**LAW SOCIETY OF NEW SOUTH WALES**

**LEGAL ASSISTANCE PROGRAMME**

***INTRODUCTION***

The Law Society of New South Wales recognises that there is a high prevalence of serious mental illness in the legal workforce. It also recognises that the inherent stressors, which characterise legal practice in all its different forms, can trigger episodes of pathological anxiety, depression, and other major psychiatric illnesses, particularly in those lawyers who are genetically at risk of developing such illnesses.

The Law Society is establishing an updated support service for members who are suffering from psychiatric illness, and encourages early and effective intervention.

Individuals suffering from mental ill-health usually experience physical and psychological, occupational, inter-personal and social functioning difficulties, which may be further complicated by alcohol or drug abuse or financial problems, and relationship difficulties.

It is also the case that most serious psychiatric illnesses can be treated very effectively, and there is clear evidence that even the most seriously adversely affected individual may make a full recovery from episodes of mental ill-health and return to a productive, well-balanced professional and personal life.

***PRINCIPLES OF APPROACH***

1) Standardised, large sample scientific surveys indicate that there is a 20% annual prevalence of significant mental illness affecting individuals within the general population, including the legal profession, and 5% of individuals in the community at any point in time are known to be suffering from a serious mental illness, such as severe Clinical Depression, Bipolar Affective Disorder, or Schizo-Affective Disorder.

2) Conditions, as listed above, plus those related to anxiety, such as Social Phobia, Panic Disorder with Agoraphobia, Obsessive Compulsive Disorder, as well as eating disorders and drug & alcohol abuse or dependence, require thorough psychiatric assessment and management. These are often chronic remitting and relapsing conditions, and are frequently triggered by work place stress.

   Most of these more serious illnesses are best managed with a combination of medication and psychotherapy, but some are amenable to psychological treatment alone.

3) The gold standard management of the serious psychiatric illnesses is an initial, thorough bio-psycho-social assessment by a fully qualified Psychiatrist, who will then formulate a comprehensive management plan, which the Psychiatrist may either implement themselves, or they may devolve part of the management to a Psychologist or counsellor.

4) The aim of the Psychiatrist is to initiate a primary, secondary and tertiary prevention approach, so that episodes of psychiatric disturbance can be prevented from developing in the first instance, and then picked up early if they do occur and managed quickly and effectively. If this is achieved, then collateral damage can be minimised, and the probability of returning to work and to full functioning, maximised.

Tertiary prevention is focused upon keeping people well and minimising any persisting collateral damage.

Complete remission of symptoms, as soon as possible, is the desired treatment outcome.

5) Good therapy should always emphasise the responsibility that the individual lawyer has for their own mental and physical health, and a lot of psychological interventions are designed to bolster coping mechanism and resilience in the face of work-related and other stressors.

6) It is important to understand that there are distinct differences between Psychiatrists, Psychologists and Counsellors, and to be aware that every psychiatric condition can have an organic, medical or even medication-based cause.

A **Psychiatrist** is a fully trained medical practitioner who, after at least six years of undergraduate study, has spent another five to six years in specialist training, after their internship year. Like any profession, the quality of the individual practitioner can vary across a spectrum, however, the Psychiatrist is the only professional trained to provide a comprehensive bio-psycho-social assessment, and qualified to exclude organic causes of psychiatric illness, to understand medical and psychiatric co-morbidity dynamics, and to formulate a comprehensive plan of management. Psychiatrists can develop prioritised problem lists, upon which rational management is based. They can prescribe medication and order investigations and tests. to clarify diagnoses, and can either implement further management themselves, or devolve management to others. Psychiatrists may specialise in psychotherapy ranging from cognitive behavioural through Dialectical Behavioural Therapy to more intensive Psychodynamic Psychotherapy. Others are more focused on pharmacotherapy, combined with cognitive and supportive psychotherapy.

**Clinical Psychologists** have usually completed a five-year training programme at university, including a period of clinical supervision.

They are not medically trained, nor qualified to perform Bio-Psycho-Social assessments. They may have various assessment and therapeutic skills and may provide limited assessment and treatment services to individuals, couples or families. They are able to conduct standardised psychological tests, which may be helpful in determining intellectual functioning, and other aspects of cognitive functioning, especially areas of cognitive strengths and weakness.

They may also perform standardised assessments of personality functioning, which can assist in planning ongoing management.

