# *Comment*

# Depression and the Law: Experiences of Australian Barristers and Solicitors

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### *Abstract*

The present research is a contribution towards understanding Australian lawyers' experiences of, and attitudes towards, depression. It was found that, like Australian law students, solicitors and barristers exhibited significantly higher levels of psychological distress than did members of the general population and that experiences of depression were disproportionately high. The research also found that many lawyers had low expectations about the efficacy of consulting mental health professionals, but that rates of help-seeking were nonetheless surprisingly high. Participants' own attitudes towards people with depression were complex and varied but there was strong agreement that discrimination was likely to arise against people with depression in their workplaces. These results are discussed within the context of the kinds of strategies that legal professional bodies might adopt in order to increase awareness of the commonality of depression amongst solicitors and barristers and to provide support and treatment for those upon whom it impacts.

## I Introduction

The incidence of mental illness amongst lawyers and law students in Australia has become a focal point of public commentaries,[1] personal stories,[2] radio interviews[3] and greater awareness of assistance

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[1] Gordon Parker, 'The Seven Ds of Mood Disorders' (2008) 46(1) *Law Society Journal* 62; Melanie Naylor, 'Depression in Lawyers' (2004) 31(9) *Brief* 12; Jennifer Wright, 'Coping with the Costs of Success' (2004) 31(9) *Brief* 10; Jodie Thomson, 'Beating the Blues' (2007) 45(8) *Law Society Journal* 18 and Steve Mark, 'Impaired Practitioners; Substance Abuse and Mental Illness in the Legal Profession' (2007) 37 *Without Prejudice* 1.

[2] Julie Lewis, 'Parents Speak Out about the Law and Depression' (2007) 45(7) *Law Society Journal* 24.

[3] ABC Radio National, 'Lawyers and depression', *The Law Report*, 25 March 2008 <http://www.abc.net.au/rn/lawreport/stories/2008/2195243.htm>.

programs for lawyers.[4] This increased public awareness of the mental health of legal practitioners has arisen partly as a result of the suicide of Tristan Jepson on 28 October 2004, and the subsequent activity of the Tristan Jepson Memorial Foundation. The Foundation, which was established in 2006 by Tristan's parents and the University of New South Wales, hosts annual lectures about depression in the legal profession and schools. These lectures are attended by a diverse range of legal practitioners, academics, students and journalists, bolstering the anecdotal evidence that Australians have noticed a link between those studying and practising law and depression, drug-abuse and other mental illnesses. Despite the burgeoning interest in this link, there have been very few Australian studies undertaken concerning mental illness and the law, with three notable exceptions:

First, the 'Report on the Retention of Legal Practitioners'[5] was compiled in 1999 by the Law Society of Western Australia and Women Lawyers of Western Australia. The report brought together the results of an 'exit survey' of 47 lawyers who had left the profession no more than five years earlier, and in-depth interviews with 21 of these respondents. One of the categories investigated was 'Quality of Life' which included the sub-categories: 'Working Conditions'; 'Working Environment'; 'Stress and Illness'; and 'Family and Social Life'. In line with the anecdotes and personal stories mentioned above, this study found that, as juniors, lawyers felt that they had worked under 'sweat-shop conditions', that there was immoderate intrusion into their away-from-work time, and that their skills for dealing with angry clients were wanting. The majority of those interviewed had suffered from physical and mental symptoms including exhaustion, ulcers, broken sleep, crying, loss of confidence and self-worth, irritability and depression. Of interest is the fact that the lawyers sampled here had an average of just 5.2 years in practice. While it may be the case that some of the stressors to do with inexperience and 'paying one's dues' as a junior would have lessened with time had these lawyers stayed in practice, one can only speculate as to whether those who opted out of the legal profession early would otherwise have developed more severe symptoms by remaining within it.

That worsening symptoms might have been the lot of these lawyers is suggested by the results of a second Australian study, 'The Annual Professions Study 2007',[6] which included a section designed

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4 Louise Aaron, 'Members' Services News: Help is at Hand with Services to Assist Members in Difficulty' (2003) 41(4) *Law Society Journal* 19; Julie Lewis, 'Calls for Help from Lawyers Soar' (2006) 44(4) *Law Society Journal* 26; Anonymous, 'You are not Alone: Help for Practitioners' (2007) 45(7) *Law Society Journal* 24; Alison Gaines, 'Caring for the Profession' (2004) 31(9) *Brief* 6.

5 The Law Society of Western Australia and Women Lawyers of Western Australia, *Report on the Retention of Legal Practitioners: Final Report* (1999).

6 Beaton Consulting, *Annual Professions Study* (2007).

by *beyondblue: the national depression initiative*, assessing levels of depression and non-prescription drug (including alcohol) use. According to this study, 'professionals' (those working in financial, legal, architectural and similar industries) as a whole had higher levels of depression than the general population, and analysis across industry types indicated that lawyers fared worse than other professionals. Furthermore, the study showed that the severity of depression scores amongst professionals increased with age. Compounding these findings is the fact that lawyers were more likely than their colleagues in other professions to use alcohol and other drugs to cope with their depression.

Finally, another study[7] found that members of some sub-sectors of the legal profession in Australia, namely those working with traumatised clients (criminal defence lawyers and prosecutors), suffered more vicarious trauma effects, depression, stress and adverse beliefs about the safety of themselves and others than did their colleagues (academics and conveyancers) who did not work with traumatised clients. Interestingly, the two groups did not differ in their usage of alcohol or medication in order to deal with work-related stress.

As is the case in Australia, North American lawyers and law students are reporting elevated levels of stress, anxiety, depression and drug abuse anecdotally[8] and there are (and have been for quite some time) outspoken advocates for law firms to understand and respond sympathetically to addiction and mental illness amongst lawyers,[9] to reform the work-culture that produces competitiveness and high levels of stress[10] and for law schools to review teaching practices and grading systems[11] as well as introduce 'faculty friend'-style counselling.[12]

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[7] Lila Vrklevski and John Franklin, 'Vicarious Trauma: The Impact on Solicitors of Exposure to Traumatic Material' (2008) 14 *Traumatology* 106.

[8] Anonymous, 'A View from the Bench (Alcoholism)' (1999) 73(11) *Florida Bar Journal* 39; Anonymous, 'A story of Recovery' (1999) 73(11) *Florida Bar Journal* 37; Anonymous, 'How I Broke through Denial to Achieve Sobriety' (1999) 73(11) *Florida Bar Journal* 35; John Harkness, 'Lawyers Helping Lawyers: A Message of Hope' (1999) 73(11) *Florida Bar Journal* 10.

