

MENTAL ILLNESS AND THE PRACTICE OF LAW

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Attorneys, like physicians, play a valuable and important role in society. Their services are almost always sought out by the general public during times of personal vulnerability, turmoil, conflict, or stress. Perhaps even more so than in medicine, the outcome of the crisis for the client is highly dependent upon the skill of the attorney in understanding and resolving the issue.

To fulfill this vital role, attorneys must possess basic cognitive, emotional, and behavioral skills. These attributes are often referred to as the "essential eligibility requirements" for the practice of law. The importance of these qualities is well recognized by state boards of bar examiners (and/or their separate character and fitness committees), whose members are charged with verifying that applicants to the bar meet these basic criteria. These criteria are frequently described as

- the ability to demonstrate knowledge of the fundamental principles of law and their application;
- the ability to reason logically and to accurately analyze legal problems; and
- the ability to and likelihood that in the practice of law one will
 - comply with deadlines;
 - communicate candidly and civilly with clients, attorneys, courts, and others;
 - conduct financial dealings in a responsible, honest, and trustworthy manner;

- avoid acts that are illegal, dishonest, fraudulent, or deceitful; and
- conduct oneself in accordance with the requirements of applicable state, local, and federal laws and regulations.

Mental illness, however, can result in cognitive, emotional, or behavioral symptoms that could impair any of these core requirements and impede the attorney's ability to effectively represent his or her client. In this article I will examine the many ways in which psychiatric disorders can affect the practice of law. I will start by defining mental illness, briefly looking at the major mental disorders, and presenting epidemiological data available on attorneys. I will then develop a model for how boards of bar examiners can decide when an applicant's file may suggest an underlying mental illness that requires further examination, treatment, or monitoring before allowing the individual to engage in the practice of law.

MENTAL ILLNESS DEFINED

Before beginning a discussion of how mental illness can affect legal practice, it is important to define what constitutes a mental illness or disorder. Psychology, like law, uses terms that are part of the popular vernacular but have specific and technical meanings within the field. Just as the term *assault* has specific legal meaning, terms like *anxiety* and *depression* have specific psychological meanings. Thus, while we may all have used the word "depressed" to describe

our feelings after an unpleasant series of events (e.g., breakup of a relationship, difficult day at work, etc.), when used by mental health professionals, the word represents a clinical diagnosis with a specific constellation of symptoms, behaviors, consequences, and treatments.

Mental illness is defined by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, known as the *DSM-IV*.¹ This text is currently in its fourth edition, with the fifth edition scheduled for publication in May 2013, and contains over 900 pages describing various mental health conditions. The *DSM-IV* uses operationally defined criteria to develop a standardized and reliable classification system for clinicians to use in determining if a person has a mental disorder. It represents the "gold standard" of diagnosis for mental illness in America. According to the *DSM-IV*, a mental disorder is defined as

a clinically significant behavioral or psychological syndrome or pattern of behavior that occurs in an individual and that is associated with

- present distress (e.g., painful symptom), or
- disability (e.g., impairment in one or more important areas of functioning), or
- a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom.²

Inherent in virtually every diagnosis in the *DSM-IV* is the requirement of personal distress or impairment in social, occupational, or other important areas of functioning. A diagnosis of a mental disorder is not trivial and is differentiated from the simple ups and downs of daily life by a specific group of operationally defined symptoms that result in distress and/or disruption in important areas of

life. Thus, when an applicant has an active mental health diagnosis or a history of mental disorder, it is imperative that the professional reviewing the file determine if and how the disorder could disrupt the individual's ability to practice law and whether a mental health evaluation or conditional recommendation is warranted.

