The New Zealand
Psychological Society
Te Rōpū Mātai Hinengaro o Aotearoa

Psychology Aotearoa

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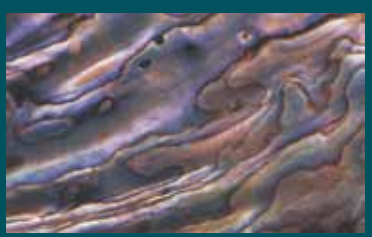


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Kia ora and welcome to *Psychology Aotearoa* the official twice yearly publication of the New Zealand Psychological Society. *Psychology Aotearoa* aims to inform members about current practice issues, discuss social and political issues of importance to psychologists, celebrate the achievements of members, provide a forum for bicultural issues and highlight research and new ideas relevant to psychology. It also aims to encourage contributions from students, hear the views of members and connect members with their peers.

Being part of *Psychology Aotearoa*

We welcome your contributions to *Psychology Aotearoa*. We are looking for submissions related to psychology which readers will find stimulating and can engage with. This can include items on practice and education issues, social and political issues impacting on psychology, bicultural issues, research in psychology, historical perspectives, theoretical and philosophical issues, kaupapa Māori and Pasifika psychology, book reviews, ethical issues and student issues.

For more information on making submissions to "*Psychology Aotearoa*" – go to www.psychology.org.nz/Psychology_Aotearoa

The New Zealand Psychological Society is the premier professional association for psychologists in Aotearoa New Zealand. Established as a stand-alone incorporated society in 1967, it now has over 1500 members and subscribers. The Society provides representation, services and support for its New Zealand and overseas members.

Psychology Aotearoa is the Society's member-only periodical published twice a year. It contains articles and feature sections on topics of general interest to psychologists including the teaching, training and practice of psychology in Aotearoa New Zealand, research and new developments in psychology, application of psychology to current and social and political issues.

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President's Korero—Kerry Gibson

I recently took part in a panel discussion which included a mental health service user. The topic for discussion was 'The future of psychology' and the service user had valuable things to say on this subject. However, what stuck in my mind was a passing comment she made about how unclear she was about the difference between psychologists and other helping professionals she had had contact with over the years. This brought home to me just how hard it is to distinguish the work of psychologists from the work of many other professionals who also offer talking therapy and other psychological interventions. Amongst those who offer services similar to our own are the obvious contenders; psychiatrists, psychotherapists and counsellors. But, as manualized protocols have made these practices more accessible, nurses and other general health workers are also able to offer these kinds of interventions. There is probably quite enough work to go around, but the difficulty is that psychologists are more expensive than some others who do this work. In a context in which money is an over-arching priority for policy makers, psychologists increasingly need to show that they are worth the extra cost.

Recent mental health policy documents have highlighted the importance of professionals working at 'the top of scope'. The essence of this is that psychologists (and others) are under pressure to demonstrate that they make maximum use of their skills and potentials. This got me thinking about whether psychologists have something unique to offer and where our 'top of scope' skills might lie. On the basis of my experience I think there are a number of areas we could highlight to demonstrate the contribution that psychologists can, or might, make in the future.

Firstly, the much touted label of 'scientist-practitioner' has been an important defining feature of psychologists work for over 60 years. This, however, is often used in what I think is its weakest form to point out that psychologists use interventions which draw from a clear research evidence base. Now this may once have been a distinguishing mark of psychologists, but in our current work environments we would hardly stand out from the crowd in using research to inform our practice. This is a standard expectation of most professional groups working in the areas in which we also work. Nonetheless, we do have good research skills developed at post-graduate level and I believe these can be used in a variety of ways to enhance our contributions to practice. We may become increasingly sought after for our ability to measure and evaluate outcomes in a system that values this. But, in addition, I would like to see psychologists being 'scientists' in the best sense of the word. Scientists, to my mind, are more than technicians or research users. Scientists think critically about existing research, combine research in new ways and remain curious and open to new knowledge. I think that psychologists have excellent potential to position ourselves as innovators, using our research skills to adapt existing models of practice and design new ones, including contributing to strong indigenous models suitable for use in Aotearoa.

Secondly, I think we can show how our in-depth training in psychological assessment and therapy makes a difference to service users. Recent findings in the evaluation of the Improving Access to Psychological Therapies programme in the UK suggests that therapist training really does influence outcomes. The data gathered over the extensive roll out of psychological therapies shows that clients' recovery is better when it is delivered by more qualified therapists (usually psychologists). Our training equips us to draw from a wide range of psychological theories to make sense of people's difficulties and to tailor interventions which are quite specific to their needs. In an ideal world all interventions would be based on this careful kind of individualized assessment and planning, but in our increasingly constrained health system it may not be considered feasible to offer this to all clients. Nonetheless, I think we can make a strong case for the value of these skills with complex and severe cases. We can also use this knowledge to inform other professionals through consultation and supervision.

Thirdly, our training gives us a very solid grounding in interpersonal theory and skills. We are accustomed to using this knowledge in our work with individuals and families, but I think these skills can also be put to good use in understanding relationships between team members and within organisations. Our skills in motivating, supporting and empowering people may not only help us to be valued team members but also equip us well to take up leadership positions. Psychologists might take on informal facilitative leadership roles but also could be more active in applying for formal leadership roles when these become available.

Fourthly, we have well-developed capacities for self-reflection that are also included in the core competencies of psychologists. These skills are important in being better able to understand our clients and our responses to them, to know our own limits and also to tolerate the emotional

burden of work with clients in distress. These skills often rely on introspection and go unnoticed by others. However, we can make them more visible by actively modelling these ways of thinking and sharing them with our colleagues in inter-disciplinary teams, supervision and consultation relationships.

Finally, our psychology training gives us a way of understanding the relationship between the individual and the social context in which they live. We are well placed to help people recognize and understand the impact of inequality; marginalization and lack of social care on people's well-being so that we can address the root causes of these problems as well as ameliorate their effects. We can make an important contribution to social discourse by putting a human face on social problems that are often reduced to money or numbers. In our local context we can, for example, draw public attention to the effects of inter-generational trauma for Māori, the mental health costs of poverty, the psychological impact of the refugee crisis and the psychological challenges of climate change. We can also translate these big issues into an understanding of how these things affect our individual and group clients and make these effects visible to our colleagues and policy makers.

These are just a few ideas of my own. I am sure that many of you have thoughts about what the particular contributions of psychologists might be and it would be useful to talk more about these with each other. I am also aware that my background lies largely in areas related to health and that these ideas may or may not resonate in other areas in which psychologists practice. We would welcome submissions to future editions of *Psychology Aotearoa* that describe the unique contribution of psychologists in your particular area of work.

However, working out exactly what psychologists have to offer is only one side of the coin. The other challenge is how we can convey exactly what it is that psychologists 'do' to policy makers, to employers and to the general public. This was part of the motivation for setting up a Psychology Week held on 9-15 November. This was an excellent opportunity for all of us to be involved in informing people about the work we do.

Editorial

Tēnā koutou colleagues,

it is again the time of year to be planning holidays and reviewing the year that was. Again I find myself awed by the quality of contributions in this edition. My appreciation of the diversity of talent within our ranks grows as I read the articles presented closely in my privileged role as co-editor. Perhaps by virtue of this close encounter I feel optimistic about what our profession has to offer. Or perhaps this is so because of my involvement with the Future of Psychology Initiative where we have had to look closely at some of the threats and dissatisfactions felt within some quarters of the profession. Featuring what we do best in *Psychology Aotearoa* provides hope and aspiration.

We feature first some of this year's NZPsS conference keynotes and opening speakers. These reflect just a portion of the variety of stimulating presentations at the conference. Mere Balzer provides her account of Te Runanga O Kirikiriroa's journey of implementing whanau ora. Mere's team's creativity and commitment to Māori values is impressive. So too is the vision for a bicultural psychology by Jeanette Berman, Terence Edwards, Jhan Gavala, Cathy Robson and Judith Ansell at Massey University. Their proposal for educational and school psychology training seeks to correct our poor history of prioritising Western approaches and knowledge and to establish culturally appropriate practice in the field now as 'we have locally developed structures and an increasing wealth of accessible indigenous literature to draw from which will support this approach.' This is an exciting development for professional psychology in Aotearoa and an important challenge for our educators to consider so that we enhance our relevance to the clients we serve.

Further on Rose Black provides some related cultural reflections from a Pākehā/Tauiwi caucus meeting in October. Discussion centred upon difficulties attracting and retaining Māori students, providing appropriate and accountable training; becoming critically aware of (de) colonisation practice; and cultural supervision.

At the root of many of these challenges lie the issues with respect to the interpretation of the Treaty. In his opinion piece, 'Pesky pronouns in Article I of te Tiriti o Waitangi', Dr Raymond Nairn helps us understand how misrepresentations occurred in relation to the translation of

the Treaty, specifically by presenting a translation offered by Ngapuhi scholars that removes any ambiguity about whose lands Hobson was allocated to govern. Such detailed study is still needed today as we grapple with our relationships.

On a different note, Willem Kuyken, in discussing the success of mindfulness-based cognitive therapy in the mainstream now addresses a theme developed in his keynote, this being:"What will support the sustainable development of this field?" Kuyken makes a plea for maintaining the integrity in our research, and in our delivery of mindfulness interventions. This is vital for us to consider as the delivery of health interventions is spread amongst more and more provider groups.

Increasing our partnerships with other providers may be part of the answer according to Gerald Monk, formerly a psychologist in New Zealand, and Sarah Hancock who make the case for psychologists and peer support specialists working together to help those recovering from severe mental illness. Their case, in support of both recovery and the recovery movement, is based upon both evidence and case study, and is compelling. The hope and empowerment emphasised in the recovery movement finds resonance with Du Villier and Reed's account of Appreciative Inquiry (AI) featured in a later article in this edition. These authors present AI as a potentially useful method to evaluate and transform practice worthy of consideration by psychologists as a means to facilitate positive change. Being strengths-based AI sits alongside the notions of recovery and collaborative care, which are strong directions in current mental health practice. As psychologists are employed in an increasingly diverse range of settings AI is a creative way of working which has the prospect of bringing a point of difference to a group, team or organisation.

How we continue to offer a unique and compelling service is a central theme in our international feature article by UK psychologists Sarah Corrie and David Lane. These authors present some big picture thinking, describing the state and future of psychology in the UK where increasing numbers of professions offer overlapping services, the role of psychological interventions is changing and budgets are shrinking. This has impacted psychologists whereby they now compete for roles with lesser qualified professionals, with potential implications in respect of quality of service. The theme is echoed here in Aotearoa where clarity about the added value and economic benefits of high quality psychology services is increasingly demanded. Their analysis of further factors involved in the changing employment landscape makes interesting reading, from the concept of state control of our professions, the changing expectations of and pressures on our professional bodies to the changing world in which we deliver our services. They set the scene of the challenge that psychologists are faced with and pose the question: Are we willing to face it? The parallels to our own context now and in the future are abundantly clear not to mention disturbing.

However, I feel that the articles featured here reflect an affirmative answer to this question. The Future of Psychology Initiative for example, which has been holding workshops and meetings across the past year or so, present the state of their project to date and makes a 'call to action' for those who wish to join the now established action groups. Please read and respond if you are keen to become actively involved in responding to this challenge for the future. In our next edition this theme continues as we will publish an account of the future of psychology, from an American perspective - that being Nadine Kaslow, recent president of the American Psychological Society which she presented at this year's annual conference.

The articles featured in the edition indeed showcase psychologists being innovative and creative and providing specialist expertise and leadership in their fields. For example, the role of psychologists in health and social services is also addressed by Peter Stanley who proposes a new standalone psychological service within CYF led by psychologists who have achieved national stature. Again the theme of psychologists taking a leadership role to determine the best method for the provision of their services at a crisis point within CYF. This proposal is based upon the wealth of experience and professional expertise as well as a sound evidence base built up over time.

In her article, 'Shouting out for working for the Family Court' – Sarah Calvert highlights another fascinating and important area of specialisation where we can provide unique expertise that exists for psychologists and one that clearly needs more of us to become engaged. Sarah describes the challenges and requirements of working in this field and encourages those of us who might be interested and who have got the relevant background and personality to become involved.

Eatwell and Malinen illustrate the impact of coaching in an organisation and describe a process by which coaching, as a leadership practice, can be implemented. This is a great example of how psychologists can be influential with regard to staff development via a coaching intervention through not only the delivery of the intervention but also the evaluation of its effectiveness.

Marc Wilson and the Youth Wellbeing Study Team report on Adolescent Non-Suicidal Self-Injury in Aotearoa New Zealand, an area which needs greater understanding both

for professionals working with populations who self-harm but also for the many adolescents and their parents who engage in self-harm. This topic is a good example of one where our specialist skills and expertise can help our communities.

Megan Laing, our featured student, also shows how the innovative use of specialist psychological knowledge has been helpful in a police-led early intervention service for child offenders. That Megan has successfully shown the value and scope of a psychologist with this vulnerable population within a challenging organisational culture such as the police is a testament to her commitment drive and skill. Well done Megan!

As always there are also many insights into current issues within the realm of both political and professional which raise the question of our role as social critics. Although a journalist, Tracey Barnett, a guest contributor, raises concerns about recent events regarding the refugee situation, highlighting the oppressive nature of Australia's response to refugees and any people who are prepared to speak out about it. Australia has just passed new legislation that effectively gags all staff, including doctors, nurses, psychologists, psychiatrists—indeed, any medical personnel—from talking to the media about conditions at the facilities. This article is a call to action for us in our role as social commentators or critics.

'One on one' provides an insight into the career of a psychologist well known to the NZPsS community, Dr Fred Seymour. His reflections illustrate his longstanding passion for social justice and cultural awareness which will resonate with many readers. Those who know him will know that these values have been major drivers as well as sustaining in his career. He is featured as he prepares for retirement from his role of Professor and Director of the clinical psychology programme at the University of Auckland.

Peter Stanley also picks up a social justice theme in his review of a book: *Hand to mouth: Living in bootstrap America* by Linda Tirado. Her book, also raises challenging questions for us as psychologists about how we balance of prevention with intervention efforts, and asks, as a profession, don't we have an obligation to at least comment about the drivers of disadvantage?

Understanding anxiety for dummies – book review by Joanne Taylor stood out for me in the astute critique of the prevailing terminology that framed the experience of anxiety in a way that reinforced unhelpful stigma and negative self-judgement.

In summary, I am impressed by what this edition reflects about our profession at this point in history. We warmly welcome contributions to our future editions which feature our everyday work as well as innovations and creativity, be they large or small, such that we can gain sustenance from each other and continue to ensure that our future is one of growth and positive contribution to the society in which we live.

Kia kaha,

Hei konā mai,

Fiona

NZPsS 48th Annual General Meeting 2015

The following is a summary of the NZPsS AGM held 30 August at the NZPsS conference in Hamilton. Thirty-nine members and six students attended the meeting and there were three apologies. Angus Macfarlane opened the meeting with a karakia.

Minutes and Reports

The 2014 minutes were accepted with an amendment. Matters arising included an acknowledgement that the Society now has an elected student representative on the Executive. Michele Blick was welcomed by the meeting to this role.

Following up last year's remit on climate change it was noted that a climate change think tank is looking at ways in which psychologists can inform and assist with of climate change issues. The Society is also in the process of gathering information on its carbon footprint and ways to reduce this.

President Kerry Gibson, acknowledged the work of the Executive, Branch and Institute Chairs and Committees and National Office staff. She announced the formation of the Institute of Organisational Psychology and spoke to her report on the developments, events and changes which had occurred in the Society over the past year.

Election of Officers and Remits

There were no officer positions vacant and no elections occurred. There were no remits.

There was a discussion on the slight decrease in number of student subscribers who had joined the NZPsS this year and there was a question on whether the loss of student allowances had an impact on the numbers. It was reported that the numbers did ebb and flow somewhat as students ended their studies and became full members.

New Fellows

Jack Austin was congratulated on his Fellowship and thanked in particular for his contribution to the Society over many years and for his work on the Otago/Southland Branch and the Ethical Issues Committee

The meeting ended with a confirmation that the 2016 conference will be in Wellington and a round of thanks for all those involved in the NZPsS and the organisers of the conference.

The meeting was followed by the signing of an MOU with the American Psychological Association (APA) which was represented by Dr Nadine Kaslow- former president of the APA.

Who's Who in the NZPsS

NZPsS Executive

President- Dr Kerry Gibson
President –Elect-Quentin Abraham
Directors of Bicultural Issues-Dr Waikaremoana Waitoki, Dr Erana Cooper
Director of Social Issues-Dr Rose Black
Director of Scientific Affairs- Dr Jackie Feather
Director of Professional Development and Training-Dr John Fitzgerald
Director of Professional Issues-John Eatwell
Student Representative- Michele Blick
Kaihautū- Professor Angus Macfarlane

National Office Staff

Executive Director-Dr Pamela Hyde
Executive Officer- Vicki Hume
Membership Administrator- (Donna Macdonald leaves at the end of November and Anne Cameron will be taking over her role)
Professional Development Coordinator- Heike Albrecht

Branch Chairs

Auckland- Alison Kirby
Waikato-Dr Carrie Barber
Bay of Plenty- Dr Peter Stanley
Central Districts- Dr Barbara Kennedy
Wellington –Dr Ruth Gammon
Nelson/Marlborough –Renu Talwar
Canterbury- Meredith Blampied/Richard Straight
Otago/Southland-Brian Dixon

Institute Chairs

Institute of Clinical Psychology (ICP)-Chris Dyson
Institute of Community Psychology Aotearoa (IComPA)-Dr Jane Furness
Institute of Health Psychology (IHP)-Iris Fontanilla
Institute of Educational and Developmental Psychology (IEDP)-Rose Blackett

Institute of Counselling Psychology (ICounsPsy)-Serena Walker

Institute of Criminal Justice and Forensic Psychology (ICJFP)-Rajan Gupta

Institute of Organisational Psychology – to be elected

NZPsS Workshops coming in early 2016

Carol Falender, 2 day supervision workshops, 22 & 23 February in Auckland, 25 & 26 February in Wellington, 29 February & 1 March in Dunedin.

Day 1 = Clinical Supervision: A Competency-Based Approach (beginner to intermediate)

Day 2 = Clinical Supervision: "You Said What?" Becoming a Better Supervisor (intermediate to advanced)

Carol Falender, Ph.D. is co--author of Clinical Supervision: A Competency--based Approach (APA, 2004) and Getting the Most Out of Clinical Supervision: A Guide for Interns and Trainees (APA, 2012) with Edward Shafranske, co--editor of Casebook for Supervision: A Competency--based Approach (APA, 2008) with Edward Shafranske, and Multiculturalism and Diversity in Clinical Supervision: A Competency--based Approach (in press) with Edward Shafranske and Celia Falicov. Dr. Falender has authored numerous articles on supervision and has conducted workshops across the United States, Canada, and internationally on the topics of clinical supervision, strength--based clinical supervision, ethics of supervision and supervision of co-occurring diagnoses.

Kris Kaniasty, 1 day workshops, 15 March Christchurch and 26 March Auckland

Individuals and communities sharing trauma: Social support as a keystone of coping and communal resilience

Kris is Distinguished University Professor Department of Psychology, Indiana University of Pennsylvania. His current research interests are: Social support exchanges in the context of stressful and traumatic life events at both individual (e.g., criminal victimization, unemployment, bereavement) and community (e.g., disasters, acts of terrorism, political crises) levels. Models estimating the role of social support and other resources as moderating and mediating factors in the stress-adjustment process. Determinants of psychological hardiness and resilience (i.e. successful adaptation) of individuals and communities facing a variety of crises, including extreme stress. Cultural influences on helping behavior, social support, and coping with stress. Application of social psychological principles (e.g., social cognition, attribution) in examining the course of coping with stressful life events.

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

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Psychology, psychologists, child welfare, and child wellbeing.

A submission to the Modernising Child, Youth and Family Expert Panel

Paula Rebstock (chair), Mike Bush, Duncan Dunlop, Helen Leahy, Richie Poulton

Peter Stanley

Dr Peter Stanley has worked in social work, teaching, counselling, and psychology. He has a particular interest in resilience and in working alongside parents and caregivers to nurture positive outcomes for children and youth.

This is an individual submission outlining some of the important contributions of psychology and psychologists to the welfare and wellbeing of children and families within the context of the transformational changes to Child, Youth and Family (CYF) that are planned. The first part of the submission provides an overview of some of the contributions that psychology can make and then it focuses on three particular areas where psychologists can assist; and these are in the provision of evidence-based programmes, systematic surveying for problem behaviours, and the prevention of problem behaviours. In the second part of the submission a case is made for a standalone psychological service within CYF.

1. What psychology can contribute

a) Assisting with a child-centred approach

Psychology can assist in detailing what a child-centred care and protection system would look like. Psychologists attend to individuality and to uniqueness, and this is according to dimensions of personal functioning that include physical development, health, personality, cognition, learning, vision, hearing, speech, language, behaviour, emotion, sociability, culture, spirituality, recreation, self-care, social service involvements, family circumstances, and neighbour context (Stanley, Rodeka, & Laurence, 2000).This perspective means that it is possible for psychologists to contribute in a meaningful way to the specification of measurable outcomes that the new system can aspire to. And in this regard, it is understood that education and schooling is the primary intervention in the life of every child and young person.

Atwool (2010) observes that 'acting in the child's best interests' does not actually tell us what to do and how to proceed. Psychology can assist here, but child-centeredness remains a complex topic. Part of the complexity arises from the inability of this conceptualisation to accommodate adult authority (Dearden, 1976). A practical response to this difficulty is to adopt a family focus rather than a child centric approach and, particularly for younger children, this acknowledges that meeting their needs and wants relates directly to their parents' and caregiver's circumstance.

b) Responses to children and young people with behaviour and emotional difficulties

Behaviour and emotional challenges are the major area of difficulty for children and young people in care, and for their carers and social workers. Challenging behaviour is a reasonably robust predictor of placement breakdown, and serial breakdowns are one of the most important practice issues that CYF must address (Atwool, 2010). Moreover, conduct issues will increasingly preoccupy the new Children's Teams, as they presently do with child mental health services and special education services. The economic costs to our community are colossal as conduct problems are correlated with premature births, child maltreatment, learning difficulties, early sexual activity, dropping out of school, dental and medical problems, depression, misuse of drugs, teenage pregnancy, partner violence, careless driving, criminal offending, unemployment, welfare dependence, and imprisonment (multiple references are available; e.g. Fergusson, Poulton, Horwood, Milne, & Swain-Campbell, 2004).

Psychology has had considerable success in mapping the pathways of conduct problems and in developing intervention systems that represent best practices in responding to them (Blissett et al., 2009; and other reports by the Advisory Group on Conduct Problems). In addition, psychology has systems for assessing

and responding to trauma (US Department of Health and Human Services 2012, cited by Ministry of Social Development 2015a). Arguably, a comprehensive set of initiatives for the psychosocial problems of children and youth will cater to both externalising issues (like aggression and violence) and internalising concerns (including anxiety and depression). New Zealand has comparatively high levels of internalising issues and, apart from the personal suffering that this represents, it is likely that depression in mothers influences the intergenerational transmission of conduct problems (Stanley, 2008).

c) Providing insights from resilience science

Resilience science is about people who have 'beaten the odds' and succeeded in difficult circumstances. It provides a coherent framework for understanding behaviour in relation to risk factors, protective factors, trajectories, and multiple environments (Stanley, 2003). And as a consequence, the resilience framework provides a "sound theoretical basis for purposeful interventions" for workers and carers (Daniel et al. 1999, cited by Atwool, 2010). For instance, we know that it is inappropriate to solely consider an occurrence of maltreatment without also considering the pattern of assets and liabilities in a situation. Equally, it is important to consider the child's developmental state in what is done for them; and we also know that interventions that ignore relationships, and the many environments in which children and young people move, are unlikely to be successful for them (Luthar, 2006).

Resilience in children and youth is not an individual characteristic but a process that is dependent on dedicated parenting by a prosocial adult. According to Masten and Reed (2002) the 'first order of business' then is a strong bond to a competent and caring adult, and the longer that a child stays in a good place the more enduring are the beneficial effects. The present author is running a small longitudinal study in Porirua and this research has demonstrated that complete 'turn arounds' are possible for young people when cohesive and consistent supports are made available to them (Stanley, 2011). The resilience approach also has the advantage of offering a hopeful adult vision, to match the optimism that can been found amongst children in care, and that counters the presumption of failure that can be implicit in a narrow care and protection orientation to services.

d) Accessing and undertaking relevant research

This country has two internationally renowned studies concerning our children and young people, and these are the Dunedin Multidisciplinary Health and Development Study and the Christchurch Health and Development Study. There is also the more recent longitudinal study, Growing up in New Zealand. The cross-sectional research of Youth2000 provides another perspective, but it is limited by not including some at-risk groups like those youngsters who leave school early (Stanley, 2010a). These research endeavours are human development and psychological investigations and they contain highly relevant insights regarding vulnerable children and youth.

There is a pressing need for studies on the care sector in this country and psychological investigations, in particular, are called for. New Zealand took a lead role internationally in placing children in the care of family members (kin care) but there are no local long-term studies on outcomes for either kin or non-kin care. An equally valid research question is why are there so many Māori children and young people entering the care system, and entering care at the high-end of need? Strong empirical work is needed otherwise we are bound by generalisations and ideological presumptions (Atwool, 2010).

2. **Evidence-based programmes**

The present review of CYF is adopting an investment approach to reform (Ministry of Social Development, 2015a; Ministry of Social Development, 2015b). It is contended that if we invest now in the best practices and programmes that are available we will limit the substantially larger costs that are likely to accrue later on. According to all of the official documents there is to be a strong focus on strengthening outcomes for vulnerable children. This is a mandate for evidence-based programmes (and the documents make this clear) and, as a corollary, it is an instruction for intervention services that target young children and families, and for preventative programmes.

Werry et al. (2010), in a submission to the Parliamentary Social Services Select Committee, provide an overview of evidence-based programmes for responding to children and young people who break the law. Similarly, in Appendix E of the Expert Panel's Interim Report there is an annotated list of best practices for child protection. Werry et al. (2010) spell out the pivotal role of psychology and psychologists in developing evidence-based programmes and in trialling, evaluating. monitoring, and supervising programme implementation. These authors observe that the delivery of all effective evidence-based programmes "require organisational structures that have a clear clinical leadership."

Few of the programmes that are listed in the Interim Report (Appendix E)

have well-conducted New Zealand trials. One of the exceptions is The Incredible Years Parent (IYP) programme, which has been subjected to a substantial cross-agency assessment conducted over two years (Sturrock, Gray, Fergusson, Horwood, & Smits, 2014). This evaluation confirmed earlier research (Fergusson, Stanley, & Horwood, 2009), and showed that IYP is effective in reducing conduct problems in both Māori and non-Māori families. Clear and significant benefits were shown in terms of family relationships, parenting, and child behaviour; and effects were maintained at 30 months. These results are in keeping with a large body of international research on IYP, which includes findings that good outcomes can be maintained a decade after programme exposure (http://www.incredibleyears.com).

Parent management training is indisputably the most successful intervention for responding to children with conduct issues (Werry et al., 2010), and it has also been likened to the discovery of antibiotics in medicine (Stanley & Stanley, 2005). It is the means for increasing the capability of state carers; and the skills of families of origin as well, so that children and young people might return to parents with enhanced parenting capacities. However, there are other advantages of a programme like IYP and they include providing a refuelling and refreshing professional experience for programme delivery staff (Hamilton, 2005) and promoting interagency connections through commitment to a common programme. Importantly, IYP is based on a collaborative model and it is designed to foster cultural diversity (Webster-Stratton, 2009). Participants are treated with dignity and respect and achieve their own goals within their own culture.

We have New Zealand evaluations of IYP and we also have an established infrastructure for delivering the programme within Education, Health, and some nongovernmental organisations. These are unparalleled advantages but further expansion needs to proceed cautiously because of the stringent requirements for programme fidelity associated with IYP (and that pertain to every evidence-based programme). Fidelity means using the programme with the families for whom it was intended; and faithfully delivering the content over the set treatment time using the processes and methods that are specified. Delivering half an IYP programme does not result in 'doing some good;' it is likely to have no effect at all (http://www.incredibleyears.com). Professor Webster-Stratton, who is IYP's creator, expects that at least one of the two Group Leaders who run an IYP programme will hold a master's degree. IYP Group Leaders are supervised by IYP Mentors, and in New Zealand our six IYP Mentors are all practicing psychologists.

3. **Systematic surveying**

It is presently not known what becomes of the children and young people who enter the CYF system but there is an equally concerning matter, and it is that we do not know with any certainty whether the children who are currently referred to CYF, and who may then be assessed, are actually the children and youth who are most needing of attention. It is easy to dismiss this question with answers that derive from intuition and work pressure; but then there are the disturbing situations that are only revealed through the media. And there are also comments by school teachers and others to the effect that the passage of time sadly confirmed the concerns that had been held for particular pupils who had never come to official notice. The Children's Commissioner contends that CYF do a good job at the 'front end' of care and protection but the State of Care report also points to significant variability in the numbers of investigations that are undertaken across CYF sites (Office of the Children's Commissioner, 2015). Contrasting interpretations are available of these disparities (Matheson, 2015) but the fact remains that the CYF system lacks useful comparative data on the clients that it connects with; and this will inevitably impact negatively on its own performance, and on the performances of the other agencies and services with which it relates.

