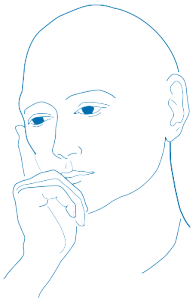
Courting the Blues:

Attitudes towards depression in Australian law students and lawyers

Dr Norm Kelk
Dr Georgina Luscombe
Dr Sharon Medlow
Professor Ian Hickie

Brain & Mind Research Institute:
University of Sydney

Conducted in conjunction with the
Tristan Jepson Memorial Foundation



brain&mind
RESEARCH INSTITUTE

The University of Sydney

Tristan Jepson
Memorial Foundation

Brain & Mind Research Institute Monograph 2009-1

This monograph was supported and funded by the Tristan Jepson Memorial Foundation.

Published by
Brain & Mind Research Institute at the University of Sydney
Building F, 94 Mallett Street
Camperdown NSW Australia 2050

First published January 2009

ISBN: 978-0-9806181-0-5

The correct citation for this publication is Kelk, NJ, Luscombe, GM, Medlow, S, Hickie, IB (2009) Courting the blues: Attitudes towards depression in Australian law students and lawyers, BMRI Monograph 2009-1, Sydney: Brain & Mind Research Institute

Introduction to the research

The Tristan Jepson Memorial Foundation was set up in memory of our son, Tristan, a former University of NSW law student, young lawyer and comedian. Tristan suffered from severe clinical depression and took his own life, just four weeks after his 26th birthday, on the 28th October, 2004. The foundation exists in memory of Tristan's love of life, his passion for the law and social justice, his wonderful sense of humour and his love for, and loyalty to, family and friends.

Tristan's death came as an incredible shock to his family and friends. Few knew of his ongoing battle with depression. At a gathering of some of his friends after the funeral, a recurrent theme emerged. Some of the young women's boyfriends who also suffered from depression had sworn them to secrecy and would not seek help. George and I then decided that we would speak out about Tristan's death and his depression, against the norm of pretending that we ought not mention his illness or that he had taken his own life. It became clear that nothing would change if we did not talk about it.

We approached the Dean of Law at UNSW and set up the Tristan Jepson Memorial Foundation in April 2006, through the UNSW Foundation, with the aims to raise awareness and work to remove the stigma of mental illness amongst law students and members of the legal profession. With the assistance of Associate Professors Andrea Durbach and Prue Vines, we decided to focus on two initiatives, one for law students at UNSW and the second, a public lecture targeting the legal profession.

A 'pressures of practice' component was added to the 4th year law curriculum at UNSW culminating in a forum panel discussion, with members of the legal profession who had suffered from depression. The panel consisted of Professor Gordon Parker (Professor of Psychiatry, UNSW and Director of the Black Dog Institute), Paul Menzies QC and Paul Urquhart QC, two members of the legal profession who had suffered from depression and were willing to talk about their experiences and Olivia Venuto, a young lawyer and one of Tristan's friends who spoke of the pressures experienced by young lawyers working in large firms. Feedback from students was overwhelmingly positive, with a large number freely disclosing that they also suffered from depression and took medication. The forum was very practical and answered many of the questions students had had, but felt unable to ask. It also gave them increased hope and confidence, that despite having this illness, success in their chosen profession was still possible.

The Inaugural Tristan Jepson Memorial Lecture was held in the Banco Court of the Supreme Court Building in September 2006. We approached Associate Professor Mamta Gautam, from Ottawa University, to speak on 'Towards Wellness in the Legal Profession', to conduct a workshop for law academics at UNSW and to speak to senior partners on the issue of depression within their firms and in the profession as a whole.

Interestingly, feedback from the academics' workshop challenged the value of the North American research referred to by Associate Professor Gautam, with the claim that it was not relevant to the Australian situation (although no research had been done on the mental health of lawyers and law students in Australia to show this). In response, our focus became clear: Australian research was necessary in order for us to move forwards and to have the profession and universities' law schools take our concerns seriously.

We approached Professor Ian Hickie at the Brain & Mind Research Institute who agreed to work with us in order to conduct the research and give us a better understanding of the Australian situation. It was agreed that the best way forwards to understand the levels of depression amongst students and the profession was to survey 4th year law students and members of the legal profession, both solicitors and barristers. The Bar Association donated $10,000 to support this research. The current report is the result of that research.

This project has been successful due to the effort of many people, whom we should like to acknowledge and thank:

Professor Ian Hickie for his support of the idea and his willingness for the Brain & Mind Research Institute to conduct the research. Ian was generous in making his time available for responding to the many questions we had and in presenting the findings of this research in the Third Annual Tristan Jepson Memorial Lecture in September 2008. The Bar Association of New South Wales, whose financial support made this research possible, and whose members actively participated in the survey. Professors Jill McKeough and David Dixon who presented our research proposal to the Council of Australian Law Deans, gaining its support for the project. The Law Society of NSW, which used its database to ensure that all lawyers were able to participate in the research. The managing partners of the major law firms, who encouraged their staff to participate in the study. Datapharm Australia Ptd Ltd, for its generous support in entering the data for the research free of charge. Dr Norm Kelk for his patience, effort and commitment to this project despite the many challenges that arose along the way.

As with many aspects of life, the completion of one project just opens up further challenges. It is our hope that this research will spark further examination of how the extremely high prevalence of mental health issues within the legal profession and student population can be addressed. We feel that the innovative Australian character will find many different approaches to achieving this. It is our prayer that at least one family will be saved and that the journey we tread will be worthwhile.

George and Marie Jepson

Foreword

This Report sets out the results of research on depression and understanding of the issues of mental illness amongst law students and practising lawyers.

As the Dean of a law faculty, it is a matter of great concern to me to see the emerging evidence that law students are particularly prone to depressive mental illness and that depression is widespread within the legal profession. This has implications both for the law school curriculum and for professional development

It is also unfortunate that depressive illness, along with other mental illness, retains a stigma which can lead to discrimination and delay in people seeking help. This may be particularly the case with respect to a cohort of students who are clever, competitive, perfectionistic, have high expectations and who are generally quite hard on themselves. In legal practice, a heavy workload, lack of autonomy with respect to work and the tendency of lawyers to adopt a pessimistic outlook (so as to protect their clients from perceived negative outcomes) may also contribute to an environment that is adverse to mental well-being. These are issues which need to be addressed within the context of the legal profession and the student experience.

The present research is part of a wider trend within the Australian law schools and legal profession to address the issue of mental illness amongst lawyers and lawyers-to-be. For example, the Council of Australian Law Deans received a large grant from the Australian Learning and Teaching Council (among other projects) to develop a set of graduate attributes related to personal behaviour in professional practice. These attributes are designed to assist students to recognise and develop the skills needed to deal with some of the challenges of life in the legal profession. Individual law schools have also developed projects aimed specifically at assisting students with mental health concerns.

In the area of legal practice, many law firms, keen to reduce the rate of staff turnover, are introducing ways to raise awareness of mental illness and improve working conditions. Similarly, the professional organisations of barristers and solicitors feel a responsibility to their members who are a part of such a depressed profession.

The Council of Australian Law Deans saw the present study as making an important contribution to the knowledge of legal mental health in Australia. As a consequence, the Council supported Professor Ian Hickie and the staff of the Brain & Mind Research Institute in recruiting 741 final-year law students from the thirteen law schools which participated in the study.

Professor Hickie's work on this project began with the support of the Tristan Jepson Memorial Foundation. I was privileged to know Tristan, both as a high school student and as a law student. Tristan was talented in every way: academically, musically and socially. He had an enthusiasm for life and was much loved. Unfortunately he was unable to live with his illness.

It is the hope of all of us, especially legal educators, that this research will lead to the development of ways that law schools can help protect our students from the development or exacerbation of depression and other mental illnesses.

Professor Jill McKeough
Dean, Faculty of Law
University of Technology Sydney

Preface

Over the last decade in Australia we have seen great progress in our community's response to those whose lives are affected by suicide, depression, anxiety or related substance misuse. This progress has been a consequence of the active engagement of people from all walks of life. Most important has been the willingness of those who have experienced these problems directly to tell their personal or family stories.

Across the board, we have also seen true leadership from politicians, celebrities, sportspersons, health professionals, the Media, community organizations and business and other commercial entities. A reduction in tragedies associated with mental health problems depends on expanding and enriching this broad-based community response. Our educational institutions and our professions have particularly important roles to play in this process.

Over recent years legal practitioners, professional societies and some Australian law schools have become more actively involved in this movement. When approached by the Jepson family to formulate a more systematic approach, we welcomed the chance to support such a positive step. Specifically, we endorsed the focus on law schools. As over 75% of common mental health problems commence before age 25 years, we need to be clear that the best opportunities for prevention or early intervention are among young people.

A detailed examination of experiences of mental health problems, as well as assessment of knowledge and attitudes to care-seeking across the legal profession, has the potential to influence greatly our educational and professional responses. That information is now available in this report. Although we do not always know why mental health problems are more common among some groups of young people than others, we do know the types of strategies that are likely to result in better outcomes for those affected.

These positive strategies include access to relevant information, broadening of peer and family support to seek professional help and active management to provide ongoing personal support within our wider educational and occupational networks. That is, our law schools, legal firms and professional societies can each play key roles in the promotion of better mental health throughout adult life as well as assisting with the prevention of major complications of mental ill-health.

I would like to take this opportunity to note the great bravery and persistence of Marie and George Jepson. Rarely are parents able to turn their own profound loss to the promotion of benefits to so many others. I commend them on their great strength. I hope that they are able to continue to emphasise the positive role that could be played in this arena by Australian law schools and our legal practitioners.

Professor Ian Hickie
Executive Director
Brain & Mind Research Institute
University of Sydney

Acknowledgements

This project could not have been conducted without the generous support of many people who have assisted the authors with a wide variety of tasks, and supplied an enormous range of information, knowledge and support. We should like to thank:

- Debbie Cole (Executive Officer and Education Coordinator, Western Australian Bar Association), Sue Dawson (Director Legal Policy and Services, Law Society of New South Wales), Cindy Penrose (Project Officer, Secretariat and Research, New South Wales Bar Association), Katie Round (General Manager Human Resources, Law Institute of Victoria), Narelle Rutz (National Occupational Health and Safety Manager, Clayton Utz), Jo Wilton (Projects Officer, Office of the Executive Director, New South Wales Bar Association) and Kate Wisdom (People Management Team, Blake Dawson), all of whom encouraged legal practitioners to take part in the survey
- Sue Dawson (Director Legal Policy and Services, Law Society of New South Wales) and Ross Nankivell (Legal Policy Officer, Victorian Bar Inc) who discussed the structure of legal careers with us during the preparation of the surveys
- Iona Renner (Henry Davis York) who generously offered us her research material
- Susanne Owen (Senior Research Fellow, Re-Imagining the Law Project, Carrick Institute for Learning and Teaching in Higher Education) who offered assistance in liaising with the Council of Australian Law Deans and encouraging participation in the research by thirteen law schools throughout Australia
- Professor Jill McKeough (Dean, Faculty of Law, University of Technology Sydney) who was constantly supportive of the project and who has had an undying recognition of its importance
- Blake Dawson (Sydney) for generously hosting Professor Ian Hickie's presentation of the research results in their offices on 18 September 2008
- Bradley Whitwell, whose deep understanding of various publishing programs has made the production of the final report possible
- Stephanie Smale, who negotiated the terrors of on-line surveys with great competence, calm and good cheer.

We wish to thank the many people, both academic and administrative, from the participating law schools for their cooperation and assistance through what was at times a minefield of research ethics applications and complex arrangements for the distribution, administration and collection of the questionnaires. Without the unrewarded assistance of all of these people, this project would not have proceeded.

Finally, we should like to acknowledge all the participants in the survey who spent their time completing the survey. We were particularly gratified by the size of the "sample" (a rather impersonal technical word to refer to all those who chose to complete the questionnaire). We think that the excellent response to the survey indicates that many members of the legal profession believe that mental health and well-being are major issues for the profession in Australia today.

The Authors

Contents

Summary

- The research reported here is a study of depression literacy and psychological distress in Australian law students and practicing lawyers. It is the first reported study of its kind in Australia. The study was conducted with the participation of 741 law students from 13 universities, 924 solicitors and 756 barristers.
- The study was a cross-sectional study of a convenience sample. The sample consisted of students and legal practitioners who voluntarily completed paper or on-line questionnaires. The survey was advertised to students through law schools and to legal practitioners through newsletters of professional bodies.
- The study employed research instruments which have been widely used and validated both in Australia and overseas.
- The study revealed high levels of psychological distress and risk of depression in the law students and practicing lawyers who participated, when compared with Australian community norms and other tertiary student groups.
- Participants also revealed a number of attitudes and behaviours which imply a general reluctance to seek help for mental health issues. These include negative attitudes and stigmatizing views towards mental illness; the view that people with mental illness are likely to be discriminated against by people such as their employers and others; low levels of confidence in mental health professionals; and, a generally low level of knowledge of issues relating to mental illness amongst a substantial proportion of the sample. Generally, these data implied a reluctance to seek help from mental health professionals across the sample (*including both those who had, and had not, experienced depression*).
- Those participants who *reported having had depression* in the past appeared to have had a higher level of treatment than might be expected of general Australian community samples. This finding might be expected of a group with such high levels of education, employment and participation in professional, educational and community groups.
- Both students and practitioners showed a high likelihood of seeking help from non-professional sources (family, friends, alternative health professionals etc).
- The findings suggest that legal educational and professional organizations should give priority to instituting changes to increase their members' awareness of issues of mental health and illness in the work place and in educational settings.
- Primary strategies for intervening to improve mental health outcomes of legal educational institutions include: increasing legal educators' and students' awareness of mental health issues; increasing the skills of legal educators in supporting law students generally and offering support to law students exhibiting psychological distress in particular; and, establishing effective links between law schools and potential sources of professional treatment for those students requiring professional help.
- Similar strategies are applicable to the management of depression and psychological distress amongst practicing lawyers by law firms and professional bodies.
- The present study is a cross-sectional assessment of the level of psychological distress and depression of law students and practicing lawyers. This study does not give any

indication of the progression or change of these characteristics of students or practitioners over time or over the course of their education and career. Other research involving the use of comparison groups or longitudinal studies will be required in order to establish such findings.

- It is recommended that future studies give emphasis to the study of interventions in law schools and law firms or professional bodies, and that any such interventions be formally evaluated.

List of Tables

List of Tables (continued)

List of Figures

Introduction

The incidence of mental illness amongst lawyers and law students in Australia has become a focal point of public commentaries (2-7), personal stories (8), radio interviews (9) and a renewed awareness of assistance programmes for lawyers (10-13), partly as a result of the suicide of Tristan Jepson on the 28th 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, has recently hosted its third annual lecture about depression in the legal profession and schools. As with previous years, the lecture was 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:

Firstly, the 'Report on the Retention of Legal Practitioners'(14) 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 forty-seven lawyers who had left the profession no more than five years earlier and in-depth interviews of twenty-one 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. A majority of those interviewed had suffered from physical and mental illnesses 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; whilst 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' (15) which included a section designed 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, a recent study (16) found that members of some sub-sectors of the legal profession in Australia, namely those working with traumatised clients (these were 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 who do not work with traumatised clients (these were academics and conveyancers). 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, American lawyers and law students are reporting elevated levels of stress, anxiety, depression and drug abuse anecdotically (17-20) 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 (21-24), to reform the work-culture that produces competitiveness and high levels of stress (25) and for law schools to review teaching practices and grading systems (26-31) as well as introduce 'faculty friend' style counselling (32). Additionally, greater numbers of large-scale studies have been conducted in the United States than in Australia, these falling neatly into the categories of 'practising lawyers' and 'students'.

Firstly, the practising lawyers. In terms of cross-industry analysis, an American survey (33) of 11789 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' (mentioned above) and indeed extends those findings because of the wider breadth of occupations included. Another study (34) revealed that 33% of practising lawyers suffered from one or more of depression (19%), alcoholism (18%) or cocaine abuse (<1%) and that whilst depression and cocaine abuse were unaffected by length of time in practise, those working in the legal profession for greater than twenty 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 (35) which was accompanied by several commentary-style responses (24, 25, 36, 37). 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 amongst this cohort. The paper's authors concluded not only that lawyers suffer from greater psychological distress than the general population, but that "these symptoms are directly traceable to law study and practice. They are not exhibited when the lawyers enter law school, but emerge shortly thereafter and remain, without significant abatement, well after graduation from law school" (p.2).

