

# **MENTAL HEALTH AND FAMILY LAW – A QUESTION OF DEGREE<sup>1</sup>**

**FEDERAL MAGISTRATE JUDY RYAN**

## **Introduction**

It is widely accepted that separation and divorce rank among life's most traumatic experiences, for adults and children. In children there is an increased risk of acute distress, depression and behaviours that are often regarded as stemming from poor self esteem. For adults there are increased rates of depression, substance abuse, suicidal behaviour and anxiety.<sup>2</sup> Thus it is not surprising that people who are vulnerable to mental illnesses appear reasonably frequently in family law courts. When it is raised, mental illness is often a pivotal issue in the determination of parenting cases, or the case is prepared as though it is. In property proceedings the issue usually centres on matters of capacity and future needs. In this paper I will discuss the applicable law for determination of cases involving mental illness including practice and procedure.

## **Mental illness and the courts**

It is well accepted that people suffering from mental illnesses have experienced prejudice and discrimination in the community. They have been, and still are, the subjects of negative stereotypes and myths. Mental illness undoubtedly carries with it social stigma. It is for this reason, Richard Evans<sup>3</sup> writes that the mentally ill require the protection of

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<sup>1</sup> A paper given to the 6th Annual Family Law Intensive in Sydney on 11 February 2006. I am grateful to Sonia Woolley, my former Deputy Associate for her assistance with researching this topic

<sup>2</sup> Pryor, J. & Rogers, B (2001) *Children in changing families: Life after Parental separation*. UK, USA: Blackwell Publishers.

<sup>3</sup> Evans, R, "Seeking Justice for the Mentally Ill" (1995) Law Institute Journal page 642

the legal system more than any other group in the community. Despite this, Evans argues that this protection is rarely afforded and as a consequence the legal system is perceived by many who suffer mental illness as prejudicial and oppressive. He argues that the community, to a large extent, misunderstands that mental illness affects individuals in different ways. In his article Evans adopts comments made by Helen Leeson from the Psychiatric Services Training Unit at the Department of Health and Community Service. She summarises numerous myths about mental illness in the community that also exist in the legal system. These myths and misconceptions are said to include:

- That the mentally ill consistently lie;
- That they cannot make decisions for themselves;
- That they are very likely to be violent;
- That they have reduced intellectual capacity (ie they are confused with the intellectually disabled);
- That they cannot be effective parents; and
- That schizophrenia is a “split personality”.

Whilst Leeson argues that these myths may be applicable to some individuals who are suffering from a mental illness, they do not apply universally to all sufferers. Evans and Leeson are not alone in their views about community prejudice relating to the mentally ill. For example Barbara Shalit, also discussed in Evan’s paper, states that many of the Mental Health Legal Centre’s clients “*faced serious discrimination from welfare agencies and the courts*”.<sup>4</sup> Moreover, she states “*we have many dealings with community service protection workers who want to take children away from their parents merely because of mental illness*” “*We have these circular arguments, where I try to persuade them not to just look at the mental illness but to look at parenting ability*” “*Mental illness may affect parenting ability, but then it may not – but this is not*

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<sup>4</sup> Evans, R supra at 643

*understood.” ... “this is an institutionalised stigma against people with a mental illness”.*<sup>5</sup>

A common theme in literature discussing the mentally ill, courts and the welfare system is that the system, as a whole, holds entrenched views that people suffering from a mental illness and/or an intellectual disability are incapable and or irresponsible parents. As a general proposition literature covering mental illness and courts suggests that the judicial system as a whole needs educating about mental illness to ensure that mentally ill people receive equal rights in the legal system. In a paper presented to the Australian Institute of Family Studies conference<sup>6</sup> Elly Robinson describes the problem thus: *“anecdotal evidence from consumers, carers and service providers, suggests that mental illness issues are predominantly misunderstood in terms of how they affect family functioning and the family members themselves, and family breakdown. This is particularly so in the legal system. At its worst it appears that judgment can be affected by stereotypical assumptions regarding mental illness”*. She writes that it is not unusual to hear stories of people fearing that a disclosure of mental health issues would be or already had been used against them in court. She documents that with limited legal aid and a perceived reluctance amongst lawyers to take on cases that involve mental health issues, many mentally ill people are forced to represent themselves. Comments like these suggest that those suffering from mental illness are vulnerable to a heightened risk that they may be denied real access to the law and in essence substantive equality within the legal system.

Elly suggests the following improvements in the legal system to assist those suffering from a mental illness:

- *“research into appropriateness of PDR resolution for people with a mental illness and whether access to such services is adequately facilitated;*
- *Broader recognition of the rights of people who have a mental illness;*

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<sup>5</sup> Evans, R supra at 643-5

- *Appropriate training of staff throughout the family law system regarding mental health issues;*
- *Continuing focus on reducing stigma and misunderstanding surrounding mental illness;*
- *Qualitative research into the experiences of consumers and carers involved in the system”.*

## **Legal capacity**

A cornerstone of the solicitor and client relationship is a legal presumption that an adult client has the legal capacity to instruct a solicitor. If a solicitor accepts the client’s retainer, having taken advice, the solicitor is required to accept the client’s direction in the matter. Without legal capacity, a person cannot instruct.

The general legal test for capacity is described by Justice Powell in *PY v RJS & Others*<sup>7</sup>, “A person is not shown to be incapable of managing his or her own affairs unless, at the least, it appears a) that he or she appears incapable of dealing, in a reasonably competent fashion, with the ordinary routine affairs of man: and b) that, by reason of that lack of competence there is shown to be a real risk that either: 1) he or she may be disadvantaged in the conduct of such affairs or 2) that such monies or property which he or she may possess may be dissipated or lost: ... It is not sufficient, in my view, merely to demonstrate that the person lacks the high level of ability needed to deal with complicated transactions or that he or she does not deal with even simple or routine transactions in the most efficient manner..” Justice Powell draws an important distinction between a person who carries out the ordinary routine affairs of life in what may seem an inefficient manner, but basically understands what they are doing, and a

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<sup>6</sup> “Steps forward for families” Melbourne February 2003

person who clearly does not understand the purport of the transactions in question. A person is not presumed to be incapable by reason only of mental illness<sup>8</sup> from providing instructions. In each case the person's particular circumstances must be examined. If a person with a mental illness lacks competence, an alternate decision-maker may be appointed.

