2002

Ray Harding, Jr. v. : Amicus Brief

Utah Supreme Court

Billy L. Walker; Counsel for Appellant.
Richard G. Uday; Counsel for Amicus Curiae.

IN THE UTAH SUPREME COURT

In re: Ray Harding, Jr.	)	**AMICUS CURIAE BRIEF**
	)	**CASE NO. 20020535-SC**

Attorney Discipline Matter

On April 19, 2004, the Utah Supreme Court granted the request of Utah Lawyers Helping Lawyers for leave to file this Amicus Curiae Brief.

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STATEMENT OF THE CASE.

The Amicus Curiae defers to the respective statements of the case as outlined in the briefs of the parties.

ISSUES PRESENTED.

The recent establishment of the Lawyers Helping Lawyers Program and considerations espoused by the American Bar Association and its Commission on Lawyer Assistance Program on the subjects of stress, addiction, recovery and confidentiality should enter into the consideration and the decision in this case.

SUMMARY OF THE ARGUMENT.

Utah Lawyers Helping Lawyers urges the Court, without advocating for

either side in this matter, that this Court should take into consideration as part of its decision the recent and more formal creation of the Lawyers Helping Lawyers Program. This decision may have implications regarding the Program as this decision will likely impact on considerations of stress and its relationship to addiction. The Court should also benefit from the arguments presented on the addiction as a disease model. Current and future contacts of the Program will likely be benefited by the Court's decision relative to confidentiality, recovery as mitigation and the interplay that the disease model has with attempts at treatment and toward recovery.

ARGUMENT

I. UTAH LAWYERS HELPING LAWYERS

A HISTORY.

Utah Lawyers Helping Lawyers ("LHL") is a not-for-profit corporation registered in the State of Utah and organized in furtherance of an American Bar Association ("ABA") concept aimed to assist judges, lawyers, clients and the profession. LHL was organized initially in the late 1980's as a Committee of the State Bar Association in furtherance of this ABA goal and ideal.

In 1988 the ABA organized what is known today as the Commission on Lawyers Assistance Programs (CoLAP) identifying the purposes as follows:

> Alcoholism, drug addiction, and mental health problems are afflictions that affect a great number of professionals including lawyers and judges. Reports now estimate that while ten percent of the general population has problems with alcohol abuse, anywhere from fifteen to eighteen percent of the lawyer population battles the same problem. Because many lawyers and

> judges are overachievers who carry an enormous workload, the tendency to "escape" from daily problems through the use of drugs and alcohol is prevalent in the legal community. Also, the daily pressures placed on these men and women can lead to inordinate amounts of stress and mental illness. Recent reports have also shown that a majority of disciplinary problems involve chemical dependency or emotional stress.

ABA CoLAP Website, (2004) (http://www.abanet.org/legalservices/colap /home.html).

In mid-2002, the Utah LHL Committee sought and received support from the Bar Association to organize more formally and to hire a part-time director to guide the efforts of the committee more consistently with the concept of the ABA. In December of 2002, with both this Court's and the Bar's approval and support, the ABA sent the Commission Chair and two Commissioners from CoLAP to review the Utah Program and to evaluate its efforts. The results of that evaluation included a number of recommendations including the need for the Program to be expanded and funded as a full time not-for-profit entity separate from the Utah Bar Association but funded by the Bar.

In response to those recommendations, the Utah Bar Association, through its Commissioners, sought approval from this Court to fund LHL full time with a grant near that amount encouraged by the ABA. A more detailed discussion of the history of LHL is unnecessary for the purposes of this brief. Prior articles discussing the history and the ABA evaluation in more detail appeared in issues of the Utah Bar Journal and are reproduced herein at Addenda 1, 2 and 3.

B ROLES OF LHL

LHL's mandate from the ABA is two-fold: (1) to assist attorneys and judges who are experiencing difficulties of mental health, substance abuse and addiction to find suitable and appropriate professional help for those specific problems; and (2) to assume responsibility for educating the bench and bar to increase the awareness and understanding of mental health issues and issues of drug abuse and addiction.[1]

Presumably, an additional benefit provided by LHL is that our two purposes, besides saving lives and law practices, contribute to the protection of the public and to the continued improvement in the integrity and reputation of the legal profession. Providing needed assistance to lawyers with impairment often prevents future ethical violations resulting in the reduction of disciplinary actions against Bar members while importantly benefiting the clients that we ultimately serve. Oregon, for example, recently conducted a study which verifies that an active LHL program saves the Bar literally hundreds of thousands of dollars each year. See Addendum 4.

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[1] The ABA evaluation of the Utah LAP, inter alia, recommended the following Rule 1(3) of the Model LAP recommends that the lawyer assistance program be the primary agency in educating the bench and bar regarding the causes of and treatment for attorney impairment Model LAP Rule 5(2) also directs the LAP to "plan and present educational programs to increase the awareness and understanding of members of the bench and bar about problems of impairment " This educational element of the program should be strongly supported in order to inform the public, the judiciary, bar association members, law students, and the disciplinary agencies of the help that is available for those in need through Utah LHL Recommendation # 7, ABA Evaluation, February 28, 2003

C. INTERESTS OF LHL AS AMICUS CURIAE.

LHL reiterates its position as filed in its request for leave to file this brief, and neither takes nor advocates a position on behalf of Mr. Harding nor the Office of Professional Conduct. Rather, this brief is filed with the Court as an attempt to meet that aspect of our second purpose discussed above, to wit: to address the role LHL plays in the legal community and to identify for the Court the impact the decision in this matter may have for current and future members of our legal community who need and seek assistance from LHL regarding issues of substance abuse, addiction and recovery. Further, additional recommendations from the ABA evaluation have yet to be put in place and this decision may either aid or impede the progress for those recommendations to be implemented.[2]

II INCREASED OCCURRENCES OF STRESS AND STRESS-RELATED RESPONSE TO A LEGAL CAREER

The legal profession is unique among professions. As absolutely wonderful and rewarding as is a career in the practice of law, some of that uniqueness is less than encouraging or promising. In 1990, the Johns Hopkins *Medical School conducted a study of over 28 professions finding the legal* profession to have the highest rate of clinical depression, a rate 3.6 times more

[2] Such as a diversion program for appropriate cases, passage of statutory protections of privilege and immunity, establish and maintain relationships with the disciplinary office, bar admissions and actively promote diversity.

likely to occur in the legal profession than the other professions examined.[3] Since 1990 the profession has not become any easier. Competition is intense, from getting accepted into law school,[4] through passing the state bar exam,[5] to obtaining eventual employment. Yet having accomplished all of that, lawyers then must compete for clientele in a diminished market, currently in a time of economic downturn. All of these pressures unquestionably can cause severe stress.

A local Psychologist, and consultant to LHL, has explained our unique predicament as follows:

> Two major factors (and a host of minor ones) contribute to the high stress in the law profession. First, the stakes are high and the consequences of error are large. This promotes an attitude of perfectionism, a chronic feeling that nothing is good enough. Perfectionism raises cortisol levels in the body, the stress hormone that is helpful in the short run and very damaging in the long run. High cortisol levels lead to burnout, vulnerability to infections, increased healing time, and mental and emotional depression. Perfectionists are more vulnerable to depression and anxiety, harder to treat with either therapy or drugs, and much more likely to commit suicide when things go very wrong.
>
> Second, law may attract pessimistic personalities. One study found that in every graduate program, optimistics outperform pessimists, except in law. There, the pessimists are ascendant.
>
> But pessimism is another risk factor for high stress and chronic depression. Pessimists expect bad things to last a long time, to affect every part of their lives, and they see themselves as the cause of bad things happening.

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[3] Myer J. Cohen, *Bumps in the Road*, (July/August 2001) GPSOLO, www.abanet.org/legalservices/colap/home.

[4] More law students applied for admission in 2003 than any other time in history. The Hoya, *Law School Applications at National High*, (September 2003), http://www.thehoya.com/news/091903/news6.cfm.

[5] Utah, for example, has recently taken steps to elevate the required passing score on the bar exam.

> Pessimistic lawyers are doubly at risk, since they are likely to see bad things happen, and they are less able to cope when they do.
>
> As a result of the professional push toward perfectionism and pessimism, many attorneys are not enjoying their careers, feeling disillusioned and unhappy. They are at risk for underperformance and increasing stress, which increases under-performing. This vicious cycle can then turn to acting out in dangerous activities - affairs, drug or alcohol abuse, and ethical problems.

Lynn Johnson, *Stress Management*, (Jan./Feb. 2003) Utah Bar Journal, http://www.utahbarjournal.com/html/january_february_2003.html (provided in its entirety at Addendum 5).

As recent as last month, March of 2004, United States Supreme Court Justice Sandra Day O'Conner included in her speech presented at the University of Wyoming numerous comments echoing the point of increased stress and pressure on today's lawyers and judges. She spoke about professionalism and civility and apparently agreeing with Dr. Johnson stated:

> It's hardly a secret that many lawyers today are dissatisfied with their professional lives. The pressures associated with the increasing commercialization of law practices have made lawyers unhappy.
> .....
> There is an increasing level of instability in the profession, and a professional environment where a "win at all costs" mentality sometimes prevails. Many attorneys believe that selflessly representing their clients means pushing all of those precedents ... to the limit.
> .....
> Many lawyers question whether at the end of the day they've contributed something worthwhile to society.
> .....
> [A]ttorneys are more than three times as likely to suffer from depression than non-lawyers, and more apt to become dependent on drugs, have health problems, get divorced or contemplate suicide.

Ethics and Professionalism, Laramie Boomerang, March 2004; Associated Press,

March 2004; see addenda 6 and 7, respectively, for news accounts of that speech.

CoLAP has identified that greater numbers of attorneys and judges are accessing the LAPs around the country. Utah is no exception. LHL has seen a dramatic increase since moving from part-time to full time in the last three years. Within the committee structure, LHL received at its busiest year no more than 11 contacts accessing the program. In calendar year 2003, a period split between 6 months of part-time and 6 months of full time organization, LHL received 39 contacts. In the first three months of 2004, LHL has been accessed by 23 contacts. While part of this increase is unquestionably a response to the increased availability of an organized LAP and LHL's efforts to promote the Program, one cannot argue that the numbers establish that Utah is an exception to the statistical data identified by CoLAP.

A. MENTAL HEAI TH ISSUES.

Besides the Johns Hopkins study identifying the depression numbers at over 3 ½ times the rate of other professions, other mental health issues exist in our profession. Suicide currently ranks as one of the leading causes of premature death in our profession.[6] Male lawyers are twice as likely as the general population to take their own life.[7]

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[6] Id.

[7] *Annual Report*, National Institute of Occupational Safety and Health, 1992. See also, Research conducted at Campbell University in North Carolina indicated that 11 percent of the lawyers in that state thought of taking their own life at least once

The ABA has identified numerous other addictive behaviors plaguing lawyers and judges in increasingly visible numbers. Problems in areas such as gambling, eating disorders, compulsive behaviors, sexual addictions and the recent increase in internet addictions have all joined the lists of recognized abuses and addictions impacting lawyers and judges at increased measure compared to the general public.[8]

B. ADDICTION/SUBSTANCE ABUSE ISSUES.

In 2002, the government estimated 22 million Americans suffered from substance abuse dependence or abuse due to drugs, alcohol or both.[9] Lawyers and judges were part of these statistics. Then ABA President Martha W. Barnett, in 2001 wrote the following:

> We have made giant strides in our awareness and understanding of the true nature of addiction--whether it is to alcohol or other substances. Substance abuse crosses all socioeconomic lines and often hides behind imposing fronts of respectability, claiming professionals, home-makers and children alike.
>
> The abuse of drugs and alcohol has proven to be one of the most recalcitrant and corrosive problems afflicting our society. It wreaks tragedy in families and wastes valuable societal resources. Yet, efforts to stop it solely by force of law have failed. It is time for the legal community to support innovative approaches that integrate effective, appropriate treatment into the justice system culture.

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a month. Lynn Johnson, *Stress Management*, (Jan./Feb. 2003) Utah Bar Journal, http://www.utahbarjournal.com/html/january_february_2003.html.

[8] Carol P. Waldhauser, *Identifying Addiction*, GPSOLO, July/August 2001, at 22.

[9] Report of the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, September 5, 2003.

Letter to the ABA members by then President Martha W. Barnett, 2001. Presented in its entirety at Addendum 8.

Currently, the ABA estimates that 15 to 18% of lawyers and judges suffer from alcohol and drug abuse. That percentage represents a rate nearly twice the rate of the general population.[10] In another study, 13% of male attorneys and 20% of female attorneys reported consuming six drinks or more per day.[11] In surveys of State Bar Associations, 60% of ethical violations involved substance abuse.[12]

C. CONNECTION BETWEEN STRESS AND ADDICTION.

The then acting director of the National Institute on Drug Abuse wrote the following about stress:

> Researchers have long recognized the strong correlation between stress and drug use, particularly relapse to drug use. In the wake of recent tragic events, our awareness of the role that stress can play in increasing ones' vulnerability to drug use is more important than ever. Exposure to stress is among the most common human experiences. It also is one of the most powerful triggers for relapse to substance abuse in addicted individuals, even after long periods of abstinence.

Glen R. Hanson, Ph.D., D.D.S. Acting Director NIDA, January 2002.

Stress is something we all experience. The difficulty lies in the fact that we each respond differently to stressors. Depending on a number of factors, stress can consume us and cause a myriad of physical and mental difficulties.

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[10] ABA CoLAP Website, (2004), http://www.abanet.org/legalservices/colap/home.html

[11] Johnson, Lynn, *Stress Management*, (Jan./Feb. 2003) Utah Bar Journal, http://www.utahbarjournal.com/html/january_february_2003.html

[12] Id.

