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Te Rōpū Mātai Hinengaro o Aotearoa

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DSM-5, ICD-10 and the Practice of Psychology- 10
Work Place Bullying Guidelines-18
Māori Men and Prison-based Psychological Rehabilitation- 20

Implementation of Drug Court Programmes- 25
Low Intensity CBT Interventions Targeting Low Mood in Adults - 43
Māori Women and Mental Health Services- 45



President's Korero 2

President **Peter Coleman** discusses what good social policy should look like

Editorial 3

Fiona Howard previews the rich variety of contributions to this edition of *Psychology Aotearoa*

NZPsS News

NZPsS Life Members, **Jan Johnson**, **Aloma Parker** and **Arnold Staite** share their career journeys 5

Psych News

Brief reports on psychology issues from a range of publications 7

A Point of View

DSM-5, ICD-10 and the practice of psychology – Part 1: The two headed monster - **John Fitzgerald & Joshua Myers** provide commentary on two of the 'maps' that are most commonly used to classify and categorize the people that psychologists work with 10
Psychology in Aotearoa 2020: Where are we going? **Anita Bellamy, Jackie Feather, Kerry Gibson, Fiona Howard and Ingo Lambrecht** discuss issues confronting psychology 14

Forum

Commentary: Best Practice Guidelines on Preventing and Responding to Workplace Bullying- **Dianne Gardner** discusses the recently released Guidelines 18

Bicultural Issues

"There's no cloud of shame on me": Māori men's experiences of prison-based psychological rehabilitation- Part I- **Damian Terrill, Neville Robertson & Marianne Lammers** explore the role of bi-cultural practice in the delivery of psychological treatment within a New Zealand correctional setting 20

Practice- Research-Education

Implementation of Drug Court Programmes and Possibilities in New Zealand - **Gen Numaguchi** discusses the need for and aspects of running drug courts in NZ 25

Interdisciplinary Perspectives

Social worker **Cynthia Spittal** discusses her work in mental health at the Canterbury District Health Board 30

One on One

NZPsS member **Marc Wilson** reflects 32

Reviews

John Fitzgerald reviews John Barletta and Jan Bond's book *The Home Therapist: A practical, self-help guide for everyday psychological problems*; **Joshua Myers** reviews David Green & Gary Latchford's book *Maximising the Benefits of Psychotherapy: A Practice-based Evidence Approach*; **Tanya Breen and Aimee Harris** review A. Scarpa, S. Williams-White & T. Attwood (eds) book *CBT for Children and Adolescents with High-Functioning Autism Spectrum Disorders*; **John Fitzgerald** reviews Carol D. Goodheart's book *A Primer for ICD-10-CM users: Psychological and behavioural conditions*; **John Thorburn** reviews John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* and **Iris Fontanilla** reviews Richard Contrada and Andrew Baum's *The Handbook of Stress Science: Biology, Psychology, and Health* 34

Student Forum

Editorial- New Student Forum Editor, **Kathryn Jenner** introduces herself and contributors. *Help Yourself to CBT' Low Intensity CBT Interventions Targeting Low Mood in Adults*- **Inga Forman and Amy Montagu** discuss their research. *Māori Women's Experiences of Mental Health Services in New Zealand*- **Gemma Tricklebank** discusses her qualitative interview study. *Civic Engagement and Wellbeing in New Zealand Youth: Initial Report*- **Jill Hayhurst** explores the relationship between civic engagement and wellbeing 42



This *Korero* has been written just after the announcement of the September election date and reflects on the Society's role in making submissions and press releases on social issues. The most recent of these (a press release) was in response to the announcement of an enhanced salary package for principals and senior

teachers from successful schools, who it is intended will be seconded for two days per week to mentor the principals and senior staff of schools which are perceived to be failing. The full press release is available on the NZ Psychological Society website but perhaps I can be forgiven for making four points.

Firstly although the Government's stated intention was for these two groups to work collaboratively together, the announcement itself wasn't preceded by collaborative discussions with representatives of the intended providers (from 'good schools') and recipients (from 'failing schools'). Secondly enhancing the salaries of relatively well-paid principals and senior teachers to the tune of \$359m will do nothing to alleviate the root problem of income inequality and its sequel, childhood poverty on which the Society has made submissions. (To its great credit the Principal's Federation has raised doubts about the proposal). Thirdly and importantly, the advent of 'failing schools' was a predictable consequence of the 1989 'Tomorrow's Schools' policy (e.g. Fiske and Ladd, 2000; Smyth, 2011) which was designed to promote competition between schools rather than collaboration. The predictable consequence is the striking increase in economic, social and ethnic stratification between schools - or put less elegantly, our failing schools. The fourth point is that social policies can only be expected to have the intended effect over a length of time and incrementally, rather than immediately. This point was somewhat lost in the debate on the removal of Section 59 of the Crimes Act on which the Society also made a submission where the prediction that squadrons of parents would receive criminal convictions hasn't yet materialised.

Ruminating on this has led me to make a few suggestions about what good social policy in the abstract should look like. A good starting point is a quote from the 'Bard of Baltimore' (Henry Louis Mencken) an editorial supporter of science during the 1920s 'Scope Monkey Trials', "For every complex problem, there is a solution that is simple, neat and entirely wrong". A second starting point is to note that punitive, 'greater-accountability' and managerialist policies are unlikely to be effective simply because as argued

in my November 2013 *Korero*, they don't collaboratively engage with either the intended beneficiaries or the providers. Inherent in any profession is the ability of practitioners to self-reflect and self-correct and this can only occur when every professional helps rather than competes with every other professional, which is discouraged by the 'Tomorrow's Schools' policy. Policies which promote professional empowerment, development and decision-making rather than competition and accountability are significantly more effective and this has been amply demonstrated in the Finnish education system reforms (e.g. Sahlberg, 2010) over a similar time period.

It is ironic that the governments of the past 20 or so years although seemingly in favour of less intrusion in the business world, in fact aspire to maintain a high level of control of professionals working in the public sector through various policy settings. They have paid more attention to trying to develop professional capacities within this sector through a competitive system of rewards and sanctions (e.g. in education through performance pay, National Standards and school rankings) than through for example raising the public status of teachers and social workers through attractive salary packages (we apparently need these to attract applications for CEO positions of our major companies but not for rank and file employees who not incidentally create the bonuses that many CEOs enjoy), or through any truly collaborative capacity-building activities.

As the year progresses we will probably therefore see an accelerated hectoring of our teachers, social workers and health practitioners (e.g. through the catch phrases of 'raising the bar', 'lifting their game', and 'accountability') who are seasonally chastised for social malaises of one sort or another. This might be good politics and journalistic copy in election year but is demonstrably bad science. It would be nice instead if we were to hear about mechanisms for enhancing the training of professionals (e.g. student allowances beyond the fourth year of study) and the provision of increased resources to build the capacities of teachers, social workers, mental health professionals and the communities which they serve. However we need to be alert to capacity building being diverted to provide training to these people into the inflexible use of prescribed strategies so that they are accountable for outcomes that have been imposed by others rather than collaboratively derived. We certainly don't need any more renting of franchised programmes that have been developed elsewhere to address social problems as has occurred in the education sector.

There is a need to focus on the wider context and the factors which are associated with perceived social problems (e.g. childhood poverty and income disparity) and address each of these. The emphasis should be on promoting social cohesion, inclusiveness, and a sense of shared community within wider society, not on criminalising or pathologising the casualties of our existing social policies and practices. So perhaps we should be saying that the policies that solely focus on the at-risk individuals and families are much less likely to be effective than policies that focus on his / her family and involve school and community resources. Policies that are family, school and community based (i.e. operate across all of the individual's environments), involve a variety of agencies, are time and personnel intensive (and will cost money!), and focus on early intervention with at-risk individuals and families are more likely to be effective.

As a general principle preventative social policies are more likely to be successful than ones which are essentially reacting to perceived problems. Early intervention with for example at-risk pupils, schools and communities is preferable to engaging with them after problems have arisen. We can reflect on our own casework evidence-base in addressing the development of effective policies. For

example where there is a choice, policies should promote a strategic intervention (i.e. use of the strategies which are predicted to have the greatest impact) and choose those which are the least intrusive and the easiest to implement, but which are also known to be effective. We should also be aware of policies that have initial intuitive face validity (e.g. youth offending 'boot camps' on which the Society made a submission) but which in the longer term might prove to be counter-productive. There is ample evidence that multi-faceted interventions are more likely to be effective than the simplistic 'single-shot' interventions which are much favoured by our politicians. Mencken perhaps was right!

As this is my last *Korero*, it is my last opportunity to badger you into making a contribution to the Society's impressive set of submissions and press releases. Thank you for listening.

Fiske E B and Ladd H F (2000), *When Schools Compete: A Cautionary Tale*. Washington DC: Brookings Institute Press.

Sahlberg P (2010), *Finnish Lessons. What can the world learn from educational change in Finland?* Teachers College Press, N.Y.

Smyth J (2011), The disaster of the 'self-managing school' – genesis, trajectory, undisclosed agenda, and effects, *Journal of Educational Administration and History*, May, 43, 2, 95-117

Editorial

Tēnā koutou colleagues,



I am delighted to be involved in co-editing this issue of *Psychology Aotearoa* for the first time. Having been involved in our profession for over 30 years, many of the topics discussed and presented are dear to my heart. Recent discussions with

colleagues in Auckland have seen us defining our strengths as a profession in the changing context of service delivery. This edition's contributors convey well how our profession becomes engaged in the challenging, the complex, the controversial, and the innovative. Threaded throughout many of the papers are a strong sense of social justice and a commitment to developing our cultural competence.

In our life members section Aloma Parker, Jan Johnson and Arnold Staite describe careers which reflect these themes. Aloma did indeed embrace innovative practice. I recall her teachings on sex therapy, a very illuminating topic for this

novice young student in her early 20s! Furthermore her engagement in gender issues is reflected in her account of her work. Likewise Jan Johnson's commitment to care of our young and vulnerable is evident as is her contribution to training (21 interns!) and ethical practice (6 1/2 years on an ethics committee!) Arnold's enjoyment of teamwork and the changes psychologists make in clients' lives is something we all share. Well done all of you.

Controversy and complexity are well articulated in the paper on the new DSM by John Fitzgerald and Josh Myers. After the great discussion at the conference last year it is good to digest in an insightful article. Part two on this topic will follow in the next issue. Controversy is no stranger to John Read, Kerry Gibson and Claire Cartwright who present some concerning findings regarding the side effects of taking antidepressants. These findings are important for those of us working with people on such medication and raise the question of our role and obligations with respect to them.

Dianne Gardner's review of the new Bullying Guidelines, a challenging area, reminded me how often this issue has surfaced in our work, especially when supervising colleagues. Thanks Dianne for your review which will no doubt be a useful professional resource.

Damian Terrill and colleagues Neville Robertson and Marian Lammers have provided an insight into the experiences of Māori men attending bicultural therapy in a prison setting. The qualitative methodology offers a different lens on the experiences of these men. This article is the first of two; our next edition will feature a deeper description of these Māori men's experiences providing insight into our practice with Māori.

Similarly, in the student section Gemma Tricklebank has utilised qualitative research to investigate the experiences of Māori women in mental health. Her findings provide some rich perspectives and suggestions of how to improve our services. Gemma won a "Best Student Conference Paper" prize at last year's conference, well done Gemma.

The cultural appropriateness of therapeutic services is also raised in our interdisciplinary perspective by Cynthia Spittal. As a social worker she recounts her experiences and passions for social justice and a broader psycho-social approach to intervention. She also raises her concerns about the loss of occupational specific roles in favour of generic ones in the DHBs. Such themes are paralleled in psychologists concerns as reflected in the article entitled "Psychology 2020" - where are we going? A group of psychologists from Auckland have laid out what they see as key issues affecting our profession going ahead given the current economic and political climate.

Perceived credibility of psychology is also raised by Marc Wilson in his one-on-one, but in this regard it is as an academic science. Marc is encouraging us to proselytize more, talking to the media and advocating for what we do to raise the public awareness and respect for our profession.

The theme of psychology reaching out to the general population, is well represented by Inga Forman and Amy Montagu who discuss their research based on the experience of running two guided self-help programmes. In addition we have a review by John Fitzgerald of a book that attempts to do the very same thing – 'The Home Therapist: A practical, self-help guide for everyday psychological problems.' Also addressing the well-being of our population, but from another perspective, Jill Hayhurst (PhD candidate) presents her paper 'Civic Engagement and Wellbeing in New Zealand Youth: Initial Report.' Jill's research is examining the ways in which wellbeing is connected to civic engagement, via the impact of

'ReGeneration' – a national changemaker network.

Innovative practice is featured in Gen Numaguchi's account of the new drug courts. Widely practiced in the US, they have had their introduction here and it is in this article that Gen offers an insight into how these operate. As Gen suggests, psychologists have a potential role here being well equipped to deal with the complex nature of addiction and its treatment.

Finally, it is with delight that I see Joshua Myers has reviewed David Green & Gary Latchford's book 'Maximising the Benefits of Psychotherapy: A Practice-based Evidence Approach.' Some of you may have been lucky enough to attend one of Dave's workshops last year; these were as very engaging as is the book from Josh's accounts. Further book reviews include one by Tanya Breen and Aimee Harris: 'CBT for Children and adolescents with high functioning Autism'. John Fitzgerald has indeed been busy as he reviews 'A Primer for ICD-10-CM users: Psychological and behavioural conditions'. John Thorburn presented a review of 'New Zealand's Mental Health Act in Practice' and Iris Fontanilla on the 'The Handbook of Stress Science: Biology, Psychology, and Health'. These were not light reads, so thank you to all for really in-depth reviews.

Thanks everyone who has contributed, I know it is not without sacrifice. These are rich reads with a vast diversity as is always the case. Your response to these papers and issues is welcomed in future editions of *Psychology Aotearoa*.

Fiona Howard

Co-Editor (f.howard@auckland.ac.nz)

CONGRATULATIONS to New Life Members

Each year the NZPsS Executive confirms and congratulates those members who have completed thirty years of membership and have become life members of the Society or those who have been members for at least twenty years and have been granted life membership in accordance with Rule 10.1 of the NZPsS Rules, having made an outstanding contribution to the Society over an extended period of time. Congratulations to those members listed below, some of whom have written about their psychology career journeys.

Jan Johnson

Dr Aloma Parker

Dr Arnold Staite

Jenny Tanner

Philippa Thomas

Jan Johnson



After 10 years teaching in primary and secondary schools in New Zealand and Germany, I completed my psychologist training at Auckland University with an internship for the PGDip. Ed.Psych. in 1979. I started work as a psychologist in 1980 in Rotorua with the Department of Education Psychological Service, (later to

become the Specialist Education Service) and was involved in a variety of work over my 18 years there – regular work in early childhood, schools, special education facilities and the community, specialist report writer for the Family Court, member of the local Care and Protection Resource Panel for 10 years and supervisor for marriage guidance counsellors for 6 years.

At the beginning of 1998 I moved to Auckland to take up one of the newly created positions of Service Leader (behaviour) in SES, based in the Auckland North/West district. Early in 2000 I set up my own private practice in Albany. My office is a 5 minute walk from home – a relief from the regular driving in Auckland's traffic- (the proximity to North Shore beaches an additional attraction for someone who grew up near the 90 Mile Beach). My initial work in private practice was providing supervision

(over two years) for a number of small groups of RTLB (Resource Teachers of Learning and Behaviour) who were completing their RTLB training at Auckland University. My involvement with RTLB has continued, and I have supervised many over the years and also provided some in-service training. I also continued to do work for the Family Courts until 2007.

In 2001 I became a field supervisor for an intern psychologist completing her PGDip.Ed.Psych. In 2013 I supervised 'my' 21st intern, so I guess I have 'come of age'. I enjoy describing those 'good old days' as a psychologist to today's interns – manual typewriters with seven carbon copies (typists did not appreciate amendments), no photocopiers, no computers or internet resources, and no mobile phones.

Working in a solo private practice I miss the day-to-day buzz from the informal contact with colleagues, but it is a privilege to have the opportunity to work with so many enthusiastic and highly energised education professionals.

I recently completed 6½ years as a member of the Massey University Human Ethics Committee, attending monthly meetings to consider research applications from staff and students. While ethics has always been an interest of mine, it has been a real learning experience to consider the ethical implications in research being proposed in a wide range of contexts.

After 34 years as a psychologist I can certainly say there is no possibility of work becoming routine or dull. It is work that has plenty of challenges and regular new learning experiences. Would I do it all again? You bet.

Dr Aloma Parker



At a recent workshop we were talking jobs and Dianne Farrell commented that just being a psychologist is a great job. When I think about the places my training and my professional curiosity have taken me I have to agree.

I've always been interested in women's issues and when I graduated from the Dip Clin Psych programme Masters and Johnson had recently published their works on human sexuality. I started in that field but it soon broadened into

other issues affecting women's lives. I finally found my career niche in 1983 working with eating disorders, which encapsulates so many insecurities around growing up, female role models, stereotyped sex roles, sexuality, body shape and social roles of food and feeding. But I've also been able to work in teaching, health service management, evaluation and outcome research.

When I joined the Society in 1972 it had only been an incorporated society for five years. For twenty years before that it had operated as the New Zealand Branch of the British Psychological Society. I remember early meetings as rather charming and erudite affairs in rooms redolent with the smell of pipe smoke. But this was the 1970s and the times they were changing. The issues of the day became issues for the Society. We championed civil rights causes and encouraged the Society to release public statements on matters such as abortion rights. Donna Awatere ran Treaty of Waitangi workshops for psychologists in Auckland. Brigid Barrer and Lynn Fry facilitated assertiveness training for women psychologists. We established a Women's Division of the Society and organised our own conferences.

We were going through a major period of social and organisational change for which I think the Society was ill-equipped. We had no professional code of ethics and no ethics committees. Professional boundaries and informed consent were not a part of our language. So when I had reason to complain about unethical behaviour of a colleague the then President of the Society told me he had broken no laws so there was nothing we could do about it.

NZPsS had no paid staff at that time so everything was done by elected officers. During the late 1970s and early 1980s I co-edited the then equivalent of *Connections* with Sara Nevezie. As co-editors we did the lot: collecting copy, typing and copying the newsletter then stuffing them into hundreds of envelopes and attaching sticky address labels. I had been chair of the Auckland Branch from about 1976 to 1981 and was President of the Society from November 1983 to August 1985. The burdens of office were heavy in those days, the nuts and bolts of administration making it difficult to get much of a sense of achievement. Our greatest accomplishment during that term for me was getting the first Code of Ethics that Barry Parsonson and others had worked on finally adopted. So it is with great pleasure that I continue to support the Society by helping organise the annual ethics workshop run by the Waikato Branch.

Dr Arnold Staite



The two highlights of 30 years as a registered psychologist have been the joys of working with colleagues and observing how the tools of psychology are catalysts for change. Working in a team with the late Bill Eggleton as the senior psychologist in the Psychological Service in

Timaru in the early 80s was an inspiring experience which helped crystallise what I wanted to do in my career- private practice. Bill's warmth and clinical skill (he was a clinical psychologist, not an educational psychologist) has been a model ever since. Working with Dr Freda Walker and her team in the Dunedin Hospital in the late 80s during my doctoral internship (Psy.D. in clinical) was another powerful and supportive exemplar. In the subsequent years, it has been my work with mostly Christchurch based colleagues that has always been a supportive affirming as well as educative experience.

The second highlight has been seeing how the tools of our profession have been such powerful change-agents in the lives of clients. Working with clients in therapy has brought countless joys as I have witnessed expected and un-anticipated changes in the patterns of thinking, feeling, relating and behaving of clients.

Doing assessments mostly for the Family Courts in the South Island has been another joy as I have seen reports commissioned by the Courts function as catalysts for change as litigants have felt as if they have been treated with respect and in a non-shaming manner. Assessments have also been catalysts for change in themselves even though their initial agenda was to achieve a win against their co-litigant!

I have no intention of retirement and I shudder at the prospect. However that will come in its own time no doubt.

Perceived racial discrimination and hypertension

A systematic review by CM Dolezsar published in *Health Psychology* 33(1):20-34, 2014 evaluated the association between perceived racial discrimination and hypertensive status including systolic, diastolic and ambulatory blood pressure (BP). Forty-four published studies involving 32,651 subjects were included in the study. Perceived racial discrimination was associated with hypertensive status (Fisher's Z score for hypertension 0.048; 95% CI 0.013-0.087), but not with resting BP (systolic 0.011; 95% CI -0.006-0.031), diastolic 0.016, 95% CI -0.006-0.034). Factors that amplified the relationship included male sex, Black race, older age, lower education and hypertensive status. Night time ambulatory BP was most strongly associated with perceived discrimination, especially among Blacks.

