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AOTEAROA NEW ZEALAND
SOCIAL WORK

VOLUME 33 • NUMBER 2 • 2021

ISSN: 2463-4131 (Online)

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Recognising the social determinants of mental distress

This issue contains a special section on mental health, co-edited by Simon Lowe and Joanna Appleby. Our thanks to Jo and Simon and all the contributors and reviewers.

In their commentary on the "Social work practice implications of upcoming mental health reforms" in this issue, Genevieve Smith and Joanna Appleby offer an informative account of the key challenges for mental health services and for people experiencing mental distress in Aotearoa New Zealand. They contextualise their discussion with reference to the impact of four decades of neoliberal reforms on our people and on our health and social services—reforms that have fostered deep economic inequality, racism, precarity and despair in the lives of the many (see, also, the review of Ferguson, 2017 in this issue). These reforms have also devastated mental health services through underfunding, service rationing and managerial business models that alienate service users, pressurise front-line workers and fracture service provision. Smith and Appleby explore four challenges faced by those who would reform mental health services: the steady growth in demand for services along with the severity of presenting problems, the failure to maintain or increase the supply of services leading to issues with service accessibility, the *postcode lottery* of service variability between the 20 District Health Boards, and staff retention and burnout (partly a product of the first two challenges).

The material results of this long-standing neglect have been highlighted in a series of recent news reports: on the decrepit, damp, mouldy and rat-infested infrastructure of mental health units (Donovan, 2021; Lewis, 2021); on acute crises in mental health teams where staff feel scared, distressed and unsafe at work (Cook, 2020; Meier, 2021); and on long and growing wait times for access to mental health services (Cardwell, 2021; Quinn, 2021). These news reports highlight, not only the crises in the public system, but that the private sector is also becoming overwhelmed. Quinn (2021) cites comments by the Executive Advisor of the College of Clinical Psychologists that, "[t]he private system always used to be the overflow from the public system, but now we're getting to the point where the overflow is overflowing."

These appalling service failures are also reflected in our stubborn youth suicide statistics, where Aotearoa New Zealand leads the world (OECD, 2017); and in the overwhelming prevalence of mental health or substance use disorders in the Aotearoa New Zealand prison system (91% of all prisoners). The Chief Executive of the Department of Corrections has declared, "[t]he high prevalence of mental illness among prisoners means that the Department of Corrections is managing more people with mental illness than any other institution in New Zealand" (The Department of Corrections, 2017).

In a study comparing mental health services in 14 developed countries, Aotearoa New Zealand was found to have the second-lowest number of general psychiatry beds per 100,000 of the population and, consequently (at 70%) the highest rate of involuntary admissions and emergency readmissions (NHS Benchmarking Network, 2019). Of course, a low ratio of psychiatric beds might indicate a positive policy preference to invest in accessible, community-based services, but the evidence above—and the emergency readmission rates—suggests otherwise. It is small wonder that Andrew Little, the health minister responsible, expressed alarm that

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the government's 2019 decision to invest $1.9 billion extra in mental health services, as part of the reforms discussed by Smith and Appleby, has, to date, resulted in only five extra acute mental health beds, and that many patients are sleeping on mattresses on the floor of mental health units (Lynch, 2021).

In their commentary, Smith and Appleby argue that the "upcoming reforms provide an opportunity to address some of the long-standing issues" in our mental health services; and that "there needs to be adequate funding so that mental health services can move from a business model to a recovery model." We agree. Indeed, arguably, one of the central barriers to achieving the reforms necessary to all public services (including Oranga Tamariki[i]) is a bankrupt business culture with its alienating language and inappropriate processes. Despite its obsession with "stakeholder engagement", "long-term pathways" and "transformational change" (Ministry of Health, 2021) the Ministry of Health stands accused of failing to deliver. The toxic managerial culture and lexicon of customers and business processes need to swept aside in favour of a public service orientation that values a cooperative approach, supports staff and welcomes the active involvement of service users in service delivery, design and improvement. More than this, we need to build a social order driven, not by the demands of profit or cold managerial efficiency, but one based on meeting human need—a social order that the recognises the social determinants of mental distress, one that the Marxist psychoanalyst Erich Fromm (1955) described long ago in his book, *The Sane Society*. The articles in the special section on mental health in this issue all emphasise the importance of listening to the voices of those with lived experience and strengthening collaborative ways of practising.

Behiye Ali, Barbara Staniforth, and Carole Adamson report on a qualitative study conducted with individuals with lived experience of suicidal ideation and/or attempt. In "Reflecting on lived experience: Suicide prevention and the importance of social work in mental health", a variety of effective interventions are identified including: exercise, addressing physical health needs, practising mindfulness, use of medications and spirituality. The authors note that social workers can make an important contribution towards wellbeing through the provision of psychosocial interventions within a holistic health approach. They also emphasise the importance of involving individuals with lived experience both within research (to inform policy and practice), and by a collaborative approach to treatment decisions.

In "Forgotten but not gone: A heuristic literature review of sibling suicide bereavement", Leah Royden notes that, while Aotearoa New Zealand's suicide rates are amongst the highest in the developed world, there is a lack of research literature which focuses on the sibling experience of suicide loss. Royden notes that suicide-bereaved siblings experience significantly higher rates of mental illness compared to control groups. Royden's literature review clarifies what international research on the sibling experience of suicide bereavement tells us and in a rich contribution, draws on her lived experience to examine key themes of guilt, "unacceptable" anger, social stigmatisation, self-judgement, isolation, and the shattering of relational trust. She calls for further attention to the needs of bereaved siblings in both practice and research.

In "Cessation strategies used successfully by individuals in recovery from methamphetamine addiction", Yvonne Gordon and Christine Stephens report on an exploratory study which aimed to gain insight from individuals in Aotearoa New Zealand who have experienced methamphetamine dependence and now identify as being in recovery, to discover which strategies, approaches or treatment appeared helpful in their recovery. In-depth interviews provided rich data which were analysed using interpretative phenomenological analysis.

Four themes emerged to describe the lived experience of recovery from methamphetamine misuse: getting away, support, personal sources of strength, and treatment. These elements provide an insight into their journey of abstention and recovery.

On the same themes of recovery from alcohol and other drug addiction, Rachel Jowett, Michael Dale, and Lareen Cooper's article, "Mitigating barriers to addiction recovery in New Zealand: A lived experience perspective", report findings from a qualitative study. Jowett and colleagues utilised a constructivist approach, conducting semi-structured interviews and undertaking thematic analysis. This article identifies themes highlighting what contributed to, and created barriers to, the interview participants' successful AOD addiction recovery. Barriers were societal, widespread and pervasive stigma, for example, and were systemic, where services did not meet needs and funding and other supports were inadequate. Enabling factors included the ability of health professionals to build effective therapeutic relationships, participants' own internal processes, good boundaries, ethical care and supportive friends and families.

Our Classic Book Review section is a space where authors are encouraged to reflect on the nature and significance of texts that have had a profound influence on the social work profession. In this review, commissioned for the special section, Iain Ferguson, author of *Politics of the Mind: Marxism and Mental Distress*, discusses R. D. Laing's *The Divided Self: An Existential Study of Sanity and Madness* and extends his review to include several other texts by this highly influential Scottish psychiatrist (1927–1989). In effect, Ferguson provides us with a comprehensive overview of Laing's profound contribution to a humane understanding of mental distress and offers insight into the life of the author, warts and all.

In "They feel like it's all based around the offender: Professionals explore how victim participation in family group conferences can be enhanced", Tracy Williams and Julia Ioane explore the effects of a 2019 pilot project that aimed to increase the participation of victims in Youth Justice family group conferences (FGCs). Earlier experiences of participation had led victims to feel that it's "all based around the offender", despite the reconciliation aims of FGCs. This Auckland-based trial changed the process of information sharing and preparation roles for FGCs, ensuring that Victim Support[ii] were notified by Police at the time Oranga Tamariki was also notified, and victims were contacted initially by Victim Support and offered information and support. This mixed methods evaluation found that the pilot did increase the participation of victims and also identified enablers of implementation. These enablers included training and resources, better streamlining of the information flow between Police, Oranga Tamariki and Victim Support, gaining feedback from victims before the FGC and ensuring timely information sharing. The importance of preparing victims for the FGC and offering emotional support in a culturally responsive manner helped ensure that victims could participate in meaningful ways. Seldom studied, this project provides important insights into victim experiences in youth justice FGCs and how to improve their woeful levels of participation.

The role of the insider researcher and the extent to which they are members of the group being studied is an intriguing feature of qualitative research, and Richard Brown bravely and creatively explores this dynamic in the article "Messages to first responders from a bereaved parent." Using autoethnography, Brown records and analyses the tragic circumstances of losing his child, doing so from a dual insider perspective—exploring his experience as both a bereaved parent, and a registered health social worker. This piece of work can only be described as taonga, a gift generously offered from the depths of painful personal experience to create awareness and offer deep insight to professionals who are first to respond to such events. Brown concludes that parents require care for both their immediate and long-term needs, as what happens in those first moments will impact on the well-being of parents over the years that follow.

Social work supervision in statutory child protection settings is the subject of Matt Rankine and Andrew Thompson's article, "'Moving out of the safe zone': Promoting learning communities and reflective supervision in a social work statutory child protection agency." Rankine and Thompson utilised critical reflection as a methodological lens, working with four experienced Oranga Tamariki supervisors in a learning community where supervision recordings were brought to each meeting to improve reflective capacity, critical reflection and skills. Data were collected from the learning community and thematic analysis was undertaken to explore current supervision practice in the organisation. The three themes generated from the learning community discussions were: *identification of supervisory skills and interventions*; *the structure of supervision*; and *working with emotion and trauma*. These themes highlighted the significance of the learning community as a forum for supervisors to engage in positive and constructive feedback with their colleagues in a supportive space.

Frank Ainsworth's contribution, "The best interests of the child: More questions about this construct", critiques the hegemony of this doctrine in Anglophone child protection systems, uncovering the issues which this overly simplistic imperative has obscured over time. Attention is given to the legalistic origins of this doctrine and the benefits to be gained from developing a wider and more inclusive community focused approach to working in the field of child maltreatment.

In a Viewpoint article, "At home: Field Education during lockdown" Yesse Cox, David McKenzie, Bronwyn Powell-Grub and Liz McCafferty provide practice reflections on the experiences of participants in student placements during the Covid-19 lockdowns in Aotearoa New Zealand. McCafferty and colleagues offer insights into what helped and what could have been done differently. Regular debriefing, supervision and a post-crisis debrief are all important elements that aid the learning and support the wellbeing of the student.

Our book reviews for the special section include two on mental health topics. Barbara Staniforth reviews *Trauma, Women's Mental Health, and Social Justice: Pitfalls and Possibilities* by Emma Tseris. Neil Ballantyne reviews *Politics of the Mind: Marxism and Mental Distress* by Iain Ferguson.

Lastly, Diane Smithson reviews *Effective Leadership, Management & Supervision in Health and Social Care* edited by Richard Field and Keith Brown.

Neil Ballantyne and Liz Beddoe
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Notes

i Oranga Tamariki is the statutory service for children and families in Aotearoa New Zealand. https://www.orangatamariki.govt.nz/

ii Victim Support provides a free, nationwide support service for people affected by crime, trauma, and suicide in Aotearoa New Zealand. https://victimsupport.org.nz/

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Reflecting on lived experience: Suicide prevention and the importance of social work in mental health

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ABSTRACT

INTRODUCTION: National suicide prevention strategies and action plans have, historically, been written without input from consumers/current users of mental health services. People who could arguably be seen as experts in this area are rarely asked for their knowledge regarding the efficacy of suicide prevention and intervention efforts. The aims of this study were to gain further insight into the effectiveness of suicide prevention intervention in Aotearoa New Zealand by asking service users "What works?" and to promote lived experience as a valid form of evidence. This article focuses on the importance of a holistic model of health and wellbeing and highlights the role played by social workers, both currently and in the future, regarding suicide prevention and intervention efforts.

METHODS: Twenty semi-structured interviews were conducted with individuals with lived experience of suicidal ideation and/or attempt.

FINDINGS: Using thematic analysis, a variety of interventions were identified which participants found effective, including exercise, addressing physical health needs, practising mindfulness, use of medications and spirituality. These interventions, and others, are presented as themes within a framework of people, body, mind and spirit.

CONCLUSIONS: It is important to view health holistically, and social workers can make an important contribution towards wellbeing through the provision of psychosocial interventions. Also, it is crucial to involve individuals with lived experience within research that informs policy and practice, and within collaborative treatment decisions.

KEYWORDS: Suicide prevention; suicide interventions; lived experience; what works; psychosocial interventions; holistic model

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Suicide is among the three leading causes of death in the world and the second leading cause of death among 15–29-year-olds (World Health Organisation, 2019); in Aotearoa New Zealand, youth suicide rates are particularly high (OECD, 2019). These figures indicate that suicide rates remain at a concerning level, with an imperative for services and policy to respond accordingly. Suicide prevention policies and action plans are often produced by national governments by and with health professionals, academic researchers, advisory groups (sometimes formed from NGO employees with professional experience) and steering groups (occasionally consisting of whānau/

family members affected by suicide). When psychological, pharmacological and/or psychosocial treatments or interventions are evaluated, the (surviving) service users themselves rarely feature in qualitative efficacy reviews of such interventions. When service users are represented, they are often shown as quantitative figures: for example, how many people had used the services and how many had gone on to re-attempt suicide.

This PhD research project (Ali, 2019) was undertaken between 2015 and 2019 by a non-Māori researcher in Aotearoa New Zealand. Between 2014 and 2019, the rate of deaths by suicide per 100,000 reached 13.93 (Coronial Services of New Zealand, 2019). Within Aotearoa New Zealand's suicide statistics, Māori are disproportionately represented. From mid-2018 to 2019, data reveal that Māori continue to have the highest suicide rate of all ethnic groups at 28.23 per 100,000 population (Coronial Services of New Zealand, 2019). Interventions targeted towards Māori (and Pacific peoples, who are also over-represented in suicide figures) focus on providing support and prevention efforts in culturally appropriate ways. This is essential, as Western models of suicide prevention interventions and mental health services often lack the dimensions, aspirations and holistic focus of Māori and Pacific peoples' models of health and wellbeing (Government Inquiry into Mental Health and Addiction, 2018). Research by Clark et al. (2011, p. 25) suggests that antiracism work is an important part of suicide prevention as "feeling uncomfortable in Pākehā [New Zealand European] social surroundings" was a risk factor among Māori youth for suicide attempts (odds ratio = 1.698, $p = 0.0040$). Clark et al. (2011) suggest this risk factor may reflect the racist environments in which many Māori youth live.

In line with social work professional values and recently developed ethical principles (ANZASW, 2019), one aim of the research was to contribute information from service users which could influence suicide prevention interventions and policy formation. The research sought to find out what works according to the people who directly receive suicide prevention and intervention services. An over-arching aim was to contribute to existing knowledge in order to improve current treatments and services, influence those provisions in the future and reduce suicide rates.

This article reflects on the research findings and discusses them in line with social work values, practices, and regarding the role of social workers within suicide prevention and intervention. The non-medical interventions described by participants provide rationale for strengths-based and recovery approaches to be used within social work. Current suicide prevention interventions, treatments and services in Aotearoa New Zealand are described using vignettes and the future of these efforts is discussed with a focus on the importance of collaboration between practitioner-experts and service-user-experts.

Promoting lived experience as evidence

The recovery movement in social work and mental health has advocated for the voice of people with lived experience of mental distress to be given choices and power in decision-making in their treatment. Consistent with this, the evidence-based practice framework as described by Drisko (2017) states that, for an evidence-based process to occur, people need to be given information about potential treatments and make choices which suit them best, not always those advocated by professionals.

In 2018, the Aotearoa New Zealand Government announced *He Ara Oranga* (Pathways to Wellness)—an Inquiry into mental health and addiction—with the aim of improving mental health services with a particular focus on equity of access. The Government intended the Inquiry to gather feedback from the mental health sector, service users and the wider community about their experiences, expectations and the current strengths and weaknesses of the mental health system. One of the resulting recommendations from the Inquiry called for the co-design and implementation of service transformation and for the Government to "Direct the Ministry of Health, in partnership with the new Mental Health and Wellbeing Commission (or an interim establishment body) to facilitate a national co-designed service transformation process with people with lived experience of mental health and addiction challenges" (Government Inquiry into Mental Health and Addiction, 2018, p. 16). Social workers can play a crucial role in efforts to implement the Inquiry's recommendations.

Furthermore, there has been a recent push for mental health service users to be co-creators in research regarding possible interventions (Halvorsrud et al., 2019). Conducting research with individuals with lived experience is vital to improving health and social care provision (Doughty & Tse, 2005; Mead et al., 2001). Service users must be included in suicide prevention research if we are to find out and then promote what works (Gibson et al., 2012) with the aim of better supporting people experiencing suicidal ideation and hopefully reducing suicide rates (Ward-Ciesielski & Linehan, 2014).

As evidenced by the findings of this research, service users want to have a say in the treatment they receive. As experts in their own care, they are also a source of invaluable knowledge into effective suicide prevention and intervention treatments and services, and without their active input, mental health support practices and suicide prevention interventions will risk being flawed. Drisko (2017) advocates for social workers' active collaboration with clients, and for practitioners to be open and reflective when using evidence-based practices to explore clients' needs and strengths, when identifying treatment options, and when deciding on a plan together.

The context of intervention and prevention

This section will outline some of the initiatives and treatments in Aotearoa New Zealand from the macro policy domain to individualised treatments.

Government policies and legislation

In response to peak suicide rates in 1998, the Aotearoa New Zealand government released a National Youth Suicide Prevention Strategy (Ministry of Health, 1998), and later, further strategies and action plans which shifted the focus to all-ages efforts. At the time of this PhD research, the Suicide Prevention Strategy (2006–2016), and the supporting Suicide Prevention Action Plan (2013–2016), provided a then-current framework for understanding how various activities within a range of sectors fit together to prevent suicide.

After analysing the feedback from the *He Ara Oranga* Inquiry, the Government later published its National Suicide Prevention Strategy *Every Life Matters – He Tapu te Oranga o ia Tangata* 2019–2029 and the linked Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand (Ministry of Health, 2019). The Strategy and the Action Plan reflected a significant change in the ways in which service users are seen as contributors of valuable knowledge; these plans have transformed the previous suicide prevention frameworks and legislation by listening to (and acting upon) the knowledge, experience and ideas shared by people with experience of suicidal ideation and attempt. And, for the first time nationally, the Aotearoa New Zealand Government are asking people for their input and are using their responses to focus efforts on reducing suicide rates.

The role of medication

Fawcett and Busch (2014) argue that pharmacologic treatments are an important part of suicide prevention, whereas other researchers state that medications, prescribed to address feelings of major depression and suicidal ideation, may in fact increase risk factors for suicide (Hammad et al., 2006). Separately, it could be argued that medications aimed at broader mental health challenges could potentially (indirectly) prevent suicide and therefore could be prescribed alongside other interventions such as psychological treatment and/or psychosocial support.

However, by recognising the social experiences and contributing factors of mental distress (including trauma, loss and abuse, and experiences in childhood and adolescence), the domain of social work brings a different perspective to the medical treatment of mental health. Allen (2014) states these determinants are often missed in purely medical, illness-based approaches and argues these approaches and the medical model of health can in fact "get in the way of recovery and change through focus on the illness rather than the person as a whole – their fundamental human potential and the opportunities they could access to bring about change" (p. 11).

The executive summary of the *He Ara Oranga* Inquiry echoed this critique of medically dominated mental health systems where medication may often be used as an intervention of first choice: "We can't medicate or treat our way out of the epidemic of mental distress and addiction … People may be offered medication, but not other appropriate support and therapies to recover." (Government Inquiry into Mental Health and Addiction, 2018, pp. 10–11).

Psychological interventions

Interventions offered by clinical social workers are underpinned by recovery approaches, strengths-based models, systemic models, indigenous models and therapies including cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT) (Appleby et al., 2020).

Moving away from a medical model of health, clinical social workers also promote person-based approaches within clinical settings, for example, through the co-design of assessment and goal setting thus aiming to reduce the power inequality between practitioners and service users (Booysen, 2017).

DBT is a cognitive-behavioural approach that enables a person to link body, mind and emotional responses to stress and several participants in this research project described finding DBT helpful. DBT has been shown to be effective in reducing suicidal behaviours by up to 50% during treatment and follow-up phases (typically at least one year each) in seven randomised controlled trials when compared to treatment as usual (Linehan et al., 2015; McMain et al., 2009). In Aotearoa New Zealand, Cooper and Parsons (2010) found their social work background aids their understanding and delivery of DBT. The authors argue, that once trained, social workers are highly skilled DBT practitioners as the therapy aligns well with social work values.

A systematic review and meta-analysis by Tarrier et al. (2008) discussed significant effects of CBT in reducing suicidal behaviour. CBT has also been adapted for use with Māori in Aotearoa New Zealand (Bennett et al., 2014). A 12-session programme, organised into five progressive treatment phases, was developed by the authors and their colleagues and was informed by dimensions of Māori culture.

There is strong evidence in support of acceptance and commitment therapy (ACT) as a way to dismantle negative, anxious or violent thoughts (Ruiz, 2010); but it is worth noting that ACT is a therapy with quite specific characteristics, and it is seldom used to respond to severe depression and suicidal ideation (Flaxman et al., 2010).

Psychosocial interventions

Outside of therapy models, there exist several psychosocial interventions that address the personal, social and vocational problems associated with mental health disorders (Cramer & Kapusta, 2017). Consistent with social work practice, psychosocial interventions discussed by participants in this study included: support groups, exercise, religious support, whānau/family, social and cultural support systems and telephone helplines. Linked to these is research into social inclusion (Silver, 2010) and family connectedness (Matlin et al., 2011) as effective suicide interventions.

Culturally focused interventions

According to the *Kia Piki te Ora* Suicide Prevention Programme Evaluation final report (Ministry of Health, 2015), a Kia Piki te Ora (Māori Suicide Prevention Service) operates in nine District Health Board regions and is one part of the health and social care sector's longer-term goals to reduce suicides and suicidal behaviours in Māori communities. The service works towards these goals by promoting mental health and wellbeing for Māori; by reducing access to means of suicide for Māori; by increasing the safe reporting of suicide by the media and by contributing to improved mental health services for Māori (Ministry of Health, 2015). The evaluation report stated that, generally, stakeholders felt that Kia Piki te Ora's contributions to Māori suicide prevention were good when providers engaged with the community, but that stakeholders were also often unclear on the role and responsibility of the service.

Te Au is the National Māori Suicide Prevention Centre of Aotearoa which focusses on promoting hauora (health and wellbeing) within Māori whānau, hapū and iwi; the organisation provides several suicide prevention initiatives through a Māori-centred approach. There exists an ongoing demand for suicide prevention interventions provided 'by Māori for Māori' (Lawson-Te Aho & McClintock, 2020), likewise from Pasifika communities (Tiatia-Seath, 2014). Le Va for example, an organisation which supports Pasifika families and communities to access the best possible health and wellbeing outcomes provides *FLO Talanoa*—a suicide prevention education programme (Le Va, 2020).

Within the emerging field of computer-based technology aimed towards mental health support, people in Aotearoa New Zealand are able to access an increasing number of websites, applications and programs. Some are focussed towards young people, whilst others may make it easier for users of any age to ask for help without having to present themselves in person to a practitioner. For example, thelowdown.co.nz is a website which helps young people to recognise and understand depression and anxiety. Similarly, commonground.org.nz provides support and advice for whānau/family and friends to help the young people in their lives enjoy positive mental health and wellbeing. Finally, sparx.org.nz helps young people with mild to moderate depression, stress and/or anxiety by guiding users through CBT techniques and problem-solving strategies.

Methodology

Theoretical orientation

Using a constructionist epistemology, the intention for this study was to generate or inductively interpret and structure meanings (Creswell, 2009) regarding *what works* for service users, with regard to their mental health wellness following suicidal ideation/attempt. Ethical concerns for sensitivity guided this research, as did a qualitative descriptive methodology (Bradshaw et al., 2017).

Recruitment

Following approval from the Health and Disability Ethics Committee (HDEC), the research was advertised through local mental health charities, non-Government organisations and District Health Board services. Posters were displayed and letters were sent by service providers to service users (past and present) who met the criteria of being over 18, not currently experiencing suicidal crisis (and to not have experienced crisis for at least the past six months) and who were able to discuss their mental wellness in a healthy way.

Method

Face-to-face, semi-structured interviews were chosen as the method most appropriate for discussing extremely personal experiences in detail. During the interview, participants were asked questions about ‘what works/had worked’ for them, including questions of what had contributed to their wellness and what had been effective for them with regard to their recovery. Participants were asked about the interventions, treatments and/or services they had accessed and what about them they found beneficial.

Sample

All 20 participants had been users of mental health services at some point and many were still accessing services. The sample was ethnically diverse (as shown in Table 1) and participants were aged between 18 and 70 with the majority identifying as female (n = 16).

Limitations

As a British researcher with no Māori affiliation and a limited awareness regarding cultural understandings of suicide, it was essential to seek guidance from relevant Māori advisors in order to conduct the research in a culturally appropriate manner. Subsequently, a research reference group consisting of service users, peer support workers, academics and health professionals with key expertise regarding Māori culture, Pasifika culture and clinical psychology, was established.

Table 1. Participants’ Ethnicity

Ethnicity	Number of participants (out of 20)
Māori	4
NZ European	4
Pacific Peoples	2
Asian	1
NZ other	5
Other	2
Preferred not to disclose	2

Ethical considerations

At the time of applying for ethics consent, no similar research had been conducted in Aotearoa New Zealand. The HDEC were concerned that this population was too vulnerable to participate in research discussing suicide and that any discussion of their experiences could lead them to self-harm. Efforts to safeguard against this concern were put in place including: inviting participants to bring a supportive individual to the interview; the researcher contacting participants following the interview to debrief and providing participants with the contact details of helplines and support networks, including a psychotherapist specialising in suicidal ideation.

(The 20 participants who took part in this research reported a positive change in wellbeing following their interview and stated that being heard had had a beneficial effect.)

The ethics application process was extensive, lasting 10 months before approval. Advertising and recruiting processes were guided by the HDEC’s recommendations.

Analysis

The interviews were audio-recorded, transcribed and verified by participants, some of whom chose to use pseudonyms while others preferred their real names to be used. Braun and Clarke’s (2006) model of thematic analysis was used as a method for identifying, analysing and reporting patterns within the data. Aided by the software NVIVO, the analysis process identified initial codes, key themes and concepts. The (de-identified) transcripts and initial codes were then shared with the research reference group; some codes were redefined following the discussions.

Findings

The data were grouped into four themes and developed through the lens of Te Whare Tapa Whā model of health established by Mason Durie (1994) as there are similarities between Durie's model and the holistic view of health and wellbeing identified from this research. Durie's (1994) model puts the individual at the centre—as an expert with knowledge about their own hauora (health and wellbeing). According to Cherrington (2009), Te Whare Tapa Whā model is beneficial for Māori *and* non-Māori alike.

The four interrelated data themes are discussed in the following section as: people, body, mind and spirit.

People

People-centred points of support ranged from formal crisis and professional mental health teams through to care provided by whānau/family. The support provided by crisis assessment teams (CATs), community mental health teams (CMHTs), community support groups, community drop-in centres and whānau/family members was influenced by *who* was providing that support. In Aotearoa New Zealand, social workers could be members of any of these teams.

Crisis teams

Four participants described concerning experiences of CATs which left them feeling frustrated, isolated and, for Anita, with an increased risk of attempting suicide:

> I don't have any respect whatsoever for the CAT team…They didn't want to listen to my family, my support network or anything. They are not interested in anything they have to say…To me it actually put me in more danger of doing something than not.

Anita's experience highlights the importance for CAT teams, and other service providers, to include whānau/family members when responding to crises. Two participants, however, reported only positive experiences, with Carol stating how her CAT had led to her accessing other services: "I think it was when the crisis team got involved then they would say go to respite because I said 'please don't put me into hospital'."

Community mental health teams

Some participants discussed their CMHTs as having been helpful to them and their wellness. In most community mental health services, case management is provided by keyworkers who come from various disciplines, including social work. Participants described the range of services provided via multi-disciplinary teams as "a massive part" of their recovery including psychosocial interventions such as effective whānau/family meetings, support to do exercise and giving advice for getting back into employment.

When discussing how CMHTs could continue to work well (or how they could improve), one participant stated that validation is the most important skill which CMHT staff can possess. Consistent with social work's emphasis on empathy (Loughran, 2018), recognising someone's feelings, acknowledging them as important and in some cases repeating back what they have said are ways in which service providers can validate a person's feelings of distress.

Other supports

Highlighting the importance of community inclusion and social wellbeing, five participants described the ways in which a local support group had been key to their wellness. One participant, Bob, emphasised how attending Narcotics Anonymous and Alcoholics Anonymous meetings "massively contributed" to his recovery by providing mutual support from his peers, leading to voluntary work and later to a career as an addiction counsellor. Three participants stated that whānau/family support had played a vital role in their wellness, and that this was an ongoing source of care unmatched by health practitioners.

Body

Medication

All 20 participants had used medications relating to their mental health at some point, with many still doing so. Nine participants reported positive effects from medication, including Anita: "I'm happy with that because honestly it keeps me stable, and I need to be stable." Five participants believed the medication was having a positive effect on their mental health and wellbeing but noted there were negative side-effects. Six participants disliked the medication they were taking either because of the side-effects or because they felt it was not having a positive effect. One participant became so addicted to diazepam that she needed to attend a drug rehabilitation programme, whilst others felt their medication was prescribed to control them: "in many ways I often feel I just take this stuff just so that they won't think I'm being stubborn or something. I take it to please them" (Ralph).

Physical activity

Of the 20 participants, nine felt that keeping physically active was essential to staying well mentally, with participants, including Claire T, acknowledging the social benefits of exercise:

> Gymnastics, running, yoga they are all like important parts of my wellness and also kind of group exercise like doing it with my sister. She is really into her sport or like doing gymnastics with other people that I know, like there is a social element to it.

Carol described how bike riding was incredibly important for her recovery and ongoing wellness, as it led to many unanticipated positive outcomes: "I started going every day and that made such a difference because then it helped with my physical as well as my mental [health] … I started sleeping better; I noticed my mood was improving."

Physical health

Several participants made links between good physical and mental health. Bob described how keeping hydrated, eating a balanced diet, exercising often and sleeping well were the "little, but very important, things that kept me well."

Another participant discussed the link between a (previously undiagnosed) autoimmune disease and their feelings of depression and suicidal ideation, advocating for early health screening when people first present with mental health distress.

Mind

Talking therapies

All 20 participants described talking therapies as one of the main components in their recovery. Treatments including ACT, DBT and CBT were provided by either a psychotherapist or a social worker. One participant described moving from feeling like a victim of her own thoughts to feeling in control of her emotions and to having an ability to challenge her own thinking. Participants described these talking therapies as an extremely valuable way to understand the meaning of their experiences, thoughts and behaviours and to make changes to become more satisfied in their lives.

Helplines

Five participants had used phone and text helplines such as those provided by Lifeline, Warmline and Youthline as well as the 1737 phone and text service launched by the Ministry of Health in June 2017. Experiences such as Delia's were largely positive: “I mean it was a helpline that, you know, ultimately helped me … and that was the start of getting assistance,” with two other participants reporting how essential helplines were to them as a way of being listened to and taken seriously, without having to physically see a practitioner face-to-face.

Mindfulness and meditation

Several participants used mindfulness and meditation to regulate their emotions and others used the practices in their daily routine to help them feel focussed and less anxious. Practising mindfulness and meditation led Tamara towards her own personal research into a gratitude practice. Carol used mindful colouring-in-pictures to occupy her hands in order to focus her emotions as it “takes away all the horrible thoughts” whereas Michael and Paula discussed their uses of mindfulness and meditation as a form of spirituality.

Spirit

This theme is broad in its scope and includes those faiths, spiritual beliefs, systems of support and places which offered a sense of purpose and connection. Participants experienced spirituality in different ways. For example, after trying many treatments for severe psychotic episodes, Amy stated that her newfound belief in God was the intervention which contributed to her continuing wellness, whilst Michael discussed the ways in which Buddhism had taught him a new way to focus on happiness and how powerful this had been after his own suicide attempt. Both Amy and Michael discussed how effective spirituality could be as an anti-suicide intervention and as a continuing source of mental health support, and they advocated for spirituality to be “taken more seriously by doctors.”

Two other participants, Ghost and Frances, discussed the ways in which local community drop-in centres provided them with a sense of purpose and connection. Their recovery was positively impacted by these connections and the effects they had on their spirit, as in, their internal, socially constructed understanding of what and who else they belong to: “I reckon having places that me as a mental health consumer can go to and like be treated non-judgementally like here … because if this place wasn’t here I literally would be six feet under” (Ghost). Frances reflected on the positive impact her local community drop-in centre had previously had on her wellbeing:

> You can go and hang out for the morning and just have a cup of coffee, chat with people. It gives people I think a purpose and with mental health something to look forward to, to think “Monday oh I’m going to meet so and so, game of pool, catch up with old mates.”

Sadly, this centre had recently been closed due to a lack of funding.

Towards a holistic model of health and wellbeing

Powerful stories of recovery and self-determination were shared during this project, uncovering a wealth of data about what works regarding participants’ experiences of treatments, services and other interventions. Similarities can be drawn between the themes of the data and the four dimensions of Durie’s (1994) Te Whare Tapa Whā model of health: Taha Whānau (Family and Social Wellbeing), Taha Tinana (Physical Health and Wellbeing), Taha Hinengaro (Mental and Emotional Wellbeing) and Taha Wairua (Spiritual Wellbeing).

Te Whare Tapa Whā model of health encapsulates the concept of hauora (health and wellbeing). The model sees family and social wellbeing as having equal importance to mental and emotional wellbeing, and so, if treatment procedures are designed to address an ongoing mental health issue such as suicidal ideation, but the issues of limited access to education, or inadequate housing are not addressed, then the holistic wellness of an individual will continue to falter. Similarly, data from this project, such as Bob's experience of Narcotics Anonymous and Alcoholics Anonymous meetings, or the social element to Claire T's exercising, showed links between different dimensions of health and wellbeing. The importance of focusing on health and wellbeing holistically was perhaps best summarised by Michael's experience:

> They gave me medications to take and I thought "great, this will work and everything will be fine now" but then I'd go back to my mildew apartment, my diabetes and my asthma, my debt, my unemployment and arguments with my girlfriend. No job meant I couldn't afford to eat healthy and a damp apartment would flare up my asthma. Everything would fall apart but it would just be numbed by my meds, but it would all still get so bad that I'd attempt suicide again.

Further implications that can be drawn from the data include the need for caring and respectful, person-centred support as advocated by social work theory (Washburn & Grossman, 2017). The interventions discussed worked best when the service provider was interested in the individual and was informed regarding that person's history, state of wellness and the importance of their whānau/family members. Other participants stated the sense of belonging and social inclusion provided by whānau/family members, community support groups and/or community drop-in centres were sources of crucial support which differed greatly from the medical-focused treatment provided by practitioners.

Participants generally accepted that, while medication played an important role in their wellness, it was unlikely to be the main answer to their difficulties. Other changes needed to happen and medication was one way to support these changes. Pattoni (2012) argued that the individual must be at the centre of these changes, not necessarily as the only person responsible for making them happen, but as the driving force behind deciding what needs to change and how.

According to the Mental Health Foundation (2018), regular exercise can have a profoundly positive impact on depression and anxiety by relieving stress, helping with sleep and improving overall mood. These benefits were reported by the nine participants who discussed physical health including Carol, whose experience of bike riding improved her physical, mental and emotional health as well as her social wellbeing.