In some circumstances it will be plain that a client lacks the mental capacity to conduct proceedings. Because incapacity can be difficult to assess, the New South Wales Law Society established the "Client capacity Sub-Committee". The committee developed guidelines to assist solicitors who are concerned that a client may not be competent to give proper instructions. The guidelines are designed to assist solicitors in fulfilling their ethical duties to their client and the court. The guidelines comprise a flow chart with a series of questions and steps that help the practitioner assess the client's capacity. The accompanying text emphasises that capacity must be assessed in terms of an individual in a particular situation, faced with particular decisions that need to be made. The committee highlighted a set of indicators, which if present it suggests require further investigation. These indicators are a working guide and are no substitute for diagnosis. Concerning mental illness and client capacity, common indicators that impair capacity are as follows:

### **Acute depression**

Acute depression is a serious mental illness. Common signs include:

- Withdrawal;
- Lack of motivation and confusion;
- Anxiety;
- Inability to make decisions;

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<sup>7</sup> [1982] NSWLR 700

<sup>8</sup> The Laws of Australia, Law Book Company., Sydney 1992

- Inability to pay attention;
- Inability to remember short-term matters.

### **Acquired brain injury and organic brain damage**

- Some of the signs of intellectual disability will be present, although some areas of ability will be intact.
- History of substance abuse or trauma resulting in brain injury.

### **Dementia**

Dementia is caused by a number of conditions, the most common being Alzheimer's disease:

- Loss of short term memory;
- General decline in intellectual ability and adjustment;
- Confusion;
- Disorientation.

### **Manic depression**

Manic depression or bipolar affective disorder may not be immediately apparent.

Common signs include:

- In the manic phase a euphoric, grandiose, extravagant mood, making large purchases regardless of financial resources;
- Dramatic mood swings;
- Flight of ideas – flitting from idea to idea with only a superficial connection between ideas.

## **Schizophrenia**

Schizophrenia is a devastating mental illness. Common signs include:

- Delusions – a persistent belief structure significantly different to that held by most members of the community, which may include grandiose ideas, or a belief of being persecuted or under surveillance.
- Hallucinations – often auditory.
- Thought disorder – contorted, chaotic thought processes.
- Extreme, rapidly changing emotions.
- Psychosocial deterioration – a personal history of declining employment and loss of friendships and family relationships.

The guidelines proffer a series of questions which the prudent practitioner will contemplate before deciding whether to act on the client's behalf or terminate the retainer. These are:

- Consider whether you can obtain proper instructions after further explanation and education of your client. Are you satisfied that you can receive proper instructions?
- The guidelines emphasise that it is important to determine whether the illness temporarily impairs the client's capacity or is chronic thus rendering the client permanently impaired. Professional health workers and close friends are identified as categories of people who can be of considerable assistance in facilitating communication between the client and the solicitor. Useful strategies are recommended which may enhance the client's capacity to

understand and participate. For example, alternative interviewing techniques, writing down the main points and taking frequent breaks. Communication giving the client the best chance to understand the solicitor's advice and communicate instructions. Clearly this is a central issue. For a client whose illness is responsive to medication, time to allow medication to become effective can be critical.

- Is the matter one where you can act without full formal instructions, for example, can a relative or friend assist with instructions clearly with the client's best interests? The Law Society indicates that taking instructions via family or welfare worker may be appropriate if the issue is minor and short term. For example, involving a fairly small monetary claim. The examples suggested do not include proceedings under the *Family Law Act 1975*.
- Will the client consent to a formal assessment of capacity by a relevant professional? If the client is willing the solicitor should arrange an assessment. The nature of the client's incapacity is best assessed by a practitioner experienced in that specialist area. The person asked to perform the assessment must have clear instructions as to the purpose of the assessment and the nature of the decisions that the client will be asked to make. There is little utility in directing a client about whose capacity the solicitor is concerned to arrange a medical assessment. Without clear direction from the solicitor it seems likely either nothing will happen or at best the solicitor may receive an one line commentary from a general practitioner advising whether the client is

fit for employment. Hardly a desirable guideline for capacity to instruct in legal proceedings.

- Is there a process to compel the client to submit to an assessment, and does the solicitor have reasonable grounds to take such a step?
- Should the solicitor cease to act? This requires careful professional judgment. If the solicitor has become, in effect, a substitute decision-maker the time has been reached to cease acting and take action to have a substitute instruction giver appointed.

### **Application for a substitute decision maker**

It must remain at the forefront of our thinking that we recognise that mental illness exists at different times. Its severity and impact on a client fluctuates, and observations and diagnosis from one period may be inapplicable at other times. Separation and litigation may accentuate depression and other illnesses in one or both of the parties or be a significant factor in its onset. In recognising the impact of litigation and separation on a person's mental health, it is vital that legal practitioners and the court differentiate temporary incapacity from a long lasting chronic mental illness. In some instances the court may consider it necessary for a party suffering from temporary incapacity to adjourn the proceedings until there are improvements in one or both of the parties' mental health. Where transitory, it may be reasonable to merely adjourn the proceedings for a short period. In *Storey & Storey* (unreported, 26 October 2000) the Full Court gave a party an adjournment of his appeal on the basis that he was suffering from a depressive illness. His doctor gave evidence that "*he is currently suffering from reactive depressive illness preventing him from being able to represent himself today. He is being treated by me, and I do not think that he will be in a fit state (to begin preparation for) to represent himself for at least a month*". Their Honours stated that they had little option but to grant

the adjournment. As the illness was transitory the hearing was adjourned until a date when the husband was sufficiently well to continue.

Until the establishment of the Federal Magistrates Court (FMC), the *Family Law Rules* (FLR) used the concept of “next friend” to describe an alternate decision maker for family law proceedings. In 1999 the Queensland Supreme Court introduced its *Uniform Civil Procedure Rules*. In these rules the court moved away from concepts such as “tutor” and “next friend” and introduced the term, “litigation guardian”. It appears to have done so because it was recognised that in this instance courts are only concerned with whether a client has the legal capacity to give instructions. Consequently, it is undesirable to use a term that could be interpreted as having wider application and which is also somewhat patronising. Litigation guardian is seen as having a narrower application and by its language makes it clear that the person has a legal incapacity only in so far as it concerns proceedings. Issues of financial management, for example, require a separate order.