Dr Matire Harwood comments that "normally a person's blood pressure will be lower at night, when they are not stressed. However, as Nancy Krieger, David Williams and others posit, there is no such 'dip' in blood pressure for people who experience racial discrimination. As a result, such people are subjected to sustained elevated blood pressure or a form of 'chronic stress.' This in turn is said to cause early aging and is associated with higher risk for cardiovascular disease (heart attacks, strokes); and as the authors of this paper argue, may explain disparities in health outcomes by ethnicity".

Source: *Māori Health Review Issue 48- 2014*

Psychological distress in family caregivers of patients with prolonged disorders of consciousness during in-hospital rehabilitation

Moretta et al conducted a study published in *Clinical Rehabilitation*, Feb 11, 2014 in Italy of 24 caregivers of 22 patients affected by prolonged disorders of consciousness admitted to a post-acute rehabilitation centre. At admission, then again after 4 and 8 months, caregivers underwent assessments of depressive symptoms, state and trait anxiety, psychophysiological disturbances, prolonged grief disorder, psychological coping strategies, quality of perceived needs, perceived social support, and caregiver burden. At admission, 20 caregivers were diagnosed with depressive symptoms, 16 had high levels of anxiety and 10 had relevant psychophysiological disturbances; 8 caregivers (32%) met criteria for prolonged grief disorder. These

findings did not differ as a function of relatives' diagnosis (vegetative state vs minimally conscious state). Levels of psychological distress tended to remain constant over time, while "emotional burden" was progressively and significantly increased during the hospital stay.

Professor Kath McPherson comments that this is a small study and therefore incidence and prevalence for total populations of carers in this situation is not possible to determine. She notes however that the figures are worryingly high and indicate a need to reflect on how we do actually care for carers.

Source: *Rehabilitation Research Review Issue 29- 2014*

New Research Standards

The World Medical Association has published a revision to its "Declaration of Helsinki" that prescribes ethical standards for conducting research with human participants. The Declaration is mainly aimed at medical researchers but the *Psychologist* 26 (12) Dec 2013 notes that it has been influential in psychology since it was first published in 1964. There are two additions which are relevant for psychology. These are that 'every research study involving human subjects must be registered in a publicly accessible database before recruitment of the first subject' and that 'researchers have a duty to make publicly available the results of research on human subjects and are accountable for the completeness and accuracy of their reports'. The Declaration goes on to say that 'negative and inconclusive as well as positive results must be published or otherwise made publicly available'. The Declaration is one of the key documents used as a reference for the British Psychological Society's Code of Ethics and Conduct.

Source: *the Psychologist* 26 (12) Dec 2013 pp854-855

Is Your Medical History Secret?

Good question...apparently your medical history may not be so secret if you reside in the United States. According to Jordan Robertson writing in the *Bloomberg Businessweek* as hospitals in the States shift to digital medical records administrators share files with state health agencies who in turn sell information to "private data-mining companies". The data is stripped of names and addresses and there is no evidence that effort is being put into identifying individual patients. Robertson is concerned however that an inquiring mind could match postcodes, patients' ages and treatment dates to files for the more aggressive companies to target advertising and lift insurance premiums. The director of

Harvard University's Data Privacy Lab Latanya Sweeney identified 35 patients from a Washington database by buying state medical data and creating a simple software programme to cross-reference the information with news reports and other public records. Commenting on this issue, American lawyer Jim Pyles suggests that "electronic health information is like nuclear energy....if it is harnessed and kept under tight control, it has potential for good...but if it gets out of control the damage is incalculable. Some health agencies are reviewing their data collection policies as a result of concerns being raised about patient privacy.

Source: Robertson, J. *Your Not-So-Secret Medical History* Bloomberg Businessweek August-12-25, 2013 pp41-42

Adverse emotional and interpersonal effects while taking antidepressants- A New Zealand study

Like other developed countries, New Zealand has seen an increasing rate of antidepressant use – with one in nine adults currently being prescribed an antidepressant each year (PHARMAC, personal communication). In the largest survey of antidepressant users to date, 1829 New Zealanders described their experiences of using antidepressants. Although 83% of participants reported that they believed the drugs had reduced their depression, the survey also shows that users report high rates of negative emotional and interpersonal side effects. The University of Auckland study which was published earlier this year in the *International Journal of Psychiatry Research*, found that users of antidepressants reported a range of negative effects, including some which have not been previously well recognised. "While various negative physical effects such as weight gain and nausea are known side effects of antidepressants, what is new in this study is that antidepressants have also been found to have substantial effects on people's emotional functioning and their relationships. "These side effects appear to be reported at much higher rates than might have been expected," says one of the article's co-authors, Dr Claire Cartwright of the University's Clinical Psychology Programme in the School of Psychology.

The study found that 62% of people reported experience sexual difficulties, 60% reported feeling 'emotionally numb', 52% reported feeling 'not like myself', 42% reported a reduction in positive feelings while 39% reported 'caring less about others'. In addition 39% of participants reported feelings of suicidality and this figure rose to more than half – 55% - for participants aged 18-25. Fifty five percent of participants also reported having experienced

withdrawal effects. Eight of the 20 adverse effects listed in the survey were reported by more than half the participants.

"Effects such as feeling emotionally numb and caring less about other people are of major concern. Our study also found that people are not being told about these effects when prescribed the drugs," says Professor John Read, the lead author on the study who recently moved from the University of Auckland to Liverpool University. Dr Kerry Gibson, also a co-author on the study, said that the findings were important for psychologists who frequently provide therapy to people who are taking antidepressants. "It is important for psychologists to be aware of the impact that antidepressants might have on their client's emotional well-being and on their relationships with important people in their lives. It is all too easy to attribute any problems a client is having to depression or another psychological problem, rather than recognising the impact of the antidepressants themselves," she said. She suggests that psychologists encourage their clients to discuss possible side effects with their prescriber and request assistance from them in weighing up the advantages and disadvantages of medication, and alternative treatments, in the context of their own particular situation.

Read, J., Cartwright, C., Gibson, K. (2014). Adverse emotional and interpersonal effects reported by 1,829 New Zealanders while taking antidepressants. *Psychiatry Research*, 216(1), 67-73.



**ALL NZPSS MEMBERS WHO REGISTER FOR THE FULL CONFERENCE CAN
ATTEND A PRE-CONFERENCE WORKSHOP FREE OF CHARGE**

Keynote speakers

Harlene Anderson - Keynote: *Rethinking Psychotherapy: Collaborative Dialogue*
Workshop: *Collaborative-Dialogue: Improving the Success of Therapy through Re-thinking the Therapist's Role and the Therapy Process*

Neville Blampied - Keynote: *Psychology in the 21st C - Getting over our addiction to p so our research can be evidence for our practice*

Ainsleigh Cribb-Su'a - Keynote: *He kākano i ruia mai i Rangiatea - Initial reflections: a Māori perspective to embarking on a large, real world Randomized Control Trial of a tauwiwi therapeutic intervention*

Michael Daffern- Keynote: *The perils of practicing psychology: Aggression, violence and other threats to wellbeing*

Workshop: *Violence within institutions*

Andrew Munro- Keynote: *The growing gap between evidence and claim - can it be closed?*

Workshop: *How ideas become practical applications with organisational and commercial impact*

Joseph Trimble- Keynote : *An Emphasis on the Ethics of Conducting Mental Health Research with Ethnocultural Populations: Listening to the Voices of the People*

Workshop: *Cultural Resonance, Competence, and Relational Collaboration with Indigenous Populations*

For more information contact Heike Albrecht
phone: 04 9141983 email: pd@psychology.org.nz.

DSM-5, ICD-10 and the practice of psychology – Part 1: The two headed monster.

John Fitzgerald & Joshua Myers



Dr John Fitzgerald is director of The Psychology Centre in Hamilton and a registered clinical psychologist. He obtained his qualification in clinical psychology from the University of Birmingham (England) in 1988 and has been in New Zealand since 1992. He completed his PhD thesis at the University of Waikato in 2002. He supervises students/interns from the Waikato University Clinical Programme and a range of other health practitioners, and maintains an active clinical caseload. His current areas of research interest include: cutting and deliberate self-harm; monitoring change and measuring

outcomes in mental health; professional ethics; family resilience and suicide risk; and psychological interventions in primary care based mental health service. He is a Fellow of the Society and editor of the Society's Journal.

Dr Joshua Myers is a consultant clinical psychologist and supervisor working at The Psychology Centre (TPC) in Hamilton. He is also an Honorary Lecturer at the University of Waikato in the School of Psychology. He completed his clinical psychology training at Indiana State University (U.S.). After spending a decade in private practice in Florida where he worked with a range of clients from children and adults to court-ordered forensic evaluations, Joshua moved to New Zealand in 2010. While initially working in forensics at the Waikato DHB, he changed roles to work as a supervisor, instructor and clinician at TPC in 2012. In addition to his supervisory and other clinical responsibilities, Joshua's research interests include; ethics in clinical practice, therapeutic relationships and client attrition from psychotherapy.

This article is the first in a short series exploring the DSM and ICD systems of classification, and their impact on our work as psychologists, and on the society in which we live.

Introduction

Like most clinical psychologists working in New Zealand we have both spent large parts of our professional careers working within a professional landscape where the Diagnostic and Statistical Manual of Mental Disorders (DSM) provides the pre-eminent 'map'. While, via various iterations of this map, we are able to trace the development of topographical features (disorders and diagnoses) it is often unclear how such features magically appear on the map, or how they are removed. We are also aware that by looking at the map we can have no idea about the forces that shape the landscape, and little conception of the detailed appearance of the land. With this metaphor clearly in mind we would do well to remember Korzybski's axiom that "the map is not the territory", that a map is only a representation of the landscape, and generally a highly stylized one.

With the release of the 5th edition of the DSM (DSM-5; American Psychiatric Association, 2013) the old maps have become obsolete, but has the landscape really changed? Were the old maps so outdated and inaccurate that there

was a danger of us all becoming lost? What credentials and credibility do the cartographers have?

Despite claims that advances in brain imaging and genetic testing would revolutionize the way we understand mental health these fields of research have yet to bear much fruit...

The purpose of this article is to provide some commentary on two of the 'maps' that are most commonly used to classify and categorize the work we do or, more accurately, the people we do it with. These maps, the DSM-5 and the World Health Organization's International Classification of Diseases (ICD), aim to reduce detail to a series of labels and symbols that are designed to provide a representation of mental health disorders which is portable, easily understood even by people who do not speak the same 'language', intuitive in their use, accessible, and an assistance in identifying important features which can help guide the lost. How well does each system achieve these goals? Why has the DSM-5 caused such disquiet?

The new roadmap: DSM-5

The DSM-5 raised quite a stir within the popular press and amongst mental health care professionals and researchers back in mid-2012 when the revised draft was released,

almost one year after its scheduled release date. This was not unexpected as even during its development concern was expressed that new and modified categories were not supported by a sound evidence base. Despite claims that advances in brain imaging and genetic testing would revolutionize the way we understand mental health these fields of research have yet to bear much fruit that is of direct benefit in everyday diagnostic practice (Philipps, 2013). This does raise the question - if there have been few substantial developments in the diagnosis and categorization of mental disorders in the last 15 years what is the justification for a new DSM, especially one that increases the number of attributable diagnoses which lack clarity? After all, if our classification system is going to define a greater number of citizens as having a mental disorder, surely we need to be confident that this is justified, that we can make these judgments consistently and reliably, and that having made such judgments we have something of value to offer by way of an intervention or support. There has been criticism of the DSM-5 on all these counts.

If we accept that a cautious approach is required when making use of a diagnostic/classification system, and that such is required because of the potential to do harm, then why do we bother with such a system in the first instance?

Allen Frances has been one of the principal critics of the DSM-5. He is well credentialed for this role as professor emeritus and former chair of the Department of Psychiatry and Behavioral Sciences at Duke University, and chair of the DSM-IV Task Force. In his book *Essentials of psychiatric diagnosis: Responding to the challenge of the DSM-5* (Frances, 2013) he suggests that the DSM-5 suffers from, "... unrealistically lofty ambitions and sloppy methodology". His view is that the American Psychiatric Association was seeking to generate a paradigm shift in psychiatry, but that the likely outcome will be the over-diagnosis and harmful over-medication as "... millions of essentially normal people will be mislabeled and subjected to potentially harmful treatment and unnecessary stigma." (p.5). His reasoning behind this is that the introduction of new diagnoses at the "fuzzy boundary with normality" (e.g., mild neurocognitive disorder, disruptive mood dysregulation disorder) and the realignment of diagnostic thresholds (e.g., including normal grieving as part of major depressive disorder) opens the door for psychiatric/pharmacological intervention to deal with experiences of everyday life. He also notes that this problem is likely to be magnified as most mental health care is provided by primary care practitioners, the situation in New Zealand as well as America and elsewhere, where decision making

around these issues may lack expert sophistication.

In his illuminating chapter in Paris & Phillips (2013) *Making the DSM-5: Concepts and Controversies* Frances presents an interesting baseball analogy, which we can translate to a cricket analogy for our purposes. At a cricket match there is one umpire who says "There are runs, no-balls and boundaries and I call them as they are", a second umpire who says "There are runs, no-balls and boundaries and I call them as I see them", and a third umpire who says, "There are no runs, no no-balls and no boundaries until I call them." Frances likens the American Psychiatric Association to the first umpire who takes a stand on his (umpires are still usually male I think) unerring ability to objectively interpret reality. This umpire is able to make use of new technology under some limited proscribed situations, and when the call is made that becomes the 'new reality', no matter the accuracy or consequences. Frances presents Thomas Szasz and the anti-psychiatry movement as the third umpire, holding the position that runs, balls, the game, competition, everything is a social construction at best and commercial social control at its worst. Of course, you try telling that to 'the man in the stand' who has taken the morning off work to watch Brendan McCullum complete his historic 300+ run innings. The more moderate position, the one which Frances claims to occupy himself, and the position occupied by many psychologists, is that of the pragmatic second umpire. Frances accepts that real life and "almost everything in psychiatric classification" are overlapping categories and not generally amenable to the application of the same standards of scientific rigor as would be found in 'gold standard' mental health research. However, this should not be seen as an excuse for adoption of a careless approach to mental health classification, but rather a highly cautious and well informed one. If one of our guiding principles is to do no harm then we err on the side of restraint. The point he makes is that we cannot have and do not need, in most circumstances, an exact map or one that is accurate to within 10cm (using our own metaphor). What we need is a map which is manageable and accurate enough, which is 'fit for purpose'. We would add our own preference that it is also uncluttered by advertising!

If we accept that a cautious approach is required when making use of a diagnostic/classification system, and that such is required because of the potential to do harm, then why do we bother with such a system in the first instance? Michael First (2010) observed that there are at least four clinical reasons why it is useful to have a classification system, (a) communication of clinical information, (b) assist in the selection and implementation of the most

effective interventions, (c) facilitate prognostic judgment about likely outcomes, and (d) differentiate disorder from non-disorder. Certainly, these characteristics would be useful if they were fully operationalized within our current or future systems. However, for comparison Reed (2010) outlines four characteristics of our current and generally un-friendly systems, (a) vagueness such as the overuse of “unspecified” (ICD term) or “not otherwise specified” (DSM term), (b) treatments effective across disorders which suggests diagnosis lacks clinical relevance, (c) diagnosis is not a good predictor of treatment outcome, and (d) criteria cross-over with people meeting criteria for multiple disorders. Hansen et al. (2013) observes that not only does the DSM-5 fail to make much headway in meeting First’s criteria of a clinically useful classification system, but that the omission of social/cultural determinants of disorders and diagnoses means that there is no process for the inclusion of population level factors. This observation speaks to the movement away from an atheoretical stance towards a position from which all mental health difficulties (‘disorders’) are seen as having a strictly biological rather than biopsychosocial origin.

How has the DSM-5 been received?

As indicated above the publication of DSM-5 has been met by a number of public statements by individuals and organizations expressing concern about the process of development and content of the new manual. One such statement is that released by the Division of Clinical Psychology (DCP), which is a division of the British Psychological Society (DCP, 2013). In their position statement they identify a range of concerns associated with the general concepts and models which underpin the DSM-5, and draw attention to the potential negative impact that these may have on service users. They argue that the practice of psychiatric diagnosis as it now stands suffers from serious conceptual and empirical limitations and that a paradigm shift is needed which both recognizes these shortcomings and embraces broader social and psychological elements impacting on mental health experience.

Specifically, the concerns raised by the DCP within the area of general concepts and models applied are; diagnoses increasingly being presented as objective facts; problems with the validity and reliability of diagnoses; diagnoses lacking utility when determining interventions or even conducting research; a shift away from an atheoretical stance to one which emphasizes biological factors; general decontextualising of mental health problems; and privileging of a Western worldview. The potential for negative consequences to follow allocation of a psychiatric

diagnosis is not a new idea. The reality of this makes it imperative that new developments in classification aim to reduce discrimination, stigma and negative self-perceptions, and enhance personal agency and authority whenever possible. The DCP reinforce these considerations and suggest that any developments which lead to an over-reliance on medication are counterproductive.

In response to these concerns the DCP advocates for greater caution and clarity on the uses and limitations of psychiatric classification, and more focus on contextual approaches which incorporate social and psychological as well as biological factors. They also advocate for the broader use of psychological formulation in describing mental health problems.

The New Zealand Psychological Society shares the concerns expressed by the DCP and released its own position statement early in 2014 (NZPsS, 2014). The Society’s own statement draws particular attention to the social and cultural contexts within which challenges to mental wellbeing have their origins and are maintained by advocating that, “... the practitioner must look beyond the mental disorder and develop an appreciation of the complexity and uniqueness of the individual and their social and cultural context.” This is consistent with Hansen et al. (2013), but not well addressed in the DSM-5. This failure to consider the wide context, generally limited clinical utility, and pathologising of everyday life experiences are some of the reasons why the Society is urging caution amongst those who use the DSM-5 by choice or necessity.

An alternative to the DSM-5

The DSM-5 has been criticized for moving into the realms of causation rather than simply providing description, and for arriving at unsubstantiated classification of some disorders based on little evidence of their actual existence. However, there is another reason why we classify things and that is so that we can count them ... red socks and blue socks. This use doesn’t tell us anything about the history, state of repair, or quality of the socks, just how many of each type there are. This task remains the principle focus of the ICD classification system (enumerating and classifying mental disorders, not socks). The origins of the ICD classification system is fascinating, if confusing. Goodheart (2014) provides a little history lesson in the introduction to her text on the ICD-10-CM (reviewed elsewhere in the issue). She observes that the origins of the ICD are in the 1851 Great Exhibition at the Crystal Palace in London when a group of statisticians attending the Exhibition became interested in techniques for comparing the outputs

of newly industrializing countries. This interest spawned the first international Statistical Conference in 1853, where a comparison of causes of death in industrial countries was discussed. In 1893 the International Statistical Institute adopted the first edition of the *International List of Causes of Death*, which by 1909 was extended to include 'Sickness and Death', and by 1948 included 'Disease, Injuries, and Causes of Death'. Also in 1948 (ICD-6) a new main sub-category was introduced to classify 'Mental, Psychoneurotic, and Personality Disorders', this was four years prior to the publication of the DSM-1 in 1952.

It has also been indicated that ICD-11 will have a primary focus on clinical utility and enhancing the match between what practitioners see in clinical practice and how it is reflected in the classification system they read in the manual.

The origins of these two classification systems could not be more different. The ICD system was developed to count things, to facilitate comparisons and, for the cynics amongst us, establish/perpetuate a hierarchy of industrial dominance. The DSM system was developed at the time of the Second World War to select, assess and treat members of the armed forces, asserting dominance of a different kind. While the two systems look similar in their structure, and some considerable effort has been taken to ensure that they are not inconsistent with each other, there are some important differences. One that seems particularly relevant is that the implementation of ICD allows for the modification of the ICD core to take account of local needs. For example, Australia and New Zealand currently use the ICD-10-AM (Australian Modification), although there are currently eight modifications of the ICD-10 in use around the world. It is anticipated that ICD-11, which is due for publication in 2017, will go much further in both encompassing local requirements and incorporating social and cultural factors associated with mental health difficulties. It has also been indicated that ICD-11 will have a primary focus on clinical utility and enhancing the match between what practitioners see in clinical practice and how it is reflected in the classification system they read in the manual.