Who enters a social service system is affected by how they enter the system and in New Zealand we are wedded to intake approaches in welfare, education, and health services. These systems are largely dependent on referrals from concerned adults, but parents, teachers, and others do not necessarily share common understandings about children's needs and wellbeing, they are unlikely to be experiencing similar exigencies and pressures, and some of them at least may be hesitant about contacting a state agency that has the capacity to remove children from their homes. The facts are, that intake approaches can only offer an illusion of rationality to the systems that they attempt to serve (Stanley & Sargisson, 2012). Some proof that intake systems across agencies are underperforming is to be found in the recent disclosure from the Growing Up in New Zealand study that only about 20 percent of families who require help for their young children are actually receiving assistance (Growing Up in New Zealand News, 2015). In addition, the Youth2000 investigation shows large unmet needs around depression

in adolescence (Clark, et al., 2013). It is an acknowledged deficiency of intake approaches that they are more responsive to externalising problems in children and youth, and they might respond to stereotypes for Māori as well.

The Ministries of Social Development (MSD) and Health have sought other measures that might complement intake information and two of the most notable developments have been the B4 School Check for all New Zealand 4 year-olds and the Gateway Assessment for children and young people in care. Both of these measures have the same two issues: they are not applied universally to the populations for which they are intended, and there is insufficient follow-up of the problems that are identified. The first concern is the more insidious because it is typically 'hard-to-reach' children who miss out on the assessments, and it is usually these youngster who have the more pressing problems.

It is suggested that systematic population screening is the way forward for the social services, as it is the only way that we can truly ascertain the dimensions, and the nature, of the problems that are confronting us. We are doing it already with the B4 School Check but, arguably, this assessment package should be administered earlier at 3 years of age (as occurs in Australia) and an additional emotional and behavioural screen should be done with all children in their first year of school. Currently, we screen for emotional and behavioural difficulties in the B4 School Check with the Strengths and Difficulties Questionnaire (SDQ) and it would be relatively easy to repeat this procedure with new entrant students. Schools have 'captive clients' and this contrasts with the more variable situation in early childhood education and care. Working through schools would be economical as well as convenient; and it would promote equity of access across problem types, across gender, across socioeconomic status, and across ethnicities.

The present author and colleagues have been working over the last five years on exploring the properties of various screening instruments and approaches. Our first report looked at how useful early assessments of language skills, physical abilities, reading readiness, and behavioural issues were in identifying children who had already been referred to the Ministry of Education (Sargisson, Stanley, & de Candole, 2013). As this study showed the importance of physical abilities as an identifier, we next explored the relationship of fine and gross motor scores with other characteristics of children at the start of primary schooling (Sargisson, Powell, Stanley & de Candole, 2014). In our recent work we have evaluated the SDQ with primary school children in the context of a Social Sector Trial. The SDQ has parent, teacher, and student versions and our research suggests that it is more efficacious to use two informant versions of the SDQ for children who are at risk from psychological problems (Sargisson, Stanley, & Hayward, 2015). The student form of the SDQ is recommended because it provides a disparate perspective on behaviour, and it is also respectful in allowing the young person to comment on his or her own personal situation.

An attempt was made reasonably recently by MSD, in the context of the Vulnerable Children's Initiatives, to introduce greater precision into the identification of families at risk using administrative data and a predictive risk modelling system (Vaithianathan, 2012). Systematic surveying is quite different from this methodology in that it is a universal approach, and the SDQ assesses children's personal assets as well as the presence of challenges. There is not the same stigmatizing potential with the SDQ, and evidence from the Hawke's Bay shows that parents agree with the assessment of their children's problem behavior derived from this instrument, and they are grateful for the support services that follow screening (Hedley et al., 2012). Professor Vaithianathan observes that we routinely screen for breast cancer in this country whereas the prevalence for maltreatment for children to 5 years of age is more than 20 times the risk of breast cancer in women aged 50-60 years. Although she is talking about predictive risk modelling, the following comment by Vaithianathan applies equally to systematic surveying:

> *We shouldn't resile from the problems we face around maltreatment of children in New Zealand or from radical solutions like this that would allow resources to be targeted accurately. The social service sector in NZ needs a data-driven, evidence-based revolution. We are still tinkering at the edges and children are the losers. (Vaithianathan, 2015)*

4. **Prevention of problem behaviour**

It is suggested that the paramount challenge facing contemporary state social services is balancing the requirement to respond to crisis situations and to provide preventative services. Crisis responses have the capacity to consume a service, and these restricted responses ultimately result in a continual recycling of notifications. As we know, this is the current situation for CYF. Quite simply, dispensing with prevention is not an option because if we become preoccupied with the most extreme cases we will never respond to the true scope and magnitude of the task (Albee, 1999). Nevertheless, some answers do exist to the dilemma of

competing service priorities and they are both conceptual and administrative.

The conceptual response is to remove the semantic distinctions around 'intervention' and 'prevention' and; to a degree, around 'assessment' as well. In medicine, comparatively clear distinctions are possible between diagnosis and treatment, but the social services deal with systems of interconnected relationships rather than with individual patients and, often, it is necessary to work with the adults in a child's life (as in parent management training) to achieve lasting changes for him or her. The situation is further complicated by the fact that it can be difficult to regularly make accurate risk determinations for children and families, and especially without a validated risk assessment tool. On first meeting, a child's circumstance can appear extremely threatening when it actually contains significant protective factors. Conversely, a situation that appears innocuous can be riddled with risk influences.

In casework practice, intervention and prevention functions typically blend and, similarly, assessment continues throughout a professional involvement, and it guides adjustments that are made to a programme. These assessment and casework realities mean that it is inappropriate to 'triage' children to institutional responses, as if they were to specialist medical facilities. It is much more relevant to support families to join streams of evidence-based programmes which overlap and that are rerun. Universal screening of young school children, and the validation and consistent use of other risk assessment instruments, is a sensible and practical first step that can guide programme engagements. Furthermore, resilience science can function as a powerful bulwark for child-centred social work and psychology, and it has already promoted a shift from deficit-based approaches to strengths-based perspectives in multiple fields of practice (Masten, 2014).

Administrative arrangements like CYF both reflect and cement how cases are conceptualised. The evolution of Children's Teams is expected to allow CYF to concentrate on its core functions, which means that it could indeed be the 'the last link in the chain'. However, a service that is always focusing on the 'worst-of-the worst' can be a highly stressful, possibly distorting, and potentially unproductive place to work. Similarly, categorical services which rely continually on psychiatric diagnoses can foster a sense of futility amongst staff. Giving 'CYF kids' new medical labels also makes it more difficult to place children in care (and especially if they are medicated), and it can limit the young person's future prospects (Bateman & Finlay, 2002; Stanley, 2006a; Stanley, 2006b). Children's Teams are expected to revolutionise services by functioning as a midpoint on a continuum of care. It is possible that they will be a pivotal point for preventative services but the teams rely on interagency liaison and intake systems for their clients; and there could be additional system churn as referrals flow backwards and forwards with the new CYF.

Do psychologists and psychology have any further contributions to make to prevention beyond systematic screening, assessment systems, and evidence-based practice? Yes, they do and these include disseminating psychological research and, in particular, the findings that have been achieved on the parenting and caregiver processes that promote conduct problems in children and young people. The work that has come out of the Oregon Social Learning Centre (https://www.oslc.org) is especially relevant in explaining the microsocial processes that sustain problematic behaviour in schools, homes, and care settings. We now know why it is so hard to change entrenched behaviour, and why it is so important to implement prevention responses at every opportunity.

5. A standalone psychological service for CYF

a) Why is a discrete psychological service needed?

A constituent psychological service has existed in child welfare before, as it has in Education and, currently, stand-alone services are to be found in Corrections and Defence. The fundamental reason for an individual psychological service within CYF is the nature and complexity of the problem behaviours that the department is now attempting to respond to, and which are beyond the capabilities and capacity of present staff (Ministry of Social Development, 2015a; Office of the Children's Commissioner, 2015). As we know, there has been a very substantial increase in children and young people presenting with emotional and behavioural difficulties. These children and youth are more likely to recycle through the system if they do not receive powerful multicomponent intervention strategies from psychologists who are highly trained in evidence-based practices. Sustained behaviour change is also dependent on the availability of expertise, and on the formation of relationships. Psychologists need to be readily available to craft (and to adjust) intervention regimes. And relationships with the significant adults in a child's life (including social workers, carers, and parents) require time to build. Conduct problems and trauma are longitudinal issues and psychologists need to have a responsive and a continuing presence within CYF.

CYF could simply employ more psychologists and distribute them across the organisation rather than re-establishing a stand-alone service. This is the situation with

the Ministry of Education (MOE) at this time, and there are real and continuing costs in terms of professionalism and capacity (Brown, 2010; Coleman & Pine, 2010; Hornby, 2010; Stanley, 2010b). By contrast, Corrections (which employs a similar number of psychologists as Education) acts as the centre of professional rigour within the department. Psychologists in Corrections deal with the most challenging case work. They influence how resources are allocated dependent on risk. They regularly contribute to service development tasks such as introducing new risk assessment instruments and evidence-based practices (http://www.corrections.govt.nz). And as much as anything else, the clear professional identity that they possess can allow them to contribute critical thinking and an independent voice to inform practice.

Another option would be for MSD to outsource psychological services to MOE and Child and Adolescent Mental Health Services (CAMHS). This alternative was suggested by Werry at al. (2010) in their Parliamentary Submission. However, the Children's Commissioner in his monitoring exercise found that the relationship of CAMHS and CYF was often quite poor (Office of the Children's Commissioner, 2015). Those who work in the human services know that multidisciplinary arrangements and engagements are rarely solutions to longstanding problems in families, and especially when the predominant issues are emotional and behavioural difficulties. Some of the obstacles to interagency work are conceptual and others are practical. It is fact that health, education, and welfare services see the world differently (Stanley, 2006c) and they will always have different servicing priorities because that is what they are. As well, it can be mistaken to assume that each service has something to contribute to cases and that they actually have the depth of capability to do this. For professionals, working with other agencies means more meetings, more reports and, ironically, less time often for working directly with children and families. For clients, multidisciplinary and multiagency work may mean more appointments, more assessments, and fractionated services.

b) What would a standalone service actually do, and what would it look like?

The constituency psychological service would function as a part of the professional practice framework and assist CYF to have a leadership role across the social service sector. It would have a part in every activity where psychological expertise and data are relevant and this will include (i) undertaking individual and family assessments and administering interventions; (ii) accessing, designing, and validating trauma, risk assessment, and other screening tools, (iii) assisting with the selection and training of child advocates, care givers, and respite carers; (iv) installing, implementing, and evaluating evidence-based programmes for children and young people, carers, and families of origin, (v) supporting social workers with transitions for children and young people (into, across, and out of care), (vi) providing psychological and developmental perspectives on access decisions concerning child clients, (vii) supervising research and evaluation projects, and (viii) contributing to the induction, training, and support of social workers. This listing is not exhaustive and there are likely to be many other possibilities for assisting with new initiatives and with policy.

The leadership of the new psychological service is critical and it needs to be led by psychologists who have achieved national stature within the profession by their practice, and through research and publications. This is a professional, rather than a managerial, response to the crisis in care, and the new service will need to be equipped with all the requirements to do the job, including research and other support staff, libraries, and professional development opportunities. Corrections has shown that is possible to grow a constituency psychological service, and a part of this is that it runs its own supervision for registration scheme. Actually, it is not possible to predict the many good things that could arise from a well-led and well-motivated psychologist workforce within CYF. At the least, a psychological service for child welfare is a logical deployment of relevant and credible professional expertise and experience.

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Pesky pronouns in

Dr Raymond Nairn

Ray is a social psychologist with many years' experience in community education and action around Te Tiriti o Waitangi (Treaty of Waitangi). With Waikaremoana Waitoki, Roseanne Black, and Phillipa Pehi, he edited *Ka Tu, Ka Oho: Visions of a Bicultural Partnership in Psychology* published by the NZPsS in 2012. Ray is a Pākehā New Zealander of Scots and English descent who was the NSCBI representative on the Code of Ethics working party (1995-2002) sparking his concern over the relationships between ethics, professional practice, Te Tiriti, and the culture of psychology. Since the late 1980s Ray's research has explored mass media portrayals of persons living with a mental disorder and representations of Māori and Māori issues in mass media.

Article 1 of te Tiriti o Waitangi

In November 2014 the Waitangi Tribunal released Part 1 of Te Paparahi o te Raki report (Wai 1040) in which they concluded that Ngapuhi signatories to Te Tiriti o Waitangi had not ceded their sovereignty. The decision confirms that, as in the Code of Ethics (Comment 1.3.1, 2002, p.6), Te Tiriti o Waitangi is the Treaty. It also confirms, as Ngapuhi speakers insisted, that *He Wakaputanga o te Rangatiratanga o Nu Tireni* (the Declaration) provides the context for and guide to understanding Te Tiriti. However it does not resolve the problem created by grammatically correct translations of Article 1 of Te Tiriti as instanced in Figure 1.

Figure 1: Article 1of Te Tiriti

Ko nga Rangatira o te Wakaminenga me nga Rangatira katoa hoki kihai i uru ki
The Rangatira of the Confederation and all those Rangatira who have not joined
taua Wakaminenga ka tuku rawa atu ki te Kuini o Ingarani ake tonu atu –
the Confederation grant to the Queen of England forever
te Kawanatanga katoa o o ratou wenua.
all the Governorship (Kawanatanga) of their lands.

An English speaker reading the inter-lined translation is being told that 'The Rangatira' granted 'Governorship of their lands' to the Queen. It works like that because the translation reads like a form of reported speech - the translator telling us what the Rangatira did – making them the only actor and therefore the obvious possessor of the lands over which Kawanatanga is to be exercised. That interpretation runs counter to the Tribunal finding and that is important because Article 1 is where the Pakeha (Crown, Government) belief that Māori ceded sovereignty has been grounded ever since 1840. In this brief note I am going to present a translation offered by Ngapuhi scholars that removes any ambiguity about whose lands Hobson was allocated to govern (See Healy, Huygens & Murphy, 2012, pp. 197–214 for translations by three Ngapuhi scholars).

However, before presenting that translation I am going to explain why, or how, the translation in Figure 1, although grammatically accurate, misrepresents the situation. Primarily the misrepresentation occurs because the translator followed the style of the English texts in which the actions of parties to the agreement are described. For example: (Article 1): "The chiefs of the Confederation… cede to her Majesty…"; (Articles 2 and 3): "Her Majesty the Queen of England extends to the Natives…". Unlike those English texts, each article of Te Tiriti has a nominated speaker, as when Article 2 begins: "Ko te Kuini o Ingarani" (the Queen of England…, Nairn, 2007, Figure 3, p. 24). It follows that any pronouns in the article must be read in relation to that speaker. So, when reading Article 1 where the rangatira: "Ko ngā Rangatira …" (Figure 1), are the nominated speaker(s) we must understand the article, including the crucial pronominal phrase: "…o o ratou wenua", as being spoken by them.

Further, the phrase, 'ka tuku rawa atu' (second line Figure 1) is translated 'grant…forever' though 'tuku' often means permit or give permission. 'Tuku' was used when, in *He Wakaputanga*, the rangatira refused to permit - 'e kore e tukua matou' – any [other] group to frame laws or exercise governorship in the lands of Te Wakaminenga without their express permission. As is clear in the Ngapuhi translation (Figure 2, Healy et al, 2012, pp.209-11); Article 1 has the rangatira giving permission for someone other than themselves to frame laws and exercise governorship in "o o ratou wenua" (their lands). If the rangatira had been referring to lands for which they were responsible they would have said, as they did in *He Wakaputanga*, 'o to matou wenua' (over our land). Consequently, and the Ngapuhi translation makes this very clear, 'o o ratou wenua' refers to "nga wahi katoa o Nu Tireni i tukua … ki te Kuini" (all the parts of New Zealand given to the Queen) (Nairn 2007, Figure 1, p. 23) - not the entire country (Healy et al, 2012, p. 210-211). Ngā Rangatira were permitting Hobson, as the Queen's envoy, to exercise her authority over her people in those "lands that had been or would be assigned for the use of the Queen and her people" (op. cit. p. 210).

Figure 2: KO TE TUATAHI The First Article

Ko nga Rangatira o te Wakaminenga me nga Rangatira katoa hoki kihai i uru ki
The members of the Confederation, and all these leaders who have not joined in
taua Wakaminenga ka tuku rawa atu ki te Kuini o Ingarani ake tonu atu –
that confederation give completely (tuku rawa atu) to the Queen of England for ever
te Kawanatanga katoa o o ratou wenua.
all the Governorship of their (the Crown's) lands.

Clearly, Article 1 of Te Tiriti is both permitting the newcomers to govern themselves, according to their own

laws, ethical principles, and institutions as Māori governed themselves according their tikanga and cultural practices. Ngāpuhi practices included Te Wakaminenga a deliberative body for addressing issues affecting everybody and the rangatira expected Hobson, as rangatira of the hapu hou, to participate enabling the newcomers to be part of the wenua rangatira ('land under authority of tribal leadership' *He Wakaputanga*, Section 3a, op cit p.84). Acceptance of Te Tiriti was driven by the priority Māori accorded relationships and their recognition that the newcomers needed their own territory where they would be responsible for applying their own tikanga in their own way. This understanding of Te Tiriti offers us a template for interactions between peoples in which the dignity of all parties is respected (Nikora, 2012; Nairn, 2007).

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Strengthening the Future of Psychology in

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This group is a subset of the Future of Psychology Initiative Coordinating Group who represent various sectors of psychology, workforce development, university training programmes, DHBs, PHOs and private psychology practice as well as health and clinical psychology.

Future of Psychology Initiative Coordinating Group

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Introduction:

The Future of Psychology Initiative was started to ensure that psychology remains a r***obust, resilient, and relevant*** profession in New Zealand. It has a particular focus on the health services, but may also be relevant to other social service areas. This initiative involves psychologists from a range of practice areas, ethnicities and service types. It includes practitioners and academics, and members of the New Zealand Psychological Society and the New Zealand College of Clinical Psychologists. It began in Auckland with colleagues who have shared similar concerns about psychology in the health sector for some years. The Future of Psychology Initiative has consulted at national forums and with psychologists from other social service sectors, and is keen to involve the professional organisations and psychologists from all areas in Aotearoa in the work to fulfil the overarching goal above.

The Future of Psychology Initiative's previous article *Psychology in Aotearoa – where are we going?* (Bellamy, Feather, Gibson, Howard & Lambrecht, 2014) invited your engagement with a series of questions about our profession's future. In this paper we bring you a summary of this dialogue to date and recent actions arising from it. We also propose the next steps and seek your involvement in actions to ensure and enhance the robust future of psychology.

What Have We Done? Defining the Issues and Strategies

In the past two years, members of the Future of Psychology Initiative have met, discussed, consulted, and planned. We have held local and national workshops, including at the 2014 NZPsS conference in Nelson, the 2015 NZCCP conference, and workshops in Auckland in 2014 and 2015. The earlier workshops explored the issues related to psychology maintaining and increasing its robustness, resilience, and relevance, and began generating strategies to address these issues. Small and large group discussions at the initial workshop (involving approximately 70 psychologists) identified the challenges facing psychology in the health and social service sectors, as well as potential mitigating strategies and actions. These were further discussed, expanded, and refined at the two subsequent professional association conference workshops (NZPsS and NZCCP) which were attended by approximately 50 and 70 people respectively. Eight major themes emerged from the issues discussed and,

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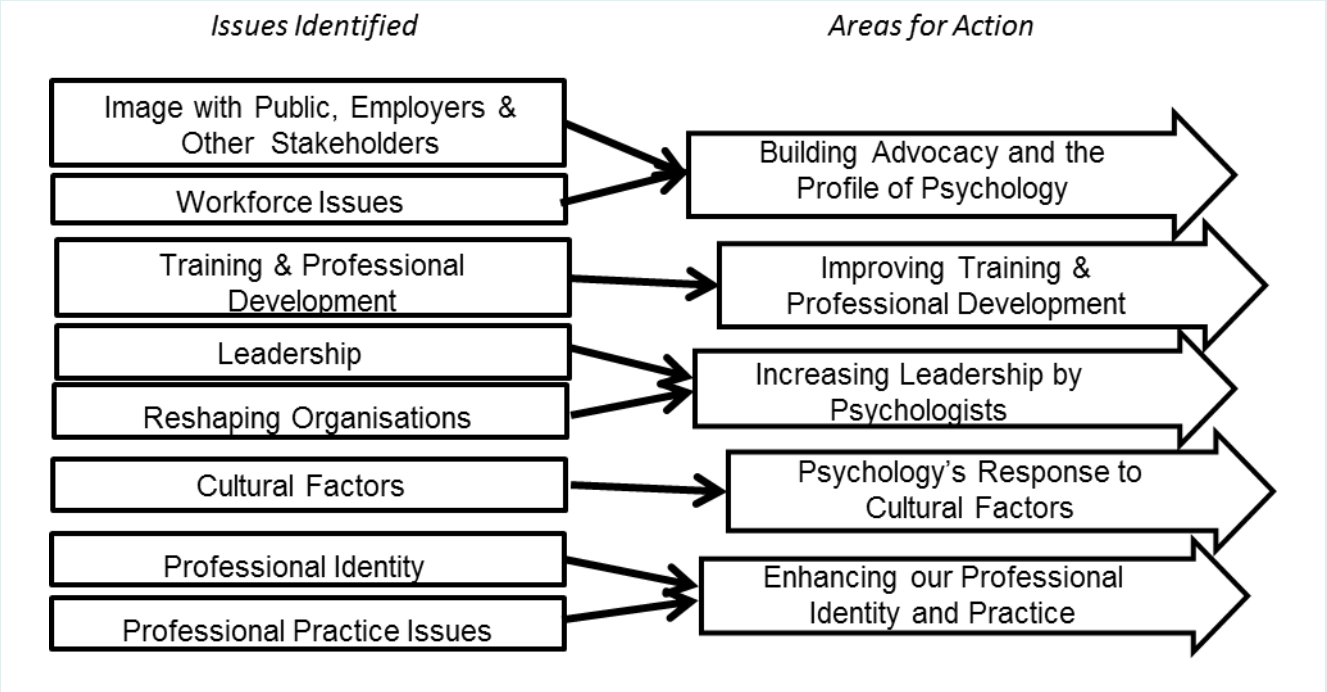
M., Stewart, M. & Verhoeven, M.

based on these themes, five areas for action were defined. Figure 1 shows the eight key themes and how they relate to the five areas for action.

Figure 1: Issues identified and Areas for Action derived from workshop discussions



The five areas for action are described in more detail below:

- ***Enhancing our Professional Identity and Practice***: This focuses on how psychologists understand and practice their own professional role. It aims to ensure that psychological practice is evolving so it will remain sought-after and valued by health and social services and by clients. The target audience for this area for action are psychologists and the practice of psychology.
- ***Building Advocacy and the Profile of Psychology***: This involves increasing knowledge and positive attitudes toward psychologists and the contribution they can and do make. It also may involve addressing the workforce issues that may limit the contribution that psychology makes. Its target audience is the public and stakeholders such as users of health systems, employers, other health professionals, and government agencies.
- ***Psychology's Response to Cultural Factors***: This aims to assist psychological practice and training to more fully reflect an increasingly multicultural Aotearoa New Zealand and to ensure that the psychological models and approaches used by psychologists are as culturally appropriate and responsive as possible. Its target audience are psychologists and the practice of psychology.
- ***Increasing Leadership by Psychologists***: This aims to increase the involvement of psychologists in clinical and organisational leadership by enhancing their level of skill and attitudinal readiness to undertake such roles and activities. It also aims to increase the opportunities and support for psychologists to take on and sustain leadership roles and activities. Its target audience are psychologists and others who may enable or block leadership by psychologists.
- ***Improving Training and Professional Development***: This involves ensuring that both pre- and post-qualification

training enables psychology to remain strong (robust and resilient) and relevant to clients and employers. It also involves ensuring that the training supports wellbeing and sustainability for psychologists. Its target audience are the training institutions and staff within them, and funders and providers of other professional development opportunities.

Table 1 briefly summarises the types of issues that were identified in the discussions and which each area of action aims to address.

Table 1: Examples of Issues Associated with each of the Areas for Action

Areas for Action	Summarised issues
Enhancing our Professional Identity and Practice (How psychology understands itself and evolves its own practice)	Lack of clarity amongst psychologists about their role and unique skills. Lack of professional confidence amongst psychologists often evident. Often focus on looking after clients and ignore other important roles outside the therapy room. Psychologists often inflexible or unduly limit practice (e.g., little use of group work) Practice sometimes does not meet system and client needs and wishes. Psychologists not seen as innovative. Increasing division and lack of communication within psychology.
Building Advocacy and the Profile of Psychology (How psychology presents to, and is seen by, others)	Non-psychologists know relatively little about what psychologists are/do. Other professions therefore may have mis-informed views of psychologists. Psychologists are often not good at promoting their skills and contribution. Inadequate representation/profile for psychology in the media. Psychologists need to advocate more about societal, community and political issues. Workforce issues – small numbers, gender dynamics, and lack of career structure limits strength of profession.
Psychology's Response to Cultural Factors	Psychology remains defined primarily by Western context: Scope for other psychologies Psychological therapy may under-estimate the importance of cultural factors. Māori psychology could be made a starting point in training rather than an "add-on" Asian mental health needs/services are expanding. Cultural needs of Māori, Pasifika, and Asian psychology trainees not well catered for. Training based outside universities may better suit the needs of Māori. Cultural supervision needs to be addressed.
Increasing Leadership by Psychologists	Psychologists could usefully take more leadership roles in teams/systems Systems and other psychologists often don't support leadership by psychologists. Psychologists are often not invited/present in forums that shape organisations. Advocacy for more psychologists in formal and informal leadership roles. Benefits and risks associated with psychologists taking on more clinical leadership roles.
Improving Training and Professional Development	Training becoming less affordable/supported – skews demographics of psychologists Relevance of training –e.g., focus on individuals, too generalist. Suitability of training programmes for non-Caucasian trainees. Lack of mentoring post-internship. Need stronger post-qualification professional development structure/opportunities.

What Are We Doing? Moving From Strategy to Action

Some initiatives have already begun to turn strategy into action. The idea of "Psychology Week" arose partly out of the clear message from the Future of Psychology Initiative meetings that the work of psychologists is not well understood in this country, and nor have we been very good at promoting our own profession and skills. The New Zealand Psychological Society has taken up the call by organising "Psychology Week", which is beginning in a small way in 2015. In consultation with the Australian Psychological Society, and with branches and institutes of the Society support is being offered to provide public events on topics of interest to communities. The response has been overwhelmingly positive and it is hoped that other organisations will join with NZPsS in the future to participate in what we anticipate will become an annual event. In Australia, psychology week is a long-standing tradition and the profession enjoys a higher profile and less 'mystery' than here in New Zealand. This has also provided the impetus for the development of brochures for the public

promoting the profession in New Zealand and showcasing what psychologists do. This brochure is produced by NZPsS with the support of the Future of Psychology Initiative, and will have a focus on health.

Other areas identified from the meetings included the need to strengthen the participation of psychologists in leadership roles and ensure that psychological practice is evolving in ways that will remain sought after and valued. There have been responses to these identified needs. NZPsS organised a free workshop open to all psychologists on leadership, presented by Chris Jansen. This was held in Auckland, Wellington and Christchurch and was very well supported. Auckland DHB also offered a leadership workshop in its Psychology Education days: "Learning from each other" which was attended by 40 psychologists.

A broader action phase is now underway. At a workshop in Auckland in June 2015, about 40 psychologists (clinical psychologists, health psychologists, postgraduate students, university teachers, and others) worked in small groups - one group for each of the five areas of action. These groups identified two key objectives for their area for action, and then selected one short-term and one longer-term key strategy for achieving each objective. They were asked to choose strategies that were realistic, achievable, and likely to make a significant difference to the future of psychology if achieved. After input from the Future of Psychology Initiative co-ordination group to ensure that the strategies from the groups are compatible and form a coherent direction, these objectives and strategies will form the major focus for Future of Psychology Initiative's continuing activities.

Where to next: If you are concerned about the future of our profession, wish to participate and can commit to working with an action group we would like to hear from you. The action groups need representation from the whole of Aotearoa and from students to experienced psychologists. These action groups can then focus on long-term and short-term strategies and targets to make a difference. There was a strong mandate from previous hui or meetings to translate our concerns about psychology into action, a phase which has now begun. One member from the Future of Psychology Initiative co-ordination group will function as a facilitator to each group and help co-ordinate its actions and communication. These facilitators will meet at six-week intervals where progress is reported and issues discussed. They will also work with the professional associations to facilitate any initiatives where needed.

