

Articles and Other Resources

I. How To Address Suspected Atty Mental Health Issues At Work
Law360.com, October 2, 2020

In this article, author, Aebera Coe, and Patrick Krill, a researcher and consultant to legal employers who specializes in attorney mental health and wellness, dive into mental health and addiction issues during the age of Coronavirus. The article, tailored specifically for legal professionals, discusses how to confront potential mental health problems and offers examples on how to provide professionals assistance.

II. The Prevalence of Substance Use and Other Mental Health Concerns Among American Attorneys
American Society of Addiction Medicine, January/February 2016

In this study, practicing lawyers completed surveys that assessed alcohol use, drug use as well as symptoms of depression, anxiety, and stress. The study stresses the need for greater education focused on prevention, better publication of the confidential nature of lawyer assistance programs, and public awareness campaigns within the profession with the goal of overcoming “the pervasive stigma surrounding substance abuse disorders and mental health concerns.”

III. Mental Health Problems in the Workplace
Harvard Mental Health Letter, February 2010

Mental health disorders often go unrecognized and untreated. This guide provides an outline on the most common mental health problems in the workplace, and how they affect both employees and employers and how to recognize symptoms.

IV. Coping with Stress
Centers for Disease Control and Prevention, December 2020

This article provides guidance on how to deal with anxiety during the pandemic and resources to address mental health issues.



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How To Address Suspected Atty Mental Health Issues At Work

By **Aebra Coe**

Law360 (October 2, 2020, 7:03 PM EDT) -- As mental health and addiction issues spike amid the coronavirus pandemic, legal employers must be knowledgeable about the right and wrong ways to confront workers about potential mental health problems and offer them help, according to two experts speaking on a Friday panel.

As rates of anxiety, depression and substance abuse rise in the general population during the pandemic, the legal industry is not immune to those challenges and, in fact, attorneys as a group have long had higher rates of mental health issues to begin with, making them particularly vulnerable during these challenging times, said Patrick Krill, a researcher and consultant to legal employers who specializes in attorney mental health and wellness.

"We've been living through a truly unprecedented year that has been posing risks to our mental health, our physical health and our personal well being," Krill said. "It's very important to be more attentive right now about how the people around you are doing than you were prior to this."

Krill presented the continuing legal education webinar course alongside Jonathan A. Segal, managing principal at Duane Morris Institute.

The two men offered up advice for how law firms and other legal employers can encourage attorneys and other workers to reach out for help with mental health issues when it is needed, and also how they can approach those who may appear to have a problem but have not taken the initiative to seek help on their own.

Encourage Help-Seeking Behavior

The first step is making sure all attorneys and staff have access to employee assistance programs and other mental health resources, that they understand what services those programs provide and what level of anonymity is available through them, Segal said.

Krill added that law firms should have clear protocols around what happens when a lawyer seeks help through an employee assistance program, so that everyone knows what information will be kept confidential and what exceptions there are to that.

It is vitally important, he said, that a culture of seeking help is nurtured and that legal employers work to make it as easy and attractive as possible so that lawyers do not hesitate to get help when needed.

"It's important to be as communicative as possible and express what the process is and make sure you're working against any misperception or misunderstanding that may exist

about what does happen," Krill said. "We need to demystify that process. In absence of clear protocol, we're oftentimes predisposed to imagining the worst case scenario."

At the same time, while employers can promise not to penalize an attorney for seeking help with a mental health issue, they cannot guard against potential legal malpractice lawsuits or attorney discipline proceedings if inappropriate behavior as a result of those issues comes to light, so there are limits to the protections that employers can offer, Segal noted.

Law firms should make it clear, though, that the goal of offering programs that aid in mental health are for people to get better, not to penalize them, he said.

Intervening When Help Is Not Sought

Still, many times people who are struggling with mental health issues will not seek help on their own, whether because they are afraid of the consequences of telling others or because they are in denial, Segal said.

He says he remembers an attorney who responded to a questionnaire once, marking "yes" when asked if they ever drank at work or if they had medical, legal and family problems caused by their drinking. But when asked, "do you think you have a drinking problem," the person responded "no."

In those cases, firms will often have to intervene and have a conversation with an attorney about behavior that could indicate a mental health issue. The key, Segal and Krill said, is for those non-medical professionals to avoid making any diagnoses or conclusions when there is a suspected issue.