The ICD system is universal both in the sense of covering all branches of medicine and being accepted as an international system, which is unlike the DSM. In New Zealand there is a large invisible army of 'coders' within District Health Boards who take diagnostic codes from different classification systems and convert them into ICD-10-AM codes to feed the Ministry of Health. Our health system runs on ICD data not DSM data.

The American Psychological Association has placed its support behind the development of ICD-11, why? Their view is that ICD is "the world's classification system", it receives huge support from the World Health Organisation, it encourages the involvement of psychologists, its products are freely available and free, it is based on multinational data, it is free of commercial influences, and it is the international classification standard even in America. Few, if any of these criteria can be extended to the DSM-5, which is produced, approved and 'owned' by the American Psychiatric Association for whom it generates substantial revenue. In 2009 Geoffrey Reed, a WHO psychologist, spoke about the future of the DSM saying that, "there would still be a role for the DSM, because it contains a lot of additional information that will never be part of the ICD. In the future, it may be viewed as an important textbook of psychiatric diagnosis rather than as the diagnostic 'Bible'." (APA, 2009).

Where do we go from here?

As the DSM system becomes more inclusive (over-inclusive?) and increasingly biological in its underpinnings, we wonder if the time is right to more closely consider whether a different cartographer might more accurately represent the territory we as psychologists survey. In our next installment we will explore the diagnostic/formulative landscape from a psychological perspective, adding what our unique professional perspective contributes to the picture of client well-being.

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Psychology in Aotearoa 2020: Where are we going?

This article was written by Anita Bellamy, Jackie Feather, Kerry Gibson, Fiona Howard and Ingo Lambrecht on behalf of a broader group of psychologists who come from a variety of work contexts and took part in a series of discussions on the future of psychology.

Who are we?

We are a concerned group of psychologists from various Auckland contexts, including District Health Boards, Department of Corrections, NGOs, PHOs, private practice, Te Pou, and universities who have been meeting to discuss some of the challenges and opportunities for psychologists' roles and identity in the future; in particular, the delivery of psychological services within mental health, across a wide range of arenas of practice. These discussions have occurred against the context of local and global agendas and international concerns about the role of psychologists. The aim of this article is to bring together some of the debates and concerns that psychologists have been articulating informally and to locate them in the wider socio-economic and global context of health reform. We hope, through this article, to invite our fellow psychologists into further dialogue on these issues with us and amongst each other.

Proposed changes in the mental health system are intended to provide strategic care that will facilitate integration back into the community more quickly.

As most psychologists will be aware, there are major changes afoot in the health sector. This represents an important juncture for psychologists to reflect on their identity and how they might continue to maintain their relevance in a changing service environment. We see that there are both challenges and opportunities

ahead, and our intention here is to highlight some of the dilemmas that we believe psychologists are facing.

Challenges in the broader context

- **The current economic and political climate:** Worldwide, health decisions are being increasingly driven by economic agendas. Against this background, population growth and aging are depicted as a burden on limited health resources in New Zealand. This has resulted in a focus on efficiency and effectiveness in relation to spending. As a result there is increasing pressure on psychologists to show that their services are worthy of their cost. Whilst there are obvious benefits to increasing efficiency it is also likely that psychologists will face disproportionate critique of their value relative to professional groups who are perceived as less expensive.
- **Mental health challenges:** There are major challenges for mental health services in New Zealand. The Ministry of Health (MOH) seeks to create more accessible and more affordable mental health care, (MOH, 2012). We face some major mental health challenges in this country – including addressing the needs of Māori who continue to experience high rates of mental health problems in the context of social disadvantage and restricted access to appropriate services (Baxter, 2008); and the needs of our youth of New Zealand who have one of the highest rates of suicide in the developed world (Patton, et al., 2012). There is also a clear need for better access to treatment for children, youth and older people, those with addictions problems, and those with disabilities. Verified ecological concerns have a direct impact on psychological wellbeing, such as trauma due to natural disasters and the negative effects of human activity on the environment (Royal Society of New Zealand, 2014). Psychologists may need to re-focus their training and practice priorities to meet these unprecedented changes to the world in which we live.
- **Workforce development:** Considerable workforce development is required to address these existing and emerging issues and psychologists are professionally well placed to contribute significantly to this. However, psychologists are also seen as an expensive resource at a time when the sector is experiencing a decrease in funding, with a shift of resources to primary care. This could mean there are opportunities for psychologists in the expanded role of talking therapies. However, the likely re-allocation of resources from secondary and tertiary level services to primary level will necessitate changes in the way that psychologists practice and envisage their role.
- **The biomedicalisation of mental health:** There has been increased

concern about the dominance of biomedical explanations for health issues, reflected in the debates about the DSM 5. Both the Division of Clinical Psychology within the British Psychological Society and the New Zealand Psychological Society have raised concerns about this emphasis (NZPsS, 2014; BPS, 2013). Reliance on biomedical aetiological explanations has facilitated the increasing prioritisation of drug treatments. In part, this position has been supported by a discourse around the assumed lesser costs of drugs versus therapies for psychological problems.

- **Evidence-based practice movement:** There have been obvious benefits arising from the increased awareness of the need to use evidence based treatment. However, the idea that adherence to manualised treatments will provide the solution to all psychological problems may limit opportunity for the use of complex individual formulation and intervention strategies, a role psychologists are specifically trained to provide.
- **Genericisation of professional roles:** The trend in health care services to reduce the specificity of job descriptions has meant that it is harder to argue that psychologists make a unique contribution to mental health. This means it is more difficult to defend the retention of positions for psychologists in areas where there are other allied health professional groups, who may be perceived as less expensive.

Some immediate concerns

Changes to mental health delivery

Proposed changes in the mental

health system are intended to provide strategic care that will facilitate integration back into the community more quickly. While this has the potential to benefit clients there is also the risk that with increasing economic constraints secondary services (CMH services) may end up providing psychiatric and psychological care in order to enable people to be regulated enough to access support in primary care rather than the intended consolidation of gains made. The secondary care could possibly become a revolving door for clients with complex mental health issues rather than a setting in which interventions are delivered targeted to ameliorating complex problems, unless new systems and models of

... psychologists are also seen as an expensive resource at a time when the sector is experiencing a decrease in funding, with a shift of resources to primary care.

care are specifically implemented to address this. This change in emphasis is already occurring in certain areas of New Zealand and may be seen as an economic and effective solution for mental health care at this level of clinical severity and complexity. This will have significant consequences for primary care, where holding severe to moderate levels of mental health issues will become increasingly common. However, the funding, the resources, as well as the capacity of mental health workers at the primary care level is not currently sufficient to deal with an increased level of complexity. Some primary health care providers already limit the number of sessions, usually six, for psychological services. This approach is not evidence based, nor evidence informed. For example, six sessions does not equate to the guidelines for moderate depression. (NICE, 2009). Such challenges in turn provide a challenge to the design and implementation of services, one that

psychologists are well equipped for.

Talking therapies and stepped

care: The future of psychologists will involve programmes such as IAPT (Increasing access to talking therapies) and stepped care. These initiatives may represent further challenges and opportunities for psychologists. The stepped care programme in the United Kingdom increased the provision of psychological therapies; however, it is also worth considering the unintended consequences and implications for psychologists. In New Zealand these initiatives are just beginning to be planned and implemented, with a pilot study finding positive outcomes for clients in line with international results (Earl, Bunting and Feather,

2013). There are certain advantages to stepped care, namely it provides in its best form increased access and resources for psychological therapies. It furthermore regulates psychological provision according to mental health complexity. This programme also acknowledges the training, seniority and leadership of psychologists who are called on to provide training and supervision of other professionals. This means the potential exists that an optimal use of a psychologist occurs within care provision, which can only benefit the clients. Stepped care allows for a client driven process, which also steps up the care according to the complexity of mental health issues. The potential exists that this also provides opportunity for more effective early intervention to occur. Clients no longer have to become very unwell to access talking therapies.

Amongst the unintended consequences in the UK have been

job losses for psychologists, as people with less specialised training provide psychological interventions. There have also been concerns raised in regards to competency. Credentialing is a complex and difficult issue and there is a risk that CBT, for example, may be provided by people with very limited training in this area and a limited psychological knowledge base. There are also risks that insufficient funding will be provided for addressing more complex and severe mental health difficulties (e.g. eating disorders, BPD, psychosis, complex trauma, co-morbid disorders). Such complex clinical work requires more time and skill, and the concern exists that there may not be adequate anticipation in terms of resourcing. Finally, there have been concerns raised in regards to the supervisory role of psychologists in relation to other professions and the questions this raises about which code of ethics and standards are psychologists to adhere to?

Māori mental health: All of the above issues are of particular concern for Māori psychologists and for Māori clients. Very likely, there would be a significant loss of complex cultural-clinical formulations and interventions, thereby negatively affecting the provision of culturally appropriate therapies. Furthermore, the shift toward primary health care through the GP and the current suggested six session psychological service framework will be likely to undermine provision for Māori as well as economically disadvantaged people. The historically determined reticence to access medical providers, combined with the costs of accessing GPs, will create a significant barrier. There will need to be an iwi approach to this issue, for the primary care approach limits not only access but also effective provision of mental

health care for Māori (Baxter, 2008). In addition, the Māori psychologist workforce is likely to be particularly badly affected by the economic and training constraints as outlined below. Other cultural minority groups as well as economically and socially disadvantaged groups such as children and older adults will also be affected by reduced access to specialist psychological mental health care with sufficient time to address complexity.

Clinical and organisational leadership:

Within mental health care provision, be it primary or secondary care, psychologists have had limited uptake of leadership roles despite the clear skills and high level of training. Historically, such leadership roles have been filled by the medical profession. There is an acceptance of our professional reticence to come out from behind the closed doors of the therapy room. For various reasons, including career advantages and training foci, psychologists may have been largely reluctant and financially disadvantaged in stepping outside the therapy role. Therefore, unlike nurses and other allied health professionals, (who are financially advantaged for seeking managerial roles), psychologists are not currently well-represented in the management, decision-making tiers within the DHBs and other agencies providing mental health care. The result is that, no matter our skills, the profession lacks sufficient heft in the planning of mental health services and policies. An important part of clinical leadership for mental health is to strengthen mental health care providers to think and strategise beyond the medicalisation of mental health care. Psychologists could provide guidance for more effective psycho-socio-cultural interventions. We have not always been able to make the most of

our ability to provide more optimal leadership in the planning of services based on our ability to conceptualise a more holistic, sophisticated and complex analysis of problems which benefits our clients.

Prescribing rights for psychologists:

This topic is currently being vigorously debated, with significant effects for our future. There are a range of views that highlight the strengths and risks of prescribing rights for psychologists. There are some advantages, such as the ability to prescribe more responsively, and to meet the integrated needs of clients. Some are concerned about the increasing biomedicalisation of psychologists, as well as the unintended consequence of becoming 'cheap psychiatrists' within institutions, compromising our role as champions of talking therapies and integrated treatments. This is therefore an important consideration in regards to our future.

Within mental health care provision, be it primary or secondary care, psychologists have had limited uptake of leadership roles despite the clear skills and high level of training

Training of psychologists:

All of these factors produce a number of challenges for the training of psychologists. Financial imperatives are currently impacting on post-graduate professional training programmes such that the students cannot access allowances and there are insufficient funded internships. This effects the population of students currently applying for the programmes. In particular, this limits the cultural and socioeconomic variability of the student demographic, including Māori, and other social and cultural minority groups. Already, a student needs to be financially advantaged

to become a psychologist. This is to the detriment of our profession and, in turn, for the population of New Zealand. It is also not in keeping with our obligations under the Treaty and our responsibilities towards ethnically diverse communities, nor is it in keeping with our Code of Ethics, or the aims of the Ministry of Health. At the level of training, there are additional challenges, namely to train to the competencies we are striving to engender. Psychologists need to be able to respond with flexibility to the changing environment. For example, there is a need beyond the clinical training, to enhance consultation and leadership skills from the outset of the psychologist's education. These challenges are becoming evident and training programmes need to continue to be flexible and responsive. Post training there are requirements to maintain and enhance skills with continuing professional development, an area in time of constrained resources which is often the first to be cut.

Where to from here?

This is a question for our profession and it is also a question for you. The above concerns are some that we as a group have identified as confronting us as a profession, and we anticipate discussing a wider variety of issues, such as:

What are our strengths as psychologists that we can build on for the future?

How will psychology be practiced in 2020?

What more might be needed from the psychology workforce in New Zealand?

How do we raise the profile of psychology and highlight the contributions that psychologists can make?

We are proposing a forum for

psychologists by psychologists to talk about these issues together. This is not designed to be a passive listening exercise, nor a talk-fest. Rather, we are seeking to provide a space to reflect and engage on the issues that will directly affect you. On the basis of the collective discussions we want to develop some strategies for making a difference to our future. Two meetings are proposed, namely one in Auckland at AUT North Shore campus, 90 Akoranga Drive, Conference Centre, Room AF116, on July 8 (9.30am) and the other at the NZ Psychological Society conference in September. We have presented you with some concerns and questions. We would also really like to hear your questions and your views on the future of psychology in New Zealand. Bring them to the either meeting or send them to Heike Albrecht at the NZ Psychological Society national office (pd@psychology.org.nz). Thank you for taking the time to read this.

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We hope you will like the look and the new functionality of the new NZPS website.

This is what the new website will allow you to do:

Our membership database (Membee) has 'widget's which are published on our new website which can do a range of things, for example:

- There will be an enhanced members' only site with a members' forum
- You will be able to pay for all events online, either by credit card or internet banking
- We will send you your membership invoice as an e-bill and you can pay it directly without having to send anything to the office
- You can apply online for Institute membership
- You can log in with your own password or use Facebook, Twitter or LinkedIn to log in.
- New members and students can apply online

Commentary: Best practice guidelines on preventing and responding to workplace bullying.

Dianne Gardner



Dianne Gardner, PhD, is a registered psychologist and senior lecturer in industrial/organisational psychology in the School of Psychology at Massey University in Auckland. She researches wellbeing and healthy work, in particular the positive and negative outcomes that can arise from work demands. She has published papers on research into work-life balance, coping, resilience, generational differences at work, the role of optimism, self-esteem and social support in work-related wellbeing and stress, emotional intelligence, the veterinary profession, learning from errors, and the effective management of hazards at work. She is particularly interested in researching effective solutions to the problem of workplace bullying.

Workplace bullying is known to be a problem in New Zealand and other countries. Recent New Zealand research has found relatively high rates, particularly in tourism, health, education and hospitality (Bentley, Catley, Cooper-Thomas, Gardner, O'Driscoll, & Trenberth, 2009). The release, by WorkSafe New Zealand and the Ministry of Business, Innovation and Employment, of the *Best Practice Guidelines on Preventing and Managing Bullying* is a positive step to help employers and employees address this problem. The Guidelines are for guidance and are not legislation, and they are free to use. They can be accessed online at <http://www.business.govt.nz/worksafe/information-guidance/all-guidance-items/bullying-guidelines/workplace-bullying>, with supporting information and links to online resources at <http://www.business.govt.nz/news-and-features/preventing-workplace-bullying>.

The Guidelines define bullying as “repeated and unreasonable behaviour directed towards a worker or group of workers that creates a risk to health and safety” (WorkSafe New Zealand, 2014, p. 6). The Guidelines clarify that bullying is not the same as setting high performance standards, providing constructive and legitimate feedback and advice, requiring reasonable work to be carried out, legitimate warnings or discipline, a single incident of unreasonable behaviour, or “reasonable management actions delivered in a reasonable way” (p. 11). A list of some behaviours which, if repeated, could be bullying is provided. Based on extensive research in New Zealand and overseas, this recognises that while one-off incidents can be harmful, it is the repeated, prolonged and often insidious nature of bullying that does harm,

and the harm can be severe. Bullying can be top-down, in which managers, supervisors or team leaders bully their subordinates; bottom-up, in which team members bully their supervisors; and lateral, in which bullying takes place among peers. All are harmful, as people targeted by bullies can experience poor self-esteem, more anxiety, stress, depression and burnout (Bentley et al., 2009). Effects can last for years and can affect witnesses as well as targets (Cooper-Thomas, Catley, Bentley, Gardner, O'Driscoll, & Trenberth, 2011). Bullying also affects organisational performance with reduced work performance and increased absenteeism and turnover as well as the costs directly associated with managing the bullying (Bentley et al., 2009).

Bullying is distinct from, but can overlap with, aggression, violence, discrimination and harassment, and different legal frameworks cover different forms of behaviour. New Zealand workplace health and safety legislation does not explicitly mention bullying although the Health and Safety in Employment Act requires that hazards be identified and managed, including hazards that arise from a person's behaviour. The Employment Relations Act 2000 and the Human Rights Act 1993 are also relevant, and cases have been brought for breach of contract, constructive dismissal and unjustified disadvantage (O'Brien & von Dadelszen, 2014). The aim of the new Guidelines is to help employers identify and manage bullying problems at work and to help employees recognise and deal with problems or find avenues for support and assistance where required.

The Guide contains a major section on “Advice to employees”, beginning with a flowchart to help readers

decide whether or not they are being bullied. A second flowchart outlines possible solutions for those who are being bullied, with an emphasis on starting with low key solutions and also identifying other possible solutions such as getting advice from experts, managers and Human Resources, laying a complaint or seeking mediation or legal recourse. There are examples of situations and solutions and the guidelines, wisely, emphasise targets' need for support, advice and self-care. Given how complicated bullying situations can be, and that it can take targets a long time to realise that they are in fact being bullied, this is useful material.

The following section is aimed at employers and managers and focuses on preventing bullying. Current research evidence indicates that the key to managing bullying requires proactive approaches which create cultures in which bullying behaviour is unlikely to flourish, and systems and procedures to deal with situations that do arise. Prevention hinges on effective leadership and a constructive organisational culture. Leadership which aims to address problems before they become entrenched is far more effective than leadership which is weak, helpless or uninterested (Strandmark & Hallberg, 2007), while leadership which is overly authoritarian, rule-based and inflexible can be seen as bullying and can create role models for bullying (Agervold & Mikkelsen, 2004). Excessive conflict and competition, whether or not in the name of achieving organisational goals, poorly managed organisational change, and job insecurity are known risk factors for workplace bullying (De Cuyper, Baillien, & De Witte, 2009; Sperry, 2009). The Guidelines emphasise leadership, good interpersonal relationships and a respectful work environment, aiming to create healthy workplace cultures and "to show what good looks like" (Frank Darby, WorkSafe NZ, personal communication).

The Guidelines clarify that bullying is not the same as setting high performance standards, providing constructive and legitimate feedback and advice, requiring reasonable work to be carried out, legitimate warnings or discipline, a single incident of unreasonable behaviour, or "reasonable management actions delivered in a reasonable way"

The Guidelines also aim to assist managers and employers who want to deal with bullying that is occurring in the workplace. There are suggestions about how to measure the extent of bullying at work; many measures are necessarily indirect as neither targets nor bullies may identify behaviour as bullying. There is an important section on

how to deal with reports of bullying. A flowchart outlines a set of processes and options for responding. More research is required to assess the contexts in which these options are likely to be most successful, so the Guidelines are not prescriptive but present a range of suggestions. There is also a section on roles and responsibilities and the ways in which employers and managers, line managers, human resources personnel, employees, health and safety representatives, contact persons and unions can contribute to preventing and managing bullying.

Included in the Guidelines are tools for preventing and managing bullying: a notification template, a sample bullying policy, a template for assessing the extent to which the workplace has the features of healthy work, an assessment of management competencies, and information on workplace features related to the effective prevention and management of bullying. Supporting the Guidelines throughout are case studies which range from straightforward examples of situations and solutions, to more complex cases with less clear outcomes. The cases provide some useful illustrations of key points.

Current research evidence indicates that the key to managing bullying requires proactive approaches which create cultures in which bullying behaviour is unlikely to flourish, and systems and procedures to deal with situations that do arise.

