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Mental Health and the Family Law System

Bryan Rodgers*
Centre for Mental Health Research, The Australian National University, Canberra

Bruce M. Smyth
Australian Institute of Family Studies, Melbourne

Elly Robinson
Centre for Mental Health Research, The Australian National University, Canberra

Mental health issues permeate the family law system – at least according to anecdote. Yet such issues are rarely mentioned in family-law research, policy, and practice. This article aims to stimulate discussion about the sometimes close and complex links between mental health issues and family law, and suggests a framework for how the family-law system might provide better emotional support to families in transition.

***Key Words**: Family Law; Mental Health; Mental Illness; Divorce; Marital Separation; Policy; Service Delivery*

There is much anecdotal evidence about the prevalence of mental health problems among certain individuals engaged in family-law disputes. Experienced clinicians (e.g. Kelly, 2003) have linked several mental disorders with difficulties encountered by children, former partners, and family-law professionals. Kelly noted, for example, that in some cases, mental health problems and aspects of the family law system can be a perilous combination, giving troubled individuals the opportunity to engage in adversarial and other conflictual actions. And, at the extreme end of the spectrum, filicide, spousal homicide, and suicide draw considerable attention from the media towards the darker aspects of mental health and family-law matters. These distressing cases are fortunately rare, but they are indicative of a larger problem that places a substantial burden on the system and on society as a whole. To date, however, there has been little research to help inform the range of mental health issues that need to

*Correspondence to: Dr Bryan Rodgers, Family & Community Health Research Unit, Centre for Mental Health Research, The Australian National University, Canberra, ACT 0200, Australia. E-mail: bryan.rodgers@anu.edu.au

be considered in the family law system, or to assist in deciding when and how support services can best help parents and children deal with such mental health problems. What would a family law system look like if it were better able to address the mental health of clients who travel through it?

In this article, several key issues at the intersection of mental health and the family law system are discussed by:

- providing information on the nature and scale of the burden of mental health problems;
- pointing to evidence on effective ways of dealing with some of these problems;
- suggesting a framework for approaches that can be used in dealing with clients who have varying degrees of distress;
- outlining a strategy for the family law system that would help organisations adopt these approaches; and
- considering some of the potential risks involved in moving along this path.

The rationale is that, despite the prominence of mental health problems in the family law system, the system has not yet developed a comprehensive and co-ordinated response to them. There is, however, sufficient research evidence and other knowledge to guide the beginnings of a response. We will begin with an outline of how mental health problems in parents are related to outcomes for children, acknowledging that the best interests of the child is a fundamental principle of family law in Australia and elsewhere. We recognise that one important area of children's outcomes following parental separation is their own mental health, but this is not a particular focus of the present paper.

Divorce and Children's Outcomes

The possible impact of divorce on children has been discussed extensively by researchers, the media, policy makers, family relationships service providers, and by parents. This degree of concern is appropriate given the two main considerations when attempting to quantify the problem. First, 23% of Australian children who are born to married or cohabiting couples will experience the separation of their original parents by the age of 15 years (deVaus & Gray, 2004). Second, many studies have shown that social and psychological difficulties are between one-and-a-half to twice as common among these children compared to their peers who do not experience family separation. These difficulties encompass important areas of educational attainment, emotional problems, aggressive behaviour, substance use, diminished self-esteem, and even some aspects of physical health. Further, these problems are persistent; studies of adult children from separated families find similar levels of difficulties in socioeconomic attainment, violence and criminal behaviour, mental health, and substance use (Amato & Keith, 1991a; 1991b; Pryor & Rodgers, 2001; Rodgers, 1996).

There are some common misconceptions about these outcomes for children after parental separation. Often, these long-term difficulties are described as a failure of children to recover from the impact of separation (National Health and Medical Research Council, 1988). Such representations do not capture the full process of family separation where factors over many years – before, during, and after separation – influence children's development. Further, the most common interpretations of why children experience such difficulties refer to either "loss" (i.e., a traumatic event) or to parental "absence" (especially father absence), but research findings do not support these theoretical models (Pryor & Rodgers, 2001). Rather, the evidence indicates the importance of several sources of adversity.