[9] Richard Marx, 'Impaired Attorneys and the Disciplinary System' (1999) 73(11) *Florida Bar Journal* 14; Myer Cohen, Harry Goodheart and Charles Hagan, 'The Lie is Over — We Do Recover. (Florida Bar Association's Florida Lawyer Assistance Program)' (1999) 73(11) *Florida Bar Journal* 26; Martin Seligman, Paul Verkuil and Terry Kang, 'Why Lawyers are Unhappy' (2005) 10 *Deakin Law Review* 49; Geoffrey Hazard, 'Commentary: Policy Implications' (1995) 10 *Journal of Law and Health* 79.

[10] James Aleini and Joseph Van Vooren, 'Is there a Solution to the Problem of Lawyer Stress? The Law School Perspective' (1995) 10 *Journal of Law and Health* 61.

[11] Anonymous, 'Making Docile Lawyers: An Essay on the Pacification of Law Students; (1998) 111 *Harvard Law Review* 2027; Nancy Rapoport, 'Is "Thinking like a Lawyer" Really What We Want to Teach?' (2002) 1 *Journal of the Association of Legal Writing Directors* 91; Robert Schuwerk, 'The Law Professor as Fiduciary: What Duties Do We Owe to our Students?' (2004) 45 *South Texas Law Review* 753; Gerald Hess, 'Heads and Hearts: The Teaching and Learning Environment in Law

Additionally, greater numbers of large-scale studies have been conducted in the United States than in Australia.

In terms of cross-industry analysis, an American survey[13] of 11 789 eligible participants who reported having held a full-time job across one of approximately 100 occupations revealed that lawyers had the highest prevalence of depression of all the workers (when adjusted for socio-demographic factors and employment status). This result lends support to the findings of 'The Annual Professions Study 2007'[14] and indeed extends those findings because of the wider breadth of occupations included. Another study[15] revealed that 33 per cent of practising lawyers suffered from one or more disorders including depression (19 per cent), alcoholism (18 per cent) and cocaine abuse (<1 per cent). While depression and cocaine abuse were unaffected by length of time in practice, those working in the legal profession for greater than 20 years had more highly elevated rates of alcoholism than those newer to the profession. The data from this study were later further analysed and the results were published in an influential paper[16] which was accompanied by several commentary-style responses.[17] This secondary analysis demonstrated in finer detail the range of mental illnesses (including: interpersonal sensitivity, anxiety, social alienation, depression, obsessive-compulsiveness, paranoid ideation, phobic anxiety and hostility) experienced by the sample of lawyers and re-emphasised the extent of alcohol abuse among this cohort.

In light of the overwhelming anecdotal evidence, the North American studies, and the few Australian studies conducted thus far, one has good reason to think that more Australian research is needed to explore a connection between mental illnesses and those engaged in law, whether professionally or as students. Accordingly, we conducted a large-scale study to provide an in-depth assessment of the literacy, attitudes, personal experiences and behaviours of lawyers and law

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School' (2002) 52 *Journal of Legal Education* 75; B A Glenser, 'Fear and Loathing in the Law Schools' (1991) 23 *Connecticut Law Review* 627; Timothy Floyd, 'Legal Education and the Vision Thing' (1997) 31 *Georgia Law Review* 853.

12 Phyllis Beck and David Burns, 'Anxiety and Depression in Law Students: Cognitive Intervention' (1979) 30 *Journal of Legal Education* 1.

13 William Eaton et al, 'Occupations and the Prevalence of Major Depressive Disorder' (1990) 32 *Journal of Occupational Medicine* 1079.

14 Beaton Consulting, above n 6.

15 G Andrew Benjamin, Elaine Darling and Bruce Sales, 'The Prevalence of Depression, Alcohol Abuse, and Cocaine Abuse among United States lawyers' (1990) 13 *International Journal of Law and Psychiatry* 233.

16 Connie Beck, Bruce Sales and G Andrew Benjamin, 'Lawyer Distress: Alcohol-related Problems and other Psychological Concerns among a Sample of Practicing Lawyers' (1995) 10 *Journal of Law and Health* 1.

17 Hazard, above n 9; Aleini, above n 10; Susan Locke, 'Lawyer Distress: A Comment' (1995) 10 *Journal of Law and Health* 87; Peter Glenn, 'Some Thoughts about Developing Constructive Approaches to Lawyer and Law Student Distress' (1995) 10 *Journal of Law and Health* 69.

students with regard to mental illnesses. Comprehensive details of this study are contained in the report 'Courting the Blues: Attitudes towards Depression in Australian Law Students and Legal Practitioners'[18] and the results pertaining to the law students were published in an earlier volume of this journal.[19] The present report focuses upon the findings pertaining to legal practitioners.

## II Methods

### A *Participants*

The study was a cross-sectional survey of 924 solicitors and 756 barristers (N=1680) working in Australia. The solicitors were recruited with the help of the Law Society of NSW and the Law Institute of Victoria, both societies contacting their members via email. The barristers were recruited through the New South Wales Bar Association by both email and post.

### B *The Questionnaire*

Participants received a letter explaining the purpose of the study, a participant information sheet, and the International Depression Literacy Survey (IDLS; the paper versions of which were entitled 'An International Health Survey').[20] The IDLS assesses participants' knowledge of, and attitudes towards, depression as it impacts upon the Australian population. The questionnaire also assesses the participants' past experiences of depression and their current levels of psychological distress. The full questionnaire is reproduced in the 'Courting the Blues' report.[21]

The present study used self-report screening instruments for determining the level of psychological distress (such as the Kessler Psychological Distress Scale or 'K10')[22] rather than questionnaires or diagnostic instruments aimed at measuring specific psychological states

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[18] Norm Kelk et al, *Courting the Blues: Attitudes towards Depression in Australian Law Students and Legal Practitioners* (Brain & Mind Research Institute, 2009).

[19] Norm Kelk, Sharon Medlow and Ian Hickie, 'Distress and Depression amongst Australian Law Students: Incidence, Attitudes and the Role of Universities' (2010) 32 *Sydney Law Review* 113.

[20] Ian Hickie et al, 'The Assessment of Depression Awareness and Help-seeking Behaviour: Experiences with the International Depression Literacy Survey' (2007) 13 *BMC Psychiatry* 48.

[21] Kelk, above n 18.

[22] R C Kessler et al, 'Short Screening Scales to Monitor Population Prevalences and Trends in Non-specific Psychological Distress' (2002) 32 *Psychological Medicine* 959.

(such as depression or anxiety). This is a common feature of larger scale community studies as screening tests are less costly and take less time for participants to complete than do psychological state questionnaires (thereby increasing completion rates).

The IDLS was presented on both a password-protected web-site and on paper. The surveys using one or other of these media differed only in that the online version allowed for the randomisation of the ordering of the variables in Questions 13–17. The solicitors had only the online survey available to them whilst the barristers had both the online and paper options (but overwhelmingly elected to complete the paper version). The number of participants who completed paper and web versions of the survey is reported in Table 1.