There is a set of online tools, accessible from <http://www.business.govt.nz/worksafe/tools-resources/bullying-prevention-tools>. These include questionnaires: "Am I being bullied" and "What can I do about being bullied?", the workplace assessment tool for workplace features that prevent and limit bullying, and flowcharts for employers on preventing workplace bullying and responding to an allegation. The online tools are a useful adjunct to the hard copy information. A particularly interesting tool which is likely to provide food for thought is a calculator for working out the costs of bullying. The stages of responding to an allegation, investigating it, responding and making improvements are considered in terms of the time commitments of those directly and indirectly involved, costs of remedies and experts, training and so on, with three sample case studies as examples: <http://www.business.govt.nz/worksafe/tools-resources/bullying-prevention-tools/calculator>.

As the Guideline has been only recently released, there is as yet no evaluation of the extent to which New Zealand business are implementing it, or of the effectiveness of implementation. This is a direction for future work as it

will be important to establish which aspects of preventing and responding to workplace bullying will have the most lasting effect on improving New Zealand workplaces.

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Abstract

Bi-cultural practice is of paramount importance for New Zealand-based practitioners. Over the next two editions of "Psychology Aotearoa" we will be exploring the role of bi-cultural practice in the delivery of psychological treatment within a New Zealand correctional setting. In Part I, we present an overview of the circumstances surrounding bi-cultural practice in the broader context of colonisation and correctional policy. We briefly review some of the literature which currently informs treatment approaches within prisons. We identify an over-reliance on quantitative research and a lack of studies of Māori men's lived experience of treatment regimes. In Part II we make a modest effort to address this lack by presenting a study of three Māori men who underwent the Special Treatment Unit – Rehabilitation Programme (STU-RP) in a New Zealand prison. Bi-cultural practice was of particular importance to these men. Amongst their many reflections, they explained how a specific bi-cultural therapy intervention played a prominent part in each of their treatment experiences, most notably in the development of a robust therapeutic alliance. We follow this up by drawing upon our collective encounters as Pākehā (New Zealand European and first generation European immigrants respectively) working in bi-cultural settings to outline some considerations which may assist other practitioners in reflecting upon and developing their own bi-cultural awareness.

Keywords: prison; rehabilitation; colonisation; bi-culturalism; Māori; qualitative.

Methods of social control and effective mechanisms for addressing transgressions of acceptable behaviour are fundamental to the welfare of communities and societies. For many centuries, tikanga prescribed what was right and proper in Aotearoa. The processes for addressing transgressions and restoring relationships were typically led by kaumatua and rangitira and involved mechanisms or tools such as whanaungatanga, whakapapa, whakama muru and utu (Ministry of Justice, 2001). Such structures, mechanisms and tools were in good health well into the nineteenth century, the arrival of sailors, whalers and settlers notwithstanding. However, despite the promises of Article II of Te Tiriti o Waitangi, the ability of hapū and iwi to maintain control over the processes needed to address transgressive behaviour was hugely undermined by the imposition of a British criminal justice system which reconceptualised transgressions as offences against the Crown, established an adversarial justice system and imposed an individual-

experiences of prison-based psychological rehabilitation - Part I

focused corrections regime. The imposition of a British-style justice system, along with other impacts of colonisation, has resulted in the incarceration of large numbers of Māori. The United Nations has expressed concern regarding Māori imprisonment rates, in particular, raising questions about the degree to which “conditions of detention respect the dignity of the person detained” (Human Rights Commission, 2003). Both ethical practice and the commitments made in Te Tiriti, mandate the provision of a culturally appropriate environment for Māori prisoners. Practitioners tasked with the provision of treatment are ethically-bound to promote wellbeing through the most effective treatment models and recognition of the Treaty of Waitangi (Code of Ethics Review Group, 2002).

The imposition of a British-style justice system, along with other impacts of colonisation, has resulted in the incarceration of large numbers of Māori.

Commentators, such as Jackson (1987), contend that the English common law system underpinning the New Zealand judiciary fails to acknowledge Māori rights and forms of social control (p.12). Jackson argues for the implementation of an indigenous justice system within New Zealand, one which is specifically designed to honour traditional Māori ideals of law, traditional ways of maintaining order, and tikanga-based ways of dealing with those who transgress. According to Jackson, whanau, hapū and iwi would play a

central role in such a system which would “see itself through the eyes of the community from which most of its defendants come” (p.44).

In their ongoing efforts to respond effectively to the cultural needs of Māori, the New Zealand Department of Corrections has developed the Framework for Reducing Māori Offending (FReMO) (McFarlane-Nathan, 1999). FReMO is a process-focused model which seeks to inform service provision so that it is best suited to support Māori cultural needs on a Department-wide level. It is described by its author as having been developed to “...guide the development of effective policy, interventions and research targeted at the reduction of Māori offending” (p.8).

FReMO, and its associated discourse, has inspired compelling academic reflection. Armon Tamatea has described FReMO as a critical first step in creating space for Māori appraisals of Department-run initiatives concerning Māori offenders. He noted, however, that the paucity of appropriately knowledgeable and mandated Māori consultants conversant in iwi (tribe) concerns, multi-level Departmental issues, and research processes limited the fidelity of the FReMO process (A. Tamatea, personal communication, June 26, 2013).

Supporting the need to appreciate cultural phenomena in the assessment and treatment of Māori offenders, Tamatea and Brown (2011) furthered McFarlane-Nathan’s (1996) original work by affirming how a lack of cultural understanding can present a substantial treatment barrier.

Tamatea and Brown recommended that therapists are best-served to recognise the importance of the treatment context and adjust their approach accordingly when working therapeutically with indigenous offenders and their whānau/fono (extended family). For example, they advocate the sharing of food and the inclusion of spiritual and musical content as conducive to the enhancement of therapeutic relationships in Pacifica settings.

Thanks largely to the humanistic schools, the psychotherapeutic literature openly acknowledges the value of interpersonal relations in the treatment delivery process. For example, commentators regularly discuss the significance of appropriately reflected empathy in building and sustaining rapport, and the importance of therapist-client interactions in achieving positive treatment outcomes (Miller & Rose, 2009). Less well-understood, however, are the benefits of cultural competence in therapeutic relationships. In conjunction with the views of Tamatea and Brown (2011), advocates of culturally-informed practice emphasise the need for therapists to continue developing their understanding of cultural factors (Dadlani & Scherer, 2009). Highlighting the relevance of socio-cultural identity (both therapist and client alike), Dadlani and Scherer draw upon the work of Hays (2008) in affirming the need for therapists to examine the relationship between their own and their client’s cultural identities (e.g. morals and values) particularly in regard to the possible effects of the two upon the client’s self-perceptions. Nevertheless,

Dadlani and Scherer suggest there is a dearth of literature regarding cultural self-assessment. They insist studies into cultural competency - and its impact upon patient engagement and therapeutic outcomes - are gravely overdue. To successfully develop cultural competence one must consider the context within which the culture is situated.

When examining prison-based cultural matters, it is important to acknowledge the long-established view that the prison environment itself harbours a distinct culture. Clemmer (1940) first suggested a series of distinct cultural features, which manifest exclusively within the prison environment and have a profound impact upon inmates' values, opinion and behaviours. Clemmer termed this "prisonization." The effects of prisonization are now recognised by many who operate in correctional settings. Consistent with this view, there is substantial international agreement (Cheliotis & Liebling, 2005; Jackson, 1988; Keith, 2006; Narey, 2001:7) that correctional systems have the potential to imbue and to manifest conditions of institutional racism.

In this regard, prisons could be thought of as a particular instance of the wider process of colonisation, as a result of which many Māori found themselves disempowered by feelings of prejudice and direct acts of discrimination including the loss of land and natural resources. Amongst the numerous consequences of colonisation, physical displacement and a loss of identity and social structure are likely to be amongst the most detrimental.

For Quince (2007), this phenomenon is exemplified in that archetype of disenfranchised urban Māori, Alan Duff's "Jake the Muss". Quince observes how, for many Māori, the

embittered, destructive anger of this character illustrates the loss of critical protective components of Māori identity: whakapapa (genealogy), whenua (land) or whānau (kinship) through the dispossession and alienation of colonisation.

Given the role of colonisation in disadvantaging Māori it is necessary to discuss some of the possible ramifications of this process openly within the penological literature.

As mentioned, Māori are overrepresented in the criminal justice system (Gilbert & Wilson, 2009; Tauri, nd; Wilson, Tamatea & Riley, 2007). It is also apparent that Māori detainees are at greater risk of developing mental health difficulties, including schizophrenia and obsessive compulsive disorder (OCD) (Simpson, Brinded, Farley, Laidlaw & Malcom, 2003) and suicidality whilst in a secure setting (Bridgman, & Dyal, 1996; Davey, 2000; Mason, Bennet & Ryan, 1988; Department of Justice, 1995; Simpson et al (2003); Skegg & Cox, 1993). Moreover, Māori are deemed more likely to recidivate at a higher rate than non-Māori (Gilbert & Wilson, 2009), thereby perpetuating the cycle.

The comparatively high rate of recidivism among Māori suggests that we should at least investigate the impact of favoured treatment modalities on Māori inmates. In many parts of the Western world, the dominant view is that cognitive behavioural therapy (CBT)-styled interventions are the most effective way of reducing re-offending (Friendship, Blud, Erikson, & Travers, 2002; Friendship, Blud, Erikson, Travers, Thornton, & Thornton, D, 2003; McGuire, 2002; Polaschek, Wilson, Townsend, & Daly, 2005; & Vaske, Galyean & Cullen, 2011). Numerous theories have been proposed to account for this; for

example, Ross and Fabino (1985) contend that an offender's cognitive impairments hamper his or her ability to establish an offence-free lifestyle by making them less able to formulate adaptive behavioural choices. Andrews and Bonta (2006) maintain that CBT is highly responsive to (capable of changing) those factors most proximally linked to recidivism (in particular antisocial cognitions, attitudes and beliefs).

In further support of the link between problematic cognitions, recidivism and therapeutic treatment, dialectical behavioural therapy (DBT), a version of CBT which emphasises a dialectical "here and now" approach to cognitive behavioural change (Shelton, Sampl, Kesten, Zhang & Trestman, 2009), has been shown to be effective in addressing treatment interfering behaviours such as emotional dysregulation and violent impulsivity in forensic samples (Evershed, Tennant, Boomer, Rees, Barkham & Watson, 2005; Nee & Farman, 2005). However, little is known about the efficacy of such approaches with Māori, although, numerous authors have raised several concerns about the impact of Eurocentric models of treatment (Lammers, 2011).

.... prisons could be thought of as a particular instance of the wider process of colonisation, as a result of which many Māori found themselves disempowered by feelings of prejudice and direct acts of discrimination including the loss of land and natural resources.

With the introduction of the FReMO protocol (McFarlane-Nathan, 1999), it is clear that the Department of Corrections recognises these concerns and is taking direct steps to address it. What is missing, however, are detailed, comprehensive understandings of the

experiences of Māori during periods of incarceration. A more nuanced, bi-culturally-orientated, spirit of inquiry into the interpersonal dynamics of criminogenic rehabilitation may assist in identifying possible limitations of current (CBT) approaches to the

Qualitative research into the experiences of Māori inmates offers a direct opportunity to inform the overall literature and to assist the Department of Corrections in honouring its commitment to bi-cultural practice.

rehabilitation of Māori offenders. In more general terms, it may further the discourse surrounding the bicultural enrichment of contemporary (New Zealand-based) CBT practices per se.

Today's political climate of accountability has fuelled a demand for outcome-focused, quantitative research. From the research discussed it is apparent that such studies are dominating the contemporary literature regarding rehabilitation within the criminal justice system. Whilst this approach adds empirical rigour to the field of criminogenic research, a substantial bias towards the quantitative is problematic. Many of the assumptions inherent in the quantitative approach pre-determine the definition and perceived meaning of fundamental discursive terms (for example "high-risk", "motivation" and "remorse" to cite but a few). As such, a heavy reliance on quantitative research may limit the overall depth of insight available to the criminogenic research community. Numerous commentators have acknowledged this point. Chwalisz, Shah and Hand (2008) observe "Qualitative research methods have much to contribute to theoretical and applied knowledge in

rehabilitation psychology. However, as a discipline, rehabilitation psychology has been behind the curve in employing qualitative methods" (p.387). Pattenau (2004) observed how research regarding correctional facilities is, for the most part, quantitative in nature. He noted that as a consequence of the methodological and epistemological paradigms underpinning it, research of this nature overlooks the "richness of meaning, depth of understanding, and flexibility that are the hallmarks of qualitative research" (p.70s). Pattenau further identified the need for prison-based research to be "pragmatic and policy-orientated" (p.70s) in order for it to be beneficial to practitioners. Drawing from Sabatier (1993), Pattenau suggested a methodological shift, emphasising the point that qualitative research is ideally suited to obtaining the subjective understanding inherent in policy-orientated learning.

Qualitative research into the experiences of Māori inmates offers a direct opportunity to inform the overall literature and to assist the Department of Corrections in honouring its commitment to bi-cultural practice. Moreover, the sort of subjective, policy-orientated learning inherent in this approach is consistent with the FReMO principles as it will aid in the development of cultural competence in research and as a corollary, inform the application of cultural safety in clinical practice.

Research of this nature provides insight into the "big questions" - the delicate processes, characteristics and interactions which occur during treatment. Qualitative analyses of offender rehabilitation programmes explore the intricate themes of offender treatment; themes which are critical in establishing a

holistic understanding of offender rehabilitation and, in the case of the New Zealand Department of Corrections, responding with sensitivity to the needs of Māori. Therefore, one may conclude, to neglect qualitative studies is to limit the overall credibility of penological research.

In our view, qualitative inquiry into the experiences of Māori offenders undergoing intensive rehabilitative treatment will broaden the discourse within the field of corrections. A deeper knowledge of the experiences of offenders undergoing treatment should advance both the implementation of treatment and the policies which govern it.

In Part II we present a study involving three Māori men who undertook an intensive criminogenic rehabilitation programme (STU-RP) in a New Zealand prison. The men's views highlight the importance of bi-cultural therapy in a correctional setting and provide insight into salient practice issues, including those interpersonal relations which are unique to the Māori worldview.

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Reviewed Article

Implementation of drug court programmes and possibilities in New Zealand

Gen Numaguchi



Dr. Gen Numaguchi is a Japanese American clinical psychologist who moved to New Zealand (Queenstown) 3 ½ years ago. He received his Ph.D. from the University of Utah. He is a trainer in motivational interviewing and specialises in the areas of depression/anxiety management, personality disorders, psychopharmacology, and effects of exercising in mental health wellbeing. He currently works for the adult team at Wakatipu Community Mental Health Team (Southern DHB) in Queenstown.

Abstract

Drug court programmes and other problem-solving courts have been in existence for over 20 years and have shown strong evidence for their effectiveness. These programmes are a multi-disciplined, well-structured, cost-effective means of dealing with various problems including substance abuse, drunk driving, family violence, and mental illness. The need for drug courts in New Zealand is explained along with different aspects of running the programmes including roles of the court systems, substance abuse treatment providers, law enforcement officers, attorneys, social service workers, mental health professionals, other relevant community agencies, and psychologists.

A drug court is a type of substance abuse treatment method which uses judicial court sessions to handle non-violent offenders with substance abuse/dependency issues. It is an alternative to incarceration and provides sustained, long-term treatment for those offenders to gain sobriety and become productive members of community.

Non-violent offenders who have committed alcohol and/or drug (AOD) or AOD-related crimes and have AOD issues are initially identified as candidates. Once a defendant enters a guilty plea, the defendant's attorney may request the judge to order an assessment to determine if the defendant is eligible for the drug court programme instead of incarceration. An eligibility screening process will be conducted by a drug court team member (i.e., substance abuse counsellor, psychologist). If the defendant is determined to be eligible, the drug court team will review the defendant's assessment and other eligibility requirements and decide whether the defendant is appropriate for the drug court programme. If the defendant is determined to be appropriate, the judge may order him or her to enter and complete the programme during sentencing.

Drug court programmes usually involve a minimum enrolment of 1 ½ years to 3 or 4 years, depending upon the recovery process of each individual. A participant is expected to be engaged in AOD treatment throughout the programme with higher intensity in the beginning (i.e., intensive outpatient programme, residential treatment) and then tapering off (i.e., aftercare group, weekly therapy). The participants attend court sessions on a weekly basis to "check-in" with the drug court team to review their progress and then as they advance further in their phases of the programme, the court attendance becomes less frequent.

The phase advancements are dependent upon the participant's length of sobriety, stability in employment, treatment group participation, and compliance with other requirements of the programme. If a participant continues to experience relapse, a higher level of AOD treatment will be considered. Each relapse, most often exhibited via positive urine analysis results, would lead to an immediate sanction of short-term incarceration (i.e., 24 to 48 hours in a jail cell). Failure to comply with drug court requirements will result in sanctions such as community service, jail and termination.

Once a participant successfully completes all requirements of the drug court programme, the judge may conditionally

discharge the remainder of the probationary period (in the case of a probation-referred participant) or dismiss the charges (in the case of diversion). In general, the basic goals of drug court programmes are to reduce recidivism for drug use or crime, to reduce substance abuse by the participants, and to rehabilitate the participants back into society as productive citizens.

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History and Data

Since the inception of the first drug court programme in Dade County, Florida, in 1989, there have been significant increases in implementation of drug court programmes in the United States as well as other countries throughout the world. As of 30/06/2012, there were 2,734 drug courts and 1,189 problem-solving courts other than drug courts operating in the United States alone (a total of 3,923) and many more developing worldwide including Australia, Canada, the United Kingdom, and New Zealand (National Drug Court Resource Centre, 2014). Within the United States, it has been estimated that over 116,300 people participate in drug courts at any given time, and over 22,584 participants successfully graduated from drug courts in 2008 with an average graduation rate of 57% (National Drug Court Institute, 2012). Ninety-six percent of U.S. states and territories reported that drug court capacity could be expanded; meaning that the primary factor limiting drug court expansion has been funding, not a lack of judicial or community interest (National Drug Court Institute, 2011).

Most research findings support the idea that drug court programmes are effective in terms of reducing substance abuse problems, cost to society, recidivism, drop-out rates, and incarcerations. For example, it is estimated that for every US\$1 spent on drug court, it resulted in an average of US\$2.21 in direct benefits back to the criminal justice system. Furthermore, for every US\$1 used towards “higher-risk drug offenders,” the average return was approximately US\$3.36 (National Drug Court Institute, 2011). Given the effectiveness of the programmes and cost-benefit nature, the US Federal funding towards drug court programmes have increased over 250% between 2008 to 2010, with over US\$243 million in 2009 alone (National Drug Court Institute, 2012).

Although “success rate” is difficult to define at times, the high retention rate, positive reports from participants themselves, and overwhelming support from communities

show that the drug court programmes have been quite successful over the years. As many studies have shown in the past, one of the best predictors for long term sobriety and recovery from substance abuse is the length of involvement in treatment; in other words, the longer time spent in treatment, the better the outcome. Participation in drug court programmes assures sustained enrolment, close monitoring, community involvement, consistency in treatment, and behavioural modification, which are all important aspects of successful recovery/rehabilitation programmes.

Problems with the System

A concept commonly known as “a revolving door” of the justice system exists not only in the United States but in New Zealand as well. This is where the offenders are incarcerated for short periods of time for their crimes related to AOD and while they are in jail or prison do not receive any form of counselling or rehabilitation. They are simply released back into society after “doing the time” and often times recommit more crimes due to their addiction. In fact, without treatment, that incarceration period actually works to increase cravings for substance rather than deter from it. The common societal perception/question is: “Why would they immediately go back to using when they just went to prison for that?” To an addict, it is more a matter of not knowing how to deal with everyday life without AOD and without some form of treatment, they will likely keep repeating the same behaviour over and over again.

In the current New Zealand judicial system, some offenders are required to enter AOD treatment subsequently or instead of incarceration. If they are placed under parole or probation, they are often restricted from use of AOD or frequenting any establishment serving alcohol. However, they do not actually test for AOD during that parole or probation period, which increases the likelihood of relapsing, continued use, and/or committing more AOD related crimes. Home detention is an alternative to incarceration and often accompanied by no consumption of AOD clause, although once again, there is no AOD testing to ensure compliance.

The idea behind Alcohol and Other Drug Treatment Courts (AODTC), a terminology used in New Zealand, is to change this revolving door process and provide more effective means of preventing reoccurrence of AOD use, criminal activities, and reducing cost to society in general. The New Zealand Police Annual Report from 2009 stated the following: “By 2011, we aim to have doubled the number of placements for prisoners in Drug Treatment

Unit programmes to 1,000 per year.” Certainly one way to ensure that placement into treatment and obtaining high retention rate is to have AODTC in place.

