Lawyers with Health Conditions[1]

Part 1: Protecting the Public, Optimizing Outcomes for Lawyers-as-Patients, and Protecting the Profession

By Charl Els, Diane Kunyk, Cherie Langlois-Klassen, and Mathew Milen

INTRODUCTION

When experienced by a member of the legal profession, mental illness and/or addiction(s) (MI/A) is a serious and complex issue for the individual suffering from the disease, as well as their families, patients, colleagues, professional body, employer / firm, and society at large. The purpose of this 3-part series of papers is to describe the presentation of commonly found impairing conditions in lawyers, and to delineate a coordinated approach dovetailing a rehabilitative approach with a disciplinary approach. This approach recognizes that both the employer (or firm) and the regulatory body are guided by a duty to accommodate[2], along with the regulatory body's duty to protect the public. The rehabilitative aspect of this approach includes pragmatic and evidence-based screening, identification, assessment, treatment, and longitudinal monitoring of lawyers impaired by health conditions. The described tailored approach has the potential to serve as a measure for restorative justice, returning the impaired lawyer to practice at the earliest possible opportunity, engaging the impacted lawyer with appropriate monitoring as soon as is feasible, while at the same time protecting both the public and the profession.

This paper is part 1 of a 3-part series on the health of lawyers. Part I addresses the impact lawyering has on the life and death of others. It addresses the harsh realities faced by those practicing law, and recognizes the challenge of being happy, healthy and maintaining ethical conduct under difficult circumstances. It defines addiction and mental disorders, addresses the features of each, the prevalence, and causes of mental illness and addiction, and outlines the challenge of stigma, resulting in underreporting of mental illness and addiction among lawyers. This section further outlines a remedial approach to the problem and briefly addresses the investigative approach to conduct complaints where mental illness and addiction may be relevant.

Part II focusses on integrating a rehabilitative approach for lawyers with mental illness and/or addiction. Mitigation of risk can occur through early self-identification and peer-identification, and the challenges associated with such. It addresses the impact of mental illness and substance use on the individual's functioning, and outlines the signs of both conditions, allowing for early recognition.

Part III addresses the comprehensive assessment and multimodal treatment approaches to the problem of mental health and addictions. It outlines evidence-based continuing care and treatment, as well as monitoring and maintenance for lawyers in recovery. It addresses the issue of toxicology drug testing and also focuses on future directions to remedy the challenge the legal profession is facing.

LAWYERING CAN IMPACT LIFE AND DEATH IN OTHERS

Rothstein (2008) suggests that the practice of law is a high-prestige, high-income, high-skill, and high-stress profession[3]. Although not immediately safety sensitive in nature, the practice of law is considered *decision-critical*[4]. Impairment[5] as a result of MI/A may result in deterioration in workplace performance, relationships, attendance, reliability, quality of work conducted, and may ultimately result in partial or total disability[6]. Unlike traditional safety sensitive workplaces, e.g. pilots, heavy equipment operators, etc., adverse consequences as a result of MI/A in the delivery of legal services to the public may not be immediately evident. A potential "orbit of harm" nevertheless exists, and which may be temporally removed or delayed. It is within this decision-critical and high-stakes context of lawyering that the decisions made by lawyers can affect life and death in others. Impairment may result in grave consequences to the individual, the public, and the reputation of the profession.

Functioning in a self-governing profession, lawyers in Canadian provinces are expected to conduct themselves and their law practices in ways, which are highly ethical, and above reproach. Province-specific Code of Conduct statements define the principles and high standards, which are applicable to every lawyer in the particular province. Lawyers' conduct, similar to health and other regulated professionals' actions and behavior,

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should be above reproach. Lawyers are expected to establish and maintain a reputation for integrity[7]. Self-regulation of the profession, either health or legal, is premised, in part, on the *social contract* between the profession and the public, whereby the regulatory body / society allows for self-regulation. In return there is a guarantee for the highest standards for competence, ethical conduct, and moral responsibility. The provincial / territorial regulatory body governs in the public interest by maintaining and strengthening an autonomous, independent and self-regulating profession[8]. Should the professional conduct of the lawyer-patient fall below the standards expected of the profession as a result of the expression of features of the MI/A, the so-called *social contract* underlying the core of self-regulation may be threatened. The resultant risk to the lawyer, the profession, and the public warrants a coordinated approach, incorporating not only a regulatory / disciplinary response, but also a rehabilitative approach.