Send your request for participation via the email contacts below according to your area of interest. They will reply to you to begin co-ordinating the next steps.

Then it is up to us to make our future count!!

Contacts & Action Group facilitators:

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References:

Bellamy, A., Feather, J., Gibson, K., Howard, F. & Lambrecht, I. (2014). Psychology in Aotearoa – where are we going? *Psychology Aotearoa, 6*(1), 15-18.

Welcome to Australia's Guantanamo

Tracey Barnett

Tracey Barnett has been a contributing columnist and commentator for The New Zealand Herald, The Sunday Star Times, TVNZ and TV3, among others. She is the author of *The Quiet War on Asylum*, a concise introduction to asylum issues in New Zealand and Australia. She is also the creator of the asylum awareness campaign, We Are Better Than That and most recently, WagePeaceNZ, an initiative to increase the refugee quota and raise awareness about refugee issues in New Zealand. Her video and television commentary can be found on her YouTube channel https://www.youtube.com/channel/UCLjWWIMmQkXLDXRB2QLC_Rw. Her columns can be found on her website, www.traceybarnett.co.nz/. Her work has been published in ten countries.

It has a name that sounds like a Mel Gibson action movie, the *Australian Border Force*. But the asylum seeker prisons that have come to be known as Australia's Guantanamo are no fiction, with allegations of waterboarding, 'zipping' (zip-tying someone's wrists and ankles to a bed frame and dropping it with force), sexual assault, child imprisonment and endemic self-harm rates.

From now on, you aren't likely to hear any first person narratives behind the news stories either. Australia has just passed new legislation that effectively gags all staff, including doctors, nurses, psychologists, psychiatrists—indeed, any medical personnel—from talking to the media about conditions at the facilities. If a staff member does talk to the press, they may face up to two years in prison.

If the media tries to confirm recent Senate reports of what is happening inside, a journalist will be charged $8,000 just to apply for a press pass from the Nauru government, whether access is ultimately granted or not.

How, then, do we tell the story of Australia's offshore refugee imprisonment? Perhaps numbers reveal what those inside cannot:
The number currently held indefinitely on Nauru, Manus Island and Christmas Island: **1810**.

The number of children included in that tally: **93** on Nauru, plus another **104** children in Australia's mainland detention centres, making **197** children detained in total.

The number of incidents of reported child abuse on Nauru: **67** -
(30 of which are against staff at the facility.)

The number of asylum seekers that have been raped or sexually assaulted: **33** (with five more being asked for sexual favours in exchange for contraband items.)

The number of suicides or 'self harm' events: **253** (on average, one person every four days). Note, 'self harm' constitutes hangings, chewing glass, drinking chemicals, self-incineration, self-cutting, sewing one's lips together and attempted self-suffocation. One whistleblower told a Senate inquiry, "We were told if we saw people protesting or self-harming, not to look at them because it empowers them. We were told to walk away."

The number of assaults on detainees: **211** (that constitutes one person every five days).

The number of detainee deaths: **2**.

The number of guards now on trial for the alleged beating death of one detainee: **2**.

The percentage of adults who seek help from mental health nurses: **57%**. (Figures may be low, as assessment is voluntary and acute cases are less likely to self-report).

The percentage of children who seek help from mental health nurses: **44%**.

Time it takes to queue for a toilet: **45 minutes+**.

Number of Manus Island asylum seekers whose cases have been processed for resettlement: **0**

The cost to the Australian taxpayer for Transfield Services' recently renewed contract to run Nauru and Manus Island: **$1.2 billion AUD**.

Australia's contentious offshore detention policy has another cost—endemic hopelessness. Men, women and children are caught in limbo between the suffering they left behind

and the indefinite imprisonment they are experiencing now.

Indeed, Australia is doing something sadly innovative; they are paying developing countries to take Australia's human rights obligations off their hands. It's working too. Australian-run and funded asylum 'detention centres' have been established on Nauru and PNG in exchange for development projects and cash.

More recently, Australia approached Cambodia with $55 million AUD to resettle the few who have been processed from these offshore facilities. But because Cambodia has said it will take those who come voluntarily, only four refugees agreed to go, so far costing Australia almost $14 million for those four refugees alone.

Australia has been internationally condemned for its practices. Back on our side of the Tasman, what has New Zealand said about Australia forcibly shipping asylum seekers to third country imprisonment? Not a word.

In 2012, New Zealand introduced a 'mass arrivals' bill that would allow any future boat arrivals to be mandatorily detained. This new policy was introduced, even though New Zealand has never received an asylum boat (at least in modern history). New Zealand has had a longstanding international reputation for allowing asylum seekers to wait in the community for their cases to be heard. The bill passed, quietly.

Many in the New Zealand refugee community were further baffled in February of 2013 in Queenstown, when then Australian Prime Minister Julia Gillard came out of a conference with John Key to say that New Zealand was invited to send any future boat arrivals to Nauru and Manus Island.

Was New Zealand now comfortable being associated with Australia's contentious offshore detention? Did Australia's invitation mean we were quietly endorsing it? No one in the international community was sure.

With the influx of refugees into Europe making headlines in the last several months, average New Zealanders have started to hold up a mirror to our own refugee policies.

The reality of that reflection was surprising to those unfamiliar with this very small sector within New Zealand life. Per capita, we rank 90th in the world for the total number of refugees and asylum seekers we host. If you measure by GDP, we rank lower still, 116th in the world.

Indeed, our tiny annual UNHCR resettlement quota of 750 has been stalled for 28 years now. Meanwhile, our population has grown by almost 40 percent since the quota was set in 1987 and our asylum arrival numbers have dropped by roughly -75 percent since 9/11, making our per capita in-take nearly half of what we used to do decades ago.

In light of the magnitude of this current refugee crisis not seen since WWII, countries with a population comparable to New Zealand's have chosen to act. Ireland has offered to take another 2,900 refugees, bringing their contribution to 4,000. Norway has agreed to take 8,000. Lebanon, also a country roughly New Zealand's population size, is now attempting to support 1.2 million refugees, mostly Syrians.

New Zealand's response has been significantly less open, with Prime Minister John Key stating repeatedly that our quota of 750 'was just about right'. Recently reacting to widespread public support, the government has now offered to host an emergency in-take of 100 refugees this year, with another 500 over the next two years, bringing our total emergency in-take to 600 over 2.5 years. Currently, there are still calls to significantly increase the permanent quota.

The annual quota is due for its three-yearly review next year. To date, there has been no public comment by the New Zealand government about Australia's practice of indefinite offshore imprisonment of asylum seekers.

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(Those interested in keeping abreast of New Zealand and international refugee issues are welcome to 'like' WagePeaceNZ at: https://www.facebook.com/wagepeacenz).

Note: The NZ Psychological Society has hosted a petition asking for the New Zealand government to speak out about Australia's offshore detention. The petition makes particular note of the new legislation that will stop health professionals from speaking out. The petition has been sent to Prime Minister John Key and the Foreign Affairs, Defence and Trade Select Committee.

A quick cheat-sheet definition of terms:

Refugee: Someone who has crossed his or her home border owing to a well-founded fear of persecution due to political opinion, race, religion, nationality or social group.

Asylum Seeker: Someone still in the process of asking for refugee protection from another country. That means their case has not been determined. They have not yet been granted 'refugee status' by authorities, which carry more protections and rights under the UN Refugee Convention.

Pākehā/Tauiwi meet to discuss bicultural responsibilities

Some reflections from Rose Black

Rose Black (PhD) is a Pākehā New Zealander of Irish and Scots descent. She is a registered psychologist with a Post Graduate Diploma in Community Psychology and has been a member of the NSCBI since 1994. She served as a Bicultural Director on the NZPsS Executive for four years and is currently the Director of Social Issues. She works as a researcher and advocate with Poverty Action Waikato and the Anglican Action Centre for Social Justice and offers professional supervision.

In writing these reflections I am very much aware of, in particular, the Māori members of the National Standing Committee on Bicultural Issues (NSCBI) who have generously offered their gifts of time, sharing knowledge and aroha to work on strengthening the inclusion of Māori knowledge and practices in psychology for the last 24 years.

Following the 2015 Annual Conference a call was made by some of the Pākehā members of NSCBI to invite Pākehā/ Tauiwi to come together with the aim of strengthening our collective bicultural responsibilities and actions. As Pākehā/Tauiwi, what are we seeing/ experiencing in psychology in relation to bicultural issues, was the main question eleven Pākehā/Tauiwi community, clinical, educational, social and academic psychologists and two students considered when they met in Hamilton on 8 October 2015. To connect with each other we firstly shared our cultural/family stories, and how we came to feel that racism was unjust. It was a profound sharing.

In the discussion about bicultural issues in psychology today three general areas came to the fore: curriculum related issues such as attracting and retaining Māori students, frameworks, and accountability; becoming critically aware of (de)colonisation practice; and cultural supervision.

Curriculum

Curriculum issues related to attracting and retaining Māori students, teaching frameworks and accountability; becoming critically aware of (de) colonisation practice; and cultural supervision were the three themes that emerged from the discussion.

There is a genuine will to engage with some of the power structures, and the operation of institutional racism in both subtle and at times blatant ways needs to be constantly examined, addressed and challenged. That is a role that we Pākehā/Tauiwi need to recognise and support each other in finding effective and collective ways to challenge. For example, the way teaching and training programmes operate as barriers for Māori to achieve full qualifications in psychology. Some of the barriers to attracting and retaining Māori students were noted as a lack of structural and academic support, a lack of inclusion of Māori epistemologies, the time it takes, and the economic burdens such as the ongoing cost of student loans and access to student allowances for the whole period of required study. Some academic staff are noticing increases in the stress students are experiencing and also a change in student demographics – for instance, there are now more supported students who are white, middle-class women, and fewer Māori and fewer men in professional training programmes.

Becoming critically aware of (de) colonisation practice

There is a need to create 'useful' psychologists who enter the local context with an understanding of biculturalism in practice. Questions were raised about the time spent in learning uncritical western frameworks at undergraduate level. A culturally appropriate, decolonising curriculum could be offered in a shorter time which would include the de-centring of Western frameworks and the centralising of indigenous concepts, in conjunction with a focus on critical approaches to psychology at stage one and the inclusion of these approaches all the way through degree structures and professional training.

There are some examples of training programmes for the 'helping' professions that have been developed such as the programme developed by Dawn Darlaston-Jones at Notre Dame University in Perth and some of the polytechs in Aotearoa. I would

also like to draw attention to the article by Berman, Edwards, Gavala, Robson & Ansell (2015) in this edition of *Psychology Aotearoa* as they write about the reflections, review and renewal of the Education Psychology training programme at Massey University informed by both Māori and bicultural frameworks.

In taking accountability to reduce and stop 'white' dominance in psychology it was suggested that increasing the membership of the Psychological Society was a way of strengthening a collective rather than an isolated and individual approach to decolonisation.

The process of becoming bicultural and critically aware of (de) colonising practices requires learning the nuances of a culture, changes in belief systems, and changes in our competency beliefs. While all of this takes time there is an urgency to step up and work together to develop effective skills and supportive ways of calling out practices that maintain racism, in ways that don't alienate people. We recognise the power of story and testimony, our stories can provoke change and provoke conversations and encourage others. Let's find ways to use them more.

Cultural supervision

As we discussed cultural supervision a number of points were raised. For example, the need to 'get it right' that dominates Pākehā worldview is almost at odds with Māori ways of being, and can act as a barrier to understanding different ways of knowing and being. Cultural (in) competency is often ignored or minimised in a system which emphasises and rewards 'competency' – how can we be more honest about our inter-cultural inadequacies?

Cultural supervision is not just around learning/speaking te reo, but involves embodied ways of being and knowing. For Pākehā/Tauiwi working with complex mental health issues, for example, requires more depth of understanding than is currently available. Specialist cultural supervision from Tohunga may need to be accessed to address such complexity, especially in regards to matekite, makutu, wairua and distress.

When we 'miss' opportunities to voice our concerns about issues of racism or colonisation – how do we debrief and learn collectively about how to do better next time so we don't keep repeating patterns of silence and letting things go? We need to keep on learning different responses.

We agreed that we would meet again before the end of the year, consider holding a Pākehā/Tauiwi caucus at annual NZPsS conferences, facilitate workshops, consider setting up a web-based discussion board, publish our views/ thoughts/questions in NZPsS publications especially *Psychology Aotearoa* and *Connections*, and learn some Pākehā songs.

"We want to be the sort of Pākehā that Māori thought they were getting when they signed the Treaty" – Mitzi Nairn

He mauri, he Māori: Te iho, te moemoea, te timatanga ō mātou journey into Te Ao Tūroa (the world in front of us) in Educational

Jeanette Berman, Terence Edwards, Jhan Gavala, Cathy Robson and Judith Ansell

Dr Jeanette Berman *(2nd from right)* is Director of Educational Psychology at Massey University. She is a registered psychologist in both Australia and New Zealand, with an interest in learning and learning difficulties. With a career of three decades as a teacher and school psychologist, Jeanette uses that professional experience to support her work as a psychologist educator. Jeanette's most recent publication is Graham, L., Berman, J. & Bellert, A., 2015. *Sustainable Learning: Inclusive practices for 21st century classrooms.* Melbourne: Cambridge University Press.

Terence Edwards (*right*) is the current coordinator of the Postgraduate Diploma in Educational Psychology (internship) at Massey University. He lays claim to being the proud product of Massey University, having completed his undergraduate, graduate, and professional training there since first enrolling there in 1995. He is a registered Educational Psychologist with 15 years professional experience in New Zealand and has had a variety of roles in applied practice, managing teams of psychologists as well as multi-disciplinary teams. He has a particular interest in the promotion of professional ethics and critical thinking as essential requirements for professional practice.

Jhan Gavala *(left)* is a NZ registered psychologist and lecturer at Massey University, School of Psychology. He has 15 years' experience in delivering child, educational, developmental and indigenous psychological services. He has work experience in hospitals, schools, Māori organisations, private practice, government departments, governance boards and university settings. He is a past Bicultural Director of the New Zealand Psychological Society (2006/7), and past member of the New Zealand Psychologist Board (2012/15).

Cathy Robson *(far right)* is an Educational Psychologist at the Ministry of Education working in the Behaviour Service. She completed the Internship programme at Massey University in 2014. She has a particular interest in using Video Self Modelling with students to support change behaviour. Cathy completed a thesis using Video Self Modelling to improve reading fluency of struggling readers.

Dr Judith Ansell *(3rd from right)* is a NZ registered Educational Psychologist with a PhD in biomedical science from the University of Auckland, and is currently teaching in the Educational Psychology programme at Massey University. Judith has a special interest in the interplay between cognitive and behavioural development, especially in the area of executive function. Judith's PhD project was titled *Children with Hypoglycaemia and their Later Development: The outcomes of neonatal hypoglycaemia* and she contributed the developmental data to her latest publication: Christopher McKinlay; Jane Alsweiler; Judith Ansell;…. Jane Harding; and the CHYLD Study group (2015). Neonatal glycemia and neurodevelopmental outcomes at 2 years. *The New England Journal of Medicine 373*(16),1507.

haerenga ki Te Ao Tūroa / Our vision and beginnings of a Psychology

We acknowledge Dr Rarawa Kohere, Nephi Skipwith, Haahi Walker, Margaret Kawharu, Dr Ray Nairn, the Massey University Educational Psychology Advisory Group, our students and their field supervisors and colleagues for their contributions to this journey.

For the last three years we have been engaged in a journey of reflection, review, and renewal. Here we share the beginnings of our journey as a professional education programme and our moemoea (vision) for establishing culturally appropriate professional practice in educational psychology. We include discussion on how we support our intern psychologists to review and plan their own development in order to best engage with and support ākonga (teachers and learners) and whānau.

Our opportunity and our responsibility

As a bicultural country with an increasing body of psychological research based in te ao Māori (a Māori worldview) and carried out through kaupapa Māori (Māori approaches) Aotearoa New Zealand (ANZ) presents a unique context for the practice of educational and school psychology related to learning and teaching. However, the psychological profession as a whole has continued to grapple with calls from the 1980s for a bicultural psychology. In order to ensure that psychological practice aligns with the realities of the cultural context within which it is practiced we need to respond to these calls purposefully, respectfully, and consciously. In 2013, tasked with renewing the educational psychology programme at Massey University, we determined that te ao tūroa needed to be firmly embedded in a bicultural foundation of discipline knowledge.

Educational and school psychology is a discipline of psychology that is most closely related to communities through their schools, working at levels of prevention and early intervention. It is imperative that psychological knowledge is able to make sense of the world views of the communities and people with whom we work, assisting in designing and maintaining the most supportive contexts possible for realising the learning potential and wellbeing of all learners.

The first calls for a distinctively appropriate psychology for Aotearoa came from work in the mental health arena in the 1980s (Durie, 1984; 1985; Abbott & Durie, 1987), and was reiterated by Ritchie (1992) with a focus on bicultural psychological practice, and Thomas (1993) who highlighted two critical considerations: the training of Māori psychologists and changing expectations for bicultural services in organisations and institutions. There was recognition of the crucial role of university training programmes in adapting curricula and teaching to support both Māori and non-Māori students to develop the competencies necessary to work effectively with both Māori and non-Māori clients. Nathan's (1999) thesis, as a follow-up of Abbott and Durie's (1987) study, indicated that little progress had been achieved in the previous 12 years. Others also report the continued predominance of a largely monocultural psychology (Levy, 2005; 2007; Milne, 2005; Gavala & Taitimu, 2007) which does not meet the needs of a bicultural society. At the 2014 *Future of Psychology* forum discussion highlighted that we largely continue to employ Western psychology, too often adding cultural components in an ad hoc and tokenistic way. This has to change.

Section 118(a) of *The Health Practitioners Competence Assurance Act 2003* requires the New Zealand Psychologists Board (NZPB) to accredit and monitor educational organisations and courses of study. The NZPB developed a set of standards and procedures in collaboration with heads of university departments, the New Zealand College of Clinical Psychologists, and the New Zealand Psychological Society (New Zealand Psychologists Board, 2012), which are used to accredit training schemes that lead to psychologist registration. Review of the Board's "Accreditation Reports" (available online) reveals that some programmes, although accredited, need to demonstrate that they are meeting the requirement that "*[t]he teaching and learning methods should include consideration of the cultural frames of reference, values, and world view of Māori*", (standard 2.1.3 New Zealand Psychologists Board, 2012). Professional training programmes are also advised to demonstrate and evidence the cultural nature of the work, the direct exposure of trainees to cultural issues, and consideration for including Māori staff within programmes. Anecdotal information supports the Board's position that further development of cultural components in psychology training is needed to enhance the relevance of psychology to Māori, Pākehā, and Tauiwi (newly arrived) students.

Our vision for bicultural psychology

Our vision is for a programme that is firmly grounded in a Māori worldview, and is enhanced and informed by Western psychology. We refer to this perspective as ***ngā tikanga rua o te taha hinengaro*** (a psychology of two protocols) which is predominantly indigenously informed and driven, for application (and critique) in Aotearoa. Western psychology has informed discipline knowledge, research and scholarship in programmes across the world, more often than not neglecting indigenous perspectives. Text book companies perpetuate Western psychology and provide learning activities and multimedia resources for teaching. It is relatively easy to develop and teach a course that is supported by pre-prepared teaching materials. It is much harder to start from the ground up and create not only the structure and topics, but the teaching materials that allow that content to be sustained.

Rather than trying to add cultural dimensions to a Western worldview, we have taken the approach that we need to ***start*** with ngā tikanga rua o te taha hinengaro discipline knowledge, scholarship and research. In Aotearoa we have locally developed structures and an increasing wealth of accessible indigenous literature to draw from which will support this approach. As a foundation we have drawn from one of the main drivers of this movement in ANZ educational psychology, Angus Macfarlane and his colleagues, to provide ways of thinking that assist us.

First is the idea of ***tō tātou waka*** (our waka), that is, culturally reasoned epistemology (Macfarlane, Blampied and Macfarlane, 2011) as a way to develop a shared meaning around psychology drawing on both Māori and Western knowledge bases. Such a process of co-construction built on a foundation of indigenous community values, knowledge and the best available research evidence will result in evidence-based, culturally responsive practice.

Second, a framework that helps us make sense of this tikanga rua discipline knowledge, is the metaphor of ***He Awa Whiria*** or braided river (Davis, Fletcher, Groundwater-Smith & Macfarlane, 2009). From this perspective psychological knowledge is viewed as fluid, fed by different streams that converge and split into new channels. Such a metaphor helps us recognise the valuable contributions that both Indigenous and Western knowledge have and the capacity for this knowledge to pool to create and inform ngā tikanga rua o te taha hinengaro. The metaphor also acknowledges the perpetual changes in our knowledge and understandings as the braided river is fed by new waters.

Our task is to set up a process of exploring the different channels and pools of mātauranga Māori and Western psychologies and seeing how they are compatible. Western psychology has been formally and explicitly deconstructing the complex multidimensional human experience through research and literature. However, in the latter part of the 20th century parts of Western psychological knowledge have been gradually reconstructed to become increasingly strengths-based and positive, inclusive, ecological, collaborative, ethical and sustainable, and these are our defining characteristics of and for contemporary educational psychology.

In contrast to the Western tradition, mātauranga Māori has remained connected and intact through tangata whenua, whakapapa, whakawhanaungatanga, mātauranga and tikanga (people, relationships, indigenous knowledge, and protocols). There is an increasing body of texts and resources available to provide access to mātauranga Māori psychological knowledge and content. Most recently, the soon to be published work of Waitoki & Levy's (2015) *E koekoe te tūī, e ketekete te kākā, e kūkū te kererū: Kaupapa Māori psychologies in Aotearoa New Zealand* will provide discipline knowledge that is firmly grounded in Māori epistemology. This new text complements the Nairn et al. (2012) book that preserves knowledge and thought from past bicultural keynote speakers at our professional conferences, all contributing ways in which we can realise ngā tikanga rua o te taha hinengaro.

Our vision for a culturally safe and responsive psychologist education programme

There is a need to develop a culturally safe, responsive and competent psychologist education programme that does not threaten nor diminish the inherent mana of its student body. We need an environment that is able to traverse the transitions from tapu to noa, and repeat this cycle appropriately within the context of ako (teaching and learning) in order to address the inherent mismatch between training programmes and the culture of the students and the communities which they will eventually serve. It should not be necessary to give up one's culture in order to become a psychologist. It is within the context of very low numbers of Māori psychologists, and perpetual national discussions about how to increase the Māori workforce, that we must reshape and reframe our tertiary education to create a programme and profession to which Māori will be attracted because they will see the profession as a place they belong and in which they can engage actively in their own learning and that of their peers.

A model of Māori student success (Ka Awatea; Macfarlane, Webber, Cookson-Cox, and McRae, 2014) derived from research within Te Arawa in the past couple of years provides us with a lens into this topic. This model articulates dimensions that support Māori student success within the context of one iwi.

Table 1: A model of Māori student success	
Mana Motuhake	a positive sense of Māori identity
Mana Tū	a sense of courage and resilience
Mana Ūkaipō	a sense of place
Mana Tangatarua	a sense of two worlds
Mana Whānau	successful students are nurtured into succeeding in both worlds by their whānau

At the level of educational settings and psychological practice these are significant drivers that can support our work. As is the model within which they were articulated (also see Abraham, Priestley, Lemmon & Berman, 2015). It firmly anchors consideration of learning and development, achievement and success, within a temporal and ecological context, without which consideration of these dimensions is meaningless. There is a significant compatibility between this model and the sociocultural, ecological frameworks taught in contemporary educational psychology.

Our vision for culturally competent and responsive psychologists

An outcome of the internship year of professional learning for our educational psychologists is demonstrated cultural competence as a foundation for all other competencies. These professionals also work in an education system that is very conscious of the need for Māori and Pasifika cultural knowledge to be inherent in all professional work and activities.

Our interns organise and manage their learning in reference to a range of cultural competence frameworks in educational and psychological professional contexts. They share and reflect on their learning journeys in peer supervision and with their supervisors through an electronic portfolio. Cultural competence is expected to be embedded within every other core competency, as a lens for considering development and learning needs across all knowledge and skills for psychological practice. Conscious explicit development of cultural competence begins in undergraduate papers, and becomes increasingly explicit throughout the Masters and professional practice papers. The lifetime journey towards increasing cultural competence is set up through reflective practice and professional development planning, as exemplified by Cathy's story of her journey.

Figure 1. A beginning psychologist's reflections on her cultural competence development

E kore e mutu te ako- Learning is a journey not a destination

Cathy Robson

During my internship year the NZ Psychologists Board Core Competencies were a springboard for my learning and myPortfolio* was the vehicle for capturing and reflecting on this learning journey. There was no set pathway for our cultural learning journey, but it was focused on the knowledge and skills of the second core competency, Diversity, Culture and Te Tiriti o Waitangi. Being completely self-directed enabled us to use our own resources, connections and interests to plan our journey and document it. Each person in the class had their own way of learning and development which was really exciting to see at the block courses.

My learning journey started out small, attending the Māori language class, this then sparked an interest for me in sharing my learning with others and engagement with Māori language week at work. Learning a Mihi and finding out about my own beliefs, family and culture also came alongside a stocktake of my learning of the Māori culture to look at how this has an influence on my work as a psychologist. Having a better understanding of these key things, I went deeper to explore the Ministry of Education point of view surrounding success for Māori people and the frameworks that sit behind this goal of success, which I was able to apply directly to my work.

In the journey from student to psychologist I have needed to weave my theory and my background together with the culture of the whānau and schools with which I am working. I use te Tiriti o Waitangi, and frameworks such as Te Pikinga Ki Runga (Macfarlane, 2009), Ka Hikitia (Ministry of Education 2013a) and Tatai Pou (Ministry of Education, 2013b) to become conscious of and responsive to the school culture and the cultural customs of the family with whom I'm working.

As I transform from intern to psychologist, I am conscious of the need for continued competence development. This process was not just something that was done for a university requirement, instead I have started to develop practices and skills, and I am making a conscious effort to continue that development and to add to my kete. I continue to reflect on practices with guidance from kaitakawaenga, using appropriate frameworks and pathways to evaluate competence and improve on practice.

* See www.myPortfolio.ac.nz

He Tohu: The beginnings of our journey

As a part of our journey, we have partnered with a number of people who have contributed kaupapa Māori māramatanga to the team's thinking. Development of He Tohu / our symbol (see Fig. 2) to represent our journey grappling with conflicting world views has been an integral part of this journey, and we have been supported in this by Dr Rarawa Kohere. He Tohu is a representation of the programme's renewed 'way of seeing' psychology for Aotearoa.

Figure 2. He Tohu

This representation illustrates the significance of Wairua, Waiora and Hauora and our spiritual, mental and physical well-being as individuals, whānau, hapū and iwi – inclusive of other cultural approaches to the way we organise ourselves (Kohere, 2014). The blue oval represents Rangi – the heavens; the three pāua koru represent mana atua, mana whenua and mana tangata; Whero (the red lines) represents toto (blood) and the interrelationships between all people, place and land; Mā (the white space) represents tikanga (spiritually derived), and all existence in between Rangi and Papatūānuku, whakapono (beliefs), whakapapa (genealogy), kaitiaki (guardians); and lastly the Greek letter Psi represents the academic vision and Western psychological knowledge that comes to join with and contribute to our Indigenous perspective. The Psi is purposefully left of centre to indicate that it, as a representation of Western thought, does not dominate or have centre stage in informing our kaupapa.

In line with the representation in He Tohu we draw on Māori ways of seeing to filter Western discipline knowledge, and actively and critically consider compatibility. Although the model is represented as a two-dimensional figure, we conceptualise it occupying at least a three dimensional space. We imagine it be a sphere, where each of the contributing elements, at varying times "come in to focus", and are more or less prominent at times dependent on circumstances. It is a fluid, dynamic, and multidimensional representation of how we have conceptualised and interpreted the koha that Dr Rarawa Kohere has offered us. The processes of culturally reasoned epistemology and the braided river are enacted in both the development of the content of our new educational psychology papers and the processes of student learning activated by the course.

At the 2014 Future of Psychology forum discussion highlighted that we largely continue to employ Western psychology, too often adding cultural components in an ad hoc and tokenistic way.

Educational psychology at Massey University is being reframed to fully realise ngā tikanga rua o te taha hinengaro. From undergraduate to postgraduate and into professional education, we are revising and updating our focus and emphases. Knowledge of mātauranga Māori as well as Western psychology is inherent in programme content.

We have reconceptualised our Master of Educational Psychology content papers to be guided and informed by Māori constructs and conceptualisations. Space constraints limit detailed discussion here so the table below reflects a at a glance view of the essence of these new papers.