A law firm managing partner or general counsel is not equipped to diagnose a mental health issue and saying something like, "I think you may have depression" can create a number of problems, including legal issues if the person believes they are being slandered.

Instead, they said, an intervention by management would address behaviors that have been noted and allow for an open discussion of performance issues and what may be impacting those as well as other observable behaviors. And then management can make clear that there are resources available for anyone who is struggling with a mental health issue.

Krill pointed to several behaviors that colleagues and management can look for and point to that often show up when someone is struggling with mental health challenges.

The first three are represented by the acronym "MAP" and include changes in mood, appearance and performance.

Another five common signs include personality changes; signs of being increasingly angry, agitated and moody; withdrawing or isolating; neglecting self care and engaging in risky behavior; and being overcome with hopelessness and overwhelmed by circumstances.

In cases where there are not performance issues, it may be a little harder to start the conversation, but it is still important, Krill said.

"Often this leads to ignoring the problem or enabling the problem. If someone seems distressed but is doing well from the performance standpoint, the tendency is to allow that person to continue to produce for the firm," he said. "I would not let the lack of work product issues keep me from having the antennae up and checking in with them generally about how they're doing," he said.

Segal reminded viewers of the webinar that confronting someone isn't an all or nothing thing, either saying "I think you're an alcoholic" or saying nothing at all.

Instead, it is best to express concern about those specific changes and behaviors that could signal an issue and then to see if the person wants to speak to a professional about any problems they're having.

When it does become clear there is a problem, it is still important to get a diagnosis and a plan of action from a mental health professional, and not rely on lay people to do so, Krill said.

"There is a continuum of options available, depending on the level of impairment and distress," he said.

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

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

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

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

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

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

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

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

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

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

outdated and poorly defined scope of the problem (Association of American Law Schools, 1994).

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

METHODS

Procedures

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

Participants

A total of 14,895 individuals completed the survey. Participants were included in the analyses if they were currently employed, and employed in the legal profession, resulting in a final sample of 12,825. Due to the nature of recruitment (eg, e-mail blasts, web postings), and that recruitment mailing lists were controlled by the participating bar associations, it is not possible to calculate a participation rate among the entire population. Demographic characteristics are presented in Table 1. Fairly equal numbers of men (53.4%) and women (46.5%) participated in the study. Age was measured in 6 categories from 30 years or younger, and increasing in 10-year increments to 71 years or older; the most commonly reported age group was 31 to 40 years old. The majority of the participants were identified as Caucasian/White (91.3%).

As shown in Table 2, the most commonly reported legal professional career length was 10 years or less (34.8%), followed by 11 to 20 years (22.7%) and 21 to 30 years (20.5%). The most common work environment reported was in private firms (40.9%), among whom the most common positions were Senior Partner (25.0%), Junior Associate (20.5%), and Senior Associate (20.3%). Over two-thirds (67.2%) of the sample reported working 41 hours or more per week.

TABLE 1. Participant Characteristics

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

*Substance use includes both illicit and prescribed usage.

Materials

Alcohol Use Disorders Identification Test

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

The AUDIT is a widely used instrument, with well established validity and reliability across a multitude of populations (Meneses-Gaya et al., 2009). To compare current rates of problem drinking with those found in other populations, AUDIT-C scores were also calculated. The AUDIT-C is a subscale comprised of the first 3 questions of the AUDIT

TABLE 2. Professional Characteristics

	n (%)
Total sample	12825 (100)
Years in field (yrs)	
0–10	4455 (34.8)
11–20	2905 (22.7)
21–30	2623 (20.5)
31–40	2204 (17.2)
41 or more	607 (4.7)
Work environment	
Private firm	5226 (40.9)
Sole practitioner, private practice	2678 (21.0)
In-house government, public, or nonprofit	2500 (19.6)
In-house: corporation or for-profit institution	937 (7.3)
Judicial chambers	750 (7.3)
Other law practice setting	289 (2.3)
College or law school	191 (1.5)
Other setting (not law practice)	144 (1.1)
Bar Administration or Lawyers Assistance Program	55 (0.4)
Firm position	
Clerk or paralegal	128 (2.5)
Junior associate	1063 (20.5)
Senior associate	1052 (20.3)
Junior partner	608 (11.7)
Managing partner	738 (14.2)
Senior partner	1294 (25.0)
Hours per wk	
Under 10 h	238 (1.9)
11–20 h	401 (3.2)
21–30 h	595 (4.7)
31–40 h	2946 (23.2)
41–50 h	5624 (44.2)
51–60 h	2310 (18.2)
61–70 h	474 (3.7)
71 h or more	136 (1.1)
Any litigation	
Yes	9611 (75.0)
No	3197 (25.0)

focused on the quantity and frequency of use, yielding a range of scores from 0 to 12. The results were analyzed using a cut-off score of 5 for men and 4 for women, which have been interpreted as a positive screen for alcohol abuse or possible alcohol dependence (Bradley et al., 1998; Bush et al., 1998). Two other subscales focus on dependence symptoms (eg, impaired control, morning drinking) and harmful use (eg, blackouts, alcohol-related injuries).