Scientists, however, have learned that enough similarities exist in each of us to recognize the damaging effects of stress.

Specifically scientists have recognized a causal connection that exists between stress and drug addiction.

> Stressful events may influence profoundly the use of alcohol or other drugs. Stress is a major contributor to the initiation and continuation of addiction to alcohol or other drugs, as well as to relapse or a return to drug use after periods of abstinence.

National Institute on Drug Abuse, Community Drug Alert Bulletin, "Stress and Substance Abuse" Bulletin attached at Addendum 9. (see website at www. drugabuse.gov/StressAlert/StressAlert.html). Scientists also have been able, through the use of animal studies, to establish a link between chronic stress and increased drug abuse. These studies demonstrate that not only does drug use alleviate emotional distress and enhance mood as we have known for years, but very importantly recent studies suggest that stress enhances the effects of drugs.

The studies explain that stress stimulates the reward pathways of the brain and that this increased activity from stress permits the drug to enhance the experience, boosting the pleasure reward and thereby the likelihood to use drugs again and again. See, "How does stress increase the risk of drug abuse and relapse?" Dr. Rajita Sinha, *Psychopharmacology*, Volume 158, 343-59 (2001); reprinted at NIDA NewsScan, April 8, 2002 (this report is attached in addendum 10).

This research demonstrates unequivocally that stress, in addition to the drug

itself, plays a key role in perpetuating drug abuse and relapse. This information has significant meaning when coupled with the knowledge that addiction is a disease.

III ADDICTION IS A DISEASE

The former Director of the National Institute on Drug Abuse (NIDA), Alan Leshner, Ph.D., effectively explained how an otherwise intelligent and capable member of society, or of the Bar, can go from substance abuse to addiction. He explained that it often starts with a desire to escape the stresses of daily life or to self-medicate for physical or emotional pain. A point is reached, and that time will vary depending on the individual, when the drug of choice is no longer used to feel "good," but instead is ingested to feel "normal." Dr. Leshner explains:

> Every drug user starts out as an occasional user and that initial use is a voluntary and controllable decision. But as time passes and drug use continues, a person goes from being a voluntary to a compulsive drug user. This change occurs because over time, use of addictive drugs changes the brain-at times in big dramatic ways that can result in compulsive and uncontrollable drug use. While every type of drug of abuse has its own individual trigger for affecting or transforming the brain, many of the results of the transformation are strikingly similar regardless of the addictive drug used. The brain changes range from fundamental and long-lasting changes in the bio-chemical make-up, to mood changes, to changes in memory processes and motor skills.

Alan Leshner, *Oops: How Casual Drug Use Leads to Addictions* (September 2000); www.drugabuse.gov/Published_Articles/Oops.html. This article is attached at Addendum 11.

Dr. Leshner, in his capacity as the then Director of NIDA has also written a short article that is renowned for its explanation of addiction as a disease presented in a simple and understandable style. This article, entitled "Addiction is a Brain Disease," is reproduced in its entirety at addendum 12, but for purposes of this amicus brief, three key points are reiterated here. First, there no longer exists a credible debate that addiction is anything other than a chronic recurring illness. He explains that addiction is a brain disease like any other brain disease.

> Over time the addict loses substantial control over his or her initially voluntary behavior, and it becomes compulsive. For many people these behaviors are truly uncontrollable, just like the behavioral expression of any other brain disease. Schizophrenics cannot control their hallucinations and delusions. Parkinson's patients cannot control their trembling. Clinically depressed patients cannot voluntarily control their moods. Thus, once one is addicted, the characteristics of the illness--and the treatment approaches--are not that different from most other brain diseases. No matter how one develops an illness, once one has it, one is in the diseased state and needs treatment.

Alan Leshner, "Addiction is a Brain Disease." Addendum 12 at 3. He further explains that although addiction starts with a voluntary act, it is no less a disease than many others in which the onset of the disease is heavily influenced by the individual's behavior such as cardiovascular diseases, diabetes and some forms of cancer. Id.; Addendum 12 at 4.

The important second point is that the old debate of whether a specific drug is "physically" or "psychologically" addicting is irrelevant to today's science. He explains that "[w]hat really matters most is whether or not a drug causes what we now know to be the essence of addiction: uncontrollable, compulsive drug

craving, seeking and use, even in the face of negative health and social consequences." Id.; Addendum 12 at 2.

Finally, the third point critical for this Court's analysis in this and future cases involving lawyers and judges is perhaps the most controversial and yet the most important for LHL. He states:

> The message from the now very broad and deep array of scientific evidence is absolutely clear. If we as a society ever hope to make any real progress in dealing with our drug problems, we are going to have to rise above moral outrage that addicts have "done it to themselves" and develop strategies that are as sophisticated and as complex as the problem itself. Whether addicts are "victims" or not, once addicted they must be seen as "brain disease patients."
>
> Moreover, although our national traditions do argue for compassion for those who are sick, no matter how they contracted their illnesses, I recognize that many addicts have disrupted not only their own lives but those of their families and their broader communities, and thus do not easily generate compassion. However, no matter how one may feel about addicts and their behavioral histories, an extensive body of scientific evidence shows that approaching addiction as a treatable illness is extremely cost-effective, both financially and in terms of broader societal impacts such as family violence, crime, and other forms of social upheaval. Thus, it is clearly in everyone's interest to get past the hurt and indignation and slow the drain of drugs on society by enhancing drug use prevention efforts and providing treatment to all who need it.

Id.; Addendum 12 at 7.

Unfortunately, addiction is a tragic, progressive, and incurable disease. Nonetheless, with treatment and support, the addict may be able to have a normal, healthy, and productive life. Dr. Leshner's article and the NIDA research inarguably support this reality.

IV. RECOVERY IS MITIGATION.

SUPREME COURT RULES OF PROFESSIONAL PRACTICE

Chapter 15. Standards for Imposing Lawyer Sanctions.

6.3. Mitigating circumstances.

Mitigating circumstances are any considerations or factors that may justify a reduction in the degree of discipline to be imposed. Mitigating circumstances may include:

> (i) mental disability or impairment, including substance abuse when:
>
> > (1) The respondent is affected by a substance abuse or mental disability; and
> >
> > (2) The substance abuse or mental disability causally contributed to the misconduct; and
> >
> > (3) The respondent's recovery from the substance abuse or mental disability is demonstrated by a meaningful and sustained period of successful rehabilitation; and
> >
> > (4) The recovery arrested the misconduct and the recurrence of that misconduct is unlikely.

LHL makes an important observation that substance abuse, chemical dependence and addiction as a brain disease are permitted as appropriate mitigation as noted above and urges this Court to emphasize these considerations in reviewing and assessing appropriate discipline in such cases before the Court.

LHL, nonetheless, cautions that the word "recovery" means more than just abstinence. As presented by Dr. Stephen Glenn at an LHL sponsored CLE event in December of 2003, "Abstinence is not recovery; it is only a prerequisite to recovery. Recovery is healthy living, changing the lifestyle that permitted the

abuse to occur." Full examination into the commitment to recovery and the effort and time extended in the recovery effort is critical for successful recovery and reducing opportunities for relapse.

V. RELEVANCE THAT ADDICTION IS A DISEASE AND THAT RECOVERY IS MITIGATION.

While Dr. Leshner makes clear that recovery from the abuse and addiction of drugs, like any disease, is a lifetime effort, he also establishes that addicts can resume otherwise normal and healthy lives. With sincere efforts to a new lifestyle and sufficient support, an addict can return to productive living and worthwhile contributions. Likewise, Rule 6.3(i) of the Standards Governing Lawyer Discipline permits deviations from the more serious sanctions available due to substance abuse or mental disability and if a cause of the misconduct. Considerations to mitigate the disciplinary sanction and to restore an attorney to his career are especially appropriate when such evidence is apparent.

LHL urges this Court to interpret Rule 6.3(i) in a fashion that accepts the insight offered by Dr. Leshner and NIDA, discussed above in Point III. His pragmatic encouragement that we rise above and not quibble over whether the addict has "brought it on himself," when coupled with the fact that mitigation evidence of recovery efforts is permitted in mitigation and approved by this Court, operates to give hope and promise to those battling the disease of addiction.

A corollary to this last point would be for the Court to emphasize less the "when" or "how" the attorney or judge comes forward seeking assistance—whether pre-arrest or post-arrest, whether of his own volition or forced by the family or by the firm—and focus instead on the result effected by the seeking of treatment and the current ability to lawyer and/or to judge. This premise is particularly true in those cases where no client has been harmed.

LHL does not suggest that consequences for behavior are not appropriate; they are indeed required as part of most treatment models and healthy approaches to continued successful rehabilitation. LHL only suggests that those consequences be tempered with the recognition of the disease model and that unlawful acts be handled in the usual and customary fashion of criminal court and other less severe disciplinary measures.

Likewise, LHL contends that the discipline also be commensurate with the disease model and that appropriate discipline be pronounced in a fashion that promotes others to seek assistance as early as possible, recalling that often the "possible" for the brain-diseased addict is measurably different than the non-addict might surmise.

An interesting decision from the Texas Supreme Court further utilizes the adoption and placement of a LAP to determine that a drug possession and use charge is not a crime involving moral turpitude. In In re Lock, 54 S.W.3d 305 (Tex. 2001), the court rejected the decision of the Texas disciplinary board and ruled that the existence of a LAP was inconsistent with the need for the

compulsory discipline on possession or use charges as ordered by the board (suspension for the term of probationary with automatic disbarment if that probation was revoked). The Texas court noted that the Texas Bar Association sponsored a LAP program which permitted impaired attorneys to confidentially seek help and work on recovery issues while still practicing law without being subject to discipline. Id. at 312. The court reasoned accordingly that the sponsorship of the LAP by the bar association, under the ultimate supervision of the supreme court, required that the court find that possession of a controlled substance was not a crime of moral turpitude. Id.

The court insisted that the ruling did not mean that an attorney's possession of, or use of, drugs would go undisciplined, but only that the discipline would be sanctioned at a reduced degree in the more standard grievance process. Id. The existence of the LAP Program permitted the court appropriately to reduce the measure of the discipline, and that order simultaneously sent a message to all members of the Texas Bar that seeking treatment for a disease would be advantageous to not only the health of the attorney, but his career as well.

LHL requests this Court in this decision to send the same message to Utah Bar members: that treatment for substance abuse is preferable and, if done soon enough, even possibly career-saving. While it might be suggested that the same message could be sent by the imposition of severe sanctions designed to deter conduct, LHL believes that such an order, particularly after a more positive decision initially from the screening panel, would do nothing more than chill

observers who are considering reaching out for needed assistance from their addiction.

VI LHL PROGRAM AND THE CRITICAL IMPORTANCE OF CONFIDENTIALITY

> LHL received the following anonymous email from a Bar member:
>
> I don't know where to start. I am either depressed and so I abuse prescription drugs, or else, I am an addict. I abuse narcotics including [ ]. [ ] I have a successful [ ] law practice, which I don't think has been impacted by my problem—yet.
>
> I am familiar with AA and NA. I just don't know what to do. What kind of services do you offer? Can you set me up with a therapist? Or make recommendations as to how to successfully withdraw from the drugs? I do NEED to maintain my confidentiality. Thus, the bogus email account, and the slow progress.

Email received at email address of LHL director within last 8 months (email has been edited to remove any potentially identifying information).

This email highlights a critical concern existing among members of the Bar who seek help but are so preoccupied about identification and potential repercussions that the existing problem exacerbates causing even more stress and delay in essential treatment. Here in this email, the need to seek relief as recognized by the intellect is subordinated to the lawyer's desire to get help only if anonymity is guaranteed. While our Rule 8.3 of the Rules of Professional Conduct[13] was amended in 1990 to expressly identify Lawyers Helping Lawyers as an approved Lawyers Assistance Program, and while our Bar and this Court

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[13] This Rule is contained in its entirety with accompanying Comment and Advisory Opinion at Addendum 13.

have approved the creation of LHL as a full time LAP, a more meaningful message from this Court would be sent to current and future LHL contacts through a clear decision recognizing appropriate recovery mitigation without imposition of the most drastic of disciplinary consequences.

Implicit in this request of the Court is the need for attorneys and judges to actually feel comfortable to contact LHL knowing that our Court has accepted the disease model and formally recognized rehabilitation as mitigation. They must have confidence in the confidentiality promise.[14]

Second, lawyers and judges must feel comfortable in making referrals to LHL knowing that both the contact they make with LHL and the person in need will be respected and treated with complete confidentiality, independence and professionalism. This mandate would dictate even more meaningful LHL sponsored CLE events involving lawyers and judges to both educate to the serious debilitating nature of these problems and the resources to combat them. Lawyers and judges additionally must be trained to recognize the debilitating effects of alcohol, drugs, stress, depression and the like occurring amongst their colleagues; and such a decision would create a trust in LHL so that members feel confident in their referrals and participation with LHL.

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[14] One of the other recommendations of the ABA evaluation is to expand the confidentiality promise by adding statutory guarantees of privilege and immunity for those who participate in LHL. The LHL Board is working on drafts to propose to the Bar and this Court for consideration and approval.

CONCLUSION

For any or all of the foregoing reasons, LHL respectfully requests that this Court author its decision in the above entitled manner reflecting and considering the issues of the disease of addiction and importance of recovery contained herein.

RESPECTFULLY SUBMITTED this 21st day of April, 2004.

