Tennessee Commission on Continuing Legal Education & Specialization

LAWYER TO LAWYER MENTORING PROGRAM

WORKSHEET F

THE LOCAL JAIL

Worksheet F is intended to facilitate a discussion about visiting clients in jail.

WHAT WENT WELL?

Start by sharing with each other a brief story of something that went well in your practice this week:

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Share your reflection by on one of these questions: What caused the good event? What does it mean? How did you contribute? Others? How can you have more such events in the future?

ACTIVITIES FOR TODAY

- Escort the new lawyer to the local jail(s) and explain the procedures for jailhouse visits.
- Discuss the following details about jailhouse visits:
  a. Where do you go when you arrive at the jail?
  b. How do you sign in to visit your client?
  c. What should you bring with you? (For example, identification, attorney registration card, etc.)
  d. What items are prohibited for jailhouse visits?
  e. What may you bring to your client?
  f. Is there a limit on the length or number of visits to clients?
- Discuss the importance of talking to your criminally-charged client about the facts of his or her case; about keeping him or her informed about the progress of the case and your case development; and about those case decisions which your client should expect to make. See Prof. Cond. Rules 1.2, 1.4, and 2.1.
- Explain to the new lawyer which decisions an attorney should make in criminal cases and which the client has a right to make, and discuss the importance of explaining this distinction to the client from the outset of representation. Discuss how to properly inform your client of the consequences to his or her decisions in the case. See Prof. Cond. Rules 1.2, 1.4, and 2.1.

ACTION STEPS

End the session by discussing what action steps you can take to either improve or set yourself up for future success based on today's discussion. Discuss how one or more of your Signature Strengths can help you achieve success in these steps.

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RESOURCES

View complete rule and comments at http://www.tsc.state.tn.us/rules/supreme-court/8

TENNESSEE RULES OF PROFESSIONAL CONDUCT

I. CLIENT-LAWYER RELATIONSHIP

RULE 1.2: SCOPE OF REPRESENTATION AND ALLOCATION OF AUTHORITY BETWEEN CLIENT AND LAWYER

(a) Subject to divisions (c), (d), and (e) of this rule, a lawyer shall abide by a client's decisions concerning the objectives of representation and, as required by Rule 1.4, shall consult with the client as to the means by which they are to be pursued. A lawyer may take action on behalf of the client as is impliedly authorized to carry out the representation. A lawyer does not violate this rule by acceding to requests of opposing counsel that do not prejudice the rights of the client, being punctual in fulfilling all professional commitments, avoiding offensive tactics, and treating with courtesy and consideration all persons involved in the legal process. A lawyer shall abide by a client's decision whether to settle a matter. In a criminal case, the lawyer shall abide by the client's decision as to a plea to be entered, whether to waive a jury trial, and whether the client will testify.

RULE 1.4: COMMUNICATION

(a) A lawyer shall do all of the following:

(1) promptly inform the client of any decision or circumstance with respect to which the client's informed consent is required by these rules;

(2) reasonably consult with the client about the means by which the client's objectives are to be accomplished;

(3) keep the client reasonably informed about the status of the matter;

(4) comply as soon as practicable with reasonable requests for information from the client;

(5) consult with the client about any relevant limitation on the lawyer's conduct when

the lawyer knows that the client expects assistance not permitted by the Tennessee Rules of Professional Conduct or other law.

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

II. COUNSELOR RULE

RULE 2.1: ADVISOR

In representing a client, a lawyer shall exercise independent professional judgment and render candid advice. In rendering advice, a lawyer may refer not only to law but to other considerations, such as moral, economic, social, and political factors, that may be relevant to the client's situation.

STATISTICAL DEMOGRAPHICS AND OUTCOME STUDY OF CHEMICALLY DEPENDENT ATTORNEYS

By Timothy J. Sweeney, J.D., CCJAP

"John" was a trial lawyer. He was estranged from his wife and children, and his once thriving solo practice was all but destroyed as a result of the alcoholism that drove him into treatment in 1996. John was diagnosed with continuous and severe alcohol dependency as well as major depression. Following detoxification (which was especially difficult due to a history of seizures and delirium tremens), it was recommended that John undertake long-term residential-type treatment in an impaired professionals program. John's treatment experience was tumultuous, marked by revocations of consents, threats of lawsuits against the provider, and numerous voiced plans to leave treatment against medical advice. John eventually did leave treatment AMA, and immediately recommenced drinking alcoholically. Over the next number of months, he continued to contact the treatment center, asking for and then refusing proffered help. Finally John was convinced to reenter treatment, but only stayed one day before leaving again. Two weeks later the treatment center was contacted by local police and advised that John was found deceased in a flop-house hotel, having apparently bled to death from the virtual disintegration of his liver. The treatment center was contacted because, when the police found John, he was wearing a placard around his neck listing his vital statistics and various phone numbers of people to be called in case of emergency. John was 51 years old.