The *Federal Magistrate Court Rules 2001* (FMCR) adopted the Queensland concept of litigation guardian. FMCR Part 11.8 sets out the test that the FMC will apply in deciding whether a person requires a litigation guardian. This rule provides that a person needs a litigation guardian in relation to a proceeding if “*the person does not understand the nature and possible consequences of the proceeding or is not capable of adequately conducting, or giving adequate instruction for the conduct of, the proceeding*”. In its recent major reform of the *Family Law Rules*, the Family Court also gave up the concept of next friend and introduced the concept of a “case guardian”. It seems likely that the rationale for describing the substitute decision-maker as case guardian rather than litigation guardian may lie in the belief that the former is better understood in the community. Whatever the rationale may be, there is an obvious benefit in our two courts harmonising at least this aspect of their rules so that both courts use identical language in this area. By FLR rule 6.08 the Family Court needs to be satisfied that the child or person

concerned understands the nature and possible consequences of the case and is capable of conducting the case.

Where a solicitor decides an application for a substitute decision maker is necessary, this requires an application supported by relevant affidavit evidence. Where the client is in hospital or under the care of a psychiatrist, the best evidence of incapacity is a short report from those managing the client's mental health. However, if undiagnosed or not presently receiving treatment, the client's general practitioner may be willing to provide a report or preferably arrange an appropriate referral. The court and solicitor will ideally receive evidence concerning the nature of the incapacity and its anticipated duration. Identifying incapacity is only the first step and if established the court must then appoint a substitute decision maker.

Obviously the pool of volunteers willing to take responsibility for another person's litigation is limited. In most civil litigation one looks to a spouse or family member. In family law proceedings the former is obviously inappropriate and the latter can be surprisingly contentious. A putative litigation guardian needs to be disinterested in the outcome of the proceedings, in the sense that they have no interest of their own in the outcome of the litigation. A substitute decision maker cannot be placed in a position where potentially their own interests may conflict with the client's. In financial proceedings in particular the solicitor needs to be sure there are no intra family loans outstanding, for example, which the putative litigation guardian may need to decide whether to forgive or pursue. In my experience, commonly an adult sibling agrees to accept an appointment and usually performs it well. Once appointed the litigation guardian provides instructions in lieu of the client, including as to final settlement. In all respects the litigation guardian assumes the rights and responsibilities of the original party as to the conduct of the proceedings. It does not necessarily follow that the original client should be ignored, and in my view best practice suggests the incapacitated client will still be involved in the process. The extent of involvement will depend on the degree of incapacity and advice from those managing the original client's treatment as to the

appropriateness of involvement. Recently I was presented with evidence by a putative father in child support proceedings that he had sustained a brain injury which resulted in him being unable to concentrate for long periods. I granted leave to allow his current wife to appear on his behalf on the first occasion and, having received medical evidence, she was subsequently appointed his litigation guardian. In another a husband was a victim of a random gang bashing causing serious organic brain damage. His brother was appointed his litigation guardian in contact proceedings. The proceedings settled with the children exercising regular supported contact.

It is feasible that the original client's incapacity will be of limited duration and before proceedings are finalised the necessity for a litigation guardian will pass. I doubt that many, if any, judicial officers would be willing to discharge a litigation guardian order if merely asked to do so by consent. By this I mean once a court is satisfied a litigation guardian is appropriate, the court requires evidence the legal disability no longer operates. Thus, although there may be agreement amongst all concerned that the order is no longer necessary, the court should receive evidence to this effect. In all likelihood this needs to be little more than a brief affidavit from a medical practitioner and perhaps also from the litigation guardian and solicitor. Armed with this evidence, the court is equipped with what it needs to discharge the earlier order.

## **Mental illness and the Family Law Act 1975**

This part looks at how courts exercising jurisdiction under the *Family Law Act 1975* take mental illness into account in determining parenting proceedings, and whether the literature covered earlier is correct in its depiction of how courts manage and decide cases which involve a mentally ill parent.

### **Best interests principle – “the paramount consideration”.**

Residence, contact and specific issue orders are parenting orders. They arise in proceedings conducted under Part VII of the *Family Law Act*. Section 60B sets out the objects of Part VII and the principles which underline those objects. They are subject to

section 65E in that in determining the outcome the best interests of the child are the paramount consideration. That is the overriding principle. In deciding the parenting orders that will promote the best interests of a particular child, the court must consider the various matters set out in section 68F(2). Its sub-sections comprise a list of matters that must be considered to the extent that each is relevant to the particular case. Paragraph (1) permits the court to take into account “any other fact or circumstance that the court thinks is relevant”. This ensures that the infinite variety of individual children’s circumstances can be addressed. *B and B: Family Law Reform Act*<sup>9</sup>. The term ‘paramount’ as used in provisions such as section 65E describes the role of the best interest principle in the determination of proceedings concerning parental responsibility.<sup>10</sup> The term can be traced back to 1896 when used by Lord Lopes LJ in *re A and B (Infants)*.<sup>11</sup> The use of the term “paramount” was used in the *Infants, Custody and Settlement Act 1899 (NSW)* which stated that the welfare of the child was to be regarded as the “first and paramount” consideration.<sup>12</sup> The principle was also central to the *Matrimonial Causes Act (1959)* so that in proceedings relating to custody of children of a marriage, the court had regard to the “welfare” of the child as the “paramount consideration”. The principle was subsequently encapsulated in section 64(1)(a) of the Family Law Act 1975 and is now found in section 65E.

Section 65E was enacted as part of the *Family Law Reform Act 1995*. The amendments introduced a new set of provisions that replaced “guardianship”, “custody” and “access” with new legal concepts such as “legal responsibility” and parenting orders, such as “residence”, “contact”, “child maintenance” and “specific issues” orders.<sup>13</sup> The use of these new concepts in child related proceedings was aimed at eliminating the idea that in contested child proceedings there were winners and losers, an idea that carried the implication that parents had proprietary rights in their children.<sup>14</sup> Section 65E of the

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9 (1997) FLC 92-755

10 Dickey, A “Family Law” page 380

11 Dickey A supra at 380

12 Chisholm R, “*The paramount consideration*” in the 10th National Family Law Conference (2002) Law Council of Australia, p 3

13 The court makes these orders under section 65E

14 Kennedy I, “Family Law Reform Act 1995 – New Laws for Children” June (1996) Australian Family Lawyer (11) 2 p 12

Act conforms to the new language and states that the court, in deciding whether to make a parenting order, must “regard the best interests of the children as the paramount consideration”. This provision replaced section 64(1)(a) which stated that in proceedings relating to custody, guardianship or welfare of, or access to, a child “...*the court must regard the child’s welfare as the paramount consideration*”.<sup>15</sup>