Table 2: New papers for the Massey University Master of Educational Psychology

256.701 Ako: Psychology of learning and teaching	256.702 Hauā: Psychology of diversity	256.703 Wharekura: Psychology of educational settings
256.704 Waiora: Psychology of wellbeing	256.705 Whanaungatanga: Psychology of relationships in ako	256.706 Whakapiki: Psychology of intervention for change & development

Our vision is more than just realising ngā tikanga rua o te taha hinengaro discipline knowledge, scholarship and research as the first core competency for our practice as psychologists. It is about having a programme that

is culturally respectful, responsive and relevant for Māori and all our students, and it is about all our practitioners being culturally competent across all domains of practice. We look forward to travelling on this journey with colleagues from other programmes and wider profession as we continue to develop our thinking. Psychology in today's world is influenced by the past, it could not be any other way. However, we argue that psychology today, here in Aotearoa, should not be confined only to the past of Western psychology. It must also be firmly embedded within the wisdom and understandings of indigenous perspectives and experiences if we are to resolve our struggle for Aotearoa and honour our bicultural heritage. We have many 'waterways', contributing to a bigger 'ocean' (to use the imagery conveyed within He Awa Whiria) and have a responsibility and opportunity to act. This thinking inspires us to actively engage and take the steps needed to finally answer the call from the 1980s for a relevant professional psychology for Aotearoa New Zealand.

We look forward to travelling on this journey with colleagues from other programmes and wider profession as we continue to develop our thinking.

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The NZPsS Conference held in Hamilton had the theme Te Ao Tūroa- The World In Front Of Us. It was a well attended and vibrant conference with the breadth of papers and workshops the NZPsS conferences are known for. We feature contributions from our opening speaker Mere Balzer and two keynote speakers, Willem Kuyken and Gerald Monk.

Opening address to New Zealand Psychological Society Conference 2015

Mere Balzer

Mere is of Te Arawa, Ngāti Raukawa and Ngāti Ranginui and Maniapoto descent. She is the Chief Executive Officer of Te Rūnanga o Kirikiriroa Trust, a Māori Urban Authority in Hamilton which recognises and acknowledges the sovereign rights of mana whenua and tangata whenua. The Rūnanga was established in the mid 1980s under the direction and guidance of the late Māori Queen Te Atairangikaahu and Mayor Sir Ross Jansen to address Article III issues of the Treaty of Waitangi and to be a voice for Māori and Pasifika peoples within the environs of Kirikiriroa. Mere's background is in health (RN) and education (HOD, Nursing and Education), she has sat on a number of local, regional and National committees including; Waikato DHB Board, National Council of Māori Nurses, Health Waikato Advisory committee, Health Research Council Māori, National Urban Māori Authority (NUMA) Executive member.

Tena koutou katoa, e te whare tena koe, Tainui tangata, tainui whenua tena koutou. E te matua e Ray nau I whakatau mai ia matou I tenei raa, ka mihi. Noreira nga mana, nga reo nga hapu karanga maha tena ra koutou katoa.

I'd like to acknowledge the team who committed to co-ordinating this, the 2015 Annual Conference of the New Zealand Psychological Society, the sponsors without whose support conferences such as these might not be viable, the esteemed guests (e nga hau e wha) from the four corners of the world, who will be presenting during this conference and you the members and friends of the Society. Without you there would be no conference.

Te Ao Tūroa- The World in Front of Us

I'm going to address the conference theme Te Ao Tūroa, the earth, nature, enduring world, natural world, by taking the concept whanau ora and looking at one organisation's journey through its implementation.

Many people associate whanau ora or family wellbeing with the honourable Tariana Turia and it would be fair to say that had it not been for Tariana the drive to examine clinical practice from a paradigm outside of the medical, professional, individualistic model might not have found a funded platform. The idea that whanau are integral to world well-being is not new -it is universal. The difference can be in one's perception of whanau. At its most basic whanau are defined by genealogical links, genealogical links that are not narrow and nuclear but wide and encompassing of the extended family. This view dramatically increases membership, contact, support, prospects and potentialities for professional practice.

When Te Runanga O Kirikiriroa adopted Whanau Ora, we made a commitment to examine every aspect of our organisation from the values that we espoused to the environment in which we worked. We wanted to ensure that our practices, were congruent with our values. We had already accepted that our values, handed down over many generations, were timeless. Those values common to a number of organisations are:

Whanaungatanga
Aroha Ki Te Tangata
Rangatiratanga
Manaakitanga.

The first thing that became patently clear following the decision to embrace whanau ora was that our working environment did not support nor enable us to work in a way that was reflective of what our understanding of whanau ora meant nor did the environment make it easy to work to those values. Our offices were arranged around contracts. We had 15 service contracts and staff associated with each contract worked in their own little siloes. While a lot of rhetoric was spoken about how as an organisation we interacted and worked in the best interests of our client

group, we couldn't. Our funding depended on, and still does, our meeting KPIs identified in the main by a faceless bureaucracy with little input from us as the service provider and none from our target communities.

Still, whanau ora introduced a new perspective to the funding of contracts and we were able to discuss the implementation of outcomes based reporting rather than outputs reporting. Note I said discuss…. A break through?

For us the recognition of whanau ora as a legitimate model of practice meant being able to utilise the expertise and skills of staff over a range of services. As well as the expertise that staff had been trained in, personal skills were introduced (Marcus- musician, Michael-poet, Shirley-budgeting and nutritious cooking on a shoe string). We discovered a wealth of skills amongst our staff that enhanced the work we did and we argued, most times successfully, sometimes not, that these personal skills be recognised as legitimate and be reported against. No the contracts did not necessarily reflect an outcomes based reporting formula but the discussions were able to be had and an opening for negotiation was born.

For us the recognition of whanau ora as a legitimate model of practice meant being able to utilise the expertise and skills of staff over a range of services.

We were aware that we needed to carry out major renovations to our work space if we were to achieve an environment conducive to working in a whanau ora way. If we were committed to moving our focus away from, for example, the number of face to face visits, the qualifications of staff or clinical versus non clinical FTEs to answering the questions; are we making a difference in the lives of those who come to us in need and how? We needed to honour our staff, indeed everyone who entered our working environment. This included the physical space that they worked in, the ambiance of that space and the ability of staff to access resources making it easier for them to (a) identify the outcomes that clients wanted to achieve and (b) facilitate the meeting of those outcomes. I use the word facilitate deliberately. Adopting whanau ora and moving it from a concept into practice meant a change in the way that our skills and expertise was implemented. Moving our thinking from one of the omniscient clinician holding power over through knowledge, to one that was more reflective of the whakatauki

"Ma to raurau, ma toku raurau, ka ora ai te iwi" Your food basket and my food basket together will feed the Iwi.

We were fortunate, a number of factors converged to allow major changes to occur. Four years ago we had architects plans and costings ($1.9million) and a staff proposal to manage the renovations. The bulk of the internal renovations took six months. During that time our staff were extra busy with not only their daily duties but on a number of projects and going paperless, introducing new IT programmes in particular a client management programme and filing programme or archival retrieval system in real time. An all new communications hardware was also on the plan of action as was a robust training programme. It was out with the old and in with the all new furniture and furnishings.

We broke every known convention and the renovation has proved a boon with a child and baby friendly environment and hot desking means that staff are free to choose where in the building they work. Some choose to work on lap tops in the kitchen which is the hub of the main office. One staff member sat, just sat for a week and did nothing. She was in shock and taking time to absorb the changes. She is now one of our most innovative staff members.

It is this inclusion of staff in all aspects of change management that reflects whanau ora in action. The family of mankind has many and varied skills that should be nurtured. If in the work environment staff are confined to meeting contractual obligations they don't thrive, they are not fed and in turn cease to feed others. It certainly helps if the governance and management bodies have a clear analysis of what it is one is striving to achieve and are able to articulate this. It is our experience that one should never wait until the last person is on board before cast off as too many people are lost during the wait. Better to pay for an airline ticket for them- with an open use by date.

So having dealt with the easy things, a full refurbishment, move from a paper to paperless environment, no set abode or desk or chair or pen or paper and ruler we come back to those values again, values that should underpin practice.

The Board of Trustees in deciding which values they would adopt chose to not define each of the terms allowing the organisation to interpret them according to the environment and services to which they were applied. However, making a statement that "we will leave you to interpret these values and apply them as needs be" then leaving staff to get on with it was both impractical and doomed to failure. We needed to create a situation whereby staff could start to define, refine and interpret those values. This was achieved at a two day wananga. Many of the established practices within the organisation already reflected our adopted values. Whanaungatanga for instance-it took staff some time to accept that it was alright

to take their partners or children on organisation wananga but they did accept this and the organisers of the wananga ensured that competent, trained child minders were present.

The approach taken for the wananga was to delve more deeply into what the words whanau, manaaki, aroha and rangatira meant and then how these meanings might be reflected in practice. Four groups were formed and each group spent half a day on each kupu or word.

Whanau- A number of meanings were identified, the most common being the extended family coming from genealogical lines. Another meaning is to give birth. In the sentence Ka whānau mai he whakaaro (an idea is born), it means to produce (an idea or thought), it is the inspiration for change. Whānau is also used as a metaphor for close friends or associates, intended to be inclusive and build a sense of group unity.

So what are the implications of whanau or whanaungatanga for practice? A common mantra of professionalism is the word objective or objectivity. This word implies notions of the professional as observer, impartial, unbiased, even handed, not involved, dispassionate. Within a whanau ora context being objective would most certainly mean not connecting with the client not having the ability to give birth to ideas or thoughts on meeting the client's needs. Not connecting with the client would mean being ineffective and meaningless as a practitioner with that client. *Recent CYFS report*.

Aroha- It was decided is much more than love. It is also mindfulness aro to look at or into. To have insight into through ha the breath of life. Being in tune with every fibre of your being through ha. Young people today spell love TIME. It's about taking the time to share one's breath together, to share intimacies to look at and into others through the sharing of breath in the moment. The feeling of oneness for another, the indescribable feeling one experiences when your moko smiles sleepily up at you in recognition as they wake.

We broke every known convention and the renovation has proved a boon with a child and baby friendly environment and hot desking means that staff are free to choose where in the building they work.

How is this expressed in practice? As a nurse I loved the poem "*Crabbit Old Woman" (by Phyllis McCormack) in particular the line "What do you see what do you see, Are you thinking when you look at me? A crabbit old woman not very wise uncertain of habit with far away eyes …..IS that what your thinking is that what you see? …….. So open your eyes nurse, open and see. Not a crabbit old woman look closer see me.*" If she is Māori, she is pleading with the nurse to see her through the lens of Aroha. Look at me by sharing our breath of life. In far too many instances we as professionals look through the book of theoretical knowledge which should only ever be applied to enhance what you have deduced through Aroha.

Manaaki- Broken down Mana Aki- Staff were asked to brainstorm mana, what it meant to them and when or where they had heard the word mana used? They came up with around 26 examples. Included were Mana muncher, Mana Rangatira, Mana Wahine, he/she has got mana. Examined more closely Mana Muncher was seen to be a derogatory term a blow off of another person. They asked the question what are the characteristics of someone who has mana, the way they conduct themselves, their language, birthright etc? And what did mana wahine or mana rangatira imply for the way we practiced? Then looked at the implications for practice.

Language- Use of names -Research the genealogy of one's name rather than using terms such as bro, cuz which are terms designed to make one invisible.

Powerful/strong women- The most powerful thing a woman has is the ability to give birth so discussions about te whare tangata as a strength and the basis for talking about sexuality, birth control etc.

Power/strong people- Whanau ora is common sense. It is at once both an extremely simple concept whilst being almost impossible to implement. It is contingent on a number of things coming together at once. First people need to be able to work together in trust and with integrity. Well that's simple to do I can hear some of you say? Take it from me in this country of individual rights and non-existent responsibilities it's far from simple.

Young people today spell love TIME. It's about taking the time to share one's breath together, to share intimacies to look at and into others through the sharing of breath in the moment.

The cost to implement whanau ora can be prohibitive especially for those in the NGO sector. Much of the sector has not had a cost of living adjustment to their contracts since 2010 yet more and more accountability requirements are imposed e.g. increased KPIs, health and safety regulations and reporting criteria. In the meanwhile salaries track up and food, petrol, electricity increase. Many NGOs are now struggling with an increasing number looking at following those who have closed their doors and liquidated. No

Canterbury Finance or Arab sheep farmer hand-outs here. While the cost of implementation may be high in the first instance, done well the long term gains will be huge across many domains. This could be reflected within the contract price.

Finally, it requires a change to the way we think about clinical practice starting with the belief that given the right environment and support most people who are currently disaffected can and want to make changes for themselves. They have the potential to be the lead partner in that change process and we are potential facilitators or agents of change. It means a complete rethink of how we operate as employers and as professionals and we need to examine what constitutes a whanau ora compliant work environment? It requires that we stop allowing ourselves to be bullied by politically inspired bureaucratic processes that are frantically spiralling out of control. When we can address these issues **Te Ao Tūroa- The World in Front of Us will be a nurturing place to be.**

In conclusion I want to take time to read some prose from a dear friend of mine Robert Mingi Elliott or Bobby as his friends call him. The words are taken from a paper he together with a group of fellow workers delivered to the Australian Congress of Mental Health Nurses Conference Adelaide 23 September 1986 entitled the Galleries.

The Natural World: The world of the Māori

We are the descendants of an ancient people
Who journeyed across the face
Of the Earth Mother, or Papa-tu-a-nuku,
To settle in Aotearoa / New Zealand
In the South Pacific.
Our culture is rich in the historically changing perspective
Of our people, of their long sea voyages,
Peace and war and of survival.
They wore the mantle of the land with dignity and respect;
Hearkened to the ways of nature; appreciated the elements;
Speculated the cosmos; identified their insignificance
With the universe and knew their human fragility
With Io, the Supreme Being, their God.
Taha Māori embodies the primal heart-beat
Of a sophisticated people-caring culture
That acknowledged the balance and effect
Of their natural and other worlds
Although no writings existed - they "read" the cosmos;
The tides and seasons; the days and nights
And their surroundings with flora and fauna.
Decorations, patterns, carvings and symbols
Spoke their own messages - personally, locally and tribally.
In the quietness of such observations the messages were clamorous.

The Enduring World:

The timeless twinkle of celestial lace in a crystal-crisp night sky;
The warm, open smile of an innocent child;
The calm, caring touch of a faithful friend;
The denial of pleasures to give to another
And the protection of basic principles
For the Families of Nature and Humankind.

The world in front of us.

Time-warps and psycho-jabble, disposable people and money "Gods";
Wasteful newsprint and instant out-dated news;
Push-button wars and constipated cities;
Concrete paddocks and flatulating freeways;
Befouled nests and fast-track neuroses.
The world In front of us is also the orderliness
Of efficiently-glazed bureaucratic pyramids;
Clinically-clean scientific practices; rotating money piles;
Free-wheeling futuristic fantasies and closed cliques of collaborators.
In TODAY's WORLD, of fast-track technology,
Human casualties litter the Environment
In greater numbers than empty beer cans…….....

Such CASUALTIES can be found in statistics and dole queues;
Prisons and on the fringe of Society; in therapy sessions
And schools; in homes and drug circles;
In the undergrowth of concrete jungles and amongst ourselves.
WHO nurtures the Dispossessed?
The Dispossessed - who are mainly WOMEN:
The Daughters and Sisters; the Wives and Partners
And the Mothers and Widows
Who bear the GREATEST burden
In this Process of Dispossession.
If THEIR Dimensions are intact, THEY do.
If THEIR Dimensions are DISINTEGRATED, WE do.
If OUR dimensions are non-existent, NO-ONE does
Although WE may pretend otherwise
Our "professionalism" can negate suspicion.

R.M. (Bob) Elliot

Mindfulness-based cognitive therapy in the mainstream

Willem Kuyken

Willem Kuyken is Professor of Clinical Psychology at the University of Oxford in England and Director of the Oxford Mindfulness Centre. He is a mindfulness researcher, teacher and trainer. His work with people with mood disorders spans twenty years, he has been teaching MBCT since 2001 and his work is underpinned by a longstanding mindfulness practice. He has published on mindfulness mechanisms, clinical trials and implementation.

It was a great privilege to give a keynote at the 2015 New Zealand Psychological Society Annual Conference. I now also have the opportunity to develop some of the ideas in a commentary for *Psychology Aotearoa*.

Mindfulness is finding its place in the mainstream in a range of contexts, including health, education, the criminal justice system and the work place. Although this brings exciting possibilities, it also raises important questions. A theme I developed in my keynote was "what will support the sustainable development of this field?" I would like to suggest four ideas.

First, any mindfulness-based intervention needs to be clear about its intentions, aims and context. When Jon Kabat-Zinn had the extraordinary insight to develop mindfulness-based stress reduction (MBSR) (Kabat-Zinn, 1990), he was clear that ancient meditative practices might have much to offer people suffering with long-term health conditions. He then considered very carefully how best to offer mindfulness in mainstream North American hospital settings. The result was the 8-week MBSR programme that has now been taken by tens of thousands of people. Zindel Segal, Mark Williams and John Teasdale were equally clear when they developed mindfulness-based cognitive therapy (MBCT) for recurrent depression (Segal, Williams, & Teasdale, 2013). Their theoretical account of depression, articulated and refined through experimental work, is the focus of MBCT (Teasdale & Chaskalson, 2011a, 2011b). The teacher conveys the MBCT course themes in all aspects of the course, so that participants have opportunities to learn to respond resiliently to those pivotal moments that can spiral into depressive relapse. Richard Burnett and Chris Cullen were equally clear when they developed a mindfulness curriculum for secondary schools to support young people's flourishing (the Mindfulness in Schools .B curriculum). Over at least six years and numerous iterations, Richard and Chris considered how best to make mindfulness accessible, relevant and engaging to young people in a classroom setting (Kuyken et al., 2013). Each of these mindfulness-based interventions has a clear intention and theoretical integrity. Each carefully considers the population for whom it is intended and has selected a pedagogy that matches the context in which it is offered.

Second, let's be "mindful of the evidence base." There is an emerging but promising science around mindfulness and MBCT. A body of scientific research suggests some encouraging insights about the role of mindfulness in mental health, resilience and the realisation of human potential (Baer, 2003; Bohlmeijer, Prenger, Taal, & Cuijpers, 2010; Chiesa & Serretti, 2011; Goyal et al., 2014; Gu, Strauss, Bond, & Cavanagh, 2015; Piet & Hougaard, 2011; Sedlmeier et al., 2012; Zenner, Herrnleben-Kurz, & Walach, 2014). We need to report the science responsibly, recognise its limits and try to answer the many remaining questions as best we can, using robust methods. Unexpected findings should be welcomed and reported transparently. They can often point to something far more interesting than the expected. For example, several recent MBCT trials point to the intriguing possibility that MBCT may be most indicated for those most at risk for depressive relapse (Kuyken et al., 2015; Segal et al., 2010; Williams et al., 2013); suggesting of course that those at lower risk may do fine with psycho-education and/or maintenance anti-depressants. Science can help us build theory, develop effective interventions, consider optimal ways of training MBCT teachers and reaching the people who might benefit.

Third, it is important to have leadership around training standards and best practice in the teaching of mindfulness. The last 25 or so years has seen centres like the University of Massachusetts Center for Mindfulness, the Oxford Mindfulness Centre, the Bangor Centre for Mindfulness Research and Practice and the University of Exeter lead the way to build a consensus about how best to train an MBCT teacher, when someone is ready to teach MBCT and when someone is ready to train others to teach MBCT. Mindfulness-based cognitive therapy has stated clearly what training is required to teach MBCT(Segal et al., 2013; p. 422) Let's honour these standards. Let's safeguard the public so that they too will know if a teacher meets these standards. I estimate that a teacher in their early thirties might teach MBCT to 4000 people in their career, so a cohort of 20 teachers graduating a training centre might teach 80,000 people. Investing in high quality training seems a worthwhile investment. The impact of these teachers is and will be profound.

....several recent MBCT [mindfulness-based cognitive therapy] trials point to the intriguing possibility that MBCT may be most indicated for those most at risk for depressive relapse

Finally, let's keep learning through our own mindfulness practice, training and the science. No one owns or has copyrighted the best way to understand, train and transform the mind. A great mindfulness teacher once said the best way to understand the mind is to stop and watch it. This work is invitational, empirical, participatory and democratic.

My colleague Jud Brewer at the Center for Mindfulness put this all much more pithily in an email to me, "our boat will be a sturdy one as long as our sea legs of integrity, teacher fidelity, and science are beneath us." He embodies the learning and humility of a mindfulness researcher and teacher.

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Recovering a Life with Severe Mental Illness: Psychologists and

Gerald Monk and Sarah Hancock

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These authors reflect upon developments within the recovery and peer support movement and comment on future relationships between mental health professionals and peer support specialists in NZ and the United States (U.S).

Preface

There are many parallels between recovering a life with a severe mental illness (SMI) and successfully completing an Olympic Triathlon. When my cousin began dreaming of competing in her first triathlon, she searched out someone who'd done one, not someone who studied completing one. She trained following their schedule, not one she learned from an expert who had never competed in a triathlon.

For 12 years I (Sarah) surrounded myself with key mental health practitioners. I followed their guidelines, took prescribed medication, dutifully attended all my counselling appointments and group sessions. I worked with many well-intentioned, competent, well-educated and highly skilled mental health practitioners, including psychologists who taught important skills. But the entire time I sat listening to professional advice, something in my head kept telling me, "But you don't know what it's like to have command hallucinations," or "You don't know what it's like to drag yourself out of bed eight hours after having taken 800 mg of Seroquel. Getting up isn't as easy as simply hearing the alarm, deciding to get up, sitting up and getting out of bed".

The missing link between well-intentioned, highly trained professionals and my ability to apply these principles in my life was the absence of hope. It wasn't until I met my first trained Peer Support Specialist (PSS) that I learned that living successfully with schizoaffective disorder was even possible. My doctors and counsellors told me recovery wasn't possible and that my life would continue in the same course for the rest of my life. I would be lucky to move out of a group home and get a part-time job. I resigned myself to their prognosis. In my mind there wasn't really any reason to fight it, it was inevitable, I could see it happening around me. It didn't seem to matter what medication I took, or how hard I worked at following treatment plans, I just did not feel there was hope…

When I met my first PSS, I assumed she'd been newly diagnosed. Imagine my surprise as I heard her story unfold and recognize its similarities with my own. She talked about learning wellness tools which altered the course of her life. I wanted to learn what she'd learned because I could see it worked for her. She taught me the 'tricks of the trade.' She taught me to run the race as a survivor, not a victim. She taught me to pace myself. She taught me to hope. If she could see me now, she'd feel as proud of me, as I do of my cousin, The Olympic Triathlete (Hancock, 2015a).

Peer Support Specialists working together

Introduction

In the last 70 to 80 years, the mental health field was almost exclusively dominated by the delivery of services within the framework of the medical model (Anthony, 1993; Davidson, Ridgway, O'Connell, & Kirk, 2014). Traditionally services were driven exclusively by medically trained professionals and mental health practitioners (Pratt, Gill, Barrett, & Roberts, 2014). Today, in NZ there is a growing recognition among mental health professionals that reframing service delivery can provide better care and treatment options for persons living with a SMI (Gordon & O'Brien, 2014). In the last two decades, providing recovery-oriented services has allowed the development of a stronger, fully-integrated service structure. This new structure recognizes the importance of the voice and full participation of the person living with the illness when designing care and treatment plans (Daniels, Grant, Filson, Powell, Fricks & Goodale, 2010; Davidson, et.al., Davidson, Bellamy, Kimberly, & Miller, 2012).

The current trend in NZ and the U.S. is towards integrating the perspectives and training of mental health professionals, peer support services and the person with a SMI in an effort to implement recovery-oriented goals and treatment plans (O'Connell, & Kirk, 2014; O'Hagan, Reynolds, & Smith, 2012). The recovery-oriented approach gained momentum in NZ in the late 1990s following the release of the 1998 Mental Health Commission's Blueprint for Mental Health Services in New Zealand (O'Hagan, Reynolds & Smith, 2012). Now, public mental health agencies worldwide are implementing recovery-oriented approaches in an effort to better serve people living with SMI.

The recovery movement gained endorsement in NZ public policy, resulting in an accompanying acknowledgment of the autonomy and human rights of those seeking treatment (Gordon & O'Brien, 2014). As psychologists, physicians, psychiatrists, and other mental health professionals are recognizing the value of a recovery-oriented approach for assisting people with SMI, it is prompting them to go beyond the previous goal of consumers attaining prolonged periods of stability and managing the symptoms of SMI (Davidson, et.al. 2014; O'Hagan, et.al. 2012). Consumers and healthcare professionals are now more likely to strive for supporting meaningful and satisfying life outcomes.

The recovery movement has been largely consumer-driven and has expanded in an era where rates of relapse for people with acute SMI symptoms are decreasing. One-year relapse rates among people with SMI in the U.S. have decreased from 20%-40% to 15% - 23% (Leucht, Pitschel-Walz, Kissling, & Engel, 2003). One in four people do seem to recover completely from these disorders. For example, Harrow, Jobe, and Faull (2012), reported that at 10 and 30-year follow-ups, 75% of people with schizophrenia are recovered, recovering or improving.

Pratt, Gill, Barrett, and Roberts, (2014) argue that when individuals with a SMI are properly prescribed medications, the results often produce a less virulent course of the illness. Growing evidence shows medication isn't the only thing impacting lower relapse rates. Numerous researchers (Campbell & Leaver, 2003; Chinman, George, Dougherty, Daniels, Ghose, Swift, & Delphin-Rittmon, 2014; Daniels, Grant, Filson, Powell, Fricks, & Goodale, 2010; Daniels, 2012; Gordon & O'Brien, 2014; Kuhn, Bellinger, Stevens-Manser, & Kaufman, 2015) show that when people experiencing SMI receive quality recovery-oriented support from psychologists, competent care from other well-trained mental health practitioners, and guidance and support from both non-peer non-government organizations and trained peer support specialists, they can live meaningful lives with a SMI.

Many people with SMI [severe mental illness] are subject to judgmental communities that spurn, reject and sometimes attack.

This article argues that mental health professionals in NZ and the U.S. can do more. Clinicians can embrace the recovery movement and fully harness the skills and abilities of peer support specialists to assist those with SMI. We address the changes needed at a systems level to open up more options for people to move forward in their recovery. Specifically, we make a plea for greater engagement by psychologists to work alongside peer support specialists to deliver care to those with SMI.

Barriers to Recovery Caused by Stigma

Kaufman, Brooks, Steinley-Bumgarner, and Stevens-Manser, (2012) describe the greatest obstacles for people with SMI are the terrible effects of stigma. Dr. Ron Bassman, (2000) a U.S. psychologist who was diagnosed with schizophrenia in his early twenties wrote about the terrible iatrogenic effects of psychiatric hospitalization

and the tremendous damage caused by having a psychiatric label. He writes about the crushed dreams and stigma associated with SMI as being more difficult to overcome than SMI symptoms (Frese III, Knight, Saks, 2009).

Many people with SMI are subject to judgmental communities that spurn, reject and sometimes attack. These persecutory rejections and attacks are present within families, communities and among mental health professionals. Stereotypes of persons with a mental illness lead people to believe that people with SMI are threatening, unpredictable, and/or incompetent. There is a pervasive judgment that people with SMI do not know what is in their own best interest and this ongoing discrimination and stigma corrodes dignity and hope.

> *When I (Sarah) was really sick, people used all kinds of words to describe me including, but not limited to: psycho, crazy, freak, nut job, insane, psychotic, schizo, bipolar, schizophrenic and frequent flier. Although these words are acceptable by the general public . . . I'm sure that anyone using the "crazy" synonyms felt uncomfortable around me and anyone hearing people describe me in those terms weren't all that eager to get to know me either. In short, I became further isolated by the terms people used to describe me to others, which only made me feel worse, mentally questioning whether I was really as bad as I was being described . . . Obviously not every person describing me was doing it in an intentionally malicious way. In fact, I'm sure there were many well-intentioned people who just wanted to warn unsuspecting people about my condition. The problem? People react to the language of the environment in which they are surrounded (Hancock, 2013).*

In the U.S., the consequences of stigma can be reflected in unresponsive policies and increasing criminalization of individuals with SMIs. In the U.S., California's Los Angeles County Jail is known for being the "nation's largest caretaking facility for the mentally ill" (Demetrius & Okwu, 2014). Bell and Shern (2002) stated that "we don't know what to expect of our mental health system, so we expect very little, and that is what millions of individuals and families receive" (p.5).

In spite of stigma, increasing numbers of health care professionals, themselves diagnosed with bipolar disorder, schizophrenia or schizoaffective disorder have become strong voices in challenging stigma through supporting the consumer advocacy movement in the U.S. For example, a U.S. psychologist, scholar and consumer rights advocate, Dr. Patricia Deegan, was diagnosed with schizophrenia in her late teens and spent considerable time hospitalized within a psychiatric facility. Because of her experience, Deegan's writings (Drake & Deegan, 2009) stress that persons in recovery should not be passive recipients of mental health services. Like so many mental health professionals diagnosed with SMI, Deegan describes her treatment as dehumanizing and spirit breaking. She spoke of learned helplessness, and having to overcome demeaning experiences with treatment to reclaim and recover a sense of self.

