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

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

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

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

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

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

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

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

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

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

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

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

Copyright © 2016 American Society of Addiction Medicine. This is an open-access article distributed under the terms of the Creative Commons Attribution-Non Commercial-No Derivatives License 4.0, where it is permissible to download and share the work provided it is properly cited.

The work cannot be changed in any way or used commercially.

ISSN: 1932-0620/15/0901-0031
DOI: 10.1097/ADM.0000000000000182

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

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

Although the consequences of attorney impairment may seem less direct or urgent than the threat posed by impaired physicians, they are nonetheless profound and far-reaching. As a licensed profession that influences all aspects of society, economy, and government, levels of impairment among attorneys are of great importance and should therefore be closely evaluated (Rothstein, 2008). A scarcity of data on the current rates of substance use and mental health concerns among lawyers, therefore, has substantial implications and must be addressed. Although many in the profession have long understood the need for greater resources and support for attorneys struggling with addiction or other mental health concerns, the formulation of cohesive and informed strategies for addressing those issues has been handicapped by the
outdated and poorly defined scope of the problem (Association of American Law Schools, 1994).

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

**METHODS**

**Procedures**

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

**Participants**

A total of 14,895 individuals completed the survey. Participants were included in the analyses if they were currently employed, and employed in the legal profession, resulting in a final sample of 12,825. Due to the nature of recruitment (eg, e-mail blasts, web postings), and that recruitment mailing lists were controlled by the participating bar members, IP addresses and geo-location data were not tracked.

As shown in Table 2, the most commonly reported legal positions were Senior Partner (25.0%), Junior Associate (20.5%), and Senior Associate (20.3%). Over two-thirds (67.2%) of the sample reported working 41 hours or more per week.

| TABLE 1. Participant Characteristics | n (%) |
|-------------------------------------|-------|
| **Total sample**                    | 12825 (100) |
| **Sex**                             |        |
| Men                                 | 6824 (53.4) |
| Women                               | 5941 (46.5) |
| **Age category**                    |        |
| 30 or younger                       | 1513 (11.9) |
| 31–40                               | 3205 (25.2) |
| 41–50                               | 2674 (21.0) |
| 51–60                               | 2953 (23.2) |
| 61–70                               | 2050 (16.1) |
| 71 or older                         | 348 (2.7) |
| **Race/ethnicity**                  |        |
| Caucasian/White                     | 11653 (91.3) |
| Latino/Hispanic                     | 330 (2.6) |
| Black/African American (non-Hispanic)| 317 (2.5) |
| Multiracial                         | 189 (1.5) |
| Asian or Pacific Islander           | 150 (1.2) |
| Other                               | 84 (0.7) |
| Native American                     | 35 (0.3) |
| **Marital status**                  |        |
| Married                             | 8985 (70.2) |
| Single, never married               | 1790 (14.0) |
| Divorced                            | 1107 (8.7) |
| Cohabiting                          | 462 (3.6) |
| Life partner                        | 184 (1.4) |
| Widowed                             | 144 (1.1) |
| Separated                           | 123 (1.0) |
| **Have children**                   |        |
| Yes                                 | 8420 (65.8) |
| No                                  | 4384 (34.2) |
| **Substance use in the past 12 mos**|        |
| Alcohol                             | 10874 (84.1) |
| Tobacco                             | 2163 (16.9) |
| Sedatives                           | 2015 (15.7) |
| Marijuana                           | 1307 (10.2) |
| Opioids                             | 722 (5.6) |
| Stimulants                          | 612 (4.8) |
| Cocaine                             | 107 (0.8) |

*Substance use includes both illicit and prescribed usage.

**Materials**

**Alcohol Use Disorders Identification Test**

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

The AUDIT is a widely used instrument, with well established validity and reliability across a multitude of populations (Meneses-Gaya et al., 2009). To compare current rates of problem drinking with those found in other populations, AUDIT-C scores were also calculated. The AUDIT-C is a subscale comprised of the first 3 questions of the AUDIT.
focussed on the quantity and frequency of use, yielding a range of scores from 0 to 12. The results were analyzed using a cut-off score of 5 for men and 4 for women, which have been interpreted as a positive screen for alcohol abuse or possible alcohol dependence (Bradley et al., 1998; Bush et al., 1998). Two other subscales focus on dependence symptoms (e.g., alcohol dependence (Bradley et al., 1998; Bush et al., 1998). Interpreted as a positive screen for alcohol abuse or possible dependence, and comparisons between groups were tested using Mann-Whitney U tests and Kruskal-Wallis tests.