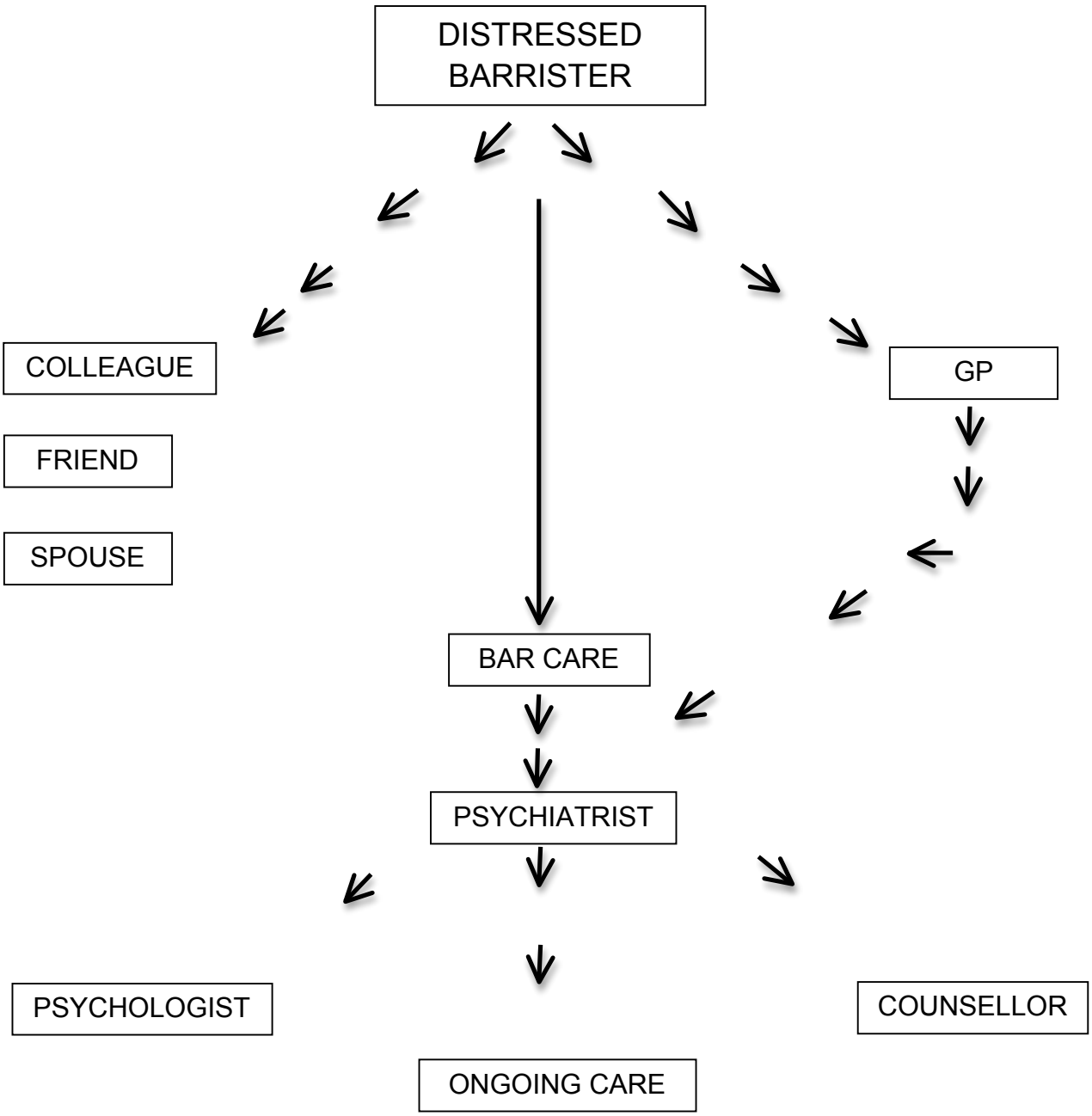
**Counsellors** usually have training in basic assessment and psychological support skills. They may provide support and triage before referring people whom they see on to a Psychiatrist or Psychologist, if they determine that a more serious illness may be present. Counsellors are often involved in assisting people who are grieving, or others who have ongoing drug and alcohol abuse or dependence problems.

7) Information Resources –

*Black Dog Institute*
*Beyond Blue*
*Wlkipedia*

8) Treatment resources –

8.1 Psychiatrists
8.2 Psychologists
8.3 General Practitioners
8.4 Counsellors
8.5 'Up Clinic' (on-line, self-help, cognitively-based treatment programme – St Vincent's General Hospital, Darlinghurst)


DISTRESSED BARRISTER
COLLEAGUE
FRIEND
SPOUSE
GP
BAR CARE
PSYCHIATRIST
PSYCHOLOGIST
COUNSELLOR
ONGOING CARE

# LAWYERS, MENTAL ILL-HEALTH and LIABILIY: PREVENTATIVE MEASURES or EXPENSIVE REMEDIES?


## ABSTRAC T

**It ha.a been well-documented that law studenta and lawyers have higher levels of mental ill-health, compared with the prevalence found in the general public and membera of other professional groups, including doctora.**

**What is not commonly recognised is that lawyers have already successfully aued their employers for workplace-induced mental ill-health and the employing bodies may well be liable to prosecution on workplace safety grounda.**

**In this paper, Consultant Psychiatrist, Dr Robert Fisher provides an overview of the nature of the common mental ill-health problems known to affect lawyers. He also discusses vulnerability factors in the individual lawyer, and the noxious workplace factors identified as contributing to mental ill-health. Finally, he outlines measures to prevent and manage mental ill-health problema in the legal profession.**

**In the second part of this paper, The Honourable Keith Mason will discuss the potentially costly legal implicationa, including both compensation claims and the risks of prosecution for unsafe workplace conditions and practices**.


## INTRODUCTION

In addressing these issues, I do so as the Psychiatrist member of the **Board of the Tristan Jepson Memorial Foundation**. This is a not-for-profit voluntary organisation, focused upon prevention and better management of mental ill-health in the legal profession.

The Foundation bas a unique Board, with representation from every facet of the legal profession, including the student body, academics, solicitors, barristers and the judiciary.

The Foundation was set up at the initiative of Tristan Jepson's parents after his suicide death.

I knew Tristan Jepson as an exceptional young person, starting off his career in the Law. He was bright, constantly inquisitive and constantly questioning, philosophically dedicated to righting injustice, and amongst his many talents was his success as a television comedian.

I have seen the enduring impact of his death on his family. I have also treated many members of the legal profession – from students to judges – who have been very seriously mentally ill, mainly with Depression or Bipolar Affective Disorder, and I have seen the negative impact these conditions have had on their capacity to work, as well as upon other aspects of their lives.

## PSYCHOLOGICAL FUNCTIONING and WORK-PLACE STRESS

Having focussed upon the educational and informational aspects of mental ill-health, the **Tristan Jepson Memorial Foundation** will now be focussing upon a range of interventions at the primary, secondary and tertiary level of management. These interventions are designed to reduce the risk of mental ill-health occurring, to manage it effectively and quickly when it does arise and, finally, to reduce the risk of relapse and ongoing collateral damage.

The following principles guide us in our approach -

1) It must be said that **many people in the legal profession are very happy and fulfilled in their work,** but the reality is that for virtually every practising lawyer, across every domain, the **work is very demanding, and the high pressure and the results-driven expectations** require a focus of attention and usually a requirement to put in much longer hours at work than many other professions.