THE HARSH REALITY OF THE LEGAL PROFESSION

There have been suggestions of the legal profession facing a "state of crisis"[9]. Despite the many perks of lawyering—which includes the social status, the intellectual challenge, and favorable remuneration — isolation, job dissatisfaction, suboptimal mental health, and substance use conditions appear to be highly prevalent in lawyers. Daicoff (2004) describes a so-called "tripartite crisis" in the legal profession, consisting of: (a). "A lack of professionalism", as evidenced by frequent (and apparently increasing rates of) complaints of incivility, discourtesy, "Rambo-style" litigation, near-unethical behavior, and poor conduct by some members of the profession; (b) Low public opinion[10] of lawyers and the profession, and; (c) Low levels of job satisfaction and mental well-being among lawyers. There is an inherent assumption that these factors are interrelated, and that the development of the current state is multifactorial in nature. The behavioral literature on lawyer personality and characteristics of those attracted to the law may help explain this apparent crisis. In addition, and perhaps amplifying the underlying factors responsible for developing this "crisis", the advent and continuation of difficult economic times has also "ushered in a stressful and harsh anxious reality" for the legal profession[11].

In part resulting from the factors causing the "crisis", there is also a disproportionate risk for ill health. The misuse of substances and/or the injudicious use of alcohol (either recreational or in the context of a *bona fide* disability of addiction) may result, in the eyes of colleagues or the public, in the perception of unethical or dishonorable behavior. In extreme cases, it may arguably result in questioning the individual's suitability to practice law. It may foreseeably impair capacity[12] and tolerance to practice law, but may also incur direct risk. Apart from the potential risk of damage to the reputation of the profession and erosion of trust in the profession, the health of the affected lawyer is also potentially at risk as the condition progresses in severity, often resulting in preventable disease, disability, or even premature death.

FEATURES OF MENTAL ILLNESS AND ADDICTION

In the workplace, the issues of mental illness, addiction, or a combination thereof, is often difficult to navigate. Understanding the threshold for meeting the criteria for either a mental disorder or an addictive condition, may determine the level of care and treatment that should be accessed, if at all.

The term *Mental disorder* is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)[13] as referring to *"a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as death of a loved one, is not a mental disorder. Further, socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual…"*

The disease of *addiction*, which is also recognized and classified as a mental disorder, is defined as *"a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death"*[14].

Addiction may be associated with a broad range of behaviors, some of which may, to varying degrees, display a nexus with the condition of addiction, while others are not *sufficiently close*[15] to suggest the presence of any link. Heyman (2009) suggests[16]: *"Drug use in addicted persons is governed by consequences that were experienced in the past and that are anticipated. Voluntary acts are governed by costs and benefits, such as concern about family cultural values, self-esteem, fear of punishment, and so on; the same holds true for drug use in addicts"* (p113). Self-destructive behavior, including substance use, is not necessarily involuntary. Under certain circumstances the immediate cost of discontinuing substance use is greater than the immediate benefit of quitting, and hence substance use (and procurement of such) continues.

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In lawyers who practice with untreated (or partially treated) MI/A, alertness, attention, concentration, reaction time, coordination, memory, multi-tasking abilities, perception, thought processing, and judgment can be compromised. MI/A may foreseeably interfere with lawyers' conduct, both personally and/or professionally, as well as the ability to observe the highest standards of conduct. Although MI/A can impact conduct, mental disorders are not generally viewed as the cause of criminal behavior. Socially deviant behavior, or conduct that does not meet ethical standards is not viewed as evidence of mental illness per se.