RICHARD G. UDAY
Director, Lawyers Helping Lawyers

CERTIFICATE OF DELIVERY

I hereby certify that on this 21st day of April, 2004, I caused to be hand-delivered two true and correct copies of the forgoing Amicus Curiae Brief to the following:

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The above described copies were delivered this ____ day of April, 2004.

Addenda

Addendum I

A LOOK AT
LAWYERS HELPING LAWYERS

By Richard G. Uday

(Reprinted from the January/February 2003 Utah Bar Journal.)

The Editors and Staff of the Utah Bar Journal have graciously announced their intent to dedicate the August issue of the Utah Bar Journal to the pursuits and purposes of Lawyers Helping Lawyers ("LHL"). Dr. Lynn Johnson's article on Stress Management makes reference to LHL so this article is intended as a brief background of LHL and how we got started. This article also takes a quick glance at what we are doing at LHL, what we have planned and what to look forward to in that upcoming August issue of the Utah Bar Journal.

In 1988 the Board of Governors of the ABA created a commission to assist lawyers and judges to overcome the problems of addiction and substance abuse. The ABA encouraged each state bar association to create a lawyer assistance program to aid those lawyers and judges whose lives and practices are jeopardized by the problems of substance abuse.

In 1996 the ABA's Commission on Lawyer Assistance Programs ("CoLAP") expanded services to include helping with problems stemming from stress, depression and other mental health issues. More recently CoLAP has assisted and encouraged the state bar programs to include services for those members of the profession who encounter other debilitating problems such as gambling addictions, professional burnout, internet addictions, sexual addictions and a variety of compulsive disorders.

Lawyers Helping Lawyers ("LHL") is the Utah Lawyer Assistance Program created originally as a committee within the Bar. In 1990 the LHL Committee sought and received an amendment to Rule 8.3 of the Rules of Professional Conduct specifically exempting LHL members from the duty to report misconduct they learn about through their work with LHL. Accordingly, all contacts with LHL are completely confidential. Rule 8.3(d) and the commentary that follows the rule provides that, when appropriate, members of the profession may choose to contact LHL as a practical alternative to meet the ethical obligation to report misconduct.

Once contacted, LHL functions as a clearinghouse to elicit and arrange help from a network of professionals who can confidentially advise and assist members of the Bar to successfully deal with the debilitating issues discussed above as well as to enhance their lives and practices in other ways.

In 2001 the Utah State Bar gave the LHL Committee a small grant to reorganize from its committee status at the Utah Bar to a not-for-profit corporation to assure independent and confidential assistance to any Utah lawyer or judge whose professional or personal life might be impaired due to addiction, mental health issues or substance abuse. (Visit our website for more information: www.LawyersHelpingLawyers.org)

We have substantiated the obvious at LHL confirming that the more visible we are, the more calls we receive. Understandably, we are excited that the Utah Bar Journal will dedicate the August 2003 edition to Lawyers Helping Lawyers and provide us the additional visibility. Members can expect in that edition to read more from Dr. Lynn Johnson on specific how-to tips for successfully reducing and handling the stress and pressures of law practice. Additionally, LHL will contribute articles on a variety of topics aimed at enhancing the law practice and the quality of life for members of the Bar.

LHL also intends to include in the issue some success stories of lawyers and judges who have confronted substance abuse and mental health issues and who have overcome those problems and continue in successful recovery as talented and wonderful members of our legal profession.

Just last month (December 11-13, 2002) the ABA sent out the Chair of CoLAP and two CoLAP commissioners to review and evaluate the program at LHL. During the evaluation process, the ABA Commissioners spoke with Bar leadership, representatives from the courts, the law school deans and others. The August issue will also contain a report on the results of that evaluation.

Stay tuned for more about LHL, but in the meantime, consider Dr. Johnson's concluding remarks in his article about managing stress:

> Do not tolerate high levels of stress in your life. If you are experiencing emotional symptoms or if you are using alcohol or drugs to cope with stress, the Lawyers Helping Lawyers program can be of great service to you. It really is quite feasible to live a happier, more productive and more fulfilling life.

Contact LHL at 579-0404 or in state 1-800-530-3743.

Addendum 2

The History and Purpose of Lawyers Helping Lawyers

by LHL Director, Richard G. Uday

(Reprinted from the August/September 2003 Utah Bar Journal.)

In 1988 the Board of Governors of the American Bar Association ("ABA") created the Commission on Impaired Attorneys to assist lawyers and judges whose lives and practices were impacted negatively by the abuse of alcohol and/or drugs. In 1996 that name was changed to the Commission on Lawyer Assistance Programs ("CoLAP") to both remove the stigma implied in the earlier name and to indicate the expanded role of the program to include lawyers and judges suffering from stress, depression and other mental health problems. (Statistical information supporting the ABA's decision to announce this program is contained in a second article I have written included elsewhere in this volume of the Utah Bar Journal.)

The ABA encouraged state bars to create a similar program within their associations to provide the much need service to members. CoLAP functions as the guiding resource to the state programs to better assist the individual lawyer and judge in need. To assist the states, CoLAP has created a model LAP for states to review and incorporate into their programs. CoLAP encourages the state affiliate to function as a clearinghouse to elicit and arrange help from a network of available professionals who can confidentially advise and assist members of the Bar to successfully deal with the debilitating issue(s) impacting them as well as to enhance their lives and practices in other ways. (See our web site at www.LawyersHelpingLawyers.org for additional information.)

The Utah Bar Association ("the Bar") accepted the challenge from the ABA and organized a Bar Committee who identified themselves as the Lawyers Helping Lawyers Committee ("LHL") to tackle this daunting task. Historically, the LHL Committee has been quietly active since the late '80s assisting lawyers and judges with addiction, substance abuse and issues affecting mental health. Since my involvement in 2001, I have heard numerous stories from judges and lawyers about the work the various LHL Committees have accomplished over the years. The lives of numerous attorneys and judges have benefited tremendously from the good work and service this volunteer committee has performed over the years.

In 1990 the LHL Committee urged and obtained an amendment to Rule 8.3 of the Utah Rules of Professional Conduct specifically exempting LHL members from the duty to report misconduct learned by them through their work with LHL. Accordingly, all contacts to LHL are completely confidential. Rule 8.3 and the commentary that follows the rule provides that, when appropriate, members of the profession may choose to contact LHL as a practical alternative to meet their ethical obligation to report misconduct.

As a committee LHL was as active as time permitted the particular committee volunteers to be. While great work was being accomplished by the committee, more needed to be done. In 2000 the committee approached the Bar with its decision to reorganize as a not for profit corporation in an effort to enhance its ability to serve members in an unquestionably confidential and independent manner separate and apart from the confines of the Bar. This option was further intended to bring itself more in line with the model LAP as recommended by the ABA. In 2001 the Bar responded and provided a $20,000.00 grant to LHL to begin the process.

I was hired as a part-time director of LHL in August of 2001. In December of that year LHL sponsored its first annual, 3 hour, Ethics Seminar. 2001 was a heavy reporting year for CLE and on a Friday afternoon, at the Law and Justice Center, approximately 170 lawyers were in attendance. They were a captive audience and we took advantage to educate the group about the purposes and justifications of LHL. Speakers Justice Matthew B. Durrant and then Bar President Scott Daniels spoke about LHL and its relationship to professionalism. Our concluding speakers were a representative from CoLAP who discussed the national program and state responses and successes, and Dr. Lynn Johnson who addressed the group on the topic of lawyers, judges and stress. He discussed recognizing stress in others, in ourselves and how to more effectively handle stress for more enjoyable and rewarding lives and practices.

The response to the Seminar was positive, in two important ways. First, the reaction was very encouraging as lawyers and judges in attendance seemed genuinely interested in receiving CLE credit for discussing quality of life issues. Second, and even more important, a number of phone calls requesting assistance were received at LHL in the immediate two weeks following the seminar. Importantly, these two successes represent two of the important purposes that LHL, applying the CoLAP guidelines, has established as program goals.

LHL's mandate from the ABA is to assist attorneys and judges in need to find suitable and appropriate professional guidance for the difficulties they are experiencing. We attempt to accomplish this all important task by establishing a network of professional resources in the community who are adept and available to work with lawyers and judges in a confidential and competent fashion. Implicit in this mandate is the need for attorneys and judges to feel comfortable to contact LHL and request assistance knowing that their inquiry will be dealt with in a completely confidential and professional manner.

Second, lawyers and judges must be able to recognize the debilitating effects of alcohol, drugs, stress, depression and the like amongst their colleagues. Lawyers and judges must feel comfortable in making referrals to LHL knowing that both the contact they make with LHL and the person in need will be respected

and treated with complete confidentiality, independence and professionalism. This mandate dictates that LHL be very active in CLE programs involving lawyers and judges to both educate to the serious debilitating nature of these problems and to create a trust in LHL so that members feel confident in their participation with LHL.

A closely related goal that the ABA and LHL recognize is the need to assist the efforts in place to upgrade professionalism within the Bar. Statistics demonstrate that a high percentage of discipline cases occurring in most state Bars, and Utah is no exception, have addiction, substance abuse and mental health problems at their base or root cause. Oregon, for example, recently conducted a study which verifies that an active LHL program saves the Bar literally hundreds of thousands of dollars each year. (This data is supplied in the second article I've written elsewhere in this volume)

Said more simply, LHL is here to assist attorneys and judges directly and/or indirectly by means of arranging assistance or arranging CLE opportunities. Additionally, LHL benefits the practice of law by importantly contributing to the protection of the public and to the continued improvement in the integrity and reputation of the legal profession. Providing needed assistance to lawyers with impairment often prevents future ethical violations resulting in the reduction of disciplinary actions against Bar members. To that end LHL has been active in traveling the state to speak with Bar sections and local Bar associations, as well as, our state Bar's mid-year and annual conventions. Most members who have attended these CLE's have noted positive comments and appreciated the important impact of discussing quality of life topics geared to give practical advice to improve the enjoyment of our legal careers and our lives in general.

One such seminar occurred in early 2002 when LHL sponsored the lunch-time CLE for the Litigation Section. LHL introduced Dr. Corydon Hammond from the University of Utah who addressed the group on reducing stress and relaxation exercises. Dr. Hammond spent about 20 minutes of his time in a relaxation technique that lawyers and judges could utilize during the work day to more effectively deal with the stresses of the job. Some lawyers and judges participated by taking the invitation from Dr. Hammond to lie on the floor; most just closed their eyes and relaxed in their chairs. Dr. Hammond then methodically walked us through a process, almost hypnotic-like, which twenty minutes later left the group refreshed and with a new technique to employ on one of those days we too routinely encounter. One attendee noted that he had fallen asleep in many a CLE, but never quite so rewardingly.

In December of 2002 LHL hosted three ABA CoLAP Commissioners who traveled to Utah to evaluate LHL as a program. (Included within this edition of the Utah Bar Journal is an article by one of those Commissioners, Ann D. Foster,

who also directs the Texas Lawyers Assistance Program.) Involved with this evaluation were members of our Supreme Court, the Utah Court of Appeals, Bar leadership including both the then current Bar President John A. Adams, and Bar President-Elect Debra Moore, Mr. Billy Walker and Mr. Colin Winchester from the Office of Professional Conduct and the Judicial Conduct Commission, respectively. Also participating were numerous Bar Commissioners, the Dean of each law school within the state and several committee members of LHL. The evaluation resulted in the ABA's preparation of a 16 page report.

The results of that evaluation were analyzed by our Supreme Court and our Bar leadership and after much discussion the Commission Highlights of our June/July Volume of the Utah Bar Journal reported acceptance by the Commission of most recommendations from the ABA. The Commission elected to fund the program to assure continued and stable operation of LHL on a full-time basis. This decision will assure independent and confidential assistance to any Utah lawyer or judge whose professional or personal life might be impaired due to addiction, mental health issues or substance abuse.

It is my personal belief that this decision to fund LHL full-time will, with time, be recognized as a courageous and responsive decision to the times in which we live. This news is, in fact, historic. For years to come, lawyers and judges will receive a members' benefit that will be immeasurable in the savings of lives and law practices, increased quality of services to clients and dollars gained through CLE education and savings in disciplinary costs. LHL both thanks and congratulates our Court and Bar leadership in this decision.

Likewise, the ABA is pleased to move Utah from the minority of seven states without a full-time program to the group of state Bars forming a coalition to assist lawyers and judges with practical and professional assistance with the debilitating problems facing us today.

Importantly, LHL has enjoyed an increase in contacts since moving to a part-time program. In not quite two years LHL has received 53 formal contacts. This number represents a significant increase from the numbers observed while structured as a committee section of the Bar. Those numbers represent actual individuals, members of the Utah Bar who have experienced struggles and reached out for assistance. Some have been serious. Some have been less serious. There have been wonderful successes among these numbers. There are touching and promising works in progress represented by these numbers. Unfortunately, there are heartbreaking failures included in these numbers, as well.

One such failure was the tragic suicide of an attorney, a husband and father, who took his life within a short time of his court-ordered disbarment. LHL, regrettably, was unaware of his predicament until after his death. Frankly, there

have been failures to maintain contacts with needed assistance. I apologize for those times we may have let some one down. The move from part-time to full-time will hopefully alleviate many of those failures and provide the more stable and consistent program the ABA recommended and the Commission contemplates us to be. LHL is committed to our purpose and we will strive to serve the members of the Bar the best we can.

Two final thoughts: First, we need members of the Bar to help us succeed in our tasks. We need volunteers to be on our lists of available contacts to work with lawyers and judges who are experiencing particular difficulties. If you have survived or are surviving a stress inducing experience and are willing to be available as a mentor or someone to talk to when that event(s) happens to someone else, please contact LHL and offer your experience and compassion. Likewise, if you are experienced with recovery and able to confidentially assist someone who has started down that road, please contact LHL and let us know of your availability to sponsor or take a call and discuss your recovery with someone who can benefit from your experience.