While there has been debate as to the term paramount and accordingly the exact role that the best interests of a child should play in the determination of proceedings under the *Family Law Act*, the dominant view<sup>16</sup> suggests that unless a consideration is linked to the child’s best interests the court does not have to give it any weight.<sup>17</sup> Simply put, it is generally irrelevant. Thus considerations other than the child’s welfare (for example a parent’s behaviour), if relevant, must be subordinated to the best interests principle. For a discussion of this principle see *re O (An Infant)*,<sup>18</sup> *Kress and Kress*<sup>19</sup> and *J v C*<sup>20</sup>. Obviously many other decisions illustrate the application of the best interest principle. In *Smythe*<sup>21</sup> it was stated that a court, when making a parenting order, should only take into account justice between the parties if the conduct has an impact on the ability of the parent and therefore the welfare of the child. Accordingly, “*The overriding principle is whether the evidence and the conduct are relevant to the welfare of the child*”.<sup>22</sup> *Barnett and Barnett*<sup>23</sup> also adopted this view “...*the welfare of the child can be best weighed by disregarding entirely any concept of claim, just or unjust, on the part of the parents. It is their conduct, in so far as it bears on welfare which is important*”.

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15 Kennedy I, supra

16 Chisholm’s paper referred to the views and the strong or weak view, the weak view is that other considerations may be influential

17 Finlay H.A “First” or “Paramount”? *The interests of the child in matrimonial proceedings* July 1968 ALJ (42) p 96

18 *Re O (An Infant)* [1965] Ch 23

19 (1976) FLC 90-126

20 *J v C* [1970] AC 668 at 710-11

21 *In the marriage of Smythe* (1983) 48 ALR 677

22 *In the marriage of Smythe*

23 Full Court delivered 5/11/1979

The main point is that a child's best interests are treated as determinative in child related proceedings and are not balanced against other competing interests.<sup>24</sup> The court's role is such that they must identify the orders that will best promote the interests of the child and subsequently make them. Other factors can still be taken into account as long as they are directly or indirectly relevant to the child's welfare. However, these other factors cannot be taken into account in their own right and they cannot become independent determinants in the proceedings, although they can be considered.

### **How does a court determine a child's best interests?**

In determining a child's best interests the court is required to look at and consider twelve factors which are set out in section 68F(2) of the *Family Law Act 1975*. These are well known and do not require restating here. More often than not, the issue of mental health is raised in proceedings relating to residence or contact to children. Relatively frequently one parent alleges that by virtue of a particular mental illness, the other parent is rendered unable to provide for their child's care, welfare and development. The question the court must ask in such cases is whether that parent's mental illness impacts upon their ability to have residence or contact with the child. Notwithstanding community myths and stereotypes there is no legal presumption that a parent, by virtue of their mental illness, is incapable of being a responsible parent, nor is there any presumption that a parent who is free of such illness is better able to care for a child. Applying the principles outlined above, it is clear that the overriding consideration in a residence or contact dispute is the child's best interests. Accordingly, the question of mental illness of one or both of the parents will only be relevant so far as it affects their parenting capacity and the child's interests.

The issue of parenting capacity is usually argued pursuant to section 68F(2)(e) which states that the court must take into account "*the capacity of each parent, or of any other*

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<sup>24</sup> Chisholm, supra p 64

*person, to provide for the needs of the child, including emotional and intellectual needs.”*

This means that diagnosis of a mental illness is to be considered along with all the other factors listed in that section. Accordingly, it is simply another consideration that the court must take into account in determining the parenting application. However, while this is so, the issue of mental illness can often occupy a substantial part of the proceedings. It is more often than not raised in proceedings as a “negative” and/or “disqualifying” factor that should carry substantial weight. The fact that a parent suffers from a mental illness can also be taken into account under paragraph 1. This section reads: “*any other fact or circumstance that the court thinks is relevant.*” Section 68F(2)(1) is an open ended paragraph which enables the court to consider anything else that is relevant to the child’s best interests, that is not expressly stated in section 68F(2). Under the section the court is accordingly able to take into account any health problems of the parents if it affects their ability to care for the child.

Significant parental mental ill health may result in a court suspending or refusing residence or contact. Another alternative is supervised contact. This contact can be implemented where the court is satisfied that there is an unacceptable risk that the child will be exposed to physical, emotional or psychological harm: *In the marriage of Bieganski*.<sup>25</sup> In many cases it is often argued that a parent’s mental illness gives rise to an unacceptable risk to the child. In the case of *In the Marriage of R*<sup>26</sup> the Full Court stated that the court has to identify a course that it considers will best advance the child’s best interests. As such, the primary question when an “unacceptable risk” is raised is whether, looking at the whole of the evidence, residence or unsupervised contact with that particular parent might expose the child to an unacceptable risk. In determining these cases the test to apply is the civil standard, that the court must be satisfied that on the balance of probabilities the child is or is not likely to be exposed to an unacceptable risk.<sup>27</sup>

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<sup>25</sup> (1993) 16 Fam LR 353

<sup>26</sup> (1998) 23 Fam LR 456

<sup>27</sup> Section 140 of the Evidence Act (Cth)

As a general proposition in relation to mental illness, an analysis of the cases shows the courts striving to ensure that children continue to have a relationship with their parents including those suffering from a mental illness. Given the available range of orders the critical issue becomes the type of parenting relationship which best promotes the child's long terms welfare. There is no one size fits all outcome to these issues. Few would argue the proposition the outcome usually focuses on the quality of the expert evidence provided to the court.

### **How does the court obtain mental health evidence?**

In a 1966 decision of *Lynch and Lynch*<sup>28</sup> Begg J said: *"In my view the evidence of a psychiatrist usually has little place in a contested custody application. In many of the cases recently I have noticed that a tendency is developing to employ a psychiatrist virtually to argue the applicant's case rather than to give a straight forward medical opinion about a child's nervous or mental condition and the possible effects of the strains and stresses. I make no secret of the fact that I seek to discourage this tendency to bolster up a claim for custody with the assistance of so-called expert evidence.*

*In a frank case of mental ill-health, such opinion evidence may be of real value to the court. In cases where neither parent has ever thought of submitting their child for a psychiatric examination before the marriage broke up and the custody fight develops, the practice is, in my view, suspect. It is not the province of psychiatrists to determine questions of custody on one-sided versions of disputed facts without the aid of sworn evidence which is subject to examination and cross-examination and without consideration of the legal principles upon which the court is required to adjudicate on the exacting questions of legal custody."*

In order for the court to adequately deal with mental health issues, there is no doubt it needs evidence from qualified health professionals. Writing ex judicially, the former

Chief Justice commented that the participation of experts is an important element in determining many cases and assists the court in arriving at sound decisions.<sup>29</sup> If there is any problem with the mental health of a client, evidence of it should always be placed before the court. Usually witnesses are unable to give opinion evidence and a persons entitlement to give opinion evidence is an exception based upon expertise. All federal courts apply the *Evidence Act 1995 (Cth)*. Opinion evidence is dealt with in ss.76 to 80 which relevantly provide as follows:-

“The opinion rule

76. Evidence of an opinion is not admissible to prove the existence of a fact about the existence of which the opinion was expressed.