The New Zealand Suicide Prevention Strategy (Ministry of Health, 2019) acknowledges poor physical health as a risk factor for suicidal behaviours and outlines the importance of enabling individuals, their whānau/families and friends to encourage each other to participate in activities that can improve physical wellbeing. Linked to this is a recommendation for the increase of GPs' resources, funding and the allocated time for appointments which could support physical screening when individuals first present with mental distress. For example, diagnosing and treating an autoimmune disease (which can cause brain inflammation and potentially a mood disorder) with diet, exercise and/or medication focussed on treating the disease could dramatically reduce an individual's chances of later developing a mood disorder (Benros et al., 2013). Typically, GP appointment times in Aotearoa New Zealand are set for 15-minute time slots, although some practices might have quick 'acute' clinics for one problem only and may be shorter (Royal New Zealand College of General Practitioners, 2018). As part of a multidisciplinary team within GP practices, social workers can play an important role in early intervention and can provide a range of support services, case management and advocacy with non-medically oriented client needs.

Research by Dobl et al. (2017) evidenced the successful integration of social workers into primary healthcare practices in Aotearoa New

Zealand with benefits including increased engagement with communities, a strengthened workforce and an enhanced access of populations to coordinated care. The authors within that study advocate for the model to be used more widely in public health services affected by health and social inequalities.

The interventions and treatments presented within the 'mind' theme each had a positive effect on the participants' ways of thinking including the way in which phone and text helplines provide support without the (socially anxious) individual having to physically visit a practitioner. Talking therapies had been accessed by, and were beneficial for, all 20 participants in varying ways, with some finding a particular therapy to be effective only after trying others. It is hoped that the range of therapies discussed in this research highlights the benefits of practitioners, including clinical social workers (Appleby et al., 2020), offering a wide range of therapies to service users. Participants indicated a desire for a wider range of treatment options outside of the medical model and this was supported by the positive effect many participants reported after using mindfulness and meditation practices.

Data presented within the broad theme of 'spirit' included participants' reflections on their religious and spiritual experiences as well as impacts on their sense of spirit. These reflections acknowledged health and wellbeing improvements as being more than physical adjustments or medical treatments.

For Ghost and Frances, community centres provided "a lifeline" to the outside world, helping them to feel connected to peers, educators and health practitioners so that they could learn household and employment skills whilst being active members of their community. And, as Amy's experience reminds us, places of worship, faith groups and the connections which these bring, can be powerful support systems for people during mental health distress and as sources of ongoing support. According to Tiatia-Seath (2015), churches and other places of worship have a large part to play within the support of people's mental wellness and, more specifically, suicide prevention. Equally, community support and outreach initiatives, such as those provided by community centres, can provide non-medical approaches to improving emotional, behavioural and mental wellbeing.

Conclusion

The varied interventions, treatments and services that participants discussed are compatible with strengths-based and recovery focussed perceptions of mental health and connected social work practices. The resulting themes of this research demonstrate the importance of viewing health and wellbeing holistically. It is hoped that this article exhibits the benefits of incorporating a holistic model, such as Te Whare Tapa Whā into health policy. The model's durability, simplicity and its widespread application mean that it can be used by healthcare and support services to deliver culturally appropriate and more holistically effective care for Māori and non-Māori alike.

Participants discussed the need for respectful, person-centred support from practitioners who were aware of their situation and who also listened to their whānau/family members. A sense of belonging to local community was also key to recovery for some, as were some psychological therapies. Medication was discussed with varying levels of positivity; some participants accepted that it was important to keeping them feeling stable, whilst others were disappointed with the lack of attention practitioners gave towards the wider picture of their lives.

The non-medical interventions discussed throughout this article advocate for strengths-based and recovery approaches to be used within the dominant medical model. Subsequently, social workers in clinical or community settings have an important role to play, currently, and in the future of suicide prevention and wider mental health service provision. The Ministry of Health (2020) supports a recovery approach to mental illness and therefore, recovery approaches which view health holistically and which are aligned with the social work values of empowerment, respect and protection of human rights. Social workers are well placed to find out what works in terms of recovery for individuals with lived experience of suicidal ideation and/or attempt.

There are several reasons why service users are not often consulted, and this may include the idea that they are too vulnerable and (an understandable) fear exists that talking to people with such experience may increase the risk of suicidal behaviours and feelings. It is hoped this research shows the benefits of including experts-by-experience in research which aims to inform policy; even when there are risk factors, consultation with service users is vital.

Accepted 23 May 2021

Published 1 September 2021

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ORIGINAL ARTICLE
THEORETICAL RESEARCH

Forgotten but not gone: A heuristic literature review of sibling suicide bereavement

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ABSTRACT

INTRODUCTION: It is often said that Aotearoa New Zealand suffers from a "culture of silence" around suicide. The sibling experience, it seems, forms a silence within that silence. Suicide-bereaved siblings face what has been termed a "double loss." Their sibling is gone, and so is their family as they knew it. Typically, they mourn both losses in isolation, the "forgotten bereaved." Although Aotearoa New Zealand's suicide rates are amongst the highest in the developed world, there are currently no academic papers dedicated exclusively to the sibling experience of suicide loss. This has serious implications, as suicide-bereaved siblings experience significantly higher rates of mental illness compared to control groups even when pre-existing psychopathology, health problems, and social disadvantages are taken into consideration. In addition, their own risk of suicide has been found to double.

METHOD: This heuristic literature review aims to clarify and summarise what research focused on the sibling experience of suicide bereavement has highlighted so far, drawing on the author's lived experience to examine key themes of guilt, "unacceptable" anger, social stigmatisation, self-judgement, isolation, and the shattering of relational trust.

FINDINGS AND IMPLICATIONS: Siblings cannot be expected to "seek" help, it needs to be offered—strongly and repeatedly. With this in mind, potential implications for mental health practice with suicide-bereaved siblings will be discussed, as well as broader social initiatives and areas in need of future research.

KEYWORDS: Sibling suicide; suicide bereavement; suicide survivors; sibling loss; bereaved by suicide

Background

The silent scream

Aotearoa New Zealand's suicide rates are high by international standards, and continue to climb unabated. Last year, 654 people took their own lives, and every tragically premature loss carves ripples of grief across families, peer groups and communities (Coronial Services of New Zealand, 2020). With the birth rate between 1960 and 2018 averaging 2.39 children per woman (Statistics New Zealand, 2019), each death typically represents at least one living sibling left behind.

It was not until I became one of their number—a number left unrecorded, unacknowledged—that I was able to truly understand what suicide bereavement looked and felt like beyond the statistics, anecdotes, and clichés. My brother was

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one of 540 people whose deaths were ruled self-inflicted that year, a rate of 12.2 per 100,000, making me one of over a thousand siblings struggling to make sense of what felt unbearably senseless. In literature, those that experience the loss of a loved one to suicide are termed “survivors,” a label that serves to acknowledge the trauma inherent in the experience, and I can think of no label more accurate (Rakic, 1992). As I wrote (anonymously) in the *New Zealand Herald* (“A Sister’s Tale,” 2011), in an attempt to enlighten those as blissfully unaware, as I had once been:

> They cross the road when they see my mother coming. The neighbours shuffle quickly back inside, as though scared it might be contagious. A hundred bunches of flowers are turning slowly brown inside the house, but the phone stays stubbornly silent. The men talk to my father of rugby. Fishing. Boating. Work. Anything but what has happened … his very name is enough to kill conversation stone dead, and make everyone look pointedly at their watches. Often, they suddenly remember they have somewhere else to be.

Yes, Aotearoa New Zealand has a “culture of silence” around suicide, to use the commonly touted media phrase. But both my lived experience and the research literature points to a silence within that silence: sibling suicide bereavement.

When I want to understand a thing, I read about it. I research, I absorb, I immerse myself, I dig and dig until I can make some sort of sense of it. I think I always knew I was never truly going to understand why my brother took his own life. But I also knew I had to try, or lose myself completely to the emotional maelstrom gathering dark and sinister around me. *Why did he die … and why do I feel like this? I never imagined I would feel like this. Why can’t I feel anything at all except rage? Why can’t I cry? Why can’t I recognise myself in the mirror anymore?*

So, I started digging. It began at my GP’s office, with a dog-eared card for a local support group I was ultimately too isolated and afraid to call. Piles of library books (including one full of real suicide notes) left me feeling a strange mix of confused, distant, and frustrated. I could find nothing specifically written for siblings, even as I watched the stack of tomes for bereaved parents grow taller by my mother’s bedside. Occasionally I would flick through them, and feel even more alone and freakish in my experience. Nothing resonated, and each page made me feel sadder and sicker and more shameful about my feelings, which none of my family (or indeed, anybody who had lived through this) seemed to share. My Google search history that year must make for curious, if morbid reading: “brother suicide angry”; “sibling suicide normal feelings”; “why do people kill themselves?”; “is suicide weak?”; “suicide when do I feel normal again?” But no matter where I looked, I could not find anything that spoke to siblings. I could not find myself.

Ten years later, I was planning my dissertation as a training psychotherapist, picking my brains for a suitable research topic.

“What you need to do,” my supervisor advised me, “is find the gap in the research. What’s an angle nobody has taken in your area of interest?” The words came to me seemingly unbidden, bubbling up involuntarily from somewhere deep in my chest: “I want to research sibling suicide.”

“Right then,” he said briskly, “let’s have a look at what’s already out there.” He punched the keyboard, hit Enter, and scrolled. And scrolled. And frowned.

In academia, I had gained access to a world of information that was not open to me as a newly bereaved sibling. But as it turned out, this new world was almost as bereft of the sibling experience as my local library was all those years ago. Eventually, my searches turned up some seemingly relevant manuscripts, but I was disheartened to discover study after study on "family suicide bereavement" lacked any meaningful inclusion of siblings whatsoever, or relied on second-hand accounts (usually from parents) to draw conclusions (Feigelman et al., 2009; Gall et al., 2014; Jordan, 2009; Lindqvist et al., 2008; Miers et al., 2012; Sandler et al., 2016; Wood et al., 2012). Similarly, articles on "sibling bereavement" tended to touch briefly on the experience of suicide loss at best, and I found the material frustratingly vague and broad.

It is a curious thing, that something affecting so many should be so invisible. I once asked a *Psychology Today* editor if I could write a column on sibling suicide. The reply: "Sorry, but that's a bit too niche. Could you just write one on grief generally?" I scrolled through the list of categories listed on *Psychology Today* in angry disbelief. There were tags for face blindness, the Keto diet, ghosting, memes, the Goldwater rule.

Is sibling suicide a niche topic?

In numbers impacted, no.

In perception? Apparently.

Methodology

Finding my voice

After many hours and many search combinations across numerous academic databases, I finally managed to find research related directly to suicide-bereaved siblings. Papers that, in some cases, spoke to me so deeply I found myself longing to reach through the words and touch the people who spoke them. But there were just nine of them. Nine papers, spanning all the way back to 1970. Of the nine, three were doctoral dissertations and one a Master's thesis, each compiled by researchers who had previously noticed the same absence of the sibling experience that I had stumbled across.

Like most populations impacted by trauma, sibling suicide survivors present ethical research challenges. Qualitative studies must generally exclude interviewees seen as *mentally fragile*, and avoid going into too much depth to prevent re-traumatisation (Powell & Matthys, 2013). This unavoidably cuts out a vast swathe of people whose experience may be vitally important, but cannot be safely examined. Some studies have attempted to circumvent this by getting one *stable* person in the family to report on the others. However, sibling suicide survivors do not typically tell their families how they really feel (Powell & Matthys, 2013; White, 2012).

Therefore, in an attempt to more clearly illuminate the sibling experience in an ethically permissible manner, I decided to engage in a systematic process of heuristic inquiry, examining what made it possible for me to put words to the experience of my brother's death. Since I would have likely been ruled too psychologically unwell following my own bereavement to take part in any of the studies I examined, I hoped to offer some deeper insight into the traumatic impact of sibling suicide. After all, what can truly be known about a psychologically debilitating event if one is prevented from studying the psychologically debilitated?

As a containing aspect, I seeded my heuristic exploration with academic literature focused on sibling suicide survivors. I began by conducting a literature review, reporting my findings from historical and current research on sibling loss generally, before turning my focus to suicide bereavement. Including only papers solely dedicated to the sibling experience of loss left me with frustratingly little source material, but it felt like a vital restriction. Siblings appeared so absent, so buried, so easily lost in more general studies in a way that seemed uncannily similar to what happens to them in the aftermath of a suicide. I would focus on siblings, and only siblings, in an attempt to avoid adding to this dynamic.

I drew key themes from my meagre pile of literature, including conflicting perspectives, in an attempt to gain an overall picture of what has been written about the sibling experience of suicide. I then turned my attention to my own experience of attempting to put words to the loss of my brother in a sustained process of heuristic enquiry, a reflexive approach in which I served as both subject and researcher. Spanning the better part of a year, this process was supported by ongoing examination and cataloguing of my thoughts, feelings, realisations and memories in response to the literature.

Through a process of sustained immersion, self-dialogue and self-discovery, I hoped to capture something of the essence of sibling suicide bereavement. Whatever I uncovered would inevitably be seen through the lens of my personal experiencing, but would likely include themes and meanings that have a universal element to them (Moustakas, 1990).

Findings

Even silence has a sound

Numerous researchers have referred to siblings as the "forgotten bereaved" in grief studies (Bolton et al., 2016; Dyregrov & Dyregrov, 2005; Fletcher et al., 2015; Haugen et al., 2016; Pettersen et al., 2013; Powell & Matthys, 2013; Rakic, 1992; Rappaport, 1994; Rostila et al., 2013; Rostila et al., 2017; Todd, 1980; White, 2012). Recorded sibling suicide research dates back only four decades, and just nine pieces of research have been dedicated exclusively to the sibling experience of suicide bereavement.

Research summary:

1. The oldest manuscript on sibling suicide, a qualitative study of the long-term effects based on taped interviews, was a doctoral dissertation focusing on 10 US siblings who were aged between 19 and 24 at the time of losing their brother or sister (Todd, 1980).

2. Twelve years later, in 1992, a second piece of doctoral research was written based around interviews with eight people who had lost a sibling—some to suicide, and some to illness—in an attempt to elucidate the unique impact of self-inflicted death on siblings (Rakic, 1992). The study also utilised the Rorschach test in an attempt to highlight unconscious emotional disturbance.

3. In 1993, Brent et al. carried out psychiatric assessments on 25 adolescent sibling suicide survivors and compared the results to those of 25 demographically matched control participants.

4. A year later, in 1994, Rappaport wrote about her experiences of psychoanalytic work with two female sibling survivors, each painfully conflicted about whether or not to bear children in light of their traumatic loss.

5. Another 12 years passed until the next study, in which Norwegian researchers Dyregrov and Dyregrov (2005) used questionnaires to explore the psychosocial situation of 70 suicide-bereaved siblings, including their psychological state, support networks, and experiences with mental health professionals.

6. Seven years later, White (2012) carried out a phenomenological study for her doctoral research that pinpointed and examined central themes in interviews with 15 US siblings bereaved by suicide.

7. Three further studies were then published in 2013. The first investigated the multiple ways in which siblings bereaved by suicide experience and manage uncertainty and loss. The study included 45 siblings, each interviewed in depth for qualitative analysis (Powell & Matthys).

8. The second 2013 study examined a national data register in Sweden (which included 13,693 sibling suicide

survivors) in search of a correlation between sibling suicide and early mortality (Rostila et al.).

9. The third and final 2013 paper examined 18 suicide-bereaved siblings' perceptions of health services, including their reasons for seeking (or not seeking) support, and their personal recommendations to healthcare professionals working with suicide-bereaved siblings (Pettersen et al.).
10. My own piece of research, completed in 2018, was the tenth (Royden, 2018).

The following sections detail what has been uncovered so far about the sibling experience of suicide bereavement. While individual sibling responses vary greatly depending on the situational and relational context of the loss, a number of key themes emerged from both the existing literature and my heuristic exploration of the research.

Psychological impact

"Who am I without you?"

In addition to the painful grief of "normal" loss, those who lose a brother or sister to suicide have been found to experience a range of uniquely challenging phenomena. Sibling suicide survivors are at particular risk of developing complicated grief reactions, depression, and post-traumatic stress symptoms (Brent et al., 1993; Dyregrov & Dyregrov, 2005; Pettersen et al., 2013; Rakic, 1992; Rostila et al., 2013; White, 2012). Common emotional responses include intense anger and guilt, a pervasive sense of responsibility for the death, and feelings of shame, worthlessness, anxiety, and fear (Brent et al., 1993; Rakic, 1992; Rappaport, 1994; Royden, 2018; Todd, 1980; White, 2012). It is also common for survivors to feel relief if the death marks the end of a long period of worry and uncertainty. This tends to fuel further guilt, creating an ongoing cycle of emotional disturbance (White, 2012).

Siblings often report feeling significant guilt, and research indicates that this can happen for a variety of reasons. Some siblings may have kept potentially deadly secrets about their brother or sister, for example, the occurrence of previous suicide attempts and/or self-destructive behaviour (Dyregrov & Dyregrov, 2005; Rakic, 1992). Many felt they did not do enough to stop the suicide or berated themselves for failing to notice their sibling was depressed. The majority reported experiencing particularly strong guilt reactions when they began to resume their lives (Powell & Matthys, 2013; White, 2012). In addition to what was overtly revealed by her interview subjects, Rakic (1992) noted signs of suppressed guilt, and felt it had such a pervasive hold on some siblings that, at an unconscious level, they believed they no longer deserved to have joy, happiness, or success in their lives. This was a realisation I eventually came to in my own therapeutic work (Royden, 2018). Rappaport (1994) made similar observations, conceptualising the drive to self-sabotage as a form of self-punishment. It is worth noting that feelings of guilt were not significant in Rakic's control group of siblings bereaved by illness (1992).

Another emotional phenomenon that warrants further discussion is the anger commonly experienced by sibling suicide survivors, which is typically uncomfortable and shameful for them (Powell & Matthys, 2013; Rakic, 1992; Rostila et al., 2013; Royden, 2018; White, 2012). White (2012) draws parallels with the murder of a family member, pointing out how much hatred is typically felt towards the killer and, in the case of suicide, the dead loved one is both victim and perpetrator. Anger is also thought to stem from deep and painful feelings of rejection and abandonment (Rakic, 1992; Rostila et al., 2013; Royden, 2018). However, the presence of anger or rage (let alone the expression of such emotions) is usually viewed as highly inappropriate and unacceptable, even in families that can speak relatively freely about emotions (Rakic, 1992;

Royden, 2018). Unable to be processed or borne, anger may then be repressed, turned inwards as self-punishment, or redirected as impulsive lashing out—all of which can serve to block resolution and acceptance of the loss (Rakic, 1992).

Family dynamics

"You've got to be strong for your parents now."

No clear picture of a "typical" reaction to sibling suicide can be drawn from the literature, but strong consensus exists about what tends to happen in the wider family structure: each person becomes too preoccupied with their own pain to offer meaningful support to the others (Brent et al., 1993; Dyregrov & Dyregrov, 2005; Pettersen et al., 2013; Powell & Matthys, 2013; Rakic, 1992; Rappaport, 1994; Rostila et al., 2013; Royden, 2018; Todd, 1980; White, 2012). Suicide-bereaved brothers and sisters often find themselves "not only neglected, but expected to put their needs aside in order to spare their parents further distress" (Rakic, 1992, p. 2). Siblings usually experience a desperate desire to make their parents happy again, and they tend to be instructed implicitly, explicitly, and repeatedly by others to "stay strong" for them (Powell & Matthys, 2013; Royden, 2018; White, 2012). Many, therefore, try to appear "emotionally together" or even cheerful around their family, despite their intense pain. The siblings' demeanour is then perceived as evidence that they have not been badly affected by the loss, making them less likely to receive the support and care they crave (Dyregrov & Dyregrov, 2005; Rakic, 1992).

Unsurprisingly, siblings still living in the family home tend to report the highest levels of psychic distress in response to the loss (Dyregrov & Dyregrov, 2005; Rostila et al., 2013; White, 2012). These siblings may be required to take on the role the deceased fulfilled within the family (Powell & Matthys, 2013; White, 2012) or "parent" their grief-crippled mothers and fathers (Dyregrov & Dyregrov, 2005; Powell & Matthys, 2013; Rakic, 1992; Todd, 1980; White, 2012). In short, survivors of sibling suicide suffer from what has been termed a "double loss": their sibling is gone, and so is their family as they knew it. Typically, they mourn both losses in isolation (Powell & Matthys, 2013; Royden, 2018).

Social stigma

"Did you hear her brother killed himself?"

The sense of utter isolation siblings experience is exacerbated to varying degrees by the social stigma around suicide, which makes discussing the death with people outside the family challenging (Powell & Matthys, 2013; Rakic, 1992; Rostila et al., 2013; Royden, 2018; Todd, 1980). Historically, surviving family members of a self-inflicted death were actively shunned by society, considered tainted by the "sinful" action of the deceased's "self-murder" (Rakic, 1992; Todd, 1980; White, 2012). Such open hostility may be rare today, and a clear shift can be observed in the language used around suicide in the academic literature over time. However, research shows that stigmatising attitudes and behaviours remain common, if more covert. Suicide-bereaved families tend to receive less community support compared to families that lose a member to "natural" causes (Rostila et al., 2013). They may be avoided and/or blamed for the death by others, and it's not uncommon for the deceased to be disparaged as "selfish" and "cowardly" for their actions (Powell & Matthys, 2013).

Self-stigmatisation

"I can't escape myself … but I can spare you, at least."

Many siblings describe being extremely hurt by the actions of those they hoped would support them following the suicide (Powell & Matthys, 2013; Rakic, 1992;

Royden, 2018; White, 2012). Some spoke of friends abandoning them altogether, while others recall people acting as though the death never occurred, silencing them with platitudes, or telling them they should not feel the way they do about the loss (Rakic, 1992; Royden, 2018; White, 2012). This typically occurred against a backdrop of deep longing and need for the siblings to have their grief heard and validated (Powell & Matthys, 2013; Royden, 2018; White, 2012). However, the relational dynamics surrounding sibling suicide survivors appear complex. During interviews, some brothers and sisters spoke of friendships ending due to impatience that they are "still not over it," but others admitted to deliberately withdrawing from their friends due to experiencing them as immature, unempathetic and/or focused on trivial concerns (Dyregrov & Dyregrov, 2005). Rostila et al. (2013) additionally point out that survivors are likely to stigmatise *themselves* negatively due to guilt, and therefore self-isolate out of shame. Rakic (1992) and White (2012) both posit that survivors' perceptions of stigmatisation can be more often related to intrapsychic processes than actual acts of rejection. Siblings often swallow their hurt to avoid awkwardness with their peers, leading them to feel "lonely in a crowd." This may contribute to an overall sense that others are rejecting or avoidant.

Whatever factors are at play, the lack of accessible support for siblings represents a significant obstacle on the road to accepting and mourning their loss (Rakic, 1992; White, 2012). In my own research, as I explored what made it possible to talk about a sibling's suicide, I devised an "equation" for the process of disclosure:

> It is possible to put words to the experience of sibling suicide when the fear of—and potential for—relational pain is outweighed by the desire for—and potential for—relational connection. (Royden, 2018, p. 65)

This mirrors the core belief of relational psychotherapy: the need for the human psyche to keep relationships intact, even at the cost of the self (Perlman & Frankel, 2009). However, it also captures the desperate longing for relief from psychic aloneness evoked by trauma (van der Kolk, 2014).

Relationships and repetition

"Everyone I love leaves in the end."

Research indicates that sibling suicide has significant, lasting effects on the emotional and relational lives of survivors. Some older siblings felt they had re-lived their lost sibling relationship with their romantic partners, entering unsatisfying or painful pairings which ultimately resulted in their being abandoned or let down again (Todd, 1980; Royden, 2018; White, 2012). Rakic (1992) wrote of the potential for a sibling's suicide to severely damage *any* sense of trust in the stability of meaningful relationships, while Todd (1980) pointed out that, in her study, the siblings who carried the most guilt around the suicide typically engaged in the most self-destructive romantic pairings (Todd, 1980). Many siblings became preoccupied with the fear of losing other loved ones to death or being abandoned by them and worry that the tragedy of suicide will be repeated in their own future families (Rappaport, 1994; Royden, 2018; Todd, 1980; White, 2012).

Todd (1980) additionally described a deep sense of "maternal inadequacy" amongst some of the female siblings she interviewed, and Rappaport (1994) described her clinical experiences of working with two such young women. Both of them longed to become mothers, but could not bear to do so until they had worked through their deeply conflicted and painful feelings about the loss in therapy. In my heuristic exploration of sibling suicide, I admitted and explored my own deep ambivalence around motherhood, including my fear that the trauma of suicide bereavement has damaged my ability to parent beyond repair (Royden, 2018).

The question of why

"The one person who knows is the one person I can never ask."

Suicide challenges fundamental notions of self-preservation, and nearly all survivors struggle for varying lengths of time to make sense of what happened and why (Rakic, 1992; Rappaport, 1994; Rostila et al., 2013; Royden, 2018; White, 2012). Several studies have shown a correlation between sibling bonds which included dual relationships (for example, one sibling acting as a "parent" for another) and more intense, lengthy grief responses (Rakic, 1992; Rappaport, 1994; Todd, 1980; White, 2012). Many siblings do report eventually making peace with the fact that unanswered questions will always remain (White, 2012). However, Powell and Matthys question the validity of "acceptance" as the end stage of grief, arguing instead that mourning a suicide is a dynamic process that evolves throughout the life stages (2013).

Supportive experiences

"You mean it's not just me?"

Support groups were named repeatedly in the literature as a helpful resource for siblings (Pettersen et al., 2013; Powell & Matthys, 2013; Rakic, 1992; Rostila et al., 2013; White, 2012). Clinicians working with survivors of sibling suicide are advised that, in many cases, simple reassurances that their grief reactions are "normal" can be extremely soothing (Powell & Matthys, 2013; Rakic, 1992; White, 2012). Additional recommendations to mental health workers include leveraging positive memories of the deceased to lessen focus on the traumatic nature of their death, while working to re-direct anger and reduce guilt (Powell & Matthys, 2013; White, 2012). Research further suggests that the remaining relationships within the family should be carefully considered, and clinicians should be proactive about providing practical guidance and resources (Dyregrov & Dyregrov, 2005; Rostila et al., 2013). Pettersen et al. (2013) warned that clinicians may have to work particularly hard to foster trust with siblings who feel their brother or sister received inadequate mental health care prior to their death. They further posit that the siblings who report the greatest difficulties in seeking help may well be those who need it most.

Post-traumatic growth

"It's not a silver lining. But it's not nothing either."

Surprisingly, some researchers described positive outcomes that can ultimately be derived from the experience of surviving a sibling's suicide. During interviews, a number of survivors spoke of experiencing noticeable personal growth and a profound shift in perspective (Dyregrov & Dyregrov, 2005; Powell & Matthys, 2013; Rakic, 1992; White, 2012). Many became involved in suicide prevention activities, and valued the increased compassion and empathy their life experiences had imbued them with (Powell & Matthys, 2013). It is poignant that sibling survivors of suicide often find a renewed sense of purpose and meaning in their lives, as they face an elevated mortality rate from all causes (Rostila et al., 2013). Brothers are most likely to die prematurely in the first year of bereavement, while sisters are at highest risk 2–5 years post-loss (particularly from cardiovascular disease). Additionally, as was long suspected but difficult to prove (Brent et al., 1993), sibling survivors of suicide appear to be at an increased risk of taking their own lives. Rostila et al. (2013) indicated that the risk of suicide roughly doubles.

Discussion and recommendations

Better silent than silenced

Sibling suicide survivors are an at-risk demographic across a wide spectrum of adverse health and social outcomes—everything from depression to cardiovascular disease. Most concerningly, they are at elevated risk of taking their own lives, causing suffering to snowball within families, peer groups, and communities. Brothers and sisters who lose a sibling to suicide are both vulnerable and easily identifiable given the need for self-inflicted deaths to be thoroughly investigated and recorded, yet there appear to be no dedicated resources available to them—and certainly no targeted support.

Currently, siblings are left to seek assistance of their own volition, with scattered community groups and online forums generally their only options unless they can afford private counselling. This contrasts starkly with, for example, Australia's StandBy suicide postvention programme, which offers targeted funded support for people bereaved by suicide—everything from printed resources to support with funeral planning to specialised counselling (www.standbysupport.com.au).

The existing literature on sibling suicide bereavement, my heuristic exploration, and my lived experience (paired with my clinical knowledge as a psychotherapist) suggest a number of recommendations that may assist suicide-bereaved siblings in Aotearoa New Zealand.

Social initiatives

Readily available information

Given the differing needs of suicide-bereaved siblings comparative to other family members, dedicated resources could be extremely helpful.

Research indicates that simple normalising of what siblings feel can be incredibly soothing, but currently most resources around sibling suicide are hidden behind academic paywalls—which could be seen as a collusion with societal silencing. Given the scarcity of such work, there are ethical questions around the continuation of this practice, and a case for constructing a publicly accessible repository of such documents (for example, establishing a dedicated website for suicide-bereaved siblings and/or developing and distributing printed resources). My decision to submit this piece of research to an open-access journal forms a small but significant act of resistance against this status quo.

In addition, I believe that other family members could benefit from learning about how siblings tend to process such a loss. Perhaps it could help families begin to allow some space for siblings' different (but no less valid) grief experiences.

Dedicated support groups

Support groups were repeatedly named in the literature as a positive resource for many siblings. However, little detail was given about the groups referenced in the research. It is not clear whether they were open to any bereaved person, restricted to people impacted by suicide, or created exclusively for those who have lost a sibling to suicide. A number of open suicide bereavement groups currently operate in Aotearoa New Zealand, but further investigation would be needed in order to make specific recommendations.

I did not attend any groups following my own bereavement, and therefore cannot contribute any insight from my own lived experience. However, I question how freely siblings would be able to speak in an open suicide bereavement group that included a diverse range of relationships and roles. The open suicide bereavement groups currently available in Aotearoa New Zealand (despite the profoundly important work they do) are not spaces created with the unique needs of siblings in mind, and research has shown that siblings generally feel their grief to be less important comparative to their parents' (a message they tend to receive both implicitly and openly).

In addition, many siblings struggle with intense anger about the death, and open expression of siblings' anger (as discussed at length in the literature) tends to be absolutely unacceptable within the wider family. As I wrote in my journal while completing this piece of work, "To try to speak in front of other parents [in a group] would mean doing it with the spectre of Mum and Dad in the room, and I cannot imagine that being possible" (Royden, 2018, p. 83). In my view, the literature strongly suggests that dedicated, sibling-only suicide bereavement support groups could be powerfully therapeutic.

Targeted support

Research indicates that the most desperate need for mental health assistance may well be experienced by the siblings who have the most powerful internal barriers to seeking it out. Siblings are generally compelled to deny the impact of their loss in their families and social relationships, and therefore they may well also deny it to themselves and/or any mental health workers tasked with assisting them. Further compounding the problem, if siblings feel their brother or sister was failed by mental health services, they are likely to be negative and/or hostile towards the idea of engaging with such services themselves.

I would also like to point out that it seems, albeit anecdotally, that many siblings do not seek mental health assistance *for* their loss. During my own training, I read a number of case studies in which, frustratingly, a sibling's suicide was mentioned almost as a footnote, behind the "presenting issue" of self-harm, or depression, or dysfunctional anger (my own reason for engaging in therapy). Reading about the struggles of these clients through the lens of my own experiencing, it felt painfully obvious to me how huge the suicide likely loomed in their psyche. There may be a tendency for siblings to downplay and deny the impact of their brother or sister's death, or simply lack awareness of how such a loss relates to the symptom/s causing their current distress. In short, siblings cannot be expected to "seek" help, it needs to be offered—strongly and repeatedly.

Implications for practice

Family support

In my view, mental health practitioners who work with suicide-bereaved families will benefit from remaining mindful of the pressure on siblings. Research indicates that what siblings speak on the surface may not be the words they wish to say and, while siblings long to be understood by their families, the risks attached to doing so can feel immense. I believe this reflects a dynamic of risk versus reward, with family therapy positioned in the space of high potential reward (feeling known and accepted by other family members), but also heightened risk (feeling rejected, unseen or wrong, even in a therapeutic environment). Mental health practitioners working in this space may also need to think about how to manage potential impasses in family therapy. Parents' acknowledgement of the sibling experience may be too much to hope for given the catastrophic loss they are trying to process themselves. On the other hand, the pain of siblings in the face of this disavowal can be palpably raw.

Individual therapeutic work

In order to prepare practitioners for working effectively with clients who have lost a sibling to suicide, research suggests that a more nuanced and differentiated understanding of suicide bereavement is necessary. The sibling experience differs greatly from how parents, children and spouses grieve, and it is hidden—potentially denied even to the self.

Research suggests that important factors to consider are:

1. Acknowledging loss of identity as a core part of the grief process of sibling suicide.

2. Respecting the sibling's defences, and not dismantling them before building a foundation of safety.
3. Being mindful of re-creating a dynamic in which the sibling feels like they need to protect or reassure.

On the basis of my own research and lived experience, I additionally wish to encourage practitioners to be aware of their own internalised systems of silencing. What occurs at a societal level tends to be reproduced in the self, and each of us has a lifetime of conditioning urging us on a visceral level to recoil from the issue of suicide. Traces are likely to remain despite our decision to work in the helping professions. However, what a mental health practitioner offers by resisting that ingrained response is valuable beyond measure, and what is risked by giving in potentially devastating.

As I wrote in my journal while completing this piece of work, I described the therapy room as the only place it felt safe to speak freely. I also pointed out how shattering it would be to experience feeling rejected or judged in that space. Therapy was a safe space I regrettably could not find "out there" in the world and had to purchase, a place to bring all that I could not say to anybody else. The literature suggests other siblings have a similar experience, being familiar with internal, family, social and societal messages that their experience is unacceptable to others.

> Within a therapeutic setting, my desire to speak and to be known could take place almost entirely free from fear. However, I can only speculate—with concern—what potential for harm exists if that sense of safety collapses. What if instead of empathy, warmth and acceptance I was met with judgement or moralising? What if I felt the need to reassure my therapist, visibly disturbed by my words? Any threat to my ability to speak freely was highly anxiety provoking for me. Reflecting on my experiences, I wonder how often my therapist may have felt the urge to direct me, or advise me, or encourage me to "move on". I know how tempting it might have been, and how devastating I would have found such well-meaning statements. (Royden, 2018, p. 79)

Creating a space in which siblings can safely speak about their experience should be a practitioner's first and most important priority in my view, irrespective of their particular mental health role or therapeutic modality.

Areas for future research

More research is needed across every facet of the experience of sibling suicide, as much of what has been found has already dated almost beyond usefulness. Broadly, this heuristic literature review invites further exploration to differentiate experiences of sibling suicide survivors across cultures and gender identities. Māori and youth perspectives in particular are incredibly important to illuminate, and given the possibility for a sibling's suicide to distort the capacity for stable relational attachment, it may also be useful to track siblings' significant relationships over time.

The scarcity of information available to the general public, mirrored within the academic community, raises additional questions around how and why such an absence endures. What (and who) within the dominant discourse benefits?

There are still more questions about the "forgotten bereaved" than answers.

Conclusion

Don't forget to remember

The current body of research appears to demonstrate what often plays out in reality following a suicide: siblings remain unseen relative to those whose pain is considered to be more intense and in greater need of attention. Suicide-bereaved siblings typically carry their experience in quiet, desperate isolation, and repetition of (or possibly even collusion with) this silence seems to be re-created at all levels, including the world of research. What other private agonies, borne unseen and unheard, may need further inspection due to similar factors at play? Does the individual's silence influence society's perception of their experience (they do not ask, and therefore they do not need)? Or does the prevailing social climate dictate the individual's ability to speak (they should not need, they are "only" siblings)? Could there be an overarching refusal to hear, a collective denial (it is too painful to see the need)? As I write, I wonder whether this manuscript, too, will be lost to time … buried deep beneath the needs of other groups impacted by suicide, for another like me to uncover one day and attempt to illuminate just as futilely.