Children's long-term difficulties arise not from family structure or transitions per se, but from a constellation of factors that occur to varying degrees before, during, and after separation. By piecing together the findings from many studies, a list of the most important factors emerges; specifically (but not necessarily in order of importance): family conflict, spousal violence, quality of parent–child relationships, abuse and neglect of the children, parental mental health and substance use, and socioeconomic circumstances of families (Rodgers & Pryor, 1998). All of these factors are known to be associated with children's outcomes (in "intact" families as well as families that separate) and all are intercorrelated to some extent (again, this is so in intact families). For example, financial hardship can impact on the mental health of family members at one point in time, and this can reflect on their future economic activity or have a "knock-on" effect on some of the other factors listed, or both. In one family, the chain of influence may be quite different from that in another family. Even highly sophisticated research designs cannot capture the full complexity of these processes. It is possible to get a sense of what the most important forces are within a population, but there is a need to be aware of the enormous variability in how these forces unfold in different families. We are not suggesting that parental mental health is the most important influence on children's outcomes from the constellation of forces, all of which are worthy of attention. However, it is central to the present argument that one of the ways in which an attempt can be made to improve outcomes for children is by addressing the mental health of their parents, and that this is an appropriate goal for services and professionals in the family law system.

The Burden of Mental Health Problems in Australia

There are several reasons why mental health should be brought more to the forefront at this point in time. In particular, mental health problems are very common and take a great toll on people's day-to-day lives; most people who suffer from such problems do not currently receive effective treatment and support; and a number of effective forms of self-help and professional treatment could be brought into play for those experiencing mental health problems.

Mental health problems are very common in the general population and they are likely to be even more of an issue for families that separate. We know from the Australian National Survey of Mental Health and Wellbeing (NSMHWB) that, in any given year, around one in five adults in the population experience a depressive, anxiety, or substance use disorder that meets conventional diagnostic criteria used in psychiatry (Andrews, Hall, Teesson, & Henderson, 1999). As well as these more common disorders, there are other serious disorders, such as schizophrenia and bipolar disorder (or manic depression), that affect 2 to 3% of adults during their lifetime. The latter are often referred to as "low prevalence" disorders but are more common than many physical diseases of comparable severity. The prevalence of some other disorders was not determined by the NSMHWB, including eating disorders and personality disorders. Thus, figures from the survey are an underestimate of the total number of mental disorders in the population. In addition to people who experience mental disorders meeting criteria for psychiatric diagnoses, many individuals experience mental health problems that do not meet criteria for diagnostic labels but, nonetheless, impact on the quality of their lives and their ability to function effectively.

Mental health problems have a substantial impact on the day-to-day lives of those who experience them. For many, such problems are not only unpleasant to experience but contribute to sickness absence and other difficulties at work, and to difficulties in family and other social relationships (Andrews, Henderson, & Hall, 2001; Lim, Sanderson, & Andrews, 2000; Mendlowicz & Stein, 2000; World Health Organization, 2001). At a population level, mental disorders are the leading cause of non-fatal disease burden in Australia (Mathers, Vos, & Stevenson, 1999). Worldwide, depression is estimated to become the second leading cause of disease burden and the major cause of disability by 2020 (Murray & Lopez, 1997). The fatal consequences of mental health problems are also significant in Australia. Suicide, although accounting for only about 2% of all adult deaths in recent years, was responsible for 10.6% of years of life lost through premature death in 2001, based on a "full" life of 75 years (Australian Bureau of Statistics, 2003). This figure reflects the comparatively young age of many people who die from suicide.

Currently, most people in Australia who experience common mental disorders do not receive adequate help. In the NSMHWB, only 28% of people with an anxiety disorder, 14% of those with a substance use disorder, and 55% of those with a depressive disorder in the past year had received some form of professional help (Andrews et al., 1999). Although the figure for accessing help for depression is comparatively high, only 32% of people doing so received an efficacious treatment (Andrews, Sanderson, Corry, & Lapsley, 2000), giving an overall proportion for obtaining appropriate help of just one in six. It is also known that many people who experience depression use self-help strategies that are ineffective and even

harmful in the long run (Jorm, Griffiths, Christensen, Parslow, & Rodgers, 2004). Self-medication using alcohol and other recreational drugs is common for anxiety disorders and depression (Hartka et al., 1991; Kushner, Sher, & Beitman, 1990) and can lead to co-occurrence of drug and other mental disorders (termed *comorbidity* or *dual diagnosis*). A likely contributory factor to low rates of receiving treatment is pessimism in the general population about the helpfulness of many interventions (Jorm et al., 1997).