New Zealand Facts

Despite being a relatively small country (2013 consensus showed a population of approximately 4.2 million), New Zealand has its share of problems with alcohol and other illicit drugs. The most recent data collected by the Department of Corrections, the New Zealand Police, Operation Unite, Drug & Alcohol strategy (2009 to 2014), and the Ministry of Justice illustrate the severity. For example, seven tenths of offenders apprehended by police in 2007 were under the influence of drugs. Sixty-five percent of sentenced prisoners were identified as having ongoing drug or alcohol related problems. The cost of treating victims of crime is estimated at more than NZ\$400 million each year. The cost to society of harmful drug and alcohol use is estimated at NZ\$6.88 billion per year. Estimated annual cost is NZ\$1.1 billion for crimes due to alcohol and drug use including costs to victims, police resources, court related costs, and prison. The cost to the justice sector was NZ\$716 million with at least NZ\$172.2 million of those costs directly related to the police. Alcohol causes more than 1,000 deaths per year; half of which are due to chronic alcohol-related diseases and the other half due to injuries. Alcohol is a factor in 70,000 physical and sexual assaults a year.

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An announcement was made in October of 2011 regarding approval for AODTC pilot programmes to be run in Auckland. The pilot programmes are to be run for five years, using a pre-sentence model by way of “adjournment and deferral of sentencing.” They are designed to treat approximately 100 offenders a year with costs of NZ\$2 million annually. There are currently two courts running as pilot programmes in New Zealand: the Auckland District Court and the Waitakere District Court (AODT Court). They were launched on November 1st, 2012. Data as of 11th of October, 2013 showed: 193 defendants have been screened, 132 defendants have been referred, and 87 defendants have been accepted into the AODTC (Ministry of Justice). According to the same data source, as of 25th of October, 2013: 25 participants have dropped out of the AODT Court for one reason or another. First of the ongoing evaluations of the programmes is scheduled to be released in early 2014.

Implementation Ideas

The Drug Court Team (DCT):

“Using a non-adversarial approach,” as mentioned in the 10 Key Components of Drug Court (National Association of Drug Court Professionals, 2004), is important in that it is very easy to have a “split” among the DCT members (i.e., therapist, judge, prosecutor, probation officer, defence attorney, etc.) due to their previous knowledge and respective roles they have held with regard to a particular client. It is crucial that all decisions are made as a group and to clarify that fact to the drug court participants. The DCT should be seen as having a strong interdisciplinary team collaboration while each member maintaining their professional independence at the same time.

To avoid viewing each participant from their respective professional views, it is beneficial to have each DCT member gain good knowledge of each discipline’s role and the system as a whole. Having a good understanding of each other’s professional roles as well as their respective fields assures that the DCT is making informed “group decisions” with regard to the best interest of the client.

Another important aspect of a successful drug court programme is to have a 24/7 drug court tracker. A tracker is usually a police, probation, or another form of law enforcement officer who is assigned to “look after” every participant in a drug court programme. Despite financial difficulties many programmes often face, it is detrimental to the programme if there is no full-time tracker who can visit participants’ houses at any time of day, validate the participants’ whereabouts, enforce curfews, and even collect urine analysis (UA) samples at random. The problem with not having a full-time tracker is that the participants can quickly figure out when, where, and how they can “get away” with using or become involved in other non-compliant behaviours when not being watched.

Procedural:

Although many facets of the drug court programmes such as participation in treatment groups, obtaining employment, and attending court sessions are key components, it has been stressed time after time in drug court conferences and professional trainings that the most important and crucial element of a successful drug court programme lies in a consistent, frequent, and well-monitored AOD testing. Most, if not all, lab technicians and UA experts will testify that “unobserved UA is worthless.” Unfortunately, the nature of the disease of addiction often makes people deceitful. With that comes various ways of “cheating” or altering drug tests. A clear

guideline for testing procedures and consequences for all positive and altered UA tests must be in place and should be communicated clearly to the participants prior to joining the programme.

An exit interview with each graduating participant is another useful tool in improving the programmes. When no legal consequences are assured (and sometimes anonymity), some participants will often reveal the “loopholes” or “cracks in the system” while sharing their experiences of going through the drug court programme. This information is extremely useful in making improvements to the programmes because they come from insider perspectives that DCT members often do not see.

The consequences for any infraction should be immediate. Taken from basic behavioural psychology approach, a punishment should be given at a moderate level so that the participant is neither discouraged by excessive punishment nor undeterred by minimal punishment. If incarceration is required, it should be short-term and then upon release, the participants need to immediately resume their treatment mode. The sanctions for non-compliance must be consistent among all participants, and rewards (reinforcement) are just as important for increasing compliance and good behaviours.

Treatment:

The minimal requirement for any drug court programme should be for a participant to go through an Intensive Outpatient Programme (IOP). IOP is approximately 12 to 20 hours of outpatient group therapy weekly; often accompanied by additional weekly individual therapy sessions and 12-step meetings. IOP is normally 10 to 12 weeks long, although some may take longer to complete. More often

than not, the participants will have mental health issues along with AOD problems, making the cases difficult for straightforward AOD treatment. Therefore, psychologists are usually most appropriate for the role of ongoing individual therapy given their ability to deal with complicated issues and dual diagnoses cases.

Being involved in their own community is crucial in the recovery process for gaining positive social support as well as giving back to the community which they have hurt in some ways in the past, either through crime or losing trust of family and friends.

Following an IOP, all participants are enrolled into an aftercare group in addition to continued 12-step programme attendance. Aside from the substance abuse treatment, the participants should be required to hold stable employment or be involved in an educational programme throughout the duration of their involvement in the drug court. Being involved in their own community is crucial in the recovery process for gaining positive social support as well as giving back to the community which they have hurt in some ways in the past, either through crime or losing trust of family and friends.

Using successful participants as models, an alumni group will help assist current participants through mentorship and providing support as an “insider” person. The alumni group members also help minimize the toxic culture of “us against them” (DCT versus participants) by showing the benefits of going through the programme and giving a positive image to the entire recovery process.

Discussion

Just as there are over 3,000 drug

court programmes around the world, each programme is unique due to the nature of DCT members, participants, locations, and culture. A drug court programme is not an exact science, which means it has to adapt to the culture and needs of the population it is serving. Just like the participants themselves, the drug court programmes are constantly evolving and improving while making adjustments. While having the two pilot programmes going in Auckland is great news, it is only the beginning. As shown in data above, there are serious substance abuse problems in New Zealand and crimes related to them. Drug court programmes have shown over the years that they are capable of making huge differences in people’s lives and ending the “revolving door” process of the ineffective justice system in dealing with addiction issues. As with those in the United States, the different drug court programme staff should be encouraged to share knowledge, ideas, and information so that all programmes could benefit from gaining better understanding of how to be more effective. Implementing other drug court programmes in New Zealand should focus on success as well as failed “stories” from the Auckland programmes and change the culture of addiction treatment by showing the communities how the programmes can be run successfully.

While the Ministry of Health in New Zealand have approved the implementation of the two pilot AODTC programmes in the North Island (Auckland area), there have been no serious consideration or plan for having AODTC in the South Island of New Zealand. Although geographically isolated, there appear to be just as many problems with substance abuse per capita in the South Island as the North Island.

Given the need for long-term ongoing therapy, not only for substance abuse problems but also for underlying mental health issues, as well as continuous assessment and monitoring process involved in the drug court programme, psychologists are most suitable for being part of the drug court team. It is important to realise that the majority of drug court clients would have co-existing problems (CEP). Simply dealing with the AOD issues is never enough for successful recovery. The complexity of the cases requires a higher level of competencies in both AOD and mental health, which fits those of psychologists well. I would encourage fellow psychologists to not shy away from substance abuse areas and realise the importance of being CEP capable. Being part of a drug court programme would provide a wonderful opportunity to show the high level of competency in the field of psychology.

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ONE-DAY WORKSHOP:

Unravelling the mystery of addiction, substance use and associated compulsive behaviours: an integrated guide to formulation and treatment

Presented by Dr Matthew Berry

Christchurch 23 May, Auckland 31 October
Wellington 3 November



Matthew Berry is a clinical psychologist specialising in addiction as well as substance use and related compulsive appetitive behaviours including sexual behaviour, overeating, and compulsive use of electronic media /internet.

He is currently in providers

practice, providing consultancy, supervision and psychotherapy in Melbourne and nationwide. His career to date has primarily been in the alcohol and other drug sector, working in voluntary and forensic, private and public, community and residential settings.

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An Interview with Cynthia Spittal, Clinical Educator, Canterbury



Cynthia Spittal has 30 years of social work practice in clinical, managerial and academic roles. She graduated with a Social Work Honours Degree from Massey University in 1981. Cynthia regards her undergraduate training as providing a solid and valuable training for the varied roles she has held since then. In particular she wants to pay homage to Merv Hancock, Ian Shirley and Ephra Garrett as inspiring teachers and mentors.

You work for the Canterbury District Health Board – are you working in a specific area of mental health?

I'm employed as a clinical educator with the Specialist Mental Health Training Unit. This is a multi-disciplinary role. The position is 0.6 FTE, so from time to time I also do short term locum cover in clinical roles, particularly with our intake and triage service.

I hold particular portfolios to develop training: risk assessment and management (both violence to others and suicide), clinical supervision, family inclusive practice, and co-existing problems. I also assist with teaching interpersonal skills as part of our "communication, de-escalation and interpersonal skills" courses (CDIS).

Do you work as part of a multi-disciplinary team- which other professions are part of this team?

There are five of us directly employed by the Training Unit – a clinical manager/training coordinator, a registered nurse who shares my role (0.4fte), a 0.5 FTE social worker who is an educator for undergraduate social work, an administrator and a librarian. We share office space and liaise closely with nursing and social work staff covering nursing and allied health (social work and occupational therapy) new entry to specialist practice.

In developing and delivering training I work with a wide variety of other professions – including psychology, psychiatry, consumer and family advisors, Māori health workers (known locally as Pukenga Atawhai), physiotherapy, occupational therapy and dietetics. A consultant psychologist, Rob Green, has huge input to the interpersonal communication skills component of the CDIS course, utilising a mentalisation approach.

What are the aspects of multidisciplinary teamwork you find most challenging – and how could these be resolved/improved?

The most challenging aspect is the predominance of a bio-medical approach

to service delivery. I see this as being driven by a need to manage scarce resources and ensure only consumers with the most severe or enduring psychiatric illnesses access specialist mental health care. I am aware it is regarded as a particularly regional problem and some other DHBs have a broader psycho-social approach to intervention. In this DHB much of that work has been contracted to the NGO sector.

One of the issues facing occupational therapists and social workers has been the loss of occupational specific roles in favour of generic ones, and the consequent reduced capacity to deliver highly skilled occupational specific interventions to consumers. I am envious of my psychology colleagues who have been able to retain their focus.

Resolution lies with allied health staff demonstrating inspiring clinical leadership and taking the initiative to practice in ways which demonstrate the effectiveness of broader approaches. This becomes contagious.

What are the skills that are particularly important for you (and other social workers) to be successful in your role?

Firstly, the capacity for critical thinking and systemic approaches – whether at an organisational level, or in clinical practice. This is then reflected in the ability to work across systems to remove barriers to resources or promote change. The recognition that "the personal is political" is the cornerstone of social work practice. It means we can work with family 'politics' in the context of family interventions, agency 'politics' to help consumers access resources, and

organisational 'politics' where these interfere with effective service delivery.

What has helped you to gain the cultural competence you require for your role?

Participation in Te Reo classes, Treaty of Waitangi training, cross cultural training workshops and 'walking the talk'. I have past experience in helping to set up social services for refugee and migrant communities, cross cultural supervision and developing and delivering cross-cultural undergraduate teaching materials in human development. I learn from ongoing work which attempts to model cross cultural partnership and reinforces my practice in this area. An open, curious, and humble approach to diversity helps.

What do you consider to be the most important social justice issues to resolve to assist people with mental health issues?

1. A society which has a demonstrated and real commitment to minimise social and economic inequity. Where this is so deeply embedded in our psyche that to consider anything else would be anathema. From that, actions to reduce stigma, discrimination, poverty would logically follow.
2. Childhood abuse and neglect. I would want every child to have the opportunity for a strong, secure attachment, with a pro-social, caring adult. A society where each child experiences

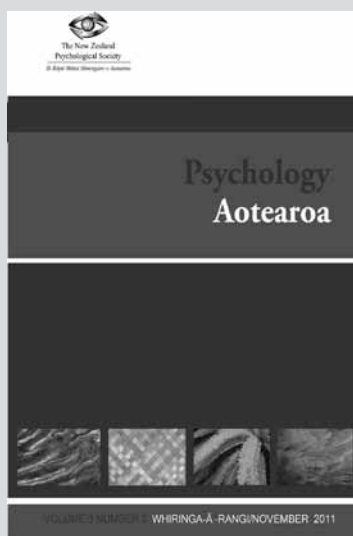
unconditional positive regard and the circumstances which foster resilience.

If you could change three things to improve the mental health of those living in Aotearoa –what would they be?

- Improved access to effective mental health treatment.
- A sense of community connectedness.
- For every person to have adequate nutrition, shelter, clothing and the capacity to participate fully in society. (A long time ago there was a Royal Commission on Social Policy)

Psychology Aotearoa- the next edition will be published mid-November

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We are interested in receiving items relating to (but not limited to)

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- Your research in progress/research outcomes
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- Celebrations
- Book/article reviews
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- Overseas issues

One on One - with NZPsS Member, Marc Wilson



Marc Wilson was invited as our 'one on one' contributor.

Associate Professor Marc Wilson is the Head of the School of Psychology at Victoria, where he has worked since completing his PhD in 1999. Originally trained in social and political psychology, his interests are broad and include research on national identity, prejudice, paranormal and religious beliefs, dietary behaviour and attitudes, and climate change. In 2011 he was awarded a significant grant by the Health Research Council of New Zealand, to research the development of non-suicidal self-injury among adolescents, and this is currently his primary research area. His teaching has been recognised with a VUW award for teaching excellence, and he is the only psychology teacher in New Zealand to receive the National Tertiary Teaching Excellence Award. He routinely provides psychological commentary to print, television and radio media, and writes a weekly psychology column for the *New Zealand Listener*.

One aspect of your role that you find really satisfying

Only one? The highlight of my year is always first-year teaching. Imagine (because you've been there) a sea of enthusiastic, yet-to-be-jaded faces in their first lecture ever. What a privilege – to seize that chance to pass on the things that made me want to carry on studying psychology. And even though I do it every year, it's always different because the class is different.

One event that changed the course of your career

Having children. Without them I certainly wouldn't have the 'career' I do now (career is in scare-marks because I don't really think of myself of having one – more like a fun hobby I get paid for). Up till then, my studies had been characterized by, ahem, being motivationally challenged (read 'lazy'). Suddenly I had twin daughters and study. No more time to muck about so I didn't, and my grades rocketed. Not that I'd recommend it for everyone.

One alternative career path you might have chosen

Until about age 9 I wanted to be an astronaut. I would love to write books, too. Fun ones that people actually choose to read.

One learning experience that made a big difference to you

I'm lucky to have had a lot of great learning experiences. One stand-out is being taught by a fellow called John Whitmore. John taught a course called 'Information and Control in Organisms' but it was really about cognitive science – artificial intelligence and what it means to have a 'mind'. No way did John do the work for us, but gave us the big

questions and a framework to explore them in – I loved it, and got the best grade I'd ever had, and from then on something to live up to. When I took his 3rd year course (the hardest one I ever took), he apologised at the end because he'd agonised over all of my assignments but couldn't give me better than the B+ my work deserved! I was blown away – I wasn't just a student ID number after all. I also remember meeting with him for an office hour after 9 pm at night in the psychophysics lab. Very weird.

One book that you think all psychologists should read

The Sneetches (Dr. Seuss) – it appears for all the world to be a story for kids, but it's really a case study in Realistic Group Conflict Theory. "Now, the Star-Belly Sneetches/ Had bellies with stars/ The Plain-Belly Sneetches/ Had none upon Thars." And it goes downhill from there. On a slightly more serious note, *The Spirit Level* – I defy you to read it and not see the problem! I also love Morton Hunt's *The Story of Psychology*, and if you're going to teach the classics I think you really should read them first-hand – Festinger's *When Prophecy Fails*, Milgram's *Obedience to Authority*, and Sherif's *The Robber's Cave Experiment*. Ah, the Golden Age of Psychology.

One challenge that you think psychology faces

Credibility as a research, teaching, and applied discipline. It's been a rough time recently for academic psychology researchers, with a few scandals over dodgy research practices. And there are more than enough critics happy to believe that our practice is pseudoscience. It undermines the success we have here in New

Zealand – psychology is identified by Government as one of the top five most productive, high quality, areas of research. In terms of teaching, a shade over twenty secondary schools teach NCEA psychology and until recently you couldn't get a Merit or an Excellence for it – and that means that there's less incentive for motivated kids to study psychology (even if they're interested). Even now, NCEA psychology credits count as generic second-class credits. And yet, for many young folk NCEA psychology might be the only science they study. In terms of practice, where do we start? We don't have enough people to fill the need, and in spite of the fact you need a minimum of six years of training to register as a psychologist, pay rates lag dramatically behind other disciplines with similar training times. AND students can't even get student allowance to study postgraduate psychology!

One thing that psychology has achieved

I think that psychology is the broadest field of human enquiry – it applies in any situation in which people are, or have been, involved. As a result, the work of psychologists and psychological researchers means we understand people better than ever before, and are able to make the world that little bit better. Yep, just as cheesy as I was worried that would be...

One aspiration for New Zealand psychology

I think we should get out more, and proselytize more about what great stuff we do. Yeah, that sometimes means talking to the media and being uncomfortable, but if we don't do it nobody will. Unless we do, the general public will continue to hold the wishy-washy stereotypes of psychology that they do - that psychologists are mainly relationship counsellors who want to

talk about your relationship with your mother!

One social justice issue psychology should focus on

Equality. If I were allowed to, I would describe myself first and foremost as a social psychologist, and working to understand prejudice and discrimination are the bread and butter of social psychology. How people think about equality is a truly potent predictor of their attitudes to most social and political issues. Marriage equality, the role of the state, improving prospects for minorities, civil rights, smacking, law and order... all (in part or strongly) founded on egalitarianism.

One big question

Why, if the consensus among experts is that our global climate is changing for the worse, do politicians and the general public not believe them? When I hear talks about climate change I want to go home and hug my children before it's too late!

One regret

That I don't have enough time to seize all the opportunities that come my way!

One proud moment

There's the everyday ones like looking at my family. In terms of work, my team recently got to see a concrete outcome of our work investigating adolescent self-injury – a graphic novel for young people focusing on help-seeking that grew out of a storyboarding group with secondary school students run by Emma-Jayne Brown, and illustrated by 'Bro Town' illustrator Ant Sang (thanks Ant!) It's not your typical 'academic output' and I love it for that.

One thing you would change about psychology

In our particular context I wish there were more opportunities for people to teach, research AND practice – I look to some of my colleagues in North America and they're like warrior monks whose research is informed by their ongoing therapeutic experience and vice versa. If I had my way we'd have split appointments across psychological services and universities that could benefit all parties.

One piece of advice for aspiring psychologists

Pay attention in your research methods and statistic classes! I know you didn't sign up for them specifically – you care about psychology right, but psychology in all its forms is an evidence-based practice, and these are the tools people like me (and one day you) use to provide that evidence-base. That, and have fun – Unless you're like me, one day you're going to have to get a real job.