Depression Anxiety Stress Scales-21 item version

The Depression Anxiety Stress Scales-21 (DASS-21) is a self-report instrument consisting of three 7-item subscales assessing symptoms of depression, anxiety, and stress. Individual items are scored on a 4-point scale (0–3), allowing for subscale scores ranging from 0 to 21 (Lovibond and Lovibond, 1995). Past studies have shown adequate construct validity and high internal consistency reliability (Antony et al., 1998; Clara et al., 2001; Crawford and Henry, 2003; Henry and Crawford, 2005).

Drug Abuse Screening Test-10 item version

The short-form Drug Abuse Screening Test-10 (DAST) is a 10-item, self-report instrument designed to screen and quantify consequences of drug use in both a clinical and

research setting. The DAST scores range from 0 to 10 and are categorized into low, intermediate, substantial, and severe-concern categories. The DAST-10 correlates highly with both 20-item and full 28-item versions, and has demonstrated reliability and validity (Yudko et al., 2007).

RESULTS

Descriptive statistics were used to outline personal and professional characteristics of the sample. Relationships between variables were measured through χ^2 tests for independence, and comparisons between groups were tested using Mann-Whitney *U* tests and Kruskal-Wallis tests.

Alcohol Use

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

Of the 12,825 participants, 11,489 completed the first 3 AUDIT questions, allowing an AUDIT-C score to be calculated. Among these participants, 36.4% had an AUDIT-C score consistent with hazardous drinking or possible alcohol abuse or dependence. A significantly higher proportion of women (39.5%) had AUDIT-C scores consistent with problematic use compared with men (33.7%) (χ^2 [1, *N* = 11,440] = 41.93, *P* < 0.001).

A total of 2901 participants (22.6%) reported that they have felt their use of alcohol or other substances was problematic at some point in their lives; of those that felt their use has been a problem, 27.6% reported problematic use manifested before law school, 14.2% during law school, 43.7% within 15 years of completing law school, and 14.6% more than 15 years after completing law school.

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

TABLE 3. Summary Statistics for Alcohol Use Disorders Identification Test (AUDIT)

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

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

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

approached significance, with higher AUDIT scores predicted for those just starting out in the legal profession (0–10 yrs of experience) ($\beta = 0.46$, Wald [$df = 1$] = 3.808, $P = 0.051$). Model-based calculated probabilities for respondents aged 30 or younger indicated that they had a mean probability of 0.35 (standard deviation [SD] = 0.01), or a 35% chance for scoring an 8 or higher on the AUDIT; in comparison, those respondents who were 61 or older had a mean probability of 0.17 (SD = 0.01), or a 17% chance of scoring an 8 or higher.

Each of the 3 subscales of the AUDIT was also investigated. For the AUDIT-C, which measures frequency and quantity of alcohol consumed, age was a strong predictor of subscore, with younger respondents demonstrating significantly higher AUDIT-C scores. Respondents who were 30 years old or younger, 31 to 40 years old, and 41 to 50 years old all had significantly higher AUDIT-C scores than their older peers, respectively ($\beta = 1.16$, Wald [$df = 1$] = 24.56, $P < 0.001$; $\beta = 0.86$, Wald [$df = 1$] = 16.08, $P < 0.001$; and $\beta = 0.48$, Wald [$df = 1$] = 6.237, $P = 0.013$), indicating that younger age predicted higher frequencies of drinking and quantity of alcohol consumed. No other factors were significant predictors of AUDIT-C scores. Neither the predictive model for the dependence subscale nor the harmful use subscale indicated significant predictive ability for the 3 included factors.