In spite of stigma, increasing numbers of health care professionals, themselves diagnosed with bipolar disorder, schizophrenia or schizoaffective disorder have become strong voices in challenging stigma through supporting the consumer advocacy movement in the U.S.

The difficulty arises because psychologists, and other mental health professionals are influenced by stigma, resulting in prejudicial attitudes which can keep practitioners at arm's length from working closely with people diagnosed with a mental illness, even when a person has progressed in their recovery to the point of becoming a trained peer support specialist. Drake and Deegan (2009) call for a partnership model in the delivery of mental health services with mental health professionals, peer support specialists and clients working together. This can be a challenging adjustment to make as O'Hagan, Reynolds, and Smith (2012) suggest, because it requires mental health professionals to change their perspective of the treatment relationship with psychiatric survivors from that of a paternalistic practice to one which evolves into a genuine partnership.

Davidson, O'Connell, Tondora, Styron, Kangas (2006) write about the considerable inertia and prejudices which must be overcome by mental health professionals if they are to embrace the true spirit of recovery. Davidson, et.al, write about common misconceptions and damaging judgments that stop mental health professionals engaging with a recovery-oriented approach. Some examples of prejudicial judgments they have heard from mental health professionals include:

> *"You mean I not only have to care for and treat people, but now I have to do recovery too?"*
>
> *"You're not talking about the people I see. Recovery is not possible for them."*
>
> *"How can I talk to them about recovery when they have no insight about being ill?""If recovery is the person's responsibility, then how come I get the blame when things go wrong?" (p. 642).*

It is encouraging to note that NZ is making headway in addressing old paternalistic dynamics as well as attempting to diminish discrimination and stigma. The NZ Mental Health Commission (2004) reports on an impressive number of anti-discrimination campaigns conducted in diverse NZ settings over many years. Targeted sectors for reducing discrimination such as including Māori and Pacific Island communities and the human services and disability sector.

Recovery and the Recovery Movement

In New Zealand, as it is in the U.S., a recovery approach to addressing mental illness emphasizes and supports a person's innate potential, approaching treatment from a perspective which focuses on a person's journey rather than stressing a set outcome or deadline for meeting treatment goals. Recovery, normally references attributes of acquiring hope, a preferred sense of self, developing supportive relationships, experiencing empowerment, being included as a valuable member of a community, and seeking meaning and purpose. William Anthony, (1993) the executive director of the Center for Psychiatric Rehabilitation in Boston, USA described recovery as "a deeply personal, unique process of changing one's attitude, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability" (p.527). The recovery movement focuses on five recovery principles: hope; choice and accountability; empowerment; recovery environment; and finding meaning and purpose in life which can frequently be achieved through spiritual exploration (Hancock, 2015b; Ashcraft, Zeeb, & Martin, 2007).

Psychologists using motivational interviewing techniques and strength-based approaches (Gehart, 2011a, 2011b) are well positioned to help develop opportunities supporting clients in creating choices in their care, foster empowerment and even assist clients to find their meaning and purpose in life. However, one of the biggest changes for health care professionals is to inspire hope in the person struggling with acute symptoms accompanying a SMI.

In the U.S. context there has been less attention paid to the socio-historical processes that enable recovery. O'Hagan, et.al. describe a radical shift taking place in NZ in the delivery of mental health services which contextualizes recovery as a social justice initiative that should diminish the mono-cultural dominance of mental health services and embrace bi-cultural services. Māori initiatives and the concentration on de-colonizing practices in the delivery of social services have helped change the evolution of recovery in NZ. In NZ, there is analysis of bi-cultural services which acknowledge issues of power and authority when recovery mental health services are provided.

Māori and Pacific Island understandings of mental health recovery such as orientations that emphasize Whanaungatanga and Fonofale (NZ Mental health Commission (2013) are connected with a broader, more holistic notion of the overall 'well-being' of the person and these worldviews are influencing mental health delivery systems today in NZ. From a Māori perspective, the centrality of the essential foundations of Whakapapa (map of existence/genealogy), Mauri (life force/essence) and Hauora (health and well-being) are integral in creating sustainable wellbeing and mental health recovery (O'Hagan, et.al. (2012). Ostrow and Adams (2014), U.S. researchers on recovery, agree with Māori when they say that the recovery work should be transforming the whole health care system, focused upon optimal mental health and whole person wellness. Ostrow and Adams suggest that NZ has much to offer the U.S. in terms of new approaches to recovery, community integration and engagement and alternatives to the medical model. They also argue that the U.S. has valuable lessons to share with other countries including NZ about the recovery movement in regards to the political influence of the consumer-advocacy movement to produce greater levels of systems change. There are new opportunities for both NZ and U.S. psychologists to learn from one another in their work with recovery-oriented approaches along-side peer support specialists following the formal agreement signed between the New Zealand Psychological Society and the American Psychological Association to forge stronger ties and greater information sharing.

Peer Support Services

The consumer-advocacy movement provides multiple new ways to deliver mental health services including a powerful service delivery system– the development of peer support services.

In our experience, the peer support specialist role in serving those who suffer from SMI is not well known among health care professionals in the U.S. A peer support specialist is a person who self-identifies as a person living with mental illness who has progressed in their own mental health recovery to the point where they have obtained perspective on how the recovery journey takes place, and specifically trained in ways to convey the lessons learned from their own lived experience in a way which essentially mentors others struggling with SMI (Ashcraft, Zeeb & Martin,

2007). Peer support specialists receive specialty training in techniques for sharing their own lived experience in ways which ignite hope, help people accept responsibility for personal choices, develop a recovery environment and foster a person's desire to find meaning and purpose in life in spite of difficult symptoms of mental illness. There is strong consensus among researchers of the power of the peer support specialist role in helping people with SMI recognize that recovery is possible (Daniels, et. al., 2010; Doughty & Tse, 2011; Holter et al., 2004; Janzen, Nelson, Trainor & Ochocka, 2006; Ostrow & Adams. 2012).

Magdel Hammond, (2015), General Manager of Peer Services, Auckland commented that the majority of health care professionals don't understand the extent and depth and provision of peer support services. Characteristic of so many settings in the delivery of mental health services here in NZ and in U.S., the challenge lies in hierarchical issues, rankism and perceived power imbalances. Key to resolving these challenges is the creation of an environment of mutual respect between clinicians and peer support specialists, recognizing both as qualified, trained professionals.

Kaufman, Brooks, Steinley-Bumgarner, Stevens-Manser (2012), report on barriers to the implementation of peer support services in the U.S. and identify the problem of the acceptance of the peer support role in mental health centers by mental health professionals. In addition, Kaufman et.al. (2012) report a profound lack of understanding of the peer support specialist's role by those working in the mental health field. Davidson, Ridgway, O'Connell and Kirk (2014) found that there have been wide differences between the perceptions and understanding of peers, peer advocates and professionals regarding the relative importance of treatment goals, identification of problems, access to service, and needs and preferences for housing and supports.

Using a peer support specialist as part of the treatment team has been shown to have a range of favourable results (Davidson, 2003; Felton, Stanstny, Shern, Blanch, Donahue, Knight & Brown, 1995; Mead & MacNeil, 2006). Information provided by peers to peers is often seen to be more credible than that provided by mental health professionals (Woodhouse & Vincent, 2006). When peers are part of hospital-based care, the results indicate shortened lengths of stays, decreased frequency of admissions, and a subsequent reduction in overall treatment costs (Chinman, Weingarten, Stayner & Davidson, 2001). Other studies also suggest that the use of peer support can help reduce the overall need and use for mental health services over time (Chinman, et. al, 2001; Klein, Cnaan, & Whitecraft, 1998; Simpson & House, 2002). Additionally, Sarah hypothesizes that when people living with SMI work with peer support specialists, they are more candid about symptoms. In turn, peer support specialists share candid conversations with mental health clinicians, creating a clearer picture of what is going on with a client, enabling the entire treatment team to provide improved individualized services.

For significant progress to be made in the successful integration of healthcare professionals partnering with peer support specialists, there needs to be a willingness for psychologists, and other mental health professionals to support the promotion of a recovery environment for people living with SMI rather than the older deficit-based models which Ashcraft, et.al. (2007) refer to as a non-recovery environment (Table 1).

Non-Recovery Environment	Recovery Environment
Stability/maintenance is goal	Recovery is the goal
There is no clearly defined exit	Clear exits; graduates return and share
Little or no access to information	Easy access to information
Compliance is valued	Self determination, critical thinking and independence is valued
Coercion is used to achieve compliance	People become experts in their own care
People are protected from their own trial/error learning	People take risks and have the "right to fail"
One-size-fits-all treatment approach	Wide range of programmes & non-programme options
People live in residential treatment centers	Opportunities for community integration with choice
People are judged by their level of motivation	Restoring hope creates new choices
Medication is the primary tool	Medication is one of several tools
Emphasis is on medical treatment	Peer support and self help are valued

Ashcraft, L., Zeeb, M. & Martin, C. (2007). Peer employment training workbook. (3rd ed.). Phoenix, AZ: Recovery Innovations, Inc.

Mental health professionals can play an important role in partnering with peer support specialists to transition from a traditional medical model focus to a recovery

oriented environment as shown in Table 1. This significant shift in focus involves moving away from a model which focuses entirely on compliance, stability and maintenance; while moving towards a model which focuses on hope, choice and agency. An article written by Mental Health America (2013) identifies six strengths that peer support specialists share with people in recovery, augmenting services provided by mental health professionals. They include:

1. Compassion and commitment
2. Understanding the experience of internalized stigma
3. Challenging the "you do not know what it's like" excuse
4. Moving from hopelessness to hope
5. Developing a relationship of trust with peers
6. Living a life holistically, including both mind and body

Essentially, peer support specialists can assist people living with SMI in breaking free from learned helplessness, allowing clients to more fully benefit from the clinical services provided by psychologists and other mental health professionals.

New Trends

Increasingly, peer support specialists are creating new healthcare initiatives and incorporating psychologists, counsellors and other mental health professionals in the healthcare team but the organizations are increasingly peer-run. For example, in NZ there are peer-led and peer run respite services such as Tupu Ake (Pathways, 2009), the first mental health and wellness peer support service of its kind in NZ. This service offered through the organization Pathways has clinicians with lived experience work with peer support specialists in offering respite services. Peer-run organizations of this kind tend to create more flat organizational structures in their delivery of services. These services are described as "lateral", participatory, and democratic (Segal, Silverman, & Temkin, (2013). Peer-run organizations demonstrate positive improvements for consumers in outcomes of stigma-reduction and empowerment over traditional hierarchical services. New service delivery models require psychologists and other mental health professionals to employ more collaborative, non-hierarchical approaches to the provision of care. Randal, Stewart, Proverbs, Lampshire, Symes, & Hamer (2009) discuss successful partnerships between experienced clinicians and peer support specialists delivering CBT-based training for groups of people with auditory hallucinations. This model of a consumer-clinician-alliance for presenting psychological strategies to others with auditory hallucinations demonstrate how psychologists can partner with peer support specialists (Hamer, Lampshire, Schneebelic & O'Brien, 2010).

Essentially, peer support specialists can assist people living with SMI [severe mental illness] in breaking free from learned helplessness, allowing clients to more fully benefit from the clinical services provided by psychologists and other mental health professionals.

In the U.S., a variety of models create a treatment team of peer support specialists, advocates and mental health professionals. Typically peer-run services have at least 51% peers administrating the facilities and include professional clinicians in service delivery. Research on degree of involvement by people with lived experience in peer-run organizations has shown that programmes that include peer support specialists in operations are more likely to engage in the strategies leading to favorable treatment outcomes (Ostrow & Hayes, 2015). A growing number of mental health services demonstrate clinician and peer support specialists can build effective, mutual, trusting relationships to deliver quality services (Ostrow, & Croft, 2015).

Conclusion

With the increasing proliferation of peer support services over the last few years and the recognition by health care professionals of the power of the recovery movement in both NZ and in the U.S., there are numerous opportunities for psychologists and peer specialists to forge a stronger alliance in delivering increasingly effective mental health services. It is critical that a coordinated partnership is formed between psychologists and peer support specialists. Implementing this partnership during the very early stages of treatment engenders hope for people living with SMIs and their families. Hope enables both people diagnosed with an SMI and mental health professionals to recognize that recovery is not only possible, but probable for people despite the presence of SMI.

Truly, the lived experiences of peer support specialists and adept application of wellness tools coupled with the technical and medical expertise of mental health providers represent what can become the equivalent of well-polished Olympic triathlon relay team—a model of service integration in the delivery of effective, recovery-oriented mental health services.

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Focus on the positive: Appreciative Inquiry a research method to consider

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Abstract

This article outlines the key elements of appreciative inquiry, which is an action research methodology that lends itself to exploring questions in a positive, curious and collaborative way, rather than traditional deficit based methodologies. The philosophical assumptions are outlined as well as aspects such as selecting the research question and the process. We present an argument for why psychologists may wish to consider using appreciative inquiry when thinking about research as it facilitates change in a hopeful, success focused way that also fits with social determination theory increasing a sense of competence, autonomy and relatedness.

Introduction

When the first author came to consider which methodology might be useful when seeking to tailor, improve and evaluate an existing intervention programme appreciative inquiry (AI) was deemed a relevant potential methodology. Appreciate inquiry has been successfully used in the United Kingdom, Canada, Brazil, Africa, Nepal, and Australia (Sorensen et al., 2010). The application of AI is diverse and has included evaluating and changing organizational or clinical processes, exploring initiatives for professional development, improving healthcare environments, developing new clinical networks, and creating a team vision, in public and private health care environments, colleges, and universities (Richer, Ritchie, and Marchionni 2010).

Psychology as a discipline has knowledge and skills that can be applied in all of these areas and psychologists are employed in an increasingly diverse range of settings where AI might be a useful method to evaluate and transform practice. The diversity of practice ranges from the psychology of aesthetics, creativity and the arts, to applied experimental and engineering psychology, counselling and clinical psychology. Psychology is described as being "grounded in science" (*Psychology Topics*, 2015) and psychologists as studying both normal and abnormal behaviours. Psychologists focus on wellbeing and resilience as well as treatment for mental and emotional problems.

To ensure psychology practice is grounded in science there is the opportunity to consider

a wide range of research questions. Farvid, Landon, and Krageloh (2014) point out that robust psychological research requires the use of an appropriate research method that can be justified and is appropriate to the subject matter of the research. In our opinion much of health research is focused on a deficit based model which is problem focused and where the attention is on analyzing causes, considering solutions, and developing a treatment plan for the problem. From the first authors' experience it is often the case that, in adopting this deficit focus, psychologists find that attempts to fix problems generate new problems or that problems do not go away. Over the last 30 years movements such as positive psychology have developed that offer a change from deficit thinking to focus on positive change and strengths based approaches (Moore & Charvat, 2006). Those changes sit alongside the notions of recovery and collaborative care, which are strong directions in current mental health practice (Mental Health Commission, 2001).

Collaborative inquiry using this methodology takes a positive, curious, open-minded stance and invites bold, imaginative, generative knowledge.

When looking for more strengths based methodologies psychological researchers may want to consider AI as a research approach. This paper argues that the philosophy and methods of AI can be useful for psychological research.

Appreciative Inquiry

AI is a form of action research first proposed by Cooperrider and Srivastva (1987) and initially applied in organizational settings. AI is a strengths based change methodology where theoretical knowledge can generate and transform social reality (Hennessy & Hughes, 2014). It focuses on language involving the researcher looking through an appreciative positive and hopeful lens in order to generate stories that can change perspectives on what is possible. The researcher participates in the exploration of organizational practices with a group of participants who have experience of and interest in the research topic and can explore it using this practice-based experience (Zandee, 2014).

Collaborative inquiry using this methodology takes a positive, curious, open-minded stance and invites bold, imaginative, generative knowledge. The inquiry itself is a vehicle for change (Gergen, 1978) challenges taken for granted knowledge and searches for ideas that may be overlooked. As scientist practitioners, psychologists are interested in intervention and change. Boyd and Bright (2007) argue that as an 'opportunity- centric' change methodology, AI fits with many of the underlying philosophical assumptions of community psychology. They consider that in particular AI connects with psychological perspectives such as empowerment and prevention. They also argue that AI represents the opposite to learned helplessness (Abramson, Seligman, & Teasdale, 1978) by creating a sense of optimism for participants by allowing participants to exercise more control and focus on what is working rather than on problems.

Philosophical foundations

At the same time as Cooperrider was developing his methodology, Gergen, an American psychologist and researcher, was developing his ideas about a new direction in social theory development which challenged traditional positivist assumptions. It was based on the idea that social psychologists doing research influence their results (Gergen, 1978). Gergen is associated with the development of the social constructionist movement where individuals are in relation to each other and knowledge is socially constructed and therefore not 'the truth', rather, knowledge impacts the way people act. This provided the theoretical foundations for Cooperrider's work ("A brief tour of the history and principles of AI," 2007).

Assumptions

As appreciative inquiry developed, it moved from a set of techniques to a philosophy and worldview based on the following assumptions:

1. In every group, society, organization something works.
2. What we focus on becomes our reality. Focusing on what works creates a sense of possibility rather than limitation.
3. There are multiple realities in the moment and reality is created.
4. The act of asking questions influences the group or organization.
5. People have more confidence in doing new things (the unknown) when they can build on the current act (the known). New processes arouse fear whilst building on what people have done before reduces this.
6. Following the previous assumption, if we are going to carry parts of the past forward we should endeavor to focus on carrying forward the best of what has already been done.
7. People will have different views and perspectives that should be valued.
8. The language we use is important in constructing reality. ("A brief tour of the history and principles of AI," 2007).

Nature of the research questions relevant to AI

Topics chosen for appreciative inquiry, according to Cooperrider, Whitney, and Stavos (2003) "can include anything related to organizational effectiveness…. They can include technical processes, human dynamics, customer relations, cultural themes, values, external trends, market forces and so on" (p.37). However they need to be stated in the positive, they should be desirable, they should be about what the group wants to learn more about and move in the group's desired direction.

Selecting participants

Appreciative inquiry holds that there should be a wide range of participants and that inclusivity is important. However participants should also bring experience and knowledge from different perspectives. It may be difficult at the beginning of the process to identify who all the participants should be. This is in contrast to quantitative methods where sampling is often randomized.

Collaboration is also an important principle so people's participation needs to be a matter of choice and control. Therefore thought has to be given as to how to invite participation. How much information to give to participants is also an issue because too much information may constrain the process.

Common methods

AI is not a linear process. The process is via cycles of repeated steps and is therefore constantly evolving. The steps form the following sequence: Discovery, Dream, Design and Destiny, known as the 4D cycle. Although there are these processes the central idea is that there is a "positive core" of strengths, goals and achievements and the basis of the inquiry is to discover this and enhance it (Cooperrider et al., 2003).

Appreciative inquiry has links to case study methodology where discrete groups and settings can be studied as a whole in the real life context. It also resonates with a narrative methodology and discourse analysis where the 'story' is central and events are personalized in a sequence of events which are contextual.

Process

AI will generally start with an interview process in which participants are asked questions which are framed in a way that will affirm what one wants to see more of. Inclusive engagement is important to bring forward experience and viewpoints and also to create a sense of being related through conversation that inspires stories of success. Norum (2008) points out that time should be allocated to developing good questions. A series of questions that establishes the positive nature of the work, "what is", are asked. This includes:

Opening questions or requests, deep story questions for example, to describe a high point:

- Please tell me about a time you believe you excelled in a leadership capacity?

Value questions, such as:

- What are the things you value most about the nature of your work?

Core factor questions such as:

- Describe what you believe were the most important factors about this experience?

The questions above can lead into further questions that are designed to ask for examples of positive change, which also assume that the participant has had the experience.

To aid the process specific exercises may be used such as "the miracle question" to generate ideas of what might be. Participants are also asked to generate "provocative propositions" that challenge the way things are currently and then concluding questions that encourage movement (Norum, 2008).

AI will generally start with an interview process in which participants are asked questions which are framed in a way that will affirm what one wants to see more of.

In their article on AI as a mode of action research, Boyd and Bright (2007) who are community psychologists, discuss a case of using AI to improve a non-profit organization. In an all-day event they used a series of breakout groups to answer questions that led to the development of themes of success that were then used as a resource. Using these themes they generated a collection of action steps, which were subsequently developed and carried out. The reported outcomes were on a number of levels: individual, for example "I learned I can make a difference with this organization" (p.1030); organisational, for example, the Board of Directors was reconfigured to create majority control via the members, membership and revenues increased; and community, for example, the number of community based publications increased by 40 percent.

All the processes above are required to be fluid and responsive therefore the facilitator needs to have a level of expertise where they will be able to judge the pace and

content of process ("A brief tour of the history and principles of AI," 2007).

Data Analysis

Data analysis requires openness to valuing outliers that may inform outcomes. The researcher needs to approach the data in an open imaginative way so as to consider a possible constructive change (Zandee, 2014).

As a form of action research that is based on a social constructionist approach, appreciative inquiry is inclusive, participatory, and collaborative and uses questions to focus on what is being done well in order to develop a series of action steps that lead to positive change. Psychologists have used AI in organisations to bring about change.

Discussion

AI focuses on evidence of and enhancement of success rather than what is not working. Appreciative inquiry provides a participatory action based process for improvement that allows ownership by the participants, and a sense of competency that respects diversity and expertise. This is supported by Deci and Ryan (2000), from the Department of Psychology , University of Rochester, who stated "An interested, open, learning organism can better adapt to new challenges and changing contexts" (p. 252). Coghlan, Preskill, and Tzavaras Catsambas (2003) point out that some critique AI as naïve and idealistic and focusing on positive aspects so much that negative experiences are ignored, however this has been countered by authors such as (McNamee, 2003) who found that problems were more likely to be discussed when an appreciative stance was taken. Barret and Fry (2005) support this by highlighting that when the need for sense of competence is met, individuals can "develop an expansive competence, an ability to see the nascent potential and radical possibilities that can expand beyond the boundaries"(p. 41).

We argue that AI can be applied across both qualitative and quantitative paradigms, in many AI projects that explore the implementation of change the consequences of the change process are evaluated in a quantitative way ("Research frameworks: Where does AI connect with research?," 2007). In contrast in a review of 50 published AI studies (Yaeger, Sorensen & Bengtsson, 2005) it was found that qualitative methodologies were implemented. We support the suggestion by Moore and Charvat (2006) that AI represents a paradigmatic shift that frees us to be more expansive in our understandings and to feel competent. Moore and Charvat believe that AI could potentially produce increased capacity for sustainable change in our clients and more joy in our work as clinicians.

We support the suggestion by Moore and Charvat (2006) that AI represents a paradigmatic shift that frees us to be more expansive in our understandings and to feel competent.

One of the few psychology research studies which has used AI was conducted by researchers based at the Open University of the Netherlands (Verleyson et al., 2015). They used concepts from self-determination theory where they identified the 'nutrients' for psychological growth, well-being, and most volitional forms of motivation, as basic psychological needs (BPN) for competence, autonomy and relatedness. Their data from 213 participants found that AI impacts by satisfying basic psychological needs (BPN). They conclude that as an experience, AI is able to address people's innate need for BPN, which then impacts on the capacity for hope, resilience, optimism and self-efficacy known as psychological capital.

In this paper we posit that the philosophy and methodology of AI can be useful for psychological research. AI has the potential to facilitate change in a hopeful, success focused ways across the range of areas in which psychologists practice. It challenges the dominant paradigm of being problem focused, and has potential for wide application across a range of settings.

Conclusion

In this paper we have argued that the AI is a research method worthy of consideration by psychologists as a means to facilitate positive change. We have summarized some of the key aspects of AI including: philosophical foundations and assumptions, potential research questions, participant selection, and data collection and analysis.

We believe that when psychologists are considering conducting research it is typically to answer questions that are about improving things, systems change, understanding behaviour, the workings of the mind, and making changes in civil society. AI has the strong potential to allow questions to be formed in a positive, collaborative, hope filled way rather than focusing on deficit based language.

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Seeking Psychologists: Interesting challenging and ever changing work

Sarah Calvert

Dr Sarah Calvert is a clinical psychologist in private practice. She has worked previously for Child, Youth and Family. Her work has included writing reports and seeing families involved in various Family Court processes (both families coping with separation and those involved with CYFS) since the beginning of the Family Court. She currently chairs the Northern Region Specialist Report Writers Group in Auckland.

There have been significant changes to the way in which the Family Court operates in New Zealand, changes which do impact on those psychologists who provide reports for it. None the less the really major issue facing the Family Court in New Zealand is the serious shortage of psychologists who can undertake this work. It was initially thought that the changes (which are supposed to divert many cases away from the Court to mediation and resolution) would lead to less work for psychologists but in fact it simply means there are no 'easy' cases.

In reality the changes have led to the Courts working hard to maintain their pool of experienced report writers. It is likely that, in time, there will be a standard fee for reports (there is always the opportunity to seek additional funding if a case needs more time) and a national list which will allow Courts to use specific skill sets as well as seeking report writers from outside their area when they need to. Family Courts and Courts which deal with care and protection issues for children remain very important and public arenas for showing the value of psychology and psychological understandings across a wide range of knowledge bases within the field. This is an area of a work which can be done within a private practice (either a part-time or full-time private practice) and is available to any registered psychologist.

Family Court work in New Zealand is related to two specific pieces of legislation, The Care of Children Act[1] and the Children, Young Persons and their Families Act[2]. The first deals with issues

1 See www.legislation.govt.nz/act/public/2004/0090/latest/DLM317233.html

2 See www.legislation.govt.nz/act/public/1989/0024/latest/DLM147088.html

where there is a dispute between two parents (and occasionally other family members) and the second deals with children who CYFS have had concerns about and are seeking the Court's mandate to intervene. It is challenging and interesting work. Each case, while often showing aspects of other cases (alienation, gatekeeping, relocation, high conflict between parents), is also unique. This means that the report writer has to gather data to think about the family and their issues, this data is always unique. It remains embedded in a very substantial literature base which includes clinical data and research work. The work is never boring, it is always challenging and thought provoking.

Family Court work is not for the faint hearted because these are very difficult and distressed families. Meeting with parents, children, grandparents and sometimes other people is stressful and requires very specific skills (but not necessarily ones you learn in your training). Given the very high level of importance of our children to us all it is easy to see why people invest so much in these cases and why they are always emotionally difficult. This is true around the world. Those are the same factors which lead to the high level of complaints because the reports prepared have a significant impact on the decisions of the Court. The work in the Family Court, throughout the world is an area of very high complaint. In some places all psychologists face complaints on all their cases (there is a degree of legal game playing involved). Here in New Zealand, thanks to an agreement reached between the NZ Psychologists Board and the Chief Family Court Judge we don't face the same pressure from complaints as many of our colleagues. Here complaints are always referred to the Court for comment and will not be addressed by the Board until all Family Court proceedings are complete at which point the Judge will provide a report to the Board. This process means that, if there is a hearing, the issues raised by one of the parties can be addressed when the psychologist gives evidence. Only after the Board receives the response of the Court will it consider the complaint. The Board has been very good in recognising the difficulties report writers face and in ensuring fair and due process.

So…..if this sounds like work you might be interested in (and it is increasingly paying reasonably well) you should start with the Practice Note which governs the work for the Family Court. The Practice Note outlines[3] what skill set a psychologist needs (those with a number of Scopes of Practice are able to apply but you do need some experience working with children and families). The Ministry has also issued a "Handbook for Report Writers"[4]. You apply to the Family Court Coordinator/s at your local Court and they will give you an application pack and you will need to prepare for an interview with a panel. It is always good to talk to an experienced report writer before starting this process and perhaps looking for a supervisor.

The work is always about what is in the best interests of children, how arrangements for children can be organised and understanding why things in a particular family or whanau haven't worked well enough. In the Family Court (COCA) there is a 'standard' brief or set of questions. This is what it looks like

i. How current arrangements for the child's care are working for the child:
ii. The child's relationship with each party, including, if appropriate, the child's attachment to each party;
iii. The child's relationship with other significant persons in the child's life;
iv. The effect or likely effect on the child of each party's parenting skills;
v. The effect or likely effect on the child of the parties' ability or otherwise to co-operate in the parenting of the child;
vi. The advantages and disadvantages for the child of the options for the care of the child.

What this will mean is that you will gather data from parents, the child or children, people like teachers, grandparents, sometimes from counsellors and you will then consider the information you have gathered in light of the questions and thinking about the literature in the area. Some cases will involve issues like domestic violence, sexual abuse, a parents request to move to another city or another country or a case where children say they don't want to see a parent. Often the issues are how the child's time with each parent should be organised.

Much of the distress in these cases is that parental separation is usually an outcome of adult focused issues and is the desired outcome of one or both parents. It is rarely the desired outcome for children who would like parents to live together (although they may wish things to be different in their family). However few parents have thought that ending an adult relationship will mean that they lose time with and aspects of their relationship with their child or children. Some parents will lose almost all their time with a child or children

3 www.justice.govt.nz/family.../practice-notes/specialist-report-writers.pdf
4 www.justice.govt.nz/publications/global.../specialist-report-writers

(if they are required to have supervised contact perhaps once a fortnight or month for an hour or two). Some parents will lose most of their time with a child or children if they have perhaps a weekend a fortnight (called a 2/14 or 3/14 arrangement) and many parents will lose half of their time with their children (a fully shared care arrangement which can be 7/7 or 2/2/5/5).