**Table 1:** Percentage of participants completing the IDLS on paper or via the internet.

| Survey version | Solicitors | Barristers |
|---|---|---|
| Paper | 0% | 64% |
| Internet | 100% | 36% |

## C *Research Ethics Approval*

Research ethics approval was granted by the Human Research Ethics Committee of the University of Sydney.

## D *Results*

Analyses were conducted using the Statistical Package for the Social Sciences (SPSS 17.0)[23] for Windows and Microsoft Excel.

23 Andy Field, *Discovering Statistics Using SPSS* (Sage, 3rd ed, 2009).

### E *Demographics*

**Table 2:** Sample demographics.

| | **Solicitors (N = 924)** | **Barristers (N = 756)** |
|---|---|---|
| **Age (years)** | | |
| • Mean (SD) | 35.6 (10.9) | 47.6 (10.4) |
| • Median | 32.0 | 48.0 |
| • Range | 19 – 77 | 23 – 80 |
| **Females (%)** | 65 | 26 |
| **English spoken at home (%)** | 98 | 99 |
| **Residence (%)** | | |
| • Urban | 85 | 89 |
| • Regional | 10 | 7 |
| • Rural | 5 | 3 |

As shown in Table 2, there was a wide range of ages amongst the solicitors and barristers surveyed, with a median age of 32 years for solicitors and 48 years for barristers. Almost two-thirds (65 per cent) of the solicitors surveyed were female whereas the corresponding figure for barristers was closer to a quarter (26 per cent). Almost the entire sample spoke English at home and greater than 85 per cent of solicitors and barristers lived in urban areas.

**Table 3:** Barristers' status and years of registration.

| **Years of Registration** | **Barrister** | **Senior Counsel** | **Totals** |
|---|---|---|---|
| Less than 1 year | 31 (5%) | 0 | **31 (4.1%)** |
| 1 to 5 years | 174 (27 %) | 0 | **174 (23.3%)** |
| 6 to 10 years | 124 (19%) | 0 | **124 (16.6%)** |
| Greater than 10 years | 321 (49%) | 97 (100%) | **418 (56.0%)** |
| **Totals** | **650 (100%)** | **97 (100%)** | **747 (100%)** |

As indicated in Table 3, almost half (49 per cent) of the barristers surveyed had been registered for ten or more years. All senior counsel (100 per cent) had been registered for at least 10 years.

**Table 4:** Solicitors' appointments and years of practice registration.

| Appointment | Frequency and percentage | Mean years of registration |
|---|---|---|
| Articles | 52 (6%) | 0.31 |
| Lawyer in early years of practice | 316 (34%) | 2.3 |
| Associate | 86 (9%) | 5.6 |
| Senior Associate | 156 (17%) | 10.2 |
| Special Counsel | 33 (4%) | 16.3 |
| Partner/Principal | 148 (16%) | 19.9 |
| Other | 133 (14%) | 14.7 |
| **Totals** | **924 (100%)** | **8.9** |

As shown in Table 4, approximately one third of the solicitors surveyed (34 per cent) were in the early years of practice with a mean of 2.3 years of registration. As expected, partners or principal solicitors had the greatest average mean years of registration (19.9 years).

### F *Psychological Distress*

There were a number of measures of psychological distress in the survey. The first of these was the K10 (see Table 5). This scale has been used extensively in Australia and internationally, and is regarded as a valid and reliable tool for the assessment of risk of mental illness. Participants were asked how often in the last thirty days they had experienced certain psychological or behavioural events and selected a response from the following alternatives: None of the time; A little of the time; Some of the time; Most of the time; All of the time. The possible range of scores was 10 to 50 and individual scores were classified as follows: 10 to 15 = No or low

distress; 16 to 21 = Moderate distress; 22 to 29 = High distress; 30 to 50 = Very high distress. This scale and these cut-offs have been used in other Australian surveys and are retained here for purposes of comparison.

**Table 5:** Distribution of K10 scores across solicitors, barristers and a general population sample (percentages).

| Level of distress | Solicitors | Barristers | General Population (aged greater than 17 years)[24] |
|---|---|---|---|
| Low or no psychological distress | 36.4 | 56.2 | 62.9 |
| Moderate distress | 31.6 | 27.2 | 24.1 |
| High distress | 22.3 | 12.5 | 9.2 |
| Very high distress | 8.7 | 4.2 | 3.8 |

A second measure of psychological distress took the form of a 'days out of role' question ('During the last one month: How many days in total were you unable to carry out your usual daily activities like going to school or work, fully?'). For purposes of comparison with national data, the results are reported in terms of percentages of participants having *seven or more* days out or role (see Table 6). As can be seen, the percentage of participants with seven or more days out of role in the month prior to survey does not indicate that legal practitioners differ greatly from the national population.

**Table 6:** Percentages of participants spending seven or more days out of role in the month prior to survey.

| | Solicitors | Barristers | General Population (aged 18-65 years)[25] |
|---|---|---|---|
| Non-performance of daily activities (eg, going to work) | 5.1 | 8.6 | 8.3 |

[24] Australian Bureau of Statistics, National Health Survey 2004-05: Summary of Results (Catalogue No. 4364.0) (2006) 35 (Table 14).

[25] Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing: Summary of Results. (Catalogue No. 4326.0) (2007) 40 (Table 9).

### G *Experiences of Depression*

Just under half of the participants reported a personal experience of depression and just over half of the participants reported someone close to them having experienced depression. (There is some overlap in these figures where both the individual participants and their close acquaintances had experienced depression; see Table 7.)

**Table 7:** Experiences of depression (percentages).

| Answered 'Yes' to … | Solicitors (N=924) | Barristers (N=756) | Totals (N=1680) |
|---|---|---|---|
| I experienced depression | 47 | 42 | 44.5 |
| Someone close to me experienced depression | 60 | 44 | 52.7 |

In a series of studies conducted by *beyondblue*,[26] participants were asked a very similar question (see Table 8). The present sample of practitioners reported a vastly higher level of personal depression than did the community samples from 2002 and 2004/5. It would appear unlikely that these large differences in the reported levels of personal experience with depression could be accounted for by the passage of time or the differences in the form of the questions. These data would seem to suggest that the legal practitioner samples reported here genuinely do have a higher level of personal experience of depression than general community samples.

**Table 8:** Data reported from two community samples collected by *beyondblue* researchers in 2002 and 2004/5 reporting levels of personal experience of depression (percentages).

| | 2002 survey (N = 285) | 2004/5 survey (N = 400) |
|---|---|---|
| I experienced depression | 11.2 | 9.5 |
| A family member experienced depression | 25.3 | 25.8 |

[26] Ian Hickie et al, 'Perspectives of Young People on Depression: Awareness, Experiences, Attitudes and Treatment Preferences' (2007) 1 *Early Intervention in Psychiatry* 333.