MAJOR MENTAL DISORDERS: AN OVERVIEW

The *DSM-IV* lists some 16 different classifications of mental disorders. Some of the major categories applicable to the present discussion include

- disorders of childhood and adolescence (e.g., Attention Deficit Hyperactivity Disorder [ADHD], Conduct Disorder);
- dementia and amnesic (memory) disorders (e.g., Alzheimer's Disorder, Traumatic Brain Injury);
- substance use disorders (e.g., Substance Abuse, Substance Dependence);
- thought disorders (e.g., Schizophrenia);
- mood disorders (e.g., Major Depressive Disorder, Bipolar Disorder);
- anxiety disorders (e.g., Social Phobia, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, Generalized Anxiety Disorder);
- impulse control disorders (e.g., Intermittent Explosive Disorder, Pathological Gambling);
- sexual disorders (e.g., Pedophilia, Exhibitionism);
- adjustment disorders; and
- personality disorders (e.g., Antisocial Personality Disorder, Borderline Personality Disorder).

The sidebar on pages 44–45 covers the characteristics of these major categories.

MAJOR MENTAL DISORDERS OF PARTICULAR CONCERN FOR THE PRACTICE OF LAW

Disorders of Childhood and Adolescence

By definition, these disorders occur early in life. In most cases the condition will likely have been resolved, or the applicant will have been able to adapt to his or her symptoms sufficiently to engage in the types of behaviors necessary to gain acceptance into law school. Several diagnoses, however, may persist to adulthood and need to be evaluated by boards of bar examiners.

Attention Deficit Hyperactivity Disorder (ADHD) represents one such condition. This diagnosis is used for individuals who demonstrate inattention or impulsivity that interferes with their daily function. It affects about 7% of children, mostly boys, and while most cases resolve by late adolescence, some individuals continue to suffer from symptoms into adulthood. These individuals frequently come to the attention of boards of bar examiners when they apply for test accommodations or reveal that they are on a stimulant medication.

Another diagnosis in this category that is potentially relevant to the practice of law is that of **Conduct Disorder**. This classification is used for youth who demonstrate a persistent pattern of behavior that violates social norms or the rights of others. A diagnosis of Conduct Disorder is important to note, because Conduct Disorder can be a precursor to Antisocial Personality Disorder (see Personality Disorders, p. 45).

Dementia and Amnesic Disorders

While diagnoses of **Dementia** will usually be restricted to the elderly (1.5% of persons older than 65 meet criteria for **Alzheimer's Disorder**), other conditions, such as **Traumatic Brain Injury**, are more common, especially in younger populations. These are the types of amnesic disorders that will usually lead to requests for test accommodations. Traumatic Brain Injury can result in a host of cognitive and behavioral deficits—including deficits in attention, memory, language, and reasoning—that can directly impact the practice of law.

Substance Use Disorders

Epidemiological research indicates that almost 9% of the population age 12 and older used an illicit drug within the last month, while almost 6% of 18- to 25-year-olds report non-medical use of prescription medication. Over 13% of adults ages 18 to 25 admit to heavy drinking.

Diagnoses of substance use disorders include **Substance Abuse** (a maladaptive pattern of use leading to clinically significant impairment and distress) and **Substance Dependence** (cognitive, behavioral, and physiological symptoms indicating continued substance use despite significant substance-related problems). The latter diagnosis is more

severe and should raise significant concerns within a bar application.

Because drugs of abuse achieve their “highs” by altering brain chemistry, they can affect every aspect of behavior. Diagnostic criteria for abuse of alcohol and virtually every other drug indicate cognitive impairments and aberrant behavior and emotions that can impact every aspect of the essential eligibility requirements for the practice of law. For example, **Cannabis (Marijuana) Intoxication** is described as “clinically significant maladaptive behavioral or psychological changes (e.g., impaired motor coordination, euphoria, anxiety, sensation of slowed time, impaired judgment, and social withdrawal).”³

Thought Disorders

Schizophrenia is the most devastating of all the mental disorders. In fact, it is one of the few diseases for which society has had to develop special centers for treating patients (state psychiatric hospitals). Schizophrenia affects approximately 1.5% of the population.

Because the age of onset for Schizophrenia is usually early adulthood, special care must be taken when any type of impaired perception of reality (e.g., **Brief Psychotic Disorder**) is noted within the bar application. In the case of Brief Psychotic Disorder, the person's symptoms, while similar to Schizophrenia, last less than a month, with a full return to the levels of functioning present prior to the disorder.