2) We know that **one in five people in the community at any point in time** will be **suffering from a diagnosable mental** disorder or illness which causes trouble for them and, usually, trouble for others.

   We need to distinguish the larger group of individuals in the workplace who are not happy or are frankly miserable, from those who are suffering from **diagnosable psychiatric illness.**

3) **Lawyers have identified the stressful factors which** have been shown to trigger situation-specific and understandable anxiety and unhappiness which, unfortunately, can – in the constitutionally vulnerable individual lead to the development of more serious and potentially life-threatening mental and physical illnesses.

4) As The Honourable Keith Mason will indicate, this nexus between identifiable work-specific stressful factors and mental and physical ill-health may become increasingly fertile ground for legal action to right the wrong, and this has already been shown to be a very expensive exercise for employing law firms.

## TABLE 1

## RELEVANT STATISTICS

1. **14,4% have an anxiety disorder, causing disability.**

2. **6.2% have a depressive disorder, causing disability.**

3. **5.1% have a substance-abuse disorder.**

4. **SO% of people have a mental illness some time in their life.**

5. **3.2% will attempt suicide at some point in their life, and 0.4% had attempted suicide in the previous year.**

6. **1.5% of all deaths registered are attributable to suicide. This amounted to 2,191 deaths from suicide registered in 2008.**

7. **The highest age-specific suicide rate for males in 2008 was found in the 40-44 age group (26.4 per 100,000), and for females in the 50-54 age group (8.2 per 100,000),**

8. **Suicide is the leading cause of death in people aged 25-64.**

9. **65% of people with a diagnosable mental disorder do not seek help.**

Other studies[1] have shown that the prevalence of mental ill-health in law students and lawyers generally is higher than in other professions and there is research evidence of an increased tendency to pessimism and perfectionism in the personality profiles of those studying law and those working within the legal profession, compared with other professions2,

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[1] 'Courting The Blues- Attitudes Towards Depression in Australian Law Students and Lawyers'. Dr Norm Kelk, Dr

[2] Distress Levels and Self-Reported Treatment Rates for Medicine, Law, Psychology and Mechanical Engineering Tertiary Students: Cross-Sectional Study'. Kathryn M Leahy, et alii, 2010, Royal Australian and NZ College of Psychiatrists

Researchers have also identified factors in law schools and in the legal workplace which have led to consistently higher rates of significant mental illness and, indeed, La Montagne[3] attributes 15% of depression detected in the workplace to be due to workplace stressors.

## TYPES OF $TRESS IN THE LEGAL WORKPLACE

## TABLE II

Table II lists the factors which legal practitioners identify as stressful and causative of anxiety and depression in their workplace.

1. **Burden of excessive work demand and excessive hours worked.**
2. **Meaningless work.**
3. **Lack of acknowledgement of effort made.**
4. **Sense of *'dog eat dog*•.**
5. **Sense of lack of support and encouragement.**
6. **Bullying and sexual harassment.**
7. **Sense of a *'treadmill'* work existence.**
8. **Culture of toughness and the need not to be perceived as weak or incapable, or to be a whinger or complainer.**
9. **Pressure of *'btllable ttme*• and now *'proftt per equity partner*•, or *'oases processed',***

The stress that is likely to be encountered will depend upon the context in which the individual is working. Stressors enco1.mtered in law school may be materially different from those encountered in a large law firm, or at the Bar, or in the judicial context, in the magistracy, or in government instrumentalities, such as might be found in the Public Prosecutor's Office.

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3 ' Job Strain Attributable to Depression in a Sample of Working Australians: Assessing the Contribution to Health Inequality'. Anthony D. La Montagne et alii, Public Health 2008: 181 (May 27, 2008)

**Stress is very much in the eye of the beholder** and each individual brings to the situation their **own levels of resilience and vulnerability.**

Not infrequently, the sequence of events will be that the individual encounters a major stress or a number of stressors that overwhelm their usual coping mechanisms. This then causes them to be highly anxious and, in this state, they often feel trapped in a situation which they are unable to control or manage. This has been referred to by **Professor Martin Seligman as a state of 'learned helplessness'**[4].

Sometimes, **cognitive behavioural psychotherapeutic interventions can help** an individual to pull themselves out of this very distressing and immobilising state. However, when the brain reaction to stress has progressed beyond the domain of the cerebral hemispheres and has triggered depletion of serotonin and noradrenalin in the mid-brain and limbic system, then antidepressant medication, combined with cognitive **behavioural psychotherapy, is likely to be required.**

## PSYCHIATRIC DISORDER IN THE LEGAL WORK-PLACE

Evidence shows **that mental disorders interfere with the capacity of those affected. to work effectively,** and lead to them having significant time off work, and also to increase the risk of death due to suicide. There is also evidence of a link between **mental disorders and. premature death, due to physical illnesses, such as heart disease, as well as due to alcohol abuse and. other drug-related diseasess.**

It is important to note that **'presenteeism' –** whe11 someone attends work when physically or mentally **ill –** can be just as damaging to the functioning of the law firm or legal organisation as 'absenteeism'.

In medicine, we tend to approach the conceptualisation of mental functioning from a dimensional, rather than categorical perspective, acknowledging that health, disorder and disease lie on a continuum.

The **current pproach to psychiatric diagnosis** is to **'operationally define'** each psychiatric condition, by which we mean the patient must have certain critical symptoms but not others and causative organic medical illness must be excluded for every psychiatric diagnosis. **Psychiatric diagnose!J are then arranged taxonomically in hierarchical fashion** so that higher order diagnoses may have symptoms found in lower order diagnostic entities but not vice versa, e.g. a patient with Alzheimer's Disease may be depressed, anxious, phobic and have a personality disorder, but they must also have significantly. impaired memory and a global

[4] Peterson, C.; Maier, S.F.; Seligman, M.E.P. (1995). A Theory for the Age of Personal Control- New York: Oxford University Press.