Very few persons with alcohol addiction engage in criminal behavior, and the DSM-5 category of Substance Use Disorder (or the DSM-IV-TR category of Substance Dependence) does not feature criminal behavior as a diagnostic criterion. The DSM-5 states: "Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time" [p.25]. Even if a person suffers from a bona fide disability, i.e. mental illness and/or addiction, it does not automatically suggest that the person did not have sufficient mental capacity (at the time of engaging in the behavior under discussion) to realize what she/he was doing was wrong. Intoxication per se does not technically constitute a defence for conduct that met the threshold of criminal behavior.

THE PREVALENCE OF MENTAL ILLNESS/ ADDICTION IN LAWYERS

There are more than 300 mental disorders described in the DSM-5[17], divided into categories that include bipolar disorders, depressive disorders, anxiety disorders, obsessive-compulsive disorders, trauma- and stressor-related disorders, substance-related and addictive disorders, psychotic disorders, neurocognitive disorders, and others. There are more than 1,000 different street drugs available, divided in the following categories: Alcohol; Caffeine; Cannabis (*marijuana*); Hallucinogens (*with separate categories for phencyclidine [or similarly acting arylcyclohexylamines] & other hallucinogens*); Inhalants; Opioids; Sedatives, *Hypnotics, and Anxiolytics*; Stimulants; Tobacco (*Nicotine*); and Other (*or unknown*) *substances.*

Individuals practicing the '*pedestal professions*' are susceptible, like the general population, to developing the same impairing conditions, i.e. MI/A, as the general population, regardless of any special knowledge, skills, or insights they may have due to their education, status, or professional experience. Empirical evidence suggests that lawyers may, in fact, even be at greater risk for specific health conditions, due to work-related factors such as high job strain, fatigue related to long work hours, high workload, the unpredictable nature of judiciary outcomes, emotional problems, the relative "normalization" of consumption of alcohol, and the creation of permissiveness toward drinking in the profession.

Over a third of people in most countries report meeting the criteria for at least one category of mental disorder (which includes addiction)[18]. The majority of individuals with psychopathology and mental disorders continue to be gainfully employed, and the presence of a mental disorder does not equate to impairment or disability. Although there is a dearth of epidemiological data regarding lawyers with health conditions, MI/A are expressed among individuals within most social, age, economic, cultural, gender, and occupational groupings. In Canada, the annual prevalence of major depressive episodes (MDE) in the general population is 4.7%, suggesting that over 1.5 million Canadians aged 15 and over experienced a current MDE in the past year[19]. Lawyers have high rates of depression, according to some studies up to four times that of the general population[20]. The rates of substance use disorders are also markedly elevated in lawyers in comparison with the general population. Based on the 2012 statistics, an estimated 3.2% of Canadians, age 15 and older, either abused or are dependent on alcohol in that year[21], while the lifetime prevalence of problem drinking in lawyers was 18% compared to 10% in the general population. According to one study, 15% of law students in their first year, and 24% of third year law students reported concerns with alcohol. The problem seems to worsen over time, with reported rates of problem drinking estimated at 25% for those with over 20 years of practice[22]. It has been reported that lawyers have addiction rates (15-18%) higher than the general population (9.4%)[23]. Approximately 4% of the general population suffers from at least one anxiety disorder, as opposed to approximately 30% of male lawyers and 20% of female lawyers[24]. Isolation and loneliness is not uncommon in the profession, and the risk of suicide represents the third leading cause of death in the law profession, and by comparison, suicide is only the 10th leading cause of death in the general population[25].