Exception: opinions based on specialised knowledge

79. If a person has specialised knowledge based on the person’s training, study or experience, the opinion rule does not apply to evidence of an opinion of that person that is wholly or substantially based on that knowledge.

Ultimate issue and common knowledge rules abolished

80. Evidence of an opinion is not inadmissible only because it is about:

- (a) a fact in issue or an ultimate issue; or
- (b) a matter of common knowledge.”

These provisions are identical to those contained in the NSW Evidence Act. Heydon J (as he then was) discussed their operation, particularly in relation to who may qualify as an expert, in the oft quoted *Makita (Australia) Pty Ltd v Sprowles*<sup>30</sup> decision. Describing his decision as reflecting a counsel of perfection, Branson J in *Sydneywide Distributors Pty Ltd v Red Bull Australia Pty Ltd*<sup>31</sup> gives these sections more generous application. Because the resolution of their different opinions rarely arises in parenting proceedings I will leave you to read and consider the debate without further discussion here. Simply

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28 (1966) FLR 433

29 Nicholson A, “Psychiatrists and Psychologists in the Family Court Process” (2000) *Psychiatry, Psychology and the Law* (7)(1) pp1-8 at 7

30 (2001) 52 NSWLR 705

put, it is clear that in addition to establishing relevance, the following must be established to permit the exception to opinion evidence to apply to expert evidence:-

- The witness must have "specialised knowledge"
- The "specialised knowledge" must be based upon persons "training, study or experience" and
- The opinion expressed of that person must be "wholly or substantially" based on that specialised knowledge.

Deciding who the most suitable person to give expert evidence can be complicated. It seems to me the determinative factor will be the nature and history of the alleged illness. A different answer to this question may be given if the party has a long standing documented history of mental illness, compared to suspicions of hitherto undiagnosed disorder. Kennedy<sup>32</sup> comments unfavourably on legal representatives who attempt to resist mental illness allegations made against their client by sending them to a general psychologist or by trying to obtain positive evidence from their treating psychologist. The foundation for his criticism is that such an expert only gives one parties account and usually lacks a comprehensive understanding of the allegations of mental illness which the report is intended to rebut. Kennedy argues that the person best suited to satisfy the court as to the relevant issues in relation to a parent's mental state is a child psychiatrist who has qualifications in general psychiatry and consults with both parents. The only qualification I would proffer to these observations is the benefit afforded the court process through having a client's long term treating doctor give evidence. Presumably, if a doctor has a long standing relationship with a mentally ill patient, they also have a long standing relationship with the patient's immediate family. Although this later relationship may be less familiar when trying to decide the long term ramifications of a mental illness, a doctor who has previously seen the patient when chronically ill and also

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31 (2002) FCAFC 157

32 Kennedy supra p 5

well can be very helpful. Of course, an expert must not be partisan or advocate on a client's behalf. *Brown and Pederson*.<sup>33</sup> Doing so undermines the voracity of their evidence. *W and W: abuse allegations and expert evidence*.<sup>34</sup> One can readily understand a doctor's disinclination to formally report on a long standing patient, particularly where doing so requires a frankly unfavourable report. Involving such a person may irreparably fracture an effective therapeutic relationship at a time when the client most needs it. On the other hand, be alert to the report that starts with "*I consider it to be in the interests of [my patients] mental health that he/she exercises regular contact*" but is silent about prognosis or risk issues. In my view the silence is revealing and the report will usually carry little weight. Primarily this is because it does not address the issue.

Kennedy argues that the preferable course is the appointment of a child psychiatrist as court expert who is asked to comment on matters of fact and opinion regarding issues concerning the mental health of parents and their impact on the children. With these comments I agree.

With the passage of the *FLR 2004* the Family Court introduced a single expert scheme for proceedings in that court. The provisions, which are found in Part 15.5 are not without controversy, a debate which is not the subject of this paper. The FLR clearly identify the procedure required for appointment as a court expert and the steps to be taken if a party seeks to adduce evidence from another expert on the same issue. The FMC has not adopted the single expert rule and its rules (Division 15.2) basically reflect those of the Federal Court. Again these are well known and accessible and do not require restating here.

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<sup>33</sup> 1989 FLC 92-019

<sup>34</sup> (2001) FLC 93-085

In family law proceedings it is generally accepted that a qualified evaluation requires the expert to evaluate both parents and the children, and to observe the parent/child relationship. The weight to be attached to such a report is a matter for the court. Importantly, the parties have a right to cross-examine the author of any such report. The use of an impartial court appointed expert assists the court in avoiding a battle of the experts. Thus, rather than the court hearing evidence from two experts, the court can appoint a neutral evaluator to make the same evaluation. Where there is more than one expert, the court can, and usually will, require a conference of experts. This gives experts an opportunity to exchange information and reconcile divergent opinions. Where a child representative is appointed, and in these cases as *re K*<sup>35</sup> makes plain they should be, it is generally accepted that one of their functions is to arrange an appropriate experts report.

In many instances usually only one of the parties is alleged to be suffering from a mental illness, however Kennedy argues that “*in the family law context, there is this interesting phenomenon called assortative mating: that likes marries like. In other words, people with the broad definition of mental health problem are more likely than expected to partner with somebody else who has a mental health problem.*”<sup>36</sup> Accordingly, Kennedy argues that if the court is concerned about the mental health of one of the parties it should also have initial concern at least, about the health of the other party.

Because expert reports are relatively expensive, courts are frequently asked to order a family report in lieu of an experts report. While this will competently address observed behaviour and shed light on children’s views, these reports are usually completed by either social workers or psychologists. There is a real question about people with these qualifications having the necessary expertise for mental health issues. Obviously they are unable to diagnose mental illness and thus are unable to express an opinion about a central issue in the case. If money is too limited to afford an experts report (and legal aid does not agree to do so) one lesser and more cumbersome option is for the parties and

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35 (1994) FLC 92-461

36 Kennedy, supra p 2.

children to participate in a family report and the allegedly ill party alone consult a psychiatrist. For the reasons discussed by Kennedy this should only be undertaken as a step of last resort.