## H *Help-Seeking*

Attitudes towards seeking help were assessed through a series of questions concerning participants' *likely behaviour* should they become depressed, their *expectations about recovery from depression* with and without treatment and the *efficacy of various forms of treatment*.

Table 9 reports the likelihood of the participants seeking help from a *professional* person if they were to become depressed. Of note here is that over a quarter of the participants say that they would *not* seek help from any professional. Amongst those who reported that they would seek help, the three major professional groups from which they would seek help were general practitioners, psychologists and psychiatrists.

**Table 9:** Sources of professional help from which participants were probably or definitely likely to seek assistance if they thought they were experiencing depression (percentages; multiple answers permitted).

| **Professional helper** | **Solicitors N = 924** | **Barristers N = 756** | **Totals N = 1680** |
|---|---|---|---|
| General or family doctor | 71 | 75 | 72.5 |
| Psychologist | 58 | 53 | 55.8 |
| Psychiatrist | 44 | 60 | 51.3 |
| Counsellor | 50 | 33 | 42.6 |
| Social worker | 6 | 3 | 4.3 |
| Pharmacist | 4 | 4 | 4.0 |
| Welfare officer | 4 | 2 | 2.6 |
| No-one/wouldn't seek help | 31 | 21 | 26.4 |

In Tables 10 and 11, the participants' views about the likely outcomes of being treated or remaining untreated by a professional person are reported. Only one quarter (26.2 per cent) of the total sample thought that professional help was likely to lead to a full recovery without relapse. However, as can be seen in Table 11, a substantial proportion of the whole sample (69.5 per cent) believed that people who had no help for depression were likely to have no improvement or to get worse. This suggests that the participants had low expectations for recovery from depression both with and without professional help.

**Table 10:** Beliefs about the likely outcome of depression if treated by a *professional* (eg doctor, psychologist, psychiatrist or other counsellor) (percentages).

| **Outcome** | **Solicitors N = 863** | **Barristers N = 688** | **Totals N = 1551** |
|---|---|---|---|
| Fully recover | 24 | 29 | 26.2 |
| Fully recover but then have the illness come back again | 21 | 15 | 18.4 |
| Have some improvement | 46 | 47 | 46.4 |
| Have some improvement but then get worse again | 5 | 5 | 4.9 |
| Have no improvement | 1 | 1 | 1.1 |
| Get worse | 0.1 | 0.4 | 0.3 |
| Other | 3 | 3 | 2.8 |

**Table 11:** Beliefs about the likely outcome of depression if *not* treated by a *professional* (eg doctor, psychologist, psychiatrist or other counsellor).

| **Outcome** | **Solicitors N = 836** | **Barristers N = 649** | **Totals N = 1485** |
|---|---|---|---|
| Fully recover | 1 | 1 | 0.9 |
| Fully recover but then have the illness come back again | 2 | 4 | 2.8 |
| Have some improvement | 5 | 7 | 5.9 |
| Have some improvement but then get worse again | 19 | 18 | 18.7 |
| Have no improvement | 20 | 19 | 19.7 |
| Get worse | 51 | 48 | 49.8 |
| Other | 2 | 3 | 2.3 |

Despite this somewhat negative view of *professionals*, the sample had a generally positive outlook regarding *treatments*. A number of treatments were rated by the sample as harmful, helpful or neither harmful nor helpful (see Table 12). Only two 'treatments' are assessed as being more harmful than helpful. These are having an

occasional alcoholic drink (seen as helpful by 21.4 per cent of the total sample and as harmful by 24.6 per cent), and using sleeping tablets (seen as helpful by 18.7 per cent of the total sample and as harmful by 55.1 per cent).

The treatments that are commonly associated with conventional mental health professionals (anti-depressant medication, sleeping tablets, brief and long-term psychotherapies) have, on average, a lower perceived level of helpfulness than those which might be self-administered (becoming more physically active, changing one's diet, reading about people with similar conditions, reading self-help books). The former group is seen as helpful by 63 per cent (and as harmful by 20 per cent), whereas the latter is seen as helpful by 77.2 per cent (and as harmful by 3.7 per cent). Even with the removal of 'sleeping tablets' from the class of treatments administered by professionals, this group of treatments was still seen as being harmful by more than twice the number of participants that see the self-administered treatments as harmful (7.4 per cent compared with 3.7 per cent). So, although treatments provided by professionals were seen as effective by large sections of the sample, they were also seen as being potentially harmful (ie, as having unwanted side effects).

**Table 12:** Frequency and percentage of sample groups which assessed various treatments in terms of their helpfulness or harmfulness (percentages).

| **Proposed Treatment** | **Group** | **Harm ful** | **Neither** | **Helpful** | **Unaware of it** |
|---|---|---|---|---|---|
| Become more physically active | Solicitors N = 916 | 0 | 2 | 98 | 0 |
| | Barristers N = 731 | 0 | 1 | 99 | 0 |
| | **Totals N = 1647** | **0.1** | **1.5** | **98.4** | **0.0** |
| Changing your diet | Solicitors N = 873 | 0 | 19 | 81 | 1 |
| | Barristers N = 683 | 0 | 20 | 78 | 2 |
| | **Totals N = 1556** | **0.1** | **19.3** | **79.5** | **1.2** |
| Occasional alcoholic drink | Solicitors N = 882 | 26 | 55 | 18 | 1 |
| | Barristers N = 694 | 23 | 51 | 26 | 0 |
| | **Totals N = 1576** | **24.6** | **53.6** | **21.4** | **0.3** |

| Proposed Treatment | Group | Harm ful | Neither | Helpful | Unaware of it |
|---|---|---|---|---|---|
| Reading about people with similar conditions | Solicitors N = 876 | 3 | 22 | 74 | 0 |
| | Barristers N = 693 | 4 | 25 | 71 | 0 |
| | **Totals N = 1569** | **3.8** | **23.0** | **72.9** | **0.3** |
| Reading self-help books | Solicitors N = 859 | 11 | 41 | 48 | 0 |
| | Barristers N = 672 | 11 | 41 | 49 | 0 |
| | **Totals N = 1531** | **10.5** | **41.2** | **48.1** | **0.1** |
| Anti-depressant medication | Solicitors N = 842 | 10 | 10 | 80 | 0 |
| | Barristers N = 681 | 10 | 9 | 81 | 0 |
| | **Totals N = 1523** | **9.7** | **9.8** | **80.4** | **0.1** |
| Natural remedies | Solicitors N = 824 | 4 | 45 | 51 | 1 |
| | Barristers N = 645 | 7 | 52 | 40 | 1 |
| | **Totals N = 1469** | **5.2** | **48.3** | **45.9** | **0.7** |
| Sleeping tablets | Solicitors N = 827 | 57 | 23 | 19 | 0 |
| | Barristers N = 646 | 52 | 30 | 18 | 0 |
| | **Totals N = 1473** | **55.1** | **26.1** | **18.7** | **0.2** |
| Brief counselling psychotherapies | Solicitors N = 828 | 3 | 16 | 80 | 1 |
| | Barristers N = 648 | 3 | 17 | 79 | 1 |
| | **Totals N = 1476** | **3.0** | **16.4** | **79.6** | **1.0** |
| Long-term counselling psychotherapies | Solicitors N = 844 | 3 | 11 | 85 | 1 |
| | Barristers N = 653 | 7 | 17 | 77 | 0 |
| | **Totals N = 1497** | **4.9** | **13.6** | **81.1** | **0.4** |