5Sapolsky, Robert (2012). Stress··Porn;4it of a Killer, National Geographic. www.shopngvideos.com

deterioration in cerebral function. In addition, there will be evidence of cortical shrinkage of the brain, on tests such as MRI scans.

**Mental Disorder is a disturbance or change in a person's thinking, emotional state or behaviour, which causes distress to the individual or others.** It disrupts their ability to work, carry out other daily activities and engage in functional inter-personal relationships. Some of these conditions are d·ue to **disorders of brain structure or brain chemistry,** the latter of which is likely to have a **genetic basis** and is often triggered by stressful environmental factors. Others are due to **psychophysiological reactions to stress** and may be seen to be at the extreme end of the normal range of reactions to the identified stress.

Not only are there different types of stress in different legal settings, but it is also the case that **one person's 'stress'** can be **another person's 'positive challenge',** thus some law firms or legal organisations may be more 'toxic' for an individual than others.

**Stress is defined as *"any situation which is interpreted as being threatening to the individual's psychological, physical, soctal or occupational integrity or safety".***

Its impact is determined by the individual's 'mind-set/world view', brain function, physical health, psychological and emotional state, personality, drug and alcohol use and any other co-existing stressful environmental factors at any given point of time.

Of great concern is the increasing evidence that recurrent bouts of 'Major Depression' or the Depressive Phase of Bipolar Affective Disorder leads to permanent shrinkage of the amygdala[6], which is evidence that the damage is not just biochemical or pathophysiological but actual pathological structural disease which is not reversible. This may be similar to the neuronal loss seen in Parkinson's Disease, or Alzheimer's Dementia.

## THE BIOPSYCHOSOCIAL 'PROBLEM-ORIENTED' PSYCHIATRIC ASSESSMENT

The assessment leading to a 'biopsychosocial, problem-oriented diagnosis' and the development of an appropriate management plan is the responsibility of a Psychiatrist, the only professional who is trained to fulfil this comprehensive task.

**Psychiatrists view each individual from the perspective of**

**i) Identifiable primary psychiatric disorders,**

[6] Praag, H.M. et alii (2004). Stress The Brain and Depression. Cambridge University Press.

ii) **Personality disorders or characteristics, including strengths and weaknesses**
iii) **Medical disorders and medication, and**
iv) **Inter-personal, social and occupational problems**

all considered in the context of the **unique developmental history and previous physical and psychological difficulties or illnesses** and **environmental factors** which have played their part in the **forming and shaping of the individual** as they present at the time of assessment.

This is referred to as a **'multi-axial assessment',** and acknowledges that the biopsychosocial paradigm allows us to conside1· contributions that each of these elements of human life may contribute to health, disorder and disease. It also reinforces the importance of doctors thinking about **each patient as an individual,** where the interplay of the biological, psychological and occupational/social aspects will be unique for each individual, in both the immediate and long-term perspective.

Sometimes there is **cross-axial or cross-domain causation of problems,** e.g., taking certain antihypertensive medication may lead to serotonin and noradrenalin depletion in the brain, which causes the patient to develop Major Depressive Disorder. Sometimes, independent, non-causative problems co-occur across domains. To properly assess and help manage the whole person, each of these factors needs to be considered.

## THE COMMON PSYCHIATRIC DISORDERS ENCOUNTERED IN THE LEGAL PROFESSION

Let us now examine the characteristics of some of the common psychiatric disorders, found in individuals working in the legal workplace, and how they impact upon the individual's capacity to function.

It is very important to recognise that having a psychiatric disorder, **such as Major Depression, may cause a cascade of negative biological, psychological, interpersonal and occupational consequences,** with **suicide or para-suicide being the most alarming of these.**

The **common Mental Health conditions occurring in the legal workplace** are outlined in Table 3.

TABLE3

COMMON PSYCHIATRIC CONDITIONS IN THE LEGAL WORKPLACE

1) Generalised anxiety and panic attacks.

2) Depressive Conditions
   i. Adjustment disorders with depressed and anxious mood
   ii. Grief and abnormal grief
   iii. Major Depressive Disorder
   iv. Depressive phase of Bipolar Affective Disorder
   v. Depression, secondary to an organic condition, such as hypothyroidism, stroke, brain tumour, dementia or Parkinson's disease or side-effects of prescribed drugs such as anti-hypertensives.
   vi. Depression, secondary to drug and alcohol abuse.

3) Substance abuse disorders.

4) Personality disorders causing trouble for the individual and those around them.

5) Co-morbid anxiety, depression and drug and alcohol abuse problems, causing family problems and financial problems, and often combined with co-existing general medical problems or general medical problems caused by alcohol abuse.

6) Para-suicide and suicide.

## ANXIETY DISORDERS

The most common psychiatric disorder is pathological anxiety, but one needs to distinguish normal, healthy anxiety from the pathological form of psycho-physiological reaction to stress.

Anxiety arises in response to the perception of a threat to one's integrity, which can include physical, emotional, social, occupational or inter-personal integrity.

Importantly, the 'perception of threat' is in the eye and brain of the beholder and may be wholly accurate, partially accurate or completely inaccurate. It is also the case that a serious threat may actually be present but the individual either does not perceive it at all or does not interpret it as significant, usually with most unfortunate sequellae.

**Anxiety is both a psychological and physiological response** to threat. Its function is to alert us and prepare us to deal with the threat which is perceived and, in its most extreme form, means either fighting or escaping for preservation of life.

We know that a certain level of anxiety is required for optimum performance, whether it be on the sporting field, in an exam, or in dealing with a Court matter or, indeed, fighting for one's life.

**The Yerkes-Dodson law proposes that too little anxiety** is likely to lead to poor preparation and poor performance, that excessively high levels of anxiety may become counter-productive, and that there is an optimal level of anxiety which will lead to optimum performance

It is useful to understand **the psycho-physiology of the anxiety reaction.** Basically, in lower order animals, this starts with any perception of threat or danger processed through the five senses of smell, hearing, touch, taste and sight being registered by the cerebral hemispheres of the brain. In the human being, the interpretation of the meaning of 01..lr thoughts about our internal or external world, may also act as 'threats' which trigger the same anxiety response.