In addition to impairment in reality perception and judgment, thought disorders also result in the inability to control emotional behavior and in cognitive impairments involving memory, attention, and cognitive flexibility—abilities vital to the practice of law. Any evidence of a thought disorder within an application should be seen as a red flag and almost always requires further evaluation.

Mood Disorders

Major Depressive Disorder is one of the most commonly occurring mental disorders, with a lifetime prevalence rate of up to 25% for women and 12% for men. **Bipolar Disorder**, in which depressive episodes are interspersed with mania or hypomania (i.e., periods of grandiosity, impulsivity, and impaired language and problem solving), is rarer, occurring in about 2% of adults.

Both conditions result in mood and behavioral changes as well as cognitive impairments. For example, both Major Depressive Disorder and Bipolar Disorder involve impaired attention, changes in social interaction, and impaired ability to engage in goal-directed behavior. Major Depressive Disorder

is characterized by a “diminished ability to think or concentrate, or indecisiveness, nearly every day...”⁴

Major Depressive Disorder can affect an individual's ability to practice law in many ways, including lack of motivation, difficulty meeting deadlines, and cognitive impairments such as decreased attention and concentration. Similarly, attorneys in a manic episode will have problems with impulsivity, impaired judgment, decreased attention, and impaired reasoning.

Anxiety Disorders

Anxiety disorders can take many forms, from specific phobias (e.g., **Social Phobia**), to **Obsessive-Compulsive Disorder**, to trauma reactions (e.g., **Posttraumatic Stress Disorder**), to more ubiquitous free-floating anxiety (**Generalized Anxiety Disorder**).

The prevalence of requests for test accommodations due to anxiety disorders illustrates the level of impairment in cognitive function associated with such disorders. While the specific symptoms vary by disorder, virtually all include some type of attenuation in thinking ability or efficiency. Anxiety disorders also can result in behavioral changes or irritability that can negatively affect interpersonal relationships.

Anxiety disorders are common, with lifetime prevalence rates for Obsessive-Compulsive Disorder of 2.5%, Posttraumatic Stress Disorder of 8%, and Generalized Anxiety Disorder of 5%. Anxiety disorders can directly affect an individual's ability to practice law. For example, an attorney with a Social Phobia may compromise a client's case to avoid having to speak in public (e.g., settling a case instead of going to trial).

Impulse Control Disorders

This class of mental disorders involves inability to resist an impulse or drive that is harmful to the person or others. Those most pertinent to the practice of law include **Intermittent Explosive Disorder** and **Pathological Gambling**. The former can result in sudden, unpredictable behavioral outbursts that can include physical assault or destruction of property. The latter involves gambling behavior that can result in financial ruin and lead to inappropriate use of client trust accounts.

While Intermittent Explosive Disorder is relatively rare, as much as 3.4% of the general population may suffer from Pathological Gambling in their lifetime.

Sexual Disorders

Sexual disorders most likely to surface during review of a bar application fall into the category of the paraphilias (sexual interests or behaviors that involve nonhuman objects, children or nonconsenting adults, suffering, or humiliation). These conditions, which include diagnoses such as **Pedophilia** and **Exhibitionism**, are rare.

Evidence of a paraphilia is usually only available through arrest records or records of school or occupational incidents (e.g., sexual harassment). While rarely interfering with a person's cognition, these disorders can result in obvious harm to clients as well as negative publicity that can be embarrassing and undermine public confidence in the legal profession.

Adjustment Disorders

Adjustment disorders represent a class of diagnoses where the person experiences a negative psychological response to an identifiable stressor (e.g., job loss, ending of a relationship, etc.). The most common reactions involve depressed mood, anxiety, or disturbance in conduct. While causing impairment in social or occupational functioning, adjustment disorders are differentiated from other diagnoses both by their duration (i.e., symptoms resolve within six months) and reduced symptom severity (i.e., not meeting criteria for another disorder). While an attorney experiencing an adjustment disorder may exhibit impairment in functioning, he or she would be expected to return to his or her prior level of functioning once the stressor abates.