## I *Behaviours*

Those participants who had had experience with depression reported on the types of treatment they (or their close acquaintances) had received. A substantial proportion of the participants who experienced depression received treatment (80.2 per cent; see Table 13). This figure is remarkably high, particularly when compared with figures from Australian community samples which show just 35 per cent of people experiencing mental illnesses receiving treatment.[27]

**Table 13:** Frequencies and percentages of participants who received treatment for depression (percentages).

| | **Solicitors (N=434)** | **Barristers (N=314)** | **Totals (N=748)** |
|---|---|---|---|
| Percentage who received professional treatment | 80.4 | 80.0 | 80.2 |

The professionals who provided treatment for the participants (or their close acquaintances) who experienced depression are listed in Table 14. By far the most accessed services were provided by general practitioners, followed by psychiatrists, psychologists and 'counsellors'. The rankings of *consulted* professionals are similar to those in Table 9, which shows the professional person from whom the participants *hypothesised* they might seek help if they were depressed (note that in the hypothetical version, psychologists were ranked slightly higher than psychiatrists). The percentages of participants who *actually* consulted various professional sources of help as a consequence of depression (as reported in Table 14) were lower than the corresponding estimates (as reported in Table 9).

[27] Australian Bureau of Statistics, above n 25.

**Table 14:** Professionals who provided treatment for participants or their close acquaintances with an experience of depression (percentages).

| **Professionals** | **Solicitors N = 642** | **Barristers N = 502** | **Totals N = 1144** |
|---|---|---|---|
| General or family doctor | 63 | 58 | 60.6 |
| Psychiatrist | 46 | 55 | 50.1 |
| Psychologist | 43 | 37 | 40.6 |
| Counsellor | 29 | 20 | 25.3 |
| Social worker | 3 | 1 | 1.9 |
| Pharmacist | 3 | 2 | 2.1 |
| Welfare officer | 1 | 1 | 1.0 |
| Other | 5 | 6 | 5.2 |
| Don't know | 3 | 2 | 2.4 |

### J *Barriers to treatment*

The group of participants who had sought treatment from their general practitioner over the past year were also asked whether they had experienced any barriers to treatment over the 'last few weeks'. The responses to this question are reported in Table 15. Interestingly, of those participants for whom treatment was necessary (ie, who did not select the 'not applicable' option), the greatest barrier was simply preferring to manage alone.

**Table 15:** Barriers to treatment over the last few weeks (percentages).

| **Barriers to treatment** | **Solicitors (N = 209)** | **Barristers (N = 85)** | **Totals (N = 294)** |
|---|---|---|---|
| Not applicable: No need for this kind of help | 43 | 42 | 42.9 |
| I preferred to manage myself | 37 | 38 | 37.1 |
| I was afraid to ask for help, or what others would think of me | 17 | 14 | 16.0 |
| I couldn't afford the money | 16 | 14 | 15.6 |
| I didn't think anything would help | 12 | 13 | 11.9 |
| I asked but did not get help | 5 | 7 | 5.8 |
| I didn't know where to get help | 6 | 2 | 4.8 |

### K *Knowledge of Depression as a Public Health Issue in Australia*

The questionnaire contained a number of items assessing the participants' knowledge of the public health consequences of depression in Australia. Just under half of the participants correctly estimated the proportion (1 in 5) of Australians who might be expected to experience depression (see Table 16).

**Table 16:** The proportion of people estimated to experience depression at some point in their lives (percentages).

| **Proportion of population who will experience depression** | **Solicitors (N = 924)** | **Barristers (N = 741)** | **Totals (N = 1665)** |
|---|---|---|---|
| 1 in 50 | 3 | 3 | 3.0 |
| 1 in 20 | 15 | 16 | 15.3 |
| 1 in 10 | 29 | 34 | 31.2 |
| 1 in 5 | 50 | 41 | 46.1 |
| Don't know | 3 | 6 | 4.4 |

Perhaps not surprisingly, participants who had experienced depression made a correct estimate more than twice as frequently than those who had not (see Table 17).

**Table 17:** The effect of having had depression (or having had a close acquaintance with depression) on the participants' estimations of the likelihood of *anyone* experiencing depression (percentages).

| | **Participant or close acquaintance has experienced depression** | | |
|---|---|---|---|
| **Estimate of the proportion of all people who have or will experience depression** | **Yes (N=1370)** | **No (N=168)** | **Totals (N=1538)** |
| 1 in 50 | 3 | 4 | 3.0 |
| 1 in 20 | 14 | 23 | 15.0 |
| 1 in 10 | 30 | 39 | 30.6 |
| 1 in 5 | 50 | 23 | 47.4 |
| Don't know | 3 | 11 | 4.0 |

## L *Information Seeking*

Over half (57 per cent) of the entire sample had sought information about depression. Two-thirds (65 per cent) of participants who had experienced depression (or who had a close acquaintance who had experienced depression) had sought this information whilst only 15 per cent of participants who had had no experience of depression had done so. Note that over a third of participants (35 per cent) who had experienced depression reported never having sought information about it.

The sources of information about depression which were used are reported in Table 18, ranked in order of frequency of use. Alternatives which ranked below 10 per cent have been omitted. The most common source of information cited is the internet, although barristers as a group consulted the internet less frequently than did solicitors.