Media database

We have established a database with Members we can contact to comment on psychology issues when the media makes contact with the Society and require subject experts. If you are not on our database, but would like to be added, we will send you the questionnaire to complete. Please contact Heike: pd@psychology.org.nz



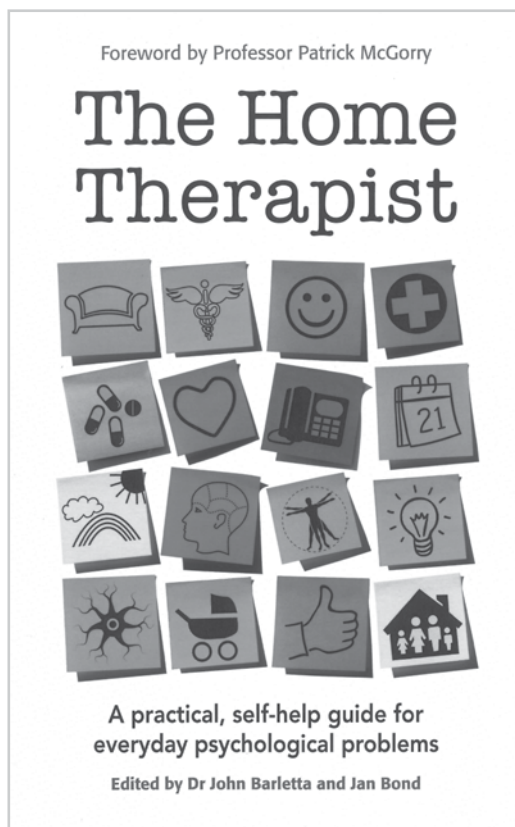
We have six book reviews this time around, and they are a real mixed bag although most have a clinical orientation. If you are interested in reviewing a book but don't have anything specific in mind, just a general area of interest, please let me know because we are receiving more unsolicited book from publishers than we have in the past. Alternatively, if you are interested in reviewing a specific book we may be able to source a review copy for you.

Once again we are grateful to Footprint Books in Australia who provide most of the books that we review (www.footprint.com.au)

John Fitzgerald- Review Editor
office@psychology.org.nz

The Home Therapist: A practical, self-help guide for everyday psychological problems.

Reviewed by John Fitzgerald, The Psychology Centre, Hamilton



This book attracted my attention because it is edited by two mental health practitioners from Queensland who have done a terrific job in securing the services of nearly 100

professional colleagues to write brief guidance notes on an impressive array of psychological issues. The book is aimed at the self-help market and is presented as a primer for the family when dealing with difficult psychological situations. Each of the 138 topics is allocated little more than 1,000 words with a brief to educate, provide tips for preliminary action, and support therapeutic interventions -- no mean feat in such restricted space. Of course, the individual topic authors manage these various challenges with variable success, but given the disparate topics it is impressive that some challenges were accepted at all.

The text is divided into 14 chapters, each of which covers between 5-14 topics. The chapters focus on areas such as personal wellbeing, family and parenting Issues, aging, sexuality, addiction, education and careers. There is a single chapter covering abuse, neglect, violence, bullying and crime (nine topics). Within each chapter the topics are similarly wide ranging, for example, the chapter on stress and

time management includes topics associated with physical and cognitive relaxation, general stress management, anger, avoiding road rage, overcoming procrastination. I was grateful to be reminded about some of the tips provided under this last topic, for example, re-establish a clear focus on the task, prioritize, face one's fear of failure, refer to personal values, and communicate. I expect this will be the response of many to this book, they knew the tips already but found it useful to be reminded about them.

I found the chapter on grief and loss issues particularly interesting. Again the range of topics is broad, but it includes some difficult areas such as suicide and death of a child, alongside some which are less obvious such as loss of a pet, loss of employment, dealing with a relationship breakup. I thought all the authors who wrote for this section displayed empathy and a gentle touch. I can imagine a person who is looking for a quick word of encouragement or advice finding something useful in this chapter. Indeed, I didn't really come across any 'dud' topics in the whole book. There are no references to follow up on, no suggestions for further reading, no detailed programmes to follow, but this is not the purpose of the book. It is a primer, the first step and in that it does a reasonable job.

This text is unlikely to be enough for anyone who makes more extensive use of self-help material, and it is unlikely that a practitioner would give it as suggested reading to a client in support of therapy, it is just too brief. However, it is likely to be more reliable and consistent than advice sourced from the internet and may be something that a lay person (whatever that is) would make occasional use of ... a bit like that book we all own which give 138 household uses for vinegar. And for all you psychologists out there I should mention that the longest topic write-up in this book is the one on work-life balance ... you need this book!

The Home Therapist: A practical, self-help guide for everyday psychological problems.

John Barletta and Jan Bond (2012)

Pbk 9781921513916, Aus\$54.95

(Review book provided by Australian Academic Press www.aapbooks.com)

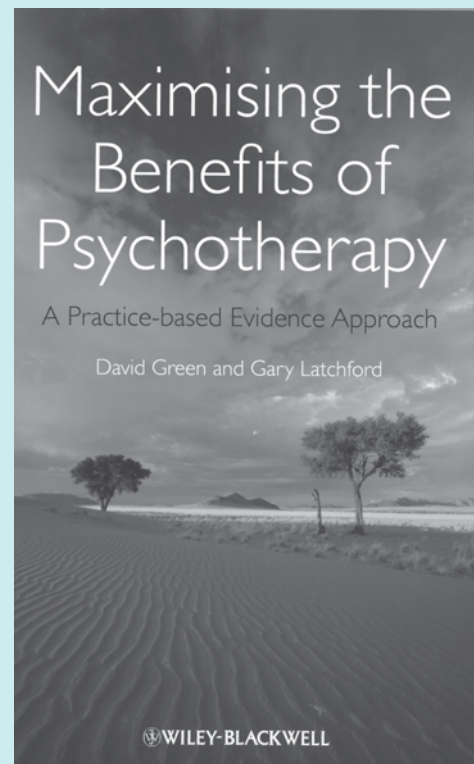
Maximising the Benefits of Psychotherapy: A Practice-based Evidence Approach

Reviewed by Joshua Myers, The Psychology Centre, Hamilton

Written primarily for the practicing clinical psychologist, David Green and Gary Latchford have written a book that might also appeal to students, supervisors or anyone interested in the current state of understanding outcomes in psychotherapy. *Maximising the Benefits of Psychotherapy: A Practice-based Evidence Approach* applies an informed, reasoned and logical approach to practice-based evidence without falling into the trap of becoming dry and cumbersome. In fact, the style of writing and tendency to quickly cut to the heart of the substantive issues makes this an engaging read. Likewise, the tone is inclusive and accepting of varying theoretical points of view leading to an evaluative, but non-judgemental approach to considering this sometimes controversial topic.

The authors attempt to deflate the issue of controversy on the topic of outcome by describing the existing literature on the equivalence of existing therapies and readily move to discussions of common factors in psychotherapeutic change and the existing evidence on “what works” in psychotherapy. They go on to challenge the reader to consider how outcome is assessed, focussing on the evidence for and against various assessment approaches. The heart of the book focuses on the value and utilization of the therapeutic relationship and the importance of process variables in building this vital alliance. They advocate for a collaborative and evidence-based approach to client interaction that is flexible and informed by client perspectives, which they often recommend to directly elicit. Refreshing are sections (including chapter 8, “Ideas in Action”) devoted to specific application and case examples of the assessment measures, techniques and approaches discussed throughout the book. In this way the practicality and accessibility of this book make it noteworthy.

These authors don't claim to have all the answers and have not attempted to write an exhaustive review of the literature on the topic of measuring and enhancing therapy outcomes. What they have done is efficiently draw attention to the core issues on these topics in an accessible and thought provoking manner. What this book lacks in depth it more than makes up for by pointing to the most relevant current literature on psychotherapy outcome and offers a jumping off point for those interested in greater exploration of this topic. Green and Latchford are certainly proponents of effortful practice for therapists at any stage of their career and make an excellent case for committing to such an approach for professional growth and enhanced client benefit. This book's strength is that it challenges the reader to consider how to assess



the process and product of psychotherapy in a way that is evidence-based, yet remains sensitive to client needs and outcomes.

Maximising the Benefits of Psychotherapy: A Practice-based Evidence Approach

David Green & Gary Latchford (2012)

Chichester, UK: Wiley-Blackwell

Pbk 978-0-470-68315-6, \$55.05 (from Kenny's Bookshop via www.librarian.com)

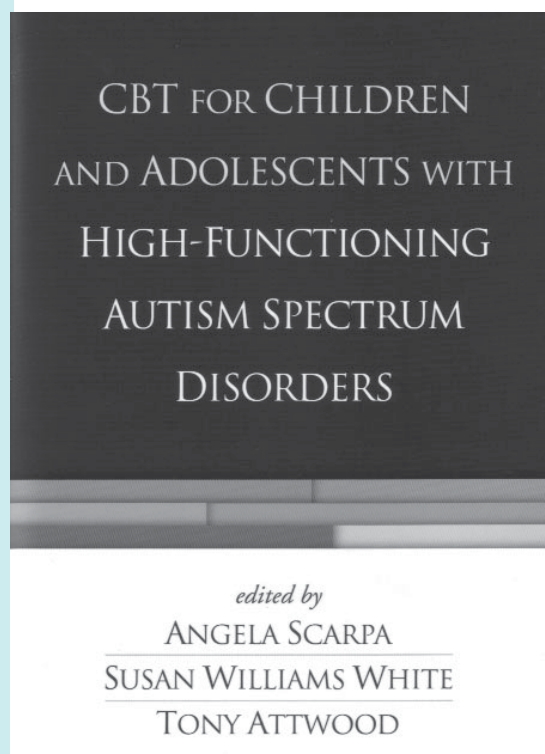
CBT for Children and Adolescents with High-Functioning Autism Spectrum Disorders.

Joint review by Tanya Breen (Clinical Psychologist) and Aimee Harris (Behavioural Psychologist), Hamilton

Although cognitive behaviour therapy (CBT) is a well-established treatment for many psychological issues, in the area of autism spectrum disorder (ASD) it is under researched. This book presents ASD specific CBT research for people aged five to 18 years (without an intellectual disability), and supplements it with expert clinical opinion. Many of the chapters are written by leading researchers and clinicians in the ASD field, and areas for further research are included.

The first section provides a succinct, informative and helpful history of CBT. Whilst probably not needed by experienced clinicians, new clinicians will find it useful and it is a good reminder. The section also covers the characteristics of people with ASD, which can impact of engagement in therapeutic sessions, understanding, participation and progress. The suggestions on how to modify CBT to more appropriately suit children and young people with ASD will be of great value to many practitioners. The modifications described are creative, sensible, and easily accommodated into therapeutic sessions (e. g., using visuals, involving parents, hands on activities, games to increase buy in and learning, rewards for therapeutic gains, and use of workbooks). Much of the advice given would also be suitable for practitioners working with adults with ASD.

The assessment and treatment planning information is informative, identifying well-established and emerging assessment tools. Obviously thorough assessment is crucial to good treatment planning and delivery, but the assessment battery described might be impractical given the constraints many of us work under. Noteworthy is the related discussion on how to differentiate between symptoms of ASD and symptoms of other mental health conditions, which provides valuable information for all clinicians who become involved in the "Is this mental health or ASD?" debate.



The next two sections address anxiety, behavioural problems and social problems, and, to a lesser extent, anger management and improving the identification of feelings. All are common areas of issue for people with ASD. A number of CBT programmes are mentioned or described including coping cat, facing your fears, multimodal anxiety and social skills intervention, and the secret agent society. The chapters follow a similar format, giving readers a good background into each, and the principles guiding each intervention. Therapeutic stages and techniques are described, along with relevant research, future directions, and limitations. This format allows the reader to compare the various approaches and programmes, but

there is some replication of information. The interest of the reader is maintained by the different approaches of the various authors.

Most interventions discussed are 'multimodal', incorporating individual work with group work, and/or work with parents/caregivers. The detail of information provided on some interventions would be close to replicable, while others, although still very helpful, require purchase of the programme itself. Many of the interventions have session times of up to 90 minutes, adjustable according to individual ability. All of the interventions described are exciting and useful to the CBT practitioner, and aspects of each noted intervention could be drawn upon in practice. The book fulfills its purpose in providing an overview of the latest and most promising interventions for practitioners.

Most clinicians do not work in laboratory or research settings, and opportunities for group work can be limited. Accordingly, not all of the interventions described in this book are easily transferable to everyday practice, and whilst not the purpose of the book, it would be wonderful to have a section addressing the constraints on time, resources, and group participants faced by practitioners.

The book also addresses sexuality, love and affection, an important area for people with ASD, but one traditionally lacking in information. Early research suggests that the interventions covered have clinical value. First described is an intervention designed to help young people with ASD to understand and express affection, along with the standardised measures of affection that were developed to measure the changes. This includes a useful breakdown of session content. Then attention is paid to an intervention increasing the understanding of relationships and sexuality in individuals with ASD. This intervention was found to improve sexual judgment and knowledge and reduce a number of problem behaviours of young people with ASD.

The final section contains concluding remarks, and provides a summary of the book.

Overall, the book was an easy, enjoyable, informative read. As well as serving its purpose of informing readers of the latest developments in the area, it provides many exciting, creative, and motivating ideas and examples for practitioners to use in their everyday practice. Complete with references, *CBT for Children and Adolescents with High-Functioning Autism Spectrum Disorders* would be a worthwhile

A Primer for ICD-10-CM users: Psychological and behavioural conditions.

Reviewed by John Fitzgerald, The Psychology Centre, Hamilton

This is an interesting little book, but one that unfortunately has limited direct applicability to health practitioners working in New Zealand. The small format (less than A5) spiral bound text is nicely presented and easy to use as a reference text, which is partially what it is intended to be as over half the pages contain a list of all the ICD-10-CM codes for mental, behavioural, and neurodevelopmental disorders. These are the F-codes taken from the clinical modification of Chapter 5 of the World Health Organisation's International Classification of Diseases – 10th Edition (ICD-10-CM). It would have been much more useful if the listing of codes had also included a brief description of the 'disorder', however, as the ICD is available free on-line there seems little value in simply reprinting it here.

For the uninitiated the ICD-10 was first published in 1990 and the final version came into use in 1994, this replaced the ICD-9 which was in use between 1979-1994. One of the attractions of the ICD system is that it allows for modifications and enhancements to be made so that 'local' needs and practices can be incorporated into the classification system. The clinical modification (CM) is one such variation with the first iteration being developed in America as a variation to the ICD-9. Initially used for research and reporting purposes, use of the ICD-9-CM expanded to reporting health service delivery data for reimbursement purposes in 1983. When the ICD-10 was released American authorities decided that the changes were not sufficient to justify the effort/cost of developing a clinical modification so they continued use of the ICD-9-CM, putting them out-of-step with most other countries in the world. At the present time the final technical work on the ICD-11 is being completed and a draft has been available for public comment since mid-2012. The official approval and release is expected sometime in 2017. Within this

CBT for Children and Adolescents with High-Functioning Autism Spectrum Disorders.

Edited by A. Scarpa, S. Williams-White & T. Attwood (2013)

NY: Guilford

Hbk 9781462510481, NZ\$58.00

context America authorities decided that the ICD-9-CM is no longer adequate and they have developed the ICD-10-CM, which is due for implementation at the end of 2014.

The potted history provided above is covered in greater detail in Goodheart's book, and it makes interesting reading. The underlying fact remains that in 2014 the American health care system will implement the ICD-10-CM, 20 years later than other countries and only two years before the rest of the world implements the ICD-11. So, here we have the rationale for this book – it will be of great use to American health care providers; and the reason for its limited applicability to New Zealand health care providers – because it outlines a soon-to-be obsolete system.

Two other points are relevant here. First, if the anticipated version changes between ICD-10 and ICD-11 were minor then this text could be more relevant, however the changes are likely to be very substantial. The second point is that New Zealand health care system also currently makes use of a modified version of the ICD-10, but not the CM. The modification we use is the ICD-10-AM (Australian Modification), although we currently use a different edition from that used in Australia, interesting but very confusing.

If the list of codes which fill more than half this book is not entirely applicable in New Zealand, and will soon become obsolete, why would anyone in New Zealand want to read this book? The main reasons that I can see is that it is a well written introduction to the ICD system, including a good general outline of what to expect in ICD-11, prepared by a psychologist for a psychology audience. The first 65 pages cover a range of topics concerning the historical development of the ICD system and disorder diagnosis/classification in general. There is a nice section on the strengths/limitations of diagnosis and the role of diagnostic formulation. The final section is on the development of the ICD-11 and it is interesting to read this in light of the aspirations and reality of the development and release of the DSM-5. The author cites sources outlining the goals of the ICD-11 as including the incorporation of scientific advancements, provision of a system which can contribute to the better management of disease, improvements in diagnostic utility, and ensuring better integration and compatibility with alternate systems. For anyone who followed the gestation and birth of DSM-5 these will be familiar. However, the differences in implementation outlined in this book seem many and varied. While the reader may be left a little sceptical until the final product is available this text provides some cause for optimism about the ICD-11.

If it was possible to obtain the first half of this book without the list of codes it would be a winner. If you get a chance to read the first 65 pages, and they are easy reading, it would be well worth the investment of time. However, there are likely to be many opportunities to explore the ICD-11 when it is released and can be downloaded free from the WHO website (<http://www.who.int/classifications/icd/revision/en/>), and that may be the better option.

A PRIMER FOR ICD-10-CM USERS

PSYCHOLOGICAL AND BEHAVIORAL CONDITIONS

A Primer for ICD-10-CM users:
Psychological and behavioural
conditions.

Carol D. Goodheart (2014)

Washington, DC: American
Psychological Association

Pbk 9781433817090, NZ\$37.35

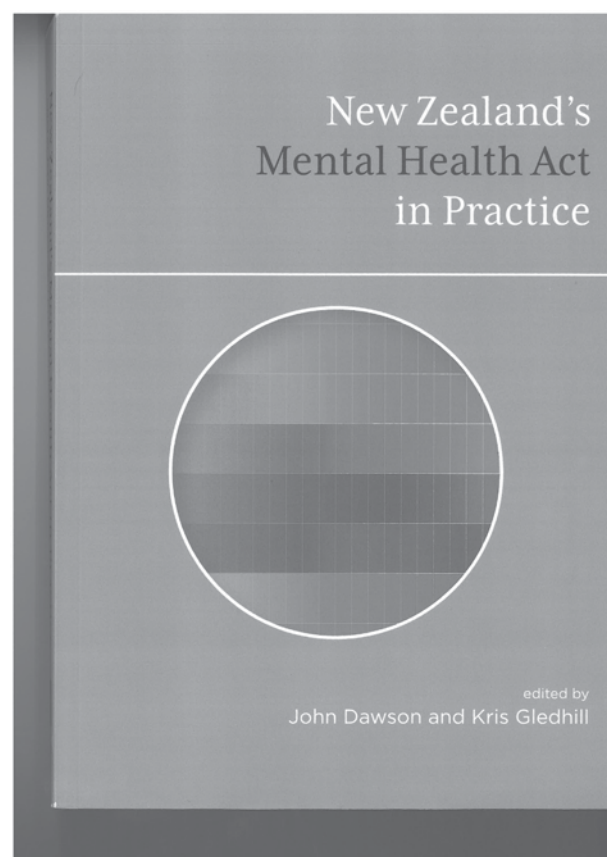
New Zealand's Mental Health Act in Practice.
Reviewed by John Thorburn, Clinical Psychologist, Whitianga

This well-organized and competent book arrived on my doorstep just before Christmas, a time more suited to novels, magazines, lounging and barbecues. It laid waiting, flaunting its title as every novel and magazine read unexpectedly included occasional content about 'madness' and mental health law, past and present. Mental health, mental disorder, disability, capacity, culpability, autonomy, human rights and many more related terms are consistently in use in daily life, formally and informally. The use of compulsion in mental health is relatively high in New Zealand compared to other similar countries and as professional psychologists I believe it is important to stay abreast of current writings and developments which affect our knowledge and our clients' understanding of mental health and disability legislation. *New Zealand's Mental Health Act in Practice*, published now at the time the Mental Health Act (1992) ('the Act') has turned 21 years old, does an excellent job with reviewing progress, discussing strengths and weakness, and debating possible changes of this and other relevant related Acts.

Professor John Dawson and Kris Gledhill (University of Otago and University of Auckland respectively) have drawn a range of authors from various professions which results in different styles in presenting information and enhances the reading experience. Five main parts cover: criteria for compulsion; review procedures; treatment without consent; cultural and human rights; and collateral legislation, all within the space of 21 chapters of similar, well-digestible length.

This book can be read from cover to cover (probably over some time), or by looking at specific parts or chapters. Some chapters are a 'must read', especially for those who are regularly involved with clients on orders under the Act. For example, part one, chapter one begins with an in-depth discussion of 'mental disorder', highlighting challenges and how through legal interpretations the term has developed meaning in the New Zealand context. It then proceeds with five more chapters related to issues about compulsion including the on-going difficulties with working with those with 'personality disorders'. These are excellent chapters which discuss risk and capacity and will assist any reader with further developing their views on these two important issues.

