tr>
<tr>
<td>~12% alcohol</td>
<td></td>
</tr>
<tr>
<td><strong>80-proof SPIRITS</strong> (hard liquor)</td>
<td></td>
</tr>
<tr>
<td>1.5 oz.</td>
<td>a mixed drink = 1 or more*</td>
</tr>
<tr>
<td></td>
<td>a pint (16 oz.) = 11</td>
</tr>
<tr>
<td></td>
<td>a fifth (25 oz.) = 17</td>
</tr>
<tr>
<td></td>
<td>1.75 L (59 oz.) = 39</td>
</tr>
<tr>
<td>~40% alcohol</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0  Did not apply to me at all
1  Applied to me to some degree, or some of the time
2  Applied to me to a considerable degree or a good part of time
3  Applied to me very much or most of the time

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (s)</td>
<td>I found it hard to wind down</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>2 (a)</td>
<td>I was aware of dryness of my mouth</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>3 (d)</td>
<td>I couldn't seem to experience any positive feeling at all</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>4 (a)</td>
<td>I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>5 (d)</td>
<td>I found it difficult to work up the initiative to do things</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>6 (s)</td>
<td>I tended to over-react to situations</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>7 (a)</td>
<td>I experienced trembling (e.g. in the hands)</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>8 (s)</td>
<td>I felt that I was using a lot of nervous energy</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>9 (a)</td>
<td>I was worried about situations in which I might panic and make a fool of myself</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>10 (d)</td>
<td>I felt that I had nothing to look forward to</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>11 (s)</td>
<td>I found myself getting agitated</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>12 (s)</td>
<td>I found it difficult to relax</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>13 (d)</td>
<td>I felt down-hearted and blue</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>14 (s)</td>
<td>I was intolerant of anything that kept me from getting on with what I was doing</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>15 (a)</td>
<td>I felt I was close to panic</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>16 (d)</td>
<td>I was unable to become enthusiastic about anything</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>17 (d)</td>
<td>I felt I wasn't worth much as a person</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>18 (s)</td>
<td>I felt that I was rather touchy</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>19 (a)</td>
<td>I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>20 (a)</td>
<td>I felt scared without any good reason</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>21 (d)</td>
<td>I felt that life was meaningless</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>
DASS-21 Scoring Instructions

The DASS-21 should not be used to replace a face to face clinical interview. If you are experiencing significant emotional difficulties you should contact your GP for a referral to a qualified professional.

 Depression, Anxiety and Stress Scale - 21 Items (DASS-21)

The Depression, Anxiety and Stress Scale - 21 Items (DASS-21) is a set of three self-report scales designed to measure the emotional states of depression, anxiety and stress.

Each of the three DASS-21 scales contains 7 items, divided into subscales with similar content. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest / involvement, anhedonia and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset / agitated, irritable / over-reactive and impatient. Scores for depression, anxiety and stress are calculated by summing the scores for the relevant items.

The DASS-21 is based on a dimensional rather than a categorical conception of psychological disorder. The assumption on which the DASS-21 development was based (and which was confirmed by the research data) is that the differences between the depression, anxiety and the stress experienced by normal subjects and clinical populations are essentially differences of degree. The DASS-21 therefore has no direct implications for the allocation of patients to discrete diagnostic categories postulated in classificatory systems such as the DSM and ICD.

Recommended cut-off scores for conventional severity labels (normal, moderate, severe) are as follows:

NB Scores on the DASS-21 will need to be multiplied by 2 to calculate the final score.

<table>
<thead>
<tr>
<th>Depression</th>
<th>Anxiety</th>
<th>Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>0-9</td>
<td>0-7</td>
</tr>
<tr>
<td>Mild</td>
<td>10-13</td>
<td>8-9</td>
</tr>
<tr>
<td>Moderate</td>
<td>14-20</td>
<td>10-14</td>
</tr>
<tr>
<td>Severe</td>
<td>21-27</td>
<td>15-19</td>
</tr>
<tr>
<td>Extremely Severe</td>
<td>28+</td>
<td>20+</td>
</tr>
</tbody>
</table>

Ethics At-Risk Test II - Lawyers
Gregory Brock, Ph.D.

Ever wonder how close you are to blundering over the ethics edge and possibly harming your clients, yourself, and/or the profession? This test may help. Check (✓) the items below that are true about you. Add the number checked and use the key for Group I to estimate your level of pile-up risk. Work on the items you checked so you can lower your level of risk. Any of the items checked in Group II pose high risk.

None of the items in either group are in themselves unethical, but all may lead to harm.

**Group I - Risks that may pile-up and result in trouble:**

1. You have never taken an academic course emphasizing practice ethics.
2. Honestly, you are unfamiliar with some parts of the latest additions to the Ethics Rules.
3. The Ethics Rules interfere somewhat with the quality of your legal or judicial work.
4. You have considered sending a false bill or a padded expense report.
5. You are asked to provide legal services to those who work closely with you including clerks and employees.
6. You have considered falsifying a CLE report.
7. You do not know the position of the Bar Association on ...???
8. Your job and/or personal financial situation cross your mind when making case management decisions.
9. You or those close to you consider your drinking, drug use, or gambling an issue of concern.
10. You are presently taking medication that may interfere with your legal work.
11. A client has given you an expensive gift or frequently gives you inexpensive gifts.
12. You are behind on your work.
13. You gossip a little about clients with close friends and/or family.
15. Client family members or associates tell you secrets that compromise you.
16. You don’t always follow through on reporting incidents of violence or abuse of others.
17. Unresolved tension exists in your work group.
18. You sometimes take off jewelry, remove shoes, loosen your tie, or become more informal during appointments.
19. The office environment where you practice communicates a tone of informality.
20. You are considering a business proposition that may create a conflict of interest.
21. You have stopped attending workshops and/or staying up-to-date with advances in the field.
22. You are considering doing work in addition to your full time responsibilities.
23. You have plagiarized in the past (used others’ words or ideas without credit).
24. You think reporting a Rules violation could be harmful to your career or more hassle than you are willing to endure.
25. You think the Ethics Rules on conflict of interest are unnecessarily restrictive.
26. You think the Ethics Rules on confidentiality create too many artificial boundaries.
27. You are sure you have violated the Rules on confidentiality or conflict of interest at some time.

0 - Excellent, you are nearly risk free.
0-2 - Re-read the Ethics Rules. Look for CLE opportunities on ethics.
2-3 - Review your practice and personal life for problem areas. Consider needed changes.
3-4 - Seek consultation. Risks are piling to an unmanageable level.
4+ - You are in a high-risk style of practice. Make immediate changes!

**Group II - Risks that by themselves may result in trouble:**

A. You fantasize about a present client.
B. You think about borrowing money from a client escrow account.
C. You are tempted to romance an ex-client.
D. Presently, you socialize more than casually with a client.
E. Presently, you are struggling with a personal, family, or legal crisis.
F. You consider going ahead with providing professional services when you are hung over from alcohol or other drugs, even if only a little.
G. You need to seek consultation about your practice with a colleague or supervisor but fear doing so will be harmful or embarrassing to you.
H. If colleagues knew all of what goes on in your practice or personal life, they would worry that you are so vulnerable to risk that you might harm clients, yourself, or the profession.
I. You feel angry, frustrated, and/or manipulated by a current client.

— If you checked (✓) any of the items in Group II, seek supervision immediately! —

Send comments and questions to Gregory Brock, Ph.D. (gbrock@uky.edu).
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