The impact of attending law school upon students' mental health has been investigated both cross-sectionally and longitudinally. The cross-sectional studies typically compare law students with medical students and what they reveal is that law students report higher

perceived stress scores, particularly with regard to academic, time, fear of failure, classroom and economic stress (38, 39), greater depression and anger and lower contentment and feelings of friendliness (40) than do medical students. Naturally, one question to arise from these results concerns whether students entering into law bring with them pre-existing personality characteristics and mental health problems from which their medical counterparts are freer. In order to shed light on this question, one must turn to the findings of the longitudinal studies.

Longitudinal studies of law students' mental well-being have been designed for the dual purposes of ascertaining whether or not these students differ significantly from the general population and other undergraduate populations prior to entering law school and whether or not their mental well-being really deteriorates during their candidature, as reported anecdotically. One study (41) found, that prior to embarking on legal-training, new law students demonstrated higher positive affect, life satisfaction and subjective well-being than did other undergraduates (with no statistically significant differences found for negative affect) and another study (42) found pre-law students' depression scores to be within the normal range for an industrialised nation. However, a rapid decline was seen across studies (41-43) regarding students' mental well-being with the onset of symptoms of obsessive-compulsiveness, interpersonal sensitivity, paranoid ideation, hostility, depression, anxiety and loss of subjective well-being once law school began. These symptoms worsened throughout the students' candidatures and, according to one study (42), were still present two years after the students' graduation.

In light of the overwhelming anecdotal evidence 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. It is the aim of the present study to provide an in-depth assessment of the literacy, attitudes, personal experiences and behaviours of lawyers and law students with regard to mental illnesses.

Methods

Participants

The study was a cross-sectional survey of 741 law students, 924 solicitors and 756 barristers (N=2421) studying and working in Australia. The students were recruited from thirteen universities and encouraged to take part in the survey by a senior member of their department. 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.

One factor that must be borne in mind concerns the extent to which the three samples are representative of their populations. Given that this survey was advertised as a survey about depression, one wonders whether the people who completed the questionnaire were likely to be more (or less) depressed than the people who failed to complete the questionnaire.

One of the few variables for which it is possible to get some general population estimate is the sex of the participants (see Table 1). For a subgroup of the universities (8 universities) it was possible to get data concerning the sex distribution of the enrolled students. This revealed that approximately 55% of the students were females, whereas approximately 65% of the survey participants were females. In the case of the NSW solicitors, approximately 45% were female, whereas approximately 65% of the participants were female. And finally, the NSW Bar association has approximately 17% female members, whereas approximately 25% of the barrister sample was female. These data suggest that a higher number of females responded to the survey than males. As detailed below (see Table 8), the female respondents reported a higher rate of risk of depression than did the male members. This suggests that the samples may be overrepresented by participants who had higher levels of depression than the populations from which they were drawn and it also contributes to explaining why the barrister sample (which had relatively few females) reported lower rates of risk for depression than did the solicitor sample.

Table 1. Comparison of sex distributions of some elements of the samples with relevant population sub-groups

Sample group	Sample Female %	Population Female %
Students from 8 universities	65.4	55.6
NSW Bar Association	17%	25.5
Law Society of NSW	65	45

The questionnaire

All 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', see Appendix A). The IDLS was devised by staff of the Brain & Mind Research Institute and has been used in several projects spanning many years (44). It is referred to as a questionnaire about 'depression literacy'; that is, it assesses a participant's understanding of the character of depression and how it affects individuals and the community. The questionnaire also assesses the participant's self-awareness of depression and his or her risk of experiencing depression. The components of the questionnaire are listed in Table 2.

Table 2. The components of the International Depression Literacy Survey (IDLS)

Part	Topic	This section deals with …
1	Demographics	Demographic characteristics of the participant. This section was modified slightly from the original for the solicitors and barristers (in order to capture details of their legal practices; see Appendices B and C).
2	Major health problems of Australia	The participant's knowledge of health issues in Australia.
3	Help and treatment	Participant's beliefs about, and experiences with, different types of professional help and treatment available to people with a mental illness.
4	Information	Information-seeking about depression (whether it has been sought and, if so, from which sources).
5	Perceived needs	How participants see their own mental health service needs.
6	Attitudes	Attitudes towards depression and how participants think a depressed person might be treated by others in Australian society.
7	General Information	Standardised questions concerning participants': levels of distress (the K10); physical and psychological well-being (SPHERE Scales); living arrangements; major daily commitments and perceptions of life stressors.

The IDLS was available for completion 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. Several universities' ethics committees decided that a classroom was an inappropriate setting for completing the survey and students of these universities had only the option of the web-based version. One university offered both the online and paper options to its students and three others used the paper version only. 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 3.

Table 3. Percentage of participants completing the IDLS on paper or via the Internet

Survey version	Students	Solicitors	Barristers
Paper	39.9	0.0	63.6
Internet	60.1	100	36.4

Measures of distress and depression

It is important to note here the nature of the measures of depression, distress and other mental illnesses used in this survey. There are three types of measures which require comment. These are the K-10 and SPHERE (Qn.s 37 and 38); two questions on "days out of role" (Qn.s 39 and 40); and the questions which ask the participants about their experiences with depression (Qn.s 25, 26 and 27).

Firstly, the K-10 and SPHERE surveys do not lead to a *diagnosis* of depression or any other mental illness. Instead, the K-10 and SPHERE give an estimate of *the risk that a person with a particular score is suffering from a mental illness*, including depression and anxiety. However, they do not confirm any particular diagnosis, nor do they clearly establish the existence of any mental illness.

The two "days out of role" questions (Qn.s 39 and 40) perform a different function. Many illnesses (both mental illnesses and physical illnesses) result in a level of *disability*. These two questions seek to establish the level of disability of the participants. It is not possible to establish whether or not the level of disability reported by the law students and practitioners results from mental illnesses[1], but it is possible to discover relationships between levels of disability and demographic data (age, sex, area of residence and so on) and levels of distress. These questions have been used with other populations, the results of which may be compared with the results from this sample.

Finally, Questions 25, 26 and 27 ask for a self-report on depression; that is, on whether or not the participants had experienced depression themselves or witnessed it in a close

[1] One participant wrote on his questionnaire: "Last Sunday I was unable to get out of bed due to a Rugby match the day before. What has that got to do with depression?" The answer is, clearly, "nothing at all". This survey is an attempt to get a *population estimate of the level of risk* of depression in the law student and practitioner populations, and as part of that we have also sought to get an estimate of the level of disability in these populations. Not all of that disability will be a result of depression or mental illness, just as not all of the level of psychological distress will be due to that cause. The results of this particular participant will tend to make the relationship between distress scores and disability scores lower than they would be if he had been in bed due to a distressing mental illness.

acquaintance. The answers to these questions are likely to give results that are far higher than the true level of diagnosed depression in this population because of the lay-use of the word ‘depression’, meaning to feel ‘down’, ‘sad’ or ‘distressed’ in a non-clinical sense. However, asking these questions enables the inclusion of a set of related questions about treatments which members of these samples have had for depression. It is thus possible to establish not only their *attitudes towards treatment* for mental illness (these are ascertained later by Qn.s 20-23), but also their *actual experience of such treatments.*

It may be asked why the survey does not contain a set of questions which would establish a clear diagnosis of depression. Such questionnaires do exist, including some which can be self-administered. However, these questionnaires are much lengthier than the present survey and would be unacceptable to many potential participants. The present survey thus uses only scales aimed at establishing levels of risk for depression and levels of disability.

Research ethics approval

Research ethics approval was initially sought and received from the Human Research Ethics Committee of the University of Sydney. Approval from the University of Sydney Human Research Ethics Committee was accepted by some of the universities whose law schools particated in the research. A number of other universities required independent approval from their own research ethics committee, and this was granted.

Analysis

This report consists largely of comparisons between the three samples (students, solicitors and barristers) and some comparisons with data that have been derived from other surveys previously conducted by BMRI staff (44, 45) or national surveys reported by the Australian Bureau of Statistics (46). Analyses were conducted using SPSS 15.0. for Windows and Microsoft Excel.

Results

Demographics

Demographic features of the three samples (Law Students, Solicitors and Barristers) are shown in Table 4-6.

Table 4. Demographics of the three samples

	Students (N = 741)	**Solicitors (N = 924)**	**Barristers (N = 756)**
Age:			
• Mean (SD)	24.8 (5.0)	35.6 (10.9)	47.6 (10.4)
• Median	23.0	32.0	48.0
• Range	19 – 53	19 – 77	23 – 80
Females (%)	65.8	65.3	25.5
English spoken at home	84.9	97.7	98.8
Residence (%)			
• Urban	82.8	85.1	89.4
• Regional	14.1	10.3	7.2
• Rural	3.1	4.7	3.3

There were expected age differences between the samples. The student population was, of course, younger than the two practitioner samples and the barrister sample was older than the solicitor sample. The gender distributions of the student and solicitor samples were similar (about 65% females) and the barrister sample was approximately one quarter female. The three samples predominantly spoke English in their homes; although approximately 15% of the students spoke other languages compared with fewer than 3% of the practitioner samples. The samples were predominantly urban-dwelling, although more than 10% of each group lived in regional and rural settings.

Two questions relating to the participants' living arrangements and daily life activities (Qn.s 41 and 42) were asked. These data are reported in Tables 5 and 6 and primarily reflect the age distribution of the three samples. Examples of this include the low percentage of students who are living with a partner or have children and the high percentage of practitioners in full-time employment.

Table 5. Living arrangements by group (frequency and percentage)

Living arrangements	**Students**	**Solicitors**	**Barristers**	**Totals**
Living alone	61 (8.3%)	131 (14.2%)	95 (12.6%)	287 (11.9%)
Living alone with children	9 (1.2%)	31 (3.4%)	25 (3.3%)	65 (2.7%)
Live with partner and no children	115 (15.6%)	328 (35.5%)	194 (25.8%)	637 (26.4%)
Live with partner and children	57 (7.7%)	237 (25.6%)	386 (52.7%)	690 (28.6%)
Live with parents	369 (50.1%)	90 (9.7%)	16 (2.1%)	475 (19.7%)
Live with other relatives	49 (6.6%)	20 (2.2%)	5 (0.7%)	74 (3.1%)
Live with friends	67 (9.1%)	72 (7.8%)	9 (1.2%)	148 (6.1%)
Shared accommodation	56 (7.6%)	41 (4.4%)	7 (0.9%)	104 (4.3%)

Table 6. Primary daily activities reported by group

Primary daily activities	**Students**	**Solicitors**	**Barristers**	**Totals**
Full time work	16 (15.7%)	816 (88.3%)	695 (91.9%)	1627 (67.2%)
Part time work	349 (47.1%)	98 (10.6%)	55 (7.3%)	502 (20.7%)
Student (school or university)	674 (91.0%)	27 (2.9%)	15 (2.0%)	716 (29.6%)
Unemployed or looking for work	18 (2.4%)	3 (0.3%)	1 (0.1%)	22 (0.9%)
Home duties	94 (12.7%)	48 (5.2%)	51 (6.7%)	193 (8.0%)
Volunteer work	77 (10.4%)	29 (3.1%)	28 (3.7%)	134 (5.5%)
Not working due to illness	6 (0.8%)	5 (0.5%)	1 (0.1%)	12 (0.6%)

The practitioner samples have notable differences in their levels of seniority (see Tables 7 and 8). It appears that it is less common for recent graduates to join the Bar than it is for them to start practice as a solicitor. As a consequence of this, younger practitioners are less represented in the barrister sample than in the solicitor sample.

Table 7. Barristers' status and years of registration

Years of Registration	Barrister	Senior Counsel	Totals
Less than 1 year	31 (4.8%)	0	31 (4.1%)
1 to 5 years	174 (26.8%)	0	174 (23.3%)
6 to 10 years	124 (19.1%)	0	124 (16.6%)
Greater than 10 years	321 (49.4%)	97 (100%)	418 (56.0%)
Totals	650 (100%)	97 (100%)	747 (100%)

Table 8. Solicitors' appointments and years of practice registration

Appointment	Frequency	Percentage	Mean years of registration
Articles	52	5.6	0.31
Lawyer in early years of practice	316	34.2	2.3
Associate	86	9.3	5.6
Senior Associate	156	16.9	10.2
Special Counsel	33	3.6	16.3
Partner/Principal	148	16.0	19.9
Other	133	14.4	14.7
Totals	924	100	8.9

Psychological Distress

There was a number of measures of psychological distress in the survey. The first of these was the K-10 (the Kessler Psychological Distress Scale (47) which appeared as Qn. 37). 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: 10-15 = 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 were used in two major Australian national surveys: The National Survey of Mental Health and Wellbeing (48) and the National Health Survey (49) and are replicated here for purposes of comparison with these earlier surveys.

A comparison of the three samples on the basis of the K-10 scores is reported in Table 9.

Table 9. Comparison of distribution of K-10 scores for law students, solicitors and barristers (percentages)

	Students	**Solicitors**	**Barristers**	**Persons**
Low	31.5	36.4	56.2	41.4
Moderate	33.3	31.6	27.2	30.7
High	21.9	22.3	12.5	19.1
Very high	13.3	8.7	4.2	8.7
Totals	100	100	100	100

The inter-sample differences were in part accountable for in terms of sex and age. Females had a higher level of reported distress than males (see Table 10). Younger age groups also had a higher representation in the moderate, high and very high distress categories (see Table 11). These differences in part account for the fact that the barrister sample has lower levels of psychological distress than the other two samples (given that it is predominantly male and older).

Table 10. Distribution of K-10 scores by sex (percentages)

K-10 Risk level	Males	Females	**Persons**
Low risk	49.9	34.0	41.4
Moderate risk	28.9	32.4	30.8
High risk	13.9	23.7	19.1
Very high risk	7.3	10.0	8.7
Totals	100	100	100

Table 11. Distribution of K-10 scores by age (percentages)

K-10 Risk Level	**AGE**					
	< 30	30 - 39	40 - 49	50 - 59	> 59	**Total**
Low Risk	30.4	41.2	48.9	58.1	63.0	41.4
Moderate risk	34.1	30.8	28.0	26.0	24.6	30.7
High risk	23.0	19.0	19.1	11.0	10.1	19.1
Very high risk	12.4	9.0	4.0	4.9	2.2	8.7
Totals	100.0	100.0	100.0	100.0	100.0	100.0

The law student sample had a higher level of reported distress than other Australian samples for which this measure is available (see Table 12). For example, in a large community sample of the Australian population, approximately 13% of people aged between 18 and 34 years reported having high or very high levels of distress (49). In comparison, law students reported 35.4%. Somewhat smaller but similar differences exist between law students and medical students (44).

Table 12. Distribution of K-10 scores across law students, medical students and a general population sample (percentages)

Level of distress	Law Students	Medical Students	General Population[a] (ages 18-34 years)
Low or no psychological distress	31.5	45.2	57.9
Moderate distress	33.3	37	28.8
High distress	21.9	12.3	10.2
Very high distress	13.3	5.5	3.1

[a] From (49) Table 12, p.35

Similar although less extreme comparisons for the practitioner samples, are reported in Table 13.

Table 13. Distribution of K-10 scores across solicitors, barristers and a general population sample (percentages)

Level of distress	Solicitors	Barristers	General Population[a] (aged greater than 17 years)
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] From (49) Table 12, p.35

Three other indicators of distress were included in the questionnaire. These were Question 38 (the SPHERE Scale (50)), Question 39 (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?), and Question 40 (During the last one month: How many days in total did you stay in bed all or most of the day because of your illness or injury?) The data for these three measures are included in Tables 14 and 15.

Again, the student sample reported higher levels of distress than the practitioner samples; in two of the three variables (SPHERE and Qn. 39), the solicitor sample reported higher levels of distress than the barrister sample; and the variables Sex and Age accounted for some of the difference in levels of distress as measured by these questions.

Table 14. Distribution of SPHERE scores across law students, solicitors and barristers

SPHERE Rankings	**Percentage of samples in SPHERE (indicating risk of mental illness)**		
	Students	**Solicitors**	**Barristers**
Low risk	14.3	20.1	35.3
Moderate Risk	35.8	38.4	37.7
High Risk	41.9	34.5	23.6
Very High Risk	7.9	6.9	3.4

Table 15. Distribution of Question 39 and 40 scores across law students, solicitors and barristers

Item	**Statistic**	**Students**	**Solicitors**	**Barristers**	**Totals**
Q39: Days … unable to carry out your usual daily activities …?	Mean	3.26	1.67	1.81	2.19
	SD	6.795	4.800	6.184	5.934
	N	721	923	735	2379
Q40: Days … Stayed in bed all or most of the day …?	Mean	0.84	0.52	0.21	0.52
	SD	1.967	1.660	0.982	1.611
	N	719	924	736	2379

Experience of depression

Two questions sought information about experiences of depression. These were:

- Question 25: Have you, or someone very close to you, ever experienced depression? (Answer alternatives: Yes; No; Don't know)
- Question 26: Who was that? (Answer alternatives: I experienced depression; Someone very close to me experienced depression)

If participants reported "No" or "Don't know" in response to Question 25, they were not required to respond to Question 26. These data are recorded in Table 16.