The chapters in part two help the reader understand many of the different roles people have within the administration of the Act. It was good to read a substantive presentation about the Mental Health Review Tribunal followed by an



excellent chapter analysing Tribunal findings and discussing the potential for reforms. Within part two is also an excellent chapter about 'regulating the detention of mentally incapacitated adults not subject to the Mental Health Act'. By this stage in the book the reader is aware of a recurring theme about the place of a person's capacity in this and other related acts. Capacity remains a theme in the third part which discusses treatment without consent. Firstly there is a discussion of the role of the responsible clinician with further chapters addressing procedural justice principles, rights to refuse, further discussion about capacity and lastly the inconsistent processes across District Health Boards.

Part five addresses cultural and human rights beginning with 'Māori and the Mental Health Act' which discusses Māori experience of the Act in a number of ways including the legislation itself, community treatment orders, mental disorder from a Māori perspective and cultural considerations around capacity. There is a very useful reference list with this chapter which ends with helpful conclusions about future steps. The next chapter (15) provides an excellent service user perspective with many observations and the challenges are well discussed. The increasing use of the Act is highlighted and questions whether complacency has crept in with its use. This

chapter also highlights other national and international laws and conventions which, though raised in previous chapters, are somehow brought together here in a way which is very powerful.

Collateral legislation is addressed in part six and chapters address the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIPA), the Protection of Personal and Property Rights Act 1988 (PPPR), the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCRA) and finally the Alcoholism and Drug Addiction Act 1966 (ADAA). Each chapter provides a good summary and discussion of the relevant Acts and their interaction with the Mental Health Act (1992) and its revisions and interpretations. The debate highlights shortfalls and deficiencies and leads to strong recommendations being made for reviews and, for the ADAA, suggestions for the proposed new Bill currently being formulated.

Overall I found this book was a good read and I greatly respect the content. It presented and discussed the legislation and its impact on people well and provided me with new information to think about. The chapter referencing and reference lists were extensive though due to author styles was presented in differing formats, one of a few points which did not aid reading. The content was largely 'adult' focused, with some good discussion of implications for older people (particularly in relation to the PPPR) however I would have liked to have seen at least some discussion about the Act with regard to children and young persons. Whether cover to cover, specific parts or chapters, this is an ideal reference book for understanding the present state of the Act. Don't be afraid to pick up this book and browse. If you work in mental health I recommend many chapters as "must read". If you are interested in the rights of people, have a browse and read at least some chapters. Students will find many chapters helpful in developing an understanding about the complexities of mental health legislation while at the same time getting to know the Act.

In brief summary, maybe not a Christmas, on-the-beach read, however a very good book to have at hand for professional information and staying personally informed about human rights and mental health legislation.

New Zealand's Mental Health Act in Practice.

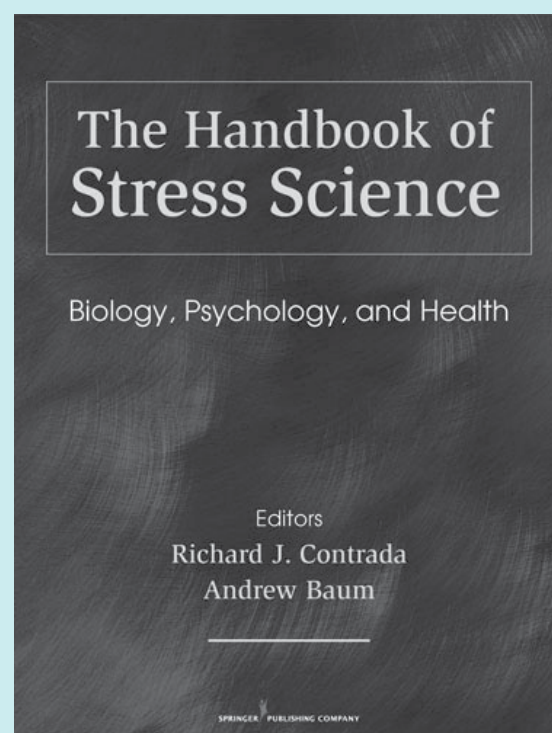
Edited by John Dawson and Kris Gledhill (2013)

Wellington: Victoria University Press

Pbk 9780864739049, NZ\$50.00

The Handbook of Stress Science: Biology, Psychology, and Health

Reviewed by Iris Fontanilla, Health Psychologist for the New Zealand Heart/Lung Transplant & Cardiovascular Services, Auckland District Health Board; Honorary Clinical Lecturer, Department of Psychological Medicine, Faculty of Medical and Health Sciences, University of Auckland; Chair of the Institute of Health Psychology, NZPsS and Executive member of the NZPsS



Please do not be overwhelmed by the size of this *Handbook*! Although, I cannot blame you if you felt daunted by the prospect of reading such a noteworthy tome on stress in the first instance.

The editors are leading health psychologists in their own right and have skilfully compiled the work of other international experts who are also interested in stress and the biopsychosocial interactions with health and the pathogenesis of many diseases states. Whilst I think Contrada and Baum's *Handbook* would be of most interest to health psychologists; psychology students, academics, researchers, and clinicians from other psychology disciplines will find it as a useful resource to their collection.

The *Handbook* is divided into five logical sections and within each section are relevant chapters written by specialists who provide a balanced account of theory and

empirical data in this burgeoning field of inquiry.

Section I provides a thorough overview of the main biological systems and structures that are concerned with the stress response especially the contribution of psychoneuroimmunology and advancements in molecular genetics. Section II focuses on the importance of the social context with chapters ranging from the importance of social affiliation in response to a stressful event to the complex associations linking social support, stress, and health. This section also gives rise to chapters addressing the psychophysiology of stress in the workplace, and stressors such as racism and socio-economic status. Section III covers psychological factors related to stress. Chapters range from the role of cognitive appraisal and emotions to coping. The latter chapters focus on stress and coping that are fundamental to understanding psychological stress along with the role of individual differences, gender, and other personality factors. Section IV is by far the longest but in my mind the most riveting section covering 15 chapters! At this juncture, you may think that I may have truly lost the plot but I kid you not the chapters embedded are noteworthy to the scientist-practitioners in all of us. These chapters review empirical research that links the role of acute and chronic stress to health related behaviours (e.g., eating and substance use) to mental (e.g., depression, PTSD) and physical health outcomes. Indeed, the successive chapters explore the growing evidence that stress directly affects autonomic, neuroendocrine, and biological processes and indirectly through health behaviours such as eating and substance use and misuse. It is also pleasing to see that the latter chapters explore the impact of psychosocial factors across the lifespan from pregnancy to the etiopathogenesis of chronic conditions such as coronary artery disease, cancer, or diabetes. This section ends with two chapters highlighting the range of psychological interventions to manage the deleterious impact of stress and other psychosocial stressors amongst a number of physical health conditions. Cognitive behavioural stress management programmes, problem solving, therapy, biofeedback and relaxation training, and self-management training are some of the interventions evaluated in this section. Finally, the last section will be of great interest to seasoned clinicians and to fledgling researchers alike. Chapters in this section describe seminal laboratory research, cardiovascular and neuroendocrine measures and innovations in neuroimaging research in relation to stress science. Strategies to develop qualitative (e.g., self-report inventory) and quantitative research are also discussed.

There is certainly no shortage of information in this *Handbook* which is enhanced by an outstanding reference list. Rest assured that your persistence in reading the relevant sections in this book is well worth it as this is one of the most comprehensive publications in stress science to date.

The Handbook of Stress Science: Biology, Psychology, and Health

Edited by Richard Contrada and Andrew Baum (2011)

New York: Springer Publishing Company

Pbk 9780826114716



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Editorial



Kathryn Jenner
Student Forum Editor

Welcome to the first issue of the *Psychology Aotearoa Student Forum* for 2014! The first thing I need to do as incoming Student Forum editor is to farewell and thank the outgoing editor, Rosalind Case, who has done such a wonderful job of editing this forum for the last two years. Rosalind has now graduated and has moved on to a career that I'm sure will lead her to great things.

By way of introduction about myself, I am a Master of Science student at Massey University, with an endorsement in health psychology. I'm often asked "what" health psychology is – as a new field it is constantly explaining itself! I often find it easiest to explain this by saying what health psychology is not. We've become accustomed to the biomedical view that our health is solely medical and can be explained by physical symptomology, but increasingly evidence shows that psychological, behavioural and cultural factors have a tremendous impact on health, from the process of becoming ill, to being ill, and to how we understand ourselves through all of this. Health does not exist in a vacuum and is

inextricably linked to context. Health psychology is also concerned with the reduction of inequalities in health and for this reason you'll often find graduates in health promotion roles, working actively to reduce the current inequalities in healthcare and status of New Zealanders. As critical health psychologists we are not satisfied with quantitative data that tells us facts about health of individuals and communities, we want to know how this occurs and what the experience is of the individual and how that is associated with the environment around them. I could talk about health psychology all day but hopefully that suffices as an overview for this new and exciting field.

That said, when you are in the throes of your own research, it can be difficult to recall that as a broad field, psychology is huge. There are so many facets to it and so many fascinating studies going on in our universities! That's why it's such an honour to present the three researchers I have here, all from different areas of New Zealand and different areas of psychology. These articles are particularly special as they are all written by students who won prizes at the NZPsS Conference in 2013. Inga Forman and Amy Montagu from Massey University were the joint winners of the Institute of Clinical Psychology Best Student Conference Paper prize, with their article entitled, 'Help yourself to CBT: Low Intensity CBT Interventions Targeting Low Mood in Adults.' Gemma Tricklebank, a PhD candidate at Auckland University won a Best Student Conference Paper prize for her preliminary findings, entitled *Māori Women's Experiences of Mental Health Services in New Zealand: A Qualitative Interview Study*. Finally, last but certainly not least, Jill Hayhurst, a PhD candidate from the

University of Otago won the Best Student Conference Poster prize for her work entitled 'Civic engagement and wellbeing in New Zealand youth'. I thoroughly enjoyed reading each of these papers and I am quite sure you will as well.

As this issue goes to print, registrations will shortly be opening for attendance at the 2014 NZPsS conference in Nelson. I really encourage you all to attend, this is such a fantastic opportunity to hear about new research findings and to really connect with others in our field and build valuable networks and progress your career. The conference is from 29 August – 1 September and information can be found at: <http://www.psychology.org.nz/conf14>. I hope to see you there!

Kathryn Jenner

kathrynajenner@gmail.com

‘Help yourself to CBT’ low intensity CBT interventions targeting low mood in adults

Inga Forman, Amy Montagu, Mei Williams and Beverly Haarhoff



Inga and Amy are both in their final year of the Doctor of Clinical Psychology (DClinPsyc) programme at Massey University. Inga is completing her internship at the Department of Corrections and Amy is completing her internship at the Centre for Psychology. This research has been presented at the AnzaCBT 2012 conference and the NZPsS conference 2013.

Depression is estimated to affect up to 1 in 6 New Zealanders (Ministry of Health, 2009). Due to an increase in prevalence of the disorder, there is in turn increased pressure on service providers to deal with the growing number of individuals needing therapeutic services. Traditional treatment approaches for depression such as cognitive behavioural therapy (CBT), although effective, are time consuming and costly processes, with the recommended number of sessions required to treat depression in many cases being between 12 and 20 sessions (Williams & Martinez, 2008).

Low intensity methods of CBT (e.g. self-help programmes) are a relatively new area of interest in the area of psychological treatment. The focus of such approaches is on using the minimum level of intervention to create maximum gain. They aim to increase people's access to evidence based methods of therapy whilst removing many of the major issues associated with traditional treatment methods, such as long waiting lists, financial limitations, and inaccessibility to many in the wider community.

Guided self-help is one such low intensity intervention which involves, in addition to a self-help component, monitoring and guidance from a trained facilitator who takes the role of an encouraging and supportive figure. The proviso of guided self-help is that it is a self-administered intervention with the facilitator simply being there to introduce materials, monitor progress, and review outcomes.

There is some indication by researchers that early rapid response may occur in low intensity CBT paradigms and this research sought to further explore this.

The use of self-help in the early treatment of mild to moderate depression has been endorsed by much of the research. Significant improvements have been noted across outcome measures for self-help paradigms compared to control groups (Williams and Whitfield, 2001). These results have been observed across a range of patient populations and for a number of different mental health issues, such as depression, anxiety, and bulimia nervosa. Results suggest that such brief approaches to treatment may offer results akin to standard treatment approaches. Such approaches have been successfully implemented through Ministry of Health initiatives in the UK, and Canada with great success.

This paper is based on the experience of running two guided self-help programmes. Two studies were run concurrently and participants were able to choose whether they wanted to be involved in an 8 week group programme (Living Life to the Full), or a 6 week individual self-help programme (Overcoming Depression and Low Mood). Within the individual programme, participants were also able to choose the mode of support, either face to face or telephone option. Both programmes were developed by Dr Chris Williams of Glasgow University.

A total of 48 people applied to take part in the programmes. Of the 48 people,

38 started in one of the programmes, with 26 people completing; 13 in the group programme and 13 in the individual programme. The studies investigated both the statistical *and* clinical significance of outcomes in an effort to capture the individual variability of treatment outcome.

For the group programme six of the 13 (46.2%) participants showed reliable and clinically significant changes in depression at programme termination.

Traditional outcome research has typically focused on aggregated outcomes and *statistical* significance over more practice-focused research. Practice-focused research methods allow for results to be readily applied in the clinical settings for which they are intended (Blampied, 2001; Lambert, 2013). In traditional outcome research there is often little information regarding variability of responses both within individuals, and between different individuals (Jacobson & Truax, 1991). Statistical significance fails to address the issue of whether the intervention resulted in any change for the client in terms of their functioning and everyday life, which is the focus of *clinical* significance. The treatment outcomes of interest for the studies were depression, psychological distress and quality of life. Analysis of individual change trajectories exploring common change patterns that are well established in the CBT literature, such as early rapid response to treatment, were also investigated. There is some indication by researchers that early rapid response may occur in low intensity CBT paradigms and this research sought to further explore this.

For the individual programme six of the seven (85.7%) participants in the

face to face condition, and four of the six (66.6%) participants in the telephone condition showed reliable and clinically significant change in depression at programme termination (as measured by the PHQ-9). Six of the 13 participants across both individual conditions experienced improvements in depression by week three of the programme, which can be defined as early rapid response. Four of these participants achieved reliable and clinically significant change by the end of the programme. For the group programme six of the 13 (46.2%) participants showed reliable and clinically significant changes in depression at programme termination. These same six participants were also noted to have experienced reliable improvement in depression by week four of the programme, which again can be defined as early rapid response. Follow up of treatment gains and the results of participants who did not complete the programmes are also being investigated currently.

Low intensity CBT self-help has been shown to significantly improve outcome measures for depressive symptoms.

The majority of participants across both guided self-help programmes reported that they were satisfied with the service they had received, that their needs had been met, and that they would recommend the programme to others.

Low intensity CBT self-help has been shown to significantly improve outcome measures for depressive symptoms. The results of these two studies support this as a viable method of intervention which warrants further exploration in a New Zealand context.

For further information please

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Māori women's experiences of mental health services in New Zealand: A qualitative interview study

Gemma Tricklebank

[Supervised by Kerry Gibson, Erana Cooper (Ngāpuhi, Ngāti Hine), and Virginia Braun]



Kia ora, my name is Gemma Tricklebank and I whakapapa back to Tainui, Ngāti Maniapoto and Ngāti Mahuta. I am 26 and currently studying a Doctor of Clinical Psychology at the University of Auckland. My research, Māori women's experiences of mental health services in New Zealand, is an amalgamation of my

identity and passions in clinical psychology, and more broadly in mental health. I hope that my research, when finished, can both recommend and improve service provisions for Māori women using mental health services in New Zealand.

Abstract

The statistics for Māori women in mental health, although improving, still highlight imbalances in engagement and outcomes. This research is being completed as part of a Doctor of Clinical Psychology degree and as yet is unfinished; however, preliminary findings will be presented. Qualitative interviews were conducted with 12 adult Māori women, asking a series of open-ended questions about their experiences of engaging as a mental health service-user in New Zealand in the past 3 years. Thematic analysis identified four broad areas focused around engagement or non-engagement in services, positive experiences within services, negative experiences within services, and recommendations made by participants that could improve future experiences for Māori women. Two preliminary themes will be discussed in this article; mental health services as allies and friends (or not), and bridging the gap between the outside and the inside.

Introduction

The statistics for Māori women in mental health, although improving, still highlight bleak imbalances. Māori women are twice as likely to have a diagnosable mental disorder compared to their non-Māori counterparts, and exhibit a greater severity of symptoms at presentation

(Bushnell, 2005). Depression rates are higher in Māori, and particularly higher in Māori women compared to non-Māori women; despite this, Māori are also less likely to be prescribed anti-depressant medication, suggesting that Māori are being diagnosed, but not treated pharmacologically for depression (Tapsell & Mellsop, 2007). In general, anxiety, depression and substance abuse disorders are also higher in Māori than non-Māori (Bushnell, 2005). Given the over-representation of Māori as mental health service-users, and the under-representation of Māori as mental health professionals, I, as a Māori woman, but also as a clinical psychologist in training, am invested in working towards improving experiences for Māori in general, and with this research in particular, Māori women, in New Zealand's mental health services.

My research aims to investigate and understand the current varied experiences of Māori women, as users of mental health services in New Zealand. Specifically, I will aim to identify the positive, negative (and neutral) experiences of Māori women's mental health service use in New Zealand, and the ways Māori women experience culturally appropriate and inappropriate service delivery. My research aims to explore what might count as more culturally-appropriate mental health services for Māori women in New Zealand, and build on women's experiences to develop relevant recommendations for policy and practice. Previous research traditionally has seldom considered the perspectives and experiences of disempowered groups, and my research seeks to gain a rich and nuanced understanding of the experiences of Māori women using mental health services. It is hoped that my investigation into their experiences may provide or confirm information on changes needed to improve mental health service provision for Māori women in New Zealand.

Methods

This research is a qualitative interview study of Māori women who have had previous experiences using mental health services. It is qualitative research informed by feminist/critical gender, Kaupapa Māori, and service-user perspectives. Qualitative interviews were chosen for their ability to gather rich and detailed experiences from participants in an active interaction between researcher and participant (Fontana & Frey, 2000).

The 12 participants were adult Māori women with (a)

previous experience(s) as a service-user in mental health services in New Zealand in past 3 years with 'service-user' being largely self-defined (participants ranged from having serious long term involvement in mental health services, to seeing a counsellor or therapist for a short period of time for a minor issue). Participants were also excluded according to the following additional criteria: primary alcohol and substance abuse (mental health had to be the primary service) and people who were currently psychotic or distressed. The emphasis was also on past experiences, so although some participants were still healing from current experiences, or had long term involvement with mental health services over their lifetime, they were only talking about the experiences from the past which they were now no longer distressed about, and could look back on retrospectively as a 'completed' experience.

It is hoped that my investigation into their experiences may provide or confirm information on changes needed to improve mental health service provision for Māori women in New Zealand.

This study uses a qualitative, semi-structured interview design. Each interview was planned to take between one and one and a half hours to complete, however some lasted for over two hours, and others lasted only forty-five minutes.

The method of analysis used is thematic analysis, as outlined by Braun and Clarke (2006). A general inductive approach has been used (Thomas, 2006), and an inductive form of thematic analysis, grounded in the details of the data, has been used to build a story of participants' responses from the ground up. There has been

no attempt to interpret the data, via a particular theory or framework. The data have been used from their raw form to build a unique understanding (Braun & Clarke, 2006). In this way, themes do not 'emerge', but are, in a sense, created, identified, or chosen by the researcher, and shaped by who I am and where I come from as an active participant in doing the research (Braun & Clarke, 2006).

In short, qualitative research was, in its essence, both practically and theoretically suited to my study. Its suitability for rich and detailed data, sensitive topics and vulnerable groups; its acknowledgement of the constraints of reality and objectivity; and its openness to reflexivity mean that I can do my research, and participants, justice.