Sibling survivors of suicide may be forgotten, but we are not gone. We show up in numerous adverse health statistics, we weigh our agony quietly in therapy rooms all over the world, we walk the jagged razor edge between longing to be heard and fearing minimisation, rejection, or abandonment. We grieve the loss of a relationship that all but defies definition, one we imagined would last the entirety of our lives.

I ask you, as one amongst our number, to not only listen carefully for our voices, but to answer. To answer with the compassion and thoughtfulness we tend to not know we need, but will struggle to survive without.

Accepted 17 May 2021

Published 1 September 2021

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ORIGINAL ARTICLE
QUALITATIVE RESEARCH

Cessation strategies used successfully by individuals in recovery from methamphetamine addiction

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ABSTRACT

INTRODUCTION: Methamphetamine (MA) misuse is a recognised health issue in Aotearoa New Zealand, and there is a lack of appropriate treatment available for individuals who are methamphetamine dependent. This exploratory study, undertaken in 2019, sought to gain insight from individuals in Aotearoa who have experienced MA dependence and now identify as being in recovery, to discover which strategies, approaches or treatment appeared helpful in their recovery.

METHODS: The participants in the study were seven adults (New Zealand European, Samoan and Māori ethnicity) who had abstained from methamphetamine for six months or more. In-depth interviews were audiotaped and transcribed before being analysed. The data were analysed using interpretative phenomenological analysis, which has its theoretical origins in phenomenology and hermeneutics.

FINDINGS: Four themes emerged to describe the lived experience of recovery from methamphetamine misuse: Getting Away, Support, Personal Sources of Strength, and Treatment. Each theme held importance in the participants' recovery from MA and provided insight into their journey in abstaining and being in recovery.

CONCLUSIONS: These findings may be used to assist others entering recovery. The present findings are limited by the size of the sample; however, they provide valuable information on this important health issue as a basis for further research, which is urgently needed in Aotearoa.

KEYWORDS: Methamphetamine; health issue; recovery; treatment

AOTEAROA
NEW ZEALAND SOCIAL
WORK *33(2)*, 32–44.

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MA has been recognised as one of the most frequently used drugs worldwide, and an important health issue that requires close attention (European Monitoring Centre for Drugs and Drug Addiction, 2018). It is a synthetic drug which is a member of a family of drugs known as central nervous system stimulants, titled amphetamine-type stimulants, comprised of amphetamines-group substances (Weisheit & William, 2009). MA comes as a clear, crystal-like compound or as a powder that can be used by snorting, injecting, inhaling or ingesting (Fields, 2017). Individuals use MA for reasons which can include physical or mental performance enhancement, experimentation as a social activity, escapism from inner issues, or through peer pressure. There are aspects of an individual's environment, biology or own personality and genetic makeup that can cause them to be more susceptible to the drug. This can include mental illness, socioeconomic status, social relationships, culture/ethnicity, hereditary predisposition, and trauma-related events (New Zealand Drug Foundation, 2018).

The issue of MA in Aotearoa New Zealand, as in other countries, has steadily escalated since the late 1990s (UNODC, 2004). The 2017/18 New Zealand Health Survey results for amphetamine use in the previous 12 months indicate a prevalence of 0.7%, which is an estimated 26,000 adults. This is a lower percentage than 2015/16. The survey found that participants aged between 24–34 (1.5%) had the highest prevalence, followed by 15–24 (1%), while ages 55–64 (0.1%) had the lowest, which shows the same pattern as in past surveys. Māori use (2.3%) remains comparatively different from non-Māori use (0.7%). The most recent government statistics show that the overall numbers of people who use MA in Aotearoa New Zealand has remained relatively consistent in the past five years (New Zealand Drug Foundation, 2018).

MA is a powerfully addictive stimulant that poses a great risk to overall wellbeing. MA has a short half-life (the time it takes for half of the drug to no longer be in the bloodstream) and therefore the user will often repeat use, which results in the onset of rapid dependence in comparison with other drugs such as alcohol. The cross-over from the initial time an individual uses MA to when they reach loss of control and become dependent on the drug can be rapid for MA users, and generally, dependence on the drug occurs and then controls the individual's behaviour long before they acknowledge it or can see what has happened (Halkitis, 2009).

Heavy use can result in neglect of self-care routines such as sleeping, eating, personal hygiene and exercise, which can lead to sleep deprivation, malnutrition, and dental damage. Long-term use can cause anxiety, depression, and damage to the nervous system and susceptibility to infectious disease. The lack of sleep can induce drug psychosis, and intravenous use increases the risk of contracting diseases such as HIV/AIDS (Gordon & De Jong, 2018). Users can have occasional episodes of sudden and violent behaviour, intense paranoia, visual and auditory hallucinations. There can also be a tendency to compulsively clean and groom, and repetitively sort and disassemble objects such as cars and other mechanical devices, or to spend hours invested in a hobby that involves the user's own handywork and concentration (Halkitis, 2009). The effects have a devastating impact on an MA user's life as they often neglect their families, friends, and communities. They then often lose their jobs, money, and family and can hit "absolute rock bottom" before trying to do something about the crippling effects this drug has had on their lives (Roll et al., 2009).

Despite their desire to use less, in a review of treatment research, Halkitis (2009) states that MA users do not typically seek help until they present with severe consequences. This is typically because they enjoy the drug's effects too much to want to seek support, and when they do seek help as the damaging effects become clear, their prolonged use often means they are by then highly addicted to the drug (Jenner & Lee, 2008). The literature suggests there is a range of individual and service level barriers that can prevent MA users from getting treatment. Barriers can include embarrassment or stigma, lack of funding and resources, privacy concerns, lack of awareness regarding treatment options, limited access to services, and lack of supports (Halkitis, 2009). Another issue undermining the success of MA treatment options is the significant shortage of providers with expertise in this specific drug addiction and an unavailability of appropriate services (Cannon, 2018).

The withdrawal symptoms that are experienced by MA users, even after long periods of abuse, do not include physical withdrawal symptoms like vomiting and shaking. MA use creates more of a psychological dependence than a physical dependence and therefore withdrawal is more likely to produce psychological symptoms such as depression, anxiety, and cravings (Drug Abuse, 2019). However, both dependence and addiction are treatable conditions. The goal is to separate the individual from the drug in a slow and controlled way to allow the body to readjust to a normal level of functioning (Drug Abuse, 2019). To date, no single modality to treat MA dependence has been identified as fully effective in community-based, clinical or research settings, so this is already a barrier for individuals to be integrated into an appropriate and successful treatment. However, there are some treatment approaches with some evidence of efficacy, with further knowledge required to understand what else may be helpful. At present, the Matrix Model remains one of the most publicised and well-respected approaches to addressing MA addiction (Cannon, 2018). Cognitive Behavioural Therapy and Contingency Management are also well supported counselling-based treatment approaches, and studies show that the contingency management approach can be useful in conjunction with the behavioural therapy as it allows the individual to engage in other negotiated or contracted desirable behaviours (Weisheit & William, 2009). Research shows that overall outcomes for MA users are improved by establishing a firm relationship (rapport), family support for the user, greater treatment satisfaction, and longer retention in treatment (McKetin et al., 2018).

Information collected by the New Zealand Ministry of Health has indicated a general increase in the number of individuals attending mental health and addiction services with a diagnosis of abuse or dependence on MA. Between 2011 and 2012, the number of individuals with a primary diagnosis of Amphetamine-Type Stimulants (ATS) abuse or dependence doubled, and significant numbers of those identified as having ATS use as a secondary issue when attending mental health and addiction services (New Zealand Ministry of Health, 2013). The pattern of contact with services in more recent years is also reflected in data provided by the Alcohol Drug Helpline, which reports that, in 2013, they were receiving approximately 300 calls about MA use every few months. These calls were mainly coming from family concerned about someone else's MA use, which is consistent with the pattern of MA users not seeking help until they present with severe consequences (Alcohol Drug Helpline, 2019).

Depending on the length and severity of dependence on MA, some individuals may be able to successfully manage their own withdrawal symptoms in the community without external support, or with support from a GP, whereas some individuals will have the need for greater support when going through withdrawal. In Aotearoa New Zealand there are Community Alcohol and Drug Services and other agencies which offer counselling, family therapy, detox programmes in a hospital or at home, medication, and referral to residential treatment programmes if required (Meth Xpert NZ, 2019). Despite there being services in Aotearoa New Zealand to cater for individuals who suffer from drug and alcohol issues, the problem faced by individuals with dependence on MA is the lack of services available or providers who cater *specifically* for treating MA (New Zealand Drug Foundation, 2018).

Most research on methamphetamine misuse, treatment and recovery has been conducted overseas rather than within Aotearoa New Zealand, so utilising the knowledge discovered overseas has been essential in developing our own framework and guidelines. In 2009, the government made an action plan to address the rising issue of MA in Aotearoa New Zealand, and, as a direct result of this, the New Zealand Ministry of Health instigated that Matua Raki (the national centre for addiction workforce development in Aotearoa New Zealand) make use of the overseas research and write guidelines for treatment providers. In 2010, Matua Raki released the comprehensive report “Interventions and Treatment for Problematic Use of Methamphetamine and Amphetamine-Type Stimulants (ATS).” In 2013, Matua Raki released a further review in a follow-up to the earlier report (New Zealand Ministry of Health, 2010, 2013).

The reports were prepared to review what treatment for MA works and what does not, and to review current and emerging developments in the treatment of problematic MA use. They were intended to be a working guide for those working with individuals affected by MA including frontline workers, Mental Health Services, police, general practitioners, addiction treatment providers, counsellors, and emergency departments. They support and recommend the few treatment modalities that have been recommended from overseas studies including the Matrix Model, Contingency Model, and working with high dose users in rehabilitation treatment centres (New Zealand Ministry of Health, 2010). There is support for these reviews from educational providers for MA such as the Dual Recovery Network in Christchurch who promote these reviews to help improve treatment in Aotearoa New Zealand and are advocating to support further use of the Matrix Model into the New Zealand health system (Dual Recovery Network, 2016). However, at present, there is still a need for an expansion in both the number of treatment services that are provided and awareness for the population group on what is available to them (New Zealand Drug Foundation, 2018).

The lack of available services has led to frustration in communities, which has led to grassroots type approaches in attempts at reducing MA use. There are drop-in centres in some regions of New Zealand run voluntarily by ex-addicts and supporters under a group called “P Pull,” treatment facilities which are stretched to capacity with long waiting lists, and there are a few rehabilitation centres which offer specialised services for MA users that have waiting lists and eligibility criteria for potential clients (*New Zealand Herald*, 2019). There is also a rehabilitation centre in the Hutt Valley, near Wellington, which is called “Red Door Recovery.” Red Door offers the “Pipe Down Meth Recovery Programme” which is specifically designed to meet the unique and difficult challenges presented by methamphetamine (Red Door Recovery, 2018). In Auckland there is a rehabilitation centre called “Higher Ground” which has an eight-bed contract through the Prime Minister’s Methamphetamine Strategy, as well as accepting methamphetamine clients into other funded beds in the wider programme. Findings from the Higher Ground 2011–2014 outcome review indicate that Higher Ground is effective in working with MA clients, with 94% abstinent at 3 months when followed up at 3, 6, 9, and 12 months post-discharge, and 87% abstinent at 12 months (King, 2014). Te Whare Oranga Ngakau is a residential alcohol and drug treatment centre in Rotorua which focuses on providing clinical services within a Kaupapa Māori framework. The 24-hour residential programme has 15 AOD beds and two methamphetamine beds and offers a 12-week programme, or longer if required (Māori and Addiction Treatment Services, 2012).

A study was carried out in Aotearoa New Zealand in 2010 to discover the most commonly used interventions with MA from six agencies who dealt with the treatment of MA. The most common interventions were discovered to be Te Whare Tapa Whā and CBT, followed by harm reduction, motivational interviewing relapse prevention, behaviour therapy, brief therapy, group- and person-centred therapy (Cobzaru, 2010). Although the Matrix Model and Contingency Model were not mentioned, the wide use of Te Whare Tapa Whā is a therapeutic approach that is culturally appropriate for Māori, and consistent with Māori values and cultural identity (New Zealand Ministry of Health, 2010).

When looking at drug dependence and recovery, it is important to pay particular attention to which population group has the highest prevalence of use to target interventions for this population group and ensure there are appropriate services and treatment available. In the most recent New Zealand Health Survey, the highest rates of use were in males, people aged from 24–35 years, and people of Māori ethnicity. There was a study carried out in Aotearoa New Zealand in 2010 to discover the most commonly used interventions with MA from six agencies who dealt with the treatment of MA. The most common interventions were found to be Te Whare Tapa Whā and CBT, followed by harm reduction, motivational interviewing relapse prevention, behaviour therapy, brief therapy, group- and person-centred therapy (Cobzaru, 2010). Although the Matrix Model and Contingency Model were not mentioned, it is pleasing to see the wide use of Te Whare Tapa Whā, which is a therapeutic approach that is culturally appropriate for Māori, and consistent with Māori values and cultural identity (New Zealand Ministry of Health, 2010).

Providing effective treatment for MA dependence is a growing need. There is knowledge that can be readily sourced on what the drug is, its effects, how it is manufactured, the seizure rates and trafficking of the drug, but less is known about the treatment options and how well these are working. It has been established that there is a need to look further at treatment options and recovery (Stoneberg et al., 2017). The study was aimed at examining the experiences of those identifying as being *in recovery* from MA dependence; at gaining insight into what approaches have helped or contributed to their journey of recovery, from the individual's perspective; and at prompting further research on the area of treatment and recovery.

Methods

Methodology

This study was motivated by the first author noticing the harm MA was causing for individuals and wider communities in Aotearoa New Zealand through coverage in the media as well as insights gained from facilitating mental health treatment for her clients. Despite this concern, the first author was committed when interviewing the participants, to have utmost respect, objectivity and nonjudgement when gaining insight into their personal experiences.

To gain an understanding of the lived experience of MA recovery, Miller et al. (2010) suggest that qualitative research is important in capturing how substance use and addiction are lived, and uncovering what the experience of recovery is like for individuals. Hermeneutic phenomenology was the theoretical framework for this research.

Participants

The criteria for participant selection was that the participants were over the age of 18 years and had abstained from MA for a period of six months or more. The participants needed to be both willing and able to articulate their lived experience of identifying as "in recovery from MA misuse" and the strategies, treatment or approaches that they have found helpful in allowing them to achieve this.

Snowball recruitment was the method employed to recruit participants. This involved finding a participant, interviewing them and then asking if they knew others who may be potential participants for the research and asking them to provide those potential participants with some information on the research, and researcher contact details (Flick, 2014).

Each individual who expressed interest in being a participant was checked to ensure they met the criteria and either emailed or posted a detailed information sheet, which outlined what the research was about, what they would be asked to do, what the information would be used for, and what they could expect from the researcher. This was a successful recruitment method and resulted in seven participants.

Semi-structured interviews were conducted with the participants in 2019. The participants were four males and three females. Ethnicities included European, Samoan, and Māori. Their ages at the time of interviewing ranged from 32 years to 53 years, with a median age of 36 years.

Interviews

The interview length was approximately one hour per participant. The interviews were conducted by the first author who used the same interview guide for each interview. The format was semi-structured, and focus was placed on allowing the participant to tell their story and describe their experiences. On completion of each interview the researcher explained what would happen with the information, which included the data being transcribed and analysed in order to form research findings, and how it would be stored.

The participants were asked if they would like a copy of the transcript to ensure they were happy with the data and make any edits they saw necessary. None of the participants chose to have a copy of the transcript and all participants consented to having their interviews audio-taped; tapes were then transcribed and analysed. The participants were provided a "summary of findings" on completion of the study.

Ethical considerations addressed included consent, data collection, documentation, recording, sharing research findings, benefits/risks, participant recruitment, privacy/confidentiality, Treaty of Waitangi and cultural considerations. The procedures were approved by the Massey University Human Ethics Committee before the start of recruitment and data collection.

Data analysis

Interpretative phenomenological analysis (IPA) was used because of its idiographic focus on phenomena that relate to experiences of some personal significance to individuals, such as drug dependence (Savin-Baden & Major, 2013). IPA is intended for a small number of participants, so was ideal for this study with seven participants. Once each interview had taken place, the researcher immediately began transcribing the interview before reading and scrutinising the data to cluster the data into common themes to develop the descriptions of experience (Moustakas, 1994).

The first author used a data analysis software program to code the data. Once the data were coded and themes were found, the emergent themes were listed on a separate document so that the researcher could look for cross-participant themes. There were 10–12 themes identified. Some of the common themes were clustered together, which reduced the findings to four main themes (Smith, 2008).

Results

The participants in this research had used MA for a period of between six months and 17 years, with a median time of six years. Participants talked about their experiences of MA use and the consequences this had on their lives. They described how they stopped caring about other people and that their life revolved around the drug. The majority talked about being in unstable and unhealthy relationships throughout their time of using. They became estranged from their friends and family and socially withdrew from them due to the ongoing dependence they had on MA. Participants talked about the various physical health problems they had experienced: becoming very thin from not eating, barely sleeping, pimples/scabs on their body, trouble with their teeth, and one participant had permanent lockjaw which he believed was from MA use.

Participants said that they struggled with terrible "comedowns" from MA and the majority experienced psychotic episodes or paranoia from the prolonged use of MA.

For some participants, the paranoia and psychotic episodes resulted in violence, aggression and getting involved in criminal activity and trouble with the law. Some participants also suffered from mental health problems while they were using MA and were trying to manage this alongside their MA use. Participants also spoke about seeing the first-hand consequences that MA had for other users such as health damage, immorality, illegal behaviour, and suicide. These observations and insights were enough to encourage them to analyse their own lives and assess that, perhaps, that was not the lifestyle they wanted to lead or the type of future they saw for themselves. This motivated them to enter their recovery journey.

Four common themes emerged as being significant to the participants' recovery from MA. These were labelled: *Support*, *Getting Away*, *Treatment* and *Personal Sources of Strength*. The first theme, Support, describes the importance that support from others had in their recovery journey. The second, Getting Away, describes how participants sought to stay away from other users and dealers, moving location, and cutting ties. The third theme, Treatment, incorporates the participants' inner issues, treatment, and education to better understand how these have impacted on their recovery. The last theme, Personal Sources of Strength, discusses individual factors that participants expressed as being helpful to their recovery. Quotations from participants used as examples of the data are presented below.

Support

All participants identified support as being crucial to their recovery. Support was identified as coming from family, partners, and treatment services. For some of the participants, their first step into recovery was surrendering and admitting to family that they needed help with their MA use, after realising that they no longer had control over it and were experiencing negative consequences. This was an important step because, while using MA, many of the participants had distanced themselves from their own families and friends. This also meant that participants felt obliged to tell the truth, which had not always been the case when they were trying to hide their drug use. When they did seek the support, it was on their terms, and at a time that they had determined was right to enter into their own recovery.

Partners and family (particularly mothers) were described as being the main supports throughout recovery. For example, one participant commented:

> Yeah, I remember we'd go up to Mum's. She was a big support. And I'd go there when I initially was coming off, for days and just kind of eat and sleep and eat and sleep. Yeah, probably for a while actually. Like the beginning part, I can't even really remember to be honest. Yeah. And then slowly, my levels started to come right and yeah.. functioning a bit more normal. (Participant F, female)

Having someone who understood the recovery journey they were on and could be there for them through that time provided comfort and support for these participants.

Previous friends did not typically form part of the support, as they had become distanced through the period of MA use due to the user instead immersing themselves into the user community. Nor did former associates from the user community provide support when abstaining and recovering from MA addiction, as the user had needed to cut ties with them in support of their own recovery. Beside family and partners, the other people who provided support, through appropriate treatment services, were health practitioners.

Getting away

All participants said that the main thing required in getting away from MA dependence was to remove themselves completely from the places, people and associates with whom they had become involved while using MA. The majority of participants stated that when they were using MA, they only associated with other MA users and became immersed in the user community. They would often push away family or friends who tried to reach out, or would isolate themselves and barely see those people due to wanting to remain hidden from being identified as a user by their loved ones. The longer the use, the more the dependence grew and the more they became immersed in the user community with others who were also using. As this woman explained: "I had to cut people off, you can't do it otherwise" (Participant A, female).

Emphasis was placed on the need to alter technology and social media so that people from the user community could not find them. For some this meant getting a new phone or deleting contacts and ignoring phone calls. Some deleted Facebook or made sure their profile information and security settings were highly anonymous. Two participants describe the lengths that were required to get away from old connections:

> I changed my phone number and I also have a very private Facebook page with a different name so people couldn't find me. I have kept it low key and cut my ties. (Participant B, male)

> Yeah, staying away from people that I used to know and be friends with. So, I don't answer any calls from any old people that I know. Um deleted all the numbers. And just, just got to refrain, try and stay away from the place where I was using a lot of meth in the area I lived, so I stay well clear of that place. Too many familiar faces. And yeah, not a good place to be for me. (Participant C, male)

Another main finding was the need to remove themselves from the location they had been living in and the places in which they had been using and dealing in MA. For some of the participants this meant having to move location. This often meant moving to stay with friends or family in a different part of Aotearoa New Zealand, or even a different country, and effectively starting over. They saw this as the only way to remove themselves completely from the situation and the triggers. For example:

> We just had to move ourselves away from friends, places, I mean still now we go to town and there are places we remember stuff. So yeah just fresh beginning, just cutting ties with everything and friends and any associations to that lifestyle. (Participant F, female)

Treatment

Treatment was helpful to some participants, but only specific types of treatments were identified as having made a difference for them. The types of treatment that some of the participants sought included inpatient treatment, outpatient treatment and speaking to their general practitioner.

Two participants entered into inpatient (residential) drug and alcohol rehabilitation treatment centres, after not having success with outpatient treatment. Both completed their programmes but lapsed after getting out. They returned to the rehab programmes and achieved abstinence after this. The participants described inpatient treatment as a positive experience for them, one they found to be very helpful:

> I found rehab was really good. That helped heaps. I was a live-in participant for four weeks the first time. And we were educated on side effects of drugs, and what damage can be done to your body and ways of coping before we left. (Participant C, male)

> I just went in there full steam, you know, like I was there to do whatever it took to change my life, you know, and I did when I was in there, for five months. (Participant G, male)

A majority of the participants had outpatient treatment (counselling treatment within the community) but participants described feeling that outpatient treatment had not helped them enough, and they did not feel they had been offered treatment that was specific to their issue with MA dependence, or that had enabled them to enter recovery. As one participant explained:

> They mean well but their stuff's crap. No one's going to come out of the outpatient treatment that's offered with a new life. You know what I mean? Yeah. (Participant G, male)

Some participants spoke to their general practitioners (GP) about low moods and bouts of depression (which can be a cause of long-term MA use). The GP was generally unaware of the MA use and would prescribe medication for these participants. It seems the medication taken alongside MA was not replacing the need for MA or fulfilling its intended purpose, so the participants did not talk about having success with that approach. One participant who was open with the GP about his MA use, was given a diagnosis and placed on medication accordingly, and was able to effectively transition onto the prescribed medication and off the MA.

The participants who did not seek or receive any treatment all spoke about other factors that enabled them to cut down or go cold turkey from the drug, which are covered under the following theme of Personal Sources of Strength as well as factors that were received from the above-mentioned themes.

Personal sources of strength

Participants spoke about personal sources of strength that they had utilised in enabling their recovery journey. These included motivation and strength, fitness, spirituality, and smoking marijuana. All but one participant expressed the pivotal role that motivation and strength play in recovery. This personal attribute is something that is seen as required to be able to abstain from MA, and enter into recovery from dependence on it. The dependence on the drug and loss of control had become clear for some of the participants, so when they decided there was a need to abstain from MA, they expressed that this would not have worked until they made a firm decision, and utilised motivation and strength in order to stick to that decision and see it through. As this woman explained:

> I've just been strong in saying no and wanting my friends to respect my wishes. And just sticking to that "no means no", don't push me. Don't tell me to do something I just said I don't want to do, yeah. (Participant E, female)

For those who did not have treatment, the mental strength and motivation was a crucial factor in successfully entering, and being in, recovery. As explained by one of the participants:

> Nah, I'm kind of stubborn like that. I just went cold turkey, eh. Cos I was still very, it's hard to explain, but very opinionated, and almost arrogant. Like I thought, you know, even though I wasn't high, it was still in my system and I was still really, you know it makes you very full of yourself. You know, you think you're untouchable and that. It's kind of like, I made the decision to do it, so I could make the decision to put it down. (Participant B, male)

Some of the participants explained that physical activity helped distract them from using MA and helped them to feel better mentally and physically. This also linked in with getting outdoors, being in nature and feeling more physically alive and able. They said this helped them to feel healthier and have more hope for their future while their recovery journey progressed:

> Definitely, like keeping active and stuff and going to the gym. I didn't really

> go to the gym too much near the end, because I put on a lot of weight obviously afterward, from being on it and then being depressed and then just sleeping and then just being quite reserved and stuff. Yeah, but still getting out, like we bought bikes and just getting out there and getting active and walking the dog. (Participant F, female)

> Fitness did help a lot. You know, with anxiety and stuff like that. Meth, you know. Later on, in life, I learnt what fitness was. I never had done any fitness. (Participant D, male)

For some participants, spirituality was a part of their recovery journey, one in which they established a connection with oneself or a higher power. One participant expressed the holistic wellbeing and centredness she tried to embrace for her sense of spirituality within, whereas another participant experienced spiritual enlightenment when finding God and Christianity. For those participants, spirituality was a part of their recovery in differing but equally important ways:

> Well, I am quite a generally quite healthy person, so I am into like meditation, naturalness, going out in the bush ya know just really chilling and getting nice quality time. (Participant E, female)

> And I was just going over the past. The past couple of years, that were probably the worst. And, and. And I remember making a bed and I remember actually saying a prayer that night. And I remember saying, "God, I've had enough. I need you to step in. I've had enough." (Participant G, male)

To abstain from MA, and cope with the withdrawal symptoms and psychological cravings for MA, some of the participants said they smoked marijuana as a personal prop. They explained that this could be seen as trading one drug for another but emphasised that it did help them. As explained:

> I found smoking a lot of weed helped [to abstain from MA]. I've heard that about other people as well. When they come off, that weed really helps. I mean, maybe replacing one for the other but it does sort of help with the rigidness, the anxiety, when you have the jitters and can't sit still and feel agitated. Have a few puffs and it helps with that. (Participant B, male)

Some participants also smoked cigarettes heavily in the initial stages of abstaining from MA but did not say that cigarettes helped with their withdrawal symptoms in the same way as marijuana did. The majority of participants who went cold turkey without treatment emphasised the role marijuana had in helping them with their recovery, over and above participants who were in treatment.

Summary of themes

There were disparate ways of coping described by the participants and it was discovered that recovery is multi-dimensional. Whilst the participants were on MA, they experienced negative consequences; entering recovery required them to try to understand the reasons behind their MA misuse such as escape from their personal issues, or enjoyment of the effects of the drug. Often drastic measures were needed in order for people to get away from MA use, such as moving location entirely and cutting ties with all former associates. The participants were at varying stages of their recovery processes, all identifying as being *in recovery* and having abstained for six months and more.

Discussion

Many theories and models exist to explain the phenomenon of drug dependence, but it does remain a subjective human experience. There is a shortage of qualitative research aimed at understanding the lived consumer perspective of recovery from MA dependence but the findings of this study are consistent with the multiple overseas studies that suggest that abstinence is an important aspect of recovery, but not sufficient (Bloom, 2016; Costello et al., 2018; Halkitis, 2009; Shinebourne & Smith, 2010). In this study, four significant themes described the general experiences of the participants: Support, Getting Away, Treatment, and Personal Sources of Strength.

Families were the main source of support for these participants as they recovered from their MA use. Despite the participants having become distanced from all previous social connections whilst they were on MA and immersed in the user community, family members, particularly mothers, provided essential support during recovery. Treatment initiatives could benefit from helping individuals reconcile with families and allowing access to support networks, to encourage successful recovery. Individuals who do not have close support could be at more risk of not successfully abstaining from MA or relapsing and returning to the user community. Further research would be useful to enquire into the close support needs of those who do not have supportive family members.

All participants emphasised that, to abstain from MA and enter recovery, it was essential to get away from the user community and the associations made through it. The companionship gained through the user community meant it was not easy for some of the participants to no longer associate with those people. In the case that individuals are struggling to get away from MA dependence within their community or region, overseas studies suggest that residential rehabilitation centres would be beneficial—especially for MA users who have unstable or no accommodation, poor or absent social supports, co-existing mental health problems or have had failed attempts in the community (McKetin et al., 2018).

Treatment was a theme that was discussed with the participants, but only some found the treatment provided was helpful. More specifically, it seemed that in-patient treatment was deemed helpful, but outpatient treatment was not. The two participants who entered in-patient treatment spoke highly of the support they received from the practitioners and treatment providers within the rehabilitation programmes they experienced. The support they received included emotional support, psychological support, and knowledge about addiction and recovery. There is a barrier in Aotearoa New Zealand because treatment for MA dependence is not easily available. There are a limited number of rehabilitation centres that provide treatment specifically for MA dependence and these have criteria to meet before being accepted for entry, with possibly waiting lists, and financial payment required.

Those who did not have any treatment relied more heavily on their own personal strengths, such as *motivation* to be successful. There was a determination in some of these individuals that meant they could abstain from MA, without treatment, but they created a sense of being in the world that was conducive to getting away from their lifestyle, whilst finding other approaches that helped them. Drawing on their own resources gave participants a sense of personal self-worth and confidence that has been found to support recovery in previous studies (Bloom, 2016; Costello et al., 2018). This sense of personal strength may be an important component of ongoing recovery.

Limitations

The methodology allowed the first author to gain knowledge on the participants' lived experience of the phenomenon of drug dependence recovery and interpret their lived experience into findings. The quality of the data gathered in qualitative research is highly subjective. Having individual perspectives and interpretations can lead to detailed findings but these may also be interpreted in different ways. As there was just one researcher involved with the data collection and analysis in this study, additional research is required to validate the findings.

Overseas studies have also found aspects including daily structure, increased self-worth and confidence, employment, and life satisfaction as areas that were part of recovery (Costello et al., 2018; Radcliffe & Tompkins, 2016). These aspects were not among the main findings of our study. This may be due to the small sample size; further research with a wider range of participants will contribute to our understandings of recovery needs.

The small sample size may not reflect important differences between ethnic groups, age groups, or social groups and this limitation also calls for further research to develop these understandings. Because there is a shortage of research on MA treatment and recovery within Aotearoa New Zealand, further research conducted within the country would be beneficial.

Conclusions

This research provides first-hand insight into the approaches, strategies, and treatment that the seven participants deemed helpful for their recovery. The lack of knowledge on appropriate treatment and recovery for MA in Aotearoa New Zealand is a concern, and this research should provide a valuable base of information on which further research can be conducted.

Accepted 31 May 2021

Published 1 September 2021

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Mitigating barriers to addiction recovery in Aotearoa New Zealand: A lived experience perspective

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ABSTRACT

INTRODUCTION: The New Zealand government's health surveys consistently identify that alcohol and other drug (AOD) addiction is an issue for New Zealanders. However, there is a lack of qualitative research on the lived experiences of health and social service professionals who have previous or current experience of AOD addiction in Aotearoa New Zealand.

METHODS: A constructivist approach was utilised, semi-structured interviews were conducted, and subsequent thematic analysis identified themes highlighting what contributed, and created barriers to, participants' successful AOD addiction recovery.

FINDINGS: Identification of nine themes illustrated that the barriers to AOD addiction recovery in Aotearoa New Zealand experienced by the research participants were systemic and preventable.

CONCLUSIONS: The recommendation of this research is that the lived experience of people who have experienced AOD addiction in Aotearoa New Zealand is better utilised in order to mitigate, and enhance, identified barriers, and contributors to, successful AOD addiction recovery.

KEYWORDS: Addiction; New Zealand; social work; lived experience; recovery

Existing Aotearoa New Zealand literature lacks qualitative research on alcohol and other drug (AOD) addiction by utilising the lived experience of people with AOD addictions. Participants in this research had all experienced AOD addiction and recovery, and then gone on to become qualified health and other social service professionals. The purpose of this research was to understand what contributes, and creates barriers to, successful AOD addiction recovery, subsequently addressing a gap in existing literature that identifies AOD addiction as a significant issue for New Zealanders and impacting negatively on holistic wellbeing for individuals, families and communities (Ministry of Health, 2015).

Available data on AOD use in Aotearoa New Zealand identifies AOD addiction as an issue, however it is inconsistent, lacks detail, and is dispersed across multiple domains of publicly accessible information. With some of the most current resources quoting data that are outdated, for example: the National Drug Policy 2015-2020 which cites data from 2007 (Ministry of Health, 2015).

The Annual Data Explorer publishes data gathered in the New Zealand Health Survey on an annual basis. An analysis of the data showed that recreational cannabis use had steadily increased over the past eight years, from 8% to 15%. Alcohol was the most used substance with four out of five adults in

AOTEAROA
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WORK *33(2)*, 45–55.

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Aotearoa New Zealand having used alcohol in the past year. Adults who had used alcohol problematically in the past year had decreased slightly from 26.2% in the 2015/16 survey but has remained relatively consistent since then; rates of problematic alcohol use in the past year were 24.9% (as at the 2018/19 survey).

Methamphetamine use in Aotearoa New Zealand continues to rise albeit at comparatively much lower levels than alcohol and cannabis with 1% of adults having used methamphetamine in the past year. Of significance is the difference in prevalence rates for Māori as opposed to the rest of the population with problematic alcohol consumption in the past year being almost double the rates of the wider population; and methamphetamine use more than double that of the wider population. (Ministry of Health, 2019).

A second source of data was the National Wastewater Testing Programme, run by the New Zealand police from November 2018 to July 2019. Due to the brevity of this programme it is difficult to establish patterns of drug use in Aotearoa New Zealand from the data. For the duration of the programme, methamphetamine was the most used drug with approximately 15kg of methamphetamine being consumed per week; MDMA was the second most common drug of use with a maximum of 7.9kg being consumed each week (New Zealand Police, 2020).

Additionally, the New Zealand Drug Harm Index estimates that the total harm from drug use in Aotearoa New Zealand equates to $1.8 billion (McFadden Consultancy, 2016). The National Drug Policy 2015–2020 also states that 12% of people who try substances will develop a substance use disorder (Inter-Agency Committee on Drugs, 2015); and that people using substances are more likely to have physical health issues such as Hepatitis C; have greater involvement with statutory agencies such as Oranga Tamariki; experience other social harms such as being involved in domestic violence incidents or engaging in behaviours such as drinking heavily whilst pregnant (Ministry of Health, 2015).

Existing data, albeit insufficient and inconsistent, do identify AOD addiction in Aotearoa New Zealand as a substantive, multi-faceted issue. AOD addiction is not, however, a new issue and additionally, is an issue that exists within a long history of moral and political narrative which has influenced if, and how, people experiencing AOD addiction access support. An understanding of the history of AOD issues in society provides a foundational understanding of the barriers to AOD addiction recovery already identified in the literature.

Background and context

Responses to AOD issues in society began with the moralisation of substance users, followed by criminalisation, and eventually leading to a medicalisation of substance use, which was posited as a brain disease and responded to by the medical sector. This finally culminated in a new age of AOD addiction epistemology that recognises the varied and complex factors that lead to the development and maintenance of a substance use disorder, requiring diverse holistic treatment responses tailored to each individual in order to meet their unique needs (Patil & Giordano, 2010; Webster & Bosmann-Wātene, 2003).

In Aotearoa New Zealand, addiction is largely still a pathologised phenomenon (Csiernik & Rowe, 2003) and classified as a psychological disorder, using similar classification systems that define other mental health disorders (American Psychiatric Association, 2013; World Health Organisation, 2005). Critics of this perspective identify the weaknesses of reducing a complex phenomenon to a discrete set of symptoms with clear diagnosis, without adequate consideration of socio-cultural factors that an individual may be facing (Patil & Giordano, 2010); especially that person's cultural worldview (Webster & Bosmann-Wātene, 2003).