Table 16. Percentage and frequency of the participants in each sample who experienced depression

Answered "Yes" to …	Students	Solicitors	Barristers	Totals
Qn. 25: You, or someone close to you, ever experienced depression	552 (74.9%)	780 (84.5%)	600 (79.9%)	1932 (80.1%)
Qn. 26: I experienced depression	259 (46.9)	434(55.7%)	314 (52.5%)	1007 (52.2%)
Qn. 26: Someone close to me experienced depression	375 (67.9%)	550 (70.6%)	335 (56.0%)	1260 (65.3%)
Qn. 26: Both I and someone close to me experienced depression	82 (14.9%)	205 (26.3%)	51 (8.5%)	338 (17.5%)

As these questions ask about whether or not the participants or someone close to them had ever experienced depression, it is likely that the two practitioner groups would report higher levels of experience of depression than the students due to their longer lives. This hypothesis was supported to the extent that the practitioners reported higher levels of personal experience of depression than the students, but was not replicated *within* the practitioner group (wherein the younger solicitors reported more experiences of depression than the barristers).

In a series of studies conducted by *beyondblue* (51), participants were asked a very similar question (see Table 17). The present samples of law students and 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 law samples reported here genuinely do have a higher level of personal experience of depression than general community samples.

Table 17. Data reported from two community samples collected by *beyondblue* researchers* in 2002 and 2004/5 reporting levels of personal experience of depression

	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%
Both I and a family member experienced depression	20.4%	25.5%

* Data reproduced from Table 5 of (51)

Knowledge of depression as a public health issue in Australia

The survey questionnaire contained a number of questions which asked about the participants' knowledge of the public health consequences of depression in Australia (Part 2: Major health problems in Australia, Qn.s 13 to 19).

Approximately half of each of the samples correctly estimated the proportion (1 in 5) of Australians who might be expected to experience depression. The solicitor sample had the highest proportion of participants selecting the correct response (50.2%), followed by the students and then the barristers. The solicitors also more accurately assessed the chance of themselves or someone close to them ever having depression (76 to 100%) with 54.4% of them selecting this alternative. The student sample had the least accurate response to this question (43.2%). These data are reported in Tables 18 and 19.

Table 18. The proportion of Australians who might expect to become depressed as identified by the survey participants

Proportion of population who will experience depression	**Students (N = 727)**	**Solicitors (N = 924)**	**Barristers (N = 741)**	**Totals (N = 2392)**
One in 50	3.0%	2.9%	3.1%	3.0%
One in 20	15.0%	14.8%	15.9%	15.2%
One in 10	30.5%	28.8%	34.1%	31.0%
One in 5	47.7%	50.2%	40.9%	46.6%
Don't know	3.7%	3.2%	5.9%	4.2%

Table 19. The chances that they, or someone close to them, will become depressed as identified by the participants

The chance that they, or someone close to them will experience depression …	**Students (N = 740)**	**Solicitors (N = 924)**	**Barristers (N = 749)**	**Totals (N = 2413)**
Zero to 25%	12.4%	9.3%	14.0%	11.7%
26 to 50%	19.7%	16.8%	15.9%	17.4%
51 to 75%	22.2%	17.3%	15.4%	18.2%
76 to 100%	43.2%	54.4%	50.1%	49.6%
Don't know	2.4%	2.2%	4.7%	3.0%

Those participants who reported that they or a close acquaintance had had depression were far more likely to give the correct responses to these questions. Those who had had an experience of depression themselves or through a close acquaintance gave the correct response (1 in 5) in 88.6% of cases, whereas those who had not had such experiences reported the correct response in only 27.1% of cases. This in part accounts for the greater accuracy of the responses of the solicitors as they had a higher level of reported experience of depression. These data are reported in Tables 20 and 21.

Table 20. The effect of having had depression (or having had a close acquaintance with depression) on the participants' estimation of the likelihood of *anyone* experiencing depression

	Participant or close acquaintance has experienced depression			
Proportion of all people who have experienced depression	**Yes**	**No**	**Don't know**	**Totals**
1 in 50	52 (2.8%)	11 (4.5%)	8 (4.2%)	71 (3.1%)
1 in 20	252 (13.6%)	63 (25.5%)	47 (24.9%)	362 (15.8%)
1 in 10	558 (30.2%)	106 (42.9%)	74 (39.2%)	738 (32.3%)
1 in 5	986 (88.6%)	67 (27.1%)	60 (31.7%)	1113 (48.7%)
Totals	1848 (80.9%)	247 (10.8%)	189 (8.3%)	2284

Table 21. The effect of having had depression (or having had a close acquaintance with depression) on the participants' estimation of the likelihood of *themselves* or *someone close to them* experiencing depression

	Participant or close acquaintance has experienced depression			
Proportion of all people who have experienced depression	Yes	No	Don't know	**Totals**
0 to 25%	176 (9.3%)	68 (27.0%)	37 (18.9%)	281 (12.1%)
26 to 50%	273 (14.4%)	79 (31.3%)	66 (33.7%)	418 (17.9%)
51 to 75%	343 (18.2%)	56 (22.2%)	39 (19.9%)	438 (18.8%)
76 to 100%	1091 (57.9%)	49 (19.4%)	54 (27.6%)	1194 (51.2%)
Totals	1883 (80.8%)	252 (10.8%)	196 (8.4%)	2331

Question 14 asked the participants to report which illnesses or injuries they saw as resulting in the most death or disability in Australia. These data are reported in Table 22, in descending order according to the total numbers for all three samples (the final column). Only data which more than 10% of the total sample selected have been reported. There appears to be a significant age effect in some of this data with the respondents selecting alternatives which are likely to affect their age groups. For example, students selected road and traffic accidents, suicide and self harm more frequently than did the other two groups, whereas they had the lowest estimates of the importance of heart attack or other heart disease, stroke or other brain disease and Alzheimer's Disease or other dementias.

Most importantly, in these data, depression was generally seen as being of lower importance as a cause of death or disability than many other diseases. Only 38.8% of the total sample saw depression as a major problem. Approximately 9% of the total sample identified alcohol abuse as a more significant health risk than depression.

Table 22. Specific illnesses or injuries nominated as the main causes of death or disability in Australia

Illness or injuries	Students (N = 741)	Solicitors (N = 924)	Barristers (N = 742)	Totals (N = 2407)
Heart attack or other heart disease	617 (83.3%)	844 (91.3%)	669 (90.2%)	2,130 (88.5%)
Stroke or other brain disease	330 (44.5%)	483 (52.3%)	381 (51.3%)	1,194 (49.6%)
Alcohol abuse	368 (49.7%)	407 (44.0%)	380 (51.2%)	1,155 (48.0%)
Lung cancer	386 (52.1%)	418 (45.2%)	338 (45.6%)	1,142 (47.4%)
Depression	294 (39.7%)	365 (39.5%)	275 (37.1%)	934 (38.8%)
Diabetes	231 (31.2%)	319 (34.5%)	250 (33.7%)	800 (33.2%)
Road traffic accidents	285 (38.5%)	263 (28.5%)	179 (24.1%)	727 (30.2%)
Colon or rectum (bowel) cancer	157 (21.2%)	270 (29.2%)	223 (30.1%)	650 (27.0%)
Suicide or self-harm	149 (20.1%)	127 (13.7%)	84 (11.3%)	360 (15.0%)
Alzheimer's disease or other dementias	83 (11.2%)	137 (14.8%)	134 (18.1%)	354 (14.7%)
Lung or other chest infections	93 (12.6%)	103 (11.1%)	84 (11.3%)	280 (11.6%)
Stomach cancer	86 (11.6%)	93 (10.1%)	73 (9.8%)	252 (10.5%)

In Question 16, the participants were asked to report on what they saw as the most typical characteristics of a person with depression. These data are reported in Table 23, and again they are presented in descending order by the total numbers of participants who selected the particular alternative (the final column).

Table 23. Typical behaviours or symptoms exhibited by people with depression as identified by survey participants

Symptoms	**Students** **N = 740**	**Solicitors** **N = 924**	**Barristers** **N = 750**	**Totals** **N = 2,414**
Withdraw from close family and friends	413 (55.8%)	574 (62.1%)	378 (50.4%)	1,365 (56.5%)
Be unable to concentrate or have difficulty thinking	315 (42.6%)	565 (61.1%)	459 (61.2%)	1,339 (55.5%)
Become dependent on alcohol, drugs or sedatives	364 (49.2%)	436 (47.2%)	396 (52.8%)	1,196 (49.5%)
Have relationship or family *problems*	286 (38.6%)	340 (36.8%)	332 (44.3%)	958 (39.7%)
Stop doing things they enjoy	269 (36.4%)	448 (48.5%)	239 (31.9%)	956 (39.6%)
Have suicidal thoughts or behaviours	314 (42.4%)	288 (31.2%)	240 (32.0%	842 (34.9%)
Stop going out	240 (32.4%)	255 (27.6%)	150 (20.0%)	645 (26.7%)
Not get things done at school/work	186 (25.1%)	188 (20.3%)	233 (31.1%)	607 (25.1%)
Have relationship or family *breakdown*	156 (21.1%)	120 (13.0%)	161 (21.5%)	437 (18.1%)
Lack of self care (e.g. have a change in their personal hygiene habits)	118 (15.9%)	120 (13.0%)	101 (13.5%)	339 (14.0%)
Develop new physical health problems	103 (13.9%)	108 (11.7%)	68 (9.1%)	279 (11.6%)

Although having experienced depression themselves or observed it in a close acquaintance made a difference to the accuracy with which participants were able to assess the frequency of depression in the population or their immediate associates (see Tables 20 and 21), it did not in general have an effect on the data reported in Tables 22 and 23. In Table 22, only depression itself is selected more frequently by participants who have experienced depression. In Table 23, five of the alternatives are affected by the participant's experience of depression. The following alternatives were increasingly selected due to personal experience of depression: Be unable to concentrate or have difficulty thinking; Not get things done at school/work; Stop doing things they enjoy; and the following decreased amongst those with personal experience of depression: Have relationship or family *breakdown*; Become dependent on alcohol, drugs or sedatives.

Help-seeking

The third section of the survey, entitled 'Help and Treatment', asked a number of questions about the participants' behaviour regarding help-seeking for depression. These consisted of a series of questions for all participants about their *likely behaviour* if they were depressed; and a second series of questions directed only to those participants who reported having had depression about the *actual treatment* that they had received when depressed.

Table 24 reports the likelihood of the participants seeking help from a professional person if they were depressed. Of note here is that over 30% of the participants say that they would *not* seek help from any professional, with students reporting this most strongly (39.4%). Amongst those who reported that they would seek help, the three major professional groups from which they would seek help were a general practitioner, psychologist and psychiatrist. However, all three samples reported lower levels of likelihood of seeking help from these groups than previously reported Australian medical student samples (44).

Table 24. Proportion of participants who were probably or definitely likely to seek professional help if they thought they were experiencing depression

Professional helper	Students	Solicitors	Barristers	Totals
General or family doctor	467 (66.1%)	654 (71.2%)	564 (77.2%)	1,694 (71.5%)
Psychologist	388 (54.5%)	532 (59.0%)	405 (56.8%)	1,325 (57.0%)
Psychiatrist	313 (43.8%)	408 (45.4%)	453 (63.4%)	1,174 (50.4%)
Counsellor	418 (58.8%)	465 (51.3%)	250 (34.8%)	1,133 (48.5%)
Social worker	134 (18.9%)	54 (5.9%)	19 (2.6%)	207 (8.8%)
Pharmacist	59 (8.3%)	39 (4.2%)	28 (3.9%)	126 (5.4%)
Welfare officer	77 (10.8%)	32 (3.5%)	12 (1.7%)	121 (5.1%)
No one/ wouldn't seek help	274 (39.4%)	289 (32.4%)	155 (22.6%)	718 (31.5%)
Other	84 (28.2%)	53 (11.8%)	60 (23.7%)	197 (19.7%)

Many people prefer to seek help for mental illness or emotional problems from non-professional sources or from "alternative or complementary" practitioners. Data relating to the likelihood of participants seeking help from these forms of assistance are reported in Table 25. A high proportion of participants reported that they would seek help from their family and friends (approximately 70%). Over 50% of the students sample reported that they would seek assistance from a "Personal trainer, exercise manager or relaxation instructor", as did over a third of the two practitioner samples. Approximately 20% of the student sample and 13% of the practitioner samples said they would consult a "Clergy, priest or other religious person" or a "Naturopath or herbalist"; and other complementary practitioners were supported by fewer than 10% of the participants. In this regard, they are similar to previously reported medical student samples (44) and may, in fact, be less frequent consumers of alternative treatments than the general Australian population (52, 53).

Table 25. Proportion of participants who were probably or definitely likely to seek non-professional or complementary help if they thought they were experiencing depression

Non-Professional helper	Students	Solicitors	Barristers	Totals
Family	542 (73.9%)	677 (74.2%)	528 (72.7%)	1,747 (73.7%)
Friends	553 (75.8%)	645 (70.4%)	461 (64.0%)	1,659 (70.1%)
Personal trainer, exercise manager or relaxation instructor	381 (52.4%)	327 (35.8%)	246 (33.9%)	954 (40.3%)
Clergy, priest or other religious person	148 (20.3%)	121 (13.2%)	92 (12.6%)	361 (15.2%)
Naturopath or herbalist	151 (20.9%)	143 (15.7%)	48 (6.6%)	342 (14.5%)
Acupuncturist	57 (7.9%)	77 (8.4%)	35 (4.8%)	169 (7.1%)
Traditional healer	41 (5.9%)	49 (5.4%)	21 (2.9%)	111 (4.7%)
Other	35 (12.5%)	31 (6.7%)	36 (13.7%)	102 (10.2%)

One of the factors which might influence help-seeking is the participant's beliefs about the effectiveness of different forms of intervention. In Tables 26 and 27, the participants' views on the likely outcomes of being treated or remaining untreated by a professional person are reported. Only one fifth (20.6%) of the total sample thought that professional help was likely to lead to a full recovery, with students in particular having a low assessment of the effectiveness of professionals (only 8.5% of students thought that professional help would lead to a complete recovery, as compared to 24.3% of solicitors and 28.6% of barristers). However, as can be seen in Table 27, a substantial proportion of the whole sample (69.8%) believed that people who had no help for depression were likely to have no improvement or to get worse. So, not only did they see professional intervention as ineffective, they also saw the eventual untreated outcome as gloomy.

Table 26. Beliefs about the likely outcome of depression if treated by a *professional* (e.g. doctor, psychologist, psychiatrist or other counsellor)

Outcome	Students N = 717	Solicitors N = 863	Barristers N = 688	Totals N = 2,268
Fully recover	61 (8.5%)	210 (24.3%)	197 (28.6%)	468 (20.6%)
Fully recover, but then have the illness come back again	112 (15.6%)	181 (21.0%)	104 (15.1%)	397 (17.5%)
Have some improvement	253 (35.3%)	397 (46.0%)	322 (46.8%)	972 (42.9%)
Have some improvement but then get worse again	209 (29.1%)	43 (5.0%)	33 (4.8%)	285 (12.6%)
Have no improvement	31 (4.3%)	9 (1.0%)	8 (1.2%)	48 (2.1%)
Get worse	5 (0.7%)	1 (0.1%)	3 (0.4%)	9 (0.4%)
Other	46 (6.4%)	22 (2.5%)	21 (3.1%)	89 (3.9%)

Table 27. Beliefs about the likely outcome of depression if *not* treated by a *professional* (e.g. doctor, psychologist, psychiatrist or other counsellor)

Outcome	Students	Solicitors	Barristers	Totals
Fully recover	16 (3.2%)	7 (0.8%)	7 (1.1%)	30 (1.5%)
Fully recover, but then have the illness come back again	9 (1.8%)	17 (2.0%)	24 (3.7%)	50 (2.5%)
Have some improvement	17 (3.4%)	41 (4.9%)	46 (7.1%)	104 (5.2%)
Have some improvement but then get worse again	53 (10.6%)	160 (19.1%)	117 (18.0%)	330 (16.6%)
Have no improvement	112 (22.3%)	167 (20.0%)	125 (19.3%)	404 (20.3%)
Get worse	244 (48.6)	430 (51.4%)	310 (47.8%)	984 (49.5%)
Other	51 (10.2%)	14 (1.7%)	20 (3.1%)	85 (4.3%)

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 28). Only two ‘treatments’ have a low level of assessed helpfulness (and a high level of assessed harmfulness). These are having an occasional alcoholic drink (seen as helpful by 19.5% of the total sample and as harmful by 28.6%), and using sleeping tablets (seen as helpful by 17.0% of the total sample and as harmful by 58.1%).