However, for most disorders, including the common disorders of depression and anxiety, there are treatments that have been demonstrated to limit the severity and duration of episodes and can reduce the risk of recurrence (Nathan & Gorman, 2002), although it should noted that efficacious treatments do not necessarily help every individual with a particular disorder. For depression, the most effective professional treatments include cognitive behavioural therapy, interpersonal therapy, several other forms of behaviour therapy (including behaviour marital therapy) and prescribed antidepressant medication (Craighead, Hart, Craighead, & Ilardi, 2002; Jorm, Christensen, Griffiths, Korten, & Rodgers, 2001; Nemeroff & Schatzberg, 2002). For generalised anxiety disorder, panic disorder, phobias (including social phobia and agoraphobia), and post-traumatic stress disorder (PTSD), effective treatments include various combinations of cognitive behaviour therapy, relaxation training, situational exposure, social skills training, and prescription of anxiolytics (Andrews & Hunt, 1998; Barlow, Raffa, & Cohen, 2002; Roy-Byrne & Cowley, 2002). Research into the effectiveness of complementary and self-help treatments is less extensive, but there is promising evidence regarding the value of a number of strategies for dealing with some common mental disorders and with general distress that does not meet criteria for specific disorders. This evidence particularly supports the use of physical exercise for depression and generalised anxiety, some types of self-help books for depression and phobias, St John's wort for depression, relaxation training for generalised anxiety and panic disorder, and kava for generalised anxiety (Gould & Clum, 1993; Jorm et al., 2001; Jorm et al., in press; Jorm, Christensen, Griffiths, & Rodgers, 2002; Wong, Smith, & Boon, 1998).

Mental Health and Relationship Breakdown

It is to be expected that an even greater rate of mental health problems will be found in people going through the process of separation or who have been separated for some time than seen in the general population. There are several reasons for this. Circumstances that lead to relationship problems and marital separation can also have a direct and detrimental impact on mental health. Family conflict, violence, poverty, and other factors can extract an emotional toll that is not dissipated by separation and will be brought into the arena of the family law system. Second, mental health problems may contribute to family separation. This is particularly so

with more serious mental disorders; follow-up studies of patients with such problems have found that they have extremely high divorce rates following diagnosis and treatment (Merikangas, 1984). Third, separation is generally acknowledged to be a very stressful experience. Even people who have not themselves experienced marital separation rank it as one of the most stressful life events of all, comparable to losing a partner or child through bereavement or receiving a gaol sentence (Henderson, Byrne, & Duncan-Jones, 1981; Tennant & Andrews, 1976). To what extent this stress arises from contact with the family law system and not just from the intrinsic burden of separation has rarely been considered (Spanier & Anderson, 1979).

It is likely that the various possible connections between relationship breakdown and mental health are intertwined in complex ways and that their effects reinforce one another. The view of marital separation as a "life event" may give an erroneous impression of the resultant distress being of limited duration. Family separation is often both the culmination of earlier difficulties and the beginning of a period of further challenges; it involves both acute stressors and chronic adversity. As expected from these several links between marital separation and mental health, the prevalence of mental health problems is indeed found to be significantly higher in divorced and separated people compared to married people. The evidence shows that this applies to all types of mental health problems (Andrews et al., 1999; Robins, Locke, & Regier, 1991). Although most individual research studies are unable to disentangle the shorter-term changes in mental health associated with separation from the longer-term aftermath, a picture of this can be constructed by looking across a number of different studies.

Separation and changes in mental health. There are several studies that provide insight into the changes in mental health and substance use of men and women going through the process of separation (Pryor & Rodgers, 2001). These studies tell us, first of all, that even the apparently short-term or acute period of distress can last for some time. Again, this will vary considerably between individuals but, averaged across all adults who separate, it is at least 2 years before levels of distress and substance use reach constant levels (Hope, Rodgers, & Power, 1999). The evidence also shows how dramatic these changes can be and this is especially evident for increased alcohol consumption. In one British longitudinal study, the likelihood of heavy alcohol use amongst adults who had separated in the past 2 years was five times that of adults who remained married, whereas it was less than doubled in those who had been separated for longer than 2 years (Power, Rodgers, & Hope, 1999). These changes were seen in women as well as men, although the generally higher levels of problem drinking in men mean that this is more of an issue for them compared to women.

There is other evidence that the acute stress of separation is felt more by men than women (Rodgers, 1995; Weston & Funder, 1993). It has been suggested that

this is because men are more likely to lose contact, or a degree of contact, with their children (Cantor & Slater, 1995). But the evidence on this is very limited and more research is required. Another factor is that men may more often be taken unawares by separation and, following this, are more likely to want a reconciliation with their former partner. Data from the 1997 Australian Divorce Transitions Project indicated that women were acknowledged as initiating the final separation in 58% of the divorced families surveyed, men were acknowledged as the initiator in 21% of the families, and in the remaining 21% of families, the decision to separate had been made jointly.

These data reinforce other indicators (e.g., applications for divorce) that women are more likely to be the "leavers" in separation, while men are more often the "left" partner. This distinction between the "leaver" and the "left" has been linked to patterns of distress and grieving where leavers (male or female) are more likely to work through some of their emotional issues before initiating separation, whereas partners who did not initiate the separation experience stronger distress following separation and have greater difficulties in coming to terms with their new circumstances (Weston & Funder, 1993).