Lawyers with substance use problems are significantly more likely to have a concurrent psychiatric disorder[26] (60%), compared to healthcare professionals (46%) and to the general population (28%). The presence of severe and persistent mental illness (SPMI), e.g. Schizophrenia, Bipolar I Disorder, Neurocognitive Disorder, is relatively rare among lawyers, in view of the high demands of the profession and the relative challenge concealing the clinical features of SPMI.

THE CAUSES OF MENTAL ILLNESS AND ADDICTION

Mental disorders and addiction may come to expression in individuals who are deemed susceptible on biological (including genetic), and where psychological, social, familial, or spiritual factors may play a role to varying degrees in the pathogenesis. Scientific findings suggest that, as is the case with most mental illness and addiction constructs, genetics play a dominant etiological role[27], and childhood experience also appears to play a compelling role for many mental disorders. Risk factors for mental disorders and addiction are inadequately described in the literature. However, a review of the etiology of mental

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illness concluded that the largest proportion of risk for mental illness is genetic, and that other relatively well-established risk factors for mental illness include pre-birth maternal stress, nutrition, and infection[28,29]. Hence, much of the relevant scientific findings suggest that the earliest time frame for prevention of mental illness begins in the second trimester of a person's pre-birth development[30].

Risk factors for mental illness include[31]:

- **Biological**: Genetic predisposition (i.e. a family history), ongoing medical conditions, e.g. diabetes, brain damage as a result of a serious injury (traumatic brain injury); suffering from a previous mental illness;
- **Psychological**: Stressful life situations; traumatic experiences, such as military combat or being assaulted; being abused or neglected as a child;
- **Social**: Use of alcohol or recreational drugs; having few friends or few healthy relationships.

Risk factors for addictions include[32,33]:

- **Biological factors**: Genetic predisposition (i.e. a family history in a primary family member), neurotransmitter dysregulation, biological phenomena (e.g. absence of aversive reactions, and "minimal responder status");
- **Psychological factors**: Boredom, other mental disorders, personality disorders (specifically bipolar disorder, antisocial personality disorder), anxiety features, poor self-esteem, low stress-tolerance, subjective distress (irritation, agitation, feelings of desperation, resentment); perception of a loss of control over circumstances;
- **Social factors**: Peers using alcohol or drugs, lack of education, condoning the use of substances, expectations about the positive effects of alcohol or drugs, poor social support systems, access to alcohol and drugs;
- **Behavioral factors**: Use of other substances, aggressive behavior in childhood, conduct disorder, avoidance of responsibilities, impulsivity and risk-taking behavior, alienation and rebelliousness, academic / behavioral problems;
- **Demographic factors**: Male gender, younger age, lack of employment opportunities, low socio-economic status, familial factors (including consumption by other members, family dysfunction, lack of positive family rituals and routines, family trauma).

Although the etiology of both MI/A is deemed bio-psycho-social-spiritual in nature, with predominantly a genetic component, the legal profession may well contain fundamental characteristics that facilitate the development of MI/A[34]. This may suggest that in a genetically vulnerable individual, given certain psychological and social components, unique elements of lawyering and the stress associated, may be associated, at least in part, with the development of psychopathology.

STIGMA LIMITS SELF-REPORTING OF MENTAL ILLNESS AND ADDICTION

Stigma associated with mental illness and addiction appears to be alive and well[35]:

- Only 50% of Canadians would tell friends or co-workers that they have a family member with a mental illness, compared to 72% who would discuss a diagnosis of cancer and 68% who would talk about a family member having diabetes.
- 42% of Canadians are unsure whether they would socialize with a friend who has a mental illness.
- A majority of Canadians (55%) say they would be unlikely to enter a spousal relationship with someone who has a mental illness.
- 46% of Canadians think people use the term mental illness as an excuse for bad behaviour, and 27% say they would be fearful of being around someone who suffers from serious mental illness.
- Only 12% of Canadians said they would hire a lawyer who has a mental illness.