International research shows the impact that the current medical model has on the individual engaged in treatment; people being more likely to internalise stigma (Wiens & Walker, 2015) in response to a treatment model that poses addiction as a symptom of internal dysfunction (Adams, 2016). This leads to outcomes such as exhibiting less agency over their alcohol use (Wiens & Walker, 2015), highlighting the need to better align existing medical models with bio-psycho-social models. Further integrating sociologically based professions such as social work into the existing system would be an ideal option to achieve this change.

The social work perspective challenges views of addiction as solely an issue of internal dysfunction, instead recognising that a person is constantly engaged in transactional processes that take place between the person and the systems they interact with. The social work perspective would consider that it is these interactions that can become problematic and provide a basis for problematic biological, psychological or sociological functioning (Corcoran & Walsh, 2010). This perspective best aligns with government guidelines on addressing AOD issues in New Zealand, with the National Drug Policy acknowledging the need for a holistic view of AOD addiction that not only responds to an individual but also their family, environment, community and employment (Ministry of Health, 2015).

Literature review

The literature review provided a better understanding of the existing literature on AOD addiction, both internationally and in New Zealand. Subsequently, no research was identified that answered the research question. However, the review identified the pervasive and systemic barriers to AOD addiction recovery helping to shape the interview questions designed to answer the research question: "What works in AOD addiction recovery?" The scope of the review included all research articles on AOD addiction between 2008 and 2018—also included were any seminal texts on AOD addiction, even if they were published outside of the review timeframe.

International and Aotearoa New Zealand based research identifies stigma as a barrier to AOD addiction recovery and, of concern is that stigma is often perpetuated within support services (Brener et al., 2010; Butler & Sheridan, 2010; Clarke et al., 2016; Csiernik & Rowe, 2003; Deering et al., 2012; Gunn & Canada, 2015; McCray et al., 2011; McKim, 2014; Roussy et al., 2015). For example, Aotearoa New Zealand research identified that stigma is perpetuated by staff attitudes in Opioid Treatment Services (Deering et al., 2012). Research investigating the attitudes of staff in primary health organisations also identified staff attitudes that perpetuated stigma. Research participants expressed beliefs that the drug misuse was the patients' "…own fault, that they are dirty people" (Butler & Sheridan, 2010, p. 4).

Stigma was identified as a complex and pervasive barrier to AOD addiction recovery. Stigma was not only experienced when people were accessing health services but was also perpetuated in wider society, within peer groups, and was internalised by people experiencing AOD addiction. Stigma reduced the likelihood that people would seek help for an AOD addiction, and when they *did* seek help, they were less likely to engage successfully in AOD treatment.

Policy responses were also identified as a primary barrier to successful AOD addiction recovery; research both internationally and in Aotearoa New Zealand (Clear & Schrantz, 2011; Drake et al., 2009; Miller & Alexander, 2016; Pratt & Clark, 2005) identified the ineffectiveness, and subsequent harm, of criminalising people experiencing AOD addictions. A recent Aotearoa New Zealand report stated that prisons have been shown to be a recruitment ground for further criminal and gang involvement often linked to the illicit drug trade; damage a person's employment, housing and familial prospects; and people in prison have high rates of undiagnosed and untreated mental health and addiction issues (Office of the Prime Minister's Chief Science Advisor, 2018).

Additionally, existing literature identified specific populations that face unique harms from AOD addictions which are inadequately addressed within existing systems. These populations were: Māori, youth, people with co-existing mental health issues, women, and families of those with AOD addiction issues.

In Aotearoa New Zealand, Māori are Tangata Whenua and have unique rights to tino rangatiratanga under the Treaty of Waitangi, a document that has been integrated as the foundation of multiple pieces of government legislation including the New Zealand Public Health and Disability Act (2000). Despite efforts to increase equity in social and health outcomes (Ministry of Health, 2008), Māori continue to experience higher rates of negative outcomes in regard to AOD addiction (Marie et al., 2008), including that Māori are more likely to be addicted to substances; and face greater harm from those addictions (Lyons & Willott, 2008; Marie et al., 2008).

Aotearoa New Zealand research identified that multiple risk factors for youth in regard to substance misuse have increased in recent years with access to alcohol being easier after the "deregulation of the commercial environment, liberalisation of marketing controls, and the lowering of the age of legal purchase" (McCreanor et al., 2008, p. 939). These changes have coincided with a developing synthetic drug market which is pertinent to youth populations because most users of synthetic drugs are young adults aged between 12 and 24 years old (Davis & Boddington, 2015). Despite youth being a targeted group for AOD support services, "young people seldom seek help for AOD problems and treatment services generally meet their needs poorly" (Christie et al., 2010, p. 406).

In Aotearoa New Zealand, approximately 12% of people will have an AOD addiction in their lifetime and 70% of these people will have co-existing mental health challenges (Ministry of Health, 2012). International research identified that, for people needing psychiatric medication, but still using illicit substances, the lack of consideration given to their complex contextual factors created an inadequate and at times dangerous pharmaco-centric response. Additionally, in the wider mental health sector, staff attitudes created barriers to service utilisation (Butler et al., 2011; Christie et al., 2010; Schlosser & Hoffer, 2012; Staiger et al., 2011).

Women face disproportionate harm from substance misuse (Simpson & McNulty, 2008) compounded by higher levels of stigma experienced by women, who are considered by wider society to have breached their traditional gender-defined roles by misusing substances (Lyons & Willott, 2008; McCray et al., 2011; Reid et al., 2008; Sallmann, 2010). Women experiencing AOD addiction are more likely to have a drug using partner; are more likely to share injecting equipment; are at increased risk of HIV and Hepatitis C infection; are more likely to be involved in sex work; have higher vulnerability to psychiatric co-morbidity including suicide attempts, eating disorders and post-traumatic stress disorder due to sexual and physical violence; and are more likely to have their children removed by child protection services (Simpson & McNulty, 2008).

The role of families in AOD addiction and recovery emerged as a dominant theme. A subsequent review of the literature identified that children exposed to problematic drinking by parents have more behavioural and emotional issues, that there is a lack of family support services, and that families provide the highest levels of recovery capital—recovery capital being defined as emotional support, or support with practicalities such as housing and finances (Copello et al., 2010; Templeton et al., 2007; Tunnard, 2002).

The AOD sector was a key component of existing systems in which gaps were highlighted across the wider AOD workforce regarding existing workforce skills including an ability to be reflexive and responsive in their practice, and able to undertake holistic assessments that inform collaborative individualised treatment plans. Of interest, however, is that existing literature identified that the peer workforce was consistently named as an important contributor to successful AOD addiction recovery.

The literature identified that the defining of AOD addiction and subsequent treatment responses were primarily influenced by which profession was assessing and responding. This contested nature of the definition of AOD addiction, and subsequent treatment responses further perpetuated systemic inequities as, in Aotearoa New Zealand, the medical model of addiction is arguably still the dominant paradigm. Current literature, however, calls for a holistic approach to AOD addiction treatment, recognising the unique individual life experiences that lead to the development of an AOD addiction and requirement for an individually tailored, holistic treatment plan.

The literature review not only confirmed the validity of the research question but also assisted the formulation of an emergent hypothesis of what works in AOD addiction recovery. This hypothesis influenced the interview process by providing a foundational understanding of existing barriers to AOD addiction recovery, including: that stigma is pervasive and creates significant barriers to AOD addiction recovery; that existing policies compounded harm caused by AOD addiction; specific populations were not adequately supported; and finally, that the lack of staff training and skills in the AOD workforce created barriers to AOD addiction recovery.

Ethical issues

The ethical foundation was designed to ensure that the research was carried out in a way that was "respectful, humane, and honest" (Cohen & Crabtree, 2008, p. 333), as well as being empathetic, collaborative and grounded in the notion of service (Cohen & Crabtree, 2008) as, ultimately, social research faces the task of conducting research to create positive social change (Aotearoa New Zealand Association of Social Workers [ANZASW], 2007; Arksey & Knight, 1999).

Small potential risks were identified including harm to participants when being asked to recount potentially traumatic experiences; harm to the researcher when receiving this information; and confidentiality of participants. The utilisation of existing external support systems was considered a possible solution for both participants and the researcher should any issues arise during the interviews. Confidentiality of participants was maximised by using locks on storage cabinets and password-protected devices, and pseudonyms. Cultural supervision was utilised to ensure that the interests of Māori were a key consideration throughout the research.

Informed consent was given by participants signing a consent form after reading the information sheet and having the opportunity to ask questions regarding the research. Participants were able to withdraw from the study at any point up until the research was published and had the opportunity to review and amend their interview transcripts. The researcher's name, qualification and job title were openly disclosed in the information sheet to mitigate any conflict of interest from the researcher knowing the participants in a professional or personal scope.

Ethics approval

A full ethics application was submitted to Massey University Human Ethics Committee

(MUHEC), was considered by the Human Ethics Southern A Committee, and final confirmation of ethics approval was given on the 17th August 2017. The ethics application process was completed under the guidance of academic supervisors Michael Dale and Lareen Cooper. This research adhered to the Massey University Code of Ethical Conduct for research, teaching and evaluations involving human participants (Massey University, 2015).

Methodology

The ontological beginnings of this research were based in the "researchers' assumptions, existing knowledge, and reasons for engaging in research" (Starks & Brown-Trinidad, 2007, p. 1372). An exploration of these assumptions was necessary as the researcher believed that research is always a subjective process (Watson, 2005). These assumptions were twofold, firstly being based in the social work profession which respects the unique, rich and diverse life experiences of people (Nelson, 2012) and the systems they operate in (Engel & Schutt, 2005, p. 11). With the goal of social work research being "not to come up with conclusions that people will like, to find answers that make our agencies look better or that suit our own personal preferences" (Engel & Schutt, 2005, p. 18). Secondly, the researcher was a New Zealand / European woman who had personally experienced AOD addiction and recovery in Aotearoa New Zealand and gone on to be a qualified and registered social service professional. Ultimately, the primary purpose of this research was to value, respect and learn from people who were AOD professionals with lived experience of AOD addiction and recovery.

The epistemological foundation and corresponding research paradigm for this research project was constructivist, and the methods employed were qualitative. Constructivism being a process that posits the researcher as an observer in the world, transforming everyday practices into a series of representations, allowing for an analysis of these practices from a naturalistic approach and attempting to understand the meanings that people bring to them (Alvesson & Skoldberg, 2009). The use of constructivism also filled a gap in local research highlighted in the literature review which showed a plethora of locally led positivist addiction research on AOD addiction; but limited qualitative research. Various researchers highlight the dominance of positivism in health-related research (Broom & Willis, 2007; Cohen & Crabtree, 2008), Prasad states that "this hijacking of routine problem solving by technical experts has some serious and undemocratic ramifications for society" (2005, p. 142), because only those with a certain level of knowledge are able to contribute to knowledge generation. Inadvertently, those who are marginalised in society, but who hold unique and valuable knowledge about social issues, will not have the ability to add their stories and experiences to academic literature (Prasad, 2005).

The method of purposive sampling was used to recruit participants (Broom & Willis, 2007). Participants must have had lived experience of AOD addiction, treatment and recovery in Aotearoa New Zealand and been employed in the AOD sector in New Zealand within the last five years. Specific demographic data regarding ethnicity were not collected—this is recognised as a potential limitation of this research because consideration of the influence of culture on AOD addiction recovery was not specifically considered in the interview schedule. An advertisement was placed in the Matua Raki addiction sector bulletin, potential participants were able to email the researcher directly and were sent the information sheet via email. Subsequently, an unintentional snowballing effect took place whereby interested participants notified other potential participants about the research. The outcome of participant recruitment was that eight research participants were recruited. One-on-one, hour-long, semi-structured interviews were conducted face to face, via Skype, or phone.

Semi-structured interviewing was chosen as the primary data collection method because it provided “a means for exploring the points of view of … research subjects, while granting these points of view the culturally honoured status of reality” (Shaw & Gould, 2001, p. 143). It allowed the researcher to observe patterns across the group’s behaviour (Broom & Willis, 2007); created a naturalistic conversational setting and one whereby only minimal steerage during the interview was required; this allowed the participants to discuss the aspects of the broader topic that were important to them (Arksey & Knight, 1999). The interview schedule was flexible so that questions could be added or subtracted according to each successive interview outcome (Rubin & Babbie, 2013).

Interviews were recorded using an audio recording device and transcribed verbatim, notes were written as soon as possible after the interview ended—this was done to capture extra details from the interview such as mood and body language that the audio recording was not able to capture (Arksey & Knight, 1999); data were then analysed using inductive thematic analysis. At all stages of the thematic analysis, a research journal was utilised as this provided a reflective space where personal assumptions about emergent themes could be unpacked and the patterns and broader thematic story in the data could be considered. A thematic map emerged during the data analysis which consisted of barriers to AOD addiction recovery, and contributors to AOD addiction recovery.

Findings

The findings are presented in this article under two subheadings: Barriers to recovery, and Contributors to recovery. Participants had a range of personal and professional experiences with ages ranging from 22 to 50 years old and having been in AOD addiction recovery from 5 to 40 years. Participants had experienced AOD addiction, treatment and recovery in Aotearoa New Zealand and other countries. Participants had experienced addiction to a range of drugs including, alcohol; amphetamines; opioids; cannabis; ecstasy; LSD; and pharmaceutical drugs such as Temazepam®. Participants held qualifications such as: Bachelor’s degrees; Postgraduate diplomas; Master’s degrees; and PhDs. Participants had been employed in non-government organisations (NGOs); the Corrections System; AOD inpatient rehabilitation services; hospital and acute care settings; national leadership positions; in self-employed counselling roles; and as lecturers in Aotearoa New Zealand universities and polytechnics.

Barriers to recovery

The results in this research identified barriers to AOD addiction recovery. With a primary barrier being participants’ experiences of stigma in their communities, in the workplace and within peer recovery groups. Participant three expressed disbelief at how pervasive stigma still is, “there is a real lack of understanding, lack of compassion for people with addiction issues.”

Participants also found that stigma prevented them from being able to define their own recoveries and lives. Some participants led fragmented, dual lives to avoid stigma. This added stress into their personal and professional lives. Participant six hinted at the repercussions she would face if she were to disclose her lived experience in the workplace:

> I am still most comfortable when I am in an NA meeting or with sex workers because it is still my stronger identity so there is always this work that I do about managing my identity. Because I never reveal in these settings my true identity because they are not forgiving.

Participants also found that working in peer roles created barriers to wellbeing in AOD addiction recovery, being stigmatised by colleagues caused participants to lose passion for their roles. As described by participant four, "it has taken its toll there have been times that I have thought, I cannot do this."

Participants also discussed their perceptions of systemic barriers in New Zealand, starting with the lack of AOD education in secondary schools. Participant two described the lengths she went to to source her own information on AODs as she was dissatisfied with the abstinence-based education taught at her college—a process that unintentionally led (by searching for information online) to her finding out how to combine various drugs to maximise their effects.

The failures of welfare support systems were also discussed, participants considered Work and Income case managers and child protection social workers to be ineffective when working with people experiencing AOD addictions. In addition, current welfare and housing systems were considered complex to navigate, with people not being able to access support to meet their basic essential needs (income and housing)—both being considered as vital in creating a successful foundation in AOD addiction recovery. Barriers to AOD addiction recovery had also been caused by the AOD sector itself through a lack of diversity in AOD interventions; an overfunding of cost-effective methods such as brief interventions; the complex structure of the AOD sector and subsequent difficulties navigating the sector.

The criminal justice system was also identified as a barrier to AOD addiction recovery in Aotearoa New Zealand. Participants recounted instances of being intentionally targeted by NZ Police for menial infringements due to being known substance users. Participants advised that the Corrections system failed to provide holistic ongoing support for people with AOD addictions, often sending people back to unchanged, unhealthy environments. Participants expressed concern that people were being locked into cycles of crime, violence and AOD addiction due to a lack of systemic change in Aotearoa New Zealand. An issue further perpetuated by the criminalisation of people using substances.

Current funding models in Aotearoa New Zealand were considered a barrier due to their focus on cost-management, and subsequent inadequate funding increases comparative to increasing demand for services leading to increased waiting lists, limited staff capacity to provide care, and limited resources. Service collaboration and holistic care were not considered to be supported by existing funding models. Participant four described the impact that the Request for Proposals (RFP) process had on her service:

> The silo thinking, the people not talking to people, so one of the things I have watched our service do really well is build relationships with other organisations who see youth as well. There were some issues to resolve initially because I think people thought we were taking money out of the sector.

Furthermore, participants also identified barriers to AOD addiction recovery created by OST services; OST was viewed as punitive, which left participants too scared to be honest about their substance use. Participants also expressed that the over-medicalisation of OST services had taken away holistic recovery support options, stating that OST services now play an active role in encouraging people to stay on OST medication, even if a person decides that is no longer their recovery goal. Participant five recalled his historic personal experiences, as well as a friends' current experience:

> … he is coming off methadone, the clinic just tried every technique and manipulation I would say by the psychiatrist with the help of the so-called counsellors, they are not really counsellors they are just case managers, to keep him on the dose that he is on. Like they do not like people coming off and they say "oh it does not really

> work and you should just stay on it a bit longer," which is the opposite of "well done that is really amazing how can we support you to come off?"

Participants recalled that the fracturing of the AOD sector that occurred between professionals who held opposing ideologies (harm reduction vs. abstinence), created conflict within the sector, this conflict created barriers for people trying to access the type of AOD addiction support that was right for them. Participant seven recalled the impact of conflict within the AOD sector:

> When harm reduction came in there was a polarisation in the sector it was either harm reduction or abstinence, and there was no matching of the person in front of you to the right way. What happened was that a lot of people went underground.

The women who participated in this research had unique experiences of trauma in AOD addiction, relationships and motherhood that made it more difficult for them to access and remain in AOD addiction treatment and recovery. Participant four described her traumatic experience with childbirth and being locked in seclusion almost immediately after giving birth:

> For the first four days of my daughter's life I did not get to see her, they would not let me, they tranquillised me they stuck me in seclusion, I just remember screaming for days, probably about 48 hours, please let me see my daughter.

Interestingly, participant experiences, both personal and professional, identified barriers that were wholly systemic. These included the pervasive nature of stigma, which was perpetuated by wider society, by support services, by peers, by colleagues (even once participants had entered recovery), and interestingly, as internalised stigma which prevented participants from contributing valuable knowledge. Organisational barriers were perpetuated by welfare services, child protection services, the AOD sector, the criminal justice system, existing funding models and underfunding of the AOD sector, OST services, the conflicting paradigms within the AOD sector, and within service responses to women experiencing AOD addiction.

Contributors to successful recovery

What was also identified in the results of this study were the factors that contributed to successful AOD addiction recovery. Participants stated that it was the ability to define their own recovery that contributed to their success and this subsequently led to the development of a redemptive self. Enabling them to gain employment that was meaningful to them by giving back to people who needed support, in turn reinforcing their personal recovery.

Participants highlighted the components of the AOD workforce that contributed to AOD addiction recovery. One component was an AOD professional who could build an effective therapeutic relationship with participants. For some participants this was an AOD professional with lived experience of AOD addiction, adding a dimension of trust and rapport that could not be emulated by AOD professionals who did not have lived experience.

Career progression also contributed to AOD addiction recovery, often beginning with entry into tertiary study and continuing once employed in their chosen profession. Participants recalled being supported and respected by colleagues and managers, which further contributed to their successes. Participants also accredited their own internal processes and external supports such as good boundaries, ethics and supportive friends and families, as a key aspect of their continued success in AOD addiction recovery, especially when working in professional roles became challenging.

Other supports that contributed to successful AOD addiction recoveries included: support provided by community based social services; access to income and housing;

having family and friends that supported them in their AOD addiction and recovery, even though these support people did not always understand their AOD addiction or how best to support them; support groups run within AOD support services; twelve-step groups; residential treatment; and gender-specific support services.

Discussion

The most recent workforce development plan for the AOD sector states that healthcare must be led by the people accessing services (Ministry of Health, 2018). However, research in Aotearoa New Zealand (Deering et al., 2011; Deering et al., 2012) and internationally (Bassuk et al., 2016; Boisvert et al., 2008; Brener et al., 2010) supports participants' experiences whereby they were not always empowered to lead their treatment and recovery process. Each participant was able to recall times when they had not been at the centre of care planning and times when they had been. It was the times when they had led their AOD addiction recovery that led to successes.

The barriers to AOD addiction recovery identified in this research are systemic and preventable. There is arguably a greater role for social work in the AOD sector in order to mitigate these barriers and enhance the contributors to successful AOD addiction recovery. Navigating the AOD sector is a confusing process, fraught with stigmatising experiences, and people with AOD addictions would benefit from having social work support to walk alongside them, providing advocacy support when needed, to ensure that the person is able to access holistic assessment and individualised treatment options. Additionally, the role of the lived experience practitioner cannot be overlooked here. While participants in this study valued the support of professionals with lived experience of AOD addiction, existing systems do not support professionals to safely disclose their lived experience and integrate this into their practice.

Conclusion

This research highlighted that people with AOD addictions are the experts in their own lives. These people are extraordinarily resilient and resourceful and, if given the right support, can harness these strengths and engage in recovery and life, in a meaningful and purposeful way. People who have been the most excluded go on to challenge, resist and change Aotearoa New Zealand society and systems in order to ensure those coming behind them face fewer barriers to AOD addiction recovery than they did.

Limitations

The limitations relate to the small sample size and subjective nature of the research results. Additionally, seven out of eight participants had been in AOD addiction recovery for more than 15 years, meaning that current issues with AOD addiction in Aotearoa New Zealand were not necessarily captured. Inherent ethnocentrism due to the researcher's NZ/European ethnicity is also recognised as a limitation. Further research into the lived experience of Māori professionals who are in AOD addiction recovery would be useful, given the current context of AOD addiction disproportionately harming M*ā*ori communities and ongoing inequities related to colonisation and subsequent removal of tino rangatiratanga from tangata whenua in Aotearoa New Zealand.

Accepted 16 September 2021

Published 1 September 2021

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R.D. Laing's The *Divided Self: An Existential Study of Sanity and Madness* (1965)

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In its February issue this year, the *London Review of Books* carried a review of *Hidden Valley Road: The Mind of an American Family* by Robert Kolker (Friedell, 2021). The book is a study of the Galvins of Colorado Springs, apparently described by one doctor as "the most mentally ill family in America". Of the 12 children born to Don and Mimi Galvin between 1945 and 1965, five were later diagnosed with schizophrenia. A sixth seemed well enough until, aged 22, he shot and killed his girlfriend and then himself—before he had been given any diagnosis. Kolker's book explores the family's history, reviews a range of theories about the nature of "schizophrenia" (more on the inverted commas below) and ends by pointing optimistically to an experiment now under way of giving pregnant women high doses of choline, a nutrient found in eggs which, apparently, is essential to foetal "brain scaffolding".

Lack of choline may, or may not, have been a contributory factor to the dreadful mental distress experienced by the Galvin children. What some may see as more pertinent, however, is the disclosure by Donald, the oldest child, to his mother a few years before his first psychotic breakdown that he and some of the other children had been sexually abused by a priest who regularly visited the house.

Debates over the causes, nature and treatment of the condition designated "schizophrenia" by the Swiss psychiatrist, Eugen Bleuler, in 1908 have raged since it was first identified some year earlier by Bleuler's German counterpart and the founder of modern biomedical psychiatry, Emil Kraepelin. Kraepelin believed that what he was observing was a form of brain disease which particularly affected young people, "a precocious madness", and had called it *dementia praecox.* However, it was Bleuler's re-branding which won out. Since then, "schizophrenia" (and, in this review, I am following the example of the writer and former mental health nurse Nathan Filer in using inverted commas to keep us mindful that there exist alternative narratives; Filer, 2019) has been seen as the epitome of "severe mental illness" or "madness". For most of that time, hegemony over both the understanding and the treatment of the condition has been exercised almost exclusively by the psychiatric profession. Other professions, such as social work or clinical psychology, may be seen to have some contribution to make towards the amelioration of "less serious" forms of mental distress such as anxiety and depression (though the trend in recent decades has been in the opposite direction and towards the increasing medicalisation of *all* forms of mental distress, including grief and bereavement). But "schizophrenia", with its characteristic "positive" symptoms of visual or auditory hallucinations and delusional ideas and "negative" symptoms such as lack of motivation and emotional flatness has been the psychiatric specialism *par excellence*. So it is perhaps not surprising that it was this condition which should have drawn the attention, and subsequently became the life work of one indisputably precocious young Scottish psychiatrist in the 1950s, Ronald David Laing, and the subject of his first book, *The Divided Self*: *an*

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Existential Study of Sanity and Madness (Laing, 1965).

Laing was born in 1927 in Govanhill, a respectable working-class suburb on the South Side of Glasgow (this biographical section draws on an earlier publication, Ferguson, 2017). His father worked as an electrical engineer with Glasgow Corporation, his mother, like most women at the time, was a housewife. Laing was a bright boy who attended a local fee-paying grammar school. According to his own account in the book *Mad to be Normal*, based on conversations with Bob Mullan, he spent a huge amount of time in his late teens in the local public library which seems to have had a particularly good European philosophy section (Mullan, 1995). There he read Nietzsche, Kierkegaard, Sartre and other existentialist philosophers. As a medical student at Glasgow University in the late 1940s, he broadened his reading to include Marx and Lenin and began what he called his "first literary project" which was to write a biography of the great Scottish revolutionary socialist, John McLean (sadly, never completed).

This was the period of National Service in the UK when all young men were required to spend time in the army and on graduating from Glasgow University in the early 1950s, Laing joined the Royal Army Medical Corps and was sent to a British Army Psychiatric Unit at Netley in Hampshire. Netley seems to have been a particularly grim place, but it confirmed Laing in his intention to become a psychiatrist. After leaving the army, he took up a post at Gartnavel Royal Hospital in Glasgow before becoming a senior registrar in Glasgow University Department of Psychiatry at the Southern General in 1955.

In *Mad to be Normal*, Laing gives a flavour of the treatments on offer within psychiatric hospitals as he found them at this time. Insulin coma was the standard practice everywhere with electric shocks sometimes being given in the middle of the coma. Both in the army and at Gartnavel, the range of treatments ranged from the pre-tranquillizers of paraldehyde and barbiturates and bromides to electric shocks and insulin and lobotomy.

At this time, as a young psychiatrist, Laing was involved in all of these practices, but was beginning to have doubts. In his autobiography *Wisdom, Madness and Folly*, he later wrote:

> I was just beginning to suspect that insulin and electric shocks did more harm than good. In fact I had begun to question my own sanity, because I was beginning to suspect that insulin and electric shocks, not to mention lobotomy and the whole environment of a psychiatric unit, were ways of destroying people and driving people crazy if they were not so before and crazier if they were. But I had to put it to myself – maybe I was completely mistaken. How could the whole of psychiatry be doing the opposite of what I assumed psychiatry was about – treating, curing if possible, arresting the course of mental illness? (Laing, 1985, p. 106)

Laing's first attempt to address these concerns and articulate an alternative way of understanding "schizophrenia" came in *The Divided Self*, originally published in 1965, but written some years earlier and based on his experiences in Netley and in Gartnavel. As he himself noted in a later self-criticism, the book does not represent a complete break with the then dominant ways of understanding severe mental disorders. So, for example, in contrast to his later work, he still talks of "schizophrenia" as a distinct psychiatric condition. In addition, written while he was working at the Tavistock Clinic, the home of British psychoanalysis, the book shows the influence of more senior colleagues such as Donald Winnicott, for example in the distinction Laing makes between the "true" self and the "false" self. In one key respect, however—its grounding in existentialism—the book was highly unusual in a psychiatric world dominated by biomedical psychiatry on the one hand and varieties of Freudianism on the other. As Peter Sedgwick, one of Laing's most perceptive critics, noted:

> One of the most difficult of philosophies was brought to bear on one of the most baffling of mental health conditions, in a manner which, somewhat surprisingly, helped to elucidate both. Existential philosophy, with its reputation of introverted cloudiness and speculative indiscipline, was here set working in a concrete, practical and socially urgent context—the understanding of the mentally ill. Conversely, a major form of psychosis was elucidated as a mental system possessing lawful shape and sequence, comprehensible in existential terms as the outcome of rational strategies adopted by the patient in the face of an ambiguous and threatening personal environment. (Sedgwick, 1982, p. 74)

That existentialist framework shaped Laing's main concern in the book, which was to understand the *experience* of being schizophrenic. What does it feel like? How can we get inside the mind of someone with this condition? How can we make sense of it?

A major barrier in the way of doing so, he argued, was a psychiatric language which viewed people labelled as schizophrenic not as whole human beings but as machines, as disembodied brains (or in our own time, as bundles of genes). Anticipating Michel Foucault's concept of the clinical gaze, he argued:

> As a psychiatrist, I run into a major difficulty at the outset: how can I go straight to my patients if the psychiatric words at my disposal keep the patient at a distance from me? How can one demonstrate the general human relevance and significance of the patient's condition if the words one has to use are specifically designed to isolate and circumscribe the meaning of the patient's life to a particular clinical entity? (Laing, 1965, p. 18)

Bleuler had once commented that, when all was said and done, the patients he was seeing were as strange to him as the birds in his garden. By contrast, Laing followed the American psychoanalyst, Harry Stack Sullivan, in arguing that "the psychotic" is more than anything else, "simply human". Connecting with that humanity, however, required the creation of a new *science of persons*, a way of understanding and relating to patients not as brains or objects but as human beings, with feelings, hopes and desires. And the key purpose of that science, Laing argued, was to render the speech of people diagnosed as schizophrenic *intelligible*—to show, in other words, that it had a meaning, rooted in past or present life experience, and was not simply the product of a diseased brain, as the dominant biomedical psychiatry would have it. So, for example, when, in a case study entitled "The Ghost of the Weed Garden', Julie, a young woman with a diagnosis of schizophrenia, talks about not being a person, being unreal and says that "a child has been murdered", Laing suggests she was describing not a literal but an existential truth, the possible origins of which he explores in the case study. And, he argued, that process of making intelligible the experience of Julie, and others similarly diagnosed, was not just an intellectual activity. It also involved "love" or what would probably be called today "empathic understanding", a quality or skill he sought to deploy while working at Gartnavel, including spend hours sitting in padded cells with catatonic patients regarded as incurable.

His experience of working with such patients led Laing to conclude that, at the root of much of what is called "schizophrenia" was what he labelled "ontological insecurity". People described as schizophrenic seemed to lack a sense of themselves as alive and real and separate from other people and therefore had to find ways to maintain boundaries to protect their sense of identity—defences that were then seen as the symptoms of schizophrenia. That strategy or response, he suggested in what he described as the central thesis of the book, was "a possible outcome of a more than unusual difficulty in being a whole person with the other and with not sharing the common-sense (i.e. the community sense) way of experiencing oneself in the world". In other words, there was a mismatch between the experiences and perceptions of the young child or adolescent and the denial and/or distortions of these experiences and perceptions of her caregivers. In *Sanity, Madness and the Family*, published in 1964, Laing and his colleague Aaron Esterson would identify the "double bind", where a family member is presented with irreconcilable demands, as a key mechanism in this process (Laing & Esterson, 1970). The classic example of a negative double bind is of a mother telling her child that she loves them, while at the same time turning away in disgust, or inflicting corporal punishment: the words are socially acceptable; the body language is in conflict with it. That was later, however, and in *The Divided Self*, he confines himself to calling for more research into family dynamics and the possibility of what he calls "schizophrenegenic families".

The central idea of *The Divided Self*—that madness might be intelligible—fitted well with other challenges to traditional psychiatric thinking that came out soon after, such as Michel Foucault's *Madness and Civilisation* (Foucault, 1964) and Erving Goffman's *Asylums* (Goffman, 1968) and, unusually for a psychiatric text, by the mid-1960s the book had become a best seller. By then, however Laing's thought had moved on. In a Preface to the Pelican edition of the book in 1964, four years after the initial publication, he commented:

> One cannot say everything at once. I wrote this book when I was twenty eight. I wanted to convey above all that it was more possible than is generally supposed to understand people diagnosed as psychotic. Although this entailed understanding the social context, especially the power situation within the family, today I feel that, even in focusing upon and attempting to delineate a certain type of schizoid existence, I was already partially falling into the trap I was seeking to avoid. I am still writing in this book too much about Them, and too little of us. (Laing, 1964, p. 11)

As this suggests (and as I have explored at greater length elsewhere: Ferguson, 2017), Laing's thought was moving in an increasingly political direction. In 1967, with his fellow psychiatrist, David Cooper, he was the organiser of the Dialectics of Liberation Conference in London, an astonishing event which explored alternatives to capitalism and brought together on one platform many of the leading lights of the 1960s' New Left, including the Frankfurt School philosopher, Herbert Marcuse, and the Black Panther leader, Stokely Carmichael. By this time Laing had himself become something of a cult figure on the Left, reflected in the huge popularity of books like *The Politics of Experience*, a collection of essays which showed his growing politicisation (Laing, 1967).

What that book and his subsequent books also evidenced, however, was his increasing attraction to mysticism, an attraction which ultimately over-shadowed any political involvement or analysis and which was the object of a biting critique by the political philosopher and activist, Peter Sedgwick.

The ascendancy of the New Right in the 1980s, spearheaded by the election of Margaret Thatcher as Prime Minister in the UK and Ronald Reagan as President in the USA, coupled with the return of an increasingly assertive biomedical psychiatry, led to a savage assault on the ideas of "anti-psychiatry" (a term, incidentally, which Laing himself rejected) and also to the demonisation of Laing himself (a task made easier, it has to be said, both by his growing tendency to turn up drunk at public lectures and interviews and by his adoption of increasingly wacky ideas and practices, such as organising mass "re-birthing" sessions on Wimbledon Common).

Some sixty years on since the publication of *The Divided Self*, it is now clear that Laing's focus on the schizophrenegenic family as a complete explanation of psychotic breakdown was both too narrow and too open to the possibility of parent-blaming. For many people, of course, it remains true that, in Philip Larkin's much-quoted words, "they fuck you, up your mum and dad" (even if, as he suggests in the next line, "they may not mean to but they do"). However, as research in recent decades into the impact of trauma on mental health has shown, so do lots of other things, including child abuse, bullying and racism. So we should read this book and Laing's later work critically. Having said that, for those of us today, mental health workers of whatever sort, who wish to develop a practice based on an understanding that the distressed people whom we are seeking to help are "simply human" and that the roots of their distress will often lie in their life experiences in an oppressive and exploitative society rather than in their brains or genes, then *The Divided Self* remains an indispensable starting point.

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Social work practice implications of upcoming mental health reforms

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The Labour-led Government has recently announced new healthcare reforms in Aotearoa New Zealand. The four changes are:

- The current 20 District Health Boards (DHBs) across the country will be replaced by one national organisation, Health New Zealand.
- A new Māori Health Authority will have the power to commission health services, monitor the state of Māori health and develop policy
- New Public Health Agency will be created
- Strengthened Ministry of Health will monitor performance and advise government

As a teaser before the announcement, the country was informed that the reforms would be about equity and access. We, the writers, are both Pākehā mental health social workers and we were eagerly awaiting news of the reforms. We have reflected on the current problems facing the mental health sector, speculated on how these may be addressed through system reform, and discussed our hopes for a better system.

Based on our experience working within and alongside different DHB mental health services in the country we identified four major sector problems. These are the increasing demand and severity of presenting problems, the associated shifting goalposts of accessibility to manage demand, service variability between regions and issues of staff workload, and training and retention. As social workers, we have seen the impact of these issues upon multi-stressed families seeking support and we hope for reforms to address these equity issues.

Increased demand and severity

The Ministry of Health (2021) has recently released the *Office of the Director of Mental Health and Addiction Services Annual Report 2018 and 2019* under a cloud of controversy surrounding the timeframe and lack of transparency (Cooke, 2021). The statistics of increased mental health service demand reflect our experience as mental health social workers. Referral demand is unprecedented, due in part to the excellent efforts of health promoters to reduce mental health stigma and encourage people to seek help. We have seen a change in recent years in how families perceive mental health issues, with increased understanding of mental health and acceptance of service involvement. The result is increased demand for mental health services without the service infrastructure to support that.