Studies of those who have recently separated add to these concerns in indicating that a large proportion does not seek help for their emotional distress. This is thought to be particularly so for men (Jordan, 1985) although, again, there is a shortage of direct research evidence. However, given what is known from the NSMHWB about the lack of receipt of effective treatments for mental health problems in the general population, this is likely to be a problem for those experiencing separation.

Long-term mental health after separation. Moving to the longer-term aftermath of separation, it is very clear that even after 2 years or more, adults have a greater prevalence of mental health problems than those who remain married or those who have never been married (Andrews et al., 1999; Hope, Rodgers, & Power, 1999). It might be expected that finding a new partner could make a difference in this respect, but remarried people also have higher levels of mental health problems than those in first marriages. However, there is some evidence that remarriage is more beneficial for men's mental health than women's (Power et al., 1999; Rodgers & Mann, 1986). A possible factor is that repartnered women are more likely to have substantial care of the children from their previous relationship. The stresses associated with blended and step-families are well documented and it is known that second marriages have a higher rate of divorce than first marriages (Haskey, 1996), especially where children from previous relationships are involved (White & Booth, 1985).

In the case of separated people who do not repartner, more is known about the long-term factors that influence the mental health of women, particularly lone mothers, than for men. An obvious factor to consider is financial hardship. The socioeconomic status of lone-parent families is substantially lower than that of

two-parent families, as indicated by such measures as home ownership, and outright poverty is much higher (Butterworth, 2004; Rodgers, 1995). These poorer material circumstances apply to lone-parent families headed by fathers, but the level of poverty is greater still in lone-mother families (Smyth & Weston, 2000). Further, levels of psychological distress in lone mothers are correlated with their degree of material hardship (Hope, Power, & Rodgers, 1999).

Although this picture presents an apparently simple account of the relevance of material circumstances, the way in which different types of adversity cluster in families needs to be kept in mind. Other research using the NSMHWB has found that lone mothers are also more likely to have experienced past violence, abuse, and other traumatic events and that they have high rates of physical disabilities (Butterworth, 2003; 2004). These, too, are associated both with levels of mental health problems and with financial hardship, bringing a more complex pattern of multiple adversity into view.

Knowledge of the factors impinging on the long-term mental health of men after separation is relatively sparse, other than for the possible buffering effects brought about by repartnering. Loss of contact with children is an obvious thing to consider but there is a paucity of research evidence on this. Too few studies specifically investigate lone-father families or include sufficient numbers of them in samples of lone-parent families to allow conclusions regarding this small but rapidly growing family form (Smyth, 2004). Open to speculation, in the absence of reliable information, is the likely relevance of housing conditions, social networks and support, and employment for men after separation. Recent data collected by the Australian Institute of Family Studies from nonresident parents (both male and female) and information available from the Household, Income and Labour Dynamics in Australia (HILDA) survey should provide much needed evidence on factors influencing the mental health of parents, especially fathers, after separation.

Separation and suicide. Suicide has been of particular concern within the family law system generally and specifically within the Family Court. Its association with filicide has made it an especially poignant and newsworthy topic (Jackman, 2003). This concern is justified because of the tragic consequences for individual families, but there are some misconceptions regarding its frequency and the attention given to separated fathers rather than mothers.

Around 1 in 50 deaths in Australia, approximately 7 per day, is attributed to suicide and this is more than the number of deaths from road traffic accidents (Australian Bureau of Statistics, 2003). However, claims that more than 2,500 suicides per year are due to men being estranged from their children are clearly exaggerated (Macdonald, 2004). Death from suicide is associated with divorce; divorced people have rates of suicide several times those of married people (Australian Bureau of Statistics, 2000). Although the focus of the media has been on divorced men, the

elevation of suicide rates is actually greater in divorced women (a four-fold increase) than in men (a three-fold increase). Men do, however, have higher rates of death from suicide than women, regardless of marital status, with overall rates being about four times higher in men than women. Suicide attempts and other forms of self-harm are more common in women than men but these actions, obviously, are not recorded in mortality data. Where men appear to be especially at risk of suicide in the context of marital breakdown is in the period immediately following separation. This cannot be seen in national suicide statistics, which are presented for legal marital status only and do not identify people who are separated as distinct from legally divorced. However, a study of suicides in Queensland did provide estimates for those who were separated but not divorced (Cantor & Slater, 1995). They found a six-fold increase in suicide for separated men compared with married men, but little increase in the figures for women. As with the national figures, they found the increase in suicide for legally divorced people to be somewhat greater in women than in men.