The symptoms of MI/A may be concealed, especially in the early stages or in less severe cases. Lawyers with MI/A often conceal their status out of fear of being diagnosed with a serious illness, or fear that a disability may not be well tolerated or accommodated in their workplace. Lawyers with MI/A may also be in denial of a disorder as a result of the stigma (fear of being viewed as morally weak) attached to suffering from such. Fear of being stigmatized is a key barrier for anyone impacted by the MI/A and stigma is not confined to the general public but also occurs among professionals[36]. There still remains a culture of viewing addicted persons as weak, immoral, or characterologically flawed. It is hence understandable that the person suffering from MI/A may be concealing their illness from colleagues. In this sense, the environment in which the lawyer works can become a part of the problem, serving as a barrier to access to effective care.

Lawyers may lack the necessary knowledge of specific disorders, or may simply not be aware that their symptoms represent a *bona fide* disabling condition. Cognitive distortions related to MI/A may further reduce the likelihood of self-report. There may also be the fear that seeking treatment may lead to professional sanctions or practice restrictions, or may result in a loss of income.

In a profession that is populated typically by highly independent and self-directed professionals, seeking care may force the individual into a psychologically discordant state, i.e. regressing into a state of weakness, helplessness,

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or vulnerability. There may be concern over confidentiality or simply the fear of being diagnosed with a mental disorder. Stigma may delay access to care and, correspondingly, may prolong recovery. Confidentiality provides a level of protection from stigma and, for this reason, is considered a prerequisite to successful treatment for individuals with substance use disorders[37]. Confidentiality may not always be afforded to regulated professionals when they are subject to formal investigations, open hearing tribunals, and publication of discipline decisions.

All these factors may culminate in a culture of silence, where the impaired lawyer remains undetected until the impairment has reached a degree of severity that is disabling or life-threatening.

TOWARDS REMEDYING THE ISSUE OF HEALTH CONDITIONS IN LAWYERS

There certainly exists no *panacea* to remedy the issue of MI/A and potentially related alleged professional misconduct in lawyers. Extrapolating from the body of evidence for other regulated professionals, a comprehensive approach is required to address what is a complex problem with a multifactorial pathogenesis. Based on a review of the literature, and consistent with a restorative justice focus, the authors suggest a two-faceted approach should be followed. Such an approach would integrate any *regulatory response* with a *rehabilitative approach*, where there is joint effort to achieve a set of goals by the lawyer-as-patient, the treating health professionals, lawyer-specific support services, and the provincial regulatory body.

REGULATORY RESPONSES TO CONDUCT COMPLAINTS[38]

When lawyers (with or without MI/A) come to the attention of the regulatory body, through a conduct complaint filed by colleagues, public members, or other individuals, the regulator is required to respond in accordance with established legislative and policy directions. These processes may vary across provincial borders, but typically, upon receipt of a complaint, either an informal or a formal resolution may occur, based on the merits of each case. Usually, a Complaints Resolution Officer will resolve complaints informally where the lawyer has taken satisfactory remedial steps, or where there has been no or a minor breach of the province-specific Code of Conduct. If serious enough, the regulatory body may default to a more formal complaint resolution process, and refer the matter to a Complaints Manager, e.g. where there is concern that the lawyer has breached the Code of Conduct and the complaint cannot be resolved informally. In Alberta, the regulatory body appears to have moved away from a process that allows the complainant to drive the complaint or determine how the regulator will resolve it. There is further a departure from using the term "complainant" in favour of "person providing information to the regulator". Once the regulator has the relevant information, the person providing the information may at most be a witness at the hearing. The person providing information is not a party to the proceeding i.e. the proceeding is not complainant v. lawyer. If a complaint is dismissed for any reason, the dismissal may be appealed. A Complaints Manager may elect to order a formal investigation of the complaint if insufficient information is available and the complexity and seriousness of the complaint. Such formal investigation may involve interviewing witnesses and gathering further documentation.