Personality Disorders

Personality disorders, or character pathology, represent enduring patterns of inflexible and pervasive behavior that deviate from expectations of the individual's culture. There are some 10 different personality disorders that fall into categories of odd and eccentric, emotionally erratic, and anxious subtypes. Specific diagnoses that are often cause for concern in the practice of law are **Antisocial Personality Disorder** and **Borderline Personality Disorder**.

Individuals with Antisocial Personality Disorder exhibit a pervasive pattern of disregard for the rights of others and societal standards of behavior. This is manifested through deceitfulness, poor impulse control, aggressiveness, and lack of remorse. Borderline Personality Disorder involves a pattern of instability in self-image, emotion, and relationships. Individuals with Borderline Personality Disorder also often have histories of self-harm through self-mutilation and suicidal behavior.

Similar to sexual disorders, personality disorders rarely lead to impaired cognition. However, because the deep-seated nature of these conditions affects virtually all aspects of the person's functioning, individuals with these disorders can often display emotionality and poor judgment that may severely compromise their honesty, professionalism, and interactions with others.

Prevalence rates for personality disorders vary considerably by specific diagnosis. For example, Antisocial Personality Disorder affects 3% of men and 1% of women, while Borderline Personality Disorder affects about 2% of the general population.

EPIDEMIOLOGY OF MENTAL ILLNESS

Mental illness is relatively common within the general population. Epidemiology data from the U.S. Centers for Disease Control reveal that 25% of Americans currently meet criteria for a mental illness and 50% will develop at least one mental illness during their lifetime.⁵ Mental illness is non-discriminatory and is found among all cultures, races, socioeconomic groups, and professions. Some data suggest a higher propensity toward certain types of mental illness within specific groups. For example, women have almost double the rate of depression as that of men, while males have higher rates of substance abuse (11.2% vs. 6.8%).

Prevalence of Mental Illness among Lawyers

Research has shown that lawyers have a rate of depression at or above that seen in the general population.⁶ A survey of mental illness among professionals by Johns Hopkins University found that out of all professionals, attorneys have the highest levels of depression.⁷ This is particularly true for female members of the bar.⁸ The American Bar Association reports that between 15% and 18% of attorneys suffer from a substance use disorder, a number equal to or greater than the rate in the general population,⁹ with an estimated 56,000 attorneys experiencing alcohol dependence during their lifetime and 30,000 bar members having another drug abuse disorder.¹⁰ Thus, boards of bar examiners must be sensitive to evaluating mental health issues in their applicants.

Average Age Onset of Mental Illness: Challenges for Bar Examiners

While some conditions such as Dementia occur mostly in the elderly, for the vast majority of psy-

chiatric illnesses, symptoms emerge early in life. For example, almost 90% of people who experience a mental illness will do so before the age of 40, with the mean onset age of psychiatric symptoms being 16 years old. Some conditions such as ADHD must, by definition, manifest before 7 years of age. Onset of Schizophrenia usually occurs between the late teens and mid-30s. Mood disorders such as Major Depressive Disorder and Bipolar Disorder most commonly appear during the early to mid-20s. While anxiety disorders such as Posttraumatic Stress Disorder are associated with a specific traumatic event and thus can occur at any age, most anxiety disorders, such as Panic Disorder, Social Phobia, and Obsessive-Compulsive Disorder, begin during the teenage years. Substance use disorders have the highest prevalence rates for people between the ages of 18 and 24 years.

The emergence of mental illness in early adulthood is important for boards of bar examiners evaluating the character and fitness of bar applicants, most of whom fall into the age demographic where symptoms of mental illness may first emerge. Boards and their experts are burdened with the task of differentiating the early signs and symptoms of mental illness from isolated behavioral issues that are innocuous parts of normal development. While distinguishing mental illness from the vicissitudes and indiscretions of youth is a difficult task, it is vital to ensure that the applicant can manifest the cognitive and behavioral attributes necessary for successful engagement in the practice of law.