A message is transmitted from the cerebral hemispheres to the .ygdala and 't'fl hypothalamus which results in stimulation of the vagus nerve and .e release of I corticotropin-releasing hormone. Both then stimulate the adrenal gland which releases adrenaline and various glucocorticoids into the bloodstream.

These hormones circulate around the whole body, stimulating the organs supplied by the circulatory system. This will, for example, lead to stimulation of the heart and diversion of blood away from the gut, (which will often lead to a sense of churning of the stomach). The muscles become hyper-reactive, the heart rate is increased and more blood is pumped into the lungs to oxygenate blood, all in preparation for the fight or flight response. Adrenaline and Cortisol have an alerting effect upon the brain with the release of serotonin and noradrenalin. The cerebral hemispheres actively 'scan' the external and internal environments, looking for ways of dealing with the threat, or escaping from it.

**Panic disorder is a reaction of extreme anxiety** and will generally be manifested by a sense of overwhelming fear with palpitations, pounding in the ear, muscle trembling or shaking, sensations of shortness of breath or a feeling of choking, chest pain or discomfort, nausea or abdominal distress, and a feeling of dizziness, unsteadiness and lightheadedness. There may also be a sense of derealisation, depersonalisation and a fear of losing control or going crazy.

Some people will think that they are dying of a heart attack and with hyperventilation may come tingling or numb sensations around their mouth or at the extremes of their fingers or toes, which may make the person think they are having a stroke. In the extreme, the muscles can actually go into 'tetanic' spasm.

This is a horrible experience, which is difficult to understand for anyone who has not been through it.

## 2. DEPRESSIVE CONDITIONS

Next we need to consider **depression.** As I have indicated above, 'depression' can be categorised into many different **sub-types, but unhappiness, realistic depression and normal grief should be distinguished from pathological mood states.** Being unhappy in reaction to a realistically depressing situation can lead to action to deal with or eliminate the misery-making factors or conditions, and should be seen as a healthy and appropriate mood state..

**As to the pathological** Depressive Disorders, generally, **Major Depressive Disorder** and the **depressive phase of Bipolar Affective Disorder** are the ones which cause most dysfunction. They tend to go on for the longest period of time and are most likely to put people at risk of significant impairment in the workplace. They also carry the highest risk of suicide.

These two sub-types of depression appear to be genetically influenced, and are the result of biochemical changes in the brain, which will affect not just mental functioning, but general physical functioning.

They are **often 'stress'-induced but,** once induced, tend to run a course of their own, so that, even if the stress is removed, the individual will continue to be in a dysfunctional state.

**It** is essential to recognise that negative perceptions and thinking can cause a depression of mood but, in addition, depletion of serotonin or noradrenalin levels in the limbic system of the brain, can lead to negative thinking. It is very much a two-way street but, once serotonin and noradrenalin levels are depleted, it will either take considerable time for them to be restored to normal levels, or treatment with antidepressant medication or electro-convulsive therapy may be required, sometimes, to save that person's life.

In the best of circumstances, an individual with severe biological or clinical depression will respond to antidepressant medication within a two to four week period, and even better results can be obtained using electro-convulsive therapy. The latter may be employed if the person has failed to respond to medication, or is at imminent risk of suicide or death due to inanition.

**It** is important to understand that **treatment with medication, or with electro-convulsive therapy does not 'cnre' the underlying condition,** but facilitates recovery from an episode, by restoring levels of serotonin and noradrenalin, necessary for stable mood, sleep, appetite, energy, libido and the rate at which the brain and body operates.

There is encouraging **evidence that staying on antidepressant medication** may contribute to **maintenance of brain cell numbers, particularly those in the amygdala.** Continuing on antidepressants as prophylaxis may indeed be highly effective in maintaining both cognitive and emotional functioning of the individual and preventing relapse.

These biological **depressive states may be of mild, moderate or severe degree,** but are usually accompanied by **co-morbid anxiety and frequently complicated** by abuse of benzodiazepine prescribed medication, alcohol or, more recently, the use of illicit drugs such as cocaine, amphetamines and ecstasy.

**Depressed individuals may engage in thrill-inducing activities,** such as gambling or other risk-taking activities, as a way of trying to feel happier. The cascade of cognitive, emotional and behavioural consequences of what starts as workplace stress is all too common and, frequently enough, leads to the threat of break-up of a marriage or the actual separation of the lawyer from his or her spouse. Dn1g and alcohol abuse, where it has occurred, will usually eventually come to the attention of family, friends, colleagues or the General Practitioner.

These complications may lead to the lawyer being properly assessed for the first time and the initial stress, anxiety and depression being addressed, however, we know that 65% of people with a mental illness will not seek help or be provided with help.

## 3. DRUG & ALCOHOL-RELATED PROBLEMS and PERSONALITY DISORDERS

I shall not go into detail in this article about the diagnostic criteria for drug and alcohol abuse and dependence or spend too much time on personality disorders. It should be recognised, however, that **obsessional perfectionistlc tendencies** can be a **two-edged sword,** which works to advantage in certain circumstances and to great disadvantage in others. Perfectionism may lead to excessive amounts of time being taken to complete a task and a failure to deliver on time, as well as cause subjective distress for the individual attempting to make things perfect, where they can't be. Unfortunately, it usually creates hell for those around them if the perfectionistic, obsessional lawyer happens to occupy a senior position. Such a person may be seen as difficult to work with and a 'control freak' and 'micro-manager'.

One also encounte1-s more than a few senior lawyers or other legal practitioners who have **narcissistic personality disorders, or are creative psychopaths,** whose ruthless behaviour may lead to them being high-earners, or to being appointed to a position of power, but at a cost to almost everyone else around them.