Upon completion of the formal investigation, the Complaints Manager may either dismiss the complaint, or may trigger a disciplinary process by submission of a report with recommendations to the Conduct Committee Panel (three lawyers who are members of the Law Society's Conduct Committee). The Panel reviews the report and all evidence provided, and may dismiss the complaint at this stage. If it is, however, determined that the lawyer's conduct was contrary to the Code of Conduct[39], a hearing may or may not be directed. In lieu of a hearing, a conduct committee panel ("Panel") has the option of directing a mandatory conduct advisory in which the lawyer meets with a Bencher to ensure the lawyer is genuinely remorseful, and to discuss the misconduct to ensure the lawyer understands the inappropriate nature of the conduct, and that it will not be repeated. If at this point a mandatory conduct advisory (which is usually not in the public domain) may be considered successful, the complaint is dismissed. When a Panel determines that, based on the evidence, there is a reasonable prospect of conviction, the Panel will direct a hearing and issue the charges or citations that the lawyer will face at the hearing. Such citations are usually published on the regulatory body's website in advance of the hearing.

The subsequent hearing is conducted in front of a committee of usually no less than three Benchers. A hearing may include oral testimony and submissions. The hearing is administrative in nature. If the lawyer is found guilty of the citation(s), sanctions or penalties may be imposed, including but not limited to: a reprimand, a fine, suspension, or disbarment, with or without the costs of the hearing. The lawyer can appeal the finding(s) of guilt or the sanction. The findings resulting from the hearing are subsequently listed on the lawyer's record (only if found guilty) and may, upon written request, be disclosed to any requesting party. The regulatory body is committed to this process to ensure that due process serves the public interest; that the public is protected; and that the profession's image is not tarnished.

Endnotes:

1 This paper was initially prepared for the **2016 Discipline Administrator's Conference** held in Banff in October 2016

2 See also: Canadian Human Rights Commission: http://www.chrc-ccdp.gc.ca/eng/content/duty-accommodate.

3 Rothstein L., *Law students and lawyers with mental health and substance abuse problems: protecting the public and the individual.* University of Pittsburgh Law Review 2008;69:531-566.

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[4] "Safety-sensitive" workers, also termed "safety-critical" workers, have been subject to fitness to work assessments due to concerns that a performance error may result in worker injury, injury to coworkers or the general public, and/or disruption of equipment, production or the environment. However, there exists an additional category of "decision-critical" workers, distinct from "safety-sensitive" workers, in whom impairment may impact workplace performance, relationships, attendance, reliability and quality. Adverse consequences in these latter areas may not be immediately apparent, but a potential "orbit of harm" nevertheless exists. Workplace consequences arising from impairment in "decision-critical" workers differ from those in "safety-sensitive" personnel. Source: Fan X, Els C, Corbet KJ, Straube S. "Decision-critical" work: a conceptual framework. Journal of Occupational Medicine and Toxicology (2016) 11:22 DOI 10.1186/s12995-016-0115-8.

[5] *Impairment* is defined by the American Medical Association (AMA) as "an alteration of an individual health status; a deviation from normal in a body part or organ system and its functioning" (AMA, 2008). The World Health Organization (WHO) defines *impairment* as "any loss or abnormality of psychological, physiological or anatomical structure or function". The AMA Guides define a "permanent impairment" as one that has reached maximum medical improvement (MMI) and is well-stabilized and unlikely to change substantially during the next year, with or without medical treatment.

[6] *Disability* is principally a legal concept, defined in the language of legislation, jurisprudence and insurance policies. AMA defines disability as "an alteration of an individual's capacity to meet personal, social, or occupational demands because of an impairment". The WHO defines *disability* as "an activity limitation that creates a difficulty in performance, accomplishment, or completion of an activity in the manner or within the range considered normal for the person"

[7] The Law Society of Alberta: Code of Conduct. URL: http://www.lawsociety.ab.ca/lawyers/regulations/code.aspx

[8] One example of such is the Law Society of Alberta: www.lawsociety.ab.ca

[9] Daicoff, S. (2004) *Lawyer, know thyself: A psychological analysis of personality strengths and weaknesses.* Washington, DC: American Psychological Association.