The pattern for suicide is, therefore, similar to that described earlier for mental health problems in general. Men appear especially at risk in the shorter-term following separation. In the longer-term, problems are more evident in women. This similarity is understandable, given that depression and substance use are risk factors linked to completed suicide. They are also implicated in serious suicide attempts, although evidence on this from Australian studies is lacking. In recent research in New Zealand, however, serious suicide attempts have been shown to be significantly associated with depression, substance use disorders, antisocial disorders, and anxiety disorders (Beautrais et al., 1996). Suicide, for all the media attention it attracts in the family-law arena, is arguably better viewed as the tip of the iceberg of mental health problems rather than as a separate phenomenon. It needs to be addressed within a general response to mental health problems and as an integral part of that strategy.

Mental Health and the Family Law System

If mental health problems are of such fundamental importance and offer such scope for intervention, why is it that they have not achieved more prominence in the family law system? There are several possible reasons for this.

Historically, the climate in which the Family Court of Australia began – gathering momentum in the early1970s followed by legislation enacted in 1975 – was a climate of "anti-psychiatry". In the highly charged atmosphere of debates about electro-convulsive therapy (ECT), the value of long-term inpatient care, and mounting scepticism about the validity of even major psychotic illnesses such as schizophrenia, the utility of psychiatric approaches to working with divorcing couples was seen as dubious. Certainly, there was a perception in the Court that divorce

should not be stigmatised with a range of mental illness labels. Thus, a social backlash against psychiatry in the mid-70s in Australia may have led to an over-reaction in which mental health is underplayed as a factor in divorce and, importantly, as a factor in dealing with parenting disputes.

A second, perhaps related, reason has been a tradition of interpreting the psychological distress of separation in terms of a grief model. For example, such a model is explicit in the current Family Court Book (Family Court of Australia, 2002). This approach has some benefits in offering individuals hope for the future and in normalising their emotional experiences, but carries the disadvantage of implying that emotional recovery ought to take a long time and that individuals should take responsibility for working through their own grief, rather than encouraging them to seek help (professional or otherwise). This emphasis reinforces existing stigma within the population regarding mental illness and attitudes towards service access in the medical sector.

Another possible reason for the invisibility of mental health issues in family law relates to a lack of information and expertise of staff. If services and individual professionals working in the family law system are to provide additional support to clients, they need basic information and training on the mental health problems they are most likely to encounter, the proportion of clients who are likely to have such problems, a sense of the history and context of these problems in respect to family separation, and a knowledge of ways of helping clients deal with mental health problems.

This invisibility of mental health issues may be reinforced by the general stigma associated with mental illness and by specific tensions within the family law system itself. As mentioned earlier, individuals with mental health problems often do not acknowledge that they are having difficulties and, even if they do, may still not seek help. Men particularly may resist formal support for relationship or emotional problems. Any attempt by others, especially a former partner, to help someone with such problems is often fraught with difficulty. One specific tension, in the context of litigation, is a reluctance by parents to have mental health issues surface for fear that they may be used as a weapon to rebut their fitness to look after children.

Responding to Clients in Distress

How can services and practitioners within the family law system deal with the mental health problems that they will inevitably encounter in their clients? Six ways are suggested that can be used in combination to formulate a response. The relevance of some of these approaches will naturally vary with the context of service provision, as will the best mode of implementing each component. Nonetheless, this framework might provide a general model for organisations and individual professionals to develop a response suited to their particular circumstances. We have brought a population health perspective to this approach. The components

range from some that are appropriate for all clients within the family law system, but which are not resource intensive, through to others that require greater resources, but which would be used with relatively few clients.

1. Stressful experiences in the family law system. What opportunities are there for reducing the stress experienced by clients who come into contact with a service? Are there any procedural changes that may help with this? For example, if there are unavoidable waiting times for clients before appointments, what uses might be made of this time? Is the expanding range of information available for clients presented in a readily accessible form? Are there also any opportunities for modifying interpersonal approaches with clients? People who feel depressed are typically more vulnerable to judgmental comments. They may need someone to listen to their concerns, and they are likely to be appreciative of positive comments in a time when the focus is on their failings rather than achievements. It is not easy for busy service providers to find time to take such issues on board, but it is worth bearing in mind that dealing with clients who continue to be overwhelmed by their emotional distress can also lead to extra demands on staff. Most service providers will already have considered many of these issues in developing their practice model. Feedback from clients themselves may be a help in continually re-evaluating procedures.

2. Information. Service providers should have information readily available on the recognition of mental health problems, on local sources of treatment and other support, and on self-help approaches that promote wellbeing or reduce psychological distress before it develops into a more serious problem (see Table 1 for useful resources). Effective self-help strategies for depression and anxiety have already been mentioned and there are simple practical guidelines for coping with sleep problems (Hickie, Davenport, & Scott, 2003). Social support from friends and relatives can be helpful provided that it is sensitive, nonjudgemental and makes individuals feel better about themselves. It may be possible to provide all clients with summaries of this type of information at little or no cost. Ideally, providers should be sufficiently familiar with this material to be able to respond to queries from clients and to engage clients who disclose or show outward signs of distress.