**Table 18.** Sources from which information was sought about depression by group

| | **Solicitors (N = 564)** | **Barristers (N = 386)** | **Totals (N = 950)** |
|---|---|---|---|
| Searched the Internet | 87 | 70 | 80.0 |
| Asked a doctor | 39 | 49 | 42.6 |
| Bought a book or magazine | 29 | 35 | 31.2 |
| Asked a friend | 19 | 15 | 17.5 |
| Asked a family member | 15 | 13 | 14.4 |
| TV or radio | 13 | 14 | 13.3 |

## M *Attitudes towards Depression*

Participants were asked to express their agreement or disagreement with a number of positive and negative statements about people with severe depression. In general, the participants believed that, when well, people with severe depression were often productive, made good employees and tried even harder to contribute to their families or work (there was less certainty about whether or not people with depression were artistic or creative when well). While many of the

participants believed that people with severe depression are difficult to talk to and often perform poorly as parents, there was little belief that they are dangerous, have themselves to blame, should pull themselves together or refrain from having children.

An overview of participants' responses to positive and negative attitude statements is presented in Table 19 which shows the percentage of participants agreeing with at least two positive or two negative statements about people with severe depression.

**Table 19:** Acceptance of two or more positive or negative attitudes towards people with severe depression (percentages).

| | Solicitors (N=924) | Barristers (N=756) | Totals (N=1680) |
|---|---|---|---|
| Percentage accepting at least TWO positive attitudes | 76 | 70 | 73.2 |
| Percentage accepting at least TWO negative attitudes | 41 | 45 | 42.7 |

While it is clear that many of the participants held positive views about the potential of severely depressed people to function well when they are well, a substantial number of participants also held two or more negative views, particularly with regard to the difficulty of communicating with severely depressed people.

Given the persistence of these negative views, one is not surprised to discover that the participants expected discrimination against depressed people. Table 20 shows some of the sources from which participants would expect discrimination against a depressed person (alternatives selected by fewer than 10 per cent of the total sample are omitted). It is interesting to note that more than half of the participants would expect discrimination from their employer. Clearly, this finding has implications for the establishment of workplace counselling and other forms of help which require depressed people to make their conditions known to their employers or other colleagues.

**Table 20:** Perceptions regarding *probable* or *definite* sources of discrimination against someone with depression (percentages).

| Discrimination by … | Solicitors (N = 924) | Barristers (N = 745) | Totals (N = 1669) |
|---|---|---|---|
| Other people who don't know the person well | 83 | 75 | 79.6 |
| Employer | 56 | 47 | 52.2 |
| A bank, insurance company or other financial institution | 46 | 57 | 50.6 |
| A government or other public welfare agency | 27 | 28 | 27.3 |
| Friends | 25 | 20 | 22.5 |
| Family | 18 | 16 | 17.1 |
| A public or private hospital | 13 | 11 | 12.2 |

## III Discussion: Depression and the Law — the Australian Picture

The present research is the first of its kind undertaken in Australia. It reveals that Australian solicitors and barristers have much higher levels of psychological distress (see Table 5) and self-reported experiences of personal and close acquaintance depression (see Table 7) than would be expected from data concerning the general national population (see Tables 5 and 8). These results go some way towards confirming the view, hitherto based largely on anecdotal evidence and the few available Australian studies, that there exists a connection between practising law in Australia and experiencing disproportionate levels of distress and depression.

Given the high rates of experience of distress and depression discovered in the survey sample, participants' attitudes towards, and experiences of, treatment by mental health professionals is of some interest and these were revealed to be varied and complex. Approximately a quarter of the participants (26.4 per cent) said that they would not seek treatment if they were experiencing depression (see Table 9). Almost half of the sample (46.4 per cent) thought that

just 'some improvement' was likely to result from professional treatment whilst only a quarter (26.2 per cent) expected an unqualified recovery (see Table 10).

Despite these somewhat negative views about the outcomes of consulting mental health *professionals*, far higher percentages of the participants had positive views about the efficacy of various *treatments* (Table 12). Almost the entire sample (98.4 per cent) thought that becoming more physically active would be helpful in managing depression and 80.4 per cent of participants thought that taking anti-depressant medication would be helpful. However, the participants' views were such, that although they might believe that a particular treatment would help depression, they would nevertheless be inhibited from seeking that treatment from the relevant health professionals.

The data in Table 12 also show another aspect of the participants' ambivalence about mental health professionals. Whereas physical activity, changing one's diet and reading about other people with similar conditions were seen as harmful by at most 3.8 per cent of participants, using anti-depressant medication and attending long-term psychotherapy counselling were seen as being harmful by 9.7 per cent and 4.9 per cent of participants respectively. Once more, this finding indicates the presence of a sub-group of participants who have views that are likely to inhibit them from seeking treatment from conventional professionals. Interestingly, the current popular practice of reading self-help books was judged to be harmful by 10.5 per cent of participants.

These data, concerning ambivalence towards consulting mental health professionals, reveal greater pessimism towards potentially good treatment outcomes than is warranted by the evidence. For example, there is clear evidence in Australia that recently reduced suicide rates are in part a consequence of the increased prescribing of anti-depressant medication.[28] There is also clear evidence from large international meta-reviews of prior studies that both depression and suicidality reduce after contact with a variety of professional interventions (including: prescription of anti-depressants by general practitioners and psychiatrists and individual psychotherapy).[29] That is, it appears that people who are able to access medical treatment for their psychological distress have substantially better outcomes than those who are not.

In addition to clinical treatments that have been found to be effective in the management of mental illness, it has also become

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[28] Wayne Hall et al, 'Association between Antidepressant Prescribing and Suicide in Australia, 1991-2000: Trend Analysis' (2003) 326 *British Medical Journal* 1008.

[29] Gregory Simon and James Savarino, 'Suicide Attempts among Patients Starting Depression Treatment with Medications or Psychotherapy' (2007) 164 *The American Journal of Psychiatry* 1029.

apparent in recent years that a number of so-called lifestyle changes are beneficial to the management of mental illness and psychological distress. These include exercise, improved sleep, improved nutrition and social connectedness. Within a modern developed society such as Australia, it is not uncommon for individuals to attempt to introduce such lifestyle changes themselves, without the direct management or suggestion of a professional person, and the evidence from the present research suggests that legal practitioners are well aware of the potential benefits of these 'treatments' (potentially reflected also in the most popularly reported 'barrier' to treatment being a preference for managing depression alone (see Table 15)).

Despite these findings about *attitudes* towards consulting mental health professionals, the sample as a whole demonstrated surprisingly high rates of consultation when they were depressed. As indicated in Table 13, *of those participants who had experienced depression personally*, 80.4 per cent of solicitors and 80.0 per cent of barristers had received treatment. Compared with the general population, this is a *very* high rate of treatment (recent figures suggest that just 35 per cent of people with a mental disorder in the 12 months prior to being surveyed accessed treatment).[30] The finding also demonstrates the importance of including assessment of actual behaviours (in addition to hypothetical, 'under these circumstances I would…' scenarios) in one's methodological design.