The treatments which are commonly associated with traditional professionals of some sort (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 63.0% (and as harmful by 20.0%), whereas the latter is seen as helpful by 77.2% (and as harmful by 3.7%). 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% compared with 3.7%). So, although treatments provided by professionals were seen as effective by large sections of the sample, they were also seen as being potentially harmful (i.e., as having unwanted side effects).

Table 28. Frequency and percentage of sample groups which assessed various treatments in terms of their helpfulness or harmfulness

Proposed Treatment	Group	Harmful	Neither	Helpful	Never heard of it	Totals
Become more physically active	Law Students	3 (0.4%)	17 (2.3%)	712 (97.1%)	1 (0.1%)	733
	Solicitors	2 (0.2%)	15 (1.6%)	899 (98.1%)	0 (0.0%)	916
	Barristers	0 (0.0%)	10 (1.4%)	721 (98.6%)	0 (0.0%)	731
Changing your diet	Law Students	5 (0.7%)	110 (15.7%)	578 (82.5%)	8 (1.1%)	701
	Solicitors	1 (0.1%)	163 (18.7%)	704 (80.6%)	5 (0.6%)	873
	Barristers	0 (0.0%)	137 (20.1%)	533 (78.0%)	13 (1.9%)	683
Occasional Alcoholic drink	Law Students	262 (37.6%)	327 (47.0%)	105 (15.1%)	2 (0.3%)	696
	Solicitors	232 (26.3%)	489 (55.4%)	157 (17.8%)	4 (0.5%)	882
	Barristers	156 (22.5%)	356 (51.3%)	181 (26.1%)	1 (0.1%)	694
Reading about people with similar conditions	Law Students	25 (3.5%)	114 (16.1%)	566 (79.8%)	4 (0.6%)	709
	Solicitors	30 (3.4%)	191 (21.8%)	652 (74.4%)	3 (0.3%)	876
	Barristers	29 (4.2%)	170 (24.5%)	492 (71.0%)	2 (0.3%)	693
Reading self help books	Law Students	84 (12.2%)	79 (11.5%)	523 (76.0%)	2 (0.3%	688
	Solicitors	90 (10.5%)	356 (41.4%)	411 (47.8%)	2 (0.2%)	859
	Barristers	71 (10.6%)	275 (40.9%)	326 (48.5%)	0 (0.0%)	672
Anti-depressant medication	Law Students	155 (23.4%)	94 (14.2%)	411 (62.0%)	3 (0.5%)	663
	Solicitors	82 (9.7%)	86 (10.2%)	672 (79.8%)	2 (0.2%)	842
	Barristers	66 (9.7%)	63 (9.3%)	552 (81.1%)	0 (0.0%)	681
Natural remedies	Law Students	32 (4.8%)	242 (36.4%)	384 (57.7%)	7 (1.1%)	665
	Solicitors	31 (3.8%)	373 (45.3%)	416 (50.5%)	4 (0.5%)	824
	Barristers	45 (7.0%)	336 (52.1%)	258 (40.0%)	6 (0.9%)	645

Table 28. cont'd

Proposed Treatment	Group	Harmful	Neither	Helpful	Never heard of it	Totals
Sleeping tablets	Law Students	439 (64.7%)	148 (21.8%)	90 (13.3%)	1 (0.1%)	678
	Solicitors	474 (57.3%)	193 (23.3%)	158 (19.1%)	2 (0.2%)	827
	Barristers	337 (52.2%)	191 (29.6%)	117 (18.1%)	1 (0.2%)	646
Brief counselling psychotherapies	Law Students	29 (4.4%)	115 (17.3%)	506 (76.1%)	15 (2.3%)	665
	Solicitors	22 (2.7%)	131 (15.8%)	664 (80.2%)	11 (1.3%)	828
	Barristers	22 (3.4%)	111 (17.1%)	511 (78.9%)	4 (0.6%)	648
Long term counselling psychotherapies	Law Students	30 (4.4%)	84 (12.4%)	558 (82.4%)	5 (0.7%)	677
	Solicitors	29 (3.4%)	96 (11.4%)	714 (84.6%)	5 (0.6%)	844
	Barristers	44 (6.7%)	108 (16.5%)	500 (76.6%)	1 (0.2%)	653

Table 29 records the number of participants in each sub-sample who reported having ever been depressed themselves or having a close acquaintance who had ever been depressed (Qn.s 25 and 26). The solicitors reported the highest levels of experience of *participant depression* followed by the barristers and then the students. The solicitors also reported the highest levels of depression *amongst close acquaintances* but here students reported higher levels than did barristers.

Table 29. Frequencies and percentages of participants who reported having ever been depressed themselves or having close acquaintances who had ever been depressed

Person who experienced depression	Group			
	Student	**Solicitor**	**Barrister**	**Totals**
Participant	259 (35.1%)	434 (47.0%)	314 (41.8%)	1007 (41.8%)
Close acquaintance	375 (50.9%)	550 (59.6%)	335 (44.6%)	1260 (52.3%)
Both participant and acquaintance	82 (11.1%)	205 (22.2%)	51 (6.8%)	338 14.0%)
Totals	737	923	751	2411

In Questions 27 to 30, those participants who had had experience with depression reported on the types of treatment they (or their close acquaintance) had received. A substantial proportion of the participants (or their close acquaintances) who experienced depression received treatment for depression (78.5%; see Table 30). This is far higher than the percentage of people who receive help reported from general community surveys. For example, in the recently released National Survey of Mental Health and Well Being (46),

only 35% of people who reported experiencing mental illness in the previous 12 months achieved access to treatment. This suggests, that as might be expected with a group with such a high level of education, employment and income, the population from which this sample is drawn is well connected with medical services and other sources of support.

Table 30. Frequencies and percentages of participants or their close acquaintances who received treatment for depression

Person who received treatment	**Student**	**Solicitor**	**Barrister**	**Totals**
Participant	196 (76.9%)	349 (81.4%)	251 (81.8%)	796 (80.3%)
Participant and/or close acquaintance received treatment	397 (71.9%)	624 (80.1%)	493 (79.6%)	1514 (78.5%)

The professionals who provided treatment for the participants (or their close acquaintances) who experienced depression are listed in Table 31. By far the most accessed services were provided by general practitioners, followed by psychiatrists, psychologists and 'counsellors'. These data are broadly similar to those in Table 18, which shows the professional person from whom the participants *hypothesised* they might seek help if they were depressed (note, in the hypothetical version, psychologists were rated slightly higher than psychiatrists). Interestingly, the percentages of participants who *actually* consulted various professional sources of help as a consequence of depression (as reported in Table 31) were lower than the corresponding estimates (as reported in Table 24).

Table 31. Professionals who provided treatment for participants or their close acquaintances with an experience of depression

Professionals	**Students N = 417**	**Solicitors N = 642**	**Barristers N = 502**	**Totals N = 1,561**
General or family doctor	253 (60.7%)	402 (62.6%)	291 (58.0%)	946 (60.6%)
Psychiatrist	155 (37.2%)	296 (46.1%)	277 (55.2%)	728 (46.6%)
Psychologist	141 (33.8%)	278 (43.3%)	186 (37.1%)	605 (38.8%)
Counsellor	149 (35.7%)	188 (29.3%)	101 (20.1%)	438 (28.1%)
Social worker	13 (3.1%)	18 (2.8%)	4 (0.8%)	35 (2.2%)
Pharmacist	11 (2.6%)	16 (2.5%)	8 (1.6%)	35 (2.2%)
Welfare officer	4 (1.0%)	6 (0.9%)	6 (1.2%)	16 (1.0%)
Other	25 (15.7%)	31 (4.8%)	29 (5.8%)	85 (6.5%)
Don't know	20 (4.8%)	18 (2.8%)	9 (1.8%)	47 (3.0%)

Table 32 reports the 'non-professional' sources of help consulted by participants (N.B. Some of the alternatives appearing in Table 32 are commonly considered to be professions. However, they are not health-professions in the modern sense). For all groups, the main source of this help came from family members (58.1%) and from friends (46.2%). Even amongst the students, who might be expected to have a stronger commitment to their peers than the practitioner samples, the level of family assistance (61.6%) exceeded that of

assistance from friends (49.1%). A number of the alternatives in this question included 'alternative' or 'complementary' health practitioners (clergy, naturopath, acupuncturist or traditional healer). Participants consulted at least one of these practitioners on 280 occasions with thirty participants consulting more than one.

Table 32. Participants with an experience of depression who received non-professional help for their depression

Non-professionals	Students N = 430	Solicitors N = 642	Barristers N = 505	Totals N = 1577
Family	265 (61.6%)	407 (63.4%)	245 (48.5%)	917 (58.1%)
Friends	211 (49.1%)	327 (50.9%)	191 (37.8%)	729 (46.2%)
Personal trainer, exercise manager or relaxation instructor	40 (9.3%)	105 (16.4%)	46 (9.1%)	191 (12.1%)
Clergy, priest or other religious person	26 (6.0%)	50 (7.8%)	29 (5.7%)	105 (6.7%)
Naturopath or herbalist	32 (7.4%)	47 (7.3%)	22 (4.4%)	101 (6.4%)
Acupuncturist	10 (2.3%)	30 (4.7%)	11 (2.2%)	51 (3.2%)
Traditional healer	3 (0.7%)	12 (1.9%)	8 (1.6%)	23 (1.5%)
Don't know	62 (14.4%)	106 (16.5%)	44 (8.7%)	212 (13.5%

These data are broadly similar to those in Table 25, which shows the non-professional person from whom the participants *hypothesised* they might seek help if they were depressed. In general, the estimates given of non-professionals whom they would consult (see Table 25) were higher than the percentages of participants who *actually* consulted those non-professionals as a consequence of depression (see Table 32).

Information seeking

Questions 31 and 32 asked about the participants' efforts to seek information about depression. Just over half (54.7%) of the entire sample had sought information about depression. Participants who had experienced depression (or who had a close acquaintance who had experienced depression) had looked for information much more frequently (62.7%) than those who had not experienced depression (15.8%). However, it is of note that over one third of those who had experienced depression reported never having sought information about it.

The sources of information about depression which were used are reported in Table 33, ranked in order of frequency of use. Alternatives which ranked below 10% have been omitted. The most common source of information cited is the Internet, although barristers as a group used the Internet much less frequently than did the other two groups. This reinforces the view formed during the data collection phase that barristers are far less

comfortable with using the Internet than the other groups as seen by their overwhelming use of the paper version of the survey rather than the web-based version.

Table 33. Sources from which information was sought about depression by group

	Students (N = 362)	**Solicitors (N = 564)**	**Barristers (N = 386)**	**Totals (N = 1312)**
Searched the Internet	303 (83.7%)	490 (86.9%)	270 (69.9%)	1063 (81.0%)
Asked a doctor	113 (31.2%)	217 (38.5%)	188 (48.7%)	518 (39.5%)
Bought a book or magazine	60 (16.6%)	162 (28.7%)	134 (34.7%)	356 (27.1%)
Asked a friend	93 (25.7%)	107 (19.0%)	59 (15.3%)	259 (19.7%)
Asked a family member	74 (20.4%)	86 (15.2%)	51 (13.2%)	211 (16.1%)
TV or radio	46 (12.7%)	71 (12.6%)	55 (14.2%)	172 (13.1%)

Perceived needs

Part 5 of the survey (Perceived needs) asked participants about services that they have had, or feel the need for, regarding emotional problems. The first of these questions (Qn. 33) asks whether participants have themselves sought help for emotional problems from a general or family doctor over the last 12 months. Responses to this question are reported in totality in Table 34a and as an effect of sex and age in Tables 34b and 34c respectively.

Almost 19% of the participants had sought such a service from a general practitioner over the preceding year. Solicitors sought such help most frequently (23.2%), followed by students (18.6%) and then barristers (13.8%). Females sought assistance at more than twice the rate (13.0%) of males (5.9%), and there was a tendency for younger participants to have sought assistance more frequently than older participants.

Table 34a. Occasions of seeking help for an emotional problem from a family or general doctor over the preceding year

	Students (N=738)	**Solicitors (N=923)**	**Barristers (N=752)**	**Totals (N=2413)**
Participant sought help from doctor …	137 (18.6%)	214 (23.2%)	104 (13.8%)	455 (18.9%)

Table 34b. Effects of sex on seeking help for an emotional problem from a family or general doctor over the preceding year

Sex of participants who sought help from doctor …	Students (N = 737)	Solicitors (N = 923)	Barristers (N = 745)	Totals (N = 2405)
Female	107 (22.0%)	161 (26.7%)	44 (23.3%)	312 (13.0%)
Male	29 (11.6%)	53 (16.5%)	60 (10.8%)	142 (5.9%)
Totals	136 (18.5%)	214 (23.2%)	104 (14.0%)	454 (18.9%)

Table 34c. Effects of age on seeking help for an emotional problem from a family or general doctor over the preceding year

Age	Participant sought help from a doctor over the last 12 month		Totals
	Yes	No	
< 29 years	203 (19.8%)	821 (80.2%)	1024 (42.4%)
30 to 39 years	114 (21.9%)	407 (78.1%)	521 (21.6%)
40 to 49 years	76 (19.0%)	324 (81%)	400 (16.6%)
50 to 59 years	49 (14.9%)	279 (85.1%)	328 (13.6%)
> 59 years	13 (9.3%)	127 (90.7%)	140 (5.8%)
Totals	455 (18.9%)	1958 (81.1%)	2413 (100%)

The participants who had approached their general practitioner in the past year were questioned about whether they would like their doctor to discuss one or more of three potential forms of service for people with emotional problems with them. These were: *Information* about emotional problems or treatment for emotional problems; *Medication* or tablets to help with emotional problems; and *Counselling* for emotional problems. Their responses are reported in Table 35.

A total of 565 participants (23.4% of the total sample) reported that they were already receiving these services from their general practitioner; 515 participants (21.2% of the total sample) said that they would like to discuss these issues with their general practitioner. As was found above (see Table 30), these data confirm the impression that this sample is well integrated into health and medical services.

Table 35. Frequencies and percentages of participants who expressed a view regarding discussing issues relating to emotional problems with a general practitioner

Type of service	Response	Students	Solicitors	Barristers	Totals
Information about emotional problems or treatment	I would like them to discuss this	66 (50.0%)	89 (42.6%)	37 (37.0%)	192 (43.%%)
	I don't need to discuss this	13 (9.8%)	18 (8.6%)	15 (15.0%)	46 (10.4%)
	I am already getting this kind of help	53 (40.2%)	102 (48.8%)	48 (48.0%)	203 (46.0%)
Medication to help with emotional problems	I would like them to discuss this	35 (26.3%)	66 (30.8%)	32 (32.0%)	133 (29.8%)
	I don't need to discuss this	46 (34.6%)	65 (30.4%)	26 (26.0%)	137 (30.6%)
	I am already getting this kind of help	52 (39.1%)	83 (38.8%)	42 (42.0%)	177 (39.6%)
Counselling to help talk through problems	I would like them to discuss this	56 (42.1%)	96 (45.9%)	34 (33.7%)	186 (42.0%)
	I don't need to discuss this	22 (16.5%)	30 (14.4%)	20 (19.8%)	72 (16.3%)
	I am already getting this kind of help	55 (41.4%)	83 (39.7%)	47 (46.5%)	185 (41.8%)

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" (Qn. 34). The responses to this question are reported in Table 36. Only one of the barriers reported here produced any significant differences between the groups of

students, solicitors and barristers. This was the issue of not being able to afford to seek treatment, which was understandably higher amongst the student population. Of the 455 participants who reported that they had sought help from their general practitioner over the past year, 169 (37.1%) reported at least one barrier to using treatment, and 163 (35.8%) reported that they preferred to manage their issue alone.

Table 36. Barriers to treatment identified by law students, solicitors and barristers

Barriers to treatment	Students	Solicitors	Barristers	Totals
Not applicable: I have not needed …this kind of help	44 (32.8%)	90 (43.1%)	36 (42.4%)	170
I preferred to manage myself	54 (40.3%)	77 (36.8%)	32 (37.6%)	163
I didn't think anything would help	17 (12.7%)	24 (11.5%)	11 (12.9%)	52
I didn't know where to get help	7 (5.2%)	12 (5.7%)	2 (2.4%)	21
I was afraid to ask for help, or what others would think of me	22 (16.4%)	35 (16.7%)	12 (14.1%)	69
I couldn't afford the money	41 (30.6%)	34 (16.3%)	12 (14.1%)	87
I asked but did not get help	11 (8.2%)	11 (5.3%)	6 (7.1%)	28

Attitudes towards depression

Attitudes towards depression are likely to affect self-care and treatment-seeking, although attitudes and help-seeking behaviour are not necessarily closely linked in all populations.