I share a quick story to establish the tremendous resources we have available to help those in need by looking within our Utah Bar. I recently presented an LHL program at the Law and Justice Center to new lawyers attending a mandatory CLE. I extended the offer just made here and after the presentation I was approached by a lawyer who shared with me her willingness to speak with and help others. She explained that she had just very recently lost a family member to suicide. As she explained what happened, she became a bit emotional as one might imagine. As I stepped toward her offering my condolences a second lawyer standing near me also stepped forward. After apologizing for overhearing our conversation and interjecting, she amazingly shared with us that she too had similarly lost a family member to suicide some time ago. The two left together talking about their experiences in common and I'm sure they have spoken since then as well. Be that person; it was a beautiful moment to watch.

Finally, please read the stories and articles in this volume of the Utah Bar Journal. These are true stories about Utah lawyers and judges. Some of them have elected to remain anonymous, but that fact does not distract from the powerful messages they provide us. We face significant problems as lawyers and judges and we need to be able to recognize them and talk openly with one another about them. Editors and Staff of the Utah Bar Journal should be commended for their support and their vision in featuring LHL in this volume.

Addendum 3

How LHL Works

(Reprinted from the August/September 2003 Utah Bar Journal.)

All contacts with Lawyers Helping Lawyers are completely confidential.

LHL's primary purpose is to assist lawyers and judges in recovery. The Secondary purpose of LHL is to assist lawyers and judges with quality of life issues confronting them through the stress and pressures of life and the practice of law.

LHL operates as a clearinghouse to help the lawyer or judge to find the professional assistance necessary and best suited for the issue presented. To that end, LHL maintains a network of treatment providers and professional services available throughout the State.

Anyone who calls LHL can be assured that COMPLETE CONFIDENTIALITY will be maintained. Utah's Rules of Professional Conduct expressly recognize LHL as an approved lawyers' assistance program.[1] By virtue of this recognition, LHL members are relieved of the duty to report ethical violations discovered as a result of their LHL work. This important exception to Rule 8.3 means that any misconduct or ethical violation discovered or revealed to a member of LHL will NOT be reported to the Office of Professional Conduct, an employer or anyone else.

Not only is confidentiality maintained, but so is the anonymity of the caller and the contact. The LHL office is independent from the Bar and is located separate and apart from the Law and Justice Center. LHL does not maintain records as to the personal information of the callers or the contacts. The only information maintained by LHL are the statistical data relating to the number of calls and general nature of the calls.

Federal regulations on privacy and confidentiality of alcohol dependency, chemical dependency and mental health information are adhered to by LHL. The LHL network consists of many attorneys who have themselves recovered from their own dependency issues or through training and experience have successfully dealt with depression, stress or other career related problems.

A lawyer, judge, member of the legal community or any family member of such may access the program by calling the confidential phone lines of LHL at 579-0404 or 1-800-530-3743 and speak directly to director Richard Uday, or his assistant, Karianne Jensen. You may also feel free to contact any LHL Board Member listed below, or visit LHL on the worldwide web at www.LawyersHelpingLawyers.org.

Stanley S. Adams Phone: (801) 363-0177	Michael E. Bulson Phone: (801) 394-9431	Louis H. Callister, Jr. Phone: (801) 530-7322
Roberto G. Culas Phone: (801) 377-7783	Les D. Curtis Phone: (801) 356-3313	Richard M. Dibblee Phone: (801) 297-7029
Dr. Vickie R. Gregory Phone: (801) 272-1977	Michael K. Jones Phone: (801) 254-9450	Rebecca R. Long Phone: (801) 328-1162
Suzanne Marychild Phone: (435) 753-7400	Jack M. Morgan Phone: (801) 531-7444	Douglas L. Neeley Phone: (435) 835-5055
Hon. Kenneth Rigtrup Phone: (801) 466-5900	Carolyn D. Zeuthen Phone: (801) 621-3646	Roger F. Cutler (Chair) Phone: (801) 277-0357
Peter Van Orman Phone: (801) 830-2189		

[1] Rule 8.3(d), Rules of Professional Conduct, Utah Code of Judicial Administration.

Addendum 4

A Newsletter from The ABA Commission on Lawyer Assistance Programs

Volume 5 Number 2 • Spring 2002

Highlights

of the American Bar Association Commission on Lawyer Assistance Programs

Mark Your Calendar

August 9 -10, 2002
CoLAP Business Meetings
during ABA
Annual Meeting
Washington, DC

Web-site: http://www.abanet.org/legalservices/colap/home.html

Steve Barrett, *Highlights* Editor

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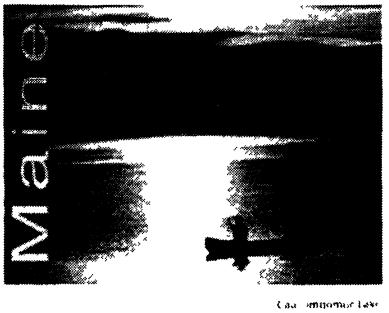
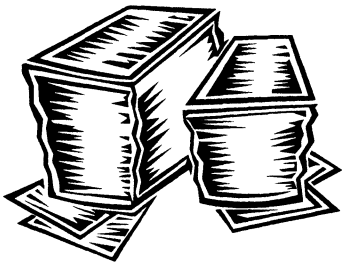


Defending Liberty
Pursuing Justice



New Study Shows Recovery Saves Dollars

by Ira Zarov and Barbara S. Fishleder

Editor's Note—*The following article contains unique statistical information from Oregon. Oregon is the only U.S. state that has a mandatory legal malpractice fund. Oregon's assistance program, The Oregon Attorney Assistance Program, is part of this unique bar-related fund. These relationships have allowed Oregon to correlate the incidence of discipline complaints and malpractice claims for lawyers before and after recovery, while still maintaining the lawyer's confidentiality. We publish this article with the hope that the documented low discipline and malpractice claim rates of lawyers in recovery will encourage disciplinary agencies and legal malpractice carriers to support assistance programs.*

The humanitarian reasons for state bars and others to fund attorney assistance programs for attorneys who suffer from alcohol or drug dependency have always been self-evident. The emotional and physical damage that untreated alcohol and drug dependency does to individuals, families, and colleagues is just too devastating to ignore. But the other fundamental rationale for assistance programs—that they simultaneously save dollars and protect the public—has been an assumption previously unsupported by concrete data. Now, a newly-released study by the Oregon Attorney Assistance Program (OAAP) provides convincing evidence that getting lawyers into recovery saves dollars as well as lives—and protects the public. The OAAP, funded by the Oregon State Bar Professional Liability Fund, provides a broad range of services to attorneys including assistance with alcoholism and chemical dependency.

The OAAP study, completed in 2001, involved 55 recovering lawyers who were in private practice for five years before their sobriety dates and five years after their sobriety dates, a ten year period in all. The first portion of the study compared the incidence of malpractice claims for each of the five-year periods, while a second portion looked at discipline complaints. In order to assure that the identity of the recovering lawyers would remain confidential, the study was conducted by OAAP program attorney Michael Sweeney.

During the five years before sobriety, the 55 lawyers had 83 malpractice claims filed against them. The number dropped dramatically—to 21 claims—in the five years after sobriety. This represents a 30 percent annual malpractice rate before sobriety and an 8 percent rate after sobriety. The same lawyers had 76 discipline complaints during the five years before sobriety and 20 discipline complaints during the five years after sobriety. This represents a 28 percent annual discipline complaint rate before sobriety and a 7 percent discipline complaint rate after sobriety.

The study shows that malpractice and discipline complaint rates for lawyers before recovery are nearly four times greater than lawyers in recovery. In addition, applying Oregon's average malpractice cost per claim ($16,500) to claims made against the 55 lawyers in the study, the reduced incidence of malpractice resulted in a savings of approximately $200,000 per year—attributable to just 55 lawyers in recovery! The costs to the Oregon State Bar disciplinary process are less quantifiable, but it is obvious that sobriety brings savings that follow from the reduction in discipline matters in need of prosecution.

Lawyers in recovery also have lower malpractice and discipline complaint rates than the general population of lawyers. In Oregon, the current annual malpractice claim rate for lawyers in private practice is 13.5 percent, compared to the 8 percent for lawyers in recovery; the current annual discipline complaint rate for Oregon lawyers is 9 percent, compared to 7 percent for lawyers in recovery.

(continued on page 2)

Message From the Chair

by John W. Clark, Jr.

A few weeks ago, the Commission distributed our Directory for the ABA Bar year 2002. Naturally, the Directory lists the members of the Commission, our telephone numbers, e-mail addresses, and the usual information that is found in any directory. Today, however, I want to draw your attention to another part of the Directory that lists the members of our Action Forum.

By some sort of Commission magic, we have created an Action Forum that serves as an Advisory Group to our Commission. Members of the Commission are appointed by the President of the American Bar Association for a one-year term. Members of the Action Forum are appointed by the Chair of the Commission for a one-year term.

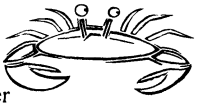
We are lucky and fortunate to have an interested, involved, and active group serving as members of the Action Forum this year and I want to thank them for their volunteer help.

Some of the people serving on the Action Forum are well known to all of us-people like Ed Blewer and Michael Cohen. Others are less well known, and this year included people like Betsy Hathaway, Bill Ide and David Brink. David Brink and Bill Ide are both former Presidents of the American Bar Association, and Betsy Hathaway is an active mother, volunteer, and participant in the recovery community. All of these people have a special place at our table, and each one of them has contributed to the activities and the services that are provided by our Commission.

Some of the members of the Action Forum will continue on with us into next year and some new faces will be rotating on the Action Forum so that we can expose ourselves to fresh, new ideas and solutions.

I especially want to thank former Commission member Linda Teplin and Action Forum members Harriet Turney and Ann Foster for completing work on the long awaited Survey of State and Local LAPs. By the time you read this column, the Survey should be in your hands, and these three women have carried the burden of getting the Survey to market.

Today I was asked to find a speaker to address the subject of suicide. Just a few years ago that subject would not have been considered within the jurisdiction of the Commission, but I now consider suicide and other mental health issues to be part of our everyday assignment, and there is a growing body of LAP directors capable and ready to speak on these subjects. Addiction and mental health issues are now clearly within our jurisdiction. I don't know where we will be a year from now, but I know it will be an exciting ride.



I hope many of you will find a way to be with us in Maine and that we can lure you to attend our Winter Meeting. The location and time have not yet been set, but I can assure you there will be no snow on the ground wherever we meet.

Please let us hear from you if there are issues and matters that you think we should be addressing. We want to be helpful to LAP Directors, volunteers and all our new friends.

Study Shows Recovery Saves

(continued from page 1)

The Oregon study is consistent with other studies looking at related questions. For example, an Illinois study indicated that 40-70% of discipline cases involved chemically dependent or mentally ill practitioners. A study of the Client Protection Fund cases in Louisiana found that 80% of their cases involved chemical dependency or gambling. A similar study in Oregon found that 80% of the Client Security Fund cases involved chemical dependency, gambling, or mental health issues.

In view of the effectiveness of attorney assistance programs as reflected in the recent OAAP study, it is important that state bar organizations and companies involved in loss prevention develop approaches to alcohol and chemical dependency problems that take advantage of the benefits assistance programs offer. One obvious step is for bar organizations to help in making the extent of the problem, and the benefits of treatment, known within the legal community. Consistent with that goal, it would show foresight to grant CLE credits to programs that provide information about alcohol and chemical dependency and the attorney assistance programs available to address the issues. It is doubtful that any single educational effort would be more likely to assure the competency of attorneys than one that helped impaired attorneys seek treatment. Diversion programs for impaired lawyers who are subject to the disciplinary process, as already operated by some states, might also be effective in facilitating long-term solutions to problems that follow alcohol or chemical dependency.

It is clear from the OAAP study that alcohol and chemical dependency is a root cause of both malpractice and discipline complaints and that the accompanying costs are great. A State of Washington study found that the prevalence rate of alcohol and chemical dependency among attorneys is 18 percent. The new OAAP study buttresses this finding and makes action imperative. The costs to the bar in lost dollars because of malpractice claims and discipline claims, and in the loss of favorable public opinion and reputation because of ethical violations, are far too high.

Ira Zarov is the CEO of the Oregon State Bar Professional Liability Fund. Barbara S. Fishleder is the program director for the Oregon Attorney Assistance Program and the director of loss prevention for the Professional Liability Fund.

Highlights is a quarterly newsletter published by the American Bar Association Commission on Lawyer Assistance Programs for the news and information exchange needs of the lawyer assistance programs community. Comment and proposed articles should be directed to spilisd@staff.abanet.org. ISSN Pending.

Addendum 5

Stress Management

Lynn Johnson, Ph.D.

(Reprinted from the January/February 2003 Utah Bar Journal.)

Stress makes you stupid.

I know many attorneys who don't believe that. They think that when they are angry, upset, or under stress, their minds are sharper and more focused.

They are wrong.

When I went to graduate school, we knew the names of all the parts of the brain, but we knew relatively little about what they did. Today we know far more, and one thing we know is that when your brain is on stress, the higher centers of the brain – the prefrontal lobes of the cerebral cortex – begin to shut down, and the unreasoning, emotional parts of your brain ramp up. There are three modes of stress response, flight, flight, and freeze. None of them help make you smarter.