Barnett and Bagshaw (2020) have described the persistent underinvestment in health services in Aotearoa New Zealand over many years due to the business culture that has been embedded within health systems. In mental health services, we have seen the business culture evident in the focus on efficiency and throughput. In response to increased service demand, many services have turned to brief intervention as a model of care. In order to access supports, families must be prepared to talk with multiple clinicians. For some this does not seem to be a problem and for others this can turn them off services completely or lead to them bouncing around different agencies, getting

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what they can, telling their story multiple times, getting support, but without treatment of the core problem. We are particularly concerned about the cultural appropriateness of the brief intervention model. It seems to be an individualistic model with time constraints limiting the scope of the engagement phase and the time to work with whānau and wider systems. This approach may exacerbate existing mental health inequalities in Aotearoa New Zealand and does not seem to be a good fit for Māori and Pacific families.

As advocates for formulation-driven work, we would like to see not only easier access, but support that can see someone through a longer period of time in the context of a trusted and stable therapeutic relationship. The quality of the therapeutic relationship is particularly important for Māori whānau (McClintock et al., 2011; Pomare, 2015) and for those who have had negative experiences with multiple services (Munford & Sanders, 2015). The therapist and service may need to take a considerably different and more culturally appropriate approach in order to build a positive therapeutic relationship with Māori whānau (Bennett et al., 2016).

Alongside the referral increase there is an increase in the severity of problems facing people, with the impacts of COVID, increases in family violence and significant financial struggles. This results in referrals accepted into service being heavily dominated by serious problems such as acute suicide risk.

Accessibility

Despite the increase in referrals, DHB mental health staffing numbers appear to have remained the same. Services may respond to this imbalance of demand and available resource by narrowing service eligibility criteria. As a result, only the most severe mental health presentations are accepted into DHB care. This is not aligned with the vision of *Te Ara Oranga* (Government Inquiry into Mental Health and Addiction, 2018) about providing services when needed or any preventative model of care. Instead, underfunded services are forced to defer or delay services until a person's problems are exacerbated to the point of crisis. Wait times have grown over the last three years in child and adolescent mental health services across the country, almost doubling in Canterbury to 59 days (Ministry of Health, 2021). This is a very long time in the life of someone with severe mental health issues, especially a young person, during which time the problems can worsen.

These accessibility issues are of concern, particularly for those people and families who are reluctant to seek help and are most in need of timely and responsive care. This may be the result of internalised mental health stigma or institutional mistrust from poor experiences with services. Many Māori have had negative experiences with health services due to racism (Graham & Masters-Awatere, 2020) that can become a double disadvantage when it results in reluctance to seek help when required. These problems stem from how services meet (or do not meet) the mental health needs of all of our communities. Accessibility and equity, the keywords from the announcement teaser, are critically important for the mental health sector.

Service variability

From our experience the *postcode lottery*, as Health Minister Andrew Little has described, is a very real phenomenon within mental health services. There are significant differences between DHBs. Our experience is primarily in child and adolescent mental health services. Effective interventions with families include Wraparound approaches, Dialectical Behaviour Therapy (DBT) and Parent–Child Interaction Therapy (PCIT), all of which are supported by local research (Cooney & Ministry of Health, 2010; Shailer et al., 2017; Woodfield & Cartwright, 2020). However, these services are not available in every DHB. For example, it is highly likely for a family to be involved in a DBT programme in one DHB, and then move to another area of Aotearoa New Zealand where a DBT programme is not available.

It appears that the services provided depend on the current staff knowledge, training and resources. This is likely due to training issues, but we also connect this with staff turnover due to the workload issues. We have seen many mental health staff join the DHB, receive training in appropriate interventions, find the unrelenting workload intolerable and then leave the public sector to work privately, taking that knowledge with them. In particular, we have seen a mass exodus of psychologists from the public service as they seek a better work environment working privately (Truebridge, 2021).

Staffing issues

In recognition of these issues, there have been efforts put into recruiting and training more mental health staff. For social workers, there is the New Entry to Specialist Practice (NESP) programme providing structured academic and clinical learning in their first year of mental health practice (Te Pou, 2021). There is current research under way about social workers' experiences of NESP to ensure the programme is meeting the needs of social workers new to mental health practice.

However, we see the staffing issues are primarily about retaining staff in mental health services. Many mental health staff are struggling with burnout in the face of ever-increasing service demand. There is a steady stream of referrals and the people who get into services tend to have significant and multiple problems. As social workers, it is challenging to practise ecologically in this work environment with limited time to work with families and other support systems. Despite efforts to support clinicians, it can be dissatisfying to work with acutely unwell people within limited timeframes to engage in meaningful work that could address some of the root causes of distress—all the while knowing that people are queuing at the door to be seen. As a result, we see a high turnover of staff resulting in less experienced clinicians and less support for those new to the role.

Health service reforms

It was against the backdrop of these four issues of service demand, accessibility, variability and staffing issues that we awaited the health service reform announcement.

We are cautiously optimistic about the proposed changes. Having Health New Zealand replace the DHBs could be helpful in addressing issues of regional service variability. Currently, the 20 DHBs are funded by the Ministry of Health to plan, purchase and provide health and disability services within defined geographical areas. They have autonomy as to how to meet the directives set by the Ministry. The creation of Health New Zealand could mean regulation of mental health service entry criteria and interventions available across the country. Ideally, this will also involve one integrated IT system across the country. It seems absurd that there are currently different IT systems between DHBs so that we cannot easily access clinical notes for people who transfer from another area.

However, we do not yet know how this will be operationalised. Goodyear-Smith and Ashton (2019) have described the seven major health system reforms between 1983 and 2000 in Aotearoa New Zealand, all of which have failed to address the persistent problems of access to care and inequitable health outcomes. We do not know what impact the organisational restructure will have on local practice decisions. While regulation will help with access, there also needs to be flexibility to be responsive to local need. This includes the specific mental health needs within rural areas and socioeconomically deprived areas.

The four issues of service demand, accessibility, variability and staff retention are intertwined and underscored by a lack of funding. Service demand results in services being less accessible through shifting goal posts of entry criteria. This creates a stressful workplace where clinicians are predominantly working with people presenting with severe problems and high risk. The business model creates pressure to work with complex problems in time-limited ways, which has likely been a major factor in a high turnover of staff. This impacts on what particular interventions are available in each service as departing staff take their expertise with them. For these health reforms to achieve their goal of equity and access, there needs to be accompanying funding to support mental health services to meet the needs of people seeking support. Lower caseloads could be one way that we can work more relationally and responsively and with meaningful engagement with families and wider systems in culturally appropriate ways, all of which are aligned with both social work and recovery principles.

The current issues within the mental health sector impact more on Māori whānau. Institutional racism is a major cause for Māori to experience a number of health disparities and ultimately to die, on average, seven years younger than non-Māori (Kerr, 2021). The current health system in general is often experienced as hostile and alienating for Māori (Graham & Masters-Awatere, 2020) and mental health services need to do better for Māori, especially regarding the use of the Mental Health Act (Baker, 2015; Elder & Tapsell, 2013; Government Inquiry into Mental Health and Addictions, 2018). We are supportive of the establishment of a new Māori Health Authority especially if this means that mental health services can be delivered in more holistic and relational ways. We hope that this new dual authority approach may move us towards a more Tiriti-centred health system that ensures equitable access and outcomes. We were particularly pleased to see that Tā Mason Durie has been appointed, with his vast experience in mental health.

The upcoming reforms provide an opportunity to address some of the longstanding issues in mental health, especially if it means an integrated network of mental health services across the country. Alongside this, there needs to be adequate funding so that mental health services can move from a business model to a recovery model. This could create a work environment where clinicians have the time to work holistically, to be able to build rapport at a pace that suits the person seeking support, and to have the capacity to work with the system surrounding people. Being resourced to provide intensive support at the outset may also avoid the revolving door in and out of mental health services for some people. We continue to hold hope for a better system for the people and communities we serve.

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"They feel like it's all based around the offender": Professionals explore how victim participation in family group conferences can be enhanced

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ABSTRACT

INTRODUCTION: The Family Group Conference (FGC) is one of Aotearoa New Zealand's most innovative features to emerge in the Oranga Tamariki Act (1989). It was designed to address the harm caused by youth offending, as well as set the scene for reconciliation to allow victims to heal. However, victim participation at such conferences remains low.

METHODS: This study focused on a 6-month pilot project in 2019 between the agencies of New Zealand Police, Oranga Tamariki and Victim Support, that aimed to increase victim participation at FGCs within the Tāmaki Makaurau (Auckland) area. Rates of victim participation were tracked and six professionals were interviewed for their observations on the pilot.

FINDINGS: Victim participation in FGCs increased during the project and interviewees identified that there had been more collaborative efforts between the professionals involved. Thematic analysis highlighted issues with 1) *Agency processes and systems* (with more training and resources needed, and more streamlined processes between the three agencies called for); 2) *Information* (youth justice information and cases were "too complicated," and tended to be offender-focused, not necessarily understanding victim's perspectives nor getting feedback from them); and 3) *Timing* (improved processes were needed around timely police referrals and there were effects of timeframes overall on victim participation).

CONCLUSIONS: Participants recommended building on this exploratory pilot to increase and maintain better outcomes. The importance of victims being well-prepared for FGCs, feeling well-supported in making an in-person submission, in culturally appropriate ways, needs timely collaboration between well-trained and well-resourced professionals from the agencies involved.

KEYWORDS: Social work practice; Family Group Conference; youth justice; youth offending; process evaluation; Aotearoa New Zealand

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Until the late 1970s, the criminal justice system globally was largely based on a retributive system, one that advocated for punishment (Strenlan et al., 2011). However, in response to the continued neglect of victims' needs and rights within such systems, "restorative justice" practices were introduced (Choi et al., 2012). These practices paved the way for addressing the "conflict and harm" associated with criminal behaviour by way of communicative and interactive practices known as "victim–offender conferences" (Bolitho, 2012). Restorative justice is seen as allowing victims the opportunity to get more of what they want from their criminal justice system (Strang et al., 2006), yet, when it comes to victims meeting their offenders through restorative processes, they are often reluctant to do so (Levine, 2000).

The Family Group Conference

In 1989, Aotearoa New Zealand was the first country in the world to develop the Family Group Conference (FGC) as a means to implement the values and principles of the Oranga Tamariki Act (1989). FGCs are used for the purposes of Youth Justice—delinquency and offending matters; and Care and Protection—to address the care and welfare needs of the child / young person. This study is exploring the Youth Justice FGC. The purpose of the Youth Justice FGC is to: a) hold the youth responsible by paying reparation to the victim and imposing a penalty; and b) explore the care and welfare of the young person (Levine, 2000). Convened by a Youth Justice Co-ordinator from Oranga Tamariki (OT), FGCs are decision-making meetings that include the young person and their family, the victim(s) and their (optional) support people, and a representative of police, to hear from all those involved (Morris & Maxwell, 1998). A rehabilitative plan for the young person, followed up by the OT social worker, aims to help to keep young people out of the punitive justice system (Levine, 2000).

Subsequently, FGCs have been introduced elsewhere (e.g., the UK, Canada, Sweden, and the USA). Research into the effectiveness of FGCs remains largely positive, finding that: families are able to follow through with effective family plans that address the welfare concerns of the child who offended; are more likely to engage in the services recommended in the FGC; and give young offenders better contact with their extended family (Huntsman, 2006; Lowry, 1997; Olson, 2009; Shore et al., 2002; Sundell & Vinnerljung, 2004).

In Aotearoa New Zealand, young Māori and Pacific people are more likely to come to the attention of the youth justice system than Pākehā (NZ Europeans) (Maxwell et al., 2004). While early legislation allowed for decisions about youth offenders to be imposed with little or no involvement from families, this was not culturally appropriate according to traditional Māori or Pacific beliefs, which are largely based on collective responsibility (Ioane, 2017; Kaho, 2016). Hence, new legislation was built on restorative principles that are similar to the values that underpin Māori and many Pacific systems of justice. As a result, professionals need to strive to acknowledge and respect the cultural background of FGC participants to better meet the specific needs of the ethnic groups to which young offenders and their families belong (Kaho, 2016).

Victim participation in FGCs

A pioneering feature and therapeutic role of the FGC allows for the victim(s) of criminal offences to be present during the conference, an essential participation (Braithwaite & Mugford, 1994) that sets the scene for reconciliation (Levine, 2000). Yet, victim attendance at youth justice FGCs in Aotearoa New Zealand remains low. In cases with a victim, only 35% of conferences had a victim present in 1992 (Thornton, 1993) and, prior to this, some studies revealed less than a quarter (24%) included victim participation (Prchal, 1991). Non-attendance at conferences has been partly attributed to victims not being consulted about the time and place of the conference, nor being given enough notice (Levine, 2000). Victims reported their only form of support came from a police representative. This led to feelings of intimidation in front of offenders and their families, often leaving the victim feeling overwhelmed (Maxwell & Morris, 1993).

In response to such criticism, as well as a lack of victim satisfaction and participation, the Act was amended in 1994, to apply best-practice guidelines, yet more recent research (Slater et al., 2015) found that victims' level of timely involvement was still problematic. Victims who did take part were shown to benefit from the restorative FGC process (Mainwaring et al., 2019), especially when they could make an informed decision to actively participate, from the information provided, and were well-supported by those involved.

Levine and Wyn (1991) also suggested that careful FGC preparation is essential in order to establish effective victim involvement. Other issues reported include victims feeling daunted and overwhelmed when arriving at an FGC—often no-one is there to greet or support them as the co-ordinator is busy with the youth offender (Maxwell et al., 2004). Also, a key feature of an FGC is that youth offenders and their families should be able to express their views in a way that is constructive and restorative to the victim, and vice versa, in order for the healing process to eventuate. A great deal of practice and training is needed by the professionals involved to ensure all parties have an active voice in the process and the FGC is managed in a way that enhances participation (Maxwell et al., 2004).

Best-practice guidelines also need to include professionals' perspectives on how to ensure victim inclusion, according to Slater et al.'s (2015) study. While consultation between youth justice co-ordinators (who are employed by Oranga Tamariki) and Youth Aid officers (who are part of the police) has been described as the first and vital phase of any FGC, some of the attitudes of frontline police (who are supposed to refer offenders aged 17 and younger to Youth Aid) are believed to deter victim attendance (Slater et al., 2015). However, it is important to note that Slater et al.'s (2015) study was drawn only from the perspectives of youth justice co-ordinators; further research should also include the views of frontline police and other stakeholders. Co-ordinators reported a poor quality of accurate information from police at times, which not only impacted on their caseload, but also compromised their ability to meet timeframes set by the Act. Moreover, Police Summary of Facts[1] sometimes contained inaccuracies that left participating victims feeling offended and unheard (Slater et al., 2015).

It would appear that the integrity of any FGC process is, to some extent, at the mercy of the involved professionals aligning their perspectives and their comprehension of the principles of the FGC Act (Slater et al., 2015), and that better processes might be needed between the various agencies and professional bodies involved in FGCs.

Purpose of study

In response to the Ministry of Justice "Youth Crime Action Plan 2013–2023" (Ministry of Justice, 2012), Tāmaki Makaurau (Auckland) police developed a local action plan in 2018 including a goal to improve FGCs. A pilot project aimed at increasing victim participation within FGCs, based on victim satisfaction studies and surveys (Ministry of Justice, 2018, 2019), started in March 2019 and ended in October 2019[2]. The pilot was between New Zealand Police, Oranga Tamariki and Victim Support[3] in Auckland, a collaborative effort between the three agencies to ensure an agreed understanding of procedures that would enable the FGC process to flow better. Instead of standard practice, where an FGC referral came from police to OT (who were responsible for contacting all participants to arrange the FGC), under the new pilot programme, the referral would still go to OT, but would also go to Victim Support (VS) who would be responsible for contacting the victim regarding the FGC. There was an initial presentation to introduce the pilot and a training session for staff on the new process of including VS in the referral chain.

This study is a process evaluation of the pilot project and was undertaken as part of Honours research. It is independent research aiming to explore the *process* by which a collaborative effort among agencies was undertaken which may lead to improvements in its future effectiveness (Patton, 2002), rather than focusing only on outcomes at the project's conclusion. Presser and Van Voorhis (2002) argued that there are few comprehensive evaluations of restorative justice interventions and yet the future possibilities of restorative justice are at the mercy of evaluation research. Moreover, they argue that evaluation research should focus more on the processes and less on the outcomes, to ensure results that are in harmony with restorative justice values.

The following research is an attempt to address this gap in the literature while keeping in mind the goal of enhancing victim participation at the FGC (Presser & Van Voorhis, 2002). The four research questions were:

1. Was the pilot programme effective and how?
2. What could have been done better, or changed in the pilot programme?
3. Did the FGC referrals during the pilot programme result in increased victim attendance at FGCs?
4. What were the common modes of victim participation at the FGC?

It is intended that results from this study will assist the stakeholders/participants to develop guidelines for professional staff to benchmark, in order to enhance FGCs.

Method

The study used a mixed methods approach to gather rich and full data for the research questions (Regnault et al., 2018). Ethics approval was granted by Auckland University of Technology (19/156) and participants were sourced by emailing all members of VS, police and OT involved in the pilot project. The email contained information about the study and an invitation to participate. To allow for a collaborative random sampling process (Howitt & Cramer, 2017), the first two participants from each organisation who accepted the invitation were selected as part of the random sampling approach and control of any biases (Howitt & Cramer, 2017). The six chosen participants (about 12% of the workforce) were contacted by telephone to arrange a time for an interview at the workplace.

Qualitative data for this study were gathered in semi-structured interviews asking about the pilot programme's effectiveness, and what could have been done better, specifically relative to victim participation. Quantitative victim participation data were sourced from VS during the pilot. These data recorded the number of victims that were eligible to participate in FGCs during the pilot process but, to maintain confidentiality, did not incorporate any personal details. It was suggested that this would allow some pre- post-pilot comparison of victim participation (Howitt & Cramer, 2017).

Analysis

Qualitative data were analysed using thematic analysis to develop themes that accurately reflected the textual data (Howitt & Cramer, 2017) and were relevant to the research questions (Braun & Clarke, 2006). A critical realist approach was adopted to understand the participants' experiences from their lived realities (Terry et al., 2017). In accordance with the critical realist worldview, the final themes were identified at a semantic surface level, as the researcher was interested in presenting what the participants reported during their interviews, rather than over-interpreting other possible "underlying" meanings (Braun & Clarke, 2006).

A summary statistic was derived from the quantitative data to numerically measure the differences in victim participation prior to, and during, the pilot project (Balnaves & Caputi, 2001; Howitt & Cramer, 2017).

Results

The sample included two professionals from each of three organisations (OT, police and VS) who had a wide range of time and experience (from 10 months to 22 years) in the youth justice sector; three were female; three were aged 31–45 and three were 46+. As the youth justice field is so small, details of professional and ethnic identification are excluded to maintain confidentiality; participants are designated *P1* to *P6* in illustrative quotes.

All participants were aware of the purpose of the pilot project; that is, to support victims attending FGCs and increase participation from victims involved. As Participant 3, with 22 years' experience in youth justice, outlined, there was no doubt that the FGC could be a challenging concept for victims of offending:

> There were times we had victims turn up to FGCs with "What the hell's going [on], why am I here? What is this kid front of me? You know, the guy who offended against me, why isn't he in prison?" All those sorts of questions will be going through the victim's mind. So, I'm guessing the pilot was probably designed to 1) make sure the victim understood the process; 2) get some input, and what that looks like; 3) probably understanding of the law, for some of them they probably don't understand that, you know, the punishments for adults and youths differ. (P3)

Qualitative data analysis

Following a robust thematic analysis of the transcribed interviews, three overarching themes (plus subthemes) were identified to respond to the four research questions. Theme 1 captures issues with *agency processes and systems* (including training needs of frontline staff and between agencies, the need for streamlined processes, and lack of resources). Theme 2 describes *information* issues (including that FGC processes seem too complicated, are overly offender-focused, sometimes not understanding the victim's point of view and value of feedback). Theme 3 gathers participants' views on *timing* (including timing of police referrals, the length of the pilot programme and other timeframes in general).

1. Agency processes and systems

This theme illustrated opinions about the need for transparent processes and systems across the agencies involved in FGCs, particularly around three subthemes of training, streamlining and resourcing.

a) Training

Participants felt more training with frontline police and between agencies was needed, so that the conference process could run smoothly. They identified a need for further initial training during the pilot project.

> I think that there were some practical measures that weren't addressed in the initial process of starting up the pilot, and that needs to be addressed if it's going to succeed. (P2)

Consequently, they suggested training solutions, such as a refresher and ongoing contact:

> Maybe a refresher training, bringing everyone back together … just reminding everyone that this has been ongoing [the pilot]. Because I think we had the training and then there's probably not much talk about it after that. (P5)

b) The need for streamlined processes

A need for better processes was highlighted in order to help collaboration across organisations, so that referrals could flow better.

> All organisations need to follow the other organisation's process and understand them… So that each organisation knows

> or puts in a process for themselves… Because there have been teething problems as we go along, we are trying to fix those teething problems, so that we know for next time how we can best provide a service. (P1)

For example, Participant 1 points out that using the contact service centre (at Victim Support) rather than emailing an individual staff member you may have happened to have dealt with before, was more efficient.

> You go straight through to the contact service centre, don't email the person that's been working on either case in the past, you know, that you've dealt with in the past. Because then it gets confusing and gets more time-consuming…You try to advise them this is our process… So, it can run smoothly. (P1)

Participants pointed out that learning each other's roles and processes in the pilot took time and effort.

> I think it's still really new, in the sense that we're all still working out the role of everybody and the process. So, I think it has the potential to be quite effective, but it's just still getting those working on, I guess, the baby steps to get there and just working out the process. (P5)

c) Lack of resources

Agencies need to have adequate resources for the additional training and streamlined processes to be implemented efficiently. As these participants point out, it was difficult to find time to complete pilot paperwork, in amongst all their other work and calls on their role.

> Just being the only [person in this role] for this pilot, and it's coming hard and fast. And, you know, having to do the pilot, as well as other stuff ... I think that's the thing, is the resources, because there was a lack of resources. (P1)

> Because what happens is just the sheer weight of paperwork that comes through, I've got it up there as my things to do and what I need to do, it's on my wall. But sometimes I forget to do it too. (P4)

2. Information

The second theme covers participants' insights on the information that had been acknowledged, uncovered, and shared within the pilot project. Subthemes highlighted the complexity of youth justice information and cases, the tendency to be offender-focused, not necessarily understanding the victim's perspective, nor getting feedback from them. These issues highlight the necessity for clearer information-sharing processes within the FGC system.

a) It's too complicated

This subtheme highlights participant accounts about how complicated youth justice can be, at times, for the professionals involved—let alone for victims.

> So, it depends on what the crime is. For car conversions, for example, you know, there will be maybe six offenders. Most of the victims have no interest in going to an FGC, they just want reparation for their car, which is obviously not practical because the offenders are minors. The more serious ones, the sexual crimes and things, that's a little bit more complex. (P2)

There may be one offender with a number of victims, each of whom need a support worker and opportunity to participate, or co-offenders who have different youth justice co-ordinators for individual FGCs, making it "a lot to manage, without a really good system to keep it on track" (P5).

> Which co-ordinator is dealing with which offender? … we kind of get muddled up, you're doing one thing for one offender, for one victim, but there's more than

> one offender. … It just needs to be a bit clearer. (P1)

The complexity can mean that the FGC is convened well after the offence has occurred, which can be problematic:

> Because it's too complicated, we could retraumatise people contacting them late, they've moved on, because that [offence] has happened two months ago. (P2)

b) Offender-focused

Participants were concerned that, at times, FGCs appeared to be nothing more than tick-box approaches that were offender-focused. There was some awareness of the implications of this for victims.

> Because I think that the way some of the organisations involved, they just do it to tick boxes. And it's not purposely done, because for some victims, they feel like it's all based around the offender. (P1)

It's so hard for these victims of the FGCs anyway, because sometimes the victims are outnumbered by the offender's supporting family, or the youth supporting family. (P4)

c) Perception of victim perspectives

Within this subtheme, participants highlight their perception of victim perspectives and the importance of them being prepared for the FGC. These issues could also be perceived as an obstacle to an FGC being effective.

> To me, we've sort of, in the past, we've had the victim, we've all gone about our business, thinking we're doing a good job, but not involving the victim enough, or not sort of making it clear as to why they're involved. (P3)

In contrast, when good support is provided for victims at FGCs, there is more opportunity to make the young offender understand the "face" of their offending.

> I have seen or experienced good FGCs, where having the Victim Support worker there has been quite effective in terms of either supporting the victims, so they've got someone there, or having someone represent the victim. (P5)

> I think it's just making the kid realise that, you know, that there's a face to this, there's a consequence, this is what's happened to this person … yeah, it's much better when it's coming from that person. (P6)

Good victim support could also ensure language was not a barrier to a victim having a say, with Participant 6 being particularly impressed by a support person who was so well-prepared that the victim was able to speak in their own language, which was then translated. This allowed the victim to go into full details about the trauma they suffered at the hands of the offender.

d) Feedback

The last subtheme in this group outlines participants' thoughts about having more feedback from victims about FGCs.

> I think any feedback … whether it's negative or positive. You just got to take the good out of it, and if it's going to help the programme get better moving forward. … Maybe at the end of the FGC when the kids finish their plan, and they get a discharge, that would be good to hear from the victim. As to "Okay, how do you think we did?" (P3)

3. Timing

The third theme describes the participants' narratives about timing within the pilot project, with improved processes needed around police referrals, and timeframes in general in FGCs.

a) Timing of police referrals

There was ongoing concern that a timely flow of referrals amongst agencies in the pilot did not seem to be improving:

> The whole process really relies on the frontline officers making the referral to Victim Support. … So, given that we've been months into the pilot, those referrals are still, we're still struggling … like we're still not getting details of the Victim Support worker or knowing that referral's actually been made. (P5)

b) Length of the pilot

A related issue was therefore whether the pilot project needed to be longer, to ensure systems really changed. Participants felt more time was needed in the project. Furthermore, the Christchurch Mosque shootings occurred in the middle of the initial project (although the pilot was in Auckland, extensive police resources from all regions were redeployed), which caused delays.

> I think it needs a longer time period, the pilot needs to be a lot longer for it to be sustainable and to find some traction. … It's too soon to say if, if any of it has worked. (P1)

> I think that there have been a few hiccups along the way. Firstly, the timing that it started [the pilot project], was around the time that the Christchurch shootings happened. So, most police officers were busy with that. (P5)

c) Timeframes in general

Relating to the complex nature of youth justice cases (as in *Theme 2: It's too complicated)*, participants commented on timeframes in general within FGCs that could compromise victim engagement. Participant 5 explains some of the time pressures arising from court requirements of timing and those who had to attend.

> One of the other, I guess, challenges is our timeframes. When something comes from court, especially if the young person is in custody, we've got, you know, a week to organise the FGC and then a week to hold it. So, when that means adding in, or finding out who the [Victim] Support worker is, contacting them and adding on that extra person to the process, when we're already having to contact all the, like the police, the lawyers, the family, all these other people, it is a bit tricky. (P5)

Quantitative data analysis

Quantitative comparison data of victim participation at FGCs before and during the pilot project are illustrated in Figure 1, including the total number of victims entitled to participate in an FGC, how many chose to attend in person or to enter a submission, and how many chose not to participate. Prior to the pilot, the percentage of victims who participated, compared to the total entitled to participate, was low (January 2019, 50%; February 2019, only 15.4%). During the pilot project, participation leapt to 100% (April, May, June 2019), and in July to October 2019, participation rates remained higher than pre-pilot. March 2019 can be seen as a transitional month, when the pilot had started, but was then interrupted by the Christchurch shootings, leaving overall attendance still relatively low that month (29.7%).

Common modes of victim participation at the FGC moved from non-participation pre-pilot, to full participation during the pilot (where non-participation dropped to 0). The most common mode of participation was through providing a submission, rather than appearing in person, a pattern which continued from July to October 2019.

Discussion

This study was inspired by the current lack of comprehensive evaluations of restorative and youth justice interventions (Presser & Van Voorhis, 2002). The aim of this study was to evaluate the process of a pilot project between New Zealand Police, Oranga Tamariki and Victim Support; the aim of the pilot was to increase victim participation

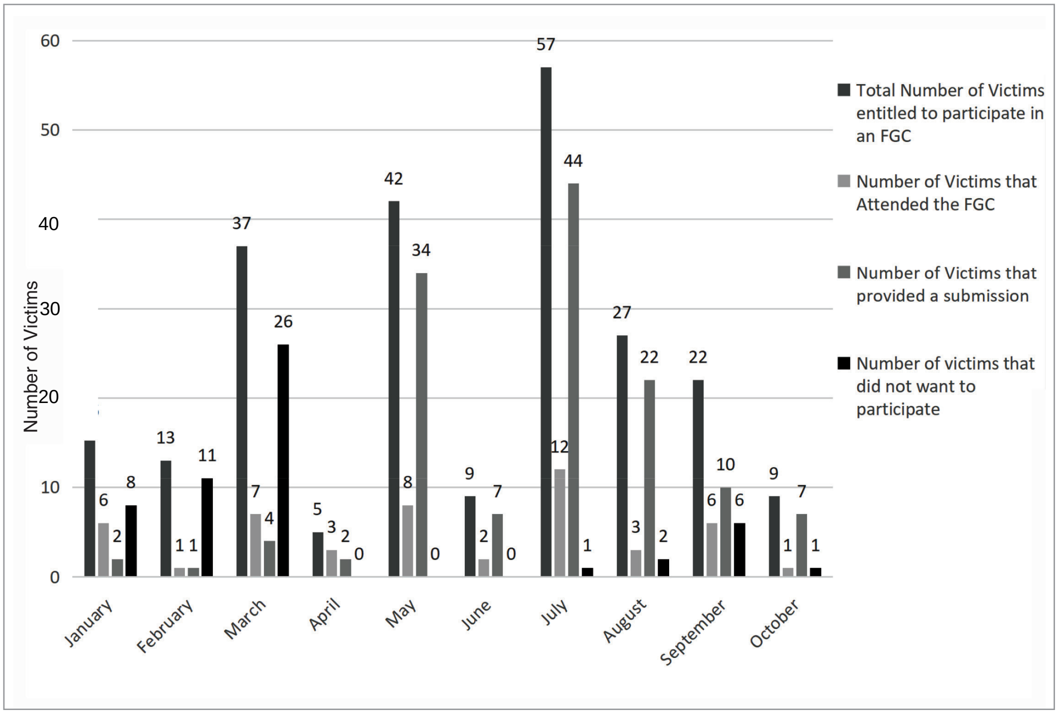

Figure 1. Victim Participation at FGCs (January–October 2019)
Note. January and February are prior to the pilot.

in FGCs in the Auckland area. It was hypothesised that a collaborative effort among these agencies would enable the conference process to flow better for victims. This section includes discussion of Research Question 1 and recommendations arising in response to Research Question 2.

Research Question 1: Was the pilot project effective and how?

Participants seemed to have a good understanding of the rationale for the pilot, suggesting a good grasp of current FGC challenges. They had a broad range and length of experience in the sector, highlighting the large amount of professional knowledge they possessed. When adding these together, the participants appeared to be the right fit to ensure a thoughtful exploration of the issues.

Efficacy of the pilot could be seen when the participants seemed to be generally aware of the importance of victims being well-prepared for conferences, even if it was not always possible to achieve that. This is also highlighted by Mainwaring et al. (2019), who found that victims need to understand the conference process, so that they can make an informed decision to attend and feel comfortable doing so. Similarly, Levine (2000) argued that lower rates of victim attendance at conferences could be partly due to the lack of preparation from the professionals involved. Further, professionals being able to describe the FGC process to victims, in a comfortable manner, provided an opportunity for restorative healing effects (Maxwell et al., 2004; Morris & Maxwell, 1998). Our participants noted that cultural support for victims was vital, including ensuring that victims could speak or write in their own languages, with professional interpretation as required, which aligns with calls that cultural appropriateness should be implemented in international best-practice FGC guidelines (Brady, 2009).

Another positive step in the pilot process was participants' awareness that FGCs could be seen as nothing more than tick-box approaches that are offender-focused, making them hard for victims. They realised that perhaps some organisations, or staff, needed to change their mindset, a change of heart that could eventuate in the victim feeling more comfortable to speak at conferences. This finding is also reinforced by Maxwell et al. (2004), who noted that victims frequently feel daunted and overwhelmed at conferences and need to feel that co-ordinators take a neutral and independent position, so that positive outcomes can be accomplished for all. Our participants' comments suggest they were aware of a need to be focused on collective outcomes at the FGC—that both offenders and victims benefit from the process—a focus that, when possible to achieve, was seen to be an effective attribute of the pilot project.

Research Question 2: What could have been done better, or changed in the pilot programme?

The findings from this question will be outlined as key recommendations.

Recommendation 1: Intensive and enhanced training is required

The research found that there was a need for more processes and systems within the pilot project (and, by implication, the FGC system overall), particularly around training. Firstly, more in-depth training was required during the initial start-up, with participants saying that better training preceding the pilot would have allowed for any practical measures to be revealed and addressed, ensuring that the pilot flowed better. This appears to be in line with Slater et al.'s (2015) findings that a successful FGC is based on having well-trained and skilled professionals to deliver good quality approaches at conferences.

Recommendation 2: Targeted training for frontline police officers would help

Participants were concerned about the amount of training for frontline police, who they felt needed more information regarding the pilot project, despite initially being spoken to by Youth Aid officers. This would ensure that other involved stakeholders could receive the correct information in the first instance, allowing the FGC process to flow better. This does not appear to be a new problem—Slater et al. (2015) also found that a lack of accurate information was handed on in referrals from police at times.

Participants also felt the training of frontline staff had an impact on the timing of referrals. While best-practice guidelines suggest that referrals should be made as early as possible, and prior to court decisions (Carruthers, 1997), findings in this study showed that referrals did not always come through in an appropriate timeframe, which left participants unable to fully prepare for the conference. As a result, referrals were delayed, timeframes were cut short, which added pressure when trying to contact victims in a timely manner—which in turn may compromise the quality of the conference, especially for victims (Slater et al., 2015). Perhaps this comes back to the role that Youth Aid officers play in the training of frontline staff, where the first and vital phase of any FGC is the consultation between co-ordinators and police Youth Aid officers (see also Slater et al., 2015), highlighting the important area of communication between professionals, and the need to enhance it.

Recommendation 3: More streamlined processes within the FGC system are needed

This would allow it to run more efficiently. Participants pointed out that there was a need to know each organisation's systems and processes better, which would allow collaboration to flow better. This is supported by previous research, when it was found that the efficacy of any FGC relies on the involved professionals aligning their perspectives (Slater et al., 2015). In addition, Case (2007) added that, when the views of professionals are not considered, it can be destructive to effective involvement for victims. The lack of streamlined processes affected the roles of some professionals within the pilot, only adding to their already large workload. Participants described feeling the added pressure that came from the pilot project and said that the extra workload that the pilot created greatly affected their active level of participation.

Recommendation 4: Information systems need improvement

Results also echoed some of the more familiar issues related to FGCs, according to the literature. There is a need for better information systems to cope with complicated areas of youth justice. The often high ratio of offenders to victims was noted by participants as placing an excessive volume of work on the professionals involved, with more resources needed. Complexity can affect timeframes in contacting victims, often leading to a higher risk of revictimisation (if a victim feels poorly prepared or unsupported in facing the offender), or simply a higher likelihood of victim non-attendance at the conference (Maxwell et al., 2004). Better information systems would allow for the easy identification of offender-to-victim ratio, as well as the correct parental information (where the victim is a minor) to be recorded. Consequently, this would save time for the stakeholders/professionals involved, as well as ensure that victims are fully supported, and so set the scene for reconciliation (Levine, 2000).