Actively seeking information is an important aspect of educating oneself about depression and its treatment. It is therefore of considerable interest to note that although over half of the total sample had sought information about depression from a variety of sources, many of the participants, including over one third of people who had experienced depression, reported never having sought information about it (see 'Information Seeking' above). Of those participants who had sought information, the majority reported using the internet most frequently as a source of information. (The actual sites consulted are unknown.) The barristers made slightly less use of this source of information than the solicitors (reinforcing the view, formed during the data-collection phase, that many barristers favour paper over the online medium). Accordingly, in seeking to influence the behaviour of barristers with regard to the management of their own depression or that of their peers, it will probably be most efficacious to target them with both printed information and information coming directly from professional sources, such as medical or psychological professionals.

The sample as a whole expressed a variety of views about discrimination against people with depression (see Table 20). Of particular note is the fact that over 50 per cent of participants thought

[30] Australian Bureau of Statistics, above n 25.

that depressed people were likely to be discriminated against by employers. This suggests that a large proportion of the sample is likely to be reluctant to discuss personal experiences of depression with employers or professional colleagues. Given these attitudes, it is important that legal employers actively demonstrate positive attitudes towards their employees' mental health problems.

The present research was specifically focused on depression and psychological distress. It contained no questions about the use of alcohol or other drugs. Yet, it has been widely reported that people who experience high levels of psychological distress are likely to be high users of alcohol and other drugs.[31] Australian data on this issue are reported in Table 21.

**Table 21:** Psychological distress, by use of selected illicit drugs, for persons aged 18 years and over, 2007 (percentages).[32]

| **Substance / Behaviour** | | **Level of psychological distress (Measured by the Kessler K-10)** | | |
|---|---|---|---|---|
| | | **Low** | **Moderate** | **High or Very High** |
| **All persons (aged >18 years)** | | 69 | 21 | 10 |
| Any illicit drug use | Used in the last month | 51 | 29 | 20 |
| | Not used in the last month | 71 | 21 | 9 |
| Marijuana / Cannabis | Used in the last month | 51 | 27 | 22 |
| | Not used in the last month | 70 | 21 | 9 |
| Heroin | Used in the last month | 21 | 14 | 65 |
| | Not used in the last month | 69 | 21 | 10 |
| Meth-amphetamines | Used in the last month | 44 | 35 | 21 |
| | Not used in the last month | 70 | 21 | 10 |
| Ecstasy | Used in the last month | 45 | 34 | 20 |
| | Not used in the last month | 70 | 21 | 10 |

31 Benjamin, above n 15 and Beck, above n 16.

32 Australian Institute of Health & Welfare, National Drug Strategy Household Survey: first results (Drug Statistics Series number 20.Cat. no. PHE 98) (2008) 49 (Table 5.6).

As can be seen from Table 21, people with moderate, high or very high levels of psychological distress are over-represented in samples of drug users, whereas people with low levels of psychological distress are under-represented in such samples. For example, while those with high and very high Kessler scores constitute only 10 per cent of the adult population, they account for 20 per cent of the illicit drug using population. As noted in the introduction, there is also some research supporting the view that legal practitioners are likely to be higher than average alcohol and drug users. It is therefore likely that if a parallel survey concerning the use of alcohol and other drugs were conducted, the respondents to this survey would have a relatively high rate of usage, compared with the general Australian population sample.

## IV Altering the Landscape — Proposals for Change

Mental illness and psychological distress are often portrayed in the popular media as issues relating to individuals; that is, to psychologically-distressed individuals. But, in working towards a series of proposals to assist legal practitioners with psychological distress, it is important to recognise that this is not a problem *for individuals*. It is a problem *for communities*; a series of overlapping communities. These include a variety of legal groups such as: law schools, institutions engaged in articles or practical legal training, major law firms, smaller law firms, solo legal practitioners, professional associations and peak legal bodies.

Each of these groups has different interests and institutional goals, and different relationships with its members. Each may require different strategies to assist its members. But an important pre-condition for effective work to be done in any institution with regard to the psychological distress of its members is that *the institution must take on the mental health of its members as an essential institutional goal*. Without recognition of mental health issues as important, it will not be possible for institutions to work constructively towards preserving the mental health of their members.

In seeking to implement changes aimed at improving institutional mental health outcomes, it is important that mental health problems be seen as legitimate health problems for which employees may seek special consideration or support. For issues related to sick leave, special support of workers with disabilities and for occupational health and safety considerations, it is critical that staff at all levels come to see support for people with mental illness as a legitimate workplace strategy.

The first step in reaching such a state is to engage in education and information dissemination with staff at all levels in the organisation. Such an educational or information package should cover not only factual issues about mental health, but issues regarding the beliefs and behaviour of others towards people with mental health problems, and issues relating to institutional policies and practices regarding the mental health of employees. Such a wide-ranging educational program will start to change negative attitudes and behaviours at all levels within the organisation, as well as to increase the recognition of the occupational health and safety responsibilities of legal employers.

Legal institutions should also consider the role of their normal workplace practices in leading to stress on their workforce. One aspect of legal *thinking* which is thought to result in stress for legal practitioners is the orientation of constantly looking for something that might go wrong in a legal or contractual arrangement.[33] This style of thinking can result in legal practitioners becoming suspicious and perhaps even paranoid about everyday affairs (whereas someone with training in mediation counselling might have a much more positive response to quite similar professional situations). Practitioners should be made aware of this style of thinking, and encouraged to use different styles in the non-work aspects of their everyday lives.

Legal training institutions must make efforts to give their students insight into their own styles of thinking and how these might affect their lives. For example, Wollongong University Law School is currently attempting to introduce its students to meditation and self-awareness techniques during their first year studies. In doing this it is hoped that students will develop greater capacity to be aware of their level of personal stress and actively seek to reduce it. Such practices are also likely to increase the students' awareness of their thinking styles and its effects on their daily lives.

Another aspect of normal legal practice which is said to be a source of stress for legal practitioners in larger firms is the constant preoccupation with short-term billing.[34] As this practice seems to be widespread in the profession, it is not proposed here that an attempt be made to dismantle it. However, law firms that use such billing strategies must come to recognise that it may be a source of difficulty for its employees and start to develop occupational health and safety strategies to manage it, just as they would with any other major source of workplace stress. Recognition that billing practices may be implicated in negative mental health outcomes for legal practitioners,

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33 Cohen, above n 9.
34 Aleini, above n 10.

and that alternative billing models are available, is already evident in the work of some legal organisations.[35]

It has been noted previously in this report that some legal practitioners are more likely to be subjected to stress due to the nature of their work.[36] Lawyers working in criminal law are in one such group which has been identified as more likely to exhibit psychological distress. Groups in such particularly stressful work settings need to be aware of this and should be offered particular support and education related to the nature of the stress they experience. Agencies in which this style of work is their primary business might consider employing an in-house counsellor or other similar staff to review staff functioning and levels of stress on a regular basis.