When Rich Uday asked me to help with his Lawyers Helping Lawyers program, I admired his taste in consultants. Who better? Then humility intruded. I am not a lawyer, I am a psychologist, and I need to have some background. I started researching the role of stress in the lives of attorneys, and found some sobering facts:

> Lawyers have a high rate of drinking and drug problems; 1 ½ times the national baseline. 8-10% of general population has a substance abuse problem vs. 15 - 18% of attorneys.
>
> In another study, 13% of male and 20% of female attorneys reported downing six drinks or more per day. If you don't think six drinks a day is a problem, we need to talk!
>
> A study at Johns Hopkins University found that attorneys are 3.6 times more likely to suffer from depression than other professions. Depression is a very serious illness, with a high mortality rate.
>
> Male attorneys are twice as likely as the general population to take their own life, according to a 1992 study by the National Institute of Occupational Safety and Health. Depression and substance abuse are both substantial risk factors for suicide. Research conducted at Campbell University in North Carolina indicated that 11 percent of the lawyers in that state thought of taking their own life at least once a month.
>
> In surveys of state Bar Associations, 60% of ethical violations involved substance abuse.

What's Behind the Stress?

Two major factors (and a host of minor ones) contribute to the high stress in the law profession. First, the stakes are high and the consequences of error are large. This promotes an attitude of perfectionism, a chronic feeling that nothing is good enough. Perfectionism raises cortisol levels in the body, the stress hormone that is helpful in the short run and very damaging in the long run. High cortisol levels lead to burnout, vulnerability to infections, increased healing time, and mental and emotional depression. Perfectionists are more vulnerable to depression and anxiety, harder to treat with either therapy or drugs, and much more likely to commit suicide

when things go very wrong.

Second, law may attract pessimistic personalities. One study found that in every graduate program, optimistics outperform pessimists, except in law. There, the pessimists are ascendant.

But pessimism is another risk factor for high stress and chronic depression. Pessimists expect bad things to last a long time, to affect every part of their lives, and the see themselves as the cause of bad things happening. Pessimistic lawyers are doubly at risk, since they are likely to see bad things happen, and they are less able to cope with they do.

As a result of the professional push toward perfectionism and the pessimism, many attorneys are not enjoying their career, feeling disillusioned and unhappy. They are at risk for underperformance, increasing stress, which increases underperforming. This vicious cycle can then turn to acting out in dangerous activities, affairs, drug or alcohol abuse, and ethical problems.

Ethics and Stress

Chronic high stress is a prime cause of ethical violations. When one feels out of control, unable to cope, and when one turns to substances - drugs and alcohol - to reduce the feeling of vulnerability, bad judgment follows. The Oregon Bar found that by energetically identifying and helping lawyers with drinking and drug problems, they were able to substantially reduce malpractice awards. It is clearly smart to take a proactive approach to reducing stress, to helping those who are depressed or who are relying on substances to cope.

Too often we shy away from talking directly to people who seem to be having problems. That is entirely understandable. Yet when we consider the higher levels of stress in the legal profession, we can see the necessity of reaching out.

As an analogy, consider the changes in cockpit management in aviation. Years ago, the person sitting in the left seat was the Pilot in Command, and his word was law. Copilots and engineers did not interfere. But in accident investigations it was learned that in case after case, the crew didn't like the way the flight was proceeding but they didn't speak up. Today, cockpit resource management rules encourage, even require that crew members assert their own opinions. Safe flight is everyone's responsibility, not just the pilot in command.

So it is with the law profession. Since the stakes are high and the stress ubiquitous, a higher level of concern and caring for colleagues is necessary.

Recognizing those who need help

In my own review of all the Lawyers Helping Lawyers programs in the country, most of the emphasis was on identifying and addressing substance abuse. I only found few that spoke of depression. This is a mistake. Anxiety and depression are serious problems in their own right, as well as being co-morbidity factors for alcohol and drug abuse. About one-third of patients diagnosed with alcohol abuse actually had a pre-existing anxiety condition that was a causal factor in the substance abuse. Here are some checklists to help you diagnose problems.

Signs of a Troubled Colleague

Attendance: arriving late, leaving early
Late returning or fails to return from lunch
Unexplained days off
Frequent injuries
Misses deadlines, court appearances

Productivity and quality of work declining
Blames others, defensive when questioned
Marital infidelity, affairs, sexual harassment of coworkers
Financial irregularities (co-mingling funds, borrows money from clients)
Client complaints - performance, attendance, attention, quality
Mood swings, erratic behavior, strong emotional reactions

Self Assessment

Ironically, it is to your advantage to become less tolerant of stress, not more. What I mean is that you ought to recognize danger signs and respond energetically to them, not tolerate them. In our next article, I will cover some positive coping strategies.

Rate yourself on the following items. Use this method of rating yourself: In the last seven days, did you experience this item?

0 Rarely or none of the time (less than 1 day).
1 Some or a little of the time (1 - 2 days).
2 Occasionally or a moderate amount of the time (3 - 4 days).
3 Most of the time (5 - 7 days).

Any 2 or 3 rating is cause for concern; if you have several of them (or, a score of 15 or more), you should get a good evaluation immediately.

___ I felt sad.
___ I felt fearful.
___ My sleep was disturbed.
___ My appetite was poor; I didn't feel like eating.
___ Things that used to please me felt flat or uninteresting.
___ There was a lump in my throat or knots in my stomach.
___ I feared I would lose control.
___ I felt like yelling or hurting others
___ I had thoughts of harming others.
___ I felt a sense of doom or dread.
___ I felt others didn't like me.
___ I couldn't stop thinking about something upsetting.
___ I felt hopeless about the future.
___ I couldn't get going on activities that were important.
___ I thought I would be better off dead.

Substance Abuse Warning Signs

These are <u>yes or no</u> items. Rather than rating them 0 -3, simply reflect on whether they are present at all. If you have any of the following, you clearly should have an evaluation of your drinking or drug use:

___ Are you able to drink more without feeling the effects?
___ Have you ever had "blackouts" i.e., when there are hours or days you cannot remember?
___ Do you desire to continue use when others stop?
___ Are you uncomfortable in situations where the substance is not present?
___ Are you preoccupied with use of alcohol or a drug?

___ Is there an urgency to use after a period without?
___ Do you have feelings of guilt about use/morning after regrets?
___ Do others express concern about your use of any substance (i.e., drugs or alcohol)?

Prevention: Leadership issues

I was asked recently to coach a poor-performing leader. 'Mel' had alienated his team and his co-workers and his job was on the line. He was seen as having personality defects that were probably impossible to fix, but as a last resort they called in the executive coach - me. I suppose the script was I would find him too difficult and then they could fire him with a clear conscience.

What I found instead was that Mel was not a difficult person. Instead, the design of his job and the leadership above him had combined to make his position an impossible one. Publicly, Mel's boss had given him one assignment; privately he had given him another. As Mel tried to comply with both assignments, he ran into conflict with coworkers and employees.

In organizational psychology we have a saying, "It is not the person, it is the system." I met with Mel's supervisor and coached him toward better leadership; we re-designed Mel's job and gave him clear and consistent assignments, and I met with Mel's peers and explained the changes in his job. Within a month, his peers and his direct reports were very pleased with Mel's work, his job was safe, and he was much happier.

How is the stress level in your practice? Much stress at work is caused by ineffective leadership. Indeed, in surveys of workplace stress, leadership is the number one cause. Danger signs here include:

- Leaders who rely on criticism to motivate.
- Supervision focus is on correcting errors.
- Absent or passive managers and directors.
- Being given contradictory assignments.
- Assignments that have responsibilities but no authority.
- Frequent changes in tasks and assignments.
- Encouragement to cut corners or engage in unethical behaviors.
- Leaders who show negative emotions, such as anger or contempt.

In this article we have reviewed danger signs. In the next issue, I will share new developments in stress management, some simple and very effective ways that focus on positive living strategies. The opposite of stress is happiness and satisfaction, feeling of fulfillment and recognition of the value you bring to your clients. In the past few years, psychologists have developed positive and practical ways of increasing happiness in professional and personal lives, and we will cover those next time.

Don't tolerate high levels of stress in your life. If you are experiencing emotional symptoms or if you are using alcohol or drugs to cope with stress, Rich Uday who chairs the Lawyers Helping Lawyers program can be of great service to you. It really is quite feasible to live a happier, more productive and more fulfilling life. Go for it, you deserve it!

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Contact Lawyers Helping Lawyers: Rich Uday, (801) 579-0404 or 800-530-3743 (in state calls only).

Addendum 6

Ethics and professionalism

By James Myers
Boomerang Staff Writer, Laramie, Wyoming, March 2004

In the first of the Carl M. Williams Speaker Series at the University of Wyoming, United States Supreme Court Justice Sandra Day O'Connor was forthcoming about her concerns with ethics and professionalism in the legal industry.

A large part of O'Connor's speech focused on the unhappiness that dwells within the legal profession. According to many of the studies she sited, most lawyers are unhappy because they feel a lot of pressure to win legal cases that often cross a lot of moral and legal boundaries.

"It's hardly a secret that many lawyers today are dissatisfied with their professional lives," O'Connor said. "The pressures associated with the increasing commercialization of law practices have made lawyers unhappy."

According to various studies O'Connor referenced, lawyers are three times as likely to suffer from depression. They're more likely to suffer from drug addiction, to get divorced and contemplate suicide. Another survey she cited from California said more than half of lawyers wouldn't be lawyers again if they had the option.

"There is an increasing level of instability in the profession, and a professional environment where a 'win at all costs' mentality sometimes prevails," O'Connor said. "Many attorneys believe that selflessly representing their clients means pushing all of those precedents ... to the limit."

Many lawyers feel that their problems with ethics and unhappiness in their jobs are fueled in part by negative stereotypes and the repercussions of those stereotypes.

"Many lawyers question whether at the end of the day they've contributed something worthwhile to society," O'Connor said. On the other hand, she also cited statistics that were telling of lawyers' and their opinions.

More than 50 percent of lawyers surveyed in a study she cited thought that their clients were obnoxious. While she didn't quote figures on what clients often think of their lawyers, she indicated a large rift between the law and the people the laws are there for.

O'Connor said the negative stigma attached to lawyers is the result of people wanting a dependable lawyer that's going to win the case and lawyers putting too much pressure on themselves to try to win cases. What is often the result is a

dogfight in the courtroom.

"I think incivility is a waste of time," O'Connor said as she prepared to read a letter from one of her correspondents.

"I want a lawyer ... who could be capable of hating my opponents. I want a person who is willing and eager to stomp my opponent into the dirt," O'Connor said as she read from the letter. The letter went on to say, "There should be absolutely no friendliness shown for the opposition."

O'Connor said this is one of the problems facing professionalism in law.

"I see it differently. In my view, incivility disserves the client because it wastes time and energy," O'Connor said. "Time that's billed at hundreds of dollars an hour and energy that's better served working on the client's case than working over your opponent."

O'Connor did argue strongly that legal representation is given to many of the wrong people. People who need it often can't afford it. To add to that, she said that many people feel that the law is unfair.

"A good many of our citizens believe that ... justice is available for the powerful, the wealthy and the elite, but not for those who lack the means to pay," O'Connor said.

After O'Connor's speech, Williams was presented with a gift from the UW Law School in thanks for his donation that made this speaker series possible. After some words from Williams, former U.S. Senator Alan K. Simpson came out to sit and talk with O'Connor.

Both recalled many of the different happenings during their times as senators and in various government positions. Most of the time was spent reminiscing about certain people both spent time working with in Washington.

While Simpson had many interesting stories laden with punch lines, intentional and otherwise, O'Connor never let the conversation get too serious. She steered away from discussion on carefully split political issues not just from today but the past. The conversation was lighthearted and was afforded a good amount of laughter.

Simpson and O'Connor apparently enjoyed a very positive working relationship and both felt strongly about the increasingly questionable legal struggles that are taking hold of courtrooms and left off with positive notions of law and the state of politics.

Addendum 7

Justice O'Connor urges lawyers to be civil

Associated Press [March 2004]

LARAMIE, Wyo. - Supreme Court Justice Sandra Day O'Connor on Tuesday urged attorneys to practice civility and provide free counsel for the poor to help restore integrity to their vocation.

Lawyers are often the subject of derision and portrayed in the media as unethical, disloyal or incompetent, she told a standing-room only crowd of more than 700 at the University of Wyoming Fine Arts Center.

"Not too many Americans even remember that our society once actually trusted and respected lawyers," she said. "I think that a decline in professionalism is partly responsible for this state of affairs."

Job dissatisfaction among lawyers is widespread, profound and growing, O'Connor said, adding that attorneys are more than three times as likely to suffer from depression than nonlawyers, and more apt to become dependent on drugs, have health problems, get divorced or contemplate suicide.

Added pressure

A "win-at-all-costs" mentality adds to the pressure, the 23-year veteran of the high court said.

"Many attorneys believe that zealously representing their clients means pushing all the rules of ethics and decency to the limit," she said. "When lawyers themselves generate conflict rather than addressing the dispute between the parties they represent, it undermines our adversarial system. It erodes the public's confidence that justice is being served.

"Greater civility can only enhance the effectiveness of our legal system. It can only improve the public's perception of lawyers and increase lawyers' professional satisfaction."

Many attorneys question whether they're contributing something worthwhile to society, said O'Connor, who suggested that helping the poor could assuage such concerns.

"Ensuring that there is equal justice under the law and not just for the wealthy but also for the poor and the disadvantaged is the sustenance that brings meaning and joy to a lawyers' professional life," she said.

Sharing stories

After her speech, O'Connor, who grew up on an Arizona ranch, and former U.S. Sen. Alan Simpson, R-Wyo., chatted onstage for nearly an hour, trading anecdotes about growing up in the West and the Washington, D.C., political scene.