The quantitative data tracked victim participation, so *Research Questions 3 (Did the FGC referrals result in victim participation at the FGC?)* and *4 (What were the common modes of victim participation at the FGC?)* really fit under the overall question of whether the pilot worked.

Research Question 3 showed that more victims were involved in FGCs during the pilot. As pointed out by Wundersitz and Hetzel (1996), when there is more effort focused on ensuring victims have equal priority to offenders when preparing for FGCs, victim attendance rates increase. Prior to the pilot project, victim participation numbers were as low as 15.4% and during the first month of getting the pilot project under way (March 2019), including teething problems, attendance was still relatively low at 29.7%. Across the first three months of the pilot proper, participation increased to 100%.

Participants wanted the pilot to be extended, partly due to the areas that required attention, and the impact on police due to the Christchurch Mosque shootings. Due to finish in June 2019, the pilot was extended through July and August and relatively good numbers of victim attendance were maintained (1 non-participant out of 57 victims in July; 2 out of 27 in August). Therefore, findings in this study show that victim participation at FGCs within the Auckland area increased during the pilot project and beyond.

Research Question 4 explored the modes of victim participation. Sometimes the serious nature of offences, such as violent or sexual assaults committed by youth (Maxwell et al., 2004), either prevents victims from attending at all, or discourages them from voicing their opinions when they do. This only highlights the importance of victims being able to enter submissions such as a victim impact statement, even if it is their sole mode of participation. There were more submissions provided by victims during and immediately following the pilot than before it. More victims chose to enter submissions as their only mode of attendance than did victims who decided to attend in person. This suggests that, in future, work could further explore the suggested gold standard of more victims participating in person, where feasible. While the literature suggests that personal attendance is warranted so that victims can express their feelings (Paul, 2016), and gain a level of emotional recovery that allows them to benefit from the restorative process (Strang et al., 2006), this is not always possible. Victims have the option to decline, though it would be helpful to explore the reasons for a submission only to ensure they are not due to systems and/or organisation barriers. Systemic and organisational barriers should be addressed to minimise further harm on a victim(s).

Nevertheless, the participants in this study suggest that the issues identified can be easily overcome. Some of the practical ways to implement the recommendations include: a) having more practitioners like *Youth Aid officers who should be trained and involved right from the beginning, so that they can communicate with frontline police officers* more often about the best ways to collaborate with Oranga Tamariki and Victim Support; b) holding *regular refresher trainings for all involved, and presenting the findings from this study to help keep professionals on track.* Best-practice guidelines recommend training with professionals involved in FGCs should be ongoing (Carruthers, 1997); and c) *Promote transparency among organisations so that they understand processes of their collaborative partners*. Some participants were more optimistic about the implementation of more streamlined processes, claiming that, as soon as each organisation understands the other's processes, systems will then become more familiar, and timely collaboration could become "business as usual."

Participants echoed key recommendations found in international FGC research by Brady (2009) in Ireland, Carruthers (1997) in Canada, and Chandler and Giovannucci (2009) in the USA, including:

> ***Stakeholder buy-in***: *Key stakeholders, such as the professionals who support offenders and victims, should be encouraged to participate and show commitment throughout an FGC programme.*
>
> ***Appropriate timing of referrals***: *Referrals should be made as early as possible, as well as prior to court decisions.*
>
> ***Adequately trained and skilled professionals***: *Adequate and ongoing training should be provided to all professionals involved in the FGC process. Moreover, importance should be placed on the idea that facilitators are independent and remain impartial.*
>
> ***Culturally appropriate processes***: *The FGC process should be conducted in a culturally appropriate manner and where possible, be in the same language as that mostly spoken by the participants.*

Our pilot's participants endorsed these areas as important, with local solutions being enacted to varying degrees within the Tāmaki Makaurau pilot, as described by participants, that need to be continued and enhanced into FGCs nationwide.

Limitations and future research

The study's exploratory nature means that the results should be interpreted with caution; the qualitative sample was small and the quantitative detail limited to broad findings (of victim involvement, rather than detail of types of crimes and other factors that might affect that involvement). Future research could include more participants, including from management (e.g., regarding resourcing challenges) and victims who have been involved in FGCs (whether in person or by submission), and those who declined involvement. It may also be helpful to draw on the perspectives of the young person involved to contribute to a holistic and overall response so that the requirements of the FGC under the Act (1989), including the needs of the victim and the responsibilities of the young person, are appropriately explored. Additionally, a larger representative sample of participants that genuinely reflects the population groups most affected by FGCs will also be advantageous for future analysis and recommendations.

Conclusion

The barriers for victims that prevent them from participating in FGCs included agency processes and systems that were affected by lack of training and resources, information that was seen to be complicated and offender focused, and timing as an issue with police referrals and general timeframes. However, with the change in process to include Victim Support, the pilot project appeared to be effective in increasing the number of victims participating in FGCs, and in highlighting some of the barriers to participation. Further work is needed to increase the number of victims participating in person (rather than just by submission, or not at all), and in implementing recommendations for streamlined and timely processes of collaboration among professionals, who need to receive sufficient training and resources. It is our opinion that referring a matter to Victim Support from the outset of the process increases participation by victims, and therefore consideration should be made as to whether this process could continue. This will support positive steps towards the future of successful family group conferencing in Aotearoa New Zealand.

Acknowledgements

The authors wish to thank all the participants for their valuable insights and time in contributing to this research. We particularly acknowledge Victim Support for the opportunity to make this possible.

Notes

1 Defined as: *A written, signed and witnessed statement produced by a victim, that is free from opinion, to be used in court.*

2 The evaluation was initially scheduled for three months 1 March–1 June 2019. However, due to the terrorist attack in Christchurch on March 15, 2019, that necessitated immediate priority by police, it was decided that the pilot would be extended for a further three months, 1 March–1 September 2019.

3 Victim Support is a non-government organisation providing support, information and advocacy to people affected by crime and trauma. They act as an advocate for victims' rights and can help eligible victims apply to receive information about the person(s) who has caused them harm.

Accepted 14 May 2021

Published 1 September 2021

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ORIGINAL ARTICLE
QUALITATIVE RESEARCH

Messages to first responders from a bereaved parent

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ABSTRACT

INTRODUCTION: This article describes the use of autoethnography to explore my experience as a bereaved parent in relation to the traumatic loss of my 12-year-old child in 2009.

METHODS: Employing an autoethnographic approach, this research articulates and investigates personal narratives associated with experiences of the death of my young child. Narratives offer a rich description of the event and allow data analysis where emerging themes stream from a personal experience.

FINDINGS: Professionals taking control and the caring role of the community are main themes identified and analysed from these personal narratives. The findings advocate for an understanding of the needs of grieving parents at a time of extreme confusion. This article concentrates on professional first responders taking control and guiding traumatised parents when their child has a fatal event. Bereaved parents experience disorientation and traumatic confusion at the sudden death of their child. Emergency responders need to offer active listening skills and guidance.

IMPLICATIONS: Professional first responders need to take control of the bereaved parent's early journey of grief as they are likely to be in a state of deep traumatic shock, where disorientation leaves them vulnerable to lowered cognitive ability. The use of active listening skills and sensitivity can direct traumatised parents, thereby assisting the short- and long-term welfare of the family by addressing their initial needs at a time of crisis.

KEYWORDS: Autoethnography; bereaved parents; first responders; professionals taking control; emergency services; bereavement support

AOTEAROA
NEW ZEALAND SOCIAL
WORK *33(2)*, 80–87.

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One night in March 2009, I was thrown into a world of personal trauma and grief through the sudden death of my young child. A search for meaning to the event led me to research and analyse a *dual insider* experience. I was walking the experience of a bereaved and traumatised parent, as a registered social worker in Aotearoa New Zealand who had previously responded to other people's traumatic events.

Amongst many social work theories, one is the theory of crisis intervention. Regehr (2011) describes *crisis* as a period where an individual is unable to cope as usual due to a psychological imbalance; an individual can have impaired ability to perform tasks or to communicate. When working in the emergency department of a hospital, I have provided support for families affected by trauma and grief at the sudden loss of a family member. This task requires patience and empathy for a social worker to appreciate that individuals may be experiencing shock and confusion. It is most important that a social worker does not assume they understand the person's experience.

Janzen et al. (2004) explained how emergency professionals cannot underestimate the effect of traumatic bereavement on a parent. As a professional social worker, I had little knowledge of how the death of my child would affect me. I did not know what to expect, either about my own emotional reactions or other people's reactions. I expected that the professional encounter would be kind, compassionate, and helpful. I assumed that professionals know what to do in a crisis, are trained to handle traumatic events. Yet I encountered some emergency first responders who were proficient and some who were not. I felt vulnerable and the reactions of others had a significant impact on me. I can remember words, said and done which were comforting and, even more, actions, said and done that were hurtful and upsetting. Janzen et al. (2004) supported this parental perspective in their research.

This article focuses on the main research question: "As a bereaved parent, what messages are important for emergency response personnel when responding to a request for help to a dying child and their parents who live in a rural community in Aotearoa New Zealand?" The purpose of the study is to create awareness of the experience of a traumatised and bereaved parent for emergency first responders called to an event where a child has died. Dyregrov and Dyregrov (2008) and Feigelman et al. (2012) referred to the phenomenon of losing a child as a devastating experience for a parent. Such traumatic impact can result in complicated grief due to the parent–child attachment and this may include witnessing the event. So, what can emergency responders learn when attending the scene of such a devastating event?

Emergency personnel responding to a traumatic incident involving a child are responsible for managing, not only the child, but the response of the parents. Aho et al. (2010) explained the follow-up intervention for grieving parents, being skills of *affect*, *aid* and *affirmation*. Parents need guidance through post-incident tasks and to feel that people are listening throughout such processes.

Emergency responders need to ensure that parents understand how and why processes may occur and what role they have, and to challenge them if necessary. Fulbrook (2015) noted that a parent must start processing the psychological reality of the death of their child. Parents have shattered assumptions of believing their child would outlive them.

The lens of my personal experience offers a rich narrative description of an event. Narrative is knowledge that captures the knowing and telling of such an event (Kim, 2016). This research facilitates an *inside perspective* that would otherwise not be captured (Pace, 2012). I thus reflect on a very personal experience, that enables an understanding of events that may occur for parents when a child dies and contributes to the research question: "What should first responders offer to traumatised parents?"

I have recently observed the 12th anniversary of the death of my child. The passage of time has allowed a reflective personal journey of grief. This research started as a quest for meaning into the loss from the beginning moment of questioning, "why me?" Severe shock engulfed close family members who could not comprehend this loss. The study has been a continuous iterative learning process along a learning path of grief; arriving at a place where I have been able to share my story, adding to the research of parental grief.

Methodology

This is a study of the experience of the death of my child. In writing about this phenomenon, I seek to interpret a meaning to my loss, approaching the research from constructivism, where my knowledge develops through experiences and interactions. O'Hara et al. (2014) asserted that social phenomena, and their interpretation, are revised through people's interaction with each other.

The research method for this study crossed methodological boundaries of ethnography, phenomenology, and narrative inquiry in the complexity of writing a personal and evocative autoethnographic study. Autoethnography is the research method chosen for this self-investigatory task due to its ability to help an inside perspective that would otherwise remain unfamiliar (Pace, 2012). Mendez (2013) describes autoethnographic method as the researcher performing a narrative analysis of themselves in relation to a noteworthy phenomenon.

Two narratives aim to capture the culture of my experience in being witness to the death of my child. They contain a raw account of my emotions and senses at the time of the event and beyond. Pace (2012) identified that the narrative explains how and why the phenomenon occurs and is thus part of the method of my analysis. These narratives are sometimes graphic in nature to put across the reality of my child's death, and my subsequent grief.

This learning process involves interaction between the environment, the learner, and the *instructor*. In this instance the instructor is the event that occurred. However, learning is forgotten without reflection, where concepts arise from feelings and thoughts (Gibbs, 2013). Moreover, it is for the reader to determine the authenticity of the narrated experience based on their own interpretation (Ellis et al., 2011). From the narrative, one can attempt to evoke a response from the reader; do you as the reader feel a vicarious emotion? Comparison between the story and the reader's life experience gives theoretical validation (Ellis, 2004).

The Toi Ohomai Institute of Technology Human Ethics Committee provided advice and guidance regarding ethical concerns relating to other family members. Not only is consent to undertake this study obtained from every member of my close family, pseudonyms also protect their identity and that of the deceased. Ellis et al. (2011) observed that researchers do not live in isolation. The author may implicate others by undertaking their research, so it is important to protect others and seek their consent to the study.

The study takes me back to that night. Thus, self-care breaks were an essential part of my study when revisiting the horror of the event. This also involves seeking psycho-social support when required, taking account of any re-traumatisation. There is a note of caution to readers who may have previous experience of child bereavement as the narratives may evoke distress or discomfort.

Data analysis

The following two narratives describe a complex weave of past and present, whilst the research can offer advice for future emergency response when working alongside bereaved parents.

1. *The event*
2. *Grief support from the family social network system*

The narratives are analysed using two perspectives; one being personal narratives as data to reflect upon my personal senses at the time of the traumatic event. Secondly, analysis of the data considers emerging themes from the narratives. I thus interpret my personal experiences through recall whilst considering a professional response from emergency personnel. Recall is a complex cognitive process of past, present, and future. Gallagher and Zahavi (2014) described analysis of any experience (perception, memory, imagination) containing a reference to past moments of experience, a primal impression of what is happening and an anticipation of what may happen.

The first level of analysis is an iterative process, where additional life events have occurred. Such events can alter a person's perspective of what occurred, as identified by Tolich and Davidson (2011). The second level of analysis is an objective thematic analysis taken from the narrative; this creates another view of the phenomenon. The researcher takes a step back from their narrative when using analytical autoethnography. Themes from the text (either within or across the text) are ideas that offer a deeper explanation of the content. Parts of the narrative may highlight an emerging issue (Ellis, 2004).

Coded themes about emergency personnel present what interactions took place, thereby identifying emerging messages. The analysis inspects the personal impact of professional interaction on myself at a time of trauma. I can then consider training and education for professional responders when managing crisis intervention.

Emerging themes from the narrative text can plan a theory (Pace, 2012). This theory explains how and why a phenomenon occurred and is not a test for generalisability. The phenomenon observed in this instance, is my experience of traumatic parental bereavement.

Findings

I have chosen parts of the narrative that describe the phenomena and once again remind readers of the evocative content and the impact it may have on them as the reader. The first piece of chosen text from the narrative expresses my feelings whilst in a state of anxious panic awaiting the arrival of first responders:

> *With time of the essence, feelings of panic were rising inside, being reminded constantly by the emergency controller to keep calm.*

As the parent of a child whose life was ebbing away before my eyes, I was reliant on emergency response personnel to assist in the resuscitation of my child. With no signs of life from them, I started to panic from rising anxiety as time was quickly passing by without professional first responder input.

Living in rural Aotearoa New Zealand brings complications when emergency services are not easily accessible, as opposed to living in the city. Through research, I discovered that it is rare for a child who is not breathing and whose heart has stopped, to survive. Not all cardiac arrests are recoverable, especially in children. Jewkes (2001) explained that most cardiac arrests in young children are secondary to hypoxia, (inadequate oxygenation of the blood), or shock. Brindis et al. (2011) stated, in their research, that out of almost four hundred child patients needing resuscitation, only four (1.2%) responded. Paramedics often find the electrical heart rhythm to be missing in young children who are not breathing, making it impossible to revive them. Upon reflection, this has changed my assumption that first responders can succeed in reviving a young child in a state of hypoxia. This is not a message I would have wanted to know but it creates an understanding whilst managing personal parental grief.

For months after the event, I agonised over my actions that night, wondering if I could have done things differently:

> *After the event, I discovered it had taken seventeen minutes for the first ambulance to arrive at the location. The volunteer emergency responder jumped from their vehicle asking the way into the home and raced off from the dark towards the light of our downstairs rumpus room area where the ranch slider entrance was ajar. Following behind the first emergency responder, phone still in hand, we reached the bedroom. On seeing X's collapsed condition, the volunteer responder asked me to return to the vehicle to search for a defibrillator machine in the rear left-hand side of the ambulance.*

Months following the death of my child, I sent a letter of complaint to the local emergency ambulance service expressing concern over the time delay before the arrival of the emergency ambulance responders. This included the initial responder failing to take a defibrillator into the house, as the emergency controller informed them that my child had no signs of life. Although this would not change the outcome for my child, it was comforting that GPS navigation systems are now fitted in all ambulance vehicles and training undertaken in relation to the defibrillator incident.

But this was not the only concern relating to the emergency response:

> *I cannot remember any further questions asked at that point, into the night's events, but can remember a diminutive guy appear from nowhere to say he was sorry and would leave a brochure on the sideboard. As a traumatised parent it was difficult to give him attention at the time.*

Aotearoa New Zealand has a victim support system. At the time of a sudden death, an amateur volunteer will attend a traumatic event to offer support. Unfortunately, the victim support volunteer failed to communicate important information that might prepare a bereaved parent for negotiation with a coroner over the issue of performing an autopsy. The coronial service in Aotearoa New Zealand sets out the right for family to challenge the need for an autopsy within 48 hours of an unexplained death. This right was not explained to a confused and disoriented bereaved parent. Although not affecting my family, I am aware this mistake may have a large impact on others whose cultural needs are different. For example, Hudson et al. (2008) explored the impact of Māori culture on forensic science practice. To be away from, and not have access to, their loved one's body may cause further distress.

I refer earlier, to the poor outcome for the survival of most young children who have hypoxia. I have reflected on this poor survival rate and recognise it is not always possible for first responders to save the life of a child who is not breathing. Thus, control over the life or death of a child with hypoxia can be random. So, what are first responders able to control at the scene of a hypoxic child? There is the important attempt to save the life of a young child, but it is also important to care for traumatised parents.

The impact of the trauma is described in this next passage:

> *Someone distracted me from my child's room, although, really wanting to remain there with them. A family member had arrived at the house. I remember standing on steps in the hallway before walking down to greet them. People were around whilst they asked what had happened; trying to tell them but failing to, I saw the distressed, yet inquisitive look on their faces of disbelief. Sounding distressed they questioned, "Why aren't you crying?" At the time there were no words due to my disorientation.*

A sudden death is often traumatic where people may be unable to process the shock immediately and their body may react in a series of symptomatic responses. Dyregrov and Dyregrov (2008) described bereaved parents' reaction to their child's death as a sense of unreal, being in a dream-like state, and wishing it were not true. There may also be a sense of remorse and blaming of themselves about not doing more to prevent the death or of the ways they reacted at the time of death.

Dyregrov and Dyregrov (2008) described the death permeating the individual when it unfolds as a trauma, where the memory of the event is etched into their mind due to the intensity of the shock and emotion. When the shock is so intense, the mind seeks to protect and does not absorb the information in one go. Often reactions to shock take over, such as shaking, palpitations, dizziness, numbness, chills, and nausea; people often become disoriented. This may continue for some time beyond the initial event with many chaotic *racing thoughts*, and the memory of bereaved parents affected where they are unable to recall the events.

It is so important that others can take charge during a period of temporary disorientation for a parent whose ability to function well is affected by a crisis. The emergency controller took charge in obtaining information from me by asking me to be calm, enabling me to contribute to the efficiency of the response.

Professionals taking control

The ability of other professionals to take control was later observed by myself and commented on. Following the arrival of the ambulance, a uniformed police officer took control of the immediate scene, information, and guided my partner and I to avoid hampering the emergency response. This enabled paramedics to take control of the resuscitation effort. Police detectives investigated an unexplained death following the initial crisis for a coronial inquiry and any criminal proceedings, but did so whilst maintaining our dignity.

It is important to note that a person in a traumatic crisis may be disorientated and reliant on the skills of professional first responders performing their roles, including communicating what is happening with their loved one. I reflect upon this approach with gratitude; professionals need to guide and direct traumatised parents. Such parents are in no fit state to organise necessary services to manage the next stage of the event, the removal of the young child's body for an autopsy. Saari (2005) describes the importance of a trained crisis intervention response allowing bereaved parents time to respond to the event in their own way.

Professional intervention is required to establish the circumstances surrounding a death, yet this is performed during a time when traumatised parents are at their most vulnerable. It can offer comfort, though, when parents who are not responsible for their child's death are questioned by police and are determined as innocent of any crime. Heltne et al. (2016) described the routine examination of the death scene following a sudden infant death in Norway. They explained that the death scene investigation determines the cause and gathers new knowledge of the death scenario. The death scene investigation also performs an important role in attributing responsibility and confirmation of the cause of death. This may reduce rumination for some bereaved parents in believing that they may have been in some ways responsible for the death, even if they are not.

The need for a sensitive approach

Having described the benefit of first responders taking control for traumatised parents, it is still important for professionals to manage their care sensitively. Janzen et al. (2004) stated that bereaved parents still need some sense of control. The police enabled me to carry my child's body to the undertaker's hearse and allowed the family to remain near my child at the mortuary, although not in the same room. The police obliged as much as they were able to, given their protocols to protect evidence of what had occurred that night. Regardless of protocols, the police detectives allowed controlled access to my child's body before the temporary removal to an autopsy. Janzen et al. (2004) noted this as an opportunity for the bereaved parents to begin grieving.

The efficiency of determining an interim assessment of the likely cause of death was another important factor in supporting the welfare of my family and me. Less than twenty-four hours after the event, the police detectives returned to the family to inform of the initial outcome of their investigation. They explained their belief that my child's death was due to misadventure, ruling out parental involvement in the cause of death. Their assessment of the event was welcomed with relief as there was vindication from the suspicion of a young child's death at our hands and grateful that the professionals had demonstrated respect for the family, and my child's body. On reflection I felt an empathic response by professional responders and, in turn, the family developed trust and confidence in their actions.

Important messages for professional services working alongside traumatised and bereaved parents

The sudden death of a child is observed by Dyregrov and Dyregrov (2008) and Feigelman et al. (2012) as a devastating event for a parent. Its impact may continue long after the initial event, especially when such grief becomes complicated due to factors related to the event, the degree of trauma and the responses of others. It is thus important that emergency response personnel have the necessary attending skills described by Aho et al. (2010) as affect, aid, and affirmation. Hermansson and Webb (2009) described one of the skills in counselling as *attending*. Some strengths involved with this skill are respect, dignity, an open attitude, and an ability to actively listen. This means putting one's thoughts aside in attending to the needs of the individual.

Aho et al. (2010) explained the meanings of affect, aid and affirmation as skills. 'Affect' is the professional's presence in which bereaved parents feel listened to and understood, creating an *active listening* environment (Hermansson & Webb, 2009). 'Aid' involves guiding parents through tasks that must occur following a sudden death. Such guidance is essential due to the potential for confusion and disorientation of the parents. Combined, 'affect' and 'aid' should ensure that the parents or their representatives have understood the procedures required post-event. 'Affirmation' enables parents to start processing the psychological reality of their child's death. Fulbrook (2015) explained how bereaved parents must begin to adapt to the sudden change of shattered assumptions. This communicative role plays a significant part in how the impact of the death may affect the parent's future wellbeing. This approach is emphasised by Saari (2005) in advocating for professional training and response toward bereaved parents. Active listening and rejecting one's own impulses to rescue the parents are essential. Stating words such as "it will be alright," "things will improve," or "they have gone to a better place," are demeaning for parents. Such comments may make the responder more at ease but may leave questions in the minds of parents, reinforcing their pain and even a sense of guilt that they should have parented better.

The initial response to parental trauma is an important start to a long journey, it is important for emergency responders to display empathy and effective control to enable the experience of grief to occur without further trauma. It is important for all emergency responders and professional supporters to be competent in advanced communication skills to manage the reactions and needs of bereaved parents. Trained emergency responders can take control of a traumatic event when others are unable to; this approach offered support to me and my partner, and a sense of protection and security.

Implications

Emergency personnel attending a traumatic death scene must consider the needs of those who are witness to the event, such as the long-term welfare of parents involved in the resuscitation effort of their child. This approach plays an important role in the later grief and healing of those affected. The key messages from my research are:

- Bereaved parents can be in such a state of shock from the trauma that they are no longer in control of their emotions, senses, and cognition.

- There is a valuable role for professionals to take control of the situation when parents are in shock and lacking

> cognitive ability. They can actively listen to parents. Their guidance is important for the legal processes, and for the long journey of grief bereaved parents will have to walk.

Effective communication can reassure the family and start to build family trust in the legal procedures occurring, as such practice is part of the ongoing journey for the family post-bereavement. This can offer an understanding of bereaved parents' rights during clinical processes such as an autopsy. Aid in guiding the family through necessary procedures reinforces their experience of feeling supported during a period of confusion and disorientation. Offering respect and empathy can enable the start of the grieving process due to bereaved parents experiencing support in such traumatic circumstances.

I have reflected on empirical and theoretical research and drawn on personal learning to offer advice to the community of professional emergency first responders. Being a dual-insider researcher has offered further insight into the world of bereaved parents that is often recorded as a third person researcher. This research is an account of the experience of loss from an individual who works within the field of social work and first response. This approach is rarely used, yet can offer greater insight to research knowledge.

Accepted 20 July 2021

Published 1 September 2021

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"Moving out of the safe zone": Promoting learning communities and reflective supervision in a social work statutory child protection agency

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ABSTRACT

INTRODUCTION: Social work supervision in statutory child protection settings is often confused with line management and has little focus on professional development, critical reflection and exploration of practice. Within Aotearoa New Zealand, the statutory child protection agency Oranga Tamariki (OT), is under considerable scrutiny regarding the management of risk, child abuse, and the over-representation of Māori tamariki within the child welfare system. This article covers the first collection of findings from a larger supervision study.

METHODS: Using critical reflection as the methodological lens, four experienced OT supervisors participated in a *learning community* where supervision recordings were brought to each meeting to improve reflective capacity, critical reflection and skills. Data were collected from the learning community and thematic analysis was undertaken to explore current supervision practice in OT.

FINDINGS: The three themes generated from the learning community discussions were: supervisory skills/interventions; the structure of supervision; and working with emotion and trauma. These themes highlighted the significance of the learning community as a forum for supervisors to share their existing supervision practice together, "moving out of the safe zone" as they engaged in positive and constructive feedback with their colleagues in a supportive space.

CONCLUSIONS: Reflective supervision, within statutory child protection, is essential for learning, critical reflection and cultivating robust decision making in social work practice. The creation and development of professional supervision spaces such as learning communities provide the basis for supervisors and supervisees to develop their skills and ensure accountable, anti-oppressive and ethical practice.

KEYWORDS: Supervision; social work; critical reflection; learning communities; professional practice

AOTEAROA
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WORK *33(2)*, 88–103.

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Globally, there is a need to explore social work supervision in different contexts, and particularly in the child protection field (Carpenter et al., 2012). Social work supervision can be caught between the competing pressures of professional and organisational accountabilities within a managerial climate of risk and outcome measures. Within this difficult climate, it is essential for social workers to develop a critical understanding of their practice with service users. In addition, the supervisor needs to have specialist knowledge in the delivery of reflective supervision (Rankine, 2017).

The context of the research is the Aotearoa New Zealand statutory care and protection agency, Oranga Tamariki (OT). The agency has been under considerable scrutiny due to the over-representation of tamariki Māori (children) being uplifted from their whānau (family). The procedures and legislation governing the agency have been criticised in reports from the Ombudsman (Boshier, 2020), the Office of the Children's Commissioner (OCC, 2020) and the Waitangi Tribunal (Waitangi Tribunal Report, 2021). All the reports identified deficits in the delivery of reflective supervision.

The OCC (2020) called for urgent changes to "strengthen and implement existing recruitment, retention, mentoring and supervision policies and practices that address interpersonal, institutional and structural racism and support staff to work effectively with pēpi Māori, their whānau, hapū and iwi" (p. 86). The Ombudsman also called for urgent changes following review of 74 newborn (and unborn) infants after OT applied for interim custody under section 78 of the Oranga Tamariki Act 1989 during the period between 1 July 2017 and 30 June 2019. "In 46 percent of cases, there was no evidence of professional supervision. Where there were records of professional supervision, 90 percent of these were focused on tasks, actions and next steps, rather than the required critical and reflective practice" (Boshier, 2020, p. 21).

It was within this current backdrop that the authors engaged in a research project with social work supervisors and supervisees at OT to explore current reflective supervision practices and strengthen practitioner development. The focus of the research was to explore ways to generate life-long learning, greater resilience, self-awareness and develop practices that support reflective capability and well-being amongst supervisors and supervisees. To explore these areas, the research comprised of three separate aspects: a supervisor's learning community; supervisor–supervisee dyads; as well as a pre- and post-intervention online survey.

This article focuses on one branch of that research, the development of a learning community with four OT supervisors. The findings from the supervisor–supervisee dyads and online survey are to be published elsewhere in social work journals. Within this context, the positioning of supervision is key to developing high quality practice and, ultimately, improving outcomes for tamariki and their whānau. The aim of the learning community, in alignment with the focus of the research outlined above, was to deepen the reflective capacity of the supervisors and create a space to critically reflect on skills and interventions used in supervision practice.

Engaging in a learning community of peers requires a high level of trust and a preparedness to be vulnerable. "Moving out of the safe zone" was a telling quote from a supervisor in the learning community. Experiential learning requires active involvement, reflection upon practice, conceptualisation of the experience, and integration of knowledge gained from the experience (Knowles, 1990; Kolb, 2014). Moving out of the safe zone recognises the shift into a learning space that may, at times, be uncomfortable and challenging. The traditional notion of a learning curve is extended by evaluation and feedback from peers that stretches the learner beyond their comfortable space and supports growth.

Defining social work supervision

Supervision is a professional process where the supervisor is responsible for the supervisee, with the intent of meeting organisational and administrative agendas, as well as personal and professional goals (Morrison, 2001). For the social worker, supervision has become an integral and lifelong part of practice across all fields of work (Davys & Beddoe, 2020). Within the last decade, the social work supervision literature has grown, with academics, practitioners, managers and policy makers all accepting that supervision is a core ingredient for high-quality social work practice (Wilkins et al., 2017). It is a regulatory and mandatory obligation in many jurisdictions, including Aotearoa New Zealand. Supervision in social work assists with the development of self-care (Rankine, 2017), resiliency (Beddoe et al., 2014), professional development (Nickson et al., 2020) and the reduction of stress and burnout (Carpenter et al., 2012; Mor Barak et al., 2009).

Supervision is at the heart of social work and should include reflection and critical reflection. Reflection is learning from past experiences, re-considering beliefs and perspectives in order to develop future actions (Kolb, 2014; Noble et al., 2016). It is vital that social workers can reflect, learn, re-imagine, assess and grow as professionals through reflection and incorporate this process in their practice. Critical reflection provides a social worker with the opportunity to question beliefs, distortions in thinking, and examine structures in the environment (Noble et al., 2016; Rankine, 2018). In addition, critical reflection assists social workers to identify and action alternative ways of practising (Fook & Gardner, 2007). Fook and Gardner (2007) have highlighted a two-stage process to critical reflection of, firstly, deconstructing beliefs and then reconstructing practice with further action strategies. Reflective supervision encompasses all these definitions and is a professional activity with accountability to professional and organisational standards (Davys & Beddoe, 2020).

Supervision in statutory child protection organisations

Child protection social work is challenging and demanding (Davys & Beddoe, 2020) and there can be negative impacts on social workers' psychological well-being (Bradbury-Jones, 2013). Within this setting, social workers require advanced skills in complex decision-making to manage the levels of bureaucracy and the realities of child abuse (Kelly & Green, 2019). Davys and Beddoe (2020) have highlighted three factors influencing reflective supervision in this environment:

a. risk discourses of blame;

b. lack of existing skills and courage to explore uncertainty and ambiguity; and

c. professional values and relationships replaced by technological systems.

The supervisor endeavours to fulfil their administrative requirements through enforced procedures nested within data management systems and managing risk. Not surprisingly, the common focus in child protection supervision is case discussion. The social work supervisee is commonly supervised by their line manager who provides oversight, performance management and organisational accountability for the social worker's practice (Baginsky et al., 2010). The high level of organisational risk associated with child protection, and the accompanying media, public scrutiny and abuse, have subjected child protection social workers to neoliberal and managerial agendas (Beddoe, 2010). Consequently, social workers strive to empower families and protect children in a cost-effective and time-focussed manner whilst often managing unrealistic caseloads, dwindling resources and staffing cutbacks (Hyslop, 2017).

These systemic pressures and expectations within child protection work can leave little room for emotional support, reflection and critical reflection (Wilkins et al., 2017). Over a decade ago, O'Donoghue (2008) identified that social work supervision needs to promote professional and client-led practice. These issues are still relevant today as evidenced by the OCC and Ombudsman reports where exploring uncertainty and ambiguity in social work practice were seen as needing to be addressed. The supervision space has become cluttered with organisational requirements and obligations that take priority over individual social worker's time and space for critical reflection.

Striving to provide a quality social work service and a more sustainable workforce, OT has recently developed changes. The changes have seen the promotion of a Professional Supervision Policy and Standards—a commitment to improve social workers' skills and knowledge through quality supervision that is committed to improving outcomes for children and families (Oranga Tamariki, Ministry for Children [OT], 2017). The policy outlines the expected outcomes from supervisors that include the promotion of reflection and critical reflection as key in developing practitioners, as well as the need to participate in their own ongoing professional development (OT, 2017). Whilst the policy itself is a positive step forward, the implementation and any changes made in supervision continue to be problematic, especially in assessing impacts on decision making and outcomes for Māori (Waitangi Tribunal, 2021).

Developing supervisors and their supervision of others

In Aotearoa New Zealand over the last two decades, supervision practice has been consolidated with recognition of its importance through training providers and social service institutions (O'Donoghue & Tsui, 2011). The Aotearoa New Zealand Association of Social Workers (ANZASW) and the Social Workers Registration Board (SWRB) have highlighted the significance of social work supervisors and need for specialised supervision training (Beddoe, 2016). A national study by Beddoe et al. (2012) linked poor supervision, as identified by practitioners, with a lack of qualifications and knowledge in their supervisor. Other studies, in the United Kingdom, such as Wilkins et al. (2017) have also detected that, in statutory child protection, a greater focus is placed on training social workers than the development of supervisors.

Within the current managerial context, supervisors need to be supported to develop and hone their skills (Rankine, 2017). Safe, ethical and accountable supervisory practice can then take place. As an initial step towards evaluating current supervision practises, supervisors may seek feedback from their supervisees. Within the current climate, however, feedback may be relatively ad hoc and informal (Davys et al., 2017). Finding more effective ways of evaluating and reviewing existing supervision is highly advantageous to developing practice (Wilkins et al., 2018).

Recording supervision sessions provides a good source of information and feedback for supervisors for development purposes (Bernard & Goodyear, 2009). This approach has been used in supervision training (Davys & Beddoe, 2020) and has been recommended to assist reflection on practice for experienced professionals regarding the supervisory relationship, expectations and roles (Hill et al., 2016). Davys et al. (2019) developed a supervisors' learning community where the goal was "to share practice in a safe environment, to reflect critically on the practice, to receive feedback and to build supervision competence" (Davys et al., 2019, p. 4). The authors concluded that, through collaborative enquiry, a learning community promoted critical reflection and learning, and was a key element in developing supervisor competence.

Methodology

Social constructionism and critical realism are the epistemological standpoints related to this research and define how knowledge, meaning and phenomena are explained by participants (Crotty, 1998). Social

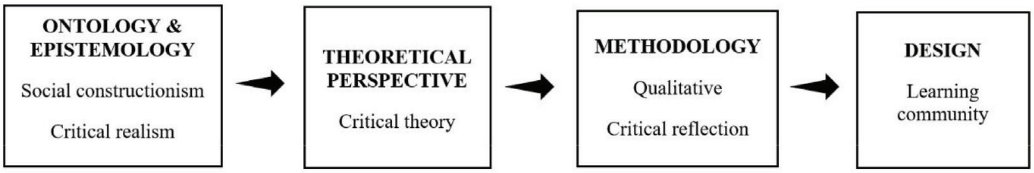

Figure 1. The Methodological Approach of the Study

constructionism focuses on how context influences people's understandings of self, others and the world around them (Crotty, 1998). Critical realism identifies dominant social structures as central to shaping causal explanations (Bhaskar, 1979). Critical realism also encourages the use of critical approaches in qualitative research and the co-construction of knowledge between participants in practice (see Figure 1).