The survey asked participants to report on a number of possible sources of discrimination which might be experienced by depressed people (Qn. 35). Table 37 reports the most frequently made responses in descending order. Alternatives which were selected by fewer than 10% of the total sample are not reported. Over 20% of participants thought that their friends might discriminate against them if they experienced depression and slightly fewer than 20% thought that their family might do so. Given that these two groups are likely to be important in assisting people to find treatment or to support them during periods of acute illness, it is of concern that such numbers would expect discrimination. Over 50% of the total sample also thought that it was likely that their employer would be discriminatory, with students (62.6%) estimating more highly than solicitors (56.0%) and barristers (47.3%).

Table 37. Perceptions regarding *probable* or *definite* sources of discrimination against someone with depression

Discrimination by …	**Students N = 737**	**Solicitors N = 924**	**Barristers N = 745**	**Totals N = 2406**
Other people who don't know the person well	592 (81.1%)	770 (83.3%)	559 (75.0%)	1,921 (79.8%)
Employer	462 (62.6%)	517 (56.0%)	335 (47.3%)	1,314 (55.4%)
A bank, insurance company or other financial institution	287 (38.9%)	423 (45.8%)	421 (56.5%)	1,131 (47.0%)
A government or other public welfare agency	203 (27.6%)	246 (26.6%)	208 (27.9%)	657 (27.3%)
Friends	217 (29.4%)	227 (24.6%)	149 (20.0%)	593 (24.6%)
Family	147 (19.9%)	166 (18.0%)	120 (16.1%)	433 (18.0%)
A public or private hospital	120 (16.3%)	121 (13.1%)	82 (11.0%)	323 (13.4%)

Question 36 surveyed the participants' various positive and negative attitudes towards people with depression (see Tables 38a, 38b and 38c). It is clear from these tables that a very large majority of the three groups disagrees with the negative attitudes and agrees with the positive attitudes indicating, that as a population, the participants in general report positive attitudes towards depressed people. However, a substantial minority of the sample reports negative views about depressed people. For example, as can be seen in the first line of Table 38a, 21.8% of law students (more than one in five) think that depressed people are dangerous to others. Similarly, in Table 38b, it appears that 8.9% of students believe that people with depression are unable to be productive in work situations even when they are not depressed.

Table 38a. Negative attitudes towards people with severe depression

People with severe depression …	**Sample**	**n**	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**	**Don't know**
Are dangerous to others	Students	737	126 (17.1%)	378 (51.3%)	146 (19.8%)	22 (3.0%)	65 (8.8%)
	Solicitors	923	161 (17.4%)	503 (54.5%)	136 (14.7%)	19 (2.1%)	104 (11.3%)
	Barristers	743	155 (20.9%)	385 (51.8%)	107 (14.4%)	11 (1.5%)	85 (11.4%)
Are hard to talk to	Students	738	20 (2.7%)	128 (17.3%)	458 (62.1%)	92 (12.5%)	40 (5.4%)
	Solicitors	923	20 (2.2%)	128 (13.9%)	582 (63.1%)	135 (14.6%)	58 (6.3%)
	Barristers	747	22 (2.9%)	114 (15.3%)	469 (62.8%)	95 (12.7%)	47 (6.3%)
Have themselves to blame	Students	738	348 (47.5%)	292 (39.9%)	48 (6.6%)	6 (0.8%)	38 (5.2%)
	Solicitors	923	508 (55.0%)	342 (37.0%)	23 (3.1%)	9 (1.2%)	35 (3.8%)
	Barristers	747	396 (53.0%)	273 (36.5%)	23 (3.1%)	9 (1.2%)	46 (6.2%)
Often perform poorly as parents	Students	735	82 (11.2%)	202 (27.5%)	229 (31.1%)	36 (4.9%)	186 (25.3%)
	Solicitors	924	116 (12.6%)	284 (30.7%)	222 (24.0%)	37 (4.0%)	265 (28.7%)
	Barristers	748	60 (8.0%)	210 (28.1%)	222 (29.7%)	39 (5.2%)	217 (29.0%)
Should pull themselves together	Students	735	223 (30.3%)	193 (26.3%)	206 (28.0%)	31 (4.2%)	82 (11.2%)
	Solicitors	924	415 (44.9%)	283 (30.6%)	130 (14.1%)	13 (1.4%)	83 (9.0%)
	Barristers	742	296 (39.9%)	262 (35.3%)	114 (15.4%)	14 (1.9%)	56 (7.5%)
Shouldn't have children …	Students	735	341 (46.3%)	289 (39.3%)	21 (2.9%)	9 (1.2%)	76 (10.3%)
	Solicitors	924	459 (49.7%)	343 (37.1%)	27 (2.9%)	8 (0.9%)	87 (9.4%)
	Barristers	742	355 (47.7%)	293 (39.3%)	14 (1.9%)	8 (1.1	

Table 38b. Positive attitudes towards people with severe depression

People with severe depression …	Sample	n	Strongly disagree	Disagree	Agree	Strongly agree	Don't know
Are often productive people when they are Well	Students	737	9 (1.2%)	57 (7.7%)	387 (52.5%)	140 (19.0%)	144 (19.5%0
	Solicitors	924	5 (0.5%)	50 (5.4%)	510 (55.2%)	199 (21.5%)	160 (17.3%)
	Barristers	749	14 (1.9%)	54 (7.2%)	408 (54.5%)	139 (18.6%)	134 (17.9%)
Often make good employees when they are well	Students	736	7 (1.0%)	51 (6.9%)	377 (51.2%)	119 (16.2%)	182 (24.7%)
	Solicitors	924	2 (0.2%)	38 (4.1%)	494 (53.5%)	188 (20.3%)	202 (21.9%)
	Barristers	748	13 (1.7%)	28 (3.7%)	424 (56.7%)	101 (13.5%)	182 (24.3%)
Often try even harder to contribute to their families or work when they are well	Students	735	11 (1.5%)	85 (11.6%)	308 (41.9%)	95 (12.9%)	236 (32.1%)
	Solicitors	924	4 (0.4%)	82 (8.9%)	364 (39.4%)	137 (14.8%)	337 (36.5%)
	Barristers	746	9 (1.2%)	71 (9.5%)	274 (36.7%)	72 (9.7%)	320 (42.9%)
Are often artistic or creative people when they are well	Students	738	33 (4.5%)	145 (19.6%)	249 (33.7%)	83 (11.2%)	228 (30.9%)
	Solicitors	924	36 (3.9%)	166 (18.0%)	305 (33.0%)	89 (9.6%)	328 (35.5%)
	Barristers	749	33 (4.4%)	166 (22.2%)	245 (32.7%)	59 (7.9%)	246 (32.8%)

Participants' responses to positive and negative attitude questions are summarised in Table 38c. This table shows that over 80% of the whole sample *accepted at least one* of the negative attitudes surveyed and 16.9% of the sample *failed to accept any* of the positive attitudes surveyed. Participants' acceptance of such negative attitudes and the absence of positive attitudes is likely to be associated with anxiety about being open about their own emotional states. It is also likely to predispose participants to seeing their teachers or management staff as being unsympathetic towards depressed people.

Table 38c. Frequencies and percentages of the sample accepting negative and positive attitudes towards people with severe depression

Acceptance of positive or negative attitudes	Students (N=741)	Solicitors (N=924)	Barristers (N=756)	Totals (N=2421)
Percentage accepting at least one negative attitude	77.3	83.3	84.4	81.8
Percentage accepting at least one positive attitude	83.7	85.7	82.5	84.1

Lifestyle data

The final section of the survey contains three indicators of the participants' current life situations. The first two indicators pertain to the participants' risk factors for depression (Qn.37: K-10 see Tables 7-9; Qn. 38: SPHERE see Table 14) which were reported above.

The third indicator is a series of questions asked of those participants *who had experienced depression*, ascertaining their views about whether their depression was caused by life stressors (Qn.s 43, 44 and 45; see Table 39). It should be noted that the percentages reported in the first row of Table 39 are quite low, indicating that of those participants who had experienced depression, fewer than 10% attributed this to life stressors. Differences between the three samples regarding sources of stress are reflective of their different life activities with, for example, students reporting their most frequent source of stress as study and the practitioners reporting their most frequent source of stress as work.

Table 39. Percentage and origin of life stressors as reported by participants who have personally experienced depression

Percentage of sample reporting that their depression was affected by life stressors	**Students (N=258)**	**Solicitors (N=394)**	**Barristers (N=308)**	**Totals (N=960)**
	7.8	9.0	5.5	7.6
The sources of stress reported (percentages)				
Work	54.0	81.8	78.1	73.5
Study	80.6	23.0	10.8	33.8
Relationships with immediate family	52.7	41.9	46.1	46.0
Relationship with peers	34.2	16.2	15.2	20.4
Relationship with partner/Girlfriend/Boyfriend etc	49.8	40.7	51.9	46.6
Worries about money	38.8	36.4	51.9	41.9

Discussion

In seeking to come to an understanding of the significance of the findings of this study, it is important to place them in the context of the general mental health situation in Australia. Despite recent attempts by elements of the mental health industry to increase public awareness of the role of mental illness as a source of death and disability within the Australian population, this source of illness is still poorly recognised, particularly with respect to the particular contribution of mental illness to death and disability in young people.

In Tables 40a and 40b, data concerning the contribution of a variety of illnesses to death and disability in Australia are reported for groups of different ages. As can be seen from these data, the major contributing conditions are intentional self harm, land transport accidents (mostly motor vehicle accidents) and accidental poisoning. These conditions are all highly associated with psychological distress and mental illness.

Table 40a. Leading causes of death in people aged 12-24 years, 2004* (percentages)

Cause of death	**Male**	**Female**	**Persons**
Land transport accidents	31.8	26.2	30.1
Intentional self-harm (suicide)	20.0	15.3	18.5
Accidental poisoning	5.5	3.9	5.0
Symptoms, signs and ill-defined conditions	4.1	3.3	3.8
Malignant neoplasms of lymphoid, haematopoietic and related tissue	2.4	3.5	2.7
Accidental threats to breathing	2.4	3.5	2.7
Accidental drowning and submersion	2.6	0.9	2.0
Congenital malformations, deformations & chromosomal abnormalities	1.1	3.9	2.0
Malignant neoplasm of brain	1.4	3.1	1.9
Epilepsy and status epilepticus	1.6	2.2	1.8
Other	27.3	34.3	29.5
All deaths	100.0	100.0	100.0

* From (54), Table 2.26, p.65

Table 40b. Leading causes of death in people aged 25-64, 2005* (percentages)

MALES					
	Age Group				
	25 – 34	**35-44**	**45-54**	**55-64**	**Total 25-64 years**
Intentional self harm	24.9	16.8	7.7	…	7.9
Land transport accidents	17.9	7.4	…	…	4.2
Accidental poisoning	11.1	6.5	…	…	…
Coronary heart disease	2.9	11.4	18.0	18.2	15.7
Other heart disease	2.7	…	…	3.8	…
Lung cancer	…	…	5.8	11.5	7.5
Colorectal cancer	…	…	4.4	5.5	4.2
Cirrhosis and other diseases of the liver	…	4.8	5.5	…	…
FEMALES					
	Age Group				
	25 – 34	**35-44**	**45-54**	**55-64**	**Total 25-64 years**
Intentional self harm	14.4	7.7	…	…	…
Land transport accidents	11.2	…	…	…	…
Accidental poisoning	7.7	4.9	…	…	…
Breast cancer	5.5	15.1	18.4	13.3	14.5
Other heart disease	4.4	…	…	…	…
Lung cancer	…	…	7.5	11.2	8.2
Coronary heart disease	…	4.9	6.0	7.6	6.5
Colorectal cancer					
Cerebrovascular disease					
Chronic obstructive pulmonary disease					

* From (55), Table 6.11, p.291.

… Not applicable because the cause of death is not one of the five most common causes of death for that age group.

Figure 1 shows the contribution of several mental illnesses to death and disability over the life cycle. It is clear from these data that mental illness, while not confined to young people, has its major impact on this group. If mental health policies do not focus on the younger sector of the population, they will clearly be missing their primary target.

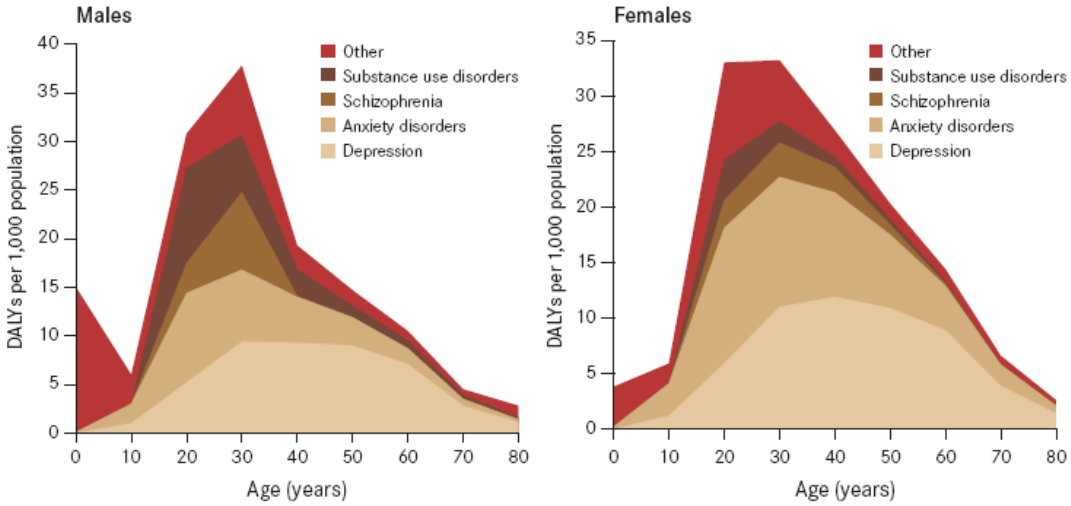


Figure 1. Incident Years Lost as a result of Disability (YLD) rates per 1 000 population by mental disorder, age and sex, Victoria, 2001.
From (1), Figure 19, p.76

Given the strength of these data, it should not come as a surprise that the law students and younger practitioners surveyed in this study have higher levels of psychological distress and reported depression than do their older counterparts. This finding is also particularly strong for the male participants. In this regard, the findings run in parallel with Australian population trends.

Against the background of these national data, the sample of law students and legal practitioners surveyed in this research still have a much higher level than expected of reported psychological distress and risk of depression on all the measures used.

As reported in Tables 10 and 11, all three groups have levels of reported psychological distress higher than previously measured population levels (using the K-10 instrument). This is particularly noticeable in the case of the student sample but it is also apparent in the two practitioner samples.

The three samples also reported much higher levels of personal lifetime experience of depression (more than 5 times greater) than previously reported community samples (Tables 10 and 11). (The two practitioner samples were higher than the student sample in this case, this reflecting their greater average age and hence a longer period within which to have experienced a depressive episode).

What can be done about the great burden of disease in the young? There is ample evidence, from research conducted over many years both in Australia and overseas, that currently available treatments for mental illness are effective in reducing mental illness and their consequences. There is clear evidence in Australia that recently reduced suicide rates are in part a consequence of the increased prescribing of anti-depressant medication (56). There is also clear evidence from large review 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) (57). 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 which have been found to be effective in the management of mental illness, it has also become apparent in recent years that a number of so-called lifestyle changes are beneficial in 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.

The groups studied in this survey revealed complex attitudes and opinions about treatment. Over one third of the participants said that they would not seek treatment if they were experiencing depression, with law students expressing this view more strongly (37.6%) than solicitors (31.3%) and barristers (21.6%) (see Table 22). In addition, only 20.6% of the whole sample thought that treatment by a professional person (doctor, psychologist, psychiatrist, or other counsellor) was likely to result in a full recovery from depression (Table 24). In this judgement, students are far less likely than practitioners to think that full recovery will occur (Students: 8.5%; Solicitors: 24.3%; Barristers: 28.6%).

Despite these negative views regarding mental health *professionals*, far higher percentages of the participants had positive views about *treatments* (Table 26). Over 95% of the total sample thought that becoming more physically active would be helpful in managing depression and over 70% of the total sample thought that anti-depressant medication would be helpful. The participants' views were such, that although they might think a particular treatment would help depression, they would nevertheless be inhibited from seeking that treatment from the relevant health professionals.

The data in Table 26 also show another aspect of the participants' ambivalence about mental health professionals. Whereas physical activity, changing one's diet, reading about other people with similar conditions or reading self-help books were seen as harmful by only 3.7%, using anti-depressant medication and attending psychotherapy was seen as being harmful by 7.4%. Once more, this indicates the presence of a sub-group of participants who have views that are likely to inhibit them from seeking treatment from conventional professionals.