In addition to maintaining awareness of what is normal practice in the workplace, it is important that some attempt be made to offer services to those who need professional help with the management of their psychological distress. There are a number of examples of services of this kind being sponsored by professional bodies in Australia, and a considerable body of international literature.[37] It is important at this stage of the development of awareness of psychological issues in legal practice that these services be systematically reviewed and efforts made to increase the use made of them by legal professionals.

The suggestions made thus far have given emphasis to work situations in which law firms or other employment settings might act to support their employees. However, there are many legal professionals who work in very isolated workplaces, such as sole practices or in regional or rural settings, in which there are very few immediate institutional supports. Professional bodies must play a major role in reaching out to more isolated workers and attempting to maintain these workers' awareness of workplace stress and their own needs for support. In this era of digital electronic communication, it is possible for professional bodies to set up or sponsor on-line services that can reach even the most geographically-isolated professionals.

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[35] Christopher Kendall, *Report on Psychological Distress and Depression in the Legal Profession* (Report, Law Society of Western Australia, 2011); John Chisholm, 'A Billing Discussion Worth Having' (2010) *Lawyers Weekly* <http://www.lawyersweekly.com.au/blogs/opinion/archive/2010/02/01/a-billing-discussion-worth-its-time.aspx>.

[36] Vrklevski, above n 7.

[37] Thomson, above n 1; Anonymous, 'A View from the Bench', above n 8; Anonymous, 'A Story of Recovery', above n 8; Anonymous, 'How I Broke through Denial to Achieve Sobriety', above n 8; Harkness, above n 8; Marx, above n 9; Cohen, above n 9; Anonymous, 'Complete the LawCare Survey for your Chance to Win an Apple iPod Nano!' (2008) *Queensland Law Society News* <http://news.qls.com.au/email_display.aspx?guid=b1c24184-0210-49b8-b15e-127177b1ece0&action=mailing>.

In addition to isolated workers, there are other groups of legal professionals who may be in need of special services to assist them to deal with specific personal and professional situations.[38] These include people making difficult transitions out of the workforce because of mental health problems and those same people upon their return. Such people must be offered appropriate levels of professional support if only from an occupational health and safety perspective.

The strategies adopted in different legal institutions to deal with psychological distress are likely to vary greatly. The particular social setting in which a problem is tackled will have a major influence on the range of potentially effective solutions. Differences in strategy between different institutions should not be seen as reflecting on the competency of programs, but as indicating effective adaptation to local conditions. Similarly, the strategies used to contact and support people such as barristers or practitioners in small community practices will be very different from those employed in major law firms. This diversity must be planned for, encouraged and recognized as a natural consequence of the range of local situations in which legal practitioners work.

## V Limitations of this Study and Future Research

Our research was cross-sectional in design, examining the level of psychological distress of lawyers at one point-in-time. This limitation was imposed on the study due to time and funding constraints. The same constraints also limited sampling to New South Wales and Victoria. It is suggested that future research might employ a nationally-based, large-scale longitudinal design that monitors lawyers' psychological well-being across various stages of their careers and explores the causal factors that are known or suspected to contribute to the symptoms of distress and depression observed in this study. If such a study were to commence with a group of young lawyers in their early years of practice, it would be likely to reveal patterns of adjustment and dysfunction which are typical of the profession. This envisaged research might also reveal complex interactions between the types of people who enter the legal profession and the characteristics of legal workplace environments. Such a study would require identification of the participants by the researchers at the commencement and subsequent follow up over longer periods of their professional lives. It would also enable a more sophisticated sampling technique than the one which was used in this study.

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[38] The Law Society of Western Australia and Women Lawyers of Western Australia, above n 5.

One of the limitations of this study is that no assessment was made of the level of alcohol and other drug use by legal practitioners. It is likely that if such an assessment had been included, males would have shown a higher level of alcohol and drug use and abuse than females (who typically report higher levels of psychological distress than males). Such an assessment is likely to be particularly informative about the levels of psychological difficulties exhibited by the barrister group, which has a much higher proportion of male members than the solicitor group. It is suggested that this kind of assessment be included in any future study.

It is strongly suggested that future research should attempt to evaluate interventions aimed to improve the psychological adjustment of lawyers in work settings. Such studies would involve documenting changes introduced in work settings, and following up the level of psychological distress and other mental health issues over several years. In the previous section it was noted that different employment settings are likely to require different styles of intervention. If several such evaluation studies were to be conducted over the next few years, it would be possible for legal employers to review a range of interventions and to conclude which might be most suitable for their situation.

## VI Conclusions

The primary finding of this survey is to confirm the view, originating largely from personal stories, that members of the legal profession in Australia exhibit higher levels of psychological distress and depression than are characteristic of the national communities from which they are drawn. It is likely that the observed levels of psychological distress derive from the elevated levels reported by Australian law students; that is, that the legal practitioners reported on in this article started to develop their higher levels of psychological distress as students.[39] The implications of this finding are as follows:

First, higher levels of psychological distress are serious risk factors for the development of depression and other diagnosable mental illnesses. The sample reported on here also indicated that they had experienced depression at much higher levels than the Australian population generally. Such findings are suggestive of a significant contribution of lawyers' psychological difficulties to problems in the workplace.

Second, there are some signs that there are attitudinal barriers to practising lawyers recognising their psychological distress and seeking

[39] Kelk, above n 19.

help for it. Quite high proportions of the participants in this survey said that they would not seek help for depression. Many expressed quite strong negative views about the effectiveness of mental health professionals in assisting people with depression. Additionally, the survey participants agreed with a variety of negative views about depressed people, which might have a detrimental effect on their seeking assistance for their own depression, or in assisting their peers or employees. In particular, more than half of the lawyers surveyed thought that they would be discriminated against for depression by an employer, which suggests that many of them would be unwilling to seek assistance for difficulties in their workplace setting.

Third, despite the above, there are signs that lawyers who do become depressed get help in high numbers. This is what would be expected of a group of such generally well-educated, highly-employed and economically well-off people. So, the situation is not all gloomy and there are clearly strengths which this community has to draw on in order to improve its situation.

A variety of suggestions has been made about changes in the employment setting which might be introduced by legal employers to improve lawyers' level of functioning regarding mental health issues. These include regularly monitoring the psychological distress of staff, offering education and information packages about mental health issues, increasing lawyers' awareness of work stress and ways of dealing with it, assisting lawyers to understand the nature of their legal skills and how these might differ from the skills that they use in everyday life and attempting to target particularly vulnerable or isolated professional groups. Finally, it is strongly suggested that such programs be conducted regularly over the course of a lawyer's professional life, rather than on one-off occasions or over short periods.