3. Encouragement to deal with mental health problems. Clients may need encouragement to deal with their mental health problems. Although it is important to maintain the view that distress and depression are common and natural responses in the circumstances of family separation, it is just as important not to rely on the passing of time as the great healer. People can take heart from hearing that life can and does get better, but things can also be done to help them feel better now. The message that some self-help strategies and professional treatments do work (see points 2 and 5) is an important source of encouragement. For clients who are focussed on other problems and are less concerned with their own wellbeing,

Table 1. Useful Resources for Service Providers: Books and Websites

Books

Bourne, E. (1995). *The anxiety and phobia workbook*. Oakland CA: New Harbinger Publications.
Burns, D. D. (1980). *Feeling good: The new mood therapy*. Melbourne: Information Australia Group.
Hickie, I., Davenport, T., & Scott, E. (2003). *Depression: Out of the shadows*. Sydney: ACP Publishing & Media 21 Publishing.
Jorm, A. F., Christensen, H., Griffiths, K., Korten, A. E., & Rodgers, B. (2001). *Help for depression: what works and what doesn't*. Canberra: Centre for Mental Health Research.
Kitchener, B. A., & Jorm, A. F. (2002). *Mental Health First Aid manual*. Canberra: Centre for Mental Health Research.
Marks, I. (2001). *Living with fear*. Maidenhead: McGraw-Hill Education.
Ryder, D., Lenton, S., Blignault, I., Hopkins, C., & Cooke, A. (1995). *The drinkers's guide to cutting down or cutting out*. Adelaide: Drug & Alcohol Services Council.
Tanner, S., & Ball, J. (2001). *Beating the blues - a self-help approach to overcoming depression*. Sydney: Susan Tanner & Jillian Ball.

Websites

Australian Drug Foundation: http://www.adf.org.au
Australian Institute for Suicide Research and Prevention: http://www.gu.edu.au/school/psy/aisrap/
"beyondblue": the National Depression Initiative: http://www.beyondblue.org.au/
BluePages: http://www.anu.edu.au/cmhr/bluepages.php
Clinical Research Unit for Anxiety and Depression (CRUfAD): http://www.crufad.com/cru_index.htm
Department of Veterans' Affairs, Health and Alcohol: http://www.therightmix.gov.au
DepressioNet: http://www.depressionet.com.au/
Drug & Alcohol Services Council South Australia: http://www.dasc.sa.gov.au
Mental Health First Aid: http://www.mhfa.com.au/
National Drug and Alcohol Research Centre: http://ndarc.med.unsw.edu.au/ndarc
Suicide Prevention Australia: http://www.suicidepreventionaust.org/index.htm

it may he helpful to point out that they will be in a better position to support their children if they look after themselves.

4. Problem solving. Problem-solving approaches are also important in preventing and ameliorating mental health problems, and these may form part of professional therapies and counselling strategies (Andrews & Hunt, 1998). In the family law context, it is known that individuals are likely to have worries in relation to financial difficulties, housing, parenting, and work-related problems, and that they may have particularly serious concerns with domestic violence or child abuse. It is important to assist individuals in coping with distress arising from these problems, but clearly preferable to attempt to deal directly with or minimise the impact of the problems in the first place. Many organisations in the family law system are already experienced in responding to these matters, but others may not have the resources. If not, they should be prepared to refer clients to other sources of assistance and also to be proactive in identifying such needs. It is not safe to make the assumption that such problems will necessarily be dealt with elsewhere in the system. They may not.

5. Referral to specialist services. Identification and referral for specialised care may be appropriate for people who have more serious mental health or substance use problems. There is no simple form of assessment that indicates exactly who is in need of referral for more specialised help. Services can use standardised questionnaires to determine this, but face the risk of clients feeling it is inappropriate or impersonal. Some clients will take the initiative in disclosing mental health problems and the need for assistance directly. Other important indicators are if they are not able to fulfil their previous daily roles (e.g., parenting, employment), whether they feel their circumstances are impossible to deal with, whether they indicate fears of "losing it" (i.e., their self-control, especially with their children), and whether they feel like giving up altogether on life or have more specific suicidal thoughts.

Many clients, even those in evident need of help, may be resistant to suggestions of referral for specialised mental health care. Their reluctance may be linked to the stigma of mental illness, concerns about the impact of disclosure on the outcome of court applications, concerns with the financial cost of treatment, and beliefs about the lack of effectiveness of treatments or their harmful side effects, especially for psychotropic medication. Clients may need reassurance that they are deserving of help and require assistance to identify care that is free or affordable. The information provided in this paper on the effectiveness of a range of professional treatments may help clients see the likely benefits. Concerns about side effects of medication may also be addressed by accurate information. There is a genuine risk of dependency on benzodiazepines, used for treatment of anxiety, but modern antidepressants are not "addictive". Vigilance regarding other side effects is important (as with all prescribed medications), and drug therapy alone is insufficient as a long-term strategy (Andrews & Hunt, 1998). However, medication is a valuable line of defence and especially useful in combination with other therapies.