Realizing that, as a result of separating, parents may not see their children for such significant amounts of time is often very difficult for people who are parents to accept and this can lead to allegations designed to support a different kind of care and contact arrangement. All of this is, of course, happening within the escalated emotional environment of adults ending their relationship. In many cases there are significant and additional issues (such as domestic violence) which the report writer has to consider in forming views about the way forward for the family.

Report writers need to be well resourced with a firm knowledge base about the specific issue as well as having a good general understanding of the literature in areas like children's development, family systems. There is an extensive literature[5] which people slowly become familiar with (and some great conferences around the world to go to if you are so inclined)[6].This is work which firmly falls within the scientist-practitioner model where it is expected that you will have good skills in actually being with people as well as a good knowledge base. It does require careful thinking as you consider your experience and your data in light of the literature.

Report writers do need to be robust. You need to feel able to manage people (and children) with high levels of distress and still gather the data you require to answer the Court's questions. Your data has to be robust because you may have to give evidence in Court, again this may be a new (and initially scary) proposition.

Many areas have a report writers' group which provides support for all those who do this work, we are a great resource for each other. It is an area of work where good and regular supervision is an essential support and 'third eye' on the complexity of the work.

For more information contact your local Family Court Coordinator at the Court or feel free to contact the writer, Sarah Calvert, at calverts@iconz.co.nz

5 See for example: Birnbaum, R., Filder, B.J. and Kavassalis, K. (2008) Child Custody Assessments :A Resource Guide for Legal and Mental Health Professionals. Thomson Carswell. Scarborough Ontario. Bow, J.N. (2006). Review of empirical research on child custody practice. *Journal of Child Custody, 3*(1), 23-50. Davis, G. and Frederick, L. (2014). Excerpted Practice Guidelines for Family Court Decision Making in Domestic Violence Related Child Custody Matters. Battered Women's Project. Galatzer-Levy, R. ,Kraus, L. and Galatzer-Levy, J. (Eds). 2009. The Scientific Basis of Child Custody Decisions. John Wiley. New York.Kelly, J.B. (2006) *Interviewing Children in Custody Proceedings: rationale,process and technique*. Focus on the Child Seminar. Auckland Family Courts Association. Kuehnle, K. and Drozd, L. (Eds.) (2012). *Parenting Plan Evaluations*. Oxford. New York. Drozd, L.M. , Olesen, N.W. and Saini, M.A. (2013). Parenting Plan and Child Custody Evaluations. Professional Resources Press. Sarasota. Kuehnle, K. and Connell, M. Eds. (2009). *The Evaluation of Child Sexual Abuse Allegations: A comprehensive guide to assessment and testimony*. Wiley, New York.

6 The best is organised by the American Family and Conciliation Courts Association, currently by His Honor Peter Boshier, formerly the Chief Family Court Judge here in New Zealand, is the President. The next one is to be held in Seattle at the beginning of June 2016.

Coaching evaluation: a case study

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Executive coaching is an increasingly popular practice for leadership development (McDermott, Levenson & Newton, 2009), with an aim to "stretch and develop an individual's current capacity or performance" (Grant, Cavanagh, Parker & Passmore, 2010, p. 126). While coaching has dramatically increased in popularity, the evidence-base for its effectiveness has lagged behind (Clutterbuck & Megginson, 2005; De Meuse, Dai & Lee, 2009; Ely et al., 2010; Grant & Cavanagh, 2004; Leonard-Cross, 2010). It follows that the evaluation of coaching assignments has been widely urged (Ely et al., 2010; Grant et al., 2010; Lowman, 2010). De Meuse et al. (2009) specifically call for case studies on coaching assignments, as such "cases are perhaps the best way to open the 'closed door' that Hall et al. (1999) identified as a barrier to understanding coaching" (De Meuse, 2009, p. 130). As little research on coaching exists in the New Zealand context (Brooks & Wright, 2007), this brief paper presents a case study of an organisation in which coaching intervention was implemented and its effectiveness evaluated. This paper highlights the impact of coaching in the organisation and illustrates a process by which coaching, as a leadership practice, can be implemented (see e.g., Clutterbuck & Megginson, 2005). While effectiveness can be measured in various ways, the present case study asks whether simply the *frequency of programmed coaching meetings* influences subordinates' perceptions of leader effectiveness, leaders' perception of their own skills and staff culture surveys.

Background

This case study was completed in an organisation of around 700 staff that had been going through a culture change process. Strikes in the mid-1990s had left relationships between management and staff in a poor state with many staff and managers actively expressing mistrust.

In 2007, staff surveys indicated that the culture had increased from being viewed as poor to being below average. The organisation adopted a culture change process to move the culture from 'below average' to 'great' -picking up on the "Good to Great" theme. (Collins, 2001).

Alongside broader leadership development, creating a coaching culture was seen as a key part of the Good to Great Strategy. Coaching was seen as providing three main benefits: to provide support for managers and team leaders with the changes being made in what was expected of them as leaders - to provide a platform to talk through the changes and priorities; as a leadership development tool - to be able to encourage the right leadership focus and prioritise these activities on the job, and; to engage the leaders, some of whom felt bypassed by previous initiatives.

Importantly, the CEO was a key driver of this initiative. His vision for the role coaching would play was:

> *'that it was fundamental to moving towards being a higher performing organisation, providing the chance at half time to impart observations on how the game is being played and what can be done to improve it and lift the performance of the team. It provides the feedback on how things are being done - not focusing on the score as everyone knows that'.*

Implementation Plan

The plan to implement coaching was threefold:

1. Put a business plan goal in place for all team leaders and managers to be coached four times a year. This goal set an expectation and could then be monitored.
2. Second, the Executive was to be coached on their coaching. The focus here was to help the Executive be confident in their coaching to maximise the chance they would do it and pass on their approach and confidence to their direct reports. Twenty team leaders and managers who were seen as having the potential to move up two levels or more within the organisation were also provided with external coaching on their coaching. Three industrial and organisational psychologists specializing in coaching (to cover different geographical regions) were contracted to assist in this process.
3. Thirdly, training in coaching was sourced. Training was compulsory for all newly appointed managers and team leaders and optional for current managers and team leaders. The training included a pre-course briefing and goal setting with the participant's line manager and the course facilitator, and monthly follow up by the line manager for three months after the course to support the participant to implement coaching. This follow up was supported by the facilitator meeting with the line manager and participant two months after the course and providing materials to assist the line manager with the follow-ups.

A coaching course was sourced to focus on key coaching outcomes, such as:

1. Building the relationship and trust to facilitate the giving of feedback and coaching
2. An opportunity to get out of the day to day frenzy of activity and think about the big picture/objectives for the year
3. The opportunity to review how the work was going and whether things could be done better
4. Identifying where manager or staff member expectations were not being met and resolving these in coaching.

Evaluation methodology

To evaluate the effectiveness of the programme, coaching surveys were completed via the company intranet, 12 and 24 months into the project. The surveys went to all managers and team leaders in the organisation and included two components. The first part was a rating of the frequency of the coaching they received and their manager's skills in coaching. The second part was a self-assessment of their own coaching skills on the same dimensions (worded to reflect self-assessment).

The database recorded the manager or team leader who had completed the survey. They received a copy of their self-assessment, and a summary of their direct report's ratings of their coaching skills. The results could also be matched to direct reports' or managers' results, course attendance and to the staff survey results.

Three areas were of particular interest from the survey data: whether the coaching course would improve manager's skills and lead to them coaching; whether the manager's skills and frequency of coaching would lead to their staff having better coaching skills and coaching more (i.e., trickledown effect); and whether the coaching initiative would lead to higher staff engagement.

Results and Discussion

Due the brevity of this paper, the findings are simply summarised here. For detailed findings, please contact the first author.

51 of the 66 managers and team leaders responded to the survey in Year 1 (Y1) and 63 responded in Year 2 (Y2). The number of managers or team leaders who had a coaching session with their manager increased from 5% at the beginning of the project to 67% at the end of Y1 to 92.1% in Y2. The average number of coaching sessions increased from 3 at the end of Y1 to 5.6 at the end of Y2.

… the Executive was to be coached on their coaching. The focus here was to help the Executive be confident in their coaching to maximise the chance they would do it and pass on their approach and confidence to their direct reports

The project did not meet the target of all managers and team leaders being coached at least four times on average as by the end of the second year there were 7.9% who were not being coached at all (or who at least did not recognize the session with their manager as coaching). However, the average number of sessions (those who had not been coached were included as a naught) exceeded the goal. Some units also started coaching operational level staff which was hoped for but was not a focus of the initiative.

Frequency of coaching

The number of coaching sessions was significantly positively related to employee rating of the usefulness of coaching,

the relevance of the objectives set in coaching and perceptions of most of their manager's skills in coaching (13 out of 16 skills measured, such as manager following up, asking questions and challenging the staff member).

Effectiveness of the Coaching Course

The coaching course was the most popular of the leadership development courses being implemented. Although it was voluntary, 60 of the 66 managers and team leaders had attended by the end of Y2 and the remainder had booked to attend the course. Managers who had attended the course coached their staff more frequently (6.5 sessions) than those who had not been on the course (5.6).

Contrary to expectations, managers who had attended the course rated their own skills as being lower in all areas than those who had not attended the course. This may have been a case of participants moving from being unconsciously unskilled to being consciously unskilled (Four Stages of Learning; Process Coaching Centre, n.d.).

Although managers who had attended the course saw themselves as less skilled in coaching, their direct reports rated them as being more skilled. This was true in 11 of the 16 areas measured. This would suggest the coaching course was effective in increasing the skill level of the manager in most areas. In addition, manager and team leaders self-reported skill level in coaching increased in the 12 months between surveys, in all measured areas.

Trickledown Evaluation

The other major initiative to encourage coaching was to equip the Executive and high potential managers with coaching skills through giving them access to external coaching experts. The focus of these experts was to coach people on the coaching of their staff. In order to see if the trickledown effect worked, the relationship between manager's and their direct report's coaching strengths were examined for similarity and whether the frequency of coaching by the line manager was related to direct reports coaching more.

The number of coaching sessions was significantly positively related to employee rating of the usefulness of coaching, the relevance of the objectives set in coaching and perceptions of most of their manager's skills in coaching

Respondent's perception of their own skills in coaching was significantly related to their perceptions of their manager's skills in all but one area. This suggests there was transfer of skills occurring. However, the number of coaching sessions executives had with senior managers was unrelated to the number of sessions senior managers had with their managers, and managers had with their team leaders. This suggests that although the skills were being passed on the habit was not.

Did Coaching Help Move from Good to Great?

The engagement model being used had four drivers of engagement – development of skills, goal focused, sense of community, and vision and values. In this section, the frequency of coaching and the skills of the manager were correlated to the four engagement drivers and to overall engagement to assess whether coaching was driving engagement.

Development

The number of coaching sessions given to a manager was significantly related to their staff's perception of the development opportunities available in their unit as measured in the staff survey. That is, the number of coaching sessions manager A had with manager B, was significantly related to the perspectives manager B's staff had of the development opportunities available in the organisation. This would suggest the trickle down of coaching was helping leaders focus on development with their staff.

Seven of the nine self-rated skills in the coaching survey were significantly related to the scores staff gave the organisation on the Developing People section of the staff survey.

Goal focused team

The other area of the staff survey significantly related to the coaching survey results was Goal Focused Team. Managers and team leaders' perception of their own coaching skill was significantly related to their team's perceptions of being a goal focused team. Again, this suggests that skill in coaching is assisting teams work better together, to know how their work impacts on the success of the organisation, and that they are seeking to achieve the best result.

The frequency of coaching or the manager's skills were not related to overall engagement. However, managers or team leaders who had attended the coaching course also had statistically significantly higher increases in the engagement index on the staff survey than those who had not been on the course.

Sense of community and vision and values, the other two drivers of engagement from the staff survey, were not impacted by the coaching initiative. Sense of community is about promoting connections between staff members and vision and values was about communicating the vision to people and promoting the values – both factors which would have perhaps

been less directly influenced by coaching.

Conclusions

Introducing coaching through having it as a business goal, providing training, and having coaching support for the executives worked as a strategy for creating a coaching culture within the organisation. The coaching course led to increased skills as perceived by direct reports, higher incidents of coaching and higher engagement for teams whose manager had attended. In particular, the coaching skills and frequency of coaching were related to the perceived focus on development and being goal focused – two of the four drivers of engagement.

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Adolescent Non-Suicidal Self-Injury in Aotearoa New Zealand

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From left: Dr. Maddie Judge, Dr. Jessica Garisch, Dr. Lynne Russell, Kealagh Robinson, Dr. Emma-Jayne Brown, Angelique O'Connell, Dr. Marc Wilson

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Non-Suicidal Self-Injury (NSSI) describes deliberate, self-inflicted injury causing tissue damage, without suicidal intent or cultural (or sub-cultural) approval (see Walsh, 2006). NSSI is distinguished from the broader term, deliberate self-harm, primarily through emphasis on tissue damage (as opposed to, for example, deliberately seeking out emotional abuse) and the lack of suicidal intent.

In the normal course of events, people (and other animals and organisms) typically go to great lengths in order to avoid harm. Indeed, pain plays an adaptive role in signalling threats to bodily integrity, so that more serious harm can be mitigated or avoided. So, it is paradoxical that anecdotes, clinical experience and research indicates at least some people, but very few animals, deliberately hurt themselves (see Jacobson & Gould, 2007; Nock, 2010, for reviews). Given this apparent aberrance, it's probably unsurprising that clinical populations tend to be more likely to report a lifetime history of self-harm. For example, Sansone and Levitt (2002) found that more than a quarter of eating disordered in- and outpatients had self-harmed while Chapman, Specht and Cellucci (2005) report that almost half of offenders have deliberately hurt themselves. Closer to home (Auckland to be specific), Fortune, Seymour and Lambie (2005) reported that

approximately 50% of adolescent clients of Child and Adolescent Mental Health services had engaged in self-harm, though self-harm was not necessarily the reason for referral. In a survey of 189 New Zealand adults with a history of self-injury, Langlands (2011) reports that 65% had received a formal psychiatric diagnosis (most commonly depression, borderline personality disorder, anxiety, and PTSD). Given that approximately one in six New Zealanders will experience a psychiatric diagnosis at some point in their lives, it is likely that self-injury is more common than we realise.

So, self-injury is relatively common among clinical populations but, until DSM-5 (American Psychiatric Association, 2013), self-injury has appeared solely as a symptom associated with specific diagnoses. In particular, self-injury has long been a criterion associated particularly with diagnosis of Borderline Personality Disorder (BPD: American Psychiatric Association, 2000). As a result, self-injury is even more common among people who receive a BPD. For example, Zanarini, Frankenberg, Hennen, Reich and Silk (2005) reported that 81% of a sample meeting BPD criteria had harmed themselves in the previous two years.

DSM-5 heralds a potential change in status for NSSI, with the inclusion of NSSI Disorder included in DSM-5 as a "condition requiring further study". Were it to be accepted in its current form, diagnosis of the proposed NSSI Disorder would require five or more days of NSSI; with the expectation of gaining relief from negative cognitive or affective states or induce a positive affective state, and/or relief from interpersonal problems; and in the presence of interpersonal difficulties, negative cognitions and feelings, premeditation of and/or rumination about self-injury. Self-injury associated with socially or sub-culturally acceptable is excluded. In anticipation of this move, Glenn and Klonsky (2013) show that comorbidity between NSSI and BPD is no greater than comorbidity between BPD and other disorders, suggesting that while BPD and NSSI are associated, it is not clear that this is an important piece of information.

That there is attention being given to a potential NSSI-focused disorder is not (solely, anyway) a reflection of the high comorbidity of NSSI with other formal diagnoses. Rather, it is a function of the growing realisation that NSSI is not limited to people with a diagnosis. Regular visitor to our shores, John Briere (and Gil, 1998) has reported lifetime prevalence of self-harm for 4% of a large adult community sample. Just as clinical adolescent populations tend to report more self-injury (e.g. Fortune et al., 2005) so too do adolescents in general, and there is reason to think that self-injury typically starts during early-to-middle adolescence (Nixon, Cloutier, & Aggarwal, 2002; Nock, Holmberg, Photos, & Michel, 2007). A recent review of 52 adolescent study samples reported an average rate of self-injury of 18% (Muehlenkamp, Claes, Havertape, & Plener, 2012).

...self-injury is relatively common among clinical populations but, until DSM-5 (American Psychiatric Association, 2013), self-injury has appeared solely as a symptom associated with specific diagnoses.

Across the ditch, Australian samples report prevalence rates of between 14.1% (e.g., Hasking, Coric, Swannell, Martin, Thompson, & Frost, 2010) and 33.3% (e.g., Martin, Swannell, Hazell, Harrison, & Taylor, 2010). And New Zealand? As is the case with any fashion, both self-injury and the study of it have taken a few years longer to reach us. We have found that between 44% and 55% of first-year students report lifetime incidence in NSSI (Wilson, Langlands, Garisch & Gilbertson, 2011). Similarly, we have reported that almost half (49%) of more than 1000 16-18 year-olds reported lifetime self-injury (Garisch & Wilson, 2015), half of whom had done so in the past year. In our current, Health Research Council-funded, longitudinal research with around 1000 young people participating from age 13, we have found a year-on-year increase in NSSI of around 5% (18% at age 13 rising to 28% by age 15). More than 80% of these are past-year incidents. At the same time, around 20-40% of young people who self-injure do so chronically, and the majority stop doing so by early adulthood. Samples of Māori have been small, but have typically shown that there isn't a pronounced difference between Māori and other groups.

Such high levels are concerning not only for the immediate personal, economic and social costs when people require treatment for self-injury, but also the long-term costs when self-injury becomes part of an ongoing pattern of behaviour. While NSSI is explicitly non-suicidal, it is also the case that lifetime history is associated with suicidal ideation and attempts. Among our first-year students self-injury behaviour is moderately correlated with part suicide attempts (r=.40; Wilson et al., 2011), and among our 13-15 year-old Youth Wellbeing Study participants, number of forms of self-injury engaged in correlate strongly with scores on the Suicide Behaviours Questionnaire-Revised (SBQ-R: Osman et al., 2001). Indeed, more than 80% of the young people reporting at least three forms of self-injury exceed the recommended

SBQ-R cutoff for concerning suicidal ideation. While not all people who self-injure experience suicidal ideation, many people who experience suicidal ideation have also engaged in self-injury (Muehlenkamp & Gutierrez, 2007). Hence, labelling self-injury as a "suicide gesture", "parasuicide", or "attempted suicide" without an appreciation of the function the behaviour serves can be problematic.

Given that self-injury seems so antithetical to 'normal' avoidance of pain and injury, why do people deliberately hurt themselves?

While laypeople commonly answer this question with some variation on "attention-seeking", the consensus among both researchers and practitioners is that self-injury may serve a range of psychological functions. In our research we have used the Functional Assessment of Self-Mutilation (FASM: see Lloyd-Richardson, Perrine, & Kelly, 1997) and the Inventory of Statements About Self-injury (ISAS: Klonsky & Glenn, 2009) to investigate the functions that self-injury serves in both clinical and community samples. Currently we exclusively use the ISAS, which asks respondents to respond to the stem "When I self-harm, I am…" by indicating the relevance of 39 potential functions of their self-injury. Examples include "punishing myself", "calming myself down", "causing pain so I will stop feeling numb", "fitting in with others", and "avoiding the impulse to attempt suicide". These 39 statements are further collapsed into 13 functions that broadly reflect a distinction between serving intrapersonal needs (for example, affect regulation, anti-dissociation/feeling-generation, self-punishment, and anti-suicide) and interpersonal needs (e.g., interpersonal influence, peer-bonding, and autonomy). In short, people can hurt themselves to achieve various different outcomes, and commonly for more than one. Contrary to the stereotype of "attention seeking", regulating affect is routinely the most common function endorsed in research on self-injury (Wilson & Langlands, 2011).

We also know an increasing amount about what predicts NSSI. Symptoms of anxiety and depression, disordered attachment and eating, impulsivity and substance use are routinely associated with NSSI. At the same time, while bullying, and physical and sexual abuse are often associated, these associations have been shown to be relatively weak compared to these other predictors. On the other hand, resilience and mindfulness are weakly protective, while self-esteem is a robust and fairly strong buffer against NSSI.

Given that one of the developmental challenges of adolescence is to learn to manage emotions, it's no surprise that adolescents are strongly represented in self-injury statistics.

In our own research (e.g., Garisch & Wilson, 2010; 2015) we have reported that trait-level difficulties in identifying, understanding, and managing emotional experience (sometimes called alexithymia) is a consistent risk factor for self-injury, and this makes perfect sense. By and large, self-injury is a maladaptive strategy for avoiding the strong (for many people, overwhelming) emotions that come from relationship and life challenges (Chapman, Gratz, & Brown, 2006), and if you don't have the skills to adaptively cope then you're more likely to self-injure as experiential avoidance. Given that one of the developmental challenges of adolescence is to learn to manage emotions, it's no surprise that adolescents are strongly represented in self-injury statistics.

So, we know that self-injury is perhaps more common than many people realise (around 10-20% of our self-injuring participants report having sought medical help for self-injury), we know what predicts it and have a good sense of why people do it. We also know that it is a potentially serious risk factor for lifetime psychological distress and suicidal ideation. What can practitioners do to help people who hurt themselves?

A just-released review of evidence-based approaches to treating adolescent NSSI identifies 29 studies of treatment efficacy with this group (Glenn, Franklin & Nock, 2015). While none of the interventions reported meet standards for acceptance as well-established treatments (in part because there are as yet too few studies), six broad treatments were classified as probably efficacious. These included cognitive behavioural, family-based, interpersonal and psychodynamic approaches, but shared common elements of family skills training, parent education and training and individual skills training. Emotion regulation and problem solving were common aspects of individual skills development. Adherents of Dialectical Behavioural Therapy (DBT: Linehan, 1993) can take heart that, while studies of DBT efficacy are few, DBT is considered an experimental treatment with considerable promise. There is considerable scope and promise for DBT-style emotion regulation-based therapy for use with self-injurious (but not borderline) clients (see Gratz, Dixon-Gordon, & Tull, 2011).

Upon first presentation (or disclosure), Walsh (2006) advocates a "low-key, dispassionate demeanor" (p.84), "respectful curiosity" and "nonjudgmental compassion" (p.85) in responding to self-injury. On the one hand, overt shock or disgust are clearly problematic reactions that may

serve to reinforce feelings of shame or poor self-esteem, but well-meant concern may over time become reinforcing for self-injury behaviour. Care should be taken when it may be appropriate to assess severity of wounds, as Walsh (2006) cautions that this too can become secondarily reinforcing, or alternatively aversive and invasive. Functional assessment of self-injury episodes is important for identifying antecedents and consequences, and for identifying next steps. Family members can often react with shock, distress, guilt, and other strong emotions that may also need to be managed (and support provided).

Such a quick once-over doesn't do justice to the great deal of excellent research and practice relating to self-injury (more than half of the research conducted on this topic has been published in less than a decade). Anyone interested in learning more should have a look at the excellent web-based resources available. These include the Cornell Research Programme on Self-Injury and Recovery (http://www.selfinjury.bctr.cornell.edu/), Non-Suicidal Self Injury in Youth (http://insync-group.ca/), or our own developing Youth Wellbeing Study home (http://www.victoria.ac.nz/psyc/research/youth-and-wellbeing-study).

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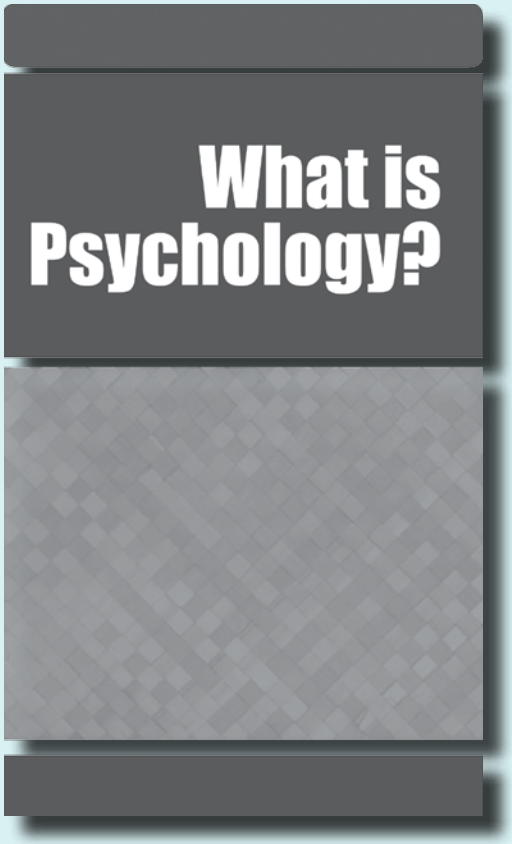

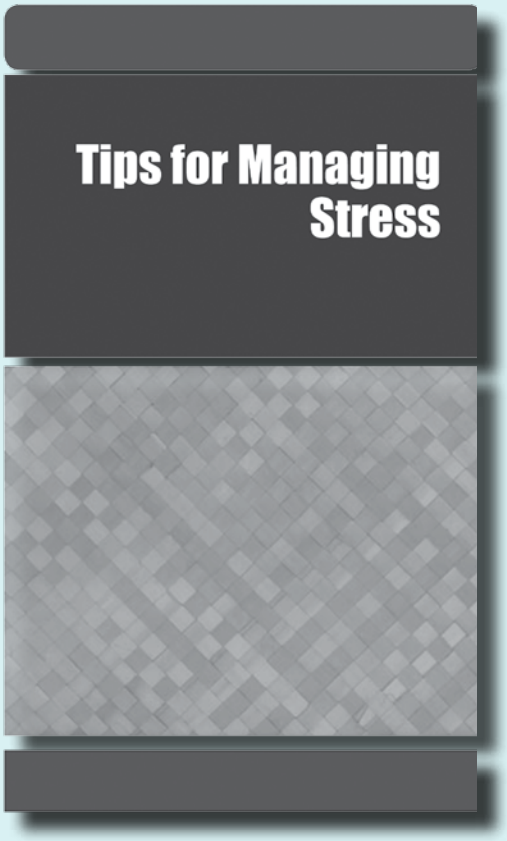

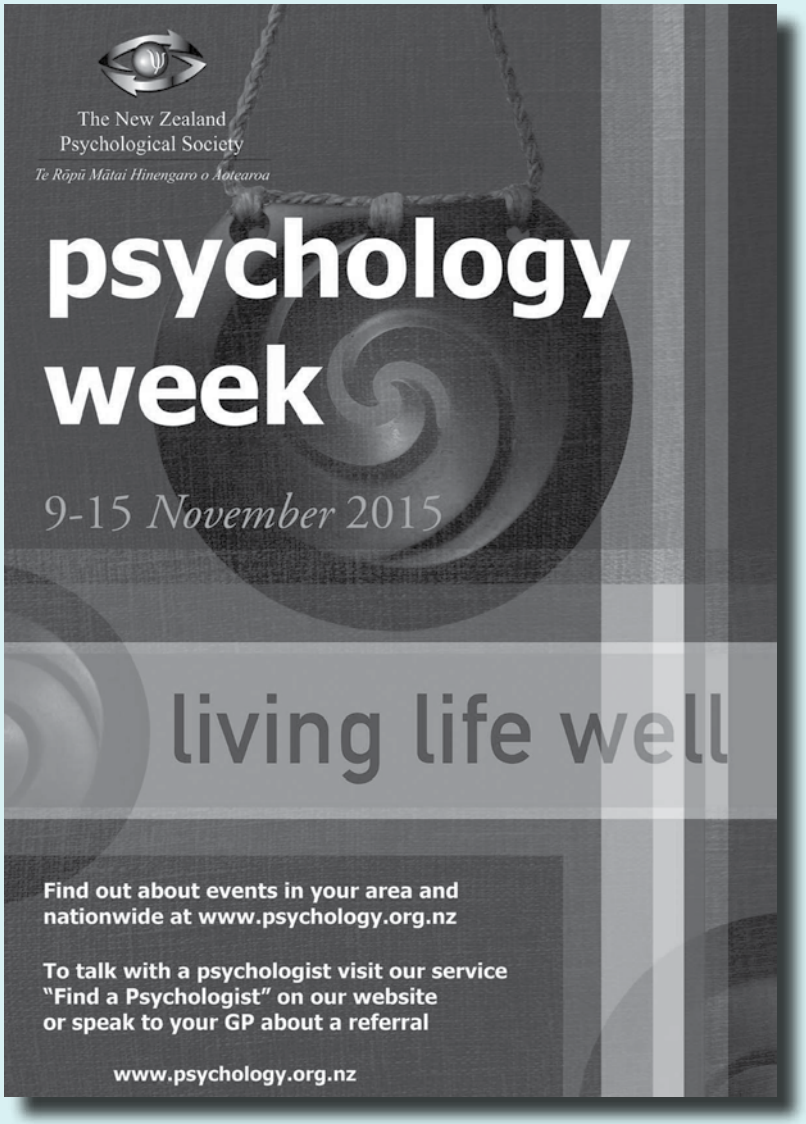

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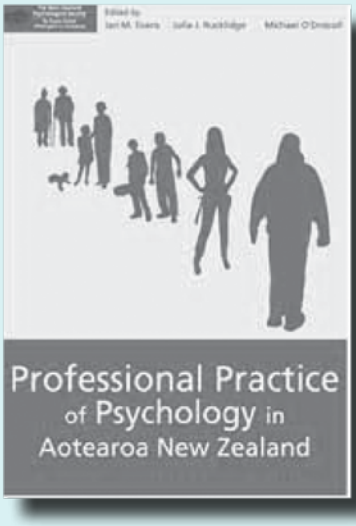

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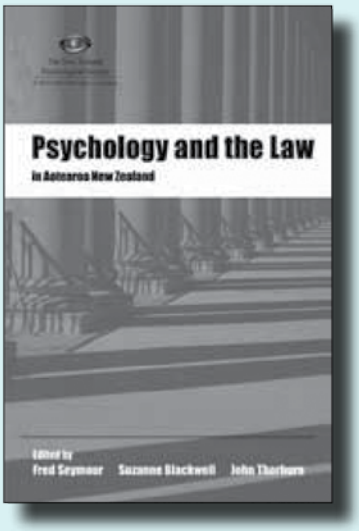

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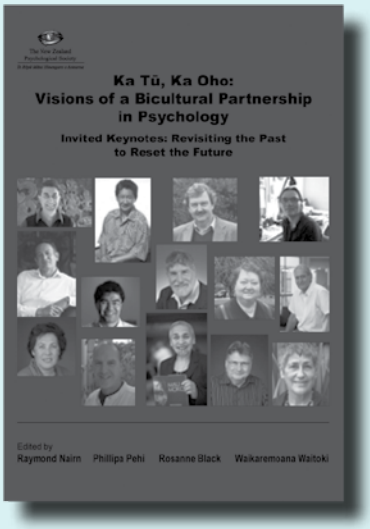

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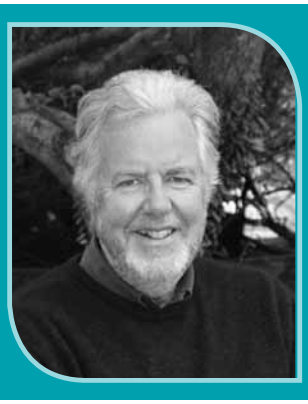
One on One - with Fred Seymour



Fred Seymour was invited as our 'one on one' contributor.