## WHAT CAN BE DONE ABOUT MENTAL ILLNESS IN THE LEGAL WORKPLACE?

Having canvassed some of the more common psychiatric disorders occurring in the legal workplace, we can reasonably start asking questions **about how such mental illness and attendant impairment of function – personal, professional and social, can be prevented, or identified early and effectively managed.** In addition, after the individual lawyer regains mental health, the treating Psychiatrist and the patient both need to think about how to reduce the risk of recurrence, and keep collateral damage to a minimum.

In medicine, we tefer to this approach to addressing and dealing with illness as **primary, secondary and tertiary prevention.**

### 1. PRIMARY PREVENTION STRATEGIES

These should be considered from the individual lawyer's point of view, as well as the employer's view.

The **culture and values of the firm or legal institution, including attitudes to working condition$, training, and professional and personal development, are all pertinent** ii!II!IUel!l.

A fundamental question. is **whether both the firm and the individual really consider** the **work/life balance** issue to be **important enough to do something about or not.**

Mental health policy information should be **provided at induction** into any legal institution or workplace, as well as at regular individual performance reviews.

**Annual workshop$ aimed at maximising good physical and mental health,** as well as improving productivity and job satisfaction, can also be seen as vital measures in primary prevention.

**Meaningful Human Resources' support and mentor's guidance and pastoral** care also have their part to play in primary prevention.

A lawyer, barrister, magistrate or a judge, will often bring to their professional role the personal expectation of **high standards of performance,** without expecting or being welcoming of professional support. They see themselves to be engaged in a highly competitive profession, where any sign of weakness or incompetence puts that individual at risk of personal humiliation and professional damage.

Part of the **'due diligence',** which we all have individual responsibility for in adult life, requires understanding what you are getting yourself into occupationally and owning **responsibility for keeping your life balanced.** This means a balance between **work, relationships and leisure** and between **self and others.** The

success of the juggling act is absolutely necessary if the individual is to have any chance of managing reasonably well all the demands encountered in everyday life.

It is a self-evident fact **that you cannot go to an extreme in any area of your** life without **paying a price in other areas.** Juggling work, relationships and leisure is an active process which requires strategy development and application of a plan. This process requires focus and consumes energy.

Self-responsibility and self-care includes ensuring that one sleeps properly, eats properly, does not abuse drugs or alcohol, takes proper, meaningful breaks from work, paces work activity and allows oneself to be 'nourished' by relationships and leisure pursuits. Engagement in regular physical activity and exposure to the sun is known to influence the serotonin and noradrenalin, as well as endorphin and encephalin levels in the brain, and can help keep depression at bay.

**Ideally, a lawyer should have a sense of enthusiasm about going to work, but also enthusiasm about going home to family and friends,** and having mental and physical breaks from the arduous aspects of their working life.

Too many judges have come to me over the years saying that the major priority that is emphasised by their managing colleague or colleagues, is 'cases processed' within time limits, as opposed to thoughtful, considered assessment, which would require time to be spent in garnering information required for the proper conduct of the inquisitorial process and sufficient time to formulate a judgement.

**Currently judges often find themselves writing their judgements** late into the night, or on weekends or during holidays, and this all takes a significant toll on every other aspect of that individual judge's life.

Many **judges, lawyers and barristers** do not relish the idea of going to work but feel they have to see out their 'sentence' before retiring on a reliable pension and then getting on with what is left of their life.

Barristers often tell me that they can't say *ano"* to a brief, and that they have to work Saturdays and Sundays, because they are the performing seal and must be present at the show and perform well, if they are to be thrown a kipper.

Many **young lawyers** come into large firms with high expectations and grand aspirations, only to find that much of what they do (in the many hours beyond the normal working day) is meaningless discovery work, sitting in oppressive office environments, fearful of being seen to get to work too late or leaving too early, competing with their colleagues, and believing that they have to spend Saturday and Sunday at work, often enough without receiving much apparent appreciation for what they're doing. If all the 'extra' hours are taken into account, they are, in fact, receiving a very lowly wage per hour, but they continue on, convincing themselves that they will actually wh1 the lucky dip of partnership in 10 or 15 years' time.

Once they have their over-sized mortgage, two and a half children at pre-school, kindergarten or private school, as well as their car leases, they feel trapped for the term of their natural life. Sadly, they discover that wh.at they thought was a noble, meaningful and fulfilling profession turned out to be a highly demanding business that might not really be much different from the 'Satanic Mills' of 19th century England.

I would strongly suggest **that the mindset of large firms and other legal organisations and the mindset of those employed there needs to change.** Firms need to be clear about their **core principles of approach,** they need to **decide whether they are primarily profit-driven, highly competitive, cut-throat 'churn and burn' businesses** on one end of the spectrum, or **primarily professional organisations,** with a **master/apprentice model of professional development,** engaging with their employees in a **contractually fair manner,** and providing **services to customers** at a good **profit margin** at the other end of the spectrum.

When the latter approach is taken, governance, leadership, and pastoral care structures within a firm or other legal organisation become extremely important in establishing principles, values and cultural practices, which move beyond lip service to actually delivering experiences that employees deem to be meaningful and which encourage best performance for the greater good of the organisation.

**As a Psychiatrist,** I encourage each individual to see it as their responsibility to **strike fair deals in their relationships with anybody** else they relate to in life, including their employer.

Too often, I see legal practitioners of one sort or another, who **feel crushed psychologically and emotionally,** by the system within which they work. They don't want to go to work but feel obliged to continue in their occupation for financial reasons, or because they believe that they are lucky to have jobs with prestige and kudos, and that they will be seen to be a failure if they leave.

The **sooner both employer and employee are clear about their expectations of each other and their expectations of themselves,** the more likely it is that a fair contract will be established, even when the reality is that the demands of the job are significant.