At one point, O'Connor said she didn't think President Ronald Reagan was serious about nominating her as the first female justice in 1981, even though he had invited her into the Oval Office for an interview.

"I think he was kind of intrigued with the cowgirl part of my background," she said to laughter.

When he called her a week later to say he would nominate her, "my heart sank," she said.

Simpson related how his son, Colin, a fraternity brother of O'Connor's son, Brian, had lobbied him to vote in favor of her nomination. As it turned out, the vote was 99-0.

Simpson, long known on Capitol Hill for his quick wit, had the justice laughing uncontrollably when he said he comes from a long line of lawyers and that the thinking in the family was, "If anyone goes to jail, make sure it's your client."

Asked about landmark decisions, O'Connor agreed the 1954 case Brown vs. Board of Education, which cleared the way for school desegregation, was one of the biggest, saying it showed courts could

be an avenue for social change.

While not commenting on the details of the Roe v. Wade abortion decision or the 2000 ruling on the presidential race, O'Connor said the two cases left Americans "deeply divided" and unhappy that the issues had to be decided in court.

The two agreed that court opinions requiring "one person, one vote" changed the face of politics across the West, diluting the long-held power of rural counties which were once guaranteed equal numbers of statehouse representatives regardless of population.

A poignant moment was shared regarding Transportation Secretary Norm Mineta, who was interned at Heart Mountain, a relocation camp for Japanese-Americans near Cody during World War II.

Simpson related how, as a Boy Scout, he had met Mineta at the camp.

"People forget in this time what was happening at that time," he said of the treatment of Americans with Japanese ancestry.

O'Connor interjected: "He was interned with his parents at that Japanese internment camp, and he loves to tell the story of how you became his friend while he was in that camp. ... It was quite a step to have the Boy Scouts willing to have some relationship with those people."

Before her talk at the Fine Arts Concert Hall, O'Connor autographed copies of her books, "The Majesty of Law: Reflections of a Supreme Court Justice" and "Lazy B: Growing up on a Cattle Ranch in the American Southwest."

Addendum 8

UNDERSTANDING, AIDING ADDICTS

Martha W. Barnett

We have made giant strides in our awareness and understanding of the true nature of addiction--whether it is to alcohol or other substances. Substance abuse crosses all socioeconomic lines and often hides behind imposing fronts of respectability, claiming professionals, home-makers and children alike.

Alcoholism and drug addiction are diseases of denial. Often those afflicted are the last to realize or acknowledge their predicament and get the help that is now widely available. Millions remain trapped in a downward spiral of dependency and addiction that eventually will destroy their lives and many of those around them.

Misguided Strategies

The tragedy, however, is that the justice system cannot solve the problem if it continues to address substance abuse as if it were a crime rather than a public health issue. More than $4 billion was spent this past year on border control efforts, construction of new prisons and law enforcement, only to fill prisons with sick people who remain untreated. The most effective countermeasure to the addiction epidemic is to encourage, sometimes even coerce, individuals into treatment.

The American Bar Association has been working diligently to integrate substance abuse and addiction treatment into the judicial system. The ABA supports the unified family court movement, which combines all the essential elements of traditional family and juvenile courts into one entity and contains other resources, such as social services, critical to the resolution of a family's problems. Substance abuse treatment is very often (indeed, nearly always, according to many judges) of critical importance in cases appearing before the unified family courts.

Where drug-related criminal offenses are concerned, a defendant might be given the opportunity to choose a family drug court rather than a normal trial. These courts offer substance abusers intensive drug treatment, as well as a range of support services for family members. Today, about 20 jurisdictions in 10 states have family drug court programs under way or planned.

Our natural allies in addressing the nation's drug problem are physicians. The ABA has entered into an exciting partnership with the American

Medical Association to encourage greater collaboration among doctors and lawyers as professionals, as community leaders and as private citizens concerned about drug abuse and addiction. The ABA, the AMA and the Officer of National Drug Control Policy have jointly published a brochure that instructs lawyers on how to spot a problem in a client or a family member, and how to help other lawyers who appear to be afflicted. Another recent ABA/AMA brochure examines how physicians and attorneys can work together to break the connection between crime and alcohol and illicit drugs.

Substance abuse and addiction frequently begin at an early age. Three million teenagers nationwide are confirmed to have an alcohol problem, and more than 100,000 preteens are known to engage regularly in binge drinking. The ABA Standing Committee on Substance Abuse is actively involved in a new, national public-private partnership, Leadership to Keep Children Alcohol Free, to educate the public about early alcohol use by children between 9 and 15 years of age. Leadership to Keep Children Alcohol Free has engaged governors' spouses around the country to participate in a range of activities that will raise awareness and encourage coalition-building among civic and corporate groups.

Confidential Help for Members

Finally, the ABA is aware and concerned that this disease affects the legal profession to an equal, or perhaps even greater, degree as the general population. Since 1987, the ABA Commission on Lawyer Assistance Programs, known as COLAP, has engaged in education, prevention and assistance efforts to help lawyers better understand and deal with substance abuse. In the event that you--or a colleague, judge or law student you--or a colleague, judge or law student you know--suffer from an addictive disorder (or, for that matter, from stress, depression or other mental health problems), COLAP's services are available to all ABA members by calling the ABA Service Center at 800-285-2221, Ext. 5359. You will be given the number of the lawyer assistance program in your area, where you can obtain completely confidential assistance.

The abuse of drugs and alcohol has proven to be one of the most recalcitrant and corrosive problems afflicting our society. It wreaks tragedy in families and wastes valuable societal resources. Yet, efforts to stop it solely by force of law have failed. It is time for the legal community to support innovative approaches that integrate effective, appropriate treatment into the justice system culture.

In memory of my sister, Dr. Helen Delight Walters.

Addendum 9

COMMUNITY DRUG ALERT BULLETIN
January 2002
STRESS AND SUBSTANCE ABUSE

Dear Colleague:
Researchers have long recognized the strong correlation between stress and drug use, particularly relapse to drug use. In the wake of recent tragic events, our awareness of the role that stress can play in increasing ones' vulnerability to drug use is more important than ever. Exposure to stress is among the most common human experiences. It also is one of the most powerful triggers for relapse to substance abuse in addicted individuals, even after long periods of abstinence.

In an attempt to update you on current research about stress and its relationship to substance abuse, we have developed this Community Alert Bulletin. The fact that a disorder called Post-traumatic Stress Disorder (PTSD) may develop in people after exposure to a severe traumatic event–such as the terrorist attacks of September 11, 2001 is another reason we are issuing this Alert. PTSD is a diagnosable psychiatric disorder that is a known risk factor for substance abuse and addiction. Because the terrorist attacks were witnessed on television by millions of people across the world, it is likely that many of us may already know colleagues, friends, patients, or family members who may be experiencing behavioral and readjustment problems.

NIDA is encouraging its researchers to conduct more studies on the important topic of stress and drug abuse. We are already supporting a number of grantees who are specifically assessing the impact of these events on the citizens of New York City in respect to drug abuse and addiction prevalence. NIDA also is focusing more attention on developing science-based interventions to help people who may be more vulnerable to addiction better cope with stress.

We hope this information will be useful to you as you continue to work on drug abuse issues in your community. Identifying potential substance abuse problems early on and referring patients to professionals with expertise in drug abuse counseling and treatment will be beneficial to all involved. We all must focus on restoring our emotional well-being, developing healthy ways to manage stress, and avoiding turning to drugs or other substances to escape from the realities of the day.

Sincerely,

Glen R. Hanson, Ph.D., D.D.S.
Acting Director
National Institute on Drug Abuse

Stress - What is It?

- Stress is a term we all know and use often, but what does it really mean? It is hard to define because it means different things to different people. Stress is a normal reaction to life for people of all ages. It is caused by our body's instinct to protect itself from emotional or physical pressure or, in extreme situations, from danger.
- Stressors differ for each of us. What is stressful for one person may or may not be stressful for another; each of us responds to stress in an entirely different way. How a person copes with stress – by reaching for a beer or cigarette or by heading to the gym – also plays an important role in the impact that stress will have on our bodies.
- By using their own support systems, some people are able to cope effectively with the emotional and physical demands brought on by stressful and traumatic experiences. However, individuals who experience prolonged reactions to stress that disrupt their daily functioning may benefit from consulting with a trained and experienced mental health professional.

The Body's Response to Stress

- The stress response is mediated by a highly complex, integrated network that involves the central nervous system, the adrenal system, the immune system, and the cardiovascular system.
- Stress activates adaptive responses. It releases the neurotransmitter norephinephrine, which is involved with memory. This may be why people remember stressful events more clearly than they do nonstressful situations.
- Stress also increases the production of a hormone in the body known as corticotropin releasing factor (CRF). CRF is found throughout the brain and initiates our biological response to stressors. During all negative experiences, certain regions of the brain show increased levels of CRF. Interestingly, almost all drugs of abuse have also been found to increase CRF levels, which suggests a neurobiological connection between stress and drug abuse.
- Mild stress may cause changes that are useful. For example, stress can actually improve our attention and increase our capacity to store and integrate important and life-protecting information. But if stress is prolonged or chronic, those changes can become harmful.

Stress and Drug Abuse

- Stressful events may influence profoundly the use of alcohol or other drugs. Stress is a major contributor to the initiation and continuation of addiction to alcohol or other drugs, as well as to relapse or a return to drug use after periods of abstinence.
- Stress is one of the major factors known to cause relapse to smoking, even after prolonged periods of abstinence.
- Children exposed to severe stress may be more vulnerable to drug use. A number of clinical and epidemiological studies show a strong association between psychosocial stressors early in life (e.g., parental loss, child abuse) and an increased risk for depression, anxiety, impulsive behavior, and substance abuse in adulthood.

Stress, Drugs, and Vulnerable Populations

- Stressful experiences increase the vulnerability of an individual to relapse to drugs even after prolonged abstinence.
- Individuals who have achieved abstinence from drugs must continue to sustain their abstinence – avoiding environmental triggers, recognizing their psychosocial and emotional triggers, and developing healthy behaviors to handle life's stresses.
- A number of relapse prevention approaches have been developed to help clinicians address relapse. Treatment techniques that foster coping skills, problem-solving skills, and social support play a role in successful treatment.
- Physicians should be aware of what medications their patients are taking but should not discourage the use of medical prescriptions to help alleviate stress. Some people may need medications for stress-related symptoms or for treatment of depression and anxiety.

What is PTSD?

- Post-traumatic Stress Disorder (PTSD) is an anxiety disorder that can develop in some people after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened.
- Generally, PTSD has been associated with the violence of modern combat. However, many people other than combat soldiers are susceptible. PTSD can result from many kinds of tragic incidents in which the patient was a witness, victim, or survivor, including violent or personal attacks, natural or human-caused disasters, or accidents.
- Symptoms of PTSD can include re-experience of the trauma; emotional numbness; avoidance of people, places, and thoughts connected to the event; and arousal, which may include trouble sleeping, exaggerated startle response, and hypervigilance.

- PTSD can occur in people of any age, including children and adolescents.

PTSD and Substance Abuse

- An emerging body of research has documented a very strong association between PTSD and substance abuse. In most cases, substance use begins after the exposure to trauma and the development of PTSD, thus making PTSD a risk factor for drug abuse.
- Early intervention to help children and adolescents who have suffered trauma from violence or a disaster is critical. Children who witness or are exposed to a traumatic event and are clinically diagnosed with PTSD have a greater likelihood for developing later drug and/or alcohol use disorders.
- Of individuals with substance use disorders, 30 to 60 percent meet the criteria for comorbid PTSD.
- Patients with substance abuse disorders tend to suffer from more severe PTSD symptoms than do PTSD patients without substance use disorders.

Helping Those Who Suffer from PTSD and Drug Abuse

- Health care professionals must be alert to the fact that PTSD frequently co-occurs with depression, anxiety disorders, and alcohol or other substance abuse. Patients who are experiencing the symptoms of PTSD need support from physicians and health care providers.
- The likelihood of treatment success increases when these concurrent disorders are appropriately identified and treated as well.
- In some cases, medications such as the antidepressant sertraline (Zoloft™), have been shown to be helpful in treating patients who suffer from PTSD and substance use disorders.
- Some reports suggest that successful detoxification of these comorbid patients will likely require inpatient admission to permit vigorous control of withdrawal and PTSD-related arousal symptoms.
- Although there is no standardized, effective treatment developed for individuals with this disorder, studies show that patients who suffer from PTSD can improve with cognitive behavioral therapy, group therapy, or exposure therapy, in which the patient gradually and repeatedly relives the frightening experience under controlled conditions to help him or her work through the trauma.
- Exposure therapy is thought to be one of the most effective ways to manage PTSD when it is conducted by a trained therapist. It has not yet been widely used with comorbid disorders, but recent studies suggest that some individuals with PTSD and comorbid cocaine addiction can be successfully

treated with exposure therapy. Patients in a recent study who suffered from both disorders showed significant reductions in all PTSD symptoms and in overall cocaine use.

- Finally, support from family and friends can play an important role in recovery.

*Information from NIDA's Community Epidemiology Work Group (CEWG), a network of epidemiologists and researchers from 21 U.S. metropolitan areas who monitor drug use trends.

Addendum 10

Understanding How Stress Increases the Risk of Drug Abuse and Relapse

NIDA NewsScan, April 8, 2002

Evidence from animal studies suggests that specific types of stressful experiences in early life may increase vulnerability to drug abuse. For example, animals that are isolated or separated from their mothers in early life increase self-administration of morphine and cocaine. Several human studies have reported a link between adverse life events, chronic stress, and increased drug abuse. Individuals with a history of physical or sexual abuse at a young age have an increased risk of abusing substances.