Drug Use

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

Mental Health

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

TABLE 4. Summary Statistics for Depression Anxiety Stress Scale (DASS-21)

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

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

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

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

Treatment Utilization and Barriers to Treatment

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

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

TABLE 5. Relationship AUDIT Drinking Classification and DASS-21 Mean Scores

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

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

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

**Means were analyzed using Mann-Whitney *U* tests.

DISCUSSION

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

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

attorneys aged 31 to 40 (26.1%), with declining rates reported thereafter.

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

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

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

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

Our study is subject to limitations. The participants represent a convenience sample recruited through e-mails and

news postings to state bar mailing lists and web sites. Because the participants were not randomly selected, there may be a voluntary response bias, over-representing individuals that have a strong opinion on the issue. Additionally, some of those that may be currently struggling with mental health or substance use issues may have not noticed or declined the invitation to participate. Because the questions in the survey asked about intimate issues, including issues that could jeopardize participants' legal careers if asked in other contexts (eg, illicit drug use), the participants may have withheld information or responded in a way that made them seem more favorable. Participating bar associations voiced a concern over individual members being identified based on responses to questions; therefore no IP addresses or geo-location data were gathered. However, this also raises the possibility that a participant took the survey more than once, although there was no evidence in the data of duplicate responses. Finally, and most importantly, it must be emphasized that estimations of problematic use are not meant to imply that all participants in this study deemed to demonstrate symptoms of alcohol use or other mental health disorders would individually meet diagnostic criteria for such disorders in the context of a structured clinical assessment.

CONCLUSIONS

Attorneys experience problematic drinking that is hazardous, harmful, or otherwise generally consistent with alcohol use disorders at a rate much higher than other populations. These levels of problematic drinking have a strong association with both personal and professional characteristics, most notably sex, age, years in practice, position within firm, and work environment. Depression, anxiety, and stress are also significant problems for this population and most notably associated with the same personal and professional characteristics. The data reported here contribute to the fund of knowledge related to behavioral health concerns among practicing attorneys and serve to inform investments in lawyer assistance programs and an increase in the availability of attorney-specific treatment. Greater education aimed at prevention is also indicated, along with public awareness campaigns within the profession designed to overcome the pervasive stigma surrounding substance use disorders and mental health concerns. The confidential nature of lawyer-assistance programs should be more widely publicized in an effort to overcome the privacy concerns that may create barriers between struggling attorneys and the help they need.

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Mental health problems in the workplace

Published: February, 2010

Low treatment rates imperil workers' careers and companies' productivity.

Mental health problems affect many employees — a fact that is usually overlooked because these disorders tend to be hidden at work. Researchers analyzing results from the U.S. National Comorbidity Survey, a nationally representative study of Americans ages 15 to 54, reported that 18% of those who were employed said they experienced symptoms of a mental health disorder in the previous month.

But the stigma attached to having a psychiatric disorder is such that employees may be reluctant to seek treatment — especially in the current economic climate — out of fear that they might jeopardize their jobs. At the same time, managers may want to help but aren't sure how to do so. And clinicians may find themselves in unfamiliar territory, simultaneously trying to treat a patient while providing advice about dealing with the illness at work.

As a result, mental health disorders often go unrecognized and untreated — not only damaging an individual's health and career, but also reducing productivity at work. Adequate treatment, on the other hand, can alleviate symptoms for the employee and improve job performance. But accomplishing these aims requires a shift in attitudes about the nature of mental disorders and the recognition that such a worthwhile achievement takes effort and time.

Here's a quick guide to the most common mental health problems in the workplace, and how they affect both employees and employers.

Key points

- Symptoms of mental health disorders may be different at work than in other situations.
- Although these disorders may cause absenteeism, the biggest impact is in lost productivity.
- Studies suggest that treatment improves work performance, but is not a quick fix.

Stealth symptoms, tangible impact

Symptoms of common problems — such as depression, bipolar disorder, attention deficit hyperactivity disorder (ADHD), and anxiety — are all described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). But symptoms tend to manifest differently at work than they do at home or in other settings.

Although symptoms may go unnoticed, the economic consequences are tangible. Studies assessing the full work impact of mental health disorders often use the World Health Organization (WHO) Health and Work Performance Questionnaire, which not only asks employees to report how many days they called in sick, but also asks them to assess, on a graded scale, how productive they were on the days they actually were at work. The results are measured in days out of work (absenteeism) and lost productivity ("presenteeism").

In one study examining the financial impact of 25 chronic physical and mental health problems, researchers polled 34,622 employees at 10 companies. The researchers tabulated the amount of money the companies spent on medical and pharmacy costs for employees, as well as employees' self-reported absenteeism and lost productivity, using the WHO questionnaire.