Although the typical first port-of-call for referral to more specialised health care is a general practitioner (GP), some relevant services and professionals may not require GP referral. The availability of services varies between geographical locations. Service providers in the family law system who feel they do not have sufficiently close relationships with their clients to recommend specialist mental health care may prefer to refer clients to other local providers within the system that have greater experience in counselling and dealing with emotional issues. Another option is to recommend tele-counselling services. Many users express satisfaction with, and benefits from, using these services (Urbis Keys Young, 2003). Some of these are generally relevant for mental health problems (e.g., *Lifeline*) and others have a focus that is particularly relevant to the family law system (e.g., *Mensline*). Encouragement to access effective care is important, because obtaining specialised mental health care usually involves some active help-seeking by those with the problem.

6. Suicidal clients. It is important for service providers to be well prepared for dealing with crises. Organisations should have a written plan of action to deal with emergencies, and members of staff need to be familiar with the recommended procedures. Valuable guidance is available on how to deal with people who are suicidal (Table 1). The following procedures are recommended:

- Have to hand the contact number of the local mental health crisis team, crisis assessment team, or community mental health service, but realise that it may not be able respond rapidly to an emergency.
- When a crisis team cannot respond quickly, dial 000 if a person is an immediate danger to themselves or to others and express this danger clearly in your message.
- If waiting for assistance, see if there is a friend or close relative of the distressed person who can be contacted and asked to come in.
- Do not leave the person on their own.

It may also be appropriate to have a plan for how to deal on the telephone with extremely distressed clients where there are concerns as to their safety. National helpline numbers, e.g., *Lifeline*, are often included in existing information for separating families. There can often be delays in getting through to helpline numbers; if you know local or regional services that can respond more quickly, include their numbers in the information for dealing with crises.

These suggestions are not a prescription for all eventualities and cannot be so, as service providers in the family law system are extremely variable in the skills and experience available within their organisation. Some services have staff members with clinical and counselling experience, while others have minimal specialist knowledge of mental health problems. People who feel unskilled may respond by ignoring problems and not engaging with clients who show signs of emotional distress, which can be the very opposite of recommended best practice for dealing with such circumstances. These basic suggestions are intended as a resource for those who have minimal experience.

Why Should the Family Law System Take on these Responsibilities?

It has been fundamental to the present argument that services in the family law system can have a beneficial impact on the mental health of its clients, and that this benefit can be seen in the short term, and may also translate into longer-lasting coping skills and resilience. The question arises as to why service providers in this area should undertake this task that appears, at first sight, to fall beyond their area of responsibility. There are two important reasons. The first comes from a growing recognition of the value of a population health approach to promotion and prevention across the health domain and that this approach cannot be conducted by the health care system alone. This has been acknowledged explicitly in the Australian National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 (Department of Health and Aged Care, 2000b):

> Mental health is influenced by risk and protective factors that occur in the many different domains of everyday life. Consequently, effective action to promote mental health, prevent the development of mental health problems, and intervene early in mental disorders requires cooperation, commitment and partnerships that reach well beyond mental health services. Effective action needs to encompass, not only the broader health sector, but family and community services, educational institutions, workplaces, correctional services, emergency services, and the sports, arts and business sectors, as well as carers and consumer groups. (p. 1)

The Action Plan 2000, as with the National Suicide Prevention Strategy (Department of Health and Aged Care, 2000a), goes on to make specific reference to risks associated with family-law matters.

The second reason for the family law system to undertake mental health promotion and prevention is the benefits it can bring within the system. The overlapping nature of family adversity, especially in the context of children's welfare, has been noted. The best interests of children has been an enduring principle in family law in recent times. Addressing parental mental health problems is one way in which an attempt can be made to reduce the range of disadvantages reported for children of separated families. Some of this influence can come through improved relationships between parents and children. Another pathway is by moderating conflict between former partners around the time of separation and helping to achieve agreements that are mutually acceptable. In the best scenario, this can help lay a foundation for more cooperative parenting in the years ahead. Parental mental health is one part of this important nexus.