Finally, the parties and children's representative must ensure a court expert is fully informed. Ideally the parties and children's representative will agree on the expertise required, the expert's identity and material to be provided. In simple terms parties must expect their clinical notes, hospital and counselling records will be examined. If a parties authority to release information is not forthcoming these documents may be subpoenaed and inspected. It is usually the case that photocopy access will be given to a child's representative so that the court expert can have the material. If an expert bases his or her opinion on material provided this way a party wishing to rely on the opinion needs to ensure that the material relied on is admissible at trial. Merely because the material is referred to in the experts report does not result in it being admitted as proof of the fact at trial. If the material relied upon is rejected one must anticipate the experts opinion is likely to be compromised and thus carry less weight than anticipated.

The above discussion generally uses language which suggests courts are mainly concerned with adult's mental health issues. This is a wrong impression to leave you with. Sadly but unsurprisingly these issues often arise in children. Save for issues about systems abuse (repetitive examinations), the forensic issues are similar. Other than in limited circumstances, section 102A of the *Family Law Act 1975* renders inadmissible evidence from a medical, psychiatric or psychological examination of a child undertaken without a courts leave. In *Separate Representative (appellant) and E and W*<sup>37</sup> the Full Court allowed an appeal against a judge's decision ordering a child to be examined by a doctor nominated by her father. Although the child, who it was claimed had been sexually abused by her father, had been interviewed by 16 people in 16 months about these allegations, the judge approved further assessment on the basis of affording the

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<sup>37</sup> (1993) 16 FamLR 485

father natural justice. After allowing the appeal the Full Court declined to grant leave for further examination.

## **How does a court respond to improvements in a parent's mental health?**

Parenting orders are never final in that the court retains jurisdiction to alter, vary and suspend them. However, when parenting orders have been recently made, the court in most cases is reluctant to reopen parenting proceedings. In order to justify a change in orders an applicant is required to prove that there has been a significant change in circumstance since the earlier order was made. This is known as the *Rice v Asplund*<sup>38</sup> principle. *Rice and Asplund* was decided before the *Family Law Reform Act 1995*. In *King and Finnernan*<sup>39</sup> the Full Court held that this principle is unchanged. Evatt CJ described the principle thus: [a court] “*should not lightly entertain an application to reverse an earlier custody order. To be so would be to invite endless litigation for ... change is an ever present factor in human affairs. Therefore the court would need to be satisfied by the applicant that, to quote Barber J, there is some changed circumstance which will justify such a serious step, some new factor arising, or at any rate, some factor which was not disclosed at the previous hearing which would have been material ... these are not necessarily matters for preliminary submission, but they are matters that the judge should consider in his reasons for decision. It is a question of finding that there are circumstances which require the court to consider afresh how the welfare of the child should best be served. These principles apply whether the original order is made by consent or after a contested hearing. The way they apply and the factors which will justify the court in reviewing a custody order will vary from case to case.*”

In the area of mental health, recovery from a prior mental illness by the non-custodial parent has been held to be a sufficient circumstance to vary an order: *Houston v*

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38 (1979) FLC 90-725

39 (2001) FLC 93-079

*Sedorkin*<sup>40</sup>. The same outcome is commonly achieved in contact cases, with improved mental health justifying increased contact or a relaxation of its conditions.

### **Some examples of cases involving mental illness**

Set out below are a series of decisions which hopefully provide a representative sample of mental health cases.

*U and U* – (unreported Full Court 20 April 1993). This is a case where a mother suffering mental illness was granted residence. The father alleged the mother was unfit by reason of her alcoholism and mental illness to have custody of their two children. The thrust of his case was that the mother’s ability to care for the children was severely affected by her dependency on alcohol and symptoms of psychiatric disorder. The majority of the trial was taken up with evidence relevant to these issues, and a considerable body of expert and eyewitness evidence of the mother’s condition and conduct, was called by both the parties. The trial judge concluded that the likelihood of re-occurrence of the mother’s psychiatric episode, which had previously led to her being hospitalised for eleven days, was not great. He concluded that even if his conclusions were wrong, the mother’s condition was unlikely to substantially impair her parenting capacity. His honour found that the mother was not disqualified, either by reason of her alcohol dependency or mental illness, from being a suitable custodial parent.

The father appealed on several grounds, one of which was that his Honour wrongly preferred the mother despite her alcohol problems and mental illness, when he was free of any such problems. The decision was upheld on appeal.

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40 (1979) FLC 90-699

**H and H**<sup>41</sup>. In this case the mother sought to reverse interim orders that gave the father residence during the week and her residence from Friday to Sunday evening. It appears the interim orders resulted from allegations as to the mother's mental state and her abuse of alcohol. The mother accepted that she had had difficulties in the past with both her mental state and alcohol abuse, but stated that the problems were brought on by the dynamics her relationship with the father. The mother relied on numerous reports which opined she could care for the children on a full time basis, and stated that she had no current problems with her mental health or consumption of alcohol. Counsel for the father submitted that two of the experts relied upon by the mother had incomplete information on the mother's history and their reports were a selective presentation of the material. His Honour found that while the mother was not exhibiting any symptoms of suffering from any mental incapacity, psychiatric illness, personality disorder, or of excessive alcohol consumption that "*...it is quite possible that that is consistent with the history of the matter that she is in remission again*". He further stated "*...as much as I can deal with the issues on a hearing like this I can say that I am not necessarily satisfied that the wife is free for all time, or for the foreseeable future, of the problems that have bedevilled her in the past. I sincerely hope that this is the case, not only for her sake but for the two young children of this marriage because obviously she will play a significant part in their future and upbringing.*" No criticism was made during the hearing of the father's care of the children. His Honour concluded that there was current stability in the children's life and that this stability should not be disturbed in the interim. He stated that even if he accepted that the mother had recovered, the best interests of the children in an interim proceeding would be best met by ensuring stability in their lives. The mother's application was accordingly dismissed.