[10] The public arguably has less respect for attorneys than for any other professional group.

[11] Seto M. *Killing Ourselves: Depression as an Institutional, Workplace and Professionalism Problem.* Western Journal of Legal Studies. 2012;2(2):1-24.

[12] Capacity should be distinguished from competency. The competent lawyer refers to the lawyer who has and applies the relevant skills, attributes, and values in a manner appropriate to each matter undertaken on behalf of a client, and includes a range of specific performance measures. Measurement of capacity is part of a fitness-to-practice (FTP) assessment, while competency is not measured by the occupational professional who conducts FTP assessments. This should also be distinguished from aspects of the Code of Conduct, whereby, among others, a lawyer has a duty to carry on the practice of law and discharge all responsibilities to clients, tribunals, the public and other members of the profession honourably and with integrity.

[13] *Diagnostic and Statistical Manual of Mental Disorders,* 5th Edition (DSM-5), American Psychiatric Association, 2013. [p. 20].

[14] The American Society of Addiction Medicine: URL: http://www.asam.org/quality-practice/definition-of-addiction (accessed October 17, 2016).

[15] Term borrowed from *Wright v. College and Association of Registered Nurses of Alberta (Appeals Committee),* 2012 ABCA 267.

[16] Heyman GM (2009). *Addiction – A Disorder of Choice* (p. 111). Harvard University Press. Cambridge, Massachusetts, London.

[17] *Ibid,* at #13.

[18] Rates of Mental / SUD, Canada, household, 15 years and older, 2012. Source: Statistics Canada, Canadian Community Health Survey – Mental Health, 2012.

[19] Lam RW, McIntosh D, Wang J, et al. (2016) Canadian Network for Mood and Anxiety Treatments (CANMAT) 2016 Clinical Guidelines for the Management of Adults with Major Depressive Disorder: Section I. Disease Burden and Principles of Care. Canadian Journal of Psychiatry 61(9):510-523.

[20] Eaton, W.W. (1990). *Occupations and the prevalence of major depressive disorder.* Journal of Occupational Medicine, 32 (11), 1079-1087.

[21] Canadian Centre on Substance Abuse (CCSA) http://www.ccsa.ca/Resource%20Library/CCSA-Canadian-Drug-Summary-Alcohol-2014-en.pdf (URL: Accessed October 18, 2016).

[22] Benjamin GAH, Darling EJ, Sales B. *The prevalence of depression, alcohol abuse, and cocaine abuse among US lawyers.* International Journal of Law and Psychiatry. 1990;13:233-246.

[23] Beck CJ, et al. (1996) *Lawyer Distress: Alcohol-related problems and other psychological concerns among a sample of practicing lawyers.* Journal of Law and Health 10,1-60.

[24] Schiltz PJ. *On Being Happy, Healthy, and Ethical Member of an Unhappy, Unhealthy, and Unethical Profession.* 1999:52 Vand L Rev.

[25] Leviant HS. *The Complex Litigator.* http://thecomplexlitigator.com/about/ (URL: Accessed October 19, 2016).

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[27] RE, Yudofsky SC, Gabbard GO, eds. *The American Psychiatric Publishing Textbook of Clinical Psychiatry.* 5th ed. Arlington, VA: American Psychiatric Publishing; 2008.

[28] Sadock BJ, Sadock VA. *Kaplan and Sadock's Synopsis of Psychiatry.* 10th ed. New York, NY: Lippincott Williams and Wilkins; 2007.

[29] Hales RE, Yudofsky SC, Gabbard GO, eds. *The American Psychiatric Publishing Textbook of Clinical Psychiatry.* 5th ed. Arlington, VA: American Psychiatric Publishing; 2008.