The Need for Further Research Evidence

Although the recommendations in this paper are developed from a range of research findings, there are still many areas in which this evidence base is flimsy or nonexistent. There is no complete picture of the time-course of distress leading up to and following separation or of the factors that influence this across individuals. There is no ideal way of identifying clients who are most at risk, and there is only rudimentary knowledge about why those who are at risk are reluctant to seek help and may resist attempts to help them. Though there is some knowledge of satisfaction rates and outcomes in family-law mediation (e.g., Moloney, Fisher, Love, & Ferguson, 1996) and in family-law litigation (Hunter, 2002), there is a lack of general understanding of how the family law system operates as a system. Prioritising client needs, both in terms of importance and timing, is necessarily determined in an ad hoc manner by individual service providers. A particularly large gap in research knowledge applies to personality disorders. This is generally so, as well as in relation to family law. The part played by antisocial personality disorder, for example, in maintaining conflict in families, in disrupting mediation and other processes of resolution, and in contributing to serial litigation is commonly referred to (Kelly, 2003), but the evidence that can

be brought to bear on these issues is minimal. Through all of these research questions, there is little reported on the significance of cultural diversity. There are several ways in which the family law system as a whole can work towards the inclusion of mental health issues in its field of activity.

A Strategy for the Family Law System

Comprehensive information sources for service providers and for families need to be developed. Emotional needs and mental health problems do not feature prominently in the most accessible materials (booklets, leaflets, and websites) and people who are extremely distressed and who are dealing with multiple difficulties are not best placed to seek out and digest more detailed material, such as self-help books for depression. As a note of caution, information in the family-law arena is growing rapidly with little concern as to the consistency or complementary nature of diverse materials that must appear bewildering to some clients. Quality assurance has not kept pace with this output and better co-ordination is needed. A clearinghouse of information relevant to family law, that could include material on mental health problems, would have much practical utility.

Issues relating to mental health can be incorporated in the mapping of best-practice guidelines for the various sectors in the family law system. These would cover equity of access to services and the dangers of discrimination, the relevance of mental health problems in the system and appropriate guidance on practical issues relevant to the particular sector. These guidelines should be linked into staff training and development in relation to mental health problems. Existing programs in suicide prevention, the more general Mental Health First Aid training (Kitchener & Jorm, 2002), and other programs developed for primary care workers, are available in some regions and these could be adapted and customised for service providers in the family law system (Table 1). Although the burden of continuing development for staff largely rests on individual organisations, this is an area where partnerships between service providers and co-ordination within the Commonwealth Family Relationships Services Program could facilitate progress.

Finally, but importantly, the family law system must present its case for funding and other resources to support these initiatives. They are consistent with a whole-of-government approach to the implementation of polices for mental health promotion and prevention and require a cross-sectoral funding base, not only for pilot programs but also to sustain successful initiatives on a larger scale.

Risk Analysis

What risks may arise if the approach being advocated is adopted by the family law system? Already mentioned is the demand on staff time (and the need to balance this with possible benefits arising from reducing distress in clients). A related question

is whether a greater focus on mental health issues in clients will increase emotional demands on staff. The mental health of the workforce in the family law system has rarely come under consideration, let alone systematic scrutiny. Hopefully, any improvements in the mental health literacy of the workforce would have a positive influence on its own mental health, but there is also reason to guard against individuals becoming too personally involved in their clients' emotional distress.

As mentioned earlier, a specific risk relating to clients is that they may not wish to disclose information on their own mental health problems for fear that this could jeopardise their position with regard to residence and contact decisions. This is an important issue for family law at a broader level, because it involves a tension between the rights of parents with a disability and the principle of the best interests of children. Outside of the family law system, policy and practice is moving in a direction of providing extra support to families in order to assist children of parents with a mental illness (COPMI), but this has not taken on board the "special" circumstances of separating or separated families (Australian Infant Child Adolescent and Family Mental Health Association, 2003). Organisations within the family law system may need to accept that some parents will not disclose such personal details, but that provision of information may assist people to seek help elsewhere. Others may need to provide assurances of confidentiality (within legal bounds) for parents to discuss their mental health problems.

A more general risk is that client needs or expectations may be raised to a level that cannot be met by existing services. Those seeking help through the health care system will not necessarily receive effective care. Developments in primary and specialist care for mental health problems are beyond the scope of this article, but some initiatives are in place, and it would be hoped that these will eventually result in improved services. For now, the best advice for clients is to seek out providers that can deliver evidenced-based treatments and not to be content with ineffective care. Persistence may be necessary due to the well-documented shortfall in efficacious treatments for mental health problems. Service providers in the family law system can play a role by highlighting difficulties in accessibility of local mental health care and advocating for more appropriate services.

Conclusion

Mental health problems are prominent in the family law system and present a number of direct challenges to that system; challenges that have rarely been articulated or given serious consideration. This article is intended to stimulate more collective attention by those working in the family law system – including practitioners, policy makers, and researchers – on mental health issues, as complex and demanding as this pursuit might be.

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