INTRODUCTION

In the spring of 2002, a retrospective study was conducted of 75 clinical case files of chemically dependent attorneys, judges and law school graduates treated at HealthCare Connection of Tampa, Inc. ("HCC"). HCC is a continuum of services treatment facility specializing in the care of impaired professionals, e.g. physicians, attorneys, nurses, pharmacists, etc., and persons with dual disorders. The continuum ranges from primary and extended care treatment, to halfway, three quarter and aftercare services. Detoxification, when necessary, is typically handled on an outpatient basis by the on-site medical clinic of David P. Myers, M.D.

The study collected and examined demographical data including median age, gender, marital status, practice type and drug of choice. The study also considered the incidence of psychiatric dual diagnosis as well as personality disorders/configurations as interpreted by the MCMI-III. Finally, data was collated regarding law enforcement and state bar association complications, as well as history of prior treatments.

The outcome statistics considered how treatment was concluded (patients leaving treatment against medical advice versus successfully completing treatment and following aftercare recommendations) with comparison of discharge types before and after formal institution of recovering attorneys' program track in October of 1999. Where available, follow up data was collected concerning Program participants' recovery progress following treatment.

METHODS

Collection of data on select professional groups is well known[1]. The data presented in this study was collected by the author, a Florida-licensed attorney and Certified Criminal Justice Addictions Professional. The data was obtained from the attorney/patients' clinical charts. Treatment was based on American Society of Addiction Medicine's Adult Patient Placement Criteria[2], and executed via the HCC Impaired Professionals' Program under the direction of Dr. David Myers. Consistency of information and measures to control for misclassification were enhanced by the fact that each patient was evaluated by the same Addictionist, all Axis II personality data was derived from the Millon MCMI-III[3], and each biopsychosocial interview and history was conducted pursuant to the same format. Post-treatment, follow up data is always difficult to obtain and, when obtained, is suspect to a degree, given the natural prevalence of denial and deception exhibited by those treatment alumni not actually in recovery. However, corroboration was obtained, when possible, through lawyer assistance program monitoring agencies, culling of public records, recovery support systems, and anecdotal evidence.

RESULTS

1. Patient Profile

Seventy-five clinical case records were examined for attorney/patients treated from 1994 through 2002. Forty-one of the seventy-five (54.66%) were treated following creation of the specialized track, the Recovering Attorneys' Program, in October of 1999. Of the seventy-five, sixty-five were men (86.7%) and ten were women (13.3%). The age of the male attorneys ranged from 27 to 65, with a median age of 43.9 years. The median age for female attorneys was slightly younger at 41.9. Thirty-eight of the lawyer/patients were married, twenty divorced and seventeen single. Nearly all reported significant marital or relationship difficulties. Forty-four (58.6%) were litigators, eight (10.6%) were transactional attorneys, seven (9.3%) were law school students or graduates awaiting admission to the bar, three (4%) were judges, four (5.3%) were disbarred and nine (12%) fit some other category.

The drug of choice for the seventy-five lawyers treated was as follows:

Drug of choice	Number	Percentage (Rounded)
Alcohol	43	57
Cocaine	19	25
Opiates[4]	6	8
Benzodiazapenes[5]	2	3
GHB[6]	2	3
Methamphetamine	2	3
Marijuana	1	1

Most engaged in polysubstance use/abuse. Forty-four of the lawyers (58.6%) had prior treatment. Of these, nineteen had one prior treatment, five had two previous experiences, and twenty had three or more, with the most being one lawyer with eight prior treatments.

Thirty-eight, or just over half of the lawyers treated, reported a history of criminal arrests. The most common offense was driving under the influence (18), followed by drug possession (12), domestic violence (10), trafficking (3), and assault and battery (3). [Note: some lawyers reported multiple offenses.] Thirty-four of the lawyers had bar complaints or other problems. These included nine suspensions and four disbarments.