**M and M**<sup>42</sup> concerns whether previous orders for supervised contact between the father and three children should continue or whether unsupervised contact was now appropriate. The central issue in the proceedings was the father's mental health, and in particular the fact that he suffered from depression. His Honour concluded that this condition was

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41 [2001] Fam CA 563

severe; however, he was not assisted by any expert evidence on this. The father had previously attempted suicide, and had also sent suicide letters to his wife and his daughter, which had a traumatic effect on the child and was an important consideration in the proceedings. The husband admitted that he had had two more suicidal incidents since this occasion. He had not been to see a psychiatrist stating that he had been unable to find one who could help him and had been off his medication for twelve months. His Honour pointed out to the father that he had problems in his case because he was not assisted by a positive report from an expert with respect to his mental health, despite being given an adjournment to gain this evidence. His Honour held that while the objects of the Act state that a child has a right to know and be cared by both parents, this is not an absolute right and is subject to the child best interests. He saw the fact that the father had not sought treatment nor continued medication were concerning matters with “*respect to potential harm to the children*”. The trial judge ordered that the contact remain supervised. He concluded “*I urge the husband in the strongest possible terms to undertake treatment, to find a psychiatrist and trust him or her because ultimately they are professionals and, although it will undoubtedly be extremely difficult perhaps at least for a short while and maybe for longer, he owes it to his children to do it. They need him to do it and if he does not do it; that is, seek treatment, I regret to have to say that he is not doing the best by his children. Move that extra step and they will be forever grateful.*”

***M and D***<sup>43</sup>. This case concerns a father’s contact with the parties two children aged 9 and 10. He sought overnight contact on alternate weekends and half school holiday contact. The mother sought the contact regime be restricted to that agreed in earlier consent orders, which gave the father contact each Sunday from 9:00 am to 5:00 pm. When the first orders were made the father had been undergoing psychiatric treatment. Originally the father was diagnosed with depression with psychotic features; however this later changed to Attention Deficit Syndrome. He took medication regularly and was no longer exhibiting many symptoms of mental illness. Both parties were found to be

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42 [2002] Fam CA 1328

devoted to the children and had a close and loving relationship with each of them. The basis of the mother's resistance to the overnight contact was that she had a genuinely held belief that the father was incapable of caring for the girls adequately due to his continuing mental problems and that these problems represented an unacceptable risk to the children's safety and emotional welfare. The parties relationship was described as always been stormy due to his mental illness and drug use which was the precursor to him seeing a psychiatrist. The mother had some frightening experiences with the father and it was accepted by his Honour that she believed the children to be at risk. The psychiatrist stated that the mother's behaviour was confusing to him because she would allow contact and then suddenly suspend it, and the children were sometimes used as "pawns" in the relationship. His treating doctor concluded that the father would cope well with overnight contact, and was capable of looking after and being responsible for the children. Further, it would be good therapy for him and he would be emotionally shattered if contact was denied.

Ultimately it was held to be in the children's best interests to introduce a graduated contact regime, consisting of one overnight contact, which would eventually lead to regular alternate weekend contact. Block holiday contact was not perused however both parties were given liberty to apply to the court if there were further problems.

*In the Marriage of H*<sup>44</sup>. This case involved a father's application for residence, responsibility of the parties two children and that limited contact be given to the mother. He proposed that the mother have no face to face contact and only supervised telephone contact each week to the daughter, and contact as requested to the older son aged 14. The mother agreed with contact to the son but sought face to face contact with the daughter. The child representative stated that the daughter's best interests would be best met by having a gradual introduction of supervised contact and telephone contact. There were difficulties in allocating a suitable supervisor. The mother had a long standing history of

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43 [2000] FamCA 1598

44 [2002] Fam CA 128

mental illness and had been admitted to a psychiatric ward on numerous occasions. The father was concerned about contact with the mother, due to her unpredictability and the risk that she would do or say something that would put the child at risk. The mother had been self destructive in the past and had, with her sisters help, tried to take the child away. He relied on his recent experiences with the wife to refute claims that she had improved. The mother claimed that she was taking a new drug and was now able to look after herself. She relied on medical and related evidence that she was able to act appropriately and responsibly during overnight contact. Both the family report, as well as a court experts report, left the court in little doubt about the appropriateness of the father's stance. The court concluded that the reports which indicated the mother had capacity to care for the child without supervision were too optimistic, probably through sympathy for her and fear that her condition would worsen if the proceedings failed. The trial judge stated "*She still seems lacking in energy, concentration and application, impatient and to have an uneven temper. She still seems obsessed with the wrong she believes the husband has done to her*". He found that her mental health had caused several problems with contact and would prevent her building a better relationship with the children. His Honour believed that unsupervised contact would result in their relationship being damaged as "*she will not adequately be able to provide for them, supervise them, entertain them or cope with their demands and maintain her composure. She is still very unwell and incapacitated.*" Concerning contact at a contact centre the judge said that institutionalised contact would be an unfair burden on the mother. Supervision in her home was not a viable option due to the mother's behaviour. Despite a child's right to know and develop relationship with their mother, face to face contact would not aid that relationship. He said "*the best which can be done to advance the children's welfare is to ensure that they continue to keep a line of communication with their mother open. They should not be put in a position where they might regret having ignored her or feel that they have denied her existence*". He found that to let the children speak freely with the mother would be harmful and therefore the father was permitted to listen to the conversations. He ordered the children only have supervised telephone contact with the mother.

*D and M*<sup>45</sup> This was a residence case concerning the parties two children. Shortly after their younger child's birth the mother was diagnosed with postnatal depression. The following May she was hospitalised for 10 days before discharging herself contrary to medical advice. The mother was diagnosed as suffering major depression, and having panic episodes. After the mother's health again deteriorated she was referred to an anxiety disorders clinic. Although offered a number of appointments in a group treatment disorder program the mother declined. Eventually she attended and entered a five day residential program. At the time of the hearing, pursuant to interim orders made by a Local Court the children were living with their father and having contact with their mother.

The father claimed that the mother's depressive illness seriously impinged upon her ability to parent the children effectively, in that she was unable to get the children to school and maintain a reasonable routine and home. He was also concerned about the mother's living arrangement, and the capacity of the mother or the children to cope with a blended household with six children. Another issue of concern for him was that the children had been moved around substantially whilst in their mother's care, and had not been provided with a particular permanent place of residence. When the children went to live with their father their care arrangements were abruptly changed. He had never previously been their primary caregiver, and whilst with him, substantial care for the children was given by the paternal grandmother. All of this contributed to the children being both unsettled and unstable, to the extent that the court concluded "*these worn out, weary children show all the signs of children who are vulnerable to the physical and emotional consequences of continuing instability*".