The stakes are high for both false-positive errors (i.e., suggesting a mental health issue where none exists) and false-negative errors (i.e., missing a problem where one really exists). The former can lead to

THE EMERGENCE OF MENTAL ILLNESS IN EARLY ADULTHOOD IS IMPORTANT FOR BOARDS OF BAR EXAMINERS EVALUATING THE CHARACTER AND FITNESS OF BAR APPLICANTS, MOST OF WHOM FALL INTO THE AGE DEMOGRAPHIC WHERE SYMPTOMS OF MENTAL ILLNESS MAY FIRST EMERGE.

burdening the applicant with the unnecessary costs and possible stigma of having to undergo a mental health evaluation. It can also expose the board to potential litigation. False-negative errors, on the other hand, put the general public at risk for inadequate representation and jeopardize the reputation of the profession. Clearly, identifying applicants with underlying mental health or character issues is a task that is as difficult as it is important. In the next section I will examine a process for reviewing applications and deciding when additional scrutiny or assessment of an applicant is warranted.

STEPS FOR THE BAR APPLICATION REVIEW PROCESS

Engage the Services of a Mental Health Expert

Obviously, a board of bar examiners will need the services of a mental health expert to assist in the application review process. While there are a number of disciplines whose practitioners potentially have the mental health expertise to consult in this process, decisions on retention of an expert must also look at the ability of the expert to stand up to voir dire challenges and cross-examination should the applicant ever decide to challenge or litigate the recommendations or requirements of the board. As a forensic psychologist who regularly testifies in legal proceedings, I treat the review of every application as if the recommendations I make were going to be challenged, and I routinely assess whether I could defend, from the file information, the decision to recommend an evaluation or to deny an accommodations request.

The level of training of the mental health expert used by the board is important, as many legal jurisdictions prefer to deal with doctoral-trained clinicians (i.e., M.D.s or Ph.D.s). Thus, in choosing an expert, the board may want to retain a psychiatrist

(M.D.) or a clinical psychologist (Ph.D.). In addition to any academic work, it is important that the expert have a history of clinical experience, in both inpatient and outpatient settings, so as to have credibility in his or her opinions regarding evidence of psychopathology and the need for further assessment. The expert should also have experience in forensic mental health (i.e., interfacing between psychology or psychiatry and the law) in order to be able to consider potential issues of litigation regarding his or her opinions and to support those opinions should he or she have to testify before some tribunal.

Evaluate the History of Psychiatric Diagnosis

The presence of a mental disorder in the applicant's record always raises concerns regarding the need for further assessment. However, past history of or present treatment for a psychological disorder does not, in my professional opinion, in and of itself suggest that further evaluation is necessary. In fact, having such an arbitrary referral mechanism would be seen as discriminatory and in violation of Equal Employment Opportunity Commission regulations and the Americans with Disabilities Act. So what additional information is needed to help identify those cases for which further evaluation is necessary?

Specific Diagnosis

While diagnoses such as Major Depressive Disorder occur frequently in the population, others such as Schizophrenia and Bipolar Disorder are more rare. Any diagnosis of a thought disorder or Bipolar I Disorder (full manic episode) requires special scrutiny.

Severity of the Diagnosis

Anyone who has worked with people with mental disorders knows that there is a tremendous amount of variability in terms of symptom severity and

effects on daily living. Thus, one person with Major Depressive Disorder may still be able to go to work, while another may not be able to get out of bed in the morning. One measure of symptom severity is whether the person has been hospitalized. Over the last two decades, significant changes have taken place regarding reimbursement for inpatient treatment, resulting in only those individuals with the most serious symptoms being admitted to the hospital. Thus, psychiatric hospitalization is an important factor to consider.

Another indication of the severity of the diagnosis is the Global Assessment of Functioning (GAF). This numerical score between 1 and 100 is recorded on Axis V of the five-axis *DSM-IV* diagnostic system (see the sidebar on this page for an explanation of the *DSM-IV* multiaxial diagnostic system) and can give an indication of symptom severity or accompanying impairment in social or occupational functioning. For example, a GAF of 61–70 indicates mild symptoms or impairment, while a score of 41–50 indicates serious symptoms or impairment. An Axis V GAF demonstrates to the board how the applicant's symptoms affect his or her functioning. It should be a part of all mental health assessments.