2. Psychiatric Data and Personality Testing

Forty-five of the attorneys (60%) presented to treatment with a co-occurring psychiatric disorder (dual diagnosis). This percentage is higher than that for health care professionals at HCC, and significantly higher than the non-professional treatment population at HCC. Of the forty-five, twenty-four (32%) were diagnosed with Major Depression, eleven (14.6%) with Bipolar Disorders and ten (13.4%) with Anxiety Disorders.

The MCMI-III personality testing scores were most interesting. Of a total of 119 personality configurations identified among the lawyers tested (some had more than one), the Antisocial Personality Classification (disorder, trait or feature), not surprisingly, was returned highest, with twenty-one lawyers (17.6%) testing as Antisocial. Predictable also were the high number of attorneys (14) with a Narcissistic Personality configuration. This is consistent with the lawyer stereotype: rule challenging, maverick, somewhat self-absorbed, egotistical. These characteristics in measured doses can define a successful attorney. When unchecked, however, these personality configurations are typical among the chemically dependent attorney population.

Three results, however, seem quite surprising. The second most frequent personality configuration identified was the Dependent Personality, with twenty lawyers (16.8%) so classified. The DSM-IV defines Dependent Personality Disorder as "a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears."[7] This seemingly flies in the face of the popular conception of attorneys as *caregivers*, solvers of other peoples' problems.

High frequency was also found in the Schizoid (10.9%) and Avoidant (10%) Personality Classifications. The DSM-IV defines Schizoid Personality Disorder as "a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings."[8] Avoidant Personality Disorder is defined as "a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation."[9] Certainly, trial lawyers (who comprise a majority of the treatment patients) would be significantly hindered by these types of personality configurations. And yet most of the lawyers entering treatment reported having very successful and lucrative practices, and these reports are confirmed by collateral contacts.

The Axis II personality data breaks down as follows:

Type	Number	Percentage	DSM Prevalence[10]
Antisocial	21	17.6	3% to 30%
Dependent	20	16.8	high
Narcissistic	14	11.7	2% to 16%
Schizoid	13	10.9	uncommon
Avoidant	12	10	10%
Borderline	9	7.6	10%
Obsessive-Compulsive	9	7.6	3% to 10%
Paranoid	7	5.8	2% to 10%
Depressed	6	5	n/a
Histrionic	4	3.4	10% to 15%
Sadistic	3	2.5	n/a
Passive-Aggressive	1	.8	n/a

OUTCOME

The average length of stay in treatment was 10.6 weeks, with a range from one day to nine months. Of the seventy-five patients, forty-eight (64%) successfully completed treatment and twenty-seven (36%) left AMA. [For the purposes of this study, the term "against medical advice" is given a broader meaning than is typical in the therapy setting, and includes all patients other than those who entirely accepted clinical recommendations for treatment, length of stay, and aftercare. For instance, a lawyer who came seeking and was admitted for one week of treatment, and who successfully completed that week, is herein nevertheless designated "AMA" if, at the end of the week he declined a recommendation for continued care.] Of the twenty-seven AMAs, eighteen occurred prior to institution of the formal Recovering Attorneys' Program; thus, 79% of the lawyers in the Recovering Attorneys' Program successfully completed treatment and followed aftercare recommendations, versus 47% successful completions pre-Recovering Attorneys' Program.

Four clients were re-treated at a later date; one was re-treated twice. Three of the re-treated patients had no further relapses. No follow up information was available relating to nine of the AMAs. Three are believed to be sober, per the monitoring agency. Eight have either self-reported or are reported to be in relapse since treatment. Four had periods of or are currently incarcerated, three have been subsequently disbarred and two suffered substance abuse-related deaths.

Of the forty-eight successful completions, forty-one (85.4%) are reported sober, evidenced by compliance under monitoring contracts, or having successfully completed a contract. Four are believed to be in relapse and no information was obtainable on the other three. Four of the successful completions currently have five or more years of documented sobriety; five have four plus years documented, one has three plus, five have at least two years sober; twelve have over one year sober, eight have six months or more and six are in their first six months of sobriety. Of the forty-one currently sober, twenty-nine report no relapse following treatment, while twelve report one or more relapses following treatment prior to achieving their current sobriety.