This **may mean dividing the work among a large number of junior lawyers and charging more or earning moderately less per unit of work done.**

What the individual lawyer, barrister or judge must not lose sight of **is the bigger picture of quality of life and the place that work occupies in the broader spectrum** of life. What is the point of being a rat on a treadmill or a pair of hands on a conveyor belt if you have the intellectual and educational qualifications to choose alternative occupations which permit a better quality of life.

Managing partners need to consider how to maintain enthusiasm, facilitate professional development, and ensure dignity and respect as cornerstone characteristics of the work environment, whilst also achieving reasonable profitability.

I believe that it is useful for **lawyers to examine their own mind.set and to design what they would consider to be their optimum/realistic job description, and also to conslder how they would ideally like professional life,** as part of their broader life, to unfold over time **until they retire.**

It is interesting that Psychologist, Professor Martin Seligman at the University of Pennsylvania has shown that, where you offer a young legal intern two hours out of their 50-70 hour working week to engage in legal work that is really of interest and meaningful to them, that they are happier, more productive, and more enthusiastic about going to work than if they are not offered those two hours. Unfortunately, the 'churn and burn' approach does not encourage such magnanimity.

**Bullying, sexual harassment and racial, sexual or religious discrimination,** are clearly **not tolerable** in the twenty-first century law firm, yet all of these issues still occur to a greater or lesser extent. As such, they may be seen as examples of the vagaries of human nature, but they are not just culturally unacceptable in any civilised workplace, they are also illegal.

A **focus on preventative measures** and the provision of clear guidelines for registering and managing complaints about these issues should be promulgated at the induction phase and reinforced at the time of personal/professional review, and scrutinised at annual partners' meetings. Where an incident is proved to have occurred, a root cause analysis should be conducted and preventative and remedial measures instituted.

## SUPPORT STRUCTURES and SUPPORT PERSONNEL

There are many potential sources of support, but **mentoring and psychological support** should be available in every law firm. These must not only be present, but be **meaningfully present.**

**Industrial psychologists** have professional training in establishing workplace structures and functions, which can bring out the best in workers and may assist in the building of teams at1d addressing friction and dispute resolution issues.

**It** is my view that the **managing partner should have the primary responsibility,** both at partners' meetings and **through the head of HR, for establishing** effective, supportive work units, as well as ensuring that primary prevention, actually occurs through information and education, together with ongoing support for extremely hard-worked staff at all levels.

If the approach that I recommend is in place and functioning, then I believe co-operation between employer and employee will be enhanced, and increased productivity is likely to occur.

In the event that an employee is failing to work productively, or the quality of work has deteriorated, processes need to be in place which capture this issue early, and determine why this is occurring, particularly in a previously mentally and physically well functioning individual.

The assessment process needs to take into account the possibility, if not the probability, that such a person is suffering from a mental illness or has been overwhelmed by the impact of a series of stressors, which has taxed their normal coping mechanisms. In-house support or referral to external helping agencies may then be the appropriate way of handling this situation.

Clearly, a firm cannot afford to carry under-performing staff, due to laziness, disinterest or mental or physical ill-health, but appropriate counselling and medical interventions may correct these problems and, if not, retrenchment can be handled in a way which is civilised and respectful or the obverse.

Ideally, where the deterioration in performance is due to mental or physical ill-health, and there has been a failure to reach full recovery, the provision of effective out-placement services can make a big difference to that individual's future quality of life and professional survival.

HR personnel are not all trained in psychology, let alone Clinical Psychology or professional counselling, yet are often expected to serve these functions, or think that they have the skills to deliver these services in the workplace. At the very least, HR personnel need to be properly trained in 'Mental Health First Aid', where their role is to provide immediate support in a crisis situation, and then to triage the lawyer to the appropriate helping agencies.

HR managers and Managing Partners need to understand that a person with a severe mental illness needs to see a Psychiatrist, not a Psychologist, and they need to have ready access to appropriately qualified Psychiatrists. Where mental ill-health affects barristers or the judiciary, this triage function can be provided through the Judicial Commission, BarCare, or Law Care.

Ideally, both the managing partner and the head of HR should have some working understanding of the non-work as well as work/life functioning of their staff. They should encourage members of the firm, from partners down to the most junior clerical employees, to seek assistance – inside or outside the firm, if they are struggling.

Managing partners and HR personnel should make it their business to ascertain whether they have a 'happy ship' and, if not, to try and determine what factors or which personnel are causing problems leadingto that unhappiness.

*'Employee Assistance Programmes'* are often found wanting by employees for a variety of reasons. These include the lack of user friendliness, the rather prosaic responses that they receive and reservations about confidentiality. Firms and legal institutions should review their usefulness or otherwise, and the money spent on them might be better diverted elsewhere.

## BUILDING RESILIENCE

Resilience refers to the capacity of an individual to cope with stress and adversity.

This coping may result in the individual rapidly 'bouncing back' to a previous state of normal functioning, or the experience of exposure to adversity may produce a 'steeling effect', and the individual may deal with the challenge or threat better than expected. This may be seen to be much like an inoculation, \Vhich gives one the capacity to cope well with future exposure to a pathogen.

**Resilience is most commonly understood** as a capability which may vary from time to time and situation to situation, rather than being a consistent trait of an individual.

**Most research** now shows that **resilience results from the individual developing confidence in their ability to interact effectively with, and successfully manage, their environment.** To be meaningful, this **requires success experiences** that justify the confidence. Effective coping strategies may be inculcated by good family models or direct teaching by parents or siblings, schools, communities and social policies that make resilience more likely to occur. In this sense, 'resilience' is more likely to be effective when there are **cumulative 'protective factors'.** These latter factors are likely to play a more and more important role, the greater the individual's exposure to life's challenges and stresses.

In a law firm, one can see that personal resilience has a vital part to play in the face of very demanding work, long hours, and lack of instantaneous reward for effort.

One can also see the role that resilience plays in the performance of 'team' or 'work' units within the firm.

Effective primary prevention may occur through a focus on personal and team resilience and may well serve as an important contributor to prevention of mental disorder, which otherwise might be inevitable in this stressful work environment.