One proposed explanation for this link between stress and increased drug abuse has been that the use of addictive substances serves to both alleviate emotional distress and enhance mood, thereby reinforcing drug taking as an effective, but maladaptive, coping strategy. However, more recent animal studies suggest that stress may enhance the reinforcing effects of drugs that are commonly abused.

With those studies, scientists have sought to elucidate the neurological events in the brain that underlie the relationship between stress and substance abuse. The two main components of the brain's stress circuitry are corticotropin releasing factor, which originates in the hypothalamus and amygdala, and the noradrenergic activation initiated in the brain stem. Activation of the stresscircuits also increases dopaminergic neuro- transmission in the mesolimbic regions of the brain.

The mesocorticolimbic dopaminergic system is generally considered to be the brain's reward pathway, and increased transmission in this pathway has been shown to be critical for the reinforcing properties of drug abuse. Thus, it seems that exposure to stress stimulates some still-to-be-identified neural activity which in turn simultaneously activates both the stress circuitry and the reward pathway and, by doing so, enhances the likelihood of taking drugs and the pleasure obtained from taking drugs.

▩**What it means:** Research shows that stress, in addition to the drug itself, plays a key role in perpetuating drug abuse and relapse.

The paper, "How does stress increase the risk of drug abuse and relapse?" was published by Dr. Rajita Sinha in Volume 158, 343-359, 2001 of the journal *Psychopharmacology*.

Addendum 11

"Oops: How Casual Drug Use Leads to Addiction"

By Alan I. Leshner, Ph.D., *Director, National Institute of Drug Abuse, National Institutes of Health*

It is an all-too-common scenario: A person experiments with an addictive drug like cocaine. Perhaps he intends to try it just once, for "the experience" of it. It turns out, though, that he enjoys the drug's euphoric effect so much that in ensuing weeks and months he uses it again -- and again. But in due time, he decides he really should quit. He knows that despite the incomparable short-term high he gets from using cocaine, the long-term consequences of its use are perilous. So he vows to stop using it.

His brain, however, has a different agenda. It now demands cocaine. While his rational mind knows full well that he shouldn't use it again, his brain overrides such warnings. Unbeknown to him, repeated use of cocaine has brought about dramatic changes in both the structure and function of his brain. In fact, if he'd known the danger signs for which to be on the lookout, he would have realized that the euphoric effect derived from cocaine use is itself a sure sign that the drug is inducing a change in the brain -- just as he would have known that as time passes, and the drug is used with increasing regularity, this change becomes more pronounced, and indelible, until finally his brain has become addicted to the drug.

And so, despite his heartfelt vow never again to use cocaine, he continues using it. Again and again.

His drug use is now beyond his control. It is compulsive. He is addicted.

While this turn of events is a shock to the drug user, it is no surprise at all to researchers who study the effects of addictive drugs. To them, it is a predictable outcome.

To be sure, no one ever starts out using drugs intending to become a drug addict. All drug users are just trying it, once or a few times. Every drug user starts out as an occasional user, and that initial use is a voluntary and controllable decision. But as time passes and drug use continues, a person goes from being a voluntary to a compulsive drug user. This change occurs because

over time, use of addictive drugs changes the brain -- at times in big dramatic toxic ways, at others in more subtle ways, but always in destructive ways that can result in compulsive and even uncontrollable drug use.

The fact is, drug addiction is a *brain disease*. While every type of drug of abuse has its own individual "trigger" for affecting or transforming the brain, many of the results of the transformation are strikingly similar regardless of the addictive drug that is used -- and of course in each instance the result is compulsive use. The brain changes range from fundamental and long-lasting changes in the biochemical makeup of the brain, to mood changes, to changes in memory processes and motor skills. And these changes have a tremendous impact on all aspects of a person's behavior. In fact, in addiction the drug becomes the single most powerful motivator in the life of the drug user. He will do virtually *anything* for the drug.

This unexpected consequence of drug use is what I have come to call *the oops phenomenon*. Why oops? Because the harmful outcome is in no way intentional. Just as no one starts out to have lung cancer when they smoke, or no one starts out to have clogged arteries when they eat fried foods which in turn usually cause heart attacks, no one starts out to become a drug addict when they use drugs. But in each case, though no one meant to behave in a way that would lead to tragic health consequences, that is what happened just the same, because of the inexorable, and undetected, destructive biochemical processes at work.

While we haven't yet pinpointed precisely all the triggers for the changes in the brain's structure and function that culminate in the "oops" phenomenon, a vast body of hard evidence shows that it is virtually inevitable that prolonged drug use will lead to addiction. From this we can soundly conclude that drug addiction is indeed a brain disease.

I realize that this flies in the face of the notion that drug addiction boils down to a serious character flaw -- that those addicted to drugs are just too weak-willed to quit drug use on their own. But the moral weakness notion itself flies in the face of all scientific evidence, and so it should be discarded.

It should be stressed, however, that to assert that drug addiction is a brain disease is by no means the same thing as saying that those addicted to drugs are not accountable for their actions, or that they are just unwitting, hapless victims of the harmful effects that use of addictive drugs has on their brains, and in every facet of their lives.

Just as their behavior at the outset was pivotal in putting them on a collision course with compulsive drug use, their behavior after becoming addicted is just as critical if they are to be effectively treated and to recover.

At minimum, they have to adhere to their drug treatment regimen. But this can pose an enormous challenge. The changes in their brain that turned them into compulsive users make it a daunting enough task to control their actions and complete treatment. Making it even more difficult is the fact that their craving becomes more heightened and irresistible whenever they are exposed to any situation that triggers a memory of the euphoric experience of drug use. Little wonder, then, that most compulsive drug users can't quit on their own, even if they want to (for instance, at most only 7 percent of those who try in any one year to quit smoking cigarettes on their own actually succeed). This is why it is essential that they enter a drug treatment program, even if they don't want to at the outset.

Clearly, a host of biological and behavioral factors conspires to trigger the oops phenomenon in drug addiction. So the widely held sentiment that drug addiction has to be explained from either the standpoint of biology or the standpoint of behavior, and never the twain shall meet, is terribly flawed. Biological and behavioral explanations of drug abuse must be given equal weight and integrated with each other if we are to gain an in-depth understanding of the root causes of drug addiction and then develop more effective treatments. Modern science has shown us that we reduce one explanation to the other -- the behavioral to the biological, or vice versa - at our own peril. We have to recognize that brain disease stemming from drug use cannot and should not be artificially isolated from its behavioral components, as well as its larger social components. They all are critical pieces of the puzzle that interact with and impact on one another at every turn.

A wealth of scientific evidence, by the way, makes it clear that rarely if ever are any forms of brain disease only biological in nature. To the contrary, such brain diseases as stroke, Alzheimer's, Parkinson's, schizophrenia, and clinical depression all have their behavioral and social dimensions. What is unique about the type of brain disease that results from drug abuse is that it starts out as voluntary behavior. But once continued use of an addictive drug brings about structural and functional changes in the brain that cause compulsive use, the disease-ravaged brain of a drug user closely resembles that of people with other kinds of brain diseases.

It's also important to bear in mind that we now see addiction as a chronic, virtually life-long illness for many people. And relapse is a common phenomenon in all forms of chronic illness -- from asthma and diabetes, to hypertension and addiction. The goals of successive treatments, as with other chronic illnesses, are to manage the illness and increase the intervals between relapses, until there are no more.

An increasing body of scientific evidence makes the compelling case that the most effective treatment programs for overcoming drug addiction incorporate an array of approaches -- from medications, to behavior therapies, to social services and rehabilitation. The National Institute on Drug Abuse recently published ***Principles of Effective Drug Addiction Treatment***, which features many of the most promising drug treatment programs to date. As this booklet explains, the programs with the most successful track records treat the *whole* individual. Their treatment strategies place just as much emphasis on the unique social and behavioral aspects of drug addiction treatment and recovery as on the biological aspects. By doing so, they better enable those who have abused drugs to surmount the unexpected consequences of drug use and once again lead fruitful lives.

http://www.drugabuse.gov/Published_Articles/Oops.html

Addendum 12

ALAN I LESHNER*

Addiction Is a Brain Disease

Greater progress will be made against drug abuse when our strategies reflect the full complexities of the latest scientific understanding.

The United States is stuck in its drug abuse metaphors and in polarized arguments about them Everyone has an opinion One side insists that we must control supply, the other that we must reduce demand People see addiction as either a disease or as a failure of will None of this bumper sticker analysis moves us forward The truth is that we will make progress in dealing with drug issues only when our national discourse and our strategies are as complex and comprehensive as the problem itself

A core concept that has been evolving with scientific advances over the past decade is that drug addiction is a brain disease that develops over time as a result of the initially voluntary behavior of using drugs The consequence is virtually uncontrollable compulsive drug craving, seeking, and use that interferes with, if not destroys, an individual's functioning in the family and in society This medical condition demands formal treatment

We now know in great detail the brain mechanisms through which drugs acutely modify mood, memory, perception, and emotional states Using drugs repeatedly over time changes brain structure and function in fundamental and long-lasting ways that can persist long after the individual stops using them Addiction comes about through an array of neuroadaptive changes and the laying down and strengthening of new memory connections in various circuits in the brain We do not yet know all the relevant mechanisms, but the evidence suggests that those long-lasting brain changes are responsible for the distortions of cognitive and emotional functioning that characterize addicts, particularly including the compulsion to use drugs that is the essence of addiction It is as if drugs have highjacked the brain's natural motivational control circuits, resulting in drug use becoming the sole, or at least the top, motivational priority for the individual Thus, the majority of the biomedical community now considers addiction, in its essence, to be a brain disease a condition caused by persistent changes in brain structure and function

This brain-based view of addiction has generated substantial controversy, particularly among people who seem able to think only in polarized ways Many people erroneously still believe that biological and behavioral explanations are alternative or competing ways to understand phenomena, when in fact they are complementary and integratable Modern science has taught that it is much too simplistic to set biology in opposition to behavior or to pit willpower against brain chemistry Addiction involves inseparable biological and behavioral components It is the quintessential biobehavioral disorder

Many people also erroneously still believe that drug addiction is simply a failure of will or of strength of character Research contradicts that position However, the recognition

that addiction is a brain disease does not mean that the addict is simply a hapless victim Addiction begins with the voluntary behavior of using drugs, and addicts must participate in and take some significant responsibility for their recovery Thus, having this brain disease does not absolve the addict of responsibility for his or her behavior, but it does explain why an addict cannot simply stop using drugs by sheer force of will alone It also dictates a much more sophisticated approach to dealing with the array of problems surrounding drug abuse and addiction in our society

The essence of addiction

The entire concept of addiction has suffered greatly from imprecision and misconception In fact, if it were possible, it would be best to start all over with some new, more neutral term The confusion comes about in part because of a now archaic distinction between whether specific drugs are "physically" or "psychologically" addicting The distinction historically revolved around whether or not dramatic physical withdrawal symptoms occur when an individual stops taking a drug, what we in the field now call "physical dependence "

However, 20 years of scientific research has taught that focusing on this physical versus psychological distinction is off the mark and a distraction from the real issues From both clinical and policy perspectives, it actually does not matter very much what physical withdrawal symptoms occur Physical dependence is not that important, because even the dramatic withdrawal symptoms of heroin and alcohol addiction can now be easily managed with appropriate medications Even more important, many of the most dangerous and addicting drugs, including methamphetamine and crack cocaine, do not produce very severe physical dependence symptoms upon withdrawal

What really matters most is whether or not a drug causes what we now know to be the essence of addiction uncontrollable, compulsive drug craving, seeking, and use, even in the face of negative health and social consequences This is the crux of how the Institute of Medicine, the American Psychiatric Association, and the American Medical Association define addiction and how we all should use the term It is really only this compulsive quality of addiction that matters in the long run to the addict and to his or her family and that should matter to society as a whole Compulsive craving that overwhelms all other motivations is the root cause of the massive health and social problems associated with drug addiction In updating our national discourse on drug abuse, we should keep in mind this simple definition Addiction is a brain disease expressed in the form of compulsive behavior Both developing and recovering from it depend on biology, behavior, and social context

It is also important to correct the common misimpression that drug use, abuse, and addiction are points on a single continuum along which one slides back and forth over time, moving from user to addict, then back to occasional user, then back to addict Clinical observation and more formal research studies support the view that, once addicted, the individual has moved into a different state of being It is as if a threshold has been crossed Very few people appear able to successfully return to occasional use after having been truly addicted Unfortunately, we do not yet have a clear biological or

behavioral marker of that transition from voluntary drug use to addiction However, a body of scientific evidence is rapidly developing that points to an array of cellular and molecular changes in specific brain circuits Moreover, many of these brain changes are common to all chemical addictions, and some also are typical of other compulsive behaviors such as pathological overeating

Addiction should be understood as a chronic recurring illness Although some addicts do gain full control over their drug use after a single treatment episode, many have relapses Repeated treatments become necessary to increase the intervals between and diminish the intensity of relapses, until the individual achieves abstinence

The complexity of this brain disease is not atypical, because virtually no brain diseases are simply biological in nature and expression All, including stroke, Alzheimer's disease, schizophrenia, and clinical depression, include some behavioral and social aspects What may make addiction seem unique among brain diseases, however, is that it does begin with a clearly voluntary behavior--the initial decision to use drugs Moreover, not everyone who ever uses drugs goes on to become addicted Individuals differ substantially in how easily and quickly they become addicted and in their preferences for particular substances Consistent with the biobehavioral nature of addiction, these individual differences result from a combination of environmental and biological, particularly genetic, factors In fact, estimates are that between 50 and 70 percent of the variability in susceptibility to becoming addicted can be accounted for by genetic factors