Despite these findings, there are data reported which indicate that both law students and practitioners are high users of treatments *if they are depressed*. 80.3% of those who had been depressed had treatment for their depression, with the barristers having the highest rate (81.8%) followed by the solicitors (81.4%) and the law students (76.9%) (see Table 28). Compared with the general population, this is a very high rate of treatment, but this would be expected given the level of income and education in this sample.

The data concerning the symptoms or signs of depression identified by the sample were complex (Table 21). Law students tended not to identify the most commonly identified symptoms as frequently as the practitioners. For example, *being unable to concentrate or have difficulty thinking* was rated by only 42.6% of law students as a symptom of depression whereas over 61% of both solicitors and barristers identified it (yet 10% of students correctly identified *feeling disappointed* as a symptom of depression whereas less than half this percentage of practitioners did so). Similarly, previous research on a sample of Australian medical students showed that medical students identified some commonly identified symptoms much more strongly than did the law students (*Sleep disturbance*: 60.5% vs 38.1%; *Being sad, down and miserable* 66.1% vs 42.8%) (44). Thus, as a group, law students appear to have less strongly committed views about the symptoms of depression, and may therefore not as readily identify depression when it occurs in themselves or their peers.

Information seeking about depression 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). In seeking to influence the behaviour of law students and practitioners regarding the management of their own depression or that of their peers, it will be necessary to focus, at least initially, on sources of information that will be highly accessible to these groups.

Students, solicitors and barristers clearly had some differences in their approach to information seeking in this area. As one might expect of younger people who live more intensely with their family of origin, family and peers were a more common source of information for students than for the other groups. Although all groups reported using the internet most frequently as a source of information, it is clear that barristers as a group were not as comfortable with this source of information. It will probably be necessary to target barristers 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 (Table 35). Of particular note is the fact that over 50% of the whole sample (including 62.6% of students) thought that depressed people were likely to be discriminated against by employers. Presumably this includes *their* future legal 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 participants themselves agreed with a number of both positive and negative views about people with depression. These views were not confined to a small or specific group of participants, but were widely distributed throughout the whole sample (Table 36c). A small number of participants agreed only with negative views (4.8%) and about a quarter of the sample agreed only with positive views (23.6%). The majority expressed mixed views about depressed people. These views might well have a strong effect on their attitudes towards their own depression and help-seeking behaviour, and towards any peers or employees who approach them for support regarding psychological distress. In attempting to change participants' attitudes towards depressed people, it will be necessary to challenge and offer alternative views about the negative attitudes in particular.

18.8% of the total sample who had sought help during the past year reported that there were active barriers to their seeking help (see Table 34). Over one third of this group (37.1%) reported at least one barrier to receiving treatment including not thinking anything would help, not knowing where to go for help, not being able to afford help and asking for help but not receiving it. Another third of this group (35.8%) said that they preferred to manage their problem alone. Although the absolute numbers of respondents to this question were quite small, the results suggest that of those who do seek help in any year, there are considerable active barriers to their achieving assistance.

This survey 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 (34, 35). Australian data on this issue are reported in Table 41. As can be seen from this table, 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, whilst those with high and very high Kessler scores constitute only 9.8% of the adult population, they account for 20.2% 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, even compared with the general Australian population sample.

Table 41. Psychological distress, by use of selected illicit drugs, for persons aged 18 years and over, 2007* (percentages)

Substance / Behaviour		Level of psychological distress (Measured by the Kessler K-10)		
		Low	**Moderate**	**High and Very High**
All persons (aged >18 years)		69.0	21.1	9.8
Any illicit drug use	Used in the last month	51.2	28.6	20.2
	Not used in the last month	70.8	20.5	8.7
Marijuana / Cannabis	Used in the last month	51.2	27.2	21.5
	Not used in the last month	70.1	20.8	9.1
Heroin	Used in the last month	20.9	14.2	64.9
	Not used in the last month	69.2	21.1	9.6
Meth-amphetamines	Used in the last month	43.5	35.3	21.2
	Not used in the last month	69.6	21.0	9.5
Ecstasy	Used in the last month	45.4	34.4	20.2
	Not used in the last month	69.5	20.9	9.6

* From (58), Table 5.6, p.49.

As noted above (beneath Table 9), females had a higher level of psychological distress than did males. Females are known to report their psychological distress more readily and frequently than males. Had a series of questions about alcohol and other drug use been included with this survey, it is very likely that the lower reported level of psychological distress amongst males would have been balanced by a higher level of drug use and misuse.

Conclusions

The primary finding of this Australian survey is to confirm the view, originating from international research, that law students and members of the legal profession exhibit higher levels of psychological distress and depression than do community members of a similar age and sex.

In drawing this general conclusion, three points should be noted:

Firstly, although the samples studied here have shown higher levels of psychological distress than both medical students and samples drawn from the general population, they should not be seen as *severely* dysfunctional. As has been pointed out above, young people, and young males in particular, exhibit quite significant levels of psychological distress in the general population in Australia; indeed, the major origin of the burden of disease amongst younger people is from mental illness and psychological distress. In this regard, law students and younger lawyers are like their community peers, but somewhat more distressed.

Secondly, there are some signs that there are barriers to law students and practicing lawyers recognising their psychological distress and seeking 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.

Thirdly, despite the above, there are signs that law students and lawyers who do become depressed get help in quite 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. In the following section, suggestions are made for changes which might produce positive outcomes for the mental health and well-being of law students and the legal community generally.

Proposals for change

There is a widespread belief amongst social policy workers that it is impossible to intervene with a social problem unless its causes are known. But, in most major social policy interventions, it is not necessary to be clear about the causes in order to formulate effective strategies (59)[2]. In a situation such as the present one, where the precise causes of depression amongst law students and lawyers are not known, it is still possible to formulate policies and procedures which will be effective in reducing the negative outcomes of mental illness in the legal community. The method for tackling such a problem is to focus on the known risk factors, to establish supportive environments and to maintain strong school, family and institutional connectedness. The effectiveness of such strategies have been well demonstrated with Australian populations in which mental health interventions have been directed at both community and professional groups (51, 60).

Although the provision of services for people in active distress is important, such a strategy will not constitute an effective solution in itself. As has been demonstrated in the present research, people who fail to recognise their personal distress, who refuse to seek help or treatment, or who have negative views about treatment methods or mental health professionals, are very unlikely to gain much benefit from even the most effective, confidential and well-advertised services (61).

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 law students and 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 - Practical Legal Training
- Major law firms
- Smaller law firms
- Solo legal practitioners
- Professional associations
- Legal peak 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 precondition for effective work to be done in any institution regarding the

[2] One of the classic tales of modern public health concerns the struggle against epidemic cholera in Great Britain and Europe which was successfully concluded long before clarity was achieved about the causes of the disease.

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.

Of course, an institution cannot take on such a goal unless at least a sub-group of its members do so. It may be that the members of a particular legal institution have a very low level of interest in such matters, and working towards mental health goals within such an institution may be almost impossible. *People with an interest in mental health issues should attempt to form alliances with other such individuals and seek to promote the mental health interests of members of their institutions*. In situations in which there is dispute between community members about the problems facing the community and the relevant strategies for solving them, a public health problem may generate a political struggle within the community. Further, it is always likely to be easier to implement positive mental health programmes if senior managers in the community and institutions are positive and in agreement about the issue.

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 students and employees may seek special consideration or support*. For example, most universities nowadays have arrangements whereby students who have 'disabilities' of any sort can register their disability in such a way as to facilitate special consideration if they are unable to perform at a normal standard due to that disability. However, some students may be unwilling to register as disabled, especially for a disability which is strongly discriminated against such as mental illness. In addition, if teaching staff are unwilling to take the disability arrangements seriously, or if they themselves do not work to support registered students or discriminate against them, such a scheme is unlikely to work effectively.

Within universities, law schools should consider establishing relationships with organisations which promote the mental health of students. These commonly include student health services, student counselling services, vocational counselling services and disability services. In addition, students' organisations such as student guilds or unions may also have policies and services relevant to this aspect of student support.

Similar considerations apply in the workplace. 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 and employees. Different institutions will need to conduct this process in different ways. With larger and more hierarchical organisations, it will have to be conducted in layers, possibly starting with more senior staff and then progressing to other

units of the organisation. In such large institutions, there may already exist institutional elements which can take over this role, such as a human resources or an occupational health and safety team. However, many institutions may benefit from an external consultant conducting at least the initial training sessions. It may well be easier for an external individual to challenge institutional or individual beliefs which work against implementing positive practices regarding mental health.

It is important that an educational or information package cover:

- factual issues about mental health
- issues regarding the beliefs and behaviour of others towards people with mental health problems
- issues relating to institutional policies and practices regarding the mental health of their members

Human resource workers might understand the contribution of mental illness to death and disability in Australia or in the workplace, yet still hold prejudicial views and exhibit discriminatory behaviours against such people in the workplace. They might even propose ‘solutions’ to the ‘problem of mental illness’ in their institution such as attempting to assess applicants for positions on the basis of their risk of developing mental illness, and discriminating against those with higher risk levels. It is only by offering a wide ranging educational programme such as that outlined above, that negative practices at the personal, operational and policy levels of an institution can be changed.

It is important in work settings that the occupational health and safety implications of mental health in the workplace be widely recognised. However, it is equally important that the workplace recognises the implications of workplace functioning on the mental health and psychological distress of their members. Larger and medium sized institutions must develop policies relating to mental health issues and implement them vigorously, widely and publically. There may be considerable benefit for those institutions which have specifically designated occupational health and safety workers in encouraging those workers to establish links with similar workers in other institutions in order to support each other in their work and to experiment with different strategies across different legal employment settings.

One strategy which is widely recognised in this type of health educational context is the use of peers who have had an experience of mental illness. If such a person who is well functioning in his or her current employment and social roles is available to discuss relevant experiences with others, often in the company of a mental health expert, it can have a major impact on the audience. Such people are often in a unique position to challenge prejudicial attitudes because they have dealt with them before in far more difficult personal settings. (However, it should be emphasised that this role is not one for a beginner, and the mental health educator does need to be well prepared for the audience beforehand). Given that there is some expectation from national data that males are likely to be more at risk of mental illness problems and are less likely to seek assistance than females, it might be more

effective if a male with experience of mental illness were to be used in educational programmes with law students. It is important that the audience members be able to identify with the speaker, and not see the speaker as someone very different from themselves.

In looking beyond information and educational strategies, there are four major components of work aimed at addressing mental health issues in legal or educational institutions. These are:

- Managing stress in normal work or training
- Support in normal work or training
- Support for people under stress
- Access to effective treatments

Almost all work will at some time be stressful and almost all workers will at some time have to deal with stress in the workplace. In the case of students training in law schools, experiences of assessment are likely to be more stressful than ordinary classroom experiences and those assessments which are conducted in public (seminar presentations, mock trials and so on) may well be more stressful than standard examinations. *Whatever the work setting, people need to be prepared for normal expected stresses and be encouraged to discuss their experiences in the workplace if they wish to*. It must not be assumed that normal workers can deal with normal stress without support or training.

It has been suggested that law education is far more competitive than other forms of tertiary education (38). Clearly, such competition might work to reduce the level of support that sub-groups of students give each other. Accordingly, competitive elements of the educational setting need to be publically acknowledged and support mechanisms made available for students (42, 62). Students need to recognise that although their educational experiences may necessitate some level of competition, the competitive element does not need to be taken into the personal aspects of their student lives. *Students must develop differing skills which can be used in the professional and personal aspects of their lives*. In this regard, legal professionals and students are no different from other professionally trained people.

A further aspect of legal thinking which is thought to result in stress for legal practitioners and students is the orientation of constantly looking for something that might go wrong in a legal or contractual arrangement (23). It is suggested that this orientation makes legal practitioners suspicious and perhaps even paranoid about everyday affairs; whereas someone with training in mediation counselling might have a much more positive orientation to quite similar professional situations. While it is not suggested here that an attempt should be made to change the fundamental style of thinking of the whole profession, it is proposed that students and practitioners should be made aware of this style of thinking, and encouraged to use different styles in their everyday lives. *Awareness of one's mental style is the first step towards taking control of one's method of thinking, and of adapting one's mental style to different situations*. What is relevant to the professional

situation is not necessarily relevant to the personal situation. It is an important personal skill to distinguish between such different styles of thinking and behaviour, and to be able to use them in different life contexts.

Another aspect of legal practice which is said to be a source of stress for legal practitioners is the constant preoccupation with short term billing (25). Again, 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 which 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.

Finally, 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 (16). 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 related to the nature of the stress they experience.

In attempting to initiate programmes to tackle the above four issues (competition, styles of legal thinking, short-term billing and particularly stressful work environments), it is critically important that workers give emphasis to social connectedness and group cohesion. The development and implementation of solutions to these problems will be facilitated by approaching these issues on a group or institutional basis, encouraging connectedness rather than isolation, autonomy rather than individualism and reducing social disintegration.

In addition to maintaining awareness of the workforce, *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 legal professional bodies in Australia, and a considerable body of international literature (5, 17-22, 61). It would seem 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 level of use which legal professionals make of them.

Many of the remarks in this section imply that the student or legal professional is working in an organisational setting in which there are individuals or management structures which might take an interest in workplace stress and in employees' psychological distress. However, it is evident that *there are many legal professionals who work in very isolated workplaces, perhaps even in solo practices, in which they have very few immediate institutional supports*. Although some people in these settings may have a strong awareness of their workplace stressors and their propensity for psychological distress, others may be quite blind to these factors. Although there may be other solutions to this problem, it appears likely that *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 need for support. How professional bodies do this may differ in different local situations, and perhaps from one professional organisation to another.

In addition to isolated workers, there are other groups of legal professionals and students who may be in need of special services to assist them to deal with specific personal and professional situations (14). These include people who have left the work force or educational situation because of mental health problems, people returning to work or education after experiencing mental health problems and people who have decided to leave the profession for mental health or other reasons. Each of these groups should be offered specific support in making these difficult transitions.

The strategies adopted in different universities or legal institutions to deal with psychological distress are likely to vary greatly. The particular social setting in which a problem is tackled is likely to have a major influence on the range of effective solutions. Differences in strategy between different universities or institutions should not be seen as reflecting the competency of programmes, but as indicating effective adaption to local conditions. Teachers working in small regional universities with large numbers of distance students are likely to develop very different working strategies to those adopted in large, inner-city based settings. 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 consequence of the diversity of local situations in which law students and legal practitioners work.

In summary,

- Assisting legal students and professionals with psychological distress is a task for legal and educational communities. It is not a problem only for the individuals with mental illnesses or psychological distress
- All legal training institutions and legal employers must take on the mental well-being of their members as a central institutional concern
- Members of legal institutions with an interest in mental health and psychological distress amongst their members should form special interest groups to promote the mental health goals of their institutions
- People working to reduce the level of psychological distress in the educational or work setting must maintain a focus on the known risk factors for psychological distress in their setting
- Mental health problems and psychological distress must be seen as legitimate health problems for which students and legal professionals can seek special consideration and support
- Education and information dissemination to all staff of legal institutions and training bodies is critical to the development of appropriate mental health practices

- The occupational health and safety implications of mental health and psychological distress in the workplace need to be widely recognised by teachers and management staff
- Law students and legal professionals need to be made aware of, and prepared for, normal forms of stress in the normal workplace
- Law students and legal professionals need to be made aware of the importance of developing different skills for managing workplace issues and personal issues. While adopting styles of vigorous competition or high levels of caution in a particular workplace or educational setting may be appropriate, such styles of behaviour are not likely to have satisfactory outcomes in everyday life, or in a situation in which a person is struggling with psychological distress or mental illness
- Services aimed directly at assisting legal professionals or students with psychological distress or mental illnesses need to be reviewed, expanded and made more accessible
- The profession as a whole needs to identify those members who are isolated or poorly supported and offer them additional education, support and services
- The diversity of educational and practice settings will generate a wide variety of strategies for dealing with psychological distress and mental illness in different local situations.

Proposals for further research

In the section called *Proposals for change*, it was noted that it is not necessary to be completely clear about the *causes* of psychological distress or mental illness to be able to intervene effectively with population groups such as law students and lawyers. Effective interventions can be designed on the basis of known risk factors even if those risk factors are not well defined causal factors.

Further research is needed in two major areas: the efficacy of interventions and the further investigation of the causal factors influencing depression in law students.