### Alcohol Use

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

Of the 12,825 participants, 11,489 completed the first 3 AUDIT questions, allowing an AUDIT-C score to be calculated. Among these participants, 36.4% had an AUDIT-C score consistent with hazardous drinking or possible alcohol abuse or dependence. A significantly higher proportion of women (39.5%) had AUDIT-C scores consistent with problematic use compared with men (33.7%) ($\chi^2 [1, N = 11,440] = 41.93, P < 0.001$). A total of 2901 participants (22.6%) reported that they have felt their use of alcohol or other substances was problematic at some point in their lives; of those that felt their use has been a problem, 27.6% reported problematic use manifested before law school, 14.2% during law school, 43.7% within 15 years of completing law school, and 14.6% more than 15 years after completing law school.

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

### Results

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

Of the 12,825 participants, 11,489 completed the first 3 AUDIT questions, allowing an AUDIT-C score to be calculated. Among these participants, 36.4% had an AUDIT-C score consistent with hazardous drinking or possible alcohol abuse or dependence. A significantly higher proportion of women (39.5%) had AUDIT-C scores consistent with problematic use compared with men (33.7%) ($\chi^2 [1, N = 11,440] = 41.93, P < 0.001$). A total of 2901 participants (22.6%) reported that they have felt their use of alcohol or other substances was problematic at some point in their lives; of those that felt their use has been a problem, 27.6% reported problematic use manifested before law school, 14.2% during law school, 43.7% within 15 years of completing law school, and 14.6% more than 15 years after completing law school.

An ordinal regression was used to determine the predictive validity of age, position, and number of years in the legal field on problematic drinking behaviors, as measured by the AUDIT. Initial analyses included all 3 factors in a model to predict whether or not respondents would have a clinically significant total AUDIT score of 8 or higher. Age group predicted clinically significant AUDIT scores; respondents 30 years of age or younger were significantly more likely to have a higher score than their older peers ($\beta = 0.52$, Wald $[df = 1] = 4.12, P < 0.001$). Number of years in the field...
approached significance, with higher AUDIT scores predicted for those just starting out in the legal profession (0–10 yrs of experience) ($\beta = 0.46$, Wald $df = 1 = 3.808$, $P = 0.051$). Model-based calculated probabilities for respondents aged 30 or younger indicated that they had a mean probability of 0.35 (standard deviation $SD = 0.01$), or a 35% chance for scoring an 8 or higher on the AUDIT; in comparison, those respondents who were 61 or older had a mean probability of 0.17 ($SD = 0.01$), or a 17% chance of scoring an 8 or higher.

Each of the 3 subscales of the AUDIT was also investigated. For the AUDIT-C, which measures frequency and quantity of alcohol consumed, age was a strong predictor of subscore, with younger respondents demonstrating significantly higher AUDIT-C scores. Respondents who were 30 years old or younger, 31 to 40 years old, and 41 to 50 years old all had significantly higher AUDIT-C scores than their older peers, respectively ($\beta = 1.16$, Wald $df = 1 = 24.56$, $P < 0.001$; $\beta = 0.86$, Wald $df = 1 = 16.08$, $P < 0.001$; and $\beta = 0.48$, Wald $df = 1 = 6.257$, $P = 0.013$), indicating that younger age predicted higher frequencies of drinking and quantity of alcohol consumed. No other factors were significant predictors of AUDIT-C scores. Neither the predictive model for the dependence subscale nor the harmful use subscale indicated significant predictive ability for the 3 included factors.

### Drug Use

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

### Mental Health

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

### Table 3: Summary Statistics for Alcohol Use Disorders Identification Test (AUDIT)

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

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

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

© 2016 American Society of Addiction Medicine
depression, and stress scores decreased as participants’ age or years worked in the field increased \((P < 0.001)\). When comparing positions within private firms, more senior positions were generally associated with lower DASS-21 subscale scores \((P < 0.001)\). Participants classified as nonproblematic drinkers on the AUDIT had lower levels of depression, anxiety, and stress \((P < 0.001)\), as measured by the DASS-21. Comparisons of DASS-21 scores by AUDIT drinking classification are outlined in Table 5.

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

### Treatment Utilization and Barriers to Treatment

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

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

### Table 4: Summary Statistics for Depression Anxiety Stress Scale (DASS-21)

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

\*Comparisons were analyzed using Mann-Whitney U tests and Kruskal-Wallis tests.
Relationship AUDIT Drinking Classification and Substance Use and Other Mental Health Concerns

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

Table 5: Relationship AUDIT Drinking Classification and DASS-21 Mean Scores

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

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

DISCUSSION

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

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

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

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

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

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

Our study is subject to limitations. The participants represent a convenience sample recruited through e-mails and...
The authors also thank the Hazelden Betty Ford Foundation and The American Bar Association for their support of this project.

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

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

Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. The alcohol use disorders identification test: guidelines for use in primary care [WHO web site]. 2001. Available at: http://whqlibdoc.who.int/hq/2001/who_msd_ms-lh_01-6a.pdf. Accessed August 5, 2014.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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