## SECONDARY PREVENTION

### 1) INTERVENING EARLY and EFFECTIVELY

Secondary prevention is the **treatment of a problem once it bas developed.** The aim is to provide **rapid, symptomatic relief with minimal adverse side-effects** of treatment, and facilitation of a return to best pre-illness levels of functioning or better.

In the legal workplace, this should commence with the individual lawyer seeking help or **'Mental Health First Aid'** being provided by a manager/colleague, or a Human Resources person. It should then lead to the referral of the lawyer to the appropriate treating professional – in the first instance, a Psychiatrist, not a psychologist or counsellor.

Once it is suspected or established that a lawyer has a significant mental health problem, the first appropriate step is a **comprehensive biopsychosocial assessment by a Psychiatrist to determine the range of problems** that the individual lawyer is suffering from, and to formulate a comprehensive management plan, which may or may not involve medication, but will, at the very least, involve a psychotherapeutic intervention.

Important issues which need to be addressed include the **impact of that lawyer's dysfunction on themselves,** their **colleagues, their clients and on family members,** with attention being paid to **drug and alcohol abuse** where that has occurred. Sometimes, professional dispute resolution is appropriate.

In the best of circumstances, **a lawyer may require only four weeks off work,** even if they are **severely ill,** or they **may be able to stay on at work,** whilst seeing a Psychiatrist or a Clinical Psychologist for supportive psychotherapy, if not so disabled.

After **a period off work for intensive treatment,** the lawyer may need a **graded return-to-work programme** and proper monitoring of their capacity to cope with their workplace demands, as well as maintaining ongoing review by a Psychiatrist.

### 21 PSYCHIATRIC and PSYCHOLOGICAL INTERVENTIONS

Where serious psychiatric illness, such as Major Depressive Disorder, particularly with suicidal ideation, or the Depressive phase of Bipolar-Affective Disorder, or panic attacks or generalised anxiety, complicated by drug and alcohol abuse occur in the legal workplace, early detection and early treatment can make a very big difference to outcome.

Once again, part of the role responsibility of the individual is to seek appropriately qualified help, and the firm can encourage this.

**Partners and team leaders, and the HR personnel, should be aware of the expected prevalence, as well as the types of psychiatric disorders which are likely to occur in law firms, and be vigilant for them.**

At the very least, they **should be trained in 'Mental Health First Aid'[7].**

**It** can be useful for people in management positions to see themselves as an **effective head of a family,** and treat their employees as they would treat their own family members. This may **involve disciplining as well as praising staff, and emphasising role responsibilities and contractual obligations.**

**Managing Partners and HR personnel should encourage people who are really sick to have sick leave,** and delegate their work to others during this period of absence from the workplace. The **sick person does not need to come back to a mountain of incomplete work** that requires urgent and time-consuming action. Proper assistance with all these issues should be part and parcel of the Managing Partner or the HR personnel role.

With **full or substantial recovery from mental illness, a return to work is most likely to occur,** however, sometimes a change of position or a change in employment, or even career choice, may make most sense if the individual's work environment is demonstrably toxic for them.

Most of **the major psychiatric conditions will require treatment with medication combined with psychological or psychotherapeutic** intervention. Psychiatrists should provide both of these modalities of intervention, after they have performed a comprehensive biopsychosocial assessment.

In my view, it is essential that any patient suffering from these severe psychiatric illnesses should be seen **in the first instance by a Psychiatrist, not a Psychologist.** Then, if the Psychiatrist deems them to require ongoing psychotherapy without medication, the services of a properly trained Clinical Psychologist might be appropriate.

Psychologists who have no clinical training, and counsellors who are not Psychologists or trained Psychotherapists, are not likely to provide the adequacy of service required and, unfortunately, the latter are often the people who 'man' the telephones for employee assistance programmes

[7] Mental Health First Aid Manual Kitchener et alii. Oxygen. Youth Health Research Unit, University ofMelboume

## 3. TERTIARY PREVENTION – KEEPING WELL

This refers to measures taken to minimise the risk of relapse and to prevent untoward complications of drug treatment and also aims to replace maladaptive ways of coping – such as alcohol abuse, used to allay anxiety or depression – with more appropriate and effective ways of coping with stress.

The fact is that many individual lawyers, barristers, magistrates and judges have suffered from very severe psychiatric illnesses sometimes complicated by suicide attempts and psychosis – and have been effectively treated and are able to return, full-time, to their previous position and function as well, if not better, than prior to becoming mentally ill.

Unfortunately, there are many other legal practitioners who have not been assessed or managed properly, or do not comply with medication or cognitive behavioural techniques or other psychotherapeutic intervention, and who do not return to work, or, if they do, relapse and lose their employment.

Worryingly, with repeated relapse, there may be severe damage to their professional reputation, the development of financial difficulties, marital break-ups and financial complications. More recent scientific evidence would also suggest that repeated bouts of Major Depressive Disorder may cause cumulative structural brain damage.

It is important to stress that the individual legal practitioner who suffers any of the major psychiatric illnesses, (which are generally recurrent by nature), have responsibility for maintaining good mental health by complying with treatment that works, and ensuring that they make regular, ongoing contact with their treating Psychiatrist or Clinical Psychologist.

In the medical profession, if a mental illness has interfered with the capacity of a doctor to function in their clinical role, they will be inducted into the Impaired Registrant's Programme of the state or Federal Medical Council, and their registration to practise will be made conditional upon compliance with a set of conditions, designed to ensure that they remain in good mental health and are not a danger to the public

These conditions usually involve regular attendance upon their treating Psychiatrist, and three to six-monthly review by the Council-nominated Psychiatrist (who is an independent assessor).

The doctor is required to have a supervisor at work and to see that supervisor at a prescribed frequency. The supervisor is permitted to notify the Medical Council if the individual's standard of work is not satisfactory or if there is evidence that the doctor has suffered a deterioration in their mental health.