DISCUSSION

1. Profile

Based on the foregoing, the typical attorney entering treatment is a male trial lawyer in his early forties, with a polysubstance addiction (often alcohol and cocaine), and who has a co-occurring mood disorder as well as a personality disorder complicating treatment. He is a veteran of multiple prior treatments, is often successful at work but rarely enjoys a satisfying home life.

The rate of psychological dysfunction and personality disorders were higher than one might expect, given the strenuous screening process inherent in becoming a member of the legal profession. With respect to the personality testing, lawyers not surprisingly tested high on the antisocial and narcissistic scales. However, a large percentage of attorneys entering treatment tested high on dependent, schizoid, and avoidant scales. As described above, these are personality configurations one would anticipate hindering the successful practice of law. But such was not the case. That means these individuals compensated for their personality proclivities by acting in a fashion contrary to their nature. Their success was tempered by an inner conflict that they in turn medicated with drugs or alcohol. In some cases this balancing act lasted for years until overtaken by the consequences of uncontrolled substance use and the lawyer sought (or, more often, was compelled to seek) treatment.

2. Outcome

Treatment outcomes improved significantly following institution of the Recovering Attorneys' Program in the Fall of 1999. It is believed that the basis for this improvement may be found in the framework of the Program:

--impaired professional treatment with additional, lawyer-specific overlay services;
--Program oversight by director with both legal and clinical background;
--proactively addressing work, Bar and criminal (if any) issues.

The Program and treatment community are well-served by keeping lawyer-patients extra busy. Boredom and ennui are counterproductive in any treatment population; with attorneys too much downtime is often a recipe for clinical disaster. Lawyers in the Recovering Attorneys' Program have three extra group activities, an additional five hours, per week.

A Program director or case manager with both legal and clinical experience is most helpful. Lawyers typically enter treatment with practice issues that must be addressed. The lawyer/patient will advise that every case requires immediate attention, to the neglect of the recovery process. This is a tailor-made way of avoiding the pain and fear inherent in getting clean and sober. Give the lawyer his way and he will never engage in treatment, being so busy running his practice from the treatment center. On the other hand, there often are real problems that must be addressed, in order to avoid new or additional Bar grievances for client neglect. The key is to accurately discern between problems that need immediate attention, versus "smokescreen" issues that are raised only as distractions or as ways to prevent or impede the treatment process. The conundrum is that the typical clinician can not and really should not be expected to know the true state of a lawyer's practice: which trials really are going forward on the next docket, which closings really can no longer be continued and so on and so forth. And even if a therapist was able to discern crises from non-crises, what to do? The truth is, judges, mediators, opposing counsel, and even clients are usually accommodating if approached in the right way. This is why having dual disciplines is effective: the legal background aids in deciding which matters are urgent and who needs to be contacted, and the clinical background is helpful in convincing of the paramount importance and need for prioritization of treatment.

CONCLUSION

Further studies of a prospective nature are needed in order to identify the causal relationship between chemical dependency/mental health problems and the legal profession. However, both ethics and compassion dictate that aggressive intervention cannot be withheld, but rather must be initiated immediately, given the large number of lawyers that may be suffering from either active or occult dependency or other mental disorders. This intervention should be initiated by state bar associations, which need to adopt a more active and confrontational role relating to its members' substance abuse and mental health issues. The intervention should then take the form of comprehensive chemical dependency and mental health assessment followed by, when dictated, lawyer specific primary and extended care treatment, and aftercare monitored by the state's lawyers' assistance program.

BIBLIOGRAPHY

1. Talbot GD, Gallegos KV, Wilson PO, Porter TL: The Medical Association of Georgia's Impaired Physicians Program-Review of the First 1000 Physicians: Analysis of Specialty, *JAMA* (1987); 257: 2927-2930.
2. Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds. (2001). *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised* (ASAM PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, Inc.
3. Millon T, MCMI-III Interpretive Reports, (1994) Dicandrien, Inc.
4. Opiates include prescription pain medication such as oxycodone (Percoset, Oxycontin), hydrocodone (Lortab, Vicodan), and hydromorphone (Dilaudid) as well as heroin and methadone.
5. Benzodiazapines, or tranquilizers, include Valium, Xanax, and Clonipin.
6. Gamma-Hydroxybutyrate
7. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Washington, DC, American Psychiatric Association, 1994. (Page 665).
8. Id. at 638.
9. Id. at 662.
10. Id. at 629-673.