[30] Melhorn MJ, Ackerman WE, Hyman MH. (2013) T*he American Medical Association Guide to the Evaluation of Disease and Injury Causation*, 2nd Ed, AMA.

[31] Mayo Clinic (adapted) URL: http://www.mayoclinic.org/diseases-conditions/mental-illness/basics/risk-factors/con-20033813 (Accessed: October 15, 2016).

[32] Substance Use Disorder in Nursing. National Council of State Boards of Nursing. 2011.

[33] Kunyk D and Els C. *Substance-Related and Addictive Disorders.* In: Psychiatric and Mental Health Nursing for Canadian Practice. Eds. Austin W and Boyd MA. Wolters Kluwer. 2015.

[34] Benjamin CAH, et al. (1990) *The prevalence of depression, alcohol abuse, and cocaine abuse among US lawyers.* International Journal of Law and Psychiatry, 13:233-246.

[35] Canadian Medical Association, 8th Annual National Report Card on Health Care, August 2008.

[36] Standing Senate Committee on Social Affairs, Science and Technology. (2006). *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada.* Chair, M. Kirby.

[37] Roberts, L., & Dyer, A. (2004). Health care ethics committees. In *Concise guide to ethics in mental health care* (pp. 295–318). Washington, DC: American Psychiatric Publishing.

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[38] Although there may be significant overlap in how different Provinces and Territories approach disciplinary proceedings, the process described in this section of the manuscript is specific to Alberta and reflects the *current* approach, and some changes are imminent. The implementation of a new Early Intervention Process, which focuses on the potential remediation of a lawyer's conduct rather than on the specific concerns of a complainant, is one such pending change. The goal is to work with lawyers to ensure that they are providing the best possible service to the public. There will exist a Resolution Counsel (instead of Complaints Resolution Officers), which will try to resolve concerns raised by members of the public, other lawyers, etc. and, if the concerns brought forward do not raise sufficient regulatory concern, that will be the sum total of the Law Society's response. If the information does raise sufficient regulatory concern, the matter will be referred to Conduct Counsel who will try to resolve concerns but who will also be tasked with deciding whether to dismiss a complaint or forward it to our Conduct Committee Panel. Conduct Counsel will be supervised by the Manager, Conduct (rather than the Complaints Manager). This suggests a more proactive rather than reactive approach in regulating the profession.

[39] The Panel does not make a determination as to whether or not the conduct was contrary to the Code – the Panel decides if the evidence meets a threshold test i.e. is there a reasonable prospect of conviction? If so, citations are issued and a hearing is directed.

Charl Els (MBChB, FCPsych, MMedPsych [cum laude], Cert. ABAM, MROCC) is a Psychiatrist, Addiction Specialist, and a Medical Review Officer. He serves on academic faculty at the Department of Psychiatry, the Department of Medicine, and the John Dossetor Health Ethics Centre. Dr. Els also serves on the Health Research Ethics Board (HREB) of the University of Alberta.

Dr. Diane Kunyk, RN, PhD, is an Associate Professor with the Faculty of Nursing and the John Dossetor Health Ethics Centre at the University of Alberta. Dr. Kunyk employs qualitative, quantitative and systematic review methodologies in her program of research in professional ethics, regulation, and occupational health. She serves on the Health Ethics Board at the University of Alberta and as reviewer for the Canadian Institutes of Health Research.

Cherie Langlois-Klassen (MSc., LL.B) is a lawyer, employed in a labour relations capacity for the United Nurses of Alberta (UNA). Cherie has a special interest in working with RNs with MI/As and represents them in disability benefit appeals as well as disciplinary and professional conduct hearings.

Mathew Milen (RSW, MSW, SAP) is a Social Worker, registered with the Alberta College of Social Workers, currently working towards registration as a Clinical Social Worker. Mathew is also registered as a Substance Abuse Professional and is a preferred provider with the Edmonton Police Service.