Critical theory identifies oppression at individual and structural levels, explores alternative approaches (Fook & Gardner, 2007) and accommodates critical reflection (Baines, 2017). Critical reflection, positioned as a research methodology (Fook, 2011), enables the conceptualisation of practice experience in context and is recognised as an effective tool for collecting and engaging with information, developing knowledge and promoting change (Ruch et al., 2015). This action research (Munford & Sanders, 2008) allows researchers to become immersed in the study, working collaboratively with participants in a co-constructed research process (Morley, 2013). The authors, with extensive experience in reflective supervision, worked alongside experienced OT supervisors to explore and deepen reflective practice.

The learning community

Stoll et al. (2006) describe a learning community as "a group of people sharing and critically interrogating their practice in an ongoing, reflective, collaborative, inclusive, learning-oriented, growth-promoting way" (p. 223). In this study, four supervisors from an OT regional office in Aotearoa New Zealand explored whether a learning community increased their reflective capacity and promoted personal growth, learning and development. The learning community was established as a forum to improve reflection and supervision skills for the supervisors.

A regional OT office volunteered to participate in the research. Participants were invited to become involved through the distribution of an information sheet to all staff at the OT office. Participants, including supervisees who were audio recorded, voluntarily completed and returned signed consent forms. Participants chose pseudonyms and all identifying participant and client information was removed. In addition, the participants signed a group agreement regarding group rules and confidentiality at the commencement of the learning community.

The group of experienced supervisors had worked together for approximately 20 years, had several years' supervisory experience each and attended various supervision programmes which created many advantages for the learning community. We noted a high level of rapport and trust that facilitated active participation, honest feedback and a respectful, supportive environment.

The learning community sessions ran over a six-month period at the participants' office (about one 90-minute session per month). The sessions were facilitated and audio-recorded by the authors and transcribed by a professional transcriber. The authors ensured that the structure of the sessions and a process of critique and feedback (as described by Davys et al., 2019) were followed. This allowed two supervisors to separately present a selected audio segment from their supervision recordings each session (see Table 1).

The supervisors' recordings of the supervision sessions were used to promote critical reflection and to encourage the deconstruction of the supervision practice. Reconstruction of practice, through the introduction of new strategies and insight from others, has been described by Fook and Gardner (2007). In this research, within the learning community, supervisors were able to listen, consider and comment on their own supervision practice, but also actively engage in feedback with others.

Ethical considerations

The research was approved by the Human Participants Ethics Committee of the University of Auckland. The authors sought written consent from the Chief Executive of Oranga Tamariki, the Senior Advisor of Regional Operations and the Regional Manager of the Oranga Tamariki site where the research was undertaken.

Data analysis

Thematic analysis, which was performed in this study, promotes an inductive process to coding and theme development from research data (Terry et al., 2017). Both authors familiarised themselves with the data and transcripts, noting content. In the research, NVivo was used to support the inductive process of identifying descriptive and interpretative coding levels. NVivo is qualitative research software that assists

Table 1. The Supervisors' Learning Community

THE SUPERVISORS' LEARNING COMMUNITY	
AIM	To deepen the reflective capacity of the supervisors and create a space to critically reflect on skills and interventions used in supervision practice.
TIMING	1. Critical reflection of recording 1 (45 mins) 2. Critical reflection of recording 2 (45 mins) Total for a session = 1.5 hours
PRIOR TO THE MEETING	**Step 1:** OT Supervisor (presenters 1 and 2) record a supervision session each. **Step 2:** OT Supervisor chooses segment for critical reflection of approx. 15 minutes.
STRUCTURE OF EACH SESSION	**Step 3:** Group meets, listens to the segment of the recording from presenter 1. **Step 4:** In session presenter 1 gives a context to the recording and supervision session and states what she/he was trying to achieve during the recording segment. Presenter 1 then shares: What they liked/strengths What they would like to improve/areas for development A question they are now considering **Step 5:** The other group members then share, in turn: Strengths (affirming statement) Areas for development (extending statement) The other group members reflect on how the presentation relates to, or resonates with, them and/or their practice. **Step 6:** Presenter 1 reflects on their responses from the group *The process is repeated by presenter 2. *These discussions are recorded onto an audio-recorder

storing, managing and categorising information (Bazeley & Jackson, 2013). Themes were developed from the codes, reviewed and tested for viability in developing a narrative from the data. The authors discussed the codes and themes on an ongoing basis and used thematic maps for deeper immersion into the data. The three themes generated from the discussions were deeper reflections on: supervisory skills/interventions; the structure of supervision; and working with emotion and trauma. The following section focuses on the value of the learning community for participants in improving reflective capacity in supervisory relationships and providing learning opportunities for the supervisors.

Findings

Supervisory skills/interventions

A first theme identified from the learning community sessions were the skills and interventions that the supervisor used, or would like to use, in their supervision. Despite being experienced supervisors, considerable uncertainty was identified around how to be present with supervisees in supervision and how to facilitate appropriate interventions.

Supervisor presence

The busy, and at times, trauma-laden OT environment was particularly challenging for the supervisors as they worked towards being active and present for supervisees. At times they recognised that they were not fully engaged in the supervision process. The spectrum of "being present" stretched the supervisors from being fully engaged and actively challenging, to taking a passive approach and allowing the supervisee to "run" with the session.

Abraham used a sledding metaphor, which may be an exciting activity, but can also be somewhat out of control. Supervision in the OT environment requires the supervisor to manage uncertainty, complexity and maintain focus.

> You give people what they want and you don't really have to think. It is easy just to slide through a supervision session and go "my mind wasn't really in that one", it is easy to jump on a sled and go down the slope and you are fine. Whereas if you are doing it properly it probably is a bit of hard work, you actually have to think. (Abraham)

Using a different, fishing, metaphor, Abraham related how the supervisor needed to be alert to interrupting and responding to the supervisee's information to allow greater critical discussion. "Snapping the reel in every now and then" connects to engagement and remaining alert to the supervisee's agenda.

The active and engaged supervisor must be ready and attentive to respond to the immediacy of the material that the supervisee brings to the session. Penny discussed the tension of intervening in supervision to promote deeper reflection whilst also maintaining active engagement:

> So if you let them go … then do you lose meaningful points at which you could get them to expand even further … if you don't interrupt … they may as well be sitting in the room on their own. (Penny)

The learning community became a useful source of feedback and affirmation when they noted that the supervisor was fully present in the session.

> You were still present with her, she hadn't lost you. You might have felt "Oh how do I bring it back?" but actually you were there because we heard you – "yes [pause] good [pause], oh okay [pause], yeah." (Penny)

> I thought you validated it and that was good and … you shouldn't try to be somebody else … what you do, you do well. And you are spending the time

> with her and you are helping to explore. (Maria)

The distractions of a busy office and the multiple pressures on the supervisor made it difficult to remain present and focused. Each of the supervisors reflected on the challenges of managing a cluttered supervision space that was packed with administrative and line management responsibilities, leaving little space for critical reflection. Supervisor presence also requires shifting from current focus to a broader view looking at trends or themes that influence future decision making and preferred outcomes. This enables the supervisor to consider how the supervision space is used and encourage "super-vision".

> It might be interesting to explore how that role looks around the ongoing lower level [social work support] moving away from that incident based [child protection intervention] stuff. (Elizabeth)

> There is a lot still to be thought about, how much work does [the supervisee] do and at what point … she shouldn't be doing much at all in actual fact. (Maria)

Empowerment in decision-making

The supervisors struggled with the quandary of how to facilitate a process where supervisees were supported and empowered, yet still challenged to think differently. The supervisors were often perceived as experts or, occasionally, parents, and recognised that this was not helpful for the professional development of the supervisee. Given the time-poor child protection context and pressure to ensure expediency, the supervisors felt cornered into giving supervisees the answers, rather than encouraging them to reflect on their own approach.

> Because supervisees want the opinion of the supervisor I find it is the easiest way. They just want to ask someone a question and have an answer, but actually I can't answer a question about your own style and way of thinking [but] I can help you explore that. (Penny)

From hearing another supervisor's recording, Maria shared her thoughts on empowering her supervisees with, "it is okay for her to come in asking questions, but I would also get her to come up with the answer." She then reflected on her own ability and difficulties in her supervision of others: "My big thing is trying to enable people to do their own thinking, and that is easier said than done really."

Elizabeth reflected on her role as a mentor for young social workers, using the metaphor of a "mother duck" in the decision-making process, yet recognising that the social worker must achieve independence.

> I think it is okay to be a mother duck for a little while … when somebody is brand new and I could tell that she was really fragile in her work [and] was probably thinking "is this for me?" ... It is her confidence more. [But] she is not going to grow confidence if she is under my wing the whole time. (Elizabeth)

The supervisors identified the developmental lens required to challenge a supervisee to think and learn at different stages of their social work career. The needs of a new graduate were different from those of a seasoned social worker.

> I think different social workers are at different places with being able to be reflective … I think it is easier with the experienced ones to be able to ask some of those questions that gets them thinking about practice. (Maria)

> The difference between supporting and challenging somebody [is] when you are at a certain level … they should be able to handle the challenge …It's a different mindset—you think differently when you know you are going to be challenged and it is a different outcome … It is a complicated process to challenge someone, it is not easy. (Abraham)

Giving advice and developing strengths-based skills

The supervisors debated the appropriateness of interrupting the supervisee's thinking by giving advice and the wish to develop more strengths-based questioning. The learning community assisted them to consider their own style of supervising and how to improve their skills.

Abraham acknowledged his uncertainty about delivering a "mini lecture" in a supervision discussion, running the risk of losing engagement with the supervisee and being seen as an expert. He expressed this as "a little bit preachy" with a level of judgement that it is bad to preach; however, the experience of the supervisor might well be highly valued by the supervisee.

The learning community affirmed for Abraham that he had successfully interrupted the supervisee's stream of consciousness in the conversation and then noted that "she really started thinking." The "preachy" disclosure from Abraham also demonstrates his trust and preparedness, despite his vulnerability, to share his practice with the learning community.

For other supervisors, like Elizabeth, importance was placed on utilising strengths-based skills to assist supervisees move past problem-saturated discussions and creating moments to engage in positive aspects of the work completed:

> It is actually about having ideas about things to interject or, finding moments or a "sample" question or something like that like: "tell me something that you think has gone really well" I need some of those just to pull in. (Elizabeth)

When the group listened to this recorded segment from Elizabeth, it created deeper learning:

> … after she had dumped all of that and you … redirected her into, "so what's gone well?"…. I'm going to take away that question about what has gone really well for you, and "what is something you are proud of?" Because I thought that was a really good question ... that is certainly a question I'm going to try. (Maria)

It was evident that the learning community were digging deeper and sharing their most difficult conversations with each other as the learning community developed. The tone of the discussions was changing and becoming strengths based.

The structure of supervision

The second theme from the learning community was the structure of supervision. A common concern identified was the administrative time required due to line-management accountabilities. This pervasive concern left the supervisors considering how it might be possible to create a reflective learning environment within supervision, when they felt so constrained by administrative and case responsibilities. The supervisors explained their pressing organisational responsibilities as supervisor managers:

> I do think that the task centred (supervision) is relevant ... Sometimes you just have to know and it is impossible to do this work where there are KPIs … without running through a caseload every so often, going "Okay actually where are you at with this?" (Penny)

> Our organisation has lots of responsibilities around managing public money ... I need to be able to record that I have had those conversations about workload, annual leave … and it has got to be recorded somewhere ... because if something crashes I need to be able to show that I've had those discussions … I've learned from having my supervision audited when a supervisor did crash and when we had complaints. (Maria)

In hearing Maria, we became aware of the burden of administrative requirements, and Maria's concern to do her best for the organisation and to keep her supervisee and herself safe.

Administration and case work

The supervisors in the learning community had their own approaches to managing administration in the supervision space. For Maria, administration items were "jotted down" as the necessary priority and "getting that out of the way [first] because that is the boring stuff."

Maria also recognised the shortcuts that she would use in supervision with her supervisee to ensure large volumes of information were shared. This included labelling clients to enable recall and meant that there was little time for critical reflection:

> We tend to use a lot more shortcuts in the way we talk than what either of us would during a usual supervision. It is more how we talk in the office rather than good reflective supervision. So tell me about mental health girl because I can't remember her name off the top of my head, but she knows who I mean. (Maria)

Whilst it was felt that the supervision space predominantly focused on administration and case work, it was also recognised that these conversations had become a safe and comfortable space. Creating space for critical reflection felt like uncharted terrain and not as comfortable for the supervisors.

> I'm the problem, I am more comfortable really staying and just doing case work. [Case work] seems much more [safe] and easier … if we start going deeper am I going to be out of my depth potentially? (Maria)

Facilitating the structure

Despite the time and administrative pressures faced by the supervisors, maintaining a meaningful focus to the session appeared problematic to the supervisors. Maria described supervisees using supervision as their "dumping ground" to offload their stream of issues and for Penny this "commandeered" the session. For Maria this needed to simply "start out with 'how are you?' and then move onto setting the agenda." The learning community highlighted for Penny the clarity of setting an agenda "and is it okay to leave stuff to another time. I am never quite sure particularly where to end supervision, because we have sat there for [up to] 2 ½ hours". Giving attention to agenda setting early on the session was agreed by the learning community as paramount to avoid drift.

By using the learning community to explore alternative ways of working, the supervisors were able to draw on their collective wisdom and develop confidence in their abilities to facilitate effective supervision. This started with the supervision contract:

> We talk about it when we do our supervision contract: what are your expectations, what do you want, how are we going to resolve things if we are talking about a case and we disagree, how are we going to deal with difficult stuff, personal stuff? (Penny)

Setting an agenda became purposeful as Penny realised that "supervision is about the supervisee" and that "each [supervisee] gets to talk about things [they] want to talk about" and that "the supervisor needs to drive it." Elizabeth offered that "by asking [supervisees] at the beginning what they want [and whether this was] achieved by the end" gave the supervisor important feedback on the session's structure.

> … you have to allow them to unpack … and to keep facilitating that, otherwise you are leading and if you are leading then your thoughts really are the ones that are directing their practice. (Abraham)

Working with emotion and trauma

The supervisors discussed the emotion that they encountered during their sessions. Their supervisees were under extreme pressure, both personally and professionally, at times. The expression of emotion brought out conflicting feelings and responses from the learning community.

> She was crying and I have a tendency not to ignore feelings by any stretch, but I kind of acknowledge them, but get to the root of the problem to get some perspective and sometimes is that the right way? No, sometimes it is depending on the situation. (Abraham)

The group went on to explore the nature of acknowledging emotions and empathising with supervisees further:

> ... where is it appropriate to empathise with the feelings of the person you are talking to? And going, "I know just how you feel because I feel the same," and where do you stay outside of that and hope that they don't feel like you are an unfeeling monster that just doesn't care. (Penny)

Containing the shared experience of trauma

The learning community acknowledged that the presentation of emotion by the supervisee can be projected from an experience that is so familiar to the supervisor that they, in turn, have difficulty containing their own feelings. The experience can be one of being retraumatised. The traumatic nature of the OT work requires a high level of resilience and the risk of traumatisation, directly or indirectly, is high amongst both supervisees and supervisors in the child protection environment.

The shared suffering or experience becomes difficult to navigate and is discussed in the learning community as a negative cycle. Penny says:

> I don't know if it is helpful or not helpful for supervisees to know that we are just as if not more stressed than they are at any given time. Sometimes you just want to go "yeah we are in this together and it is just as terrible for me" and other times you just want to go "hang on let's just pretend to be above this" … you just end up that circling the drain together … and I don't know if that is helpful, but the temptation is there and you have to actually stop yourself from doing it or know when you are doing it. (Penny)

Discussion: The value of the learning community

Supervisors within statutory child protection organisations struggle to balance administrative requirements and obligations alongside a professional space that supports reflection and learning. The OT supervisors from the learning community described the cluttered supervision space and heavy expectations to meet various managerial demands. The description from the OT supervisors mirrors current criticisms from the Ombudsman (Boshier, 2020), the Office of the Children's Commissioner (OCC, 2020) and the Waitangi Tribunal (Waitangi Tribunal, 2021). These expectations have been related to procedure, risk and case management systems (Beddoe, 2010) at the expense of skills and time to deepen professional capacity that assists in working with families (Davys & Beddoe, 2020). Such supervision practices align better with line-management and, arguably, do not support the development of the social worker's personal and professional practice (Morrison, 2001).

Reflective supervision becomes pivotal for social workers to develop critical reflection in their practice (Rankine, 2018). Within the current neoliberal environment, managerial and organisational issues weigh heavily on practitioners' minds and dominate work commitments. A learning community provides practitioners time to engage in practice reflection with colleagues (Davys et al., 2019). Spaces for supervisors to regularly review and discuss how they "do" reflective supervision need to be amplified in ongoing professional routines. Reflective supervision, underpinned by critical reflection, provides the vision for improved practice for children and families, especially Māori.

The learning community created a new experience for supervisors that did not previously exist in their workspace. Participants were able put aside their day-to-day managerial routines and reflect further on the skills and interventions, the structure of the supervision session and how to effectively work with emotion and trauma. Furthermore, the learning community provided the space for supervisors to: 1) reflect on practice together through hearing and listening to their own and others' supervision experiences; 2) engage in feedback and gather personal reflections that challenged existing practices; and 3) express vulnerability and be supported by colleagues through the learning community process which led to strengthened working relationships. Such outcomes are consistent with previous research of learning communities (Davys et al., 2019). Throughout the learning community experience, the supervisors reflected on the valuable time away from the social work front line and recognised the critical importance of being open to challenge so that they could learn and grow.

> One thing was … moving out of the safe zone, you know, just for myself as a supervisor and being challenged about that and where the growth [is] happening and … reminding myself about that so I now carry that with me again … and I need not be worried about it. Just cross that threshold and see what happens. (Maria)

Moving out of the safe zone became a catch-phrase for the learning community to critically reflect and challenge one another. As illustrated in Figure 2, challenges promoted growth and experience for the supervisors through reflection and integrated learning. Through evaluation and feedback at several points, the learning community extends traditional understandings of learning cycles and experiential learning (Knowles, 1990; Kolb, 2014).

The cyclical nature of learning, not only creates growth for the supervisor, but promotes synergy and growth for the entire

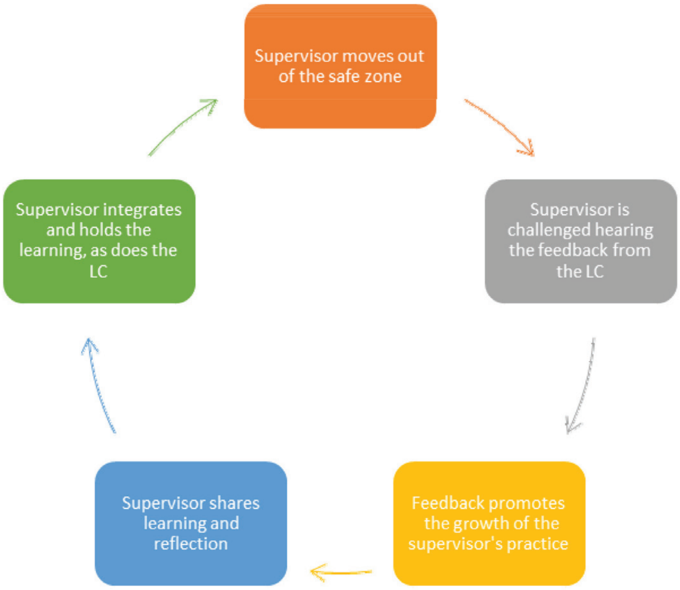

Figure 2. The Reflection and Learning Cycle of the Supervisor

learning community:

> I am constantly learning things about myself even though it is somebody else's session. I constantly think … I've been there … I miss opportunities all the time and it is just such a good reminder to me when I hear somebody else doing the same. (Penny)

The learning community is isomorphic in nature as changes can then be replicated in other relationships (Davys & Beddoe, 2020). There is the potential for the supervisors' learning to then be transported into their supervision sessions with supervisees and consequently, an impact on practice outcomes through collaborative decision making. From the perspective of critical reflection, practice is reconstructed through these new strategies and generates agency (Fook & Gardner, 2007).

For critical reflection and learning to occur, the practitioner requires the time to analyse events, interactions and plans (Davys & Beddoe, 2020). In order that social work maintains its professional integrity, the exploration of structural barriers and risk factors affecting children and families is essential. This process is particularly transformational, unsettling and perhaps uncomfortable when done with the support of others (Carroll, 2010). Maria acknowledged the vulnerability required to move out of the safe zone to achieve rewards.

> [The learning community] is a unique opportunity really isn't it like you are putting yourself in a vulnerable position but there are rewards from that just getting the feedback. The suggestions and also the things you come away feeling not quite so bad as you think you might have. (Maria)

The reciprocal sharing of learning and the supervisors' preparedness to be vulnerable, was also reported to strengthen the working relationship of the supervisors. Abraham stated he "enjoyed every minute of it" as "you are continually picking up stuff —I have learnt from everybody."

> I think it strengthens our relationships too, because we come to this place of vulnerability … that actually is like a gift … for me I felt that has been one of the biggest benefits is feeling like developing more trusting relationships because you do have to trust your colleagues and put yourself on the table. (Maria)

For many supervisors there may be a feeling of isolation as reviewing and evaluating supervision practice for learning and development has been recognised as rare alongside being extremely advantageous if it is undertaken (Davys et al., 2019; Wilkins et al., 2018). Abraham concurred: "you don't get to hear other people's supervision sessions and so it has been nice to have it affirmed" claiming that "those [admin] responsibilities get in the way and [occupy] so much time. I don't think you can get to this stuff that you need to get to … it should be professional supervision." Critical to current social work practice in OT is the space to review supervision practice and explore wider environmental issues impacting on social work decision making involving whānau Māori (Waitangi Tribunal, 2021). The learning community provides the opportunity for supervisors and social workers to collaboratively engage in these key practice conversations.

The supervisors concurred with the study's aim that the learning community space deepened their reflective capacity. This process had a transformative effect which challenged the way the supervisors viewed their role towards facilitating reflective supervision and, moreover, how a learning culture could be promoted in the organisation. In doing so, supervisors can develop critical conversations around social justice and the impact of practice decision making on Māori. Abraham stated that "[learning communities] is the development stuff that so many supervisors in this place

[OT] need" and that "it would be a lot more effective if this sort of thing was rolled out across the country." Such initiatives like the development of learning communities, Maria felt, would "improve the practice onsite [and have] a flow-on effect." Such a flow-on effect from reflective spaces can generate intervention and the development of anti-oppressive practice (Baines, 2017)—an area desperately needed for partnerships with Māori.

In social work, learning is seen as life-long. To aspire to this, individual practitioners need to take responsibility for their own professional development in supervision. The question for the learning community was how to juggle this commitment alongside managerial risk and time constraints. Penny acknowledged the espoused commitment to learning in her organisation and that it had to start with her personal accountability towards developing her own critical reflection and promoting social justice for the communities she worked with:

> So there is a very strong push in this organisation for professional development to happen for staff [and] that is the supervisor's responsibility … [But] nobody else is taking care of my professional development except for me. (Penny)

Limitations of study

Engaging in a learning community with peers requires a high level of trust and a preparedness to be vulnerable. In addition, members of the learning community need to hold a commitment to regularly meet and put aside other organisational demands. Whilst this learning community comprised experienced supervisors and positive experiences of knowing one another beforehand, future learning communities may not have this experience. Mistrust, unconscious and conscious individual and group agendas would lead to degenerate and negative experiences of a learning community—this would not be conducive to reflective processes occurring. Developing a group agreement at the commencement of the learning community is one important avenue that provides structure and agreed ways of working.

One participant in the learning community had a hearing impairment and this was a factor that required group consideration. Therefore, a decision was reached that audio recordings were shared prior to the session so that everyone could engage equally when the learning community met. This was a cue for the authors to consider accessibility issues that might impact on future learning community groups.

The supervisors' experiences and reflections are exclusive to the learning community in this study. The learning community comprised only four participants. Therefore, views related to cultural diversity, understandings of critical reflection and participant experience were not captured on a significant scale. The collection of data may not represent other OT offices or statutory social work organisations so claims of transferability and generalisability are limited. Despite the small sample presented, this study contributes towards the evidence base of supervision literature in social work practice through an Aotearoa New Zealand lens. More importantly, the study provides a pathway in statutory social work, such as OT, for the future development of effective learning communities. Such spaces provide critically reflective conversations to emerge that challenge existing structural and power issues in supervision and explore alternatives to social work practice with families.

Conclusion

The learning community offers a proven approach to building reflective supervision capacity in statutory social work. The implementation of learning communities across the social work sector promotes practice efficacy and could provide a response to the criticisms levelled at OT, from the OCC, the Ombudsman and the Waitangi Tribunal. Within the bureaucratic and crisis-driven environment of statutory child protection, social workers need reflective supervision to learn, critically reflect and develop robust decision making in their practice with children and families. Reports and literature in child protection nationally (and internationally) point to such recommendations and requirements within social work practice on a continual basis. The creation of learning communities could improve practice and be a regular part of professional practice routines. Whilst a focus for on-going training might predominantly be on frontline social workers, their supervisors also need training to develop and ensure that their support of social workers is competent, safe and accountable. This study has demonstrated that a learning community provides an ideal protected space for evaluating, critiquing and developing supportive practice within a busy statutory environment.

Acknowledgements

Sophia de Fossard and Laia Bolibar Navarro for their assistance in the analysis of the data.

Accepted 18 July 2021

Published 1 September 2021

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The best interests of the child: More questions about this construct?

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ABSTRACT

In this article I examine the *best interests of the child* construct and raise questions about the utility of the construct. I also draw attention to Winnicott's *good enough parenting* proposal as an alternative conceptualisation that addresses the issue of parental child-rearing capacity.

The best interests construct that emanates from the US has been the dominant international child-protection paradigm for at least two decades. Associated with this construct is a focus on individual parental pathology and child-rearing deficits. Yet, family poverty is the dominant factor, rather than parental pathology or incapacity, that precipitates many child abuse and neglect cases. The question is, has the best interests construct, one that ignores poverty and social disadvantage, outlived its usefulness? This construct has certainly affected Aboriginal families and led, as evidence shows, to the over-removal of children from these families. A range of alternative interventions and a social model of child protection is then canvassed.

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WORK *33(2)*, 104–113.

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Introduction

Since the publication of *Beyond the Best Interests of the Child* (Goldstein et al., 1973) and *Before the Best Interests of the Child* (Goldstein et al., 1979), plus *In the Best Interests of the Child* (Goldstein et al., 1986) and finally, *The Best Interests of the Child. The Least Detrimental Alternative* (Goldstein et al., 1996), international child protection legislation and casework practice has been shaped by this construct. A cross-national analysis of child welfare decisions in relation to child removals supports this view (Burns et al., 2017). In 2009 and 2011, two publications (Hansen & Ainsworth, 2009, 2011) raised questions about the construct, the *best interests of the child*. This article again takes up this theme.

An alternative conceptualisation

A powerful, alternative conceptualisation and a challenge to the best interests of the child construct is Winnicott's *good enough parenting* proposal (Winnicott, 1973). One reason for this is that the good enough parenting idea is less dependent on legalistic thinking and it is firmly rooted in knowledge about child and family development. The phrase *good enough parent* was first used by Bettelheim (1987), before the Goldstein et al. (1973) best interests construct that is steeped in Freudian psychoanalytic theory, began to dominate child protection practice.

The Winnicott proposal, that is also influenced by Freudian theory, takes us away from the legalistic best interest construct about which there is no agreed definition, in child protection law or science (Hansen & Ainsworth, 2009). Central to the position put forward in this article is Winnicott's prime focus on the parent–child (especially the mother) relationship as the foundation of a child's healthy growth into adulthood (Winnicott, 1960). This theory does not separate the child from the parent, as does the best interests construct with its singular focus on the child's alleged best interests at the expense of all else

(Featherstone et al., 2018), resulting in what these authors label as:

> [An] "atomised" child, severed from family, relationships and social circumstances: a precarious object of "prevention" or rescue. (Featherstone et al., 2018, p. 27)

In that respect, the best interests construct is best characterised as social aspiration (Spinak, 2007). The Winnicott proposal is also more amenable to the creation of guidelines for use by practitioners, the absence of which makes for a resort to rule-of-thumb decision making by child protection and legal personnel (Kahneman, 2011). It is also likely to be more comprehensible to parents who are involved with child protection services.

The further advantage of the good enough parenting idea is that is keeps the focus on parents and their parenting capacity—which is at the centre of child protection concerns. It does not solely focus on the child. The sole focus on the child separates the interests of the child from those of the parents, when it can be argued that these interests are inextricably linked (Guggenheim, 2007).

It is potentially enlightening to consider why the best interests of the child construct has been so widely accepted and why the good enough parenting proposition did not gain ascendancy as a concept to guide legislation and policy. The following points have a bearing on this in my view. The first is that, for children's rights advocates, Winnicott's proposal is too sympathetic to parents. The second is that children's rights activists, including many lawyers, were sympathetic to the best interests construct as it was, in the main, authored by lawyers. Thirdly, it can be argued when it comes to child protection legislation, lawyers are in the best place to influence the drafting process. The best interests construct is not embedded in knowledge about child and family development. Social workers and psychologists, working in child protection services generally have a wider grasp of this knowledge, and in an earlier era before the best interests construct (Goldstein et al., 1973), the Winnicott good enough parenting proposal was favoured. Indeed, while not a faculty member, Winnicott taught child development to students on the London School of Economics social work qualifying course at least between 1968 and 1969 (I was one of his students). However, social workers and psychologists do not have the same influence as lawyers in the law-making process and those drafting the relevant legislation may not have been aware of Winnicott's good enough parenting proposal. Finally, Winnicott did not have as strong an affiliation with a distinguished university as Goldstein, Freud and Solnit did. I will argue here that it is time to move on from the historical conjunction that enabled the adoption of the best interests of the child construct and to establish principles which promote a more equitable family and child well-being system (Dreyfus, 2020).

Differential community values

The Goldstein texts are shaped by US values as they are products of Yale Law School, and the Yale Child Study Centre. The individualistic focus of the best interests construct was also enhanced by Anna Freud's child development knowledge derived from her British clinical practice. Winnicott's good enough parenting proposal is drawn from an identical British clinical base but, as can be seen, the outcome is different. The explanation for this may be that Winnicott wrote independently and stayed within his knowledge base. On the other hand, Freud lent her knowledge to children right's lawyers who may have diluted her input.

Importantly, the Goldstein texts and the best interests construct that they promote are not value free. Indeed, Dallek (2018) the biographer of Franklin D. Roosevelt cites David Kennedy who pointed out that, in the US, in the 1930s:

> The Depression … revealed one of the perverse implication of American

> society's vaunted celebration of individualism. In a culture that ascribes all success to individual striving, it seemed to follow automatically that failure was due to individual inadequacy.
> (Dallek, 2018, p. 153)

The recent Trump presidency confirmed that this value position remains a central feature of American culture. Regardless of this, over time there has been little criticism or reworking of the best interests construct to account for cultural variations and the vastly altered social circumstances of families since the original publications. Nor has there been an examination of the way US social and political values (and the associated commitment to individualism) has influenced the best interests construct. In concert with the emphasis on individualised rights, a focus on parental psychopathology is embedded alongside the best interests construct. This thinking has influenced the development of clinical programmes such as Multi-Systemic Therapy, Child Abuse and Neglect (MST-CAN)® and Family Functional Therapy, Child Welfare (FFT-CW)®, that seek to change aspects of parental behaviour. The programmes essentially locate causation individually and do not take account of social factors.

What is remarkable is that the best interests of the child construct has been embraced by child protection legislators and practitioners from countries that have a commitment to a set of social values significantly different from the US. Britain, Australia and Aotearoa New Zealand for example, have generally subscribed to policy frameworks with a stronger social and community centred perspective (Everson, 2016a, 2016b; Forbes, 2019). The argument put forward in this article is that this construct consequently needs to be re-examined both because of its 46-year history and because of the cultural context of countries like Britain, Australia and Aotearoa New Zealand, where there is a commitment to a different set of social values from the US. There is of course, an increasingly vocal lobby in the US that seeks to change these social values. This drive is epitomised by the passing into federal legislation of the hard-fought Patient Protection and Affordable Care Act 2010, colloquially known as Obamacare, and described as *socialist* by its Republican opponents.

Poverty and social disadvantage

The next section of this commentary focuses on a range of social factors that have a significant bearing on the incidence of child abuse and neglect (CAN). A recent Australian study reinforces this position, and I quote:

> We estimate that 27% of all child maltreatment was jointly attributable to economic factors. These findings suggest that strategies that reduce economic disadvantage are likely to hold significant potential to reduce the prevalence of child maltreatment.
> (Doidge et al., 2017, p. 14)

This quotation confirms that poverty/economic disadvantage is a major influence on the incidence of CAN. Other research from the US provides evidence of the impact of economic inequality as a factor that has a significant influence on CAN (Eckenrode et al., 2014). From England, the Rowntree Foundation report, "The relationship between poverty, child abuse and neglect" (Bywaters et al., 2016) reaches a similar conclusion. Further confirmation is to be found in a later, UK four-nations study of child welfare inequalities (Bywaters et al., 2018). Given this evidence, some scholars are beginning to argue that there is a causal link between low income and child maltreatment, not just a correlation as is often stated (Cancian et al., 2013; Institute for Research on Poverty, 2017; Doidge et al., 2017). There is also much earlier evidence that underlines how living in an area of social disadvantage produces significant misery and depression and is undermining of good parenting (Ghate & Hazel, 2002). Furthermore, it is well established that child protection authorities engage in stricter surveillance of poor neighbourhoods and communities (Cocks, 2018).

Given that US and English studies underline poverty and social disadvantage as crucial factors in cases of CAN, these factors need to be examined before overly simple judgments are made about parenting capacity. It may be that these factors offer a better explanation for CAN and show why some parents, when under stress, abuse or neglect their children. In these circumstances, individual treatment interventions, resulting from an adherence to the best interests construct, can be viewed as inappropriate and misused, or at least as an incomplete explanation and response to CAN.

The work of Krumer-Nevo (2020) on poverty-aware practice for social work, coupled with that of Saar-Heiman and Gupta (2019) in relation to child protection that is based on the view that poverty is a violation of human rights and thereby a breach of social justice, further underlines the issue of poverty and CAN.

Disadvantaged communities

There are several epidemiological studies that look at the geographical distribution of CAN cases. A study in Hong Kong identified the neighbourhoods that generate the most cases of CAN. The neighbourhoods were distinguished by high levels of public housing and the low socio-economic status of residents (Government of Hong Kong, 2013). A similar study in Fort Worth that used a terrain-mapping methodology to predict CAN also found that geographic locations characterised as socially disadvantaged and with high levels of poverty were the places that generated the most CAN cases (Daly et al., 2016). An older study of the geographic distribution of child abuse cases in an inner London borough reports similar findings and suggests that the areas identified as generating a high level of CAN cases should be targeted for community-level interventions (Cotterill, 1988). From the UK, there is also a recent study of child welfare inequalities in England, Wales, Scotland and Northern Ireland that shows that structural inequalities between the four nations, differentially shape social care interventions in the lives of children and families (Bywaters et al., 2018). There is also a New South Wales (NSW) study that used post-code analysis to identify areas that generate CAN cases. As expected, the areas identified were low-income, socially disadvantaged communities (Weatherburn & Lind, 2001).