The major elements of evaluations of interventions should include:

- Educational interventions aimed at university staff and students
- Skill training enabling university staff to offer effective support to their students as a whole, and students with high levels of distress in particular
- Skill training to enable students to differentiate between personal and professional communication skills, and to become competent in both
- The creation of effective referral patterns for students who require professional services for the management of their depression or psychological distress

The major elements of the investigation of the causal factors influencing depression should include:

- Changes and developments in psychological distress over the course of law training
- Levels of depression and psychological distress at commencement of law training
- Comparison between law students and other students in depression and psychological distress
- Comparison between styles of teaching and their effects on depression and psychological distress (if these can be identified in different universities or cohorts of students)

The present study does not give any information about how the participants got to their present situation. It was designed to be conducted in less than a year, on a relatively small budget and to produce a 'snapshot' view of the depression literacy of law students and lawyers in Australia. It is a one-off, cross-sectional study conducted at a particular 'point' in time. It gives a view of the level of psychological distress of a sample of Australian law students and legal practitioners at a particular moment.

To gain information about *how participants reach the observed levels of psychological distress*, it is necessary to conduct studies with certain comparison (control) groups; or, ideally, to conduct long-term prospective studies. In both forms of research outlined above, it is strongly recommended that some form of control or comparison group be used, or longitudinal designs be adopted. These might be designed as follows:

One relevant style of future research involves using *comparison groups* composed of different groups of students. Such a study would collect a series of related samples from people at different stages of their legal education and careers. In a study of students, for example, it would be possible to collect samples of students in each year of their undergraduate training and compare their levels of psychological distress and depression literacy. Such data would enable conclusions to be drawn about the contribution of the university experience to the mental health outcomes of the students. Ideally, such a study might also involve comparisons with other student groups (such as medical, engineering or arts students). By comparing law students with other groups of students, it would be possible to determine whether there were differences between the different groups of students at the start of their university education.

Another appropriate style of study involves using *prospective designs*, in which the sample of students is followed over a longer time period. Such a study would collect data from a group of students and follow them over the course of their legal education, observing changes or developments in their psychological distress and depression literacy. Again, such a study might be conducted with comparison groups of other types of students. Prospective studies have the disadvantage of taking a longer period for completion, of costing far more and have methodological issues with the loss of subjects over the course of the study. However, they do offer one of the most powerful methods of studying the 'psychological career' of the participants.

If Australian universities choose to introduce various mental health related interventions for their students, it is strongly recommended, that at a minimum, they conduct before-and-after evaluations of the intervention group, even if they do not employ any form of comparison or control group.

Finally, it needs to be noted that it would be of great value to evaluate the effects of university based interventions on the students' transition-to-work. The legal workplace is, after all, the situation in which many law students eventually find themselves. If it were possible to follow up a group of students until they were established in professional practice, the true longer-term value of a university-based mental health intervention might be established. Such a study is likely to be quite difficult to implement due to the problem of maintaining contact with the sample after it leaves university, but the value of such a study would be immense.

References

1. Victorian Burden of Disease Study: Morality and Morbidity in 2001. 2005 [updated 2005]; Available from: http://www.health.vic.gov.au/healthstatus/downloads/bod_2001.pdf.
2. Parker G. The seven Ds of mood disorders. Law Society Journal. 2008 February 2008:62-5.
3. Naylor M. Depression in lawyers. Brief. 2004 October 2004;31(9):12-4.
4. Wright J. Coping with the costs of success. Brief. 2004 October 2004;31(9):10-1.
5. Thomson J. Beating the blues. Law Society Journal. 2007;45(Sept.):18-20.
6. Cooke J. A third of solicitors depressed. The Sydney Morning Herald. 18th Sept. 2008. Available from: http://www.smh.com.au/text/articles/2008/09/17/1221330929894.html
7. Mark S. Impaired practitioners; substance abuse and mental illness in the legal profession. Without Prejudice. 2007;37:1-3.
8. Lewis J. Parents speak out about the law and depression. Law Society Journal. 2007 August 2007;45(7):24-5.
9. Law Report - Lawyers and depression. Interview on Radio National; [25th March 2008]; Available from: http://www.abc.net.au/rn/lawreport/stories/2008/2195243.htm.
10. Aaron L. Help is at hand with services to assist members in difficulty. Law Society Journal. 2003 May 2003;41(4):19.
11. Lewis J. Calls for help from lawyers soar. Law Society Journal. 2006 May 2006;44(4):26-7.
12. Anonymous. You are not alone: help for practitioners. Law Society Journal. 2007;45(7):24-5.
13. Gaines A. Caring for the profession. Brief. 2004 October 2004;31(9):6-7.
14. Report on the Retention of Legal Practitioners. In press 1999.
15. Annual Professions Study 2007. Beaton Consulting.Melbourne.2007.
16. Vrklevski LP, Franklin J. Vicarious Trauma: The Impact on Solicitors of Exposure to Traumatic Material. Traumatology. 2008 March 1, 2008;14(1):106-18.
17. Anonymous. A view from the bench (Alcoholism). Florida Bar Journal. 1999 December 1999;73(11):39-41.
18. Anonymous. A story of recovery. Florida Bar Journal. 1999 December 1999;73(11):37-41.
19. Anonymous. How I broke through denial to achieve sobriety. Florida Bar Journal. 1999 December 1999;73(11):35-8.
20. Harkness JF. Lawyers helping lawyers: A message of hope. Florida Bar Journal. 1999 December 1999;73(11):10.
21. Marx RB. Impaired attorneys and the disciplinary system. Florida Bar Journal. 1999 December 1999;73(11):14-23.
22. Cohen MJ, Goodheart HG, Hagan CO. The lie is over - we do recover. (Florida Bar Association's Florida Lawyer Assistance Program). Florida Bar Journal. 1999 December 1999;73(11):26-35.

23. Seligman MEP, Verkuil PR, Kang TH. Why lawyers are unhappy. Deakin Law Review. 2005;10(1):49-66.
24. Hazard GC. Commentary: policy implications. Journal of Law and Health. 1995;10(1):79-85.
25. Alfini J, Van Vooren J. Is there a solution to the problem of lawyer stress? The law school perspective. Journal of Law and Health. 1995;61:61 - 77.
26. Anonymous. Making Docile Lawyers: An Essay on the Pacification of Law Students. Harvard Law Review. 1998 May 1998;111(7):2027 - 44.
27. Rapoport NB. Is "thinking like a lawyer" really what we want to teach? Journal of the Association of Legal Writing Directors. 2002;1:91-108.
28. Schuwerk RP. The law professor as fiduciary: What duties do we owe to our students? South Texas Law Review. 2004 Fall 2004;45(3):753-813.
29. Hess GF. Heads and hearts: The teaching and learning environment in law school. Journal of Legal Education. 2002;52(1):75-111.
30. Glenser BA. Fear and loathing in the law schools. Connecticut Law review. 1991 Spring 1991;23(3):627-68.
31. Floyd TW. Legal education and the vision thing. Georgia Law Review. 1997;31(4):853-78.
32. Beck PW, Burns D. Anxiety and Depression in Law Students: Cognitive Intervention. Journal of Legal Education. 1979;30:1-60.
33. Eaton WWP, Anthony JCP, Mandel WP, Garrison RMA. Occupations and the prevalence of major depressive disorder. Journal of Occupational Medicine. 1990;32(11):1079-87.
34. Benjamin GAH, Darling EJ, Sales B. The prevalence of depression, alcohol abuse, and cocaine abuse among United States lawyers. International Journal of Law and Psychiatry. 1990;13(3):233-46.
35. Beck CJA, Sales BD, Benjamin GAH. Lawyer distress: alcohol-related problems and other psychological concerns among a sample of practicing lawyers. Journal of Law and Health. 1995;10(1):1-60.
36. Locke SS. Lawyer distress: a comment. Journal of Law and Health. 1995;10(1):87 - 94.
37. Glenn PG. Some thoughts about developing constructive approaches to lawyer and law student distress. Journal of Law and Health. 1995;10:69-77.
38. Heins M, Fahey SN, Henderson RC. Law Students and Medical Students: A Comparison of Perceived Stress. Journal of Legal Education. 1983;33(3):511-25.
39. Heins M, Fahey SN, Leiden LI. Perceived stress in medical, law, and graduate students. Journal of Medical Education. 1984;59:169-79.
40. Kellner R, Wiggins RJ, Pathak D. Distress in medical and law students. Comprehensive Psychiatry. 1986;27(3):220-3.
41. Sheldon KM, Krieger LS. Does legal education have undermining effects on law students? Evaluating changes in motivation, values, and well-being. Behavioral Sciences and the Law. 2004 March / April 2004;22(2):261-86.

42. Benjamin GAH, Kaszniak A, Sales B, Shanfield SB. The Role of Legal Education in Producing Psychological Distress Among Law Students and Lawyers. American Bar Foundation Research Journal. 1986;11(2):225-52.
43. Sheldon KM, Krieger LS. Understanding the negative effects of legal education on law students: A longitudinal test of self-determination theory. Personality and Social Psychology Bulletin. 2007 June 1, 2007;33(6):883-97.
44. Hickie IBA, Davenport TA, Luscombe GM, Rong Y, Hickie ML, Bell MI. The assessment of depression awareness and help-seeking behaviour: experiences with the International Depression Literacy Survey. BMC Psychiatry. 2007 Sep 13;7(1):48.
45. Highet NJ, Hickie IB, Davenport TA. Monitoring awareness of and attitudes to depression in Australia. Medical Journal of Australia. 2002 May 20;176 Suppl:S63-8.
46. National Survey of Mental Health and Wellbeing: Summary of Results. Canberra: Australian Bureau of Statistics; 2007. (Catalogue No. 4326.0).
47. Kessler R C, Andrews G, Colpe L J, Hiripi E, Mroczek D K, S-L T N, et al. Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychological Medicine. 2002;32(6):959-76.
48. Andrews G, Hall W, Teesson M, Henderson S. The mental health of Australians. Canberra: Department of Health and Aged Care; 2000.
49. National Health Survey 2004-05: summary of results. Canberra: Australian Bureau of Statistics; 2006. (Catalogue No. 4364.0).
50. Hickie IB, Davenport TA, Hadzi-Pavlovic D, Koschera A, Naismith SL, Scott EM, et al. Development of a simple screening tool for common mental disorders in general practice. Medical Journal of Australia. 2001 Jul 16;175 Suppl:S10-7.
51. Hickie I, B., Luscombe G, M., Davenport T, A., Burns J, M, Highet N, J. Perspectives of young people on depression: awareness, experiences, attitudes and treatment preferences. Early Intervention in Psychiatry. 2007;1:333-9.
52. Ian D Coulter EMW. The rise and rise of complementary and alternative medicine: a sociological perspective. Medical Journal of Australia. 2004;180(11):587.
53. Bensoussan A. Complementary medicine - where lies its appeal? Medical Journal of Australia. 1999;170:247-8.
54. Australian Institute of Health and Welfare. Young Australians: Their Health and Wellbeing 2007. Cat No. PHE 87. Canberra: AIHW.2007.
55. Australian Institute of Health and Welfare. Australia's Health 2008. Cat No. AUS 99. Canberra: AIHW.2008.
56. Hall WD, Mant A, Mitchell PB, Rendle VA, Hickie IB, McManus P. Association between antidepressant prescribing and suicide in Australia, 1991-2000: trend analysis. BMJ. 2003 May 10;326(7397):1008.
57. Simon G, E. , Savarino J. Suicide Attempts Among Patients Starting Depression Treatment With Medications or Psychotherapy. The American Journal of Psychiatry. 2007;164(7):1029-34.
58. 2007 National Drug Strategy Household Survey: first results. Canberra: AIHW; 2008 (Drug Statistics Series number 20.Cat. no. PHE 98.
59. Koch T. Cartographies of disease: Maps, mapping, and medicine. Redlands California: ESRI Press; 2005.

60. Naismith SL, Hickie IB, Scott EM, Davenport TA. Effects of mental health training and clinical audit on general practitioners' management of common mental disorders. Medical Journal of Australia. 2001 Jul 16;175 Suppl:S42-7.
61. Complete the LawCare survey for your chance to win an Apple iPod Nano! : Queensland Law Society News; 2008 [updated 2008; Accessed 18 March 2008]; Available from: http://news.qls.com.au/email_display.aspx?guid=b1c24184-0210-49b8-b15e-127177b1ece0&action=mailing.
62. Krieger LS. What we're not telling law students - and Lawyers - that they really need to know: Some thoughts-in-action toward revitalizing the profession from its roots. Journal of Law and Health. 1998;13(1):1-48.

Appendices

Appendix A:

International Depression Literacy Survey

for Australian Law Students

An International Health Survey

Law Students

This survey is being conducted in partnership with the Tristan Jepson Memorial Fund.

This survey is anonymous. It should take between 15 and 20 minutes to finish.

Your will be asked questions about your views on the general health and well being of people in Australia. It is not a test, so there are no right and wrong answers.

Your views will help to inform local health policy, research and education programs.

Thank you for taking the time to complete this survey.

Part 1: Demographics

1. Age …… years

2. Gender ☐ Male ☐ Female

3. Nationality ☐ Australian ☐ Other (Please state)

……

4. Which language do you speak at home?

☐ English ☐ Other (Please state) ……

5. Do you live in a rural, urban or regional area?

☐ Rural ☐ Regional ☐ Urban

6. What is the postcode of your residence? .....

7. Are you enrolled in an undergraduate or postgraduate program?

☐ Undergraduate ☐ Postgraduate

8. Are you enrolled full-time or part-time?

☐ Full-time ☐ Part-time

9. Are you a distance student or an on-campus student?

☐ Distance ☐ On-Campus

10. Which year of your course are you currently in?

(Please specify) …… year

11. In which year do you expect to finish your studies?

(Please specify) ……

12. Which University do you attend? (Please state)

……

Part 2: Major Health Problems in Australia

13. Right now, what do you think are the main causes of death or disability in Australia? [Please choose at most 4 answers]

☐ Cancer (eg lung, liver, breast)

☐ Heart disease and stroke

☐ Stomach, bowel and liver disease (eg stomach ulcer, cirrhosis of the liver)

☐ Complications of pregnancy or childbirth

☐ Infectious diseases (eg HIV/AIDS, diarrhoea, tuberculosis)

☐ Muscle or joint diseases (eg arthritis)

☐ Non-accidental injuries (eg self-inflected, suicide, violence, war)

☐ Lung or chest diseases (eg asthma, emphysema)

☐ Diabetes (high blood sugar)

☐ Brain, behavioural and mental health disorders (eg depression, alcohol and drug abuse, dementia, manic-depressive illness, schizophrenia, anxiety, neurasthenia)

☐ Lung and chest infections (eg pneumonia)

☐ Accidental injuries (eg traffic accidents, falls)

☐ Vision or hearing impairment or loss

☐ Other (please specify ……)

14. **Right now, which of these specific ILLNESSES or INJURIES cause the most death or disability in Australia?** [Please choose at most 6 answers]

☐ Alzheimer's disease or other dementias	☐ Lung cancer
☐ Alcohol abuse	☐ Measles
☐ Asthma	☐ Osteoarthritis
☐ Cataracts	☐ Lung or other chest infections
☐ Colon or rectum (bowel) cancer	☐ Road traffic accidents
☐ Depression	☐ Schizophrenia
☐ Diabetes	☐ Stomach cancer
☐ Diarrhoea or dysentery	☐ Stroke or other brain disease
☐ Emphysema or chronic bronchitis	☐ Suicide or self-harm
☐ Hearing impairment or loss	☐ Tuberculosis
☐ Heart attack or other heart disease	☐ Vision impairment or loss
☐ HIV infection or AIDS	

15. Right now, which MENTAL HEALTH problems cause the most death or disability in Australia?

[Please choose at most 3 answers]

☐ Schizophrenia and other psychoses	☐ Dementia, Alzheimer's disease or other brain damage
☐ Personality disorders	☐ Eating disorders (eg anorexia nervosa, bulimia nervosa, severe obesity)
☐ Alcohol abuse or addiction	☐ Mental retardation, intellectual disorders
☐ Anxiety, neurosis or panic disorder (e.g. neurasthenia)	☐ Manic depressive illness (or bipolar disorder)
☐ Adolescent behavioural or emotional disorders	
☐ Depressive illness	☐ Drug abuse or addiction
☐ Other (please specify ……)	☐ Don't know

16. Which of the following are the most typical of a person with depression?

[Please choose at most 5 answers]

☐ An upset stomach	☐ Being indecisive
☐ Being irritable or cranky	☐ Being sad, down or miserable
☐ Being unhappy or depressed	☐ Feeling disappointed
☐ Feeling frustrated	☐ Feeling guilty
☐ Feeling overwhelmed	☐ Feeling sick and run down
☐ Feeling tired all the time	☐ Having no confidence
☐ Headaches and muscle pains	☐ Poor appetite
☐ Sleep disturbance	☐ Thinking “I’m a failure”
☐ Thinking “I’m worthless”	☐ Thinking “It’s all my fault”
☐ Thinking “Life is not worth living”	☐ Thinking “Nothing good ever happens to me”
☐ Weight loss	☐ Don’t know

☐ Other (Please specify: ……)

17. Which of the following are people with depression most likely to do or to have happen to them?

[Please choose at most 4 answers]

☐ Be unable to concentrate or have difficulty thinking	☐ Lose their job
☐ Not get things done at school/work	☐ Have suicidal thoughts or behaviours
☐ Experience discrimination	☐ Stop doing things they enjoy
☐ Stop going out	☐ Develop new physical health problems
☐ Have relationship or family problems	☐ Withdraw from close family or friends
☐ Have relationship or family breakdown	☐ Lack self-care (eg have a change in their personal hygiene habits)
☐ Become dependent on alcohol, drugs or sedatives	
☐ Other (please specify ……)	☐ Don't know

The word depression often means different things to different people. In the following questions, what we mean by "depression" is an illness that is more severe, more prolonged and more disabling than normal sadness, grief or other normal feelings of sadness or loss.