When researchers ranked the most costly health conditions (including direct and indirect costs), depression ranked first, and anxiety ranked fifth — with obesity, arthritis, and back and neck pain in between.

Many of the studies in this field have concluded that the indirect costs of mental health disorders — particularly lost productivity — exceed companies' spending on direct costs, such as health insurance contributions and pharmacy expenses. Given the generally low rates of treatment, the researchers suggest that companies should invest in the mental health of workers — not only for the sake of the employees but to improve their own bottom line.

Depression is the mental health disorder that has been best studied in the workplace, partly because it is so common in the general population. One survey of a nationally representative sample reported that about 6% of employees experience symptoms of depression in any given year.

Although the *DSM-IV* lists low mood as the defining symptom of depression, in the workplace this disorder is more likely to manifest in behaviors — such as nervousness, restlessness, or irritability — and in physical complaints, such as a preoccupation with aches and pains. In addition, employees may become passive, withdrawn, aimless, and unproductive. They also may be fatigued at work, partly as a result of the mood disorder or because they are having trouble sleeping at night. Depression may also impair judgment or cloud decision making.

Researchers who analyzed employee responses to the WHO questionnaire found that workers with depression reported the equivalent of 27 lost work days per year — nine of them because of sick days or other time taken out of work, and another 18 reflecting lost productivity. Other research has found that employees with depression are more likely than others to lose their jobs and to change jobs frequently.

Part of the problem may be lack of treatment. In one study, only 57% of employees with symptoms of major depression said they had received mental health treatment in the previous 12 months. Of those in treatment, fewer than half — about 42% — were receiving treatment considered adequate, on the basis of how consistent it was with published guidelines about minimal standards of care. The researchers estimated that over all, when lack of treatment or inadequate treatment was taken into account, only about one in four employees with major depression received adequate treatment for the disorder.

Bipolar disorder is typically characterized by cycling between elevated (manic) and depressed moods. In a manic phase, employees may appear highly energetic and creative, but actual productivity may suffer. And during full-blown mania, a person may become self-aggrandizing or disruptive, flout workplace rules, be overly aggressive, and make mistakes in judgment (such as overspending a budget). During the depressive phase, an employee may exhibit depressive symptoms as described above. Although mania may be more noticeable at work, the research suggests that the depressive phase of bipolar disorder can impair performance more than the manic phase.

One nationally representative study estimated that about 1% of American employees suffer from bipolar disorder in any year. Based on employee responses to the WHO questionnaire, the researchers estimated that employees with bipolar disorder lost the equivalent of about 28 work days per year from sick time and other absences, and another 35 in lost productivity. The authors note that although bipolar disorder may be more disabling to employees on an individual level, the cost to employers is still less than that attributed to depression, because the latter is more common in the population.

In a departure from findings about treatment rates for other mental health disorders, about two-thirds of employees with bipolar disorder said they had received treatment for it. But the likelihood of receiving adequate care depended on the type of clinician they saw. Only about 9% of those who sought care from general practitioners received care in keeping with published guidelines for bipolar disorder, compared with 45% of those who sought care from mental health professionals.

Anxiety disorders in the workplace may manifest as restlessness, fatigue, difficulty concentrating, and excess worrying. Employees may require constant reassurance about performance. Sometimes, as with depression, physical symptoms or irritability may be noticeable.

Anxiety disorders affect about 6% of the population at some point in life, but typically go undiagnosed for 5 to 10 years. And only about one in three individuals with a diagnosed disorder receives treatment for it. At the same time, the studies suggest that people with anxiety disorders are more likely than others to seek out medical care — but for problems like gastrointestinal distress, sleep disturbances, or heart trouble rather than for anxiety.

It is probably not surprising, then, that anxiety disorders cause significant work impairment. Generalized anxiety disorder, for example, results in work impairment (as measured by sick days and lost productivity) similar to that attributed to major depression.

ADHD is often considered a problem only in childhood, but it also affects adults. An international survey in 10 countries (including the United States) estimated that 3.5% of employees have ADHD. In the workplace, symptoms of ADHD may manifest as disorganization, failure to meet deadlines, inability to manage workloads, problems following instructions from supervisors, and arguments with co-workers.