Over time the addict loses substantial control over his or her initially voluntary behavior, and it becomes compulsive For many people these behaviors are truly uncontrollable, just like the behavioral expression of any other brain disease Schizophrenics cannot control their hallucinations and delusions Parkinson's patients cannot control their trembling Clinically depressed patients cannot voluntarily control their moods Thus, once one is addicted, the characteristics of the illness--and the treatment approaches--are not that different from most other brain diseases No matter how one develops an illness, once one has it, one is in the diseased state and needs treatment

Moreover, voluntary behavior patterns are, of course, involved in the etiology and progression of many other illnesses, albeit not all brain diseases Examples abound, including hypertension, arteriosclerosis and other cardiovascular diseases, diabetes, and forms of cancer in which the onset is heavily influenced by the individual's eating, exercise, smoking, and other behaviors

Addictive behaviors do have special characteristics related to the social contexts in which they originate All of the environmental cues surrounding initial drug use and development of the addiction actually become "conditioned" to that drug use and are thus critical to the development and expression of addiction Environmental cues are paired in time with an individual's initial drug use experiences and, through classical conditioning, take on conditioned stimulus properties When those cues are present at a later time, they elicit anticipation of a drug experience and thus generate tremendous drug craving Cue-induced craving is one of the most frequent causes of drug use relapses, even after long periods of abstinence, independently of whether drugs are available

The salience of environmental or contextual cues helps explain why reentry to one's community can be so difficult for addicts leaving the controlled environments of treatment or correctional settings and why aftercare is so essential to successful recovery The person who became addicted in the home environment is constantly exposed to the cues conditioned to his or her initial drug use, such as the neighborhood where he or she hung out, drug-using buddies, or the lamppost where he or she bought drugs Simple exposure to those cues automatically triggers craving and can lead rapidly to relapses This is one reason why someone who apparently overcame drug cravings while in prison or residential treatment could quickly revert to drug use upon returning home In fact, one of the major goals of drug addiction treatment is to teach addicts how to deal with the cravings caused by inevitable exposure to these conditioned cues

Implications

Understanding addiction as a brain disease has broad and significant implications for the public perception of addicts and their families, for addiction treatment practice, and for some aspects of public policy On the other hand, this biomedical view of addiction does not speak directly to and is unlikely to bear significantly on many other issues, including specific strategies for controlling the supply of drugs and whether initial drug use should be legal or not Moreover, the brain disease model of addiction does not address the question of whether specific drugs of abuse can also be potential medicines Examples abound of drugs that can be both highly addicting and extremely effective medicines The best-known example is the appropriate use of morphine as a treatment for pain Nevertheless, a number of practical lessons can be drawn from the scientific understanding of addiction

It is no wonder addicts cannot simply quit on their own They have an illness that requires biomedical treatment People often assume that because addiction begins with a voluntary behavior and is expressed in the form of excess behavior, people should just be able to quit by force of will alone However, it is essential to understand when dealing with addicts that we are dealing with individuals whose brains have been altered by drug use They need drug addiction treatment We know that, contrary to common belief, very few addicts actually do just stop on their own Observing that there are very few heroin addicts in their 50 or 60s, people frequently ask what happened to those who were heroin addicts 30 years ago, assuming that they must have quit on their own However, longitudinal studies find that only a very small fraction actually quit on their own The rest have either been successfully treated, are currently in maintenance treatment, or (for about half) are dead Consider the example of smoking cigarettes Various studies have found that between 3 and 7 percent of people who try to quit on their own each year actually succeed Science has at last convinced the public that depression is not just a lot of sadness, that depressed individuals are in a different brain state and thus require treatment to get their symptoms under control The same is true for schizophrenic patients It is time to recognize that this is also the case for addicts

The role of personal responsibility is undiminished but clarified Does having a brain disease mean that people who are addicted no longer have any responsibility for their behavior or that they are simply victims of their own genetics and brain chemistry? Of

course not Addiction begins with the voluntary behavior of drug use, and although genetic characteristics may predispose individuals to be more or less susceptible to becoming addicted, genes do not doom one to become an addict This is one major reason why efforts to prevent drug use are so vital to any comprehensive strategy to deal with the nation's drug problems Initial drug use is a voluntary, and therefore preventable, behavior

Moreover, as with any illness, behavior becomes a critical part of recovery At a minimum, one must comply with the treatment regimen, which is harder than it sounds Treatment compliance is the biggest cause of relapses for all chronic illnesses, including asthma, diabetes, hypertension, and addiction Moreover, treatment compliance rates are no worse for addiction than for these other illnesses, ranging from 30 to 50 percent Thus, for drug addiction as well as for other chronic diseases, the individual's motivation and behavior are clearly important parts of success in treatment and recovery

Implications for treatment approaches and treatment expectations Maintaining this comprehensive biobehavioral understanding of addiction also speaks to what needs to be provided in drug treatment programs Again, we must be careful not to pit biology against behavior The National Institute on Drug Abuse's recently published Principles of Effective Drug Addiction Treatment provides a detailed discussion of how we must treat all aspects of the individual, not just the biological component or the behavioral component As with other brain diseases such as schizophrenia and depression, the data show that the best drug addiction treatment approaches attend to the entire individual, combining the use of medications, behavioral therapies, and attention to necessary social services and rehabilitation These might include such services as family therapy to enable the patient to return to successful family life, mental health services, education and vocational training, and housing services

That does not mean, of course, that all individuals need all components of treatment and all rehabilitation services Another principle of effective addiction treatment is that the array of services included in an individual's treatment plan must be matched to his or her particular set of needs Moreover, since those needs will surely change over the course of recovery, the array of services provided will need to be continually reassessed and adjusted

What to do with addicted criminal offenders One obvious conclusion is that we need to stop simplistically viewing criminal justice and health approaches as incompatible opposites The practical reality is that crime and drug addiction often occur in tandem Between 50 and 70 percent of arrestees are addicted to illegal drugs Few citizens would be willing to relinquish criminal justice system control over individuals, whether they are addicted or not, who have committed crimes against others Moreover, extensive real-life experience shows that if we simply incarcerate addicted offenders without treating them, their return to both drug use and criminality is virtually guaranteed

A growing body of scientific evidence points to a much more rational and effective blended public health/public safety approach to dealing with the addicted offender Simply summarized, the data show that if addicted offenders are provided with well-

structured drug treatment while under criminal justice control, their recidivism rates can be reduced by 50 to 60 percent for subsequent drug use and by more than 40 percent for further criminal behavior. Moreover, entry into drug treatment need not be completely voluntary in order for it to work. In fact, studies suggest that increased pressure to stay in treatment--whether from the legal system or from family members or employers--actually increases the amount of time patients remain in treatment and improves their treatment outcomes.

Findings such as these are the underpinning of a very important trend in drug control strategies now being implemented in the United States and many foreign countries. For example, some 40 percent of prisons and jails in this country now claim to provide some form of drug treatment to their addicted inmates, although we do not know the quality of the treatment provided. Diversion to drug treatment programs as an alternative to incarceration is gaining popularity across the United States. The widely applauded growth in drug treatment courts over the past five years--to more than 400--is another successful example of the blending of public health and public safety approaches. These drug courts use a combination of criminal justice sanctions and drug use monitoring and treatment tools to manage addicted offenders.

Updating the discussion

Understanding drug abuse and addiction in all their complexity demands that we rise above simplistic polarized thinking about drug issues. Addiction is both a public health and a public safety issue, not one or the other. We must deal with both the supply and the demand issues with equal vigor. Drug abuse and addiction are about both biology and behavior. One can have a disease and not be a hapless victim of it.

We also need to abandon our attraction to simplistic metaphors that only distract us from developing appropriate strategies. I, for one, will be in some ways sorry to see the War on Drugs metaphor go away, but go away it must. At some level, the notion of waging war is as appropriate for the illness of addiction as it is for our War on Cancer, which simply means bringing all forces to bear on the problem in a focused and energized way. But, sadly, this concept has been badly distorted and misused over time, and the War on Drugs never became what it should have been: the War on Drug Abuse and Addiction. Moreover, worrying about whether we are winning or losing this war has deteriorated to using simplistic and inappropriate measures such as counting drug addicts. In the end, it has only fueled discord. The War on Drugs metaphor has done nothing to advance the real conceptual challenges that need to be worked through.

I hope, though, that we will all resist the temptation to replace it with another catchy phrase that inevitably will devolve into a search for quick or easy-seeming solutions to our drug problems. We do not rely on simple metaphors or strategies to deal with our other major national problems such as education, health care, or national security. We are, after all, trying to solve truly monumental, multidimensional problems on a national or even international scale. To devalue them to the level of slogans does our public an injustice and dooms us to failure.

Understanding the health aspects of addiction is in no way incompatible with the need to control the supply of drugs In fact, a public health approach to stemming an epidemic or spread of a disease always focuses comprehensively on the agent, the vector, and the host In the case of drugs of abuse, the agent is the drug, the host is the abuser or addict, and the vector for transmitting the illness is clearly the drug suppliers and dealers that keep the agent flowing so readily Prevention and treatment are the strategies to help protect the host But just as we must deal with the flies and mosquitoes that spread infectious diseases, we must directly address all the vectors in the drug-supply system

In order to be truly effective, the blended public health/public safety approaches advocated here must be implemented at all levels of society--local, state, and national All drug problems are ultimately local in character and impact, since they differ so much across geographic settings and cultural contexts, and the most effective solutions are implemented at the local level Each community must work through its own locally appropriate antidrug implementation strategies, and those strategies must be just as comprehensive and science-based as those instituted at the state or national level

The message from the now very broad and deep array of scientific evidence is absolutely clear If we as a society ever hope to make any real progress in dealing with our drug problems, we are going to have to rise above moral outrage that addicts have "done it to themselves" and develop strategies that are as sophisticated and as complex as the problem itself Whether addicts are "victims" or not, once addicted they must be seen as "brain disease patients "

Moreover, although our national traditions do argue for compassion for those who are sick, no matter how they contracted their illnesses, I recognize that many addicts have disrupted not only their own lives but those of their families and their broader communities, and thus do not easily generate compassion However, no matter how one may feel about addicts and their behavioral histories, an extensive body of scientific evidence shows that approaching addiction as a treatable illness is extremely cost-effective, both financially and in terms of broader societal impacts such as family violence, crime, and other forms of social upheaval Thus, it is clearly in everyone's interest to get past the hurt and indignation and slow the drain of drugs on society by enhancing drug use prevention efforts and providing treatment to all who need it

Recommended reading

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Addendum 13

RULES OF PROFESSIONAL CONDUCT

Rule 8.3. Reporting professional misconduct.

(a) A lawyer having knowledge that another lawyer has committed a violation of the Rules of Professional Conduct that raises a substantial question as to that lawyer's honesty, trustworthiness or fitness as a lawyer in other respects, shall inform the appropriate professional authority.
(b) A lawyer having knowledge that a judge has committed a violation of the applicable Rules of Judicial Conduct that raises a substantial question as to the judge's fitness for office shall inform the appropriate authority.
(c) This Rule does not require disclosure of information otherwise protected by Rule 1.6.
(d) ***This rule does not require disclosure of information provided to or discovered by members of the Utah State Bar during the course of their work on the Lawyers Helping Lawyers Committee, a committee which has as its purpose the counseling of other bar members about substance abuse or psychological or emotional problems.***

History: Amended effective October 10, 1990. The 1990 amendment added Subdivision (d).

COMMENT
Self-regulation of the legal profession requires that members of the profession initiate disciplinary investigation when they know of a violation of the Rules of Professional Conduct. Lawyers have a similar obligation with respect to judicial misconduct. An apparently isolated violation may indicate a pattern of misconduct that only a disciplinary investigation can uncover. Reporting a violation is especially important where the victim is unlikely to discover the offense.
A report about misconduct is not required where it would involve violation of Rule 1.6. However, a lawyer should encourage a client to consent to disclosure where prosecution would not substantially prejudice the client's interests.

If a lawyer were obliged to report every violation of the Rules, the failure to report any violation would itself be a professional offense. Such a requirement existed in many jurisdictions but proved to be unenforceable. This Rule limits the reporting obligation to those offenses that a self-

regulating profession must vigorously endeavor to prevent. ***A measure of judgment is, therefore, required in complying with the provisions of this Rule.*** The term "substantial" refers to the seriousness of the possible offense and not the quantum of evidence of which the lawyer is aware. ***A report should be made to the bar disciplinary agency unless some other agency, such as a peer review agency, is more appropriate in the circumstances. Similar considerations apply to the reporting of judicial misconduct.*** The duty to report professional misconduct does not apply to a lawyer retained to represent a lawyer whose professional conduct is in question. Such a situation is governed by the rules applicable to the client-lawyer relationship.

ETHICS ADVISORY OPINIONS

A lawyer is required to report to the Utah State Bar any unlawful possession or use of controlled substances by another lawyer if two conditions are satisfied: (1) the lawyer has actual knowledge of the illegal use or possession, and (2) the lawyer has a reasonable, good-faith belief that the illegal use or possession raises a substantial question as to the offending lawyer's honesty, trustworthiness or fitness as a lawyer in other respects. ***A lawyer is excused from this reporting requirement only if*** (i) the lawyer learns of such use or possession through a bona fide attorney-client relationship with the offending lawyer, or ***(ii) the lawyer becomes aware of the unlawful use or possession through providing services to the offending lawyer under the auspices of the Lawyers Helping Lawyers program of the Bar.*** Utah Ethics Advisory Op. No. 98-12 (Utah St. Bar).

Emphasis added for handout purposes, LHL (12/01).