Length of Time since the Diagnosis

In deciding whether an applicant requires further mental health assessment, the board should consider when the diagnosis was made and the applicant's subsequent level of function. For example, a person who was diagnosed with Major Depressive Disorder 10 years ago following the death of a parent, even if that resulted in hospitalization, and has since completed college and law school without incident would likely not require further examination. On the other hand, a person with Bipolar I Disorder who was hospitalized three years ago with no subsequent follow-up would raise more concern.

THE *DSM-IV* MULTIAXIAL DIAGNOSTIC SYSTEM

Diagnosis in the *DSM-IV* is based on a multiaxial format:

- **Axis I** includes the diagnosis of all major mental illnesses.
- **Axis II** is limited to the diagnosis of Personality Disorders and Mental Retardation.
- **Axis III** is reserved for general medical conditions that are relevant to understanding or treating the person's mental disorder (e.g., cancer).
- **Axis IV** refers to psychological and environmental problems that may affect the diagnosis, treatment, and prognosis of an Axis I or II mental disorder (e.g., loss of job, poverty, etc.).
- **Axis V** provides the Global Assessment of Functioning (GAF). This numerical score between 1 and 100 represents the clinician's judgment as to the person's overall level of functioning in terms of symptom severity and impairment in social or occupational functioning.

Treatment History

While mental illness can be chronic, most individuals experience significant improvement in symptoms and functioning with treatment. Thus, an individual's treatment history and compliance can serve as good indicators of whether further assessment is needed. For example, an individual who was hospitalized for Bipolar I Disorder three years ago but has a letter in the file from the treating professional indicating regular treatment and compliance with medication would seem to be less in need of a follow-up evaluation. Similarly, a person with Major Depressive Disorder in the past who has voluntarily sought treatment when needed will be likely to do so again, should the need arise, making further assessment unnecessary.

On the other hand, a person who was hospitalized for Bipolar I Disorder five years ago who attended only one follow-up appointment and has not

been seen by anyone since that time may require an evaluation to provide information regarding his or her current mental status and psychiatric functioning. This is because Bipolar I Disorder is a chronic condition with research indicating approximately four manic episodes within 10 years if untreated.

Watch for Behaviors Suggestive of a Personality Disorder

Personality disorders represent underlying character conditions that, while important and disruptive to social and occupational functioning, are much less likely to be diagnosed than Axis I disorders (see the sidebar on page 48 for an explanation of the *DSM-IV* multiaxial diagnostic system). Part of this is related to the individual's lack of awareness of his or her condition. Thus, individuals rarely seek professional help for these underlying character conditions. When they do come in for treatment, it is usually to deal with some secondary issue (e.g., depression at being fired secondary to their inability to get along with others). Additionally, diagnosis of a personality disorder often requires information about the person from a variety of different settings. Such information is rarely sought in a typical clinical interview, resulting in the Axis II diagnosis being listed as "deferred."

However, these behavioral patterns are pervasive and chronic and can severely impair the applicant's ability to function as an attorney. Thus, reviewers must look for aberrant behaviors within the file that might suggest the presence of a personality disorder and warrant further assessment. It is important to note that none of the behaviors below is, by itself, indicative of a personality disorder. Rather, the reviewer needs to be mindful of patterns of behavior that would suggest additional assessment. These behaviors include

- failure to conform to societal standards of behavior as evidenced by
 - arrest history
 - disciplinary actions received in school or at work
 - less than honorable discharge from the military
 - repeated appearance as a plaintiff or defendant in civil actions
 - job terminations
- deceit as illustrated by
 - lack of candor on applications
 - student honor code violations
- impulsivity and irresponsibility as manifested by
 - sudden and frequent job changes
 - poor work or academic performance
 - multiple academic transfers without receipt of a degree
 - repeated traffic violations or arrests
 - financial problems/unpaid debt
 - failure to meet deadlines
 - failure to honor alimony or child support obligations
- violence as evidenced by
 - history of fighting
 - history of arrest
 - evidence of domestic violence
 - intimidation/bullying
 - restraining orders
 - accusations of sexual misconduct
- emotional instability suggested by
 - multiple marriages/relationships
 - interpersonal conflict with coworkers
 - polarized relationships

A mental health expert can utilize the vast amount of information within the typical applicant file to determine if there exists a pattern of behavior suggestive of an underlying personality disorder. The applicant can then be reasonably sent for a mental health evaluation to determine if such a diagnosis can truly be made. The evaluating professional, armed with the collateral information in the file and specifically charged to evaluate Axis II psychopathology, would be in a position to make such a diagnosis and aid the board in its decision making.