Workplace performance — and the employee's career — may suffer. Studies estimate that people with ADHD may lose 22 days per year (a combination of sick days and lost productivity), compared with people without the disorder. In addition, people with ADHD are 18 times as likely to be disciplined for behavior or other work problems, and likely to earn 20% to 40% less money than others. They are also two to four times as

likely as other employees to be terminated from a job.

Treatment rates among employees with ADHD are especially low. In the United States, for example, only 13% of workers with ADHD reported being treated for this condition in the previous 12 months.

An investment in health

The literature on mental health problems in the workplace suggests that the personal toll on employees — and the financial cost to companies — could be eased if a greater proportion of workers who need treatment were able to receive it. The authors of such studies advise employees and employers to think of mental health care as an investment — one that's worth the up-front time and cost.

Most of the research on the costs and benefits of treatment has been done on employees with depression. The studies have found that when depression is adequately treated, companies reduce job-related accidents, sick days, and employee turnover, as well as improve the number of hours worked and employee productivity.

But the research also suggests that treatment for depression is not a quick fix. Although adequate treatment alleviates symptoms and improves productivity, one study found that in the short term, employees may need to take time off to attend clinical appointments or reduce their hours in order to recover.

To overcome barriers to accessing care, and to make it more affordable to companies, the National Institute of Mental Health is sponsoring the Work Outcomes Research and Cost Effectiveness Study at Harvard Medical School. The researchers have published results from a randomized, controlled trial of telephone screening and depression care management for workers at 16 large companies, representing a variety of industries.

During the two-phase study, mental health clinicians employed by an insurance company identified workers who might need treatment, provided information about how to access it, monitored adherence to treatment, and provided telephone psychotherapy to those workers who did not want to see a therapist in person. The outcomes of 304 workers assigned to the intervention were compared with 300 controls, who were referred to clinicians for treatment but did not receive telephone support.

The researchers found that workers assigned to the telephone intervention reported significantly improved mood and were more likely to keep their jobs when compared with those in the control group. They also improved their productivity, equivalent to about 2.6 hours of extra work per week, worth about \$1,800 per year (based on average wages) — while the intervention cost the employers an estimated \$100 to \$400 per treated employee. The researchers are conducting additional research on how to improve access to mental health care in the workplace, and to quantify costs and benefits for employers.

Studies such as these suggest that, in the long term, costs spent on mental health care may represent an investment that will pay off — not only in healthier employees, but also for the company's financial health.

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For more references and a list of resources for employees and companies, please see www.health.harvard.edu/mentalextra.

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COVID-19

ACT NOW!



WEAR A MASK



STAY 6 FEET APART



AVOID CROWDS

Coping with Stress

Updated Dec. 11, 2020



Pandemics can be stressful

The coronavirus disease 2019 (COVID-19) pandemic may be stressful for people. Fear and anxiety about a new disease and what could happen can be overwhelming and cause strong emotions in adults and children. Public health actions, such as social distancing, can make people feel isolated and lonely and can increase stress and anxiety. However, these actions are necessary to reduce the spread of COVID-19. **Coping with stress in a healthy way will make you, the people you care about, and your community stronger.**

Stress during an infectious disease outbreak can sometimes cause the following:

- Fear and worry about your own health and the health of your loved ones, your financial situation or job, or loss of support services you rely on.
- Changes in sleep or eating patterns.
- Difficulty sleeping or concentrating.
- Worsening of chronic health problems.
- Worsening of mental health conditions.
- Increased use of [tobacco](#), and/or [alcohol and other substances](#).



Take care of your mental health

You may experience [increased stress](#) during this pandemic. Fear and anxiety can be overwhelming and cause strong emotions.

Get immediate help in a crisis

- Call 911
- [Disaster Distress Helpline](#) [↗](#) : CALL or TEXT 1-800-985-5990 (press 2 for Spanish).
- [National Suicide Prevention Lifeline](#) [↗](#) : 1-800-273-TALK (8255) for English, 1-888-628-9454 for Spanish, or [Lifeline Crisis Chat](#) [↗](#) .
- [National Domestic Violence Hotline](#) [↗](#) : 1-800-799-7233 or text LOVEIS to 22522
- [National Child Abuse Hotline](#) [↗](#) : 1-800-4AChild (1-800-422-4453) or text 1-800-422-4453
- [National Sexual Assault Hotline](#) [↗](#) : 1-800-656-HOPE (4673) or [Online Chat](#) [↗](#)
- [The Eldercare Locator](#) [↗](#) : 1-800-677-1116 [TTY Instructions](#) [↗](#)