Results

The data were first experienced in the interview, live, and audio-recorded at the time. They were then transcribed verbatim, checked, read, and re-read several times. Initial codes were generated under four broad areas: 1) ways mental health is dealt with outside of services, for example, within whanau, 2) positive/culturally safe experiences, 3) negative/culturally unsafe experiences, and 4) recommendations for the future. Identified themes will be refined over multiple analyses of the data. With each stage of analysis, the themes will be refined and reviewed further. As the themes are currently preliminary, they will likely be further refined at the completion of this research. Nevertheless, two preliminary themes are discussed below in their current state.

Theme: Mental Health services as allies and friends (or not)

The first preliminary theme identified is the idea that mental health services have the potential to be positioned as

'allies' and 'friends' to service users, and that this would be beneficial in terms of engagement, treatment, and outcomes. Being treated like a friend by mental health services meant that participants engaged with ease and wanted to return to the service. In a psychological sense, staff who were visibly unassuming, non-judgemental, did not "push it" or think the participants were "crazy", utilised normalisation, empathy, validation and collaborative processes, were greatly appreciated. Services that were clearly tailored to the needs of the participants were highly praised. In a more practical sense, accessibility, easy of transport, and practical support helped to strengthen this relationship. When mental health services were experienced as friendly, familiar, and welcoming, participants' experiences were more positive.

Participants spoke positively of having someone present who was a friend or ally (particularly during engagement or assessment), whether it was a friend or whanau member accompanying them, or simply the presence of another Māori person. One participant shared a story in which she was feeling apprehensive in the service, but immediately felt better when she came across a Māori woman who was employed in the same building, even though she was not a staff member of that particular service and would have nothing to do with the participant's involvement in the service. Just knowing that somebody who was potentially an ally was in proximity, and experiencing some familiarity in a new place, eased the participant's fear.

When mental health services were not experienced as 'allies' or 'friends', or "on your side" as one participant phrased it, participants felt alienated, and often acutely aware of the cultural isolation they were experiencing. One participant expressed her thoughts

when first engaging in home visits:

"And, ah, I sort of like the idea of them coming but oh, I thought wow, ah, how come there's no Māori people here? Um, not, that's not to say that they're misplaced or anything but, um, then the second one came was a woman and I thought I could open up to her more. But yeah, in, in the recent one [...] that to me is, ah, seems to be, has got no cultural, ah, you know, support. They need to have some brown, browning up, some brown people." P06

This participant acknowledges that having being matched with another woman allowed her to "open up to her more", but this was not enough to instil a sense that 'someone like me' was available and willing to provide a service. Because of this, she shied away from support being offered to her. Remarkably, another participant was able to create the feeling of having an ally present, even when alone:

"I didn't have my aunty, but we went to a meeting [...] and I got this thing that I should take, I mean I've got like this big folder that has all our whakapapa and family korero in it, and I just got this thing that I should take that with me, and I just sat there with it on my lap. And it was kind of like that's what it felt like it was, it felt like a way of having them with me (laugh), almost like a bridge. No, not so much a bridge but a barrier between me and the doctor." P07

In an unfamiliar situation, she was able to hold her whanau, in a physical form, close to her, in the place of her aunty who could not attend the assessment. This served not only to keep her company and feel she had some strength with her in the room, it also served to protect her, as a whanau member might advocate on her behalf if they had been present.

Given the importance of having an ally present, and the difference this can make in experiences for service-users, increasing Māori presence in the mental health workforce should be given high priority, along with a strong encouragement of friends or whanau members attending engagements or assessments with service-users. If Māori women can have an ally within mental health services (a member of staff) and/or an ally which they can bring with them (a friend or whanau member), engagement can be greatly improved and the experience is much more pleasant for service-users. To improve experiences for Māori women, a change in the relationship between services and service-users, and treating our clients as we would treat our own family and friends, should be prioritised. This, of course, will not be easy, given that professionalism must remain intact as we become more humanistic, but will be

exceedingly rewarding for professionals and service-users alike.

To improve experiences for Māori women, a change in the relationship between services and service-users, and treating our clients as we would treat our own family and friends, should be prioritised.

Theme: Bridging the gap between the outside and the inside

The second preliminary theme identified is the notion that there is a 'gap' between the world outside of mental health services, and the world inside mental health services. Participants expressed negative experiences when this 'gap' was not bridged appropriately. This 'gap' appeared in many different forms. A disconnect between mental health services and other support services was expressed, meaning that participants often had to juggle a number of services, or had to negotiate between whanau support and mental health services as separate entities. They also expressed a 'gap' between Māori and non-Māori values and beliefs, for example, participants were surprised at not being asked about their religion or spirituality, or being given advice that was culturally incompatible with their way of living. Overwhelmingly, participants talked about the 'gap' between whanau involvement in their life, and whanau involvement in their mental health treatment; whanau were not often involved with services, but participants expressed that they would have liked them to be, and although this 'gap' was sometimes partially bridged, it felt strange, such as when talking about whanau with professionals, but without whanau present in the room.

One of the most common ways this 'gap' was expressed was in terms of whanau being missing or removed from the engagement, treatment, and outcomes in mental health services. One participant expressed her concern at the service seeming unwilling or afraid to engage her whanau:

"I just didn't think that there was enough. I, I just don't think that they were strong enough to call a meeting with the whole family." P05

This participant expressed her sense that involving her whanau was simply 'too hard' for the service to do, despite it being of utmost importance to the participant and her recovery. Below, another participant shared her experience, which was otherwise helpful; she was actively discouraged from affiliating with a particular whanau member, a recommendation which was culturally impossible for the

participant to carry out, even if she had wanted to:

"And it was really helpful, but the only thing that I found wasn't helpful, and maybe it's because I had a Pākehā counsellor, was the thing she said to me, maybe you shouldn't have anything to do with your sister. Like, what? She said, for the sake of your own emotional state. And I just remember saying to her, I can't." P02

For this participant the suggestion was jarring, but the counsellor's unawareness was also surprising, particularly given the fact they had spent several sessions talking about the importance of family previous to this suggestion being made. In this case the participant also experienced ongoing pressure to follow through on this suggestion, despite making it clear that estranging herself from her sister was not an option. This gap between values meant that the participant was left alone to formulate her own, culturally possible, solution. She was wanting the counsellor to meet her halfway to 'bridge the gap', and formulate together on something that would be do-able for the participant. Ideally, the counsellor would have already been aware of why this suggestion was not appropriate and would not have continued to 'push it' after it was expressed.

To bridge these gaps, services need to be co-ordinated seamlessly for service-users; part of this process would also be to weave whanau (as they are so often the primary 'service' helping service-users) more tightly into the process. This would also address the current perceived lack of invitation for whanau involvement (as an aside, given that participants overwhelmingly made use of their whanau as a 'service' in itself, a legitimacy needs to be lent to the value of whanau support in mental health). If service-users can experience the

world inside mental health services as being similar, relatable, and connected to the world outside, their engagement and experiences will be more positive. This, of course, also relates to the first preliminary theme; if friends and whanau are allowed into the world of mental health services, and more Māori health professionals or non-Māori professionals who 'get it' are visible and present, the gap can be bridged, and experiences can be more positive.

They also expressed a 'gap' between Māori and non-Māori values and beliefs, for example, participants were surprised at not being asked about their religion or spirituality...

Conclusions

Every time I present my initial findings, or write about them, I realise, to some listeners and readers, they may seem like common sense. However, common sense as they may seem, these practices need to be more visible to service-users, more consistent across and within services, and positioned and recognised as legitimate practice at an institutional level. This will not only empower service-users to feel entitled to an appropriate service (and therefore potentially increase their engagement and positive experiences, and improve outcomes), but allow those professionals who are already delivering appropriate services in this vein to do so with conviction and confidence. For those who are already supportive of or practicing culturally appropriate and culturally safe Māori mental health treatment, I hope that my initial findings encourage you to continue walking this path. I also hope that at completion of this research, I will be able to provide clear and detailed outlines for a more culturally appropriate service provision for Māori women in mental health.

Perhaps the most exciting thing about these suggestions for improvement is that implementing these recommendations into practice will have benefits for all service-users, not just Māori women. When I consider many of these recommendations (invitations to be accompanied by friends and family; non-judgemental, empathetic, genuine, and validating health professionals; engaging with professionals and services who are warm, friendly, familiar, and share the same values; being offered agency and choice in my treatment) I cannot help but think: *Who wouldn't want this offered if they began to engage with mental health services?* Being a Māori woman myself, my preferences are obviously biased, but I believe as we move towards a more humanistic approach as a broad mental health profession, we will also move towards providing a more culturally safe and culturally appropriate mental health service for Māori, and in regards to this research, Māori women.

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Civic engagement and wellbeing in New Zealand youth: Initial report

Jill Hayhurst



Jill Hayhurst is a PhD candidate in social psychology at the University of Otago, where she is exploring the links between youth wellbeing and civic engagement. Jill's current research goal is to elucidate what makes people engaged citizens, in the hopes that we can create resilient and thriving individuals and communities. Her other research interests include generosity in schools and encouraging resilience and self-esteem through youth development programmes. She has co-authored eight articles and three book chapters, and has presented at conferences both nationally and overseas. Jill has been the recipient of numerous scholarships and awards, and she has recently been shortlisted for the Society of Australasian Social Psychologists Outstanding Postgraduate Research Award.

Introduction

Evidence suggests that civic engagement is declining in Aotearoa New Zealand, especially among young New Zealanders (Catt, 2005; Vowles, 2004). Low levels of engagement have caught the attention of researchers, educators, and policy-makers as values and behaviours tend to solidify in adolescence – if a young person fails to vote when they first become eligible, they are less likely to vote in future elections. The International Civics and Citizenship Study reports that compared to other countries, New Zealand students “show relatively modest levels of engagement with social and political issues” (Bolstad, 2012, p. 33). This trend has implications for democracy as well as for young people's capacity to address the “unprecedented challenges facing society” (Cogan & Derricott, 2000, p. 6; see also Wood, 2011).

Psychology research adds to these concerns. Many argue that today's youth experience more risk and stress than in the past, as rates of depression, suicidality and child poverty continue to rise (Goldstein & Brooks, 2005; Hayhurst, Hunter, Kafka, & Boyes, 2013). In light of compelling international research on generosity and happiness, (see Aknin et al., 2013; Aknin, Dunn, & Norton, 2013) and on contribution and positive youth development (Bowers et al., 2010; Keyes, 2013), we suggest that when youth are less civically engaged, they may also be less resilient.

The present study aims to explore the civic intentions, behaviours, and values of New Zealand adolescents and emerging adults, and the relationship between civic engagement and wellbeing. We will also examine the differences between highly engaged and less engaged young people in terms of wellbeing, behaviour and values. We predict that the people involved in ReGeneration – a national changemaker network – will have higher levels of civic engagement and wellbeing compared to other groups, but that these psychosocial factors will be strongly linked for all participants. The goal of our wider study is to elucidate ways to encourage wellbeing and citizenship in young people, regardless of their background, and in turn promote a healthy population and society.

Methods

Participants. Six hundred and eighty-two people (396 female, 284 male, 2 transgender) took part in this study. Two hundred and fifty-three people were in the experimental group (hereafter referred to as ReGeneration), and 429 were in control groups (secondary students, tertiary students, and people involved in other youth development events). The age range was 16-32, with a mean age for both control and experimental groups being just under 20 years. Most participants identified as Pākehā/New Zealand European (43%), followed by Māori (10%), Pasifika (7%), and Asian (7%). Every decile was represented in our secondary school sample.

ReGeneration. ReGeneration is a national network of changemakers that works with youth who want to create positive change locally and globally. ReGeneration events focus on issues that are important to participants (e.g. climate change and global poverty), as well as skills that are useful in enabling solutions (e.g. leadership, communication and creative storytelling). A key aim of ReGeneration is to connect people to people and people to place.

Procedure. Participants completed two surveys: one at the start of their event or school year (T1), and one either at the end of their event or a week following their first survey (T2). Due to time restraints not all participants completed full surveys. Surveys included a series of wellbeing and civic engagement scales (Flanagan, Syversten, & Stout, 2007; Keyes, 2013; Zaff, Boyd, Li, Lerner, & Lerner, 2010). For the purpose of this report only T1 findings will be explored.

The present study aims to explore the civic intentions, behaviours, and values of New Zealand adolescents and emerging adults, and the relationship between civic engagement and wellbeing.

Aims and hypotheses. We aim to examine the civic intentions, behaviours and beliefs of young people, and the key differences between the ReGeneration and control groups. We predict that: 1) the ReGeneration group will have higher levels of civic engagement and wellbeing; and 2) wellbeing and civic engagement will be strongly linked for all participants.

Results

Wellbeing. The majority of participants reported high levels of social, emotional, and psychological wellbeing. Most participants felt happy, interested in life, and satisfied with life either almost every day or every day (66%), while few participants felt happy, interested in life, or satisfied once a week or less (11%). ReGeneration participants were more likely to report often feeling emotionally, socially, and psychologically well compared to control participants. Control participants were more likely to report rarely or never feeling emotionally,

socially, and psychologically well.

Civics Behaviours. Civics behaviours were measured by asking questions about future intentions and past civic acts. ReGeneration participants were more likely to agree or strongly agree that they would vote (67%) and volunteer (63%) in the future compared to controls. Less than half of control participants had strong civic intentions. The most popular civic activities for ReGeneration participants included being a tutor (54%), being a leader in an organisation (31%), volunteering (28%), being a mentor or peer advisor (28%), and working to make their town or city a better place (25%). The most popular civic activities for control participants were helping out at a school (19%) and helping a neighbour (14%). Control participants were more likely to help out at a church, synagogue, or place of worship than ReGeneration participants (7% vs. 4%).

Citizenship values and beliefs. More ReGeneration participants were likely to agree or strongly agree to statements addressing participatory citizenship and justice orientation compared to control participants. The majority of ReGeneration participants (83%) agreed or strongly agreed that by working with others in the community they could help make things better. Half of the control group agreed or strongly agreed that they think it is important to challenge inequalities in society.

Differences between groups.

Independent-samples t-tests were performed to compare the wellbeing and civic engagement scores between the ReGeneration and control groups. As expected, there was a significant difference for all variables. Specifically, ReGeneration participants reported higher levels of emotional, social, and psychological wellbeing compared to

controls. ReGeneration participants were more likely to expect to vote and volunteer in the future and to have participated in civic activities in the past. Likewise, ReGeneration participants reported higher levels of participatory citizenship and social justice.

Links between civic engagement and wellbeing.

The relationship between total wellbeing and civic engagement (intentions, participation and beliefs) was investigated using a Pearson product-moment correlation coefficient. Civic engagement and wellbeing were strongly related for both groups. None of the differences between correlation coefficients were statistically significant. Further analysis revealed that civic intentions, behaviours, and beliefs were significantly correlated to each subscale of wellbeing - emotional, psychological and social.

Only 55% of all participants thought they would vote regularly in future elections.

Discussion

The present report examined civic engagement and wellbeing in a national group of changemakers compared to other young people, and the links between wellbeing and civic engagement in both groups. As predicted, the ReGeneration group had higher levels of wellbeing, intentions to engage, civic behaviours, and sense of commitment to participatory citizenship and social justice values. The most popular civic activities for the ReGeneration group (e.g. being a tutor or a leader) were different to the most popular activities of the control group (e.g. helping a neighbour or at a school). Only 55% of all participants thought they would vote regularly in future elections. If we generalise from these findings, we can

expect youth voter turnout to remain low unless this issue is addressed.

Despite differences, wellbeing and civic engagement were strongly linked for both groups. This finding highlights the importance of civic behaviours and beliefs for wellbeing. It also raises the question of whether civic engagement and wellbeing create a positive feedback loop like that suggested in Aknin and colleagues' (2012) experiment on generosity and happiness. A positive feedback loop may explain the higher levels of engagement and wellbeing in the ReGeneration group, while allowing for the strong link found between factors for both groups.

However other factors may have mediated these findings: education, school climate, parent engagement, SES, ethnicity, sex and age are all important predictors of civic engagement (see Flanagan et al., 2007). Future analysis will explore these in depth. We will also examine the role that other civic variables, such as generosity, social trust, and community belonging, play in engagement and wellbeing levels. Zaff and colleagues (2010) argue that civic behaviours are not enough, but that civic values are essential to creating engaged citizens. However, research on mandatory volunteering suggests that when youth act civically, their beliefs and values change to align with their actions (Yates & Youniss, 1999). We hope our research will shed some light on these conflicting hypotheses.

Future research will explore whether we can foster civic engagement in young people, and whether civic activities are a useful resource for promoting wellbeing. Our initial analyses suggest that the ReGeneration events increase wellbeing and civic engagement, independent of initial levels of wellbeing or background. Longitudinal, qualitative and experimental studies are planned to explore these effects further.

The findings highlight the important relationship between wellbeing and civic intentions, behaviours, and beliefs...

Conclusion. The present study reports some of the ways that young people engage as citizens in Aotearoa New Zealand. The findings highlight the important relationship between wellbeing and civic intentions, behaviours, and beliefs - findings that suggest that there is more to wellbeing than just being happy. While there are obvious differences between highly engaged and less engaged young people, the relationship between civics and wellbeing is nonetheless strong. Future research will explore these differences and similarities in greater depth in the hopes of elucidating a strategy to turn the tides of disengagement, and encourage a

happier, healthier people and society.

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Presenter: Scott Miller

Scott D. Miller, Ph.D. is a co-founder of the Center for Clinical Excellence, an international consortium of clinicians, researchers, and educators dedicated to promoting excellence in behavior health. Dr. Miller conducts workshops and training in the United States and abroad, helping hundreds of agencies and organizations, both public and private, to achieve superior results. He is one of a handful of “invited faculty” whose work, thinking, and research is featured at the prestigious “Evolution of Psychotherapy Conference.” His humorous and engaging presentation style and command of the research literature consistently inspires practitioners, administrators, and policy makers to make effective changes in service delivery.

Scott is the author of numerous articles and co-author of *Working with the Problem Drinker: A Solution Focused Approach* (with Insoo Berg [Norton, 1992]), *The “Miracle” Method: A Radically New Approach to Problem Drinking* (with Insoo Kim Berg [Norton, 1995]), *Finding the Adult Within: A Solution-Focused Self-Help Guide* (with Barbara McFarland [Brief Therapy Center Press, 1995]), *Handbook of Solution-Focused Brief Therapy: Foundations, Applications, and Research* (with Mark Hubble and Barry Duncan [Jossey-Bass, 1996]), *Escape from Babel: Toward a Unifying Language for Psychotherapy Practice* (with Mark Hubble and Barry Duncan [Norton, 1997]), *Psychotherapy with Impossible Cases: Efficient Treatment of Therapy Veterans* (with Mark Hubble and Barry Duncan [Norton, 1997]), *The Heart and Soul of Change* (with Mark Hubble and Barry Duncan [APA Press, 1999] and Bruce Wampold [2nd Edition, 2009]), *The Heroic Client: A Revolutionary Way to Improve Effectiveness through Client-Directed, Outcome-Informed Therapy* (with Barry Duncan [Jossey-Bass, 2000]), and *Jacqueline Sparks* [Revised, 2004]), and the forthcoming *Achieving Clinical Excellence: Lessons from the Fields Most Effective Practitioners*.

Workshop 1: Feedback Informed Treatment (FIT): Improving the Quality and Outcome of Behavioral Health Services One Person at a Time

In this one day workshop, participants will learn:

- Two research-based factors responsible for client change in treatment, regardless of professional discipline or preferred treatment model.
- A systematic method for assessing client progress and satisfaction so that therapy may be empirically tailored to the individuals’ needs and characteristics.
- Three ways to use progress and satisfaction feedback to enhance the quality and outcome of behavioral health services.

Workshop 2: Reach: Pushing your Clinical Skills and Effectiveness to the Next Level

In this workshop, participants will learn three specific strategies that separate the good from the great. Attendees will not only learn a simple method for determining their effectiveness but also how to develop a profile of their most and least effective practices—what works and what doesn’t. Step-by-step, evidence-based instructions will be given for using the profile to identify and eliminate weak spots while enhancing their effectiveness and efficiency.

Throughout the two day training, participants will learn directly from top performing clinicians around the world. Each specific principle and practice will be illustrated with videos from interviews with highly effective therapists. Additionally, video examples of real life clinical work in public sector settings with the most challenging clinical encounters (people who are mandated into care, considered chronic, severely and persistently mentally ill, or dually diagnosed) will be used to insure that participants can immediately apply what they learn in the workshop to their clinical practice setting.

Date: 2 & 3 October 2014 in Auckland

For more information contact Heike: pd@psychology.org.nz