Fred Seymour was appointed to The University of Auckland in 1988. Previously he worked as a practitioner and manager of child and family mental health services. He is a former President of the NZ Psychological Society and has been a Member (2004-10) and Deputy Chair of the NZ Psychologists Board (2009-10). Fred received the Public Interest Award from the NZ Psychological Society in 2005, and was elected a Fellow in 2004. He received the award of Officer of the New Zealand Order of Merit (ONZM) for services to psychology in 2014. Fred's research interests include the development and evaluation of effective therapy interventions for children and their families, and psychology and the law and he also has interests in professional ethics.

One aspect of your role that you find really satisfying

My most enjoyable time as a psychologist was always in the therapy room. In my case, this was usually family therapy. Being part of people's attempts and achievements in making change I find enormously satisfying. As an academic my greatest satisfaction comes in a similar way: being part of clinical psychology students' journey through their years of uncertainty about their knowledge and skills to completing their research projects and becoming competent practitioners. It's perhaps an overused term, but the opportunity to experience these things really is a privilege. Working with a great team of like-minded colleagues is also a privilege.

One event that changed the course of your career

In 1987 Jenni Ogden invited me to apply for a position within the clinical psychology programme. The timing was perfect as I had been planning to leave my position at Leslie Centre, a family therapy agency, where I had been Director for most of the previous 10 years. Fortunately I had the necessary credentials as I had managed to publish research throughout my career while working as a full time practitioner and manager. I had not anticipated a second career as a university lecturer, but looking back I feel fortunate indeed to have had this opportunity.

One alternative career path you might have chosen

I was a boy from Eketahuna so I left for university (Victoria) with the idea of becoming a lawyer. The status appealed to me. However, in my very first Legal Studies lecture I realised this was not the career for me. I completed the course anyway - never a quitter – and switched to one of my other Stage One subjects, psychology. But there must have been something genuine in my initial pursuit of law because during my psychology career I have invested a great deal of time as a practitioner and researcher in law related work; in particular, the Family Court and criminal courts in respect of child complainant witnesses and sexual abuse trials.

One learning experience that made a big difference to you

In my first job, aged 22 years, as a psychologist at an institution for female youth offenders in Western Australia, my boss was a clinical psychologist who thought programme development should be research based. This included conducting our own research within the programme as well as following best practice as researched elsewhere. Rob Sanson-Fisher was my first mentor. This lesson stayed with me as I endeavoured to be both a practitioner and a researcher in my subsequent positions.

One book that you think all psychologists should read

For sheer enjoyment and affirmation of why being a therapist is such a wonderful thing, Stephen Grosz's *The Examined Life: How We Lose and Find Ourselves*. Yes, it was a best seller – which is I guess why I and two others I lent it to each read it in a single sitting – but it also teaches. Reading therapy stories provides a great balance to texts that more directly address how to do therapy. Psychology may just place too much emphasis on the latter. We should perhaps pay more attention to story-telling practices such as that of my friend David Epston of Narrative Therapy fame.

One challenge that you think psychology faces

In regard to clinical psychology, the greatest challenge may be how to maintain our place in the mental health system in these budget conscious times. It is pressing that we adopt roles that justify our salaries and our more extensive and costly training. The work that is being done now on the future of psychology is increasingly important, and congratulations to that group (including my colleagues) for forging ahead with this work. It seems to me that psychologists' success within Corrections provides an exemplar of the flexibility and adaptability needed. Meeting this challenge will be assisted further by resistance to further splintering of psychology: the profession and academia, clinical and other professional disciplines.

One thing that psychology has achieved

Wide acceptance of the significant contribution psychologists make to the settings in which we work. But as discussed above, there is more to do.

One aspiration for New Zealand psychology

To remain connected rather than splintered. To look beyond our immediate group membership or identification, so that we can benefit from the knowledge, perspectives and knowledge of others. Ultimately to be capable of speaking with a unified voice that is better informed and stronger as a result.

One social justice issue psychology should focus on

Without a doubt, poverty. The fact that poverty is disproportionately experienced across cultures and gender raises additional concerns. Of priority is the need to address more effectively the gaps between Māori and the rest of society.

One big question

How can psychology become more relevant to achieving social justice? In decrying the direction taken by psychology away from a wide focus into mental health provision at the individual level, George Albee in 1986 reminded us that "Epidemiological studies find clear correlations between most forms of psychopathology and one or more of the following: (a) emotionally damaging infant and childhood experiences; (b) poverty and degrading life experiences; (c) powerlessness and low self-esteem; and (d) loneliness, social isolation, and social marginality". I did my PhD in community psychology in the early days of this emerging discipline, and the field seemed to me to hold great promise. Unfortunately however, prevention does not pay, and the narrower focus on individual-focused mental health provision is where the jobs are to be found. So the sub-question to that above is how we find support for psychologists working at this broader level?

One regret

Regrets, I have a few. But I'm an optimist, so I try to not focus on these. Regrets are past failures and invite pessimism.

One proud moment

No one thing stands out. I am proud of how I have lived my career. I leave university next February, and although it's not the end of my career as a psychologist, it is gratifying that I have done this university-based work for 28 years.

One thing you would change about psychology

To become more NZ influenced and in particular to embrace the cultural perspectives of Māori and other groups that make up our society. That is, we need to attend better to what we have here, recognising the unique issues we have and acknowledging and strengthening our own resources with which to address these issues.

One piece of advice for aspiring psychologists

Always have a mentor. This may not be your supervisor or therapist. Don't be afraid or embarrassed about asking for this mentor's time. A true mentor gains satisfaction for being just that: it's a pleasure to give. You owe them nothing.

Things to Keep Us Awake at Night: The Challenges of being a Psychologist in the UK

Sarah Corrie and David A. Lane

Sarah Corrie is a Visiting p\Professor at Middlesex University, a chartered psychologist specialising in coaching psychology, and a consultant clinical psychologist. She has extensive experience in both public and private sector services and runs her own coaching and therapy practice as well as working as a freelance supervisor and trainer. Sarah is an academic advisor for Middlesex University (Doctorate in Professional Studies), a faculty member of the Professional Development Foundation, and between 2012 and 2014 was Chair of the Special Group in Coaching Psychology (British Psychological Society). Her other posts include Director of the Postgraduate Diploma & MSc in Cognitive Behavioural Psychotherapy offered by Royal Holloway University of London and Central and North West London Foundation NHS Trust. She is the author of a wide range of articles and books including (conjointly with David Lane), The Modern Scientist-Practitioner (Routledge), Making Effective Decisions in Counselling and Psychotherapy (Open University Pres), Constructing Stories, Telling Tales: A Guide to Formulation in Applied Psychology (Karnac) and CBT Supervision (Sage).

We live and work in a time of unprecedented uncertainty, volatility and complexity. For psychologists, this climate presents significant challenges and many emerging questions about our identities, roles and contribution in a changing social and economic landscape.

In this article, we focus a lens on some of the challenges currently facing psychologists in the UK. The rapid expansion of psychology into new areas and domains of practice dictates that this short review will be selective rather than comprehensive. We do not claim that our account is representative of psychology in its entirety, nor do we assume that the issues we describe are unique to the UK (indeed, some clearly have a global reach). Rather, through highlighting certain aspects of the British 'picture', and drawing on an agenda for the future by Gray, Garvey and Lane (2015) as well as our own work arising from our examination of psychology as a profession (Lane and Corrie, 2006), we set out to identify areas of shared concern that might represent a focus of dialogue and debate, and perhaps inspire new collaborations at both national and international levels.

An overview of the UK landscape

The role of the professions in society has changed dramatically in recent years and the UK is no different in this regard from any other part of the world. As Lane and Corrie (2006) indicated the context for our work has become more diverse and the number of providers offering services that overlap with psychology has increased to match. One illustration of this is the field of coaching. Psychologists (including IWO and coaching psychologists) who have claimed coaching as amongst their professional services may now find themselves competing for business alongside others who have more limited experience, training and expertise (coaching is still an unregulated industry) but who offer their skills at a significantly lower cost. Thus, the question becomes how does being a psychologist add value for money and how can this 'added value' be communicated to buyers of coaching?

A further, and more radical, example of the changing role of psychological interventions has been England's Improving Access to Psychological Therapies initiative (IAPT; Department of Health, 2008). IAPT was devised, delivered and funded in order to improve the psychological well-being of the population through providing more rapid and consistent access to evidence-based therapies. This initiative has resulted in the emergence of a new workforce to deliver routine and first-line stepped care interventions. The function of this workforce is to enable primary care services to implement National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders.

Described at a recent conference symposium as "...the world's largest attempt to disseminate evidence-based

interventions" and an initiative that has "revolutionised" the treatment of anxiety and depression (Clark, 2015) it was reported that IAPT services are now in place for every care commissioning group in England and that the IAPT initiative has to date been responsible for training over 7,000 new psychological therapists (Jarman, 2015). As the original programme, aimed at adults, now seeks to enhance recovery rates, IAPT is being 'rolled out' to other populations that include children and young people (based on a service transformation model of existing CAMHS services); long term conditions and couple-based interventions as well as focusing on increasing access to, and uptake by, older people and BME populations.

At the same time, the public sector services by whom many psychologists are employed or otherwise connected are facing seemingly unresolvable financial difficulties. Concerns about staying 'in budget' and the impact on staff morale and subsequent quality of care have been highlighted as major concerns (http://qmr.kingsfund.org.uk/2015/15). In such a climate, as Pemberton (2015) observes, "…there is bound to be more pressure on psychology services, and we are going to need to be very clear about the added value and economic benefits of high quality psychology services" (p.55). This recognition has given a new impetus to workforce planning initiatives as well as attempts to secure funding commitments for NHS mental health services.

Emerging themes for professional practice that have specific implications for us as psychologists

These three examples of pressure points (we could identify many more) illustrate two themes that must ultimately inform any analysis of our future: namely that there are monumental shifts taking place in how professional services are delivered, and that psychologists face a critical transitional point in their collective history. Pemberton (2015) in his capacity as Chair of the Division of Clinical Psychology, comments on "…how fragmented the profession has become" (p.56), a statement that could be seen as extending to all branches of psychology. This transition (at best) or fragmentation (at worst) reflects a range of intersecting factors, some of which are outlined below:

State control of the professions:

Psychologists, like many other professionals, have lost one of the defining hallmarks of a profession: namely, the autonomy to set standards and judge one another's work. This responsibility now resides with the State on whom we are increasingly dependent for our income. Previously it was a choice to work for the public sector, the third sector, the private sector or as an independent practitioner. Now the changing landscape dictates that regardless of whom a psychologist is employed by, dependence on the State is increasingly a feature. This might be as an employee of a public body, as a staff member at a charity providing contracted services on behalf of the State, as part of a private company, or through independent bidding for public contracts to provide health care, social care, adoption services, employment, assessment or training contracts.

One of the core trends promoted by the State is the move to both control of the professions and the de-professionalisation of service provision. Traditional professional structures are breaking down as people seek new ways to get help and so new groupings emerge in roles which psychologists have traditionally fulfilled. Coaching is an example of this. For example, it is possible to obtain coaching for health, development, change, life challenges and leadership, amongst others, all of which are trespassing on those areas where psychologists seek to work.

The changing expectations of, and pressures on, our professional bodies:

The unprecedented expansion of those claiming to use psychological knowledge alongside greater State control of the professions has created mounting pressure on the professional bodies to represent members' interests in new ways.

… the public sector services by whom many psychologists are employed or otherwise connected are facing seemingly unresolvable financial difficulties.

At the time of writing the British Psychological Society is undergoing a review of its member networks to ensure fitness for purpose for the future. This has been welcomed by many, as well as criticised by others who are in favour of reviewing the Society's Royal Charter to further enable its evolution as a professional body. The concept of a learned society that sees itself as responsible for the "... development, promotion and application of psychology for the public good" (http://www.bps.org.uk/) has created debate about whether the Society is principally concerned with representing psychology or psychologists, as well as prompting a re-examination of what its members actually need.

There is also the matter of the credentialing and registration of an increasingly diverse workforce. IAPT for example, has resulted in professional organisations

such as the British Association for Behavioural & Cognitive Psychotherapies (BABCP) creating pathways to accredit a new workforce. Previously individuals needed to have completed a core professional training in a relevant mental health field prior to undertaking specialist training in cognitive behaviour therapy. Now, psychologists choosing to specialise in this area are competing for work alongside others who make the claim for having the equivalence of a core profession.

Thus, as the State takes control not just of services but the bodies that provide them through contracts, commissioning and regulation we see a move to reduce the requirements for those who practice in the field. An example of this is the use of one year trained practitioners in delivering guided self-help as part of a stepped care service. Other examples include plans for more health care assistants to undertake nursing roles, and a proposal for paramedics to be given prescribing authority in GP surgeries to reduce the need for more general practitioners. It makes sense for the State to seek to provide services at the lowest possible cost but it does mean that a more narrowly trained cadre of paraprofessionals are replacing highly qualified practitioners as the front line of services to clients.

Psychology services are delivered in a turbulent world:

Services are developed and delivered based on a set of assumptions grounded in notions of prediction and control. However, the world is uncertain and turbulent and aiming for predictability and control may prove counter-productive, reflecting a defensive desire to exert control in the face of uncertainty (Cavanagh and Lane, 2012).

Birkenshaw (2010) has described traditional ways in which organisations (with psychology services in our view being no exception) are managed through processes of alignment: everything we do is aligned with the purpose of the organisation and employees are checked, evaluated and measured against their ability to fulfil that purpose. This is based on a set of beliefs that it is possible to predict and to some extent control the world in which we are operating.

As we have to deal with more complex scenarios we need to think about how much time in the work place we devote to the enhancement of our expertise.

Nonetheless, if the world of work is increasingly turbulent (as Lane and Down, 2010, contend) we will, according to Birkenshaw (2010) have to work on 'obliquity' – a term he takes from Wollhein and Kay (see Birkenshaw, 2010) which describes how the process of achieving our goals often occurs indirectly. In practice, regardless of the management mantra, overcoming obstacles or meeting our targets is often achieved through working around them, pursuing the outcomes in ways that appear inconsistent with the original plan. We have to learn to pursue indirect and creative goals, and learn how to take leaps of faith. This may be anathema to the way we were trained but is consistent with the idea of psychologists as professionals capable of dealing with complexity.

The development of expertise:

If professional practice is becoming increasingly complex then we have to spend more time getting good at what we do – we have to 'practice' in our daily work as opposed to just 'delivering' in our daily work. However, it is difficult to retain confidence in our individual and collective expertise when knowledge is changing so rapidly. Even keeping on top of the evidence-base is a challenge. Drawing on research into expertise (Ericsson, Prietula and Cokely, 2007) it can be argued that elite performers (for example in sports or chess) spend relatively little time performing and most of their time practising. But people in services do the opposite.

As we have to deal with more complex scenarios we need to think about how much time in the work place we devote to the enhancement of our expertise. We need to think about CPD in increasingly sophisticated ways, and reframe CPD as an essential aspect of practice rather than an optional ideal. This in turn gives rise to questions about who should take responsibility for, and fund, our CPD. Is it the responsibility of the individuals themselves, or should this fall to their employers, or even local education and training boards? Ericsson et al. (2007) argue that we need time for deliberate practice. It is not possible to become an expert without continuous practice and coaching. The coach acts as a guide to that deliberate practice but crucially helps the performer become their own coach. So how do we establish frameworks for deliberate practice for professional services to develop expertise and how are we going to fund the 'coaches' and supervisors to facilitate that deliberate practice?

Big K and little K:

Garvey and Williamson (2002) have discussed two types of knowledge. Big K refers to the domains that evolve into specialisms (reflecting an understanding of what counts as good evidence) which is not the property

of individual minds. Little K is knowledge firmly in the realms of individual educational experience and personal professional experience. Little K is increasingly being used by numbers of paraprofessionals where they are not subject to the rules of practice that apply to Big K. Psychologists could traditionally draw on both for client benefit but the complexity involved in making such decisions (Lane and Corrie, 2012) takes considerable practice to ensure client benefit. This is less likely to be available to those whose training is based on limited competence models who as Wheelahan (2007) contends are denied access to the knowledge-base necessary to contest the assumptions behind the service they provide.

The demographic time bomb:

We face as Rajan (1990) has long warned a demographic time bomb. We are an ageing population with a smaller economically active base to support it. We are not paying adequate attention to our increasingly ageing society. We will struggle to find entrants to the professions for the work that is available unless we accept significant increases in immigration of qualified younger professionals. Yet in doing so we deprive other countries of their own economic assets. Ageing represents an opportunity and is an increasing area of activity for psychologists (see EFPA report on Geropsychology, 2013) but is also a threat if there are insufficient younger people to provide services to older people.

Global connectivity:

The influence of emerging technologies (including the so-called 'GRIN' technologies [Genetics, Robotics, Information Technology and Nanotechnology]) is ever more apparent. Machines are becoming smarter and capable of providing expert services. Nonetheless, we have been slow to look at the implications of this for professionals. The biggest growth is likely to be in the use of diagnostic, training and simulation systems in health, social and occupational areas. Machines have immediate access to large databases and as a result, an expert diagnostic system delivered by a machine has the potential to be more accurate than a person. So what role will we play as psychologists in building, using and dealing with the consequences of such systems?

In industry there is much talk of disruptive technologies that change the rules by which we live and work. Imagine that a local health service decides to greatly extend the use of supervision to support service provision. The service puts this out to tender and a technology company based in (for example) Egypt bids, claiming that it can deliver at a fraction of the cost using expert systems. Based on their previous experience, the company confidently proposes a payment by results contract – if the local health service is not satisfied, no costs will be incurred. Would this health service be tempted to buy such a service? More locally in the UK is the issue of 'Any Qualified Provider' (AQP) commissioning. Also known as 'free choice', the AQP model aims to improve quality and offer service users choice across services. It also aims to encourage innovation through enabling new providers to offer services. One consequence is that private companies with no previous background in psychology can win tenders to deliver psychological therapies services, as has occurred in other areas of health. This has implications in relation to working conditions for psychologists.

….as a collective we need to be prepared to voice more forcefully where the added value comes from commissioning the services of a psychologist over other providers.

How to avoid being kept awake at night: A tentative conclusion

The trends outlined above pose significant challenges for psychologists. But might they also present opportunities? At the time of writing, a clinical psychologist has just been elected Member of Parliament. This is the first time that a clinical psychologist in the UK has held such a position. The current Chair of the British Psychological Society's Division of Clinical Psychology has rightly identified this as a cause for celebration, reflecting as it does a long-standing aspiration for many – namely that psychologists occupy far more frequently the leadership roles that bring with them real influence.

If we are to identify the opportunities amidst the challenges psychologists must, both individually and collectively, garner a much more sophisticated and responsive understanding of the contexts in which they live and work, and be willing to become a louder voice in the professional arena. Psychology is a diverse field and each practitioner needs to make a coherent case for the work they do. But as a collective we need to be prepared to voice more forcefully where the added value comes from commissioning the services of a psychologist over other providers.

No profession, including psychology, can or should make special pleading for their right to be the provider of choice. What we have to do is be clear what our offer is and why it is worthwhile (our purpose), the ideas and approaches we bring that add value (our perspectives) and the particular methodologies and techniques that we have to enhance

well-being for people, persons and society (our process). Our offer has to be worth accepting. This is our challenge as individual psychologists and as a profession – are we willing to face it?

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There are two clinical books this issue, neither of which appear to be about to set the literary world on fire. However, *Hand to Mouth: Living in Bootstrap America* may be an entirely different prospect. Peter Stanley has provided us with an accessible introduction to an important book, one that should be widely read even in Aotearoa New Zealand. The Huffington Post described the author, Linda Tirado as "The woman who accidentally explained poverty to (a) nation" and even if that nation is not our nation I am sure that there is much to learn from her "constructive resentment".

John Fitzgerald- Review Editor
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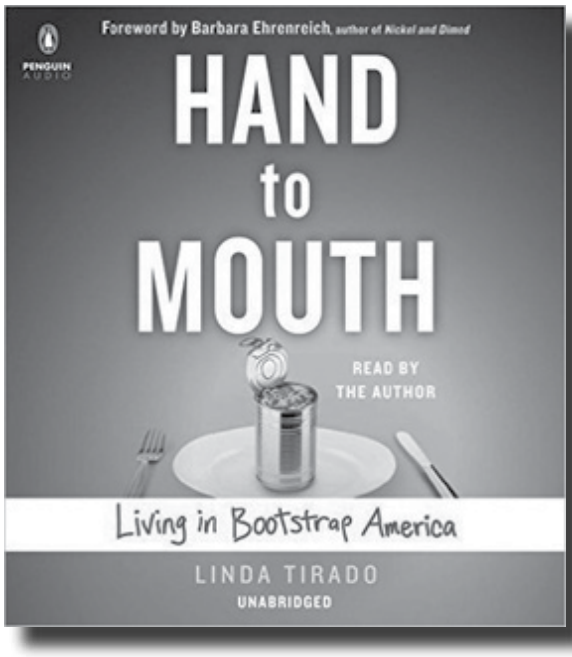
Hand to mouth: Living in bootstrap America

Reviewed by Peter Stanley, Counselling Psychologist, Tauranga

In August of this year I visited Sydney. Between the coffees, shopping, and shows I observed the beggars on the streets. The beggars in New Zealand's cities may be different, but these individuals were recognizable by their downcast eyes and an extraordinary immobility, by the dirty skin that gave them a suntanned appearance, and by the assortment of domestic goods that surrounded them (and this could extend to a dog companion that seemed as sad as themselves). Why do such people obtain money in the solitary, silent, and somewhat staged way that they do, when most other people of a similar age are active, have jobs, attend to their physical hygiene, and have homes that they go to at night?

Explanations for beggars and homelessness probably abound. It could be that the individuals who solicit money on the streets are the 'losers' in a capitalistic economic system. If the deinstitutionalization of psychiatric care had not occurred then there would still be a place for people who are so 'unwell.' Linda Tirado in *Hand to Mouth* takes an altogether more nuanced and human view of poverty, and it is an understanding that arises from sustained personal experience. According to Tirado, life is similar to a game of snakes and ladders. We may get lucky and find



ourselves cosseted by an array of supports and influences; and in these circumstances we will probably redefine our assets as 'attainments' and disparage the lifestyles of the poor (who should try harder). Or, we might have some serious bad luck. As the consequence of problems in health, relationships, or career, we could find ourselves slipping into the comprehensive and remorseless world of poverty where we cannot get ahead again no matter what we do.

Hand to Mouth accesses the mind-set, and the choices, which arise from continually being overworked and tired; and from being denied the rewards, compensations, and opportunities that others enjoy. This book is a useful primer on a host of deprivation-related issues that are now to the fore in this country including child poverty, zero contract hours, minimum wage, social housing, warrants of fitness for rental properties, drug use and cessation, selling from trucks in low socioeconomic areas, the long 'tail' of educational underachievement, and workplace accidents. It might be argued that people who become poor have personal vulnerabilities that predispose them to this outcome, but the composite of factors that maintain impoverishment cannot be denied. This text poses a number of questions for professional psychology, like what should be the balance of prevention programmes to reactive interventions? And as a profession, don't we have an obligation to at least comment about the drivers of disadvantage?

Tirado's book is gritty (it contains lots of swear words) and it is uncompromising. It is also amusing in parts, and it provides some rare and apposite observations on some of the behaviours of people with money. For instance, there are jibes about exorbitant salaries, government subsidies and services for rich people, capital gains, retail therapy, alternative medicine, abuse of prescription drugs; and about meeting attendance as group therapy for the middle class, and as an accepted alternative to work. What I especially enjoy, however, are the commentaries on some varieties of parenting amongst the affluent. The author raises questions about nannies, designer accessories, "the antibacterial-spray fetish," and "the anti-vaccination kick." It is best to let the author speak for herself a little more here as it will also show this book's inimitable style:

> *I disapprove of about as many of the upper class's child-rearing habits as they do of mine. Rich and poor are different, you see, and as such, we value different things. I have trouble with the way you're raising your kids. They're not all special precious unicorns, destined to cure cancer. And if you tell them that they are, they feel entitled to act as though it were true.*
>
> *You can stop this cycle, rich people. Just teach your kids that they're human like everyone else. Maybe a special snow-flake, but one that will still get in trouble if they misbehave on the playground. I have faith in your ability to heal the next generation. I am counting on you, rich people. Don't let me down. (pp 182-183)*

Hand to Mouth has provoked enormous interest in the United States and it should do so here as well. It is a book for today, and it is on a subject that is significant for us all. It takes us to new places in our understanding of the determinants, the costs, and the psychology of being poor and being rich.

Hand to mouth: Living in bootstrap America

Linda Tirado (2014)

New York: Putnam

ISBN 978-0-399-17198-7. NZ$33.20 (Hardback)

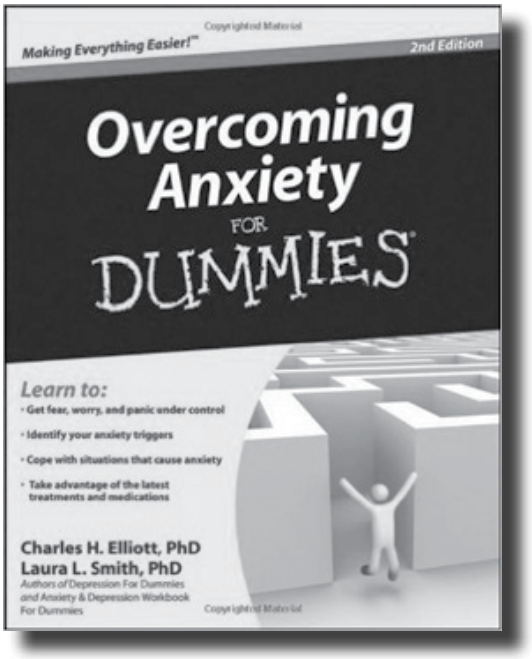
Overcoming Anxiety for Dummies (Australian & New Zealand Edition)

Reviewed by Joanne Taylor, Massey University, Palmerston North

Who would have thought that, 23 years after the publication of *DOS for Dummies* in 1991, there would be more than 1,800 *For Dummies* titles, ranging from books on *automotive, cooking and entertaining, green living, home and garden, pets, and parenting*? *For Dummies* books have been translated into about 30 languages, including Arabic, Estonian, Greek, Russian, and Vietnamese, and in Australia, one *For Dummies* book is sold every three minutes. If you can think of something not yet in the over 1,800 titles, you too could be a *For Dummies* author (see http://www.dummies.com/about-for-dummies/write-dummies-books.html).