18. What proportion of people do you think experience depression at some point in their lives?

☐ 1 in 50 people

☐ 1 in 20 people

☐ 1 in 10 people

☐ 1 in 5 people

☐ Don't know

19. What chance is there that you, or someone very close to you, will experience depression at some point in their lives?

☐ Zero to 25%

☐ 26% to 50%

☐ 51% to 75%

☐ 75% to 100%

☐ Don't know

Part 3: Help and treatment

20. What would be the most likely result if you, or someone very close to you, <u>received professional help</u> for depression (e.g. from a doctor, psychologist, psychiatrist or other counsellor)?

[Please choose 1 only of the following]

☐ Fully recover	☐ Fully recover but then have the illness come back again
☐ Have some improvement	☐ Have some improvement but then get worse again
☐ Have no improvement	☐ Get worse
☐ Don't know	☐ Other (please specify:.....)

21. What would be the most likely result if you, or someone very close to you, <u>did NOT receive professional help</u> for depression? [Please choose 1 only of the following]

☐ Fully recover	☐ Fully recover but then have the illness come back again
☐ Have some improvement	☐ Have some improvement but then get worse again
☐ Have no improvement	☐ Get worse
☐ Don't know	☐ Other (please specify:……..)

22. If you thought <u>you</u> might be experiencing depression, how likely would you be to seek help from each of the following professionals? [Please rate all 9 categories]

	Definitely unlikely	**Probably unlikely**	**Probably likely**	**Definitely likely**	**Don't know**
1. Counsellor	☐	☐	☐	☐	☐
2. General or family doctor	☐	☐	☐	☐	☐
3. Pharmacist	☐	☐	☐	☐	☐
4. Psychiatrist	☐	☐	☐	☐	☐
5. Psychologist	☐	☐	☐	☐	☐
6. Social worker	☐	☐	☐	☐	☐
7. Welfare officer	☐	☐	☐	☐	☐
8. No one/ wouldn't seek help	☐	☐	☐	☐	☐
9. Other (please specify: ……)	☐	☐	☐	☐	☐

23. If you thought <u>you</u> might be experiencing depression, how likely would you be to seek help from each of the following people? [Please rate all 8 categories]

	Definitely unlikely	Probably unlikely	Probably likely	Definitely likely	Don't know
1. Acupuncturist	☐	☐	☐	☐	☐
2. Priest or other religious person	☐	☐	☐	☐	☐
3. Family	☐	☐	☐	☐	☐
4. Friends	☐	☐	☐	☐	☐
5. Naturopath or herbalist	☐	☐	☐	☐	☐
6. Exercise manager or relaxation instructor (e.g. massage therapist, yoga or meditation teacher, et al)	☐	☐	☐	☐	☐
7. Traditional healer (e.g. Qigong master, shaman, et al)	☐	☐	☐	☐	☐
8. Other (please specify: ……)	☐	☐	☐	☐	☐

24. Do you think each of the following types of treatment for depression are helpful or harmful? [Please rate all 11 categories]

	Harmful	Neither	Helpful	Never heard of it	Don't know
Becoming more physically active (e.g. playing sport, walking, gardening)	☐	☐	☐	☐	☐
Changing your diet	☐	☐	☐	☐	☐
Having an occasional alcoholic drink	☐	☐	☐	☐	☐
Reading about people with similar problems and how they have dealt with them	☐	☐	☐	☐	☐
Reading self-help book(s)	☐	☐	☐	☐	☐
Taking antidepressant medications	☐	☐	☐	☐	☐
Taking natural remedies (e.g. vitamins)	☐	☐	☐	☐	☐
Taking sleeping tablets or sedatives	☐	☐	☐	☐	☐
Using brief counselling therapies (e.g. cognitive and/or behavioural therapies)	☐	☐	☐	☐	☐
Using long-term counselling	☐	☐	☐	☐	☐
Other (please specify: …….)	☐	☐	☐	☐	☐

25. Have you, or someone very close to you, ever experienced depression?

☐ Yes (go to next question) ☐ No (go to Question 31) ☐ Don't know (go to Question 31)

26. Who was that?

☐ I experienced depression ☐ Someone very close to me experienced depression

27. Did you, or someone very close to you, receive any help for this?

☐ Yes (go to next question) ☐ No (go to Question 31)

28. Who provided this help? [Please choose all that apply]

☐ Counsellor ☐ General or family doctor ☐ Pharmacist

☐ Psychiatrist ☐ Psychologist

☐ Social worker

☐ Welfare officer ☐Other (please specify ……)

☐ Don't know

29. Did any of these other people provide help?

[Please choose all that apply]

☐ Acupuncturist	☐ Priest or other religious person
☐ University teaching staff	☐ University counselling staff
☐ Exercise manager or relaxation instructor	☐ Family
☐ Friends	
☐ Naturopath or herbalist	☐ Traditional healer
☐ Other, please specify ……	☐ Don't know

30. Where did you, or the person close to you, receive help for depression?

☐ Specialist mental hospital

☐ General medical hospital

☐ General or family doctor's rooms or clinic

☐ Specialist doctor's rooms or clinic

☐ Other medical specialist doctor's rooms or clinic (eg neurologist, cardiologist)

☐ Other counsellor or therapist's rooms or clinic

☐ Clinic run by nurses or other health professionals

☐ Other (please specify) …….

Part 4: Information

31. Have you ever looked for information about depression?

□ Yes (Go to next question) □ No (Go to Question 33)

32. How did you get this information?

[Please choose all that apply]

☐ Asked a doctor

☐ Asked a friend

☐ Asked a family member

☐ Bought a book or health magazine

☐ Called a helpline

☐ Contacted a community health centre

☐ Contacted a mental health organisation

☐ Printed information from pharmacies or medical centre

☐ Searched the internet

☐ Visited the library

☐ Television or radio

☐ Don't know

☐ Other (please specify) ……

Part 5: Perceived needs

33. Have you personally sought help from a general or family doctor for an emotional problem in the last 12 months?

☐ Yes ☐ No (Go to Question 35)

34. The following questions ask whether you would like your general or family doctor to discuss with you any of the following kinds of help for common emotional problems such as feeling depressed or anxious. Your general or family doctor might offer to help you in this way, or you might prefer your general or family doctor to suggest an alternative source of help.

	I would like my general or family doctor to discuss this kind of help with me	**I don't need to discuss this kind of help**	**I am already getting this kind of help (either from my general or family doctor or from somewhere else)**
1. Information about emotional problems or getting treatment for these problems	☐	☐	☐
2. Medication or tablets to help you with emotional problems	☐	☐	☐
3. Counselling: including any type of help to talk through your problems	☐	☐	☐

34a. Have any of the following reasons stopped you in the last few weeks, from getting any of these kinds of help, or from getting as much help as you may have needed?

[Please choose all that apply]

☐ Not applicable, I have not needed any of these kinds of help …

☐ I preferred to manage myself

☐ I didn't think anything would help

☐ I didn't know where to get help

☐ I was afraid to ask for help or what others would think of me

☐ I couldn't afford the money

☐ I asked but didn't get help

Part 6: Attitudes

The following questions ask about the experiences people with mental illness sometimes have. Discrimination here means that a person with depression is treated unfairly just because they have a mental illness, rather than for any other reason.

35. If you, or someone very close to you experienced depression, do you think you would be discriminated against by …

[Please rate all 9 categories]

	Definitely unlikely	**Probably unlikely**	**Probably likely**	**Definitely likely**	**Don't know**
1. A bank, insurance company or other financial institution	☐	☐	☐	☐	☐
2. A government or other public welfare agency	☐	☐	☐	☐	☐
3. A public or private hospital	☐	☐	☐	☐	☐
4. Other people who don't know you well	☐	☐	☐	☐	☐
5. Your doctor or other health professional	☐	☐	☐	☐	☐
6. Your employer	☐	☐	☐	☐	☐
7. Your family	☐	☐	☐	☐	☐
8. Your friends	☐	☐	☐	☐	☐
9. Other (please specify) …… ……..	☐	☐	☐	☐	☐

The following question asks about people with severe depression. By "severe depression" we mean a depressive illness which is so extreme and distressing that the person may require specialised medical treatment, or the impact of the depression on their lives is very large (the person may not be able to work or socialise).

36. To what extent do you agree or disagree with the following statements regarding people with severe depression? [Please rate all 10 categories]

"People with severe depression …"	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**	**Don't know**
1. Are dangerous to others	☐	☐	☐	☐	☐
2. Are hard to talk to	☐	☐	☐	☐	☐
3. Are often artistic or creative people when they are well	☐	☐	☐	☐	☐
4. Are often very productive people when they are well	☐	☐	☐	☐	☐
5. Have themselves to blame	☐	☐	☐	☐	☐
6. Often make good employees when they are well	☐	☐	☐	☐	☐
7. Often perform poorly as parents	☐	☐	☐	☐	☐
8. Often try even harder to contribute to they families or work when they are well	☐	☐	☐	☐	☐
9. Shouldn't have children in case they pass on the illness	☐	☐	☐	☐	☐
10. Should pull themselves together	☐	☐	☐	☐	☐

Part 7: General Information

The following questions ask about how you have been feeling in recent times …

37. In the past *30 days* how often …

[Please rate all 10 categories]

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. Did you feel tired out for no good reason	☐	☐	☐	☐	☐
2. Did you feel nervous	☐	☐	☐	☐	☐
3. Did you feel so nervous that nothing could calm you down	☐	☐	☐	☐	☐
4. Did you feel hopeless	☐	☐	☐	☐	☐
5. Did you feel restless or fidgety	☐	☐	☐	☐	☐
6. Did you feel so restless that you could not sit still	☐	☐	☐	☐	☐
7. Did you feel depressed	☐	☐	☐	☐	☐
8. Did you feel that everything was an effort	☐	☐	☐	☐	☐
9. Did you feel so sad that nothing could cheer you up	☐	☐	☐	☐	☐
10. Did you feel worthless	☐	☐	☐	☐	☐

38. Over the past *few weeks* have you been troubled by …

[Please rate all 12 categories]

	Never or some of the time	A good part of the time	Most of the time
1. Feeling nervous or tense?	☐	☐	☐
2. Muscle pain after activity?	☐	☐	☐
3. Feeling unhappy and depressed?	☐	☐	☐
4. Needing to sleep longer?	☐	☐	☐
5. Prolonged tiredness after activity?	☐	☐	☐
6. Feeling constantly under strain?	☐	☐	☐
7. Poor sleep?	☐	☐	☐
8. Everything getting on top of you?	☐	☐	☐
9. Poor concentration?	☐	☐	☐
10. Tired muscles after activity?	☐	☐	☐
11. Losing confidence?	☐	☐	☐
12. Being unable to overcome difficulties?	☐	☐	☐

39. During the last *one month*: How many days in total were you unable to carry out your usual daily activities, like going to work or school, fully?

Number of days ……

40. During the last *one month*: How many days in total did you stay in bed all or most of the day because of your illness or injury?

Number of days .....…

41. Who do you live with?

[Please choose all that apply]

☐ Live alone

☐ Live alone with children

☐ Live with partner and no children

☐ Live with partner and children

☐ Live with parents

☐ Live with other relatives

☐ Live with friends

☐ Live in shared accommodation

☐ Other (please specify ……..)

42. Which of these best describes your main activities?

[Please choose all that apply]

Activities	**Please tick**
Full-time work	☐
Part-time work	☐
Full-time study	☐
Part-time study	☐
Unable to carry out normal work, study or social activities due to illness	☐
Unemployed or looking for work	☐
Volunteer work	☐
Home duties	☐
Other (Please specify) …… ……	☐

43. If you have experienced depression yourself, do you think your depression was affected by life stresses? Yes ☐ No ☐

44. If YES, which of the following areas were sources of stress in your life?

[Please choose all that apply]

Work	☐
Study	☐
Relationships with your immediate family	☐
Relationships with your peers	☐
Relationships with partner/girlfriend/boyfriend	☐
Worries about money	☐
Other (Please specify) …… ……	☐

45. If you ticked any of the above alternatives could you please elaborate on them.

……

……

……

……

…….

Thank you for your participation!

Appendix B:

International Depression Literacy Survey

(Solicitor Version)

This appendix contains only the first section of the solicitors' questionnaire, which contains only the demographic questions. The remainder of the questionnaire was the same as the law students' questionnaire.

An International Health Survey

Australian Solicitors

This survey is being conducted in partnership with the Tristan Jepson Memorial Fund.

This survey is anonymous. It should take between 15 and 20 minutes to finish.

Your will be asked questions about your views on the general health and well being of people in Australia. It is not a test, so there are no right and wrong answers.

Your views will help to inform local health policy, research and education programs.

Thank you for taking the time to complete this survey

Part-1: Demographics

3. Age |__|__|

4. Gender ☐ Male ☐ Female

Nationality ☐ Australian ☐ Other (Please state) ……

Which language do you speak at home?

□ English □ Other (Please state) ……

Do you live in a rural, urban or regional area?

□ Rural □ Regional □ Urban

Which of the following educational levels have you completed?

(Tick more than one if necessary.)

☐ Senior high school

☐ Certificate or diploma (including TAFE / Trade qualification)

☐ Undergraduate Degree

☐ Postgraduate diploma, Masters or Doctoral degree

☐ Other (please specify) ……

3. Your legal practice

How many legal practitioners are there in your law firm?

☐ Sole practitioner ☐ 2 to 5 ☐ 6 to 10

☐ 11 to 50 ☐ 51 to 100 ☐ Greater than 100

Over how many years have you been registered to practice as a lawyer? |__|__| years

What kind of legal practice do you work in?

☐ General legal practice ☐ Specialist legal practice ☐ Large law firm

☐ Other (Please describe) ……

What is your current appointment?

☐ Articles / Practical Legal Training ☐ Lawyer in early years of practice

☐ Associate ☐ Senior Associate ☐ Special counsel

☐ Partner / Principal ☐ Consultant

☐ Other (Please describe) ……

What is the postcode of your practice address? |___|___|___|___|

Appendix C:

International Depression Literacy Survey

(Barrister Version)

This appendix contains only the first section of the barristers' questionnaire, which contains only the demographic questions. The remainder of the questionnaire was the same as the law students' questionnaire.

An International Health Survey:

Australian Barristers

This survey is being conducted in partnership with the Tristan Jepson Memorial Fund.

This survey is anonymous. It should take between 15 and 20 minutes to finish.

Your will be asked questions about your views on the general health and well being of people in Australia. It is not a test, so there are no right and wrong answers.

Your views will help to inform local health policy, research and education programs.

Thank you for taking the time to complete this survey.

Part 1: Demographics - 001

5. Age 17 – 20 21 to 25 26 to 30
31 to 40

41 to 50 51 to 60 61 to 65
Greater than 66

6. Gender ☐ Male ☐ Female

3. Nationality ☐ Australian ☐ Other (Please state)
……

4. Which language do you speak at home?

☐ English ☐ Other (Please state) ……

5. Do you live in a rural, urban or regional area?

☐ Rural ☐ Regional ☐ Urban

{There is no Question 6}

7. Years of registration at the Bar:

☐ Less than 1 year

☐ 1 to 5 years

☐ 5 to 10 years

☐ More than 10 years

8. Are you a barrister or senior counsel?

☐ Barrister ☐ Senior Counsel

☐ Other (please specify) ……

9. What is the postcode of your practice address? |__|__|__|__|

10. Which of the following educational levels have you completed?

(Tick more than one if necessary.)

☐ Senior high school

☐ Certificate or diploma (including TAFE / Trade qualification)

☐ Undergraduate Degree

☐ Postgraduate diploma, Masters or Doctoral degree

☐ Other (please specify) ……

Courting the Blues:
Attitudes towards depression in Australian law students and lawyers

ISBN: 978-0-9806181-0-5