- [Veteran's Crisis Line](#) : 1-800-273-TALK (8255) or [Crisis Chat](#) or text: 8388255

Find a health care provider or treatment for substance use disorder and mental health

- [SAMHSA's National Helpline](#) : 1-800-662-HELP (4357) and TTY 1-800-487-4889
- [Treatment Services Locator Website](#)
- [Interactive Map of Selected Federally Qualified Health Centers](#)

Everyone reacts differently to stressful situations

How you respond to stress during the COVID-19 pandemic can depend on your background, your social support from family or friends, your financial situation, your health and emotional background, the community you live in, and many other factors. The changes that can happen because of the COVID-19 pandemic and the ways we try to contain the spread of the virus can affect anyone.

People who may respond more strongly to the stress of a crisis include:

- People who are [at higher risk for severe illness](#) from COVID-19 (for example, older people, and people of any age with certain [underlying medical conditions](#)).
- [Children](#) and [teens](#).
- People [caring for family members or loved ones](#).
- Frontline workers such as [health care providers and first responders](#),
- Essential workers who work in the [food industry](#).
- People who have existing [mental health conditions](#).
- People who use [substances](#) or have a substance use disorder.
- People who have lost their jobs, had their work hours reduced, or had other major changes to their employment.
- [People who have disabilities](#) or developmental delay.
- People who are [socially isolated](#) from others, including people who live alone, and people in rural or frontier areas.
- People in some [racial and ethnic minority groups](#).
- People who do not have access to information in their primary language.
- People experiencing [homelessness](#).
- People who live in [congregate \(group\) settings](#).

Take care of yourself and your community

Taking care of your friends and your family can be a stress reliever, but it should be balanced with care for yourself. [Helping others cope with their stress](#), such as by providing social support, can also make your community stronger. During times of increased social distancing, people can still maintain social connections and care for their mental health. Phone calls or video chats can help you and your loved ones feel socially connected, less lonely, or isolated.

Healthy ways to cope with stress

- **Know [what to do if you are sick](#) and are concerned about COVID-19.** Contact a health professional before you start any self-treatment for COVID-19.
- **Know where and how to get treatment** and other support services and resources, including counseling or therapy (in person or through telehealth services).
- **Take care of your emotional health.** [Taking care of your emotional health](#) will help you think clearly and react to the urgent needs to protect yourself and your family.
- **Take breaks from watching, reading, or listening to news stories**, including those on social media. Hearing about the pandemic repeatedly can be upsetting.
- **Take care of your body.**
 - Take deep breaths, stretch, or [meditate](#) .

- Try to eat healthy, well-balanced meals.
 - Exercise regularly.
 - Get plenty of sleep.
 - Avoid excessive alcohol and drug use.
- **Make time to unwind.** Try to do some other activities you enjoy.
- **Connect with others.** Talk with people you trust about your concerns and how you are feeling.
- **Connect with your community- or faith-based organizations.** While social distancing measures are in place, consider connecting online, through social media, or by phone or mail.

Know the facts to help reduce stress

Knowing the facts about COVID-19 and stopping the spread of rumors can help reduce stress and stigma. Understanding the risk to yourself and people you care about can help you connect with others and make an outbreak less stressful.

Take care of your mental health

Mental health is an important part of overall health and wellbeing. It affects how we think, feel, and act. It may also affect how we handle stress, relate to others, and make choices during an emergency.

People with pre-existing mental health conditions or substance use disorders may be particularly vulnerable in an emergency. Mental health conditions (such as depression, anxiety, bipolar disorder, or schizophrenia) affect a person's thinking, feeling, mood or behavior in a way that influences their ability to relate to others and function each day. These conditions may be situational (short-term) or long-lasting (chronic). People with preexisting mental health conditions should continue with their treatment and be aware of new or worsening symptoms. If you think you have new or worse symptoms, call your healthcare provider.

Call your healthcare provider if stress gets in the way of your daily activities for several days in a row. Free and confidential resources can also help you or a loved one connect with a skilled, trained counselor in your area.