There is also an extensive list of titles in the *self-help and relationships* category, one of which is this title on overcoming anxiety, which is basically a self-help guide on cognitive behavioural therapy for problematic anxiety. This Australian and New Zealand Edition is authored by Christopher Mogan, the director of an outpatient programme for OCD and related disorders at The Anxiety Clinic in Melbourne, and two clinical psychologists from California, Charles Elliott and Laura Smith. It is clear that some content has been changed to better reflect the state of play of anxiety problems in these parts of the South Pacific,

such as including information about local organisations and resources, but the book retains the *For Dummies* flavour, with trademarked statements like "Makes Everything Easier!" on the front cover. There is a strong U.S. influence right from the start, where readers are told "just as we don't want to become victims of terror, we can't let ourselves become victims of anxiety". In fact, the language used throughout the book refers to anxiety as "an epidemic" and something that people (often referred to as "victims") "suffer" from and are "afflicted with". I was surprised to see this kind of pejorative language in what is supposed to be a self-help book. How is it helpful for someone to consider themselves to be afflicted by or suffering from anxiety? How are we supposed to address the ongoing problems with stigma about experiences of mental distress when this kind of language is used?



Having said that, this book does exactly what it purports to do, which is to provide simple and practical strategies for dealing with mild anxiety. There is information on how to identify various kinds of problem anxiety and understand how it can develop, followed by techniques for dealing with the physical, emotional, cognitive, and behavioural aspects of anxiety using basic cognitive behavioural approaches. The book extends into aspects of lifestyle, stress, support, helping others with anxiety, and dealing with anxiety in children, and finishes with concise suggestions for stopping anxiety quickly, dealing with relapse, and identifying when professional help is needed. This kind of approach is useful as it encourages the reader to sample from an array of strategies and find out what works for them. There are some aspects that are already out of date, such as the description of the symptoms of PTSD which are out of step with the new DSM-5, but that is really a fairly minor point in the scheme of things, given that this is a self-help book for people who experience minor anxiety or want to support a friend or family member who experiences anxiety.

Would I recommend *Overcoming Anxiety for Dummies* to clients with mild anxiety? No. I have to say that the way the book refers to and frames the experience of even mild anxiety was unacceptable to me. It's a shame, because the book has a lot of useful information, but I just couldn't envisage giving a book or a chapter to anyone when it describes the experience of anxiety as an "affliction" and as people "suffering from" anxiety. That kind of subtle language of the experience of anxiety and of people who have the experience can only serve to reinforce stigma, especially self-stigma, and I don't think it's acceptable to expect clients or other members of the public to look past that and just focus on the substance of the book in terms of the information it provides and strategies it suggests. For that reason, I would instead reach for or recommend one of the other available self-help books. I can only hope that, if this review makes its way to the publisher (the very respectable John Wiley & Sons, Inc.), that it results in change.

PS. When pressed the reviewer suggested an alternative text would be Bourne, E. J. (2011). The anxiety and phobia workbook. New Harbinger Publications.

Overcoming Anxiety for Dummies (Australian & New Zealand Edition)

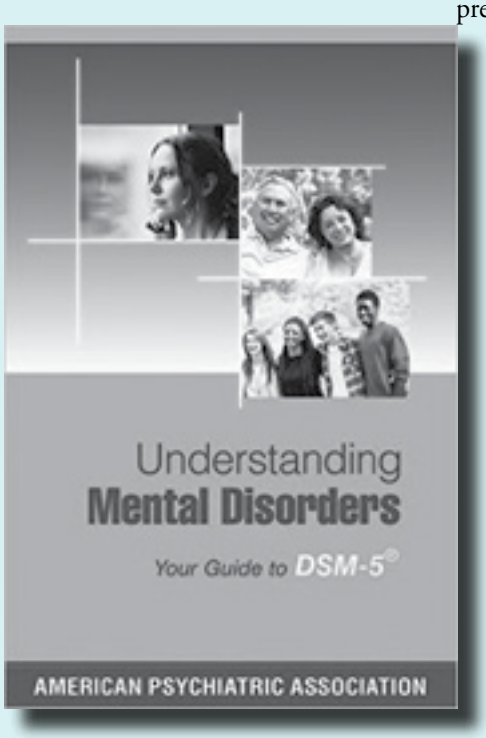
Christopher Mogan, Charles H. Elliott, & Laura L. Smith (2014).

Queensland: Wiley

384 pages, AU$34.95

Understanding Mental Disorders: Your Guide to DSM-5

Reviewed by John Fitzgerald, Massey University, Wellington



There have been a number of books published about the new DSM-5, both commentaries and critiques. Some of them must have been in preparation well before the DSM was actually released, either that or the authors are prolific. Not only has the quantity of books been impressive but so, generally, has been the quality. The text Understanding Mental Disorders: Your Guide to the DSM-5, authored by the American Psychiatric Association is a worthwhile addition to the expanding library, if what you are looking for is a text providing a simple explanation of each disorder, the diagnostic criteria, risk factors, 'real life' stories, treatments and helpful advice. This book has been prepared for a non-specialist audience, although I cannot imagine many members of the general public rushing out to purchase a copy. It is the sort of text you would find on the shelf in a public library or that you may purchase as a practitioner so you could provide clients with a little more information than a printed page off the internet.

The book is nicely formatted and presented. It is not divided into chapters directly reflecting the structure of the DSM-5, but into more intuitive and helpful sections. Each chapter commences with a brief general introduction. Often this is followed by intervention outlines which include life-style and healthy body components. For example, the chapter on anxiety disorders introduces cognitive-behaviour therapy before medications, and then moves on to a brief section entitled maintaining a healthy mind and body which highlights the importance of relaxation, exercise, avoidance of caffeine and getting support, before any of the DSM disorders are even introduced in detail. The 'real life' stories are also quite nice. They are not extreme caricatures, but examples that most people would recognize.

Chapter 20 is entitled "Treatment Essentials". It introduces the range of health practitioners, including psychologists, who provide mental health care. There is an emphasis on the medical model of assessment-diagnosis-treatment and although medication as a treatment option is presented alongside (but after) a range of psychological/talking therapies it is presented as the most potent form of intervention.

The appendices are useful. There is a glossary of terms and a list of DSM-5 disorders. There is also a list of medications (generic and brand names) and their uses. As expected the book has an almost exclusively American focus, although there are some Australia/New Zealand resources listed at the back of the book, including the web address of the New Zealand Psychological Society.

This might be a useful book for a clinic to have on its public library shelf and would certainly assist a practitioner in preparing client-focused information materials. It is functional rather than exciting.

Understanding Mental Disorders: Your Guide to the DSM-5

American Psychiatric Association (Author)

Washington, DC

ISBN: 978-1-58562-491-1

Editorial

Kathryn Jenner
Student Forum Editor

Welcome to another issue of Student Forum!

I don't know why but it always catches me by surprise when we find ourselves in the tail end of another calendar year – I know it's a cliché but they go by faster and faster every year! I must be getting older…

I hope your year has gone well though, by the time you read this, most of you will be finally into your summer holidays, so I hope that exams and thesis submission has gone well.

The Society held another successful conference in Hamilton this year. Next year's conference is in Wellington, the dates are 25-28 August and it is never too early to start thinking about whether you might be interested in presenting at the conference. From a personal perspective, I have done this twice so far, at separate events, but they have been some of the most affirming moments of my career to date – looking out into the audience and realising that some of the attendees were taking notes was a real confidence builder for me and really brought home to me that the hard work I had put into my research was valuable to my field. So I challenge you – it may not be the NZPsS Conference if it doesn't suit your location or availability, but find a conference that works for you and submit an abstract for consideration. Not only is it a fantastic confidence booster but it's a great chance to network and looks impressive on your resumé.

This month I've been fortunate enough to have two students who have done just that. Megan Laing is breaking new ground in the NZ Police and has provided a valuable insight as to how her role is providing a new way of caring for children and youth. Julia Hill also works with children, however from an educational perspective and has kindly offered her poster from conference for publication. So, enjoy. I hope that your summer holidays are restful and refreshing and that you feel ready to take on 2016 and all the challenges it may bring.

Kathryn Jenner

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In Partnership for Children: New Zealand Police and Psychology

Megan Laing

Megan has been employed by NZ Police as the Child Case Manager in Palmerston North since 2011. Whilst working full time in this position she completed a Master's thesis focussed on the victim's experience of parent abuse which was inspired by her work with children who come to police attention for being abusive towards their parents or caregivers. Prior to this, as an undergraduate Megan gained experience working part time in a youth justice residential facility. Megan is now continuing in the role of Child Case Manager as an intern psychologist in the Post Graduate Diploma in Psychological Practice at Massey University. Megan presented at the recent NZPsS conference about her experience of the personal and professional development involved in becoming an Intern Psychologist working for the police as well as the organisational challenges and exciting benefits of having a psychologist delivering police-led early intervention to child offenders. Megan was the winner of NZPsS Best Student Presentation at the 2015 NZPsS Conference in Hamilton.

In New Zealand, the interface between policing and psychology has been quite limited, with even the internal staff welfare roles being filled by professionals of varying disciplinary backgrounds. However, the central purpose of the police service is public safety, which fundamentally, is driven by human interaction and behaviour-core business for psychology. An initiative of the Manawatu Police District has provided a unique opportunity for an innovative partnership between police and psychology.

Internationally, investigating and resolving crime remain central to day to day operations for police. However, New Zealand Police are pioneering strategies to modernise and future-proof the practices that keep the New Zealand public safe by also taking a preventative focus. The New Zealand Police Strategic Plan 2011-2015 presents a model of policing that takes a three-pronged approach to responding to crime by putting prevention first, having a people and victim focus and placing importance on continuous improvement.

This focus on prevention is widely addressed in the Police Prevention First: National Operating Strategy 2011-2015 by outlining a need to tackle the drivers of crime, predict and deploy to meet demand, and develop and maintain the prevention mind set of all New Zealand (NZ) Police staff and ultimately the public. To tackle drivers of crime, police have identified five priorities, including youth and families. 'Prevention First' holds that New Zealand police will support and protect vulnerable and dysfunctional families, lift the veil of secrecy around family violence and child abuse and expose familial organised crime groups. Furthermore, NZ Police commit to keeping vulnerable children and young people safe and endeavour to decrease the number of young people represented in our criminal justice system.

Therefore, NZ Police began to focus their attention on establishing the best way to prevent children firstly entering the youth justice system and subsequently becoming life time persistent offenders. Acknowledgement of research evidence on the positive impact of early intervention in reducing future offending provided the impetus to change from the historically reactive stance to a proactive approach to policing child offenders. The Children, Young Persons, and their Families Act 1989, requires not only that children be held accountable for their offending but also

that their needs be addressed. NZ Police considered their role in this context and responded by piloting the Child Case Manager role. Under this initiative, Police employed four non-sworn civilians with various qualifications and experience to work with child offenders. Previously, the responsibility to provide intervention for these children lay primarily with Child, Youth and Family Services and partnering support agencies. Alternatively, these children simply progressed on to the youth justice sector where they could be held accountable by the court. Formative evaluation of the Child Case Manager initiative was encouraging and subsequently Child Case Managers with youth work, social work, counseling, psychology, education and law backgrounds were appointed at 22 sites nationwide.

These Police Child Case Managers work with children 13 years and under who have come to police attention for offending or other incidents. These children are identified as being medium to high risk of reoffending based on the Youth Offending Risk Screening Tool (YORST). A YORST is completed at intake and again at termination as a means of tracking changes in dynamic risk factors. Alongside this screening tool is the Youth Development Assessment Tool (YDAT) which is a more comprehensive assessment template that considers offending risk factors not captured by the YORST. In becoming an intern psychologist I have further developed my assessment process which is having a very obvious positive impact on the accuracy of case formulation and consequently intervention and treatment outcomes. Since the referral source is a time pressured police officer, the information contained in the referral is often limited. So for me, assessment starts with a thorough investigation of the underlying motive for a referral. The offence the child committed provides the basis for the referral; however the context surrounding the offending must be understood before proceeding with the intake.

Accepting a case is based on a number of factors including the context of offending and ongoing risk as well as the appropriate fit of the services and case load capacity. My assessment then seeks to examine how factors such as attachment, trauma, self-concept and -esteem, family stressors, learning disabilities, developmental disorders, and mental health diagnoses (among other psychological and psychosocial issues) impact behaviour and risk of reoffending. In some cases, identification of the possible existence of psychological disorder means children are able to access DHB mental health services earlier than might otherwise have occurred.

So a valid question to consider is how appropriate it is for the police to be offering a service like this, which (in the Manawatu) provides a psychological assessment, formulation and subsequent treatment plan for these young offenders and their families. The traditional view of police responsibilities would say that there is plenty of government and community based organisations to which police could refer child offenders for intervention to reduce their risk of re-offending. However, since the inception of the Child Case Manager (CCM) role, it has become evident that the service has a valuable place in the social service sector: it both plugs gaps between existing services and supports inter-organisational coordination where appropriate. Many of the children that come to police attention present with a complex web of inter-systemic risk factors, however when these risk factors are viewed in isolation they rarely meet criteria to receive support from appropriate services. The police CCM is able to act as a net to catch and address the needs of these children who would otherwise very likely progress with escalating antisocial behaviors until they do meet criteria for other agencies.

An important difference between the CCM and other conventional counseling or psychological services is the case management capacity which is valuable in the multi-disciplinary nature of working with clients with complex needs. Additionally, as an intern psychologist, I am able to conduct in-depth assessments that are more likely to get to the root of issues perpetuating offending. This additional capacity to draw on psychological knowledge to make sense of behaviour, frame it in context, respond accordingly and communicate it effectively to other stakeholders is a major benefit of having an intern psychologist in the position and serving as a lead agent in multi-disciplinary approaches to complex cases.

CCMs are also supported and resourced by the police to be completely mobile and are encouraged to break down the barriers that stand in the way of client engagement. We have the resources to work safely within the family home as well as in school and out in the community. We do not have administratively imposed session limits or constraints on the length of time we hold a client. Although this requires competent clinical management in appropriately managing termination, it has an extremely positive impact in developing a trusting therapeutic alliance with a client and their family.

Although it is sometimes very difficult for families to overcome their pre-existing beliefs about police to accept

the child case manager service, the "brand" can also be valuable in that it suggests strength, safety and protection which is priceless when working with children who have experienced the adversity that has led them to come to police attention. The CCM presents the caring face of the police to Client families who are then able to see the police as a part of their support network. The staying power and feasible intensity of the service is also highly valued by parents and caregivers who are often exhausted, "at their wits end" and feeling helpless after failed attempts of other support agencies to find engagement and treatment success. Being able to now introduce myself to families as an intern psychologist is an additional advantage: in comparison to explaining myself a para-professional with a background in psychology, it seems to be much easier for them to understand the kind of support that I can offer.

This transition from para-professional to intern psychologist has been extremely beneficial, but it has not happened without its challenges, both personally and organisationally. Although there is a registered psychologist employed as a CCM in another region, at this early stage, the roles have been shaped differently across regions and this is the first time a CCM has progressed through tertiary education and modified the delivery to become a psychological service. The issue of professional isolation was identified at the outset and has been closely monitored. Becoming an intern psychologist is more than learning an art and solidifying a specialised set of skills; it is a personal development which for me involves taking the final steps from being a para-professional to acquiring the identity of a psychologist. The experience could be compared to that of a new recruit graduating from Police College and completing the two year probationary period. The recruit is armed with knowledge and skill, and then immersed in a culture and required to develop a way of thinking and acting. I have been immersed in this same culture, yet the identity I am nurturing is often contrary to the surroundings. To counter this I have placed importance on strengthening my ties with community based psychologists as well making clinical supervision a thorough learning experience.

It is worth noting that the implementation of a prevention-first model of policing, as discussed above, has initiated a change of mindset within the police and the flow-on effect of this means that officers are more attuned to considering the underlying causes of offending. As a result; my ongoing professional development has been encouraged and welcomed within the Palmerston North Policing Area and especially within the Youth Services Team. The team that I entered four years ago remains intact today and they comment on the personal and professional growth that has occurred during this internship year. They place value on the credible knowledge I have as an intern psychologist and as a result, I am being asked to consult on an increasing number of cases outside of my core role.

The growth of my psychologist "skin" is something that has been noticed and acknowledged not only by my colleagues but also co-workers in the community. As I am now working purely from a psychological paradigm there is more rigor in the way in which I frame aspects of a case. At times this has been met with confusion and challenge and I have had to be mindful of being sensitive to the clash of philosophies when working with people from different disciplines and different backgrounds. I have placed importance on being prepared and poised in order to present psychoeducation in these situations which itself is challenging, since I am also still learning and in the process of building confidence in my knowledge and ability whilst remaining within my boundaries of clinical competence. A second challenge has been maintaining service and role boundaries. My professionalism is trusted and therefore this intern psychologist title has given community co-workers from other agencies tacit permission they felt they needed to attempt, at times, to make more aspects of a case my responsibility. It has therefore been important to constantly reflect on two major inquiries of practice; "Is this my responsibility as the Police Child Case Manager?" and "Am I being a Psychologist?"

In summary, the Prevention First model of policing represents a change in practice, mindset and importance placed on early intervention with child offenders. Child Case Managers have been employed as a means of providing this intervention to children who are 13 years and under and have come to police attention. 22 non-sworn professionals with varying qualifications and experience have been employed nationwide and deliver the service in their location under CCM standard operating procedures, with modifications appropriate to their skill set and competence. Now in my fourth year employed as the CCM for Palmerston North Police I have undergone the personal and professional growth of becoming an Intern Psychologist. Being the only intern psychologist in the Police I have faced and overcome the challenge of developing my professional identity within a compelling organisational culture. With the support of NZ Police, I have been able to develop and deliver the CCM service in my area within a psychological framework and this has been welcomed by the police and community co-workers. I have shown how this position definitely has capacity and scope for a psychologist and the value of having a psychologist in the youth services team is recognized by peers and

colleagues. I am committed to continue making sure I am becoming a competent evidence-based and reflective intern psychologist and I am encouraged to continue improving the service I offer to families.

Finally, I feel optimistic about the place psychology has in the New Zealand Police and believe there are reciprocal benefits for both police and psychology. The Child Case Manager role provides the opportunity for psychology to be practiced in a way that makes it incredibly accessible for families facing adversity. The role breaks down barriers by providing the opportunity for the skills and knowledge held by an intern psychologist to step outside of the office and be applied to the context and reality of our most at risk children. Forecasting the need of suitable psychological services and matching these to the needs of consumers is important. As NZ police respond to the evolving nature of society they do so by changing mindset, purpose and practice. It is a privilege to be a part of this movement and more so an honour to be providing a support service for children and families. I look forward to consolidating my knowledge and skills within the Police and continue delivering the fantastic Child Case Manager service as a psychologist.

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Young Children's Intuitive Understanding of Substances: Evidence from the United Kingdom

Julia Hill

Julia Hill is currently a post-graduate student at Massey University (Auckland), she is completing a Masters degree in Educational Psychology with the intention of working as a Psychologist from 2018. She has a Bachelor of Medical Science from Macquarie University (Sydney) and completed the coursework towards a Diploma of Education (Secondary Science) at University of Notre Dame (Sydney). Since completing her under-graduate degree in 2007, she worked for 3 years as a Research Assistant at Neuroscience Research Australia and the School of Child Psychiatry at UNSW. She contributed to research investigating neurofunctional and emotional recognition deficits in children with autism and conduct disorder using fMRI. She then moved to London where she continued with employment as a Research Assistant, contributing to a cognitive development project being completed by University College London (UCL) and Cambridge University. She has co-authored a number of papers and conference presentations in child psychiatry and cognitive development.

Julia won best student poster prize at the NZPsS conference in Hamilton. Her poster titled *Young Children's Intuitive Understanding of Substances: Evidence from the United Kingdom* is on the next page.

Young Children's Intuitive Understanding of Substances: Evidence from the United Kingdom.

Julia Hill[1], Anne Schlottmann[1], Michelle R Ellefson[2] & Keith S Taber[2]

[1]University College London [2]University of Cambridge

A Puzzle

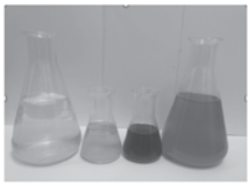
Young children have sensible expectations about substances/materials: Infants already expect liquids to behave differently than solids, liquids pour, solids tumble (Hespos, 2012). By 3 years, children have "substance permanence", knowing that sugar, even though it can't be seen anymore when dissolved, still remains in the water (Au et al., 1993). But other aspects of substances seem difficult, and chemistry is not taught until secondary age.

Sugar-water illustrates an important class of materials: Mixtures. In fact, everyday materials (wood, tap water etc.) are almost always mixtures. The proportion of components determines mixture concentration. Concentration in turn is crucial for other mixture properties, e.g. the more sugar and less water, the sweeter it is.

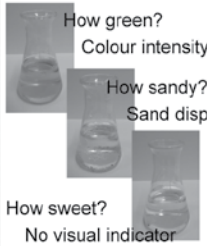
Yet children may not understand concentration until the late primary years: They choose a glass of water with a spoon of sugar as sweeter than half a glass with the same sugar (e.g., Stavy et al.,1982; Nunes et al., 2003). They do not seem to understand that water dilutes mixtures. Such difficulties would make it very difficult to learn about more complex chemistry, where concentration can, for instance, affect reaction rate and size.

This Study:

Some mixtures occur in nature, others are human-made. Children presumably learn initially about everyday human-made mixtures and their behaviour, so it is surprising that they seem to know so little about sugar concentration. The advantage of human-made mixtures may be that children can learn from the experience of making mixtures. In previous work, however, children were not given any such opportunities. **In the present study, children made mixtures from variable amounts of solid and liquid, prior to assessment of understanding.**



Initial mixtures: Variation of solid and liquid highlights role of both factors



When substances mix, sometimes one can still see the components in the mixture, but in other cases components disappear, or lose individual identity. It seems reasonable to expect that children first learn about mixture properties, such as concentration, for substances with a perceptual indicator of concentration. **Here, children took part in 3 concentration tasks, in different sessions, order counterbalanced. We expected that sugar mixtures would be most difficult.**

This study also moved from choice to judgment. Prior research used choice tasks ("Is this sweeter or this or are they the same?") while we asked children for judgments on a graphic scale (longer sticks for more intense mixtures). In other domains, the judgment method is more sensitive than choice (Schlottmann & Wilkening, 2011).

Stick scale with solid and liquid amounts

Participants:

30 Reception children (mean age 5 years)
30 Year 2 children (mean age 7 years 1 month)
27 Year 4 children (mean age 8 years 10 months)
28 Year 6 children (mean age 10 years 9 months)
24 adults (mean age 21 years)
All children were from South-East London state schools

Design and Procedure:

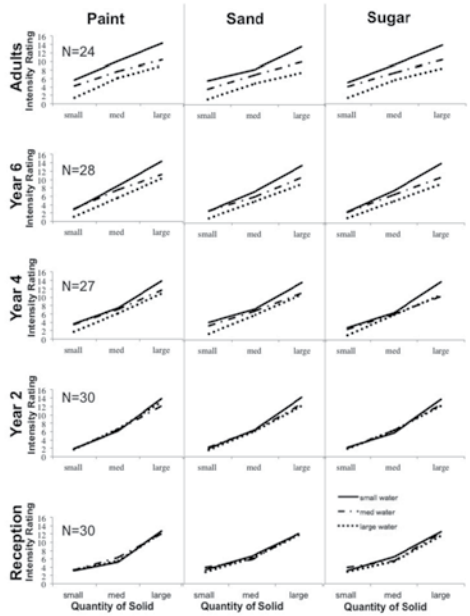
Each participant judged mixture intensity for 2 replications of all mixtures created from small, medium, large solid volumes (about 0.1, 0.7, 2.5ml) factorially combined with small, medium and large water volumes (50, 250, 1000ml), in sand, sugar and colouring tasks..

Mixed model design: 5 age x 6 task order x 3 task x 3 solid x 3 liquid amount (repeated measures on task, solid, liquid). DV: mixture strength on the stick scale; scale usage was practiced prior to experimental trials.

During instruction, children mixed solid and liquid, then rated mixture intensity. On subsequent experimental trials they did not see the mixtures, merely judged the intensity that would result if solid and liquid were mixed.

Results: Group Data

The figure shows intensity ratings as a function of amount of solid (horizontal) and liquid (curve factor).



As expected, intensity judgments increased with solid amount (slopes) and decreased with liquid amount (curve ordering), F>145 in the overall ANOVA.

The normative proportion model also predicts curve divergence to the right, i.e., an interaction with bilinear trend. Both were found, F>26.

Liquid, solid, and the interaction differed by age, with smallest F(14.63, 296.31) = 1.89.

No interaction of liquid and solid with task or task order (except one uninterpretable high order interaction)

When each age group was analysed separately, all ages had solid main effects, F>152. The liquid effect was significant from year 2, F>6, as was the interaction, with bilinear component, both F>8, corresponding to the visual impression, but the bilinear for year 4 failed significance.

Results: Individual Subject Data

Effect	Age Group	Inverse	Direct	None	N
SOLID	R	0	**100**	0	30
	2	0	**100**	0	30
	4	0	**93**	7	27
	6	0	**100**	0	28
	Adults	0	**100**	0	24
LIQUID	R	**7**	7	87	30
	2	**7**	0	93	30
	4	**44**	0	56	27
	6	**68**	0	32	28
	Adults	**96**	0	4	24

The table shows % of participants at each age showing each type of effect.

Direct effect: mean intensity of the large amount was rated 2 points or more above mean intensity for the small amount, or if a smaller difference was significant (<.05) in the solid x liquid x task, single participant ANOVA (with 27 df for error).

Indirect effect: intensity of the large amount was rated 2 points or more below intensity for the small amount, or if a smaller means difference was significant.

A sizable percentage of liquid effects at the individual level appeared only from year 4.

Baseline Without Any Mixing Experience:

To check whether the initial mixing experience helped, an additional group of 32 Reception children was tested with this (sugar only). At the group level, again only the solid effect was significant, F>90. At the individual level, we found increased numbers of children with direct liquid effect: **38% of children now had a direct effect**, 13% an inverse effect, and 50% had no effect.

Discussion:

This study, using a sensitive method, found earlier dilution effects in concentration judgment than previous work, from Year 2. However, the improvement was small and appeared mainly at the group level; effects appeared at the individual level only from Year 4.

As expected, opportunity to initially make mixtures helped children. However, rather than leading to more pronounced dilution effects, this mainly reduced the number of "direct function errors" (Stavy et al., 1982). These errors would thus seem to reflect a superficial expectation that is revised with minimal experience, not a deep, cognitive-developmental limitation.

Contrary to expectation, children were not helped at all by the use of materials with visual indicators of concentration. We were surprised by this, but now realise that taste may be more important than vision for perceptual learning about concentration – visual cues are often misleading.

The study highlights that UK children do have some difficulty with dilution reasoning. HK children, in contrast, engage in dilution reasoning from age 4 to 5 (Hill et al. 2014). Future work will focus on ways to improve UK children's understanding.

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The New Zealand Psychological Society

Te Rōpū Mātai Hinengaro o Aotearoa

NZPsS Annual Conference 2016

PLEASE NOTE CHANGED DATES FOR THIS CONFERENCE NOW 1-4 SEPTEMBER.

Massey University advised that the earlier dates are no longer available.

PSYCHOLOGY WITHOUT BORDERS

Where: WELLINGTON, Massey University

When: Thursday 1st to Sunday 4th September

Confirmed keynote speakers:

Jennifer Muehlenkamp - is a clinical psychologist and associate professor at UW-Eau Claire. She specializes in understanding and preventing suicidal and non-suicidal self-injury in youth. She has published over 60 peer-reviewed articles and book chapters on self-injury and suicide in adolescents and college students, some of which have informed the non-suicidal self-injury diagnostic category for DSM-V. She is a founding member of the International Society for the Study of Self-Injury, and co-author of a treatment book titled Non-Suicidal Self-Injury that is part of the Advances in Psychotherapy Series. Her research and clinical guidelines are internationally recognized and have earned awards from the American Association of Suicidology.

Suzanne Chambers - Professor at Griffith University. She is a health psychologist who has worked as a practitioner- researcher in psychological support for people with cancer for over 20 years. She Chairs the Quality of Life and Supportive Care Committee for the Australia and New Zealand UroGenital and Prostate Cancer Trials Group.Professor Chambers has published extensively on the psychological effects of cancer and is currently leading large scale randomised control trials of interventions that address couple support and sexuality, lifestyle and unmet supportive care needs, and psychological distress in men with prostate cancer.

Jan Jordan - Associate Professor and Deputy Director, Institute of Criminology Victoria University of Wellington. Her research specialties are women, rape and the police; sex work; gender issues in crime and policing. Her current research in regards to Police responses to rape/sexual violation; women surviving rape; researching sexual violence; prostitution law reform.

More speakers to be confirmed soon.