More recently, a 2020 special edition of *Children Australia* contained a section that focused on Poverty and Child Abuse. An article by Ainsworth (2020) in that edition offered commentary on this issue and cited key US and British studies that pointed to the social and economic origins of child abuse and neglect. In doing so, the article noted the sparsity of Australian studies about these origins.

The argument so far

The argument so far is that the best interests of the child construct, with its focus on the rights of the child and parental pathology to protect a child, has the effect of harming a child, except in circumstances such as non-accidental injury (NAI) (Hansen & Ainsworth, 2020). What the best interest construct has led to is an increase in the removal of children from parental care (Australian Institute of Health and Welfare [AIHW], 2021; Burns et al., 2017).

What this article proposes is a move away from this construct and, instead, a focus on the complex social determinants of CAN of which Bywaters' (2018) project on child welfare inequalities, has much to say. This is because a range of social determinants is viewed as offering a better explanation for the incidence of CAN than the best interests construct, with the result that this proposal has a *preventative*, not just a *surveillance and detection*, focus.

Substance abuse, domestic violence, and child abuse and neglect

Both substance abuse and domestic violence are critical challenges for child protection services (Maluccio & Ainsworth, 2009). The key issue is about the complex interaction between poverty, substance abuse and domestic violence. The National Council on Drug Abuse (NCDA) lists the following factors as common to poverty and substance abuse.

> Low status and low skilled jobs, unstable family and interpersonal relationships, illegitimacy, dropping out of school, high arrest rates, high incidence of mental health disorders, poor physical health, and high mortality rates.
> (National Council on Drug Abuse, 2018).

In turn, similar risk factors feature in accounts of domestic violence. They include:

> [A]lcohol and drug use, previous experience of DV, pregnancy, age, separation, violence by an ex-partner, disability (intellectual or psychiatric), financial stress, employment status, income source (*welfare*).
> (Australian Parliamentary Library, 2015).

Curiously, substance abuse is rarely mentioned in a special edition of *Australian Social Work* (April 2018) devoted to Child Protection and Domestic Violence, even though substance abuse is a feature of many domestic violence situations (Humphreys et al., 2018).

Given the above, there appears to be enough consensus that poverty, substance abuse and domestic violence are closely inter-twined and that, in some cases, this trio contributes significantly to the causes and consequence of CAN and other pernicious social ills.

Unemployment and child abuse and neglect

This section (and the next), of this article draw attention to the impact of unemployment and family structure on the incidence of CAN. Unfortunately, the best interests construct with the narrow focus on parental pathology obscures the way unemployment, and potentially family structure, increases the likelihood of CAN. In the US, the evidence points to the fact that children in families with "no parent in employment" are two to three times more likely to be the subject of maltreatment compared to children with employed parents (Sedlak et al., 2010. p. 11). This result is further confirmed by a recent English study of the impact of unemployment on child maltreatment (Brown & de Cao, 2017).

Contributing to un-employability is low levels of parental education that, in turn, leads to increased family stress levels. The result is that children in lower socioeconomic status households "experienced some type of maltreatment at more than 5 times the rate of other children; they were more than 3 times as likely to be abused, and about 7 times as likely to be neglected" (Sedlak et al., 2010, p. 11). It is likely that the situation in other comparable countries is similar.

Family structure and child abuse and neglect

There is also the issue of family structure and living arrangements. It has recently been argued that non-traditional family structures (e.g., single-parent families), place children in greater danger of abuse and neglect (Sammut, 2014). This author, a historian, is known for his off-centre views about child protection and the endorsement of widespread use of adoption of children from out-of-home care, His comment about family structure is in that category (Sammut, 2015; Sammut, 2017).

Nevertheless, evidence from the US does show that compared to children "living with married biological parents, those whose single parent had a live-in partner had more than 8 times the rate of maltreatment overall, over 20 times the rate of abuse, and nearly 8 times the rate of neglect" (Sedlak et al., 2010.

p. 12). We know that, in Australia in 2011–2012, at least 32.5% of cases of substantiated abuse and neglect came from single-parent families (AIHW, 2013, Table A9). These data are not included in the AIHW report for 2017–2018 or beyond.

Aboriginal circumstances

The issues of poverty and social disadvantage have special resonance for the Australian Aboriginal community, where the construct, the best interests of the child, has been applied and has resulted in an over-representation of Aboriginal children in out-of-home care (OOHC). Indeed, one third of all children in OOHC in NSW are Aboriginal (AIHW, 2018). This over-representation of Aboriginal children may be because the issues of parental poverty and community disadvantage have been largely discounted as factors in abuse and neglect cases. Colonisation and dispossession of native lands have powerfully reinforced Aboriginal poverty and disadvantage, and this continues to this day (Working with Indigenous Australians, 2021). The current allegiance to the individually focused best interest construct has resulted in far too many Aboriginal children being removed from family, community, and culture, at great cost to everyone. The Australian Bureau of Statistics (ABS) publish a social-economic index of areas (ABS, 2018) of advantage and disadvantage by local government areas. In NSW, the bureau nominates Brewarrina, Claymore, Lightning Ridge, Walgett, Wilcannia and Windale as the most disadvantaged post-codes. There are significant Aboriginal populations in these shires. AIHW also use the same index as the basis for a similar nomination (AIHW, 2018, p. 70).

The 2018 AIHW report further indicates that high rates of substantiation of abuse and neglect are linked to remoteness and areas of social disadvantage.

> Children who were the subject of substations were more likely to be from the lowest socioeconomic areas (35% in the lowest socio-economic area compared with 7% in the highest) (ABS, Table S12). Indigenous children who were the subject of substantiations were far more likely to be from the lowest socioeconomic areas (45%) than non-indigenous children (31%).
>
> (AIHW, 2018; Figures 3.5 and 3.6).

And herein lies part of the explanation as to why Indigenous children are over-represented in the OOHC population. Data about the overrepresentation of Black and Hispanic children in the foster care system in the US tells the same story (Williams & Offutt, 2020).

Alternative interventions

It has been argued in this article that poverty and social disadvantage are fundamental causes of the high incidence of CAN, and that the way to address this issue is not by way of interventions that are clinically focused. In this respect, the best interests of the child construct is unhelpful as far as these communities are concerned. The major child protection effort should instead be focused on prevention and be made up of community-building interventions. In fact, the focus on individual causation of CAN and its simplistic linkage to the best interests of the child with its moralistic overtones and potential explanatory bias, has obscured the social factors that may precipitate a CAN event.

This view is the result of the author's more than 10 years of Children's Court experience. This experience has included multiple conversations with parents about the impact of poverty on their child-rearing capacity. Other, similar conservations have taken place through calls by parents to the Family Inclusion Network – New South Wales (FIN -NSW) telephone information line (Ainsworth & Berger, 2014). In addition, there is evidence that child removal by child protection authorities, as reported by Bennett et al. (2020) worsens parental circumstances through the loss of income and social housing and makes restoration of a child to parental care less than likely (Broadhurst & Mason, 2020).

These proposals are, therefore, not about structural reform and the removal of social disadvantage and poverty, as desirable as this may be. Such reform is a long-term goal that would require a major anti-poverty campaign to encourage national and state government to act in relation to items such as income maintenance and social housing. An example is the Rowntree campaign (Rowntree Foundation, 2016) in England, although this is about poverty in general and is not CAN-specific. These items are beyond the traditional terrain of state child protection authorities. In addition, the long-term goal of structural reform will not aid parents who are currently accused of CAN that, for many, has its origins in social disadvantage and poverty.

My proposal is that child protection workers should work in the heart of a community, in schools and neighbourhood centres, and not in a distant town or city office. When located in high-needs communities, child protection workers can listen to parents and other community members, engage them and offer practical interventions such as budgeting, housekeeping, and parenting programmes relevant to low-income parents, as well as counselling when necessary. The focus should be on mentoring or teaching parents about how to manage their life circumstances and keep children safe (Ainsworth & Hansen, 2018), not about surveillance as a prelude to court action. Working in this way, child protection workers can identify with the community within which they work and, in turn, put themselves in a position to build relationships with vulnerable families. Once established, these relationships provide opportunities for interventions that modify inappropriate parenting practices and make children safer. You cannot do this from a distance or via office-based counselling. Workers must be close to the families in question. The issue with the best interest construct is that it moves child protection workers away from community involvement through its focus on individual parental pathology. In that respect, it isolates potential abusive or neglectful parents from other community members who might be supportive of these parents—one consequence of which is a culture of parent blaming, shaming and stigmatisation within child protection departments (Leigh, 2017). A community-level involvement ensures that the feared "knock on the door" late in the evening by departmental caseworkers who have arrived unexpectedly to investigate a possible risk of significant harm report (ROSH) is avoided—and that is in the "best interest of the child."

Protecting children is everyone's business

This heading is taken from the Annual Report of the Council of Australian Governments for 2009–2010 in relation to the National Framework for Protecting Australia's Children (Commonwealth of Australia, 2010). If protecting Australia's children is everyone's business, then a community focused approach (rather than individualised intervention) to the detection and prevention of CAN is called for.

The *social model* for protecting children as outlined by Featherstone et al. (2018) who coined the phrase "the atomised child" has many of the required features. In particular, the social model seeks to replace reliance on the justice system and individualised, government-sponsored, child protection services with community-based interventions. The argument is that persons living in local communities, and professionals, if they are embedded in these communities as suggested, will know the families that are struggling and vulnerable to the abuse and/or neglect of their children. Importantly, localised services are better able to reach out to these families, are less stigmatising, and therefore more likely to be able to engage these families in services that can prevent CAN. This is not to say that all families will respond to these initiatives. Some will not, and children may need to be removed from parental care. Nevertheless, this approach is likely to reduce the number of situations where removal of children from parental care, at least for a period, is necessary. An aware and vigilant local community ensures that these children are not left at risk.

In the Aboriginal community, this is illustrated by the endeavours of "Grandmothers Against Removal" (GMAR NSW). In NSW, these Aboriginal Elders (GMAR NSW, 2019) are working with the Department of Community Services to develop binding protocols to be followed in cases whenever the Department is considering the removal of children from an Aboriginal family. These protocols seek to involve the Grandmothers, as key representatives of the Aboriginal community, in the decision-making process. Before a removal decision is made, the Grandmothers ensure that community resources that might prevent removal have been fully utilised. If, the decision for removal is made (and the Elders do not oppose all removals), the Elders then make sure that the Aboriginal placement principles that are in the Care Act are observed (CYCP Act, 1988, s. 13). No child is left at risk. The social model of child protection, based on community ownership of the social issue of CAN, that is echoed in the title of this section of this article, is fully committed to maintaining the safety of children. It is also compatible with Winnicott's good enough parenting.

Conclusion

This article has raised questions about the utility of the best interests of the child construct. It has also promoted Winnicott's good enough parenting proposal as an alternative conceptualisation when CAN cases are under consideration.

In summary, there is concern about the underlying value base of the best interests construct. This construct grew out of work at Yale University and is influenced by the individualistic culture of the US. In addition, the construct is heavily influenced by Freudian theory as both Solnit and Freud were psychoanalytically trained psychotherapists. Moreover, the US culture that gave birth to the best interests construct holds parents fully responsible for CAN and largely ignores the influence of social factors, such as poverty and social disadvantage. As a result, when the best interests construct is in play, the focus in suspected cases of CAN is on individualised parental assessments and any case interventions are shaped by the belief that CAN is solely a product of parental psychopathology. In this article we have documented the influence of substance abuse, domestic violence, unemployment, and family structure on the incidence of CAN. All of which correlate with poverty and social disadvantage.

While substance abuse and domestic violence may require interventions that address parental pathology, not all CAN cases feature these issues as the dominant factors. When this is the case, individualised treatment models may serve an important purpose—but not otherwise. Finally, it is worth remembering that, between 2018 and 2019, there were 44,906 children in out-of-home care (OOHC) in Australia. The rate of indigenous children in care was 54 per 1,000 children, *11 times* the rate for non-indigenous children where the rate was 5.2 per 1,000 children (AIHW, 2020. Figures 5.1 and 5.4). It is highly unlikely that all these children were removed from families where parental pathology was the sole precipitating factor for their placements in state care.

We need a new balance between explanations about CAN that takes account of both poverty and social disadvantage and those that have a clinical focus on parental pathology. The Featherstone et al. (2018) social model for protecting children is a move in that direction. It is for the above reasons that the best interest of the child construct warrants critical re-examination.

A further move is that by the Anne E. Casey Foundation which, in 2020, announced a first-of-a-kind partnership between the US Children's Bureau, Casey Family Programs and Prevent Child Abuse America that aims to redesign child welfare into child and family well-being systems. This will almost certainly require a re-consideration of the best interests of the child construct and recognition of the contribution of poverty and disadvantage to child abuse and neglect. That poverty is a driving factor that shapes child welfare interventions is also highlighted in a "Protecting young children at risk of abuse and neglect" report released this year by the London based Nuffield Foundation (Nuffield Foundation, 2021).

Accepted 13 June 2021

Published 1 September 2021

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At home: Field education during lockdown

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ABSTRACT

Field education during the 2020 Aotearoa New Zealand Covid-19 lockdown was a new experience for social work educators and students alike. This case study captures the experience of one social work student during this time while on placement at the Salvation Army. Included in the account are the perspectives of the Community Ministries Manager, the placement supervisor and the placement field coordinator. Due to the Covid-19 restrictions, the student undertook the placement while at home. A pandemic can offer students opportunities to learn about managing difficult situations. Reflection on the experience provided insight into what helped and what could have been done differently. Regular debriefing, supervision and a post-crisis debrief were all important elements that aided the learning and supported the wellbeing of the student.

KEYWORDS: Field education; Covid-19; Social work education; Student experience

AOTEAROA
NEW ZEALAND SOCIAL
WORK *33(2)*, 114–117.

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In March 2020, Aotearoa New Zealand went into lockdown, intending to eliminate Covid-19 from the country. At that time Yesse, a social work student at the University of Otago was one month into her final placement at the Salvation Army. The following account is Yesse's impression of field education while under lockdown conditions. It includes the perspective of those working alongside Yesse to support her placement: David McKenzie, Manager, the Salvation Army Dunedin; Bronwyn Powell-Grub, Yesse's supervisor; and Liz McCafferty, Field Co-ordinator, University of Otago. There were several organisational supports required to make the placement work both from a practical perspective and to meet policy requirements. This brief Viewpoint article explores some of the lessons learned from the experience.

Yesse's account

In March 2020, I was one month into my placement at the Salvation Army working alongside transitional housing social workers and spending one day a week in the foodbank. The placement was going well and the focus was on observing social workers and formulating learning goals. There were many discussions at the Salvation Army about Covid-19, but as my thoughts were taken up with working towards developing a caseload of my own, I was not following the news closely. The news about COVID-19 did not make me think there would be major changes to my placement. The Salvation Army was an essential service and the manager (David) had spoken me about being involved in a work bubble. I was comfortable with this plan, as it seemed that my placement routine would not be disrupted. In conversations with David, we discussed how the Salvation Army would continue to work during the pandemic under government guidelines.

At the time lockdown was announced, I was in town doing the groceries, oblivious to the news. My university field education coordinator (Liz) rang me to say that the country would be going into lockdown in two days. Liz sounded optimistic about the placement continuing with no issue. Two days later I got another call from Liz, she told me that the University of Otago had decided that I could not attend placement onsite. I was pulled off placement, which was quite a shock as both David and Liz had seemed open to my continuing. I had assumed that there would be no problem continuing with placement, as it was in an organisation providing an essential service.

The following week Liz got in touch to say that placement could continue at home. David sent me the tasks that would shape my new lockdown-based placement. The outline was very different from my placement up to that point, so I needed to read the description and think before agreeing to continue. The new description of tasks included operating the phone lines into the service while I was at home and responding to any situations this presented. It was expected that most calls would be referrals for the foodbank and I was concerned that this might not meet my final assessment requirements. It was difficult to envision how my placement would be on a day-to-day basis by just reading the job description. While Liz indicated that I had a choice whether to accept the new placement, my financial constraints meant I had no other option than to continue. Passing the placement was important, but so, too, was the consideration of adding to debt if I decided to delay.

Returning to placement, it was clear that everyone had a great deal of work to do and the pressure was on. Observing this validated my decision to stay, as my contribution to the work had the potential to take the pressure off the other staff. The workload at the Salvation Army had risen due to a sharp increase in foodbank referrals. Compounding this was the fact that the foodbank usually had many volunteers supporting the work, so the restriction on volunteering under the level 4 rules increased the work for paid staff. Several workers had not worked in the foodbank before and had to learn this skill on the job. The foodbank was normally open a set number of days a week, but during level 4 the foodbank operated five days a week.

My role during lockdown involved being part of a team of people taking all the calls coming into the local branch of the Salvation Army. This kind of work was new to me and I wanted to be able to do a good job. I was nervous initially that I would give the wrong advice to people calling in. What really helped was David's availability. David let me know that I was able to contact him any time during a shift and that he would call me at the end of each shift. Initially, I phoned him a lot because I did not know how to respond to some of the phone calls and he was very helpful. It was reassuring to be able to debrief with someone, as David made himself available whenever I needed to talk. I was not alone in my uncertainty, as all the staff within the team were trying to work out how to do their jobs at level 4. Team meetings were held each morning via video conference and I talked individually with other members of the team. They wanted to hear how I was going and I wanted to hear how they were going.

I was more stressed by the work than I let on at the time. There were so many calls coming in in the first couple of weeks. In those weeks there would be two or three calls waiting while I was on the phone to someone else. It was non-stop and many people calling were in distress. Many people were suffering financially and needed food parcels. Some were facing household financial deprivation for the first time. Others just wanted to ring and talk, as they were living on their own and felt isolated and alone. Because I wanted the placement to go well, I did not talk about how hard it was on me emotionally. Support was on offer from weekly supervision; however, at the time of the events I was focused on getting through the day to day. The usual coping strategies that I relied on such as going to the gym or meeting up with friends were not available to me.

Conversations with staff who were doing the same work and also working remotely helped me manage the stress and made me feel less isolated.

I learned so much doing my placement in the way I did. I learned to be adaptable and to be able to do the work alongside the team. A learning opportunity came from receiving all the calls from around the community. I got to know how the community and individual members of it were being affected by lockdown. I had calls from Civil Defence referring people and calls from individuals who needed help. It gave me a good idea of how the community was coping and who was struggling—it was a completely different one than I had expected, as the lockdown affected many people who had not previously been struggling financially.

A positive aspect that came out of working in a crisis was that I formed strong relationships with the team I was working with. The shared experience of working during lockdown created a bond. When the lockdown was over and I was back on site it was easier to work collaboratively because of the relationships formed during lockdown. Working alongside the team as closely as I did gave me insight into how much the staff cared about the work they were doing. They genuinely cared about each person they worked with and the long-term outcomes for that person. This was demonstrated in small, significant, caring actions and the language they used when speaking about clients. The staff would listen to people, allow them to share their story and would do whatever they could to support community need. It demonstrated to me that you can treat people as human beings while working within complex systems.

The backdrop

Individuals from the Salvation Army and the University of Otago communicated to decide what needed to be put in place to provide Yesse with optimal levels of support. Bronwyn (supervisor) and David (manager) decided that they were committed to providing extra levels of contact to ensure that Yesse was well supported. This initially involved daily phone calls from the manager who became Yesse's field educator. The whole team had daily team meetings in the morning via video conference, in which Yesse was included. The field education coordinator committed to texting, emailing, and calling as regularly as was required by Yesse. Bronwyn provided supervision over the phone, on top of the extra work she had as a result of the pandemic. Bronwyn and David were committed to supporting Yesse's placement through to completion. They had a strong sense of loyalty to Yesse to ensure that her education could continue despite the lockdown.

Lessons learned

Elements of this placement provide useful considerations for field education placements in crisis situations. In a placement of this nature, the learning needs of the students have to be weighed up against the organisation's capacity to include a student during a crisis. The health of the community is the primary consideration. Without the manager's willingness to be a field educator and the supervisor to continue to offer supervision, the placement would not have been able to continue. As the pandemic environment becomes our established way of working, social work students' learning needs will continue to be important, alongside consideration of the capacity of the organisation to support the placement.

Communication through technology was a significant factor in the success of placement. The support requirements for a placement undertaken at home involved using technology in innovative ways. Video conferencing, texting, and phone calls all facilitated continued communication and Yesse was supported to do the work. Overcoming the challenge of supporting the student without face-to-face contact was necessary to make this placement possible. In this way, even though the student is physically isolated, they can remain connected.

A student in this situation might not hold all the same information surrounding the crisis as the rest of the people involved. While experienced social workers might be used to dealing with the competing demands of the practice environment along with demands outside of work, students are not always practised at this (Prost et al., 2016). Students have that extra level of concern around finances and passing the placement, which may mean their focus is quite different from other parties involved. Field education coordinators need to have full and frank conversations with students about the implications of a crisis. Being transparent with information in this way reduces confusion.

The effects of the crisis may mean those involved cannot fully reflect during the events, as they are focused on the immediate decision making (Prost et al., 2016). Students who are in the midst of a crisis situation will respond in human ways, focusing on the task in front of them and getting through it as best they can. Reactions of the brain to the stress can have the positive effect of helping them to accomplish tasks, but it can also restrict their ability to reflect with depth on what is happening (Prost et al., 2016). Educating students in the initial phases of a crisis placement about the human stress response has the benefit of lessening the impact of this stress (Prost et al., 2016). From Yesse's experience, regular daily debriefs were what reduced her stress levels and helped her progress with the work. What was missing from the structure of this placement was an externally facilitated debrief after the placement was over. We know from practice that this is beneficial for crisis practitioners and students. (Findley et al., 2017). This would have been useful for the student, manager, supervisor, and field coordinator.

With the right support, placements undertaken at home in a crisis can provide great learning opportunities. The experience of managing a challenging situation successfully can boost confidence in the student's abilities. This demonstration of resilience offers the student a sense of their strength when situations are challenging (Papouli et al., 2020). We know that positive relationships with others in the organisation facilitates learning (Young et al., 2016). Going through a crisis situation together can strengthen bonds and provide a good learning environment.

Conclusion

The factors required to make a field education experience possible in national emergency conditions will not exist for every organisation or every student. Students need to be in a position where they are prepared to undertake a different placement from what may have been originally outlined to them. If we want to continue to have more social workers coming into the workforce, finding ways to provide social work experience amongst pandemic conditions is necessary. As the pandemic continues and we adapt to a different way of learning, we must also adapt our placement approach to support social work education.

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Politics of the mind: Marxism and mental distress

Iain Ferguson
Bookmarks Publications, 2017.
ISBN 978-1-910885-65-9, pp. 149, paperback, NZD19.73

Like the author of this text, I was very influenced by the work of the Scottish anti-psychiatrist R.D. Laing during the seventies. In fact, although it was by a very circuitous route, reading the work of Ronnie Laing was one of the reasons I eventually became a social worker. Nowadays, I look back on the iconoclastic ideas of the anti-psychiatrists, as they became known, with a critical eye, but still recognise the value of their challenge to the psychiatric establishment. In this little gem of a text, which belongs on the bookshelf of every social worker, Iain Ferguson offers another challenge to mainstream psychiatry and the dominance of the biomedical model, but this time from a Marxist and materialist perspective.

The first chapter sets the scene and the context of the crisis in mental health facing the populations of all developed countries. According to the World Health Organisation, mental health conditions are on the rise globally: depression, for example, affects over 300 million people worldwide, and has become the single leading cause of disability in the world (WHO, 2018). In the opening chapter Ferguson explains why he chooses to use the term *mental distress* as a more neutral term than *mental illness*, a term that is less stigmatising and better captures the multidimensional nature of the phenomena. Mental distress is common in Aotearoa New Zealand with about four in five adults (aged 15 years or more) having experienced it personally or knowing someone who has (Kvalsvig, 2018). Although anyone can experience mental distress, in Aotearoa New Zealand, it is strongly associated with being young, deprived or Māori and with feelings of isolation (Kvalsvig, 2018).

Ferguson highlights the relationship between unemployment, beneficiary status and the intensification of work processes under neoliberalism as a key correlate of mental distress. These points resonate strongly with the New Zealand data where the highest levels of life satisfaction are reported by the retired population and the lowest amongst beneficiaries, people looking for work and students (Kvalsvig, 2018). Ferguson states that the central argument of his text is that “it is the economic and political system under which we live–capitalism–that is responsible for the enormously high levels of mental health problems which we see in the world today” (p.15). He argues in favour of a Marxist analysis that is *materialist* (recognises the material facts of experience), *historical* (acknowledges the impact of current political and social forces) and *dialectical* (rejects reductionism in favour of an approach that traces the interaction between material circumstances and human agency).

In the chapters that follow Ferguson develops his argument with clarity and rigour. Chapter two, *All in the Brain*, summarises the history and hegemony of brain-based psychiatry from models of madness in antiquity, to the history of the asylum, to the current dominance of the *Diagnostic and Statistical Manual of Mental Disorders* (produced by the American Psychiatric Association) which has, as Ferguson argues, “contributed to the medicalisation of human nature and everyday life” (p.43). The following chapter on *Marxism and Psychoanalysis* gives a well-rounded assessment of the contribution of psychoanalysis to our understanding of mental distress contrasting the conservative views of conventional Freudians on sexuality with the feminist psychoanalytic perspectives of Juliet Mitchel and others. Included in the scope of this chapter is a fascinating aside on the positive attitudes towards psychoanalytic thought held by members of the Bolshevik party in the early years of the Soviet Union and a section introducing some key ideas from the "notoriously difficult" (p. 69) French psychoanalyst Jacque Lacan.

Chapter four addresses the anti-psychiatry movement of the 1960's and 1970s associated with the work of R.D. Laing, David Cooper and Thomas Szasz, outlining the similarities and differences in thinking between these anti-psychiatrists and how their arguments developed over time. Ferguson's assessment of R.D. Laing is particularly well-informed, finely nuanced and compelling (see also Ferguson's classic book review of *The Divided Self* elsewhere in this issue). The penultimate chapter on *New Challenges to the Psychiatric Hegemony* offers an assessment of contemporary alternatives to the prevailing biomedical model including trauma studies, dissociation, attachment theory and the mental health service user movement. In this chapter Ferguson critiques the arguments of the University of Auckland sociologist Bruce Cohen (Cohen, 2016) who argues that a Marxist analysis of the hegemony of psychiatry leads inevitably to a recommendation for the wholesale abolition of psychiatric services, a perspective that has an odd alignment with the views of the Church of Scientology (McAllan, 2021). As Ferguson asserts, arguments for the abolition of psychiatric services that are already under significant material duress would be, "music to the ears of right-wing politicians" (p.116) and bring nothing but misery to people experiencing mental distress and their families. Rather than abolishing psychiatric services, Ferguson argues for a radical, humane, social and dialectical approach:

> A model for mental distress which recognises–and provides empirical evidence for–the causal role played by early life experience, poverty, inequality, racism, sexism and other forms of oppression in the genesis of mental health problems is a huge step forward from a model which locates such problems primarily in faulty genes or biochemical deficiencies. The fact also that the new paradigm does not discount genes, brains and biochemistry but rather emphasises the interaction between our brains and our environments...allows for a much more dialectical understanding of mental distress (p. 104).

In the final chapter *Taking control: Alienation and Mental Health* Ferguson contrasts the views of human nature espoused by Freud and Marx with the former highlighting the struggle of the ego to repress the unruly needs of the id, and the latter emphasising the compelling need for humans to produce *the means of subsistence* by transforming the world through labour. Ferguson argues, from a Marxist perspective, that what makes us truly human is the ability to consciously control our own labour. And yet, it is precisely this aspect of our humanity that is most suppressed by an economic system founded on class division, competition and ruthless individualism. The key Marxist concept for thinking about mental distress, Ferguson argues, is alienation: alienation from the products of our labour, alienation from the labour process and alienation from each other. The real value of the Marxist concept of alienation is that it helps to trace the impact of capitalism on social relations and on individual consciousness. The societal impact of four decades of neoliberalism has not only deepened economic inequality, it has induced profound sense of powerlessness, disconnection and precarity. Ferguson argues that we need more than a revolution in mental health services, to counter these conditions, and concludes that:

> …the priority for all of us who wish to improve our own mental health and the mental health of those around us is both to participate in collective struggles for more and better mental health services–to support the shift back from "worry lines to picket lines"–and also to fight for a world where such services are no longer required (p. 134).

Reviewed by **Neil Ballantyne**, Senior Lecturer in Social Work, Open Polytechnic of New Zealand

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Trauma, women's mental health, and social justice: Pitfalls and possibilities

Emma Tseris
Routledge, Australia, 2020
ISBN 9780367660277, pp.138, paperback, NZD86.89

This book encapsulates some of the central tensions in social work that have occurred historically and occur today. Where should social work place its energies in the change-making endeavour? While what sets social work apart from other helping professions is its commitment to an examination of power and oppression in relation to social justice, often where it ends up focussing is in keeping people's heads above water in relation to access and advocacy or in helping people "fix" themselves through therapeutic processes. (See for example, Payne, 2021, or Dominelli, 2003, for a further discussion on approaches.) This is often evident for social workers working in mental health systems co-opted by medical models, but also occurs in relation to our work with trauma.

Emma Tseris is a Lecturer in Social Work and Policy at the University of Sydney and was previously a social worker working in the child and adolescent mental health area. She has published extensively in the areas of critical mental health and gender issues and brings both her academic and practice experience to this book. Her central premise is that, while trauma-informed theories may have come some way in validating women's experiences of gender-based violence, and moved us beyond psychiatric paradigms of symptom presentation, we need to be careful of this "new" view and not accept it without question. She advocates for a critical consideration of trauma-based models which, for the most part, still locate the problem and solutions within women, and ignore the socio-political and power contexts that are the sources of/cause the trauma in the first place.

Chapter One sets the scene, beginning with an introduction to trauma paradigms, situating it within a post-structuralist and feminist understanding that the defining of trauma itself occurs within socio-political and professional contexts which may not always place the voices of women service users at the forefront.

Chapter Two considers the evolution of mental health and trauma discourses and sits current views within a neoliberal paradigm which encourages personal responsibility for recovery and change and paints all women who have experienced trauma as "damaged". While a strengths perspective, focus on resilience and recovery-oriented approaches appear to move the narrative towards more consideration of social causation, Tseris contends that "they are often limited by their ongoing acceptance of notions of individual 'dysfunction', an insufficient analysis of how notions of mental health are shaped by power relations, and an over-reliance on therapy as a strategy for managing distress" (p. 14). She advocates for more critical analysis, which examines how psychiatric diagnosis and treatment occurs within "Eurocentric, masculine, and heterosexist norms and power relations" (p. 21).

Chapter Three presents the evolution and growing use of trauma-informed narratives within psychiatric settings. Tseris believes that there has sometimes been an uncritical acceptance that this has enhanced women's experience of mental health settings, and that there is still a need to consider symptoms of things such as Borderline Personality Disorder and Post Traumatic Stress Disorder within structural forms of oppression. She discusses the experiences of indigenous peoples as an example of how once intergenerational trauma may have been relegated to individual symptoms but is now understood more in relation to the effects of colonisation and ongoing racism.

Chapter Four considers some of the recent narratives in neuroscience and accepts that, while some feminists initially welcomed the apparent validation of the impacts of trauma (women maybe were not just making it up!) that there is a worrying trend to once again align trauma response to a medical view, and that women are encouraged to take responsibility for changing themselves, rather than looking to social and power structures that do not address violence against women in society. A consideration of negative presentations of impacts of trauma on mothering is also explored.

Chapter Five describes the results of a qualitative narrative research project exploring the views of women who have experienced gender-based violence and their experiences of navigating mental health services. This study revealed that most of her subjects (n = 18) saw therapy as a tool for moving beyond their trauma experiences. Tseris argues that this is once again a reaction to discourses which value this approach and that there is often little else is available to women.

The final chapter considers alternative possibilities and the de-therapising approach to working with women who have experienced trauma. Tseris states that we must "explore both the hazards of pathologising women and enacting unwanted mental health interventions that medicalise women's experiences, while at the same time avoiding a cruel detachment from the immediate needs of women in distress" (p. 112). This brings us back to social work's mission of ensuring that the structural issues maintaining the problem of violence against women are considered in all areas and that interventions, which include social action, community development and provision of adequate resources for women to live safely, are all important.

While not always an "easy read," this is an important book for social workers and other social service and mental health practitioners to remind us of the ongoing importance of a critical feminist consideration of the work that we do, however well-intentioned we are. This is important so that we do not contribute to situating the problem within the person and forgetting about some of the important structural issues that enable violence against women and children to be perpetuated.

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Effective leadership, management and supervision in health and social care (3rd ed.)

Richard Field and Keith Brown (Eds.)
Sage, London, 2020
ISBN 978-1-5264-6840-6, pp.213, paperback, approx. NZD40.00

Kia ora koutou! Ko Parehaka tē Maunga

Ko Hatea tē awa

Ko Pākehā tē iwi

Ko Tangiteroria te hapori

Ko Emerge Aotearoa te māhī

Ko Diane āhau

I was attracted to read this book as I am in a role where I am managing two small teams within a mental health residential setting. I am a registered social worker and I have been working as such since 2001. I have predominately worked across health services. This is my first management position, and I was briefly in a mental health professional role which also required some coaching and mentorship. I have previously competed a postgraduate Diploma of Social Services Supervision at Massey University (grad 2014) and this year I also have attended two full days of leadership training in my organisation. My first impressions were that this book led on from these learnings and strengthened my understanding in both leadership models and practice.

This book is based on an English health and social service system where the focus is on the wellbeing of older people. However, I believe that there are similarities in the issues discussed, both here and in the UK. The main one being: the helping professions and this field of practice bring multiple challenges, in particular, resourcing and complex presentations of those people we work with. I found the book to be easily read. It outlines clearly its objectives, uses simple language, and it poses questions for review within each chapter. This book has two editors, who have included a cross-section of views including chapters from a nurse consultant, a specialist in leadership development an event facilitator, a researcher and a social work consultant. This is the 3rd edition.

The introduction of the book discusses some basic assumptions including what leaders do and how they do things is important. Self-leadership is a concept I first heard this year, but on reflection I have been practising for a long time. On a personal level, it is about continual learning, both in professional and personal worlds. In a management context, it is about getting the team to also engage, so they aren't doing just the "basics" but that the work is almost a cross-over into their own life journey, "all development activity should be an opportunity for both personal and organisations growth leading to better outcomes for patients, service users, staff and other stakeholders" (Field & Brown, 2020, p. xv). Supervision is identified as a key tool along with a management style which is authentic. There is also a focus that staff need both challenges and support to be effective workers.

There are 12 chapters after the Introduction. These are: Context; Leading services and care for older people; Self-leadership; Developing your leadership style; Supervision; Leading successful teams in health and social care; Strategic thinking, commissioning and planning; Effective budget management; Leading the workforce for health and social care services for older people; Impact evaluation of leadership programmes; Developing collaborative skills; and Further key theoretical perspectives.

The structure of the book also is easily engaged with. Each chapter begins with "Chapter outcomes" and it is anticipated that you will understand the concepts outlined here by the end of the chapter. Next in each chapter is an introduction, then the development of concepts and ideas. The review/reflection points are included in this part of the discussion. The chapters then end with key learnings. As well, the book offers case study in practice; you do not have to work with the elderly to get a lot out of the book. I thought the concepts linked well with my field of practice, mental health, and more recently, mental health with adults and older people.

I thought this book was well worth a read. There are some significant challenges in making the time, and then being able to realistically implement the learnings. This is a challenge always! I think the authors do a pretty good job of holding a balance of practical interventions and helping us to think about what is practical. I do think you could use this book to just look at chapters which you need at the time. For example, self-leadership is a concept I am relatively new to, so it was great to read and extend my understanding on that. However, the chapter on budgets I am not quite ready for (and also am not really in control of yet) so I could scan this, but focus on the things I was more interested in.

Reviewed by **Diane Smithson**, Service Manager, Emerge Aotearoa