Get immediate help in a crisis

- Call 911
- [Disaster Distress Helpline](#) : CALL or TEXT 1-800-985-5990 (press 2 for Spanish).
- [National Suicide Prevention Lifeline](#) : 1-800-273-TALK (8255) for English, 1-888-628-9454 for Spanish, or [Lifeline Crisis Chat](#) .
- [National Domestic Violence Hotline](#) : 1-800-799-7233 or text LOVEIS to 22522
- [National Child Abuse Hotline](#) : 1-800-4AChild (1-800-422-4453) or text 1-800-422-4453
- [National Sexual Assault Hotline](#) : 1-800-656-HOPE (4673) or [Online Chat](#)
- [The Eldercare Locator](#) : 1-800-677-1116 [TTY Instructions](#)
- [Veteran's Crisis Line](#) : 1-800-273-TALK (8255) or [Crisis Chat](#) or text: 8388255

Find a health care provider or treatment for substance use disorder and mental health

- [SAMHSA's National Helpline](#) : 1-800-662-HELP (4357) and TTY 1-800-487-4889
- [Treatment Services Locator Website](#)
- [Interactive Map of Selected Federally Qualified Health Centers](#)






Suicide

Different life experiences affect a person's risk for suicide. For example, suicide risk is higher among people who have experienced violence, including child abuse, bullying, or sexual violence. Feelings of isolation, depression, anxiety, and other emotional or financial stresses are known to raise the risk for suicide. People may be more likely to experience these feelings during a crisis like a pandemic.

However, there are ways to protect against suicidal thoughts and behaviors. For example, support from family and community, or feeling connected, and having access to in-person or virtual counseling or therapy can help with suicidal thoughts and behavior, particularly during a crisis like the COVID-19 pandemic.

Learn more about CDC’s work in [suicide prevention](#).

Other Resources:

- [National Suicide Prevention Lifeline](#)  : 1-800-273-TALK (8255) for English, 1-888-628-9454 for Spanish, or [Lifeline Crisis Chat](#)  .
- [SAMHSA Suicide Prevention](#) 
- [Suicide Risk Factors and Warning Signs](#) 
- [Five Action Steps for Communicating with Someone Who May Be Suicidal](#) 

Recovering from COVID–19 or ending home isolation

It can be stressful to be separated from others if you have or were exposed to COVID-19. Each person ending a period of home isolation may feel differently about it.






Emotional reactions may include:

- Mixed emotions, including relief.
- Fear and worry about your own health and the health of your loved ones.
- Stress from the experience of having COVID-19 and monitoring yourself, or being monitored by others.
- Sadness, anger, or frustration because friends or loved ones have fears of getting the disease from you, even though you are cleared to be around others.
- Guilt about not being able to perform normal work or parenting duties while you had COVID-19.
- Worry about getting re-infected or sick again even though you’ve already had COVID-19.
- Other emotional or mental health changes.





[Children may also feel upset](#) or have other strong emotions if they, or someone they know, has COVID-19, even if they are now better and able to be around others again.

Resources


For Everyone





- [How Right Now](#) 
- [Coping with a Disaster or Traumatic Event](#)
- [HHS ASPR TRACIE COVID-19 Behavioral Health Resources](#) 
- [Coronavirus Tax Relief and Economic Impact Payments](#) 
- [General Public: Care for Yourself](#) 
- [Young Adults: Care for Yourself](#) 

For Communities

- [Coping with Stress During an Infectious Disease Outbreak](#)  
- [Taking Care of Your Behavioral Health during an Infectious Disease Outbreak](#)  

For Families and Children




- [Helping Children Cope during an COVID-19 Outbreak](#)
- [Helping Children Cope with Emergencies](#)
- [Coping After a Disaster](#)  – A Ready Wrigley activity book for children age 3-10

- [Teen Depression](#) 
- [Parents: Care for Yourself](#) 
- [Family Caregivers: Care for Yourself](#) 
- [Students: Care for Yourself](#) 




For People at Higher Risk for Serious Illness

- [Serious Illness Care Program COVID-19 Response Toolkit](#) 
- [Older Adults: Care for Yourself](#) 

For Healthcare Workers and First Responders

- [Healthcare Personnel and First Responders: How to Cope with Stress and Build Resilience During the COVID-19 Pandemic](#)
- [Emergency Responders: Tips for Taking Care of Yourself](#)
- [Disaster Technical Assistance Center](#)  (SAMHSA)
- [First Responders: Care for Yourself](#) 
- [Clinicians: Care for Yourself](#) 

For Other Workers

- [Employees: How to Cope with Job Stress and Build Resilience During the COVID-19 Pandemic](#)
- [Working Adults: Care for Yourself](#) 
- [Critical Workers: Care for Yourself](#) 
- [Teachers: Encourage Your Students to Care for Themselves](#) 

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