The children's schooling had previously been interrupted as a consequence of the mother's depression. When the daughter commenced kindergarten, the mother would often collect her at lunch time because she was lonely. Eventually the school intervened however, in their mother's care, both children accrued a significant number of

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45 [2004] FMCAfam 694

unexplained absences, likely to have resulted from the mother's inability to organise the children and her desire to keep them at home with her. The mother minimised the effect of her depressive order on her capacity to care for the children to the extent that, even by the commencement of the hearing, she had not addressed the issue other than claiming to be well. During the hearing the mother consulted a psychiatrist, who provided the court with a written report and gave oral evidence. It was his opinion that, with treatment, the mother would be capable of caring for all of the children that would be in her care and that there would be no significant risk to the children that she would cause them harm. He also considered she was only moderately likely to develop post-natal depression from her current pregnancy. Under cross-examination however he accepted that the mother's actual history of illness was more serious than she had portrayed to him. He also asserted that she was in fact highly likely to develop post-natal depression, and that fortnightly attendance upon a psychiatrist would be required.

The court was not satisfied that the mother was in a position to provide the children with the stable long term living arrangement they required. The court considered it highly likely that the mother would suffer post-natal depression as, when added to her background of anxiety disorders, panic attacks and agoraphobia, the risk that her various disorders would recur was high. This in turn would undoubtedly impact upon her capacity to meet the children's intellectual, physical and emotional needs, particularly if untreated. Essentially, rather than meeting the children's' needs during this time, they would by necessity be meeting hers. In this instance, residence was granted to the father, with the mother to have alternate weekend and holiday contact. A condition of contact was that the mother attend a treating psychiatrist, and abide by the psychiatrists recommendation. As to the later order, in *L and T*<sup>46</sup> the Full Court held there is power under ss 65D(1), 67ZC, 68B or 114 to order that a party attend upon a psychiatrist and undergo treatment as a condition of contact or residence, but there is no such power to make a non-conditional order. After referring to *AMS v AIF*<sup>47</sup> the Full Court held the

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46 (1999) FLC 92-875

47 (1999) FLC 92-852

welfare and *parens patriae* jurisdiction will support a variety of orders but the power is not so wide as to support any order that would promote a child's welfare.

***Re Alex; Hormonal Treatment for Gender Identity Dysphoria.***<sup>48</sup> Alex was a child under the legal guardianship of the State Welfare authority. This matter commenced upon an application to the court by that welfare authority for authorisation of medical treatment for the child. It was undisputed that anatomically and legally Alex was a girl, diagnosed as having Gender Identity Dysphoria. Essentially, as a result of this disorder, Alex had a “*profound and longstanding wish to undergo a transition to become a male in appearance*”, and his Honour was required to determine whether he should authorise medical treatment which would ultimately be the beginning of the sex change process. There was no issue of surgical intervention whilst the child was under the age of 18 years. Procedurally this matter was heard in an unusual manner. The matter itself was conducted in a conference room rather than a court, and often took the form of an orderly discussion between an array of medical experts and other witnesses, and also the legal representatives (including a children's representative) and the former Chief Justice. For his Honour, this process led to “*a very illuminating discussion among medical experts concerning the nature and timing of hormonal treatment in which each commented upon the evidence given by the others during the course of a telephone linkup*”.

Alex came to Australia at the age of about nine, after his mother remarried. Whilst he had had a very close and loving relationship with his father, who died when Alex was five or six, he had a distant and affectionless relationship with his mother. Not long after arriving in Australia a child protection notification was made which asserted that the mother had rejected Alex and no longer wanted him in her life. It was also at this time that it was first noted that Alex identified as a boy, and wished to be one. This constellation of factors resulted in Children's Court proceedings. During the Children's Court proceedings, an assessment was carried out on Alex by a child psychiatrist, who noted

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48 (2004) FLC 93-175

him as having perpetual disturbance. Alex's identification as a male was attributed to both the loss of his father and conflict with his mother. It was recommended that his depression be treated and monitored.

Expert reports prepared for the Family Court proceedings documented Alex's desire to live as a male and his longstanding frustration with being born and having had to live as a female. Feelings of anger, depression, self-harm and suicide were noted. There was some concern that Alex's problem may have been a sexual identity issue, rather than a gender identity one. Whilst his Honour accepted it a possibility that adolescent development may have led Alex to view himself as a female lesbian, rather than as a male, he was not of the opinion that this meant delaying treatment. His Honour was satisfied that the ongoing psychological and psychiatric assistance that Alex would be receiving in conjunction with hormone treatment would mean that there would be appropriate attention given to any changes in self-perception which may emerge and impact upon the treatment his Honour would be authorising.

In line with *Marion's*<sup>49</sup> case Chief Justice Nicholson considered whether Alex was capable of consenting to the relevant treatment, and whether the subject matter of the application itself was a special medical procedure. Whilst his Honour considered Alex to have obtained *Gillick*<sup>50</sup> competence, he decided that the evidence did not establish Alex had the capacity to consent to the proposed treatment. The distinction being that while Alex understood the nature and extent of the proposed treatment, he did not have sufficient maturity to fully understand its gravity. As to whether the procedure was one to which the court could give its consent, he was satisfied that the case was one which fell within the category of cases requiring court authorisation, owing to the risks that embarking on such a process would mean for Alex, and the very nature of the procedure itself. His Honour agreed with written submissions from the Human Rights and Equal Opportunity Commissioner insofar as they purported that it was the right of a child to live

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49 (1992) 175 CLR 218

with a transgender identity, free from discrimination. Ultimately the application succeeded.

## Sample orders

1. Pursuant to Part 15 Rule 9 of the *Federal Magistrates Court Rules 2001* [name] is appointed court expert to prepare a report to assist the court in relation to these proceedings. This report to address the following matters:
  - (a) The relationship between the children, the parties, any significant other person and each other;
  - (b) The children's wishes and the weight to be given to such wishes insofar as they relate to these proceedings;
  - (c) The effect on the children if their wishes are not acceded to;
  - (d) The parenting capacity of each of the parties;
  - (e) The emotional state of each of the parties;
  - (f) Whether the children have been subjected to any form of physical, emotional or sexual abuse and if so, the identity of the perpetrator of such abuse on the children.
  - (g) Whether either party has any psychiatric condition;
  - (h) If yes, whether this condition is likely to have an effect upon their parenting capacity;
  - (i) Any other matter which the court expert thinks is relevant to the best interests of the children.
  
2. An order that [name] is appointed as the litigation guardian of [name].