Address Any Current Psychiatric Diagnosis

The purpose of requesting a mental health evaluation after the board consultant reviews the applicant file is to identify any ongoing cognitive, emotional, or behavioral issues that may interfere with the practice of law. But what approach should be taken when the person is currently or has recently been diagnosed with a mental health condition? Again, this depends somewhat on the diagnosis, with thought disorders almost always requiring further scrutiny. However, with other diagnoses such as Bipolar Disorder or Major Depressive Disorder, further evaluation may not be necessary.

In most situations, if the diagnosis is clear and the person has a history of treatment compliance, no further assessment may be necessary. Simple review of the progress notes or letters from treatment professionals is usually sufficient to document that the person's diagnosed mental health condition does not impair his or her ability to function as an attorney. However, in situations where there are questions about the accuracy of the diagnosis, compliance with treatment, or current functioning, some type of additional evaluation may be necessary.

In those cases it is important that the board have mental health professionals (Ph.D.s or M.D.s) to


whom the applicant can be referred. Having a list of providers that the board has pre-approved based on their credentials and experience—or approving a professional based on these criteria prior to the evaluation—will help the board have confidence in the quality of the evaluation. In almost all cases, the evaluation should be done by an independent evaluator and not by the applicant's treating professional. This is because treatment providers have a close relationship with their patients and are advocates for them. This could cause them to minimize the applicant's symptoms or impairment in functioning. Rather, it is better to have the applicant evaluated by a neutral third party who has no vested interest in the evaluation results.

It is important that the evaluator make clear to the applicant that the evaluation is being done at the request of the board. Use of a thorough informed consent form will help protect both the evaluator and the board from any future complaints from an applicant who might be unhappy with the results of the evaluation. It is also important to provide the mental health evaluator with a specific referral question (e.g., determination of the presence of an underlying personality disorder and how it could impact the practice of law), rather than simply asking for a mental health evaluation. To do this, the evaluator should be provided with the applicant file so that he or she has access to the same collateral data that caused the board's mental health consultant to request an evaluation. Finally, in most cases, the evaluation should include psychological testing. The value of testing is that it provides an objective assessment of the applicant's cognitive or personality functioning that can help clarify diagnostic impressions.

If a diagnosis is relatively new, a recommendation for conditional admission can be made (if the jurisdiction's rules provide for such admission)

where admission to the bar is predicated upon the applicant participating in treatment and having his or her provider supply regular reports to the bar or attorney assistance program on the treatment compliance and level of functioning. Generally these periods of monitoring range from 12 months to 5 years, with some cases requiring lifelong monitoring.

CONCLUSION

The presence of mental illness can have a devastating impact upon an attorney's ability to meet the essential eligibility requirements for the practice of law. Mental illness is much more common than many laypersons recognize, and it tends to emerge in early adulthood, a time when many new law school graduates are applying to their state bars. What should become evident from this article is the importance and complexity of evaluating mental health issues, illustrating how crucial it is that boards of bar examiners utilize appropriate mental health experts in this process. 

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NOTES

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2. *Id.* at xxxi.
3. *Id.* at 238.
4. *Id.* at 356.
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6. W.W. Eaton, *Occupations and the Prevalence of Major Depressive Disorder*, 32(11) J. OCCUPATIONAL MEDICINE 1079–1087 (1990).
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9. M. Greiner, *What About Me?* TEXAS BAR J., Sept. 1996.
10. D. Jones, *Career Killers*, in A GUIDE TO THE BASIC LAW PRACTICE, 180–197 (B.P. Crowley & M.L. Winick, eds